Psychosexual Counseling in Andrological Surgery

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A Multidisciplinary Approach to the Patient and His Family

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Foreword

The Centre for Sexual Medicine at the Department of Urology, IRCCS San Raffaele, Milan, Italy, was established in 2000. Eighteen years on from the first integrated andrologist-sexologist approach, and under my scientific direction, Prof. Andrea Salonia and Dr. Elena Longhi have adopted a multidisciplinary approach to resolving male and female sexual dysfunctions, of pathological, surgical, and psychogenic origin.

Clinical and research activities have often shown how the andro-sexological approach delves deep into the clinical and interpersonal reasoning of each individual patient.

In this way, a personalized approach toward the patient, the clinical history, and the couple's relationship and toward the implications of the same for the quality of life of each individual is built, thus favoring a strong therapeutic contract and the patient's compliance.

Discussing psychosexological rehabilitation in the andrological surgical approach may seem reductive, but team discussion of each individual surgical theme highlighted in this text offers an analysis of the variants of the pathology and above all an in-depth approach to the individual themes of the patient and the partner.

The surgeon, the psychosexologist, and the medical and paramedical staff constantly interface to promote patient compliance and to accompany the patient from diagnosis to hospitalization, from surgical treatment to discharge, and from the resumption of sexuality to dealing with everyday life.

What kind of psychosexologist are we talking about? A clinician, familiar with the use of video recordings of surgery, an expert in neurological and psychiatric rehabilitation, with training in psychotherapy but no stranger to the clinic. How is this achieved? Not without neuropsychological knowledge of post-traumatic stress and the resulting behavior dynamics.

A hyper-specialized team, respectful of one another's competences and accustomed to debate and communication, where the psychosexologist becomes a "facilitator" of the clinical and therapeutic process, a support for the emotionality of the patient and the partner (or family), and a counsellor for the surgical team, all of these functions are performed with professionalism and empathy.

Each therapeutic team has its own communicative style and a volitive clinical approach, and the choice of the psychosexologist cannot ignore these characteristics.

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Foreword

On the Importance of the Sexological Approach in Andrological Surgery

As stated by Dr. Leonore Tiefer, the ability to procreate, to fulfill the conjugal duty and potency are requirements for the male role everywhere in the world. Before some years, as medical professionals, we still called the loss of this male role "impotence." We have since recognized that "erectile dysfunction" is probably better terminology, for according to Kelley when a man says to his partner that he is impotent, he is saying much more than that his penis cannot become erect. In spite of progressing insights and nuances in the definitions used in the field of andrology, feelings of impotence in the male role as a whole still accompany many andrological conditions such as Peyronie's disease, erectile dysfunction, penile cancer, infertility, and low testosterone. It is evident that throughout the course of these conditions, from the first symptoms to diagnosis to treatment, the sexologist plays an important role in guiding these men by counselling to achieve an increased understanding and acceptance of their condition, as well as defining realistic treatment goals and/or alternative strategies to keep enjoying their sex life.

There are several examples where the sexologist comes in to play a key role in achieving the best attainable result in andrological surgery. The technical and mechanical success of penile implant surgery has been evidenced by a large body of literature. However, thoroughly conducted follow-up studies show that a relatively large proportion of patients and partners fail to achieve sexual satisfaction, and a surprising proportion only infrequently uses their prosthesis. In this setting, both pre- and postoperative (psycho) sexological guidance of the couple has proven successful in both setting realistic expectations, as well as identification of barriers in the postoperative period to resume sex successfully, especially taking into account the fact that these couples have frequently been devoid of penetrative and/or other forms of sexual activity for long periods of time between diagnosing erectile dysfunction and final surgical treatment. They have often undergone a series of unsuccessful and thus frequently disappointing medical approaches, further decreasing their self-confidence. Likewise, sexological counselling may just as well be an integral part in a holistic vision toward incorporation of intracavernosal injections or PDE5 inhibitor therapy in a couple's sex life. In our institute, we do indeed send the

large majority of penile implant candidates to the sexologists to receive additional counselling. While the urologist often focusses on the technical aspects of surgery and erectile dysfunction treatment, the sexologist creates realistic expectations on the impact of penile implant surgery on the couple's sexual dynamic.

