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Associations Between Gender Role Conflict, Sexual Dysfunctions, and Male Patients' Wish for Physician–Patient Conversations About Sexual Health

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Masculine norms are in part defined by sexual functioning. However, adherence to masculine norms may at the same time hinder men's willingness to obtain help when problems involving sexual functioning arise. The current study analyzed the association between gender role conflict and the prevalence of self-reported sexual dysfunction or men's expectations of being asked by a physician about sexual health issues. In all, 130 men (M_{age} = 59.4, SD = 14.6) participated in the study. In a structured interview, they were asked to self-report the prevalence of sexual dysfunctions. The criterion of distress was also given consideration. The frequency of previous conversations with a physician about sexual health issues and the desire to be asked in future about sexual health issues were assessed by administering a questionnaire. The Gender Role Conflict Scale–Short Form was used to measure gender role conflict. The most prevalent sexual dysfunctions were erectile dysfunction (10.0%), diminished sexual desire (7.7%), and premature ejaculation (4.6%). The prevalence of erectile dysfunction and diminished sexual desire was positively associated with restrictive emotionality. Premature ejaculation was positively associated with men's restriction about showing positive affection toward other men. Overall, men expected their physicians to ask them about their sexual health. Restrictive emotionality was positively associated with the disinclination to be asked about this topic. Physicians should be aware of the close association between masculinity and sexual functioning. When asking about sexual health issues, physicians should be sensitive to patients' gender role conflict and attempt to create a gender-sensitive environment.

Keywords: male sexual dysfunction, masculinity, gender role conflict, patient–physician communication, male patients' expectations

Sexual dysfunctions constitute a heterogeneous group of disorders (American Psychiatric Association [APA], 2013, p. 423) that are experienced by a significant proportion of the male population (McCabe et al., 2016). Sexual dysfunctions are characterized by the inability to respond sexually or to experience sexual pleasure (APA, 2013, p. 423). The most studied male sexual dysfunctions are erectile dysfunction (ED) and premature ejaculation (PE; McCabe et al., 2016). ED is the inability to have a penile erection, the inability to have a rigid erection, or the inability to have an erection of long enough duration to have satisfying sexual activity even though the man receives sufficient and adequate stimulation (APA, 2013, p. 582). PE is defined as the inability to delay or control ejaculation during sexual activity to such an extent that sexual activity is satisfactory (World Health Organization [WHO], 2008, p. 235). Less often studied is the prevalence of male hypoactive sexual desire disorder (deficient or absent sexual thoughts and desire for sexual activity; APA, 2013, p. 440), orgasmic dysfunction (no orgasm or markedly delayed orgasm; WHO, 2008, p. 235), or pain during sexual activity (McCabe et al., 2016).

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This study was conducted as part of Nikola Komlenac's doctoral dissertation. Preliminary results were presented at the 19th Congress of the European Society for Sexual Medicine (2017). At the meeting of the Austrian Association for Gender Medicine (2017), at the 8th Congress of the International Society for Gender Medicine (2017), at the World Congress of Psychiatry (2017), and at the congress of the World Association for Sexual Health (2017), parts of the results based on the whole dataset were presented each time in the format of a poster.

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Research on the prevalence of sexual dysfunctions was mostly conducted in heterosexual men. A recent review on the prevalence of male sexual dysfunctions (McCabe et al., 2016) reported that ED affects 2%–40% of men aged between 40 and 69 years. In older men, a prevalence of 50%–100% is reported in the literature. The second most prevalent sexual dysfunction is PE, with a prevalence between 8% and 30%. Male hypoactive sexual desire disorder is found among 15%–25%, and orgasmic dysfunction is reported to affect 5%–8% of men (McCabe et al., 2016). The prevalence of pain during intercourse was reported to be around 2% (Moreau, Kågesten, & Blum, 2016). In Austria Nicolosi et al. (2006) found that 13% of men had at least one sexual dysfunction. However, other studies of sexual dysfunctions conducted in Austria are scarce or report only the prevalence of ED (Madersbacher et al., 2003; Ponholzer et al., 2005).

An online survey in Portugal found that heterosexual men are as often affected by a sexual dysfunction as are gay-identified men (Peixoto & Nobre, 2015). The one exception was PE. This sexual dysfunction was more prevalent among heterosexual men than it was among gay-identified men (Peixoto & Nobre, 2015).

Most of the reviewed prevalence rates may overestimate the prevalence of sexual dysfunctions, because most of these studies do not assess distress caused by a specific sexual difficulty. A sexual difficulty can be classified as a sexual dysfunction only when it is experienced as distressing (APA, 2013). Not every man experiencing a sexual difficulty (e.g., low sexual desire or difficulty in getting a rigid erection during sexual activity) is also distressed by this experience. Men may feel well the way they are and have satisfactory sexual lives. A pathologization or stigmatization of such men's sexual functioning as a dysfunction is not justified (APA, 2013). Hendrickx, Gijs, and Enzlin (2016) found a marked contrast between the prevalence of sexual difficulties that did not cause distress and sexual dysfunctions, whereby sexual dysfunctions are reported to have a lower prevalence than are sexual difficulties. Therefore, prevalence rates of sexual dysfunctions are more accurate and less likely to be overestimated if distress concerning a sexual difficulty is assessed alongside its frequency of occurrence.

Masculinity and Sexuality

Men with a sexual dysfunction may, in addition to experiencing the dysfunction, also experience a conflict with their sense of masculinity. