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Self-Monitoring and Self-Focus in Erectile Dysfunction

Catherine S. Fichten, Eva Libman, Janet Takefman, and William Brender

Self-focused attention can cause anxiety and poor performance in those with low self-efficacy expectations. Self-monitoring is frequently used in sex therapy assessment. If self-monitoring is conceptualized as a self-focusing manipulation, it would be expected to cause "spectatoring," anxiety and deterioration in individuals with erectile dysfunction. Therefore, this investigation explored the relationship between the dispositional tendency to focus attention on the self (self-consciousness) and sexual behavior in males with erectile dysfunction, and evaluated the effects of self-monitoring on erectile dysfunctional males who differed in dispositional self-consciousness. Results indicate that (a) individuals with erectile dysfunction were less dispositionally self-conscious than nondysfunctional individuals, (b) self-monitoring had no adverse effects on any aspect of sexuality investigated, and (c) manipulated and dispositional self-focus had no interactive effects. Implications of these results for sex therapy and for a better understanding of etiological and maintaining factors in sexual dysfunction are discussed.

Self-regulation models generally propose a self-evaluation and feedback process whereby individuals monitor their behavior and compare it against some ideal or standard.¹⁻³ Should performance fall below the "standard," attempts are made to reduce the discrepancy. When self-efficacy expectations concerning performance are high, positive affect and improved performance are likely. Conversely, when self-efficacy expectations are low, awareness of the discrepancy between one's perform-

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ance and the "standard" can result in withdrawal, anxiety and impaired performance.⁴

These self-evaluation and self-regulatory processes are generally enhanced when attention is deliberately focused on the self by the presence of television cameras, observers or a mirror.^{1,5} Attention focused on the self through the presence of a mirror appears to make people more aware of their own bodies and internal states (private self-focus), while self-focused attention instigated by the presence of television cameras and observers seems to cause people to become more aware of how they are perceived by others (public self-focus). The Self-Consciousness Scale developed by Fenigstein, Scheier and Buss⁶ measures the dispositional tendency to be aware of 1) one's private thoughts and feelings (private self-consciousness) and 2) the impression that one is making on others (public self-consciousness). Self-focused attention manipulated by the presence of a mirror and dispositional private self-consciousness appear to have similar effects on a host of variables.⁷ Manipulation of self-focus through the presence of television cameras or observers and dispositional public self-consciousness also have comparable consequences.⁸ Regardless of whether the focus is on the private or on the public aspects of the self, focusing attention on the self actuates self-evaluation and self-regulatory processes.⁴ Therefore, any form of self-focus (private or public), whether manipulated or dispositional, can be expected to interact with self-efficacy expectations in self-regulation, facilitating performance and inducing positive affect in those who expect to do well and causing deterioration in those who expect to do poorly.

It has been suggested in the clinical literature that *excessive* self-focus, public self-consciousness in particular, may lead to heightened anxiety and impaired performance.⁸⁻¹⁰ In particular, individuals who expect to do poorly, by focusing on probable negative evaluation by others and on the unattainability of the "standard," are likely to feel anxious and to ignore available external cues which could facilitate performance. In the sexual dysfunction literature, it has been suggested that private self-consciousness may also be implicated in erectile disorder.¹¹

The technique of self-monitoring, whereby clients keep daily records of their behavior, is a frequently used assessment strategy in behaviorally oriented therapies. Self-monitoring is used to obtain a baseline prior to treatment, to evaluate progress during therapy, and to determine therapeutic effectiveness. In spite of its typical use as an assessment technique, it is well known that self-monitoring is often a reactive process which causes either improvement or deterioration.^{12,13} Data on the conditions which lead to one or the other effect are, however, far from conclusive. Conceptualizing self-monitoring as a self-focusing manipulation would suggest that reactivity is due to enhanced self-regulatory processes. Thus, individuals with low self-efficacy expectations who monitor problematic behaviors would be expected to withdraw, experience anxiety, and manifest impaired performance.

In the sex therapy literature, self-focused attention has been implicated in both the maintenance and treatment of sexual dysfunction. It has been

suggested that "spectatoring" (i.e., focusing on and evaluating one's performance) is a key source of maladaptive anxiety involved in the etiology and maintenance of sexual dysfunction.^{14,15} Therapy is designed to change this self-conscious orientation by teaching individuals to focus on their own positive thoughts, feelings and sensations through "sensate focus" exercises.