Peyronie's disease is a currently incurable, sexually debilitating fibrotic disease of the penis that results in penile deformity, coital failure, erectile dysfunction, and significant psychological stress for patients and their partners. It has a devastating impact on mental health, as it was shown that an overwhelming 48% of men with this condition develop a clinically meaningful depression. It is therefore important that these patients not only receive medical information on their condition but are also counselled by a psychosexologist on the potential detrimental effect of their condition on their mental and sexual well-being. In terms of surgery, there are currently no ideal surgical solutions for these patients. Just like the disease itself, the surgical procedures currently widely practiced for the treatment of Peyronie's disease can have devastating impact on the patients' self-confidence, body image, and sexual satisfaction as side effects which include penile shortening (plication procedures), numbness or hypesthesia of the glans and foreskin (procedures with mobilization of the neurovascular bundle), and sometimes loss or impairment of spontaneous and erogenous erectile capacity (including the need for penile implant surgery). Again, it is evident that a completely happy patient and partner can only be achieved if both pre- and postoperative sexological counselling is done in a rigorous fashion.

Penile cancer patients form a complex group of patients who do not only face the fear for the life-threatening aspect of their disease but also undergo often mutilating and disfiguring surgery to treat the primary tumor. While advances in organ-sparing surgery have been made over the past decades, a significant proportion of patients still face penile loss, shortening, or surgeries that—while preserving the erectile capacity—have a lasting impact on the esthetical aspects and sensation of the penis. The fears and worries surrounding both quality and quantity of life issues in this group of patients should be targeted, and regarding the profound impact on sexual function, the psychosexologist is indeed best suited to execute this delicate task.

Summarizing, the role of the psychosexologist in counselling, guiding, and treating patients planned to undergo or having undergone andrological surgical procedures cannot be underestimated and is of capital importance in a modern holistic and patient-centered healthcare setting. In this book, Dr. Longhi and colleagues provide more in-depth and detailed information on the various aspects of psychosexology for andrological surgical patients, which I am sure will help you forward in developing your practice in this field. I wish the reader a pleasant and educative read.

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Foreword

I primi anni della mia storia di medico li ho divisi tra l'ospedale e il mio studio di medico di famiglia. E mi sono spesso confrontato con storie di pazienti che dovevano subire, o avevano subito, interventi chirurgici andrologici. A quel tempo, soprattutto per la chirurgia prostatica, l'arrivo di complicanze come l'incapacità di raggiungere o mantenere l'erezione e l'incontinenza erano purtroppo frequenti. E quando si tocca la sfera della propria sessualità, pur comprendendo che quell'intervento probabilmente ti ha salvato la vita, l'ansia del paziente per le possibili conseguenze è altissima. Ho accompagnato diversi pazienti in sala operatoria e li ho poi seguiti nel tempo. E mi raccontavano, a volte disperati, di com'era cambiata la loro vita sessuale, cambiato il rapporto con la propria compagna, e anche il loro approccio con una nuova donna. E il terrore di "non farcela", malgrado l'arrivo dei farmaci per la disfunzione erettile, che pure molto son serviti. E l'eiaculazione retrograda o la mancanza di eiaculazione. Insomma, un diverso sentire del proprio corpo. E una vita segnata dal prima e dopo l'intervento. Ecco, a quei tempi avrei davvero avuto bisogno di avere accanto una professionista come l'autrice e curatrice di questo volume, in grado di spiegare come affrontare gli eventuali esiti di questi interventi. E per spiegare che spesso è solo la paura che non fa funzionare, che la sensibilità e l'orgasmo possono essere diversi, ma sempre piacevoli. E che si è uomini anche senza la prostata. E, anche, per spiegare alle partner come affrontare una nuova vita sessuale di coppia.

Oggi, con l'arrivo della "chirurgia robotica" le cose son cambiate. Ma la preoccupazione dei pazienti per questo tipo di interventi rimane altissima. Per questo, il ruolo dello psico-sessuologo è - e resterà – essenziale. Per "riattivare" velocemente il paziente, e aiutarlo a riprendere una vita sessuale, forse diversa, ma comunque appagante.

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Foreword

Uro-Oncological Surgery is a delicate surgery, which both in the case of Radical Cystectomy and in the case of Radical Prostatectomy affects the sexual function of our patients.

In recent years, our surgery has undergone an exponential evolution. We have moved from open surgery to laparoscopic surgery and, more recently, to robotic surgery. Already with laparoscopy, the operation had become much less traumatic involving much less physical effort for the patient. In fact, what we call the "surgical disease" was absent. The absence of pain in the postoperative period, the conservation of blood crisis due to the lack of hemorrhaging and, in synthesis, prompt recovery, had an extremely positive impact on the patient. With robotic surgery, this situation has further moved in a positive direction given the greater precision of the operation, which has resulted in even less trauma for the patient.