Current sex therapy procedures frequently use self-monitoring, both in assessment and during the course of treatment. It may be the case that, paradoxically, self-monitoring might induce the very spectator focus which therapy is expected to eliminate. Thus, the anomalous situation could exist wherein an assessment strategy may have iatrogenic effects. One would expect sexual performance in individuals whose sexual self-confidence is already eroded to deteriorate when they are forced to become self-conscious through self-monitoring of their sexual difficulties and through monitoring of sexual difficulties by their partners. Such an effect is particularly likely during baseline assessment conducted prior to the commencement of therapy. Because of the frequent use of self-monitoring in the assessment of sexual dysfunction and because of the key role accorded to self-focus, in the form of "spectatoring," in the etiology and maintenance of erectile problems, it was the objective of the present investigation to explore 1) the relationship between dispositional self-consciousness and sexual behavior in males with erectile problems and 2) the differential effects of self-monitoring on erectile dysfunctional males who vary in dispositional self-consciousness.

METHOD

Subjects

Subjects were 16 couples who had sought sex therapy for erectile dysfunction and who had experienced erectile problems in more than 25% of sexual encounters. All were participating in a larger investigation of effective components in sex therapy.¹⁶ Average age was 48 years for males and 46 for females. Mean educational level was 12 years for males and 13 years for females. Couples had been married for an average of 20 years and the mean duration of the sexual problem was 4 years.

Measures of Erectile Functioning

Goals for Sex Therapy Scale. This measure¹⁷ deals with the male's ability to engage in various sexual activities. It consists of 15 items and uses a 7-point rating scale. The measure yields one score which reflects the male's satisfaction with his sex life. The instrument has been shown to be sensitive to pre-post sex therapy changes.¹⁸

Sexual History Form (SHF). The SHF is a 28-item self-report sexual inventory measure designed to assess sexual functioning. It utilizes a fixed alternative format and is the measure used in the evaluation procedure of LoPiccolo and his colleagues at Stony Brook. This measure is

typically scored on an item-by-item basis, resulting in 28 variables. Some normative data is available.^{19,20} In the present investigation, only items 16 and 17 were used; these evaluate difficulties obtaining and maintaining erections, respectively.

Erectile Difficulty Questionnaire (EDQ). This measure includes 24 items on the frequency of occurrence of erection difficulties and attitudinal and behavioral reactions to erectile disorder.²¹ Scores range from 24 (good functioning) to 120 (poor functioning). Although no reliability information has been reported, this instrument has demonstrated convergent validity.²²

Measures of Couple Sexual Adjustment

Sexual Interaction Inventory (SII). This instrument, compiled by Lo-Piccolo and Steger,²³ is the most frequently used measure of sexual harmony. It lists 17 heterosexual couple behaviors. For each behavior, subjects answer six questions using a 6-point scale. Although the scale provides five subscales for each partner, only the global couple summary scale (Scale 6) was used in the present investigation; this scale incorporates both spouses' responses and provides a measure of total disharmony and dissatisfaction in the sexual relationship. The test has been shown to be reliable on test-retest and to have good internal consistency. In addition, scores on all scales are correlated with self-reports of sexual satisfaction, and scores are reactive to treatment and able to discriminate sexually dysfunctional clients from nonclients.²³

Sexual Happiness. A single question asked subjects to indicate, on a 10-point scale, their current overall level of happiness with various aspects of their sexual relationship.

Self-Consciousness Scale. This widely used 23-item measure developed by Fenigstein, Scheier, and Buss⁶ has three subscales: Public Self-Consciousness, which measures awareness of oneself as a social object (e.g., I'm concerned about what other people think of me), Private Self-Consciousness, which evaluates the tendency to be aware of one's thoughts and feelings (e.g., I'm always trying to figure myself out), and Social Anxiety (e.g., I get embarrassed very easily). Subjects indicate, on 5-point scales, the extent to which each statement is characteristic of them. Satisfactory reliability and validity for the scale have been reported.⁷

Procedure

A test battery was administered to all subjects four times at 1-month intervals: prebaseline, postbaseline/preintervention, postintervention, follow-up. The test battery for the present investigation included four measures of erectile functioning and two measures of satisfaction with the couple sexual relationship. In addition, during the first testing session male subjects completed the Self-Consciousness Scale. Both spouses also completed daily record keeping sheets for 3 months; these were similar to Libman, Fichten, Binik and Brender's Jewish General Hospital Sexual

TABLE 1
Mean Self-Consciousness Scale Scores

Samples	<i>n</i>	Public Self-Consciousness	Private Self-Consciousness	Social Anxiety
Erectile Dysfunctional				
Present Study	16	12.44 (6.42)	17.31 (5.85)	11.00 (6.21)
Beck & Barlow ²⁵	12	16.08 (5.35)	21.83 (6.25)	10.50 (3.50)
Nondysfunctional				
Beck & Barlow ²⁵	12	20.25 (4.78)	22.08 (5.95)	11.08 (5.58)

Note. The higher the score, the greater the self-consciousness or anxiety. Values in parentheses are standard deviations.

Self-Monitoring Form.²⁴ On a daily basis spouses, without consulting each other, reported on the frequency of noncoital and coital couple activities, masturbation, and orgasm, as well as on erection quality, concern about erection and quality of general interpersonal functioning. After completing the postbaseline/preintervention testing battery, subjects were administered one of two experimental therapy interventions. These were self-administered over a 1-month period and are fully described by Taffman and Brender.¹⁶ Subsequently, subjects completed the postintervention and the follow-up test batteries. As is common in sex therapy research and practice, self-monitoring was carried out during the baseline, intervention, and follow-up periods.

RESULTS

Since the design of the larger study in which subjects were participating did not include a nondysfunctional comparison group, data from an independent investigation conducted by Beck and Barlow²⁵ were included in the analyses. These data were derived in the context of a complex investigation of erectile dysfunction which included a comparison between the Self-Consciousness subscale scores of 12 males with erectile dysfunction and 12 age-matched nondysfunctional males. Screening criteria and mean age in the Beck and Barlow²⁵ sample were similar to those in the present investigation; *t*-tests using means and standard deviations provided by Beck²⁶ indicated no significant differences between the Self-Consciousness subscale scores of our sample and those of Beck and Barlow's dysfunctional group (see Table 1).

Functional vs. Dysfunctional Subjects

Comparison between scores of dysfunctional males in the present sample and Beck and Barlow's nondysfunctional group indicated that dysfunctional subjects had significantly lower Public Self-Consciousness scores

than functional subjects $t(26) = 2.17, p < .05$; this comparison was also significant in Beck and Barlow's²⁵ study. Furthermore, while the difference was not significant in Beck and Barlow's study (although the means were in the same direction), males in the present sample scored significantly lower on Private Self-Consciousness than did nondysfunctional subjects, $t(26) = 2.11, p < .05$. There were no significant differences between dysfunctional and nondysfunctional subjects on Social Anxiety.

Dispositional Factors and Sexual Functioning

To evaluate the relationship between dispositional factors and sexual functioning in the present sample, males' Social Anxiety, Private Self-Consciousness and Public Self-Consciousness scores were correlated with their prebaseline scores on the four measures of erectile functioning and the two measures of satisfaction with the couple's sexual relationship. None of the correlations with Social Anxiety or with Public Self-Consciousness were significant. Higher Private Self-Consciousness was marginally related to greater couple sexual harmony (SII: lower scores indicate better adjustment), $r(14) = -.378, p < .10$, and significantly related to satisfaction with the sexual relationship, $r(14) = .641, p < .01$; t -test comparisons between those scoring high and low on the Self-Consciousness subscales (median splits were used) again indicated only that those high in Private Self-Consciousness had significantly better scores on both measures of couple sexual adjustment, $t(14) = 3.10, p < .01$; $t(14) = 2.98, p < .01$, respectively.

Self-Monitoring

The effects of self-monitoring on all males in the present sample were examined using correlated t -tests on pre- and postbaseline scores (i.e., assessment phase) on the six dependent measures. Means in Table 2 indicate that scores improved on all measures; however, only one comparison (SHF #17: ability to maintain erections during intercourse) was significant, $t(15) = 4.33, p < .001$.

Of the 18 correlations between Self-Consciousness subscale scores and pre- to postbaseline change scores, only three were significant and three approached significance; these yielded inconsistent results both for measures of erectile ability and for measures of couple sexual satisfaction. The paucity of significant results and the inconsistencies were also true of t -test comparisons on subjects who scored high and low on the Self-Consciousness subscales.

The larger investigation¹⁶ showed that, while both experimental interventions resulted in substantial improvement, there were no significant differences between the two treatments. Therefore, correlational analyses and t -test comparisons on those scoring high and low on the Self-Consciousness subscales were made on follow-up scores on the six dependent measures. Again, only a few comparisons reached significance and no consistent pattern emerged for any of the Self-Consciousness subscales.