Moreover, it would be very regrettable if the surgeon were to think of solving all the problems associated with these destructive operations by means of surgery alone.

A destructive act by definition but one that today, thanks to the increase in our knowledge and the synergy with psychology, sexology, and neuro-urology, enables us to see the patient not as the bearer of a life-threatening disease but as a person who can and must be helped in a positive way in his journey toward a "Restitutio ad integrum."

In 1999, I did an epistolary survey of about 500 patients who underwent radical prostatectomy and, to my surprise, many of them complained that they had not received adequate psychological or functional support after surgery. This last word comprised not only the rehabilitation phase of continence but also the resumption of sexual activity. It was obvious to me that the surgeon does not have the ability, the training, or even the time to follow his patients through this rehabilitation process. It was then that I realized the need to organize a team of professionals to fill this void.

The first aspect, perhaps the most important, was undoubtedly the psychosexual aspect. In fact, neuro-urological rehabilitation is able to accelerate the recovery of urinary continence, but it is the loss of sexual life that can easily lead the patient to a quite severe depression.

In our shared work experience, we have learned many things that you will find in the framework of this valuable book. I would also like to draw your attention to the

importance of a patient–psychologist relationship that must begin even before the surgical operation and precisely within that limbo that leads from diagnosis, with its surgical indication, to the moment of hospitalization.

Those are the days, and unfortunately sometimes weeks, in which the patient is abandoned to himself and accumulates sometimes deadly amounts of stress. All this can be avoided or at least corrected, with appropriate and professional psychological assistance.

The other very important phase is obviously the postoperative rehabilitation phase, where the collaboration between the psychologist and the patient should always be extended to the partner as well. In fact, a therapy without the involvement of the partner would have little chance of success and in our experience we have seen that the best results are obtained when the couple functions well.

I would like to close these few words with a heartfelt thanks to Dr. Elena Longhi who has helped us in recent years to become aware of our patients' problems. The multidisciplinary approach to postoperative rehabilitation has certainly helped our patients, but it has also enabled us surgeons to better perform our profession.

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Preface

There are many ways to practice a profession as delicate and complex as that of the psychosexologist. I have always chosen to learn: from doctors, surgeons, nurses, and patients. I was fortunate to have many mentors who gave me the opportunity to enter the operating theater, to understand the complexity of their profession, to learn their language. Practical, certain, and capable of turning all sorts of knowledge into action. Without hierarchy and without competition.

I was welcomed by the most experienced nurses, not only so that I might learn about pharmacological formulations but above all about the ways of administering them, not without space for communication but listening to the patient and family members.

Although coming from a background in psychological studies, I studied these disciplines on the ward, transforming my profession into that of a clinician who learns rather than remaining in the realms of a science which, due to prejudice, is often perceived as "vague, made of abstract words, of emptiness."

While specializing, I was fascinated by the publication by Milton Erickson, entitled *My Voice Will Go with You*.

I have personally experienced, speaking with patients, during these years as a professional, that very often I have become, against my will, a mental ritual for many of them: "I was reminded of what you told me Doctor and ..." "I did my homework, like you told me to ..." "how many times you came to mind ...."

I feel lucky to have always had patients motivated to tell me their story, their knowledge of life, sharing with me the deepest part of their sensitivity. They have taught me to have a "centimeter more of courage than of fear" and to want to build at any cost. Maybe I also projected a part of my personal history. I owe my survival to a neonatal surgeon.

Since then, I have always tried to see beyond the pathology, to make the patient as much a protagonist in the disease as in health.

This book, the first of a trilogy, on Clinical Sexuality aims to show how the multidisciplinary approach satisfies all the protagonists. Among the specialists, it facilitates communication, intensifying interpersonal and professional relations without affecting their clinical autonomy or their contract of trust with the patient. I still think that the contract par excellence is between the andrologist surgeon and the patient, while the psychosexologist is a "facilitator of the entire therapeutic process of the individual patient."

As I often say, “a bespoke tailor” invests in the individual patient and not in the pathology, making a unique approach, not forgetting the discussion with doctors, surgeons, and nurses.