TABLE 2
Effects of Self-Monitoring on Sexual Functioning

Measures	Pre Self-Monitoring ¹	Post Self-Monitoring ²
Erectile Ability		
Goals for Sex Therapy	48.81 (15.51)	50.50 (15.37)
Erectile Difficulty Questionnaire (EDQ) ³	70.63 (12.57)	64.50 (13.26)
Sexual History Form (SHF #16) ³ (obtaining erections)	4.00 (1.66)	3.69 (1.49)
Sexual History Form (SHF #17) ³ (maintaining erections)	5.00 (1.06)	4.19 (1.24)
Couple Sexual Satisfaction		
SII Scale 6 (couple sexual adjustment) ³	109.94 (35.29)	104.19 (38.52)
Happiness with Sexual Relationship	3.50 (1.66)	4.00 (1.73)

Note. Values are means. Numbers in parentheses are standard deviations. $N = 16$.

¹Pre-baseline scores.

²Post-baseline/pre-intervention scores.

³The lower the score the better. Otherwise, the higher the better.

DISCUSSION

Results on dispositional factors indicate not only that social anxiety was unrelated to either the presence or the severity of erectile dysfunction but also that dispositional public self-consciousness was *lower* in dysfunctional than in nondysfunctional individuals both in the present study as well as in Beck and Barlow's²⁵ investigation. While data on private self-consciousness are inconsistent, neither the present study nor the investigations of Beck and Barlow²⁵ or of Quadland¹¹ showed greater private self-consciousness on the part of erectile dysfunctional subjects. These findings are of considerable interest given the central role accorded to anxiety and spectating in many current conceptualizations of the etiology and maintenance of erectile dysfunction. As noted by Beck and Barlow,²⁷ the rubric "anxiety" subsumes a variety of physiological, cognitive and behavioral components; in different circumstances, anxiety may facilitate, impair, or exert no effects on erectile responding. Certainly, the results of the present investigation suggest that neither dispositional social anxiety nor the generalized tendency to spectator in social contexts is implicated in erectile disorder. Nevertheless, as suggested by others,¹¹ global measures of dispositional tendency may not provide an adequate test of the construct of spectating in specific situations. Before making firm conclusions about the role of these factors in sexual dysfunction, measures of interpersonal anxiety and private and public self-consciousness, with sexuality as the focus, will have to be developed.

The finding that private self-consciousness was related to better scores on couple variables suggests that the tendency of males to be introspective is related not only to greater happiness with the sexual relationship by the male but also to greater sexual harmony between spouses. Whether the tendency to be introspective is related, generally, to better couple sexual adjustment is an empirical question and deserves further exploration in both dysfunctional and functional samples.

The findings on self-monitoring, as those on dispositional self-consciousness, imply that "spectatoring," per se, is not a significant contributor to erectile dysfunction. First, self-monitoring did not have differential effects on individuals who differed in dispositional social anxiety or self-consciousness. Second, self-monitoring of sexual activities and difficulties in the context of assessment definitely did *not* cause deterioration in either the couple's sexual relationship or in the presenting symptoms. Indeed, there was a trend toward improvement in all domains investigated.

Because there was no non-self-monitoring control group in the present study, the possibility exists that any beneficial effect of self-monitoring was due to factors such as expectancy or test-retest effects. Nevertheless, previous test-retest data on a sex therapy waiting list sample suggest that this was not the case. When dysfunctional subjects and their spouses did not engage in self-monitoring but completed the same test battery at intake and at pretherapy testing times, there was no tendency for sexual functioning scores to improve during the waiting period.²⁸ While this suggests that the active ingredient in the present investigation was probably self-monitoring, research in which self-monitoring and non-self-monitoring subjects are directly compared is needed before firm conclusions can be made.

It has been shown that individuals with erectile dysfunction have low sexual self-efficacy expectations.²⁹ Therefore, one could have expected men in the present study to show deterioration in sexual functioning by self-monitoring the problematic sexual behaviors. Such an effect was not reflected in the findings; this suggests that self-monitoring may either sensitize individuals to different facets of the sexual experience or may highlight positive sexual experiences which occur. Although the circumstances and mechanisms by which self-monitoring may exert positive or negative effects on sexual functioning are yet to be identified, it is of considerable clinical importance that self-monitoring can be used without risk as an assessment technique in cognitive-behavioral sex therapy.

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