The stories of patients and their partners show how the process of the disease also highlights “the couple’s contract,” the type of relationship between the two, the sexuality, the plans for the future, the relationship with physicality, and the relationship with the medical environment and hospitalization.

Even patients who are “difficult” in character or temperament are often the “supervisors of a medical team” which sometimes gets distracted, gets too involved, and has difficulty communicating with any type of patient. Even doctors, like the rest of humanity, sometimes struggle to communicate with characters removed from their own sensitivity, and the psychosexologist may be helpful in easing tensions, misunderstandings, or just fear or fatigue reactions, on both sides.

The psychosexologist: a deus ex machina? Certainly not. Rather, a clinician who wants to make every meeting with a colleague, a patient, and a family member a motive for learning and well-being.

It is customary to thank the experts in these cases and to give them heartfelt gratitude. I like to turn my gratitude to anyone, doctor, patient, family member, who has allowed me to enter their life and motivate a new narrative.

I thank the one who taught me to respect the fragilities of others, to stimulate healthy female enterprise, and never to be without a smile, a feeling, and a human and therapeutic complicity, with humor and simplicity: my father.

Milan, Italy Elena Vittoria Longhi

Preface

Cooperating with a Psycho-sexologist in Surgical Andrology—The Andrologist's Perspective

Compared to other surgical fields, andrological surgery entails specific psychological aspects and peculiarities. In any kind of surgery, in fact, patient expectations and hopes are usually very high since it is considered the faster and more effective solution in resolving the problem in a definitive way. However, when the problem entails his sexual organs, the penis in particular, and his sexuality, psychological implications are usually deeper and more consistent and therefore expectations are even higher. Body images, concerns, and dysmorphophobias are also magnified and are of relevance when dealing with the genitals compared to other body parts. This is why when we assess an andrological patient and offer him a surgical solution, a special care has to be given to the immediate and delayed psychological consequences of that procedure on that specific patient. Although in some instances the sensitivity and experience of the urologist–andrologist might be enough to evaluate and address the psychosexual aspects of a patient to be operated on, in most situations the help of a psycho-sexologist is advisable.

For example, patients who develop penile deformities due to fibrous plaques of Peyronie's disease are commonly psychologically distressed for the deformity and indications to surgery must be properly addressed by the andrologist after careful assessment of their psychological status and real reason for distress: penile aesthetic appearance, difficulties or discomfort during intercourse, dyspareunia, presence of erectile dysfunction. Indications to and type of surgical reconstruction may vary significantly according to the reason of distress perceived by the patient. Another typical situation is represented by the youngster who requests augmentative surgery for a supposed inadequate size of his genitalia (dysmorphophobia), or by the old patient who requires a penile hydraulic prosthesis implantation. The psychological implications of all these conditions are often better detected and investigated by a dedicated psycho-sexologist, with a structured interview or with the aid of specific questionnaires aiming at assessing the impact of the condition on the patient well-being, mood and sexual life, and the chances of surgery to improve patient satisfaction and psychological status [1, 2].

Therefore, there are many reasons why a psychological consultation represents an advantage, if not a necessity, in the assessment and treatment of andrological patients who require a surgical procedure.

And what about the drawbacks of patient referral to a psycho-sexologist? Probably the only ones are represented by increased costs and time, or by the patient refusal of a psychological assistance not to be considered a "psychological patient." To partly avoid this last situation, an optimal care might be represented by a combined simultaneous patient consultation by the andrologist and the psychologist, but this situation is hardly possible and logistically difficult. What appears to be a good solution is to refer patients to the psychologist specifically trained in sexology, providing specific questions or surgical indications, maybe grouping them on specific days in the same consultation room of the andrologist. Patient will be happy to be thoroughly investigated preoperatively in the same center without feeling himself a "psychological patient." The andrologist will take his final decision after reviewing the psychologic consultation report.

Once the indication to surgery has been confirmed, special attention is to be made to the informed consent acquisition. Legal considerations are in fact very important in this kind of surgery. Experience has shown that in andrological surgery the rate of legal litigation is higher than other kind of surgery. First of all, an accurate psychosexual history and physical examination must be obtained. After this, a careful explanation of the proposed intervention, and of its most frequent complications, has to be given, possibly with the aid of drawings and schemes. The psychologist in many instances can help the patient in the understanding and decision-making process of giving the consent to surgery.

In conclusion, when dealing with surgery and its consequences, psycho-sexologists are the andrologists' best friends!

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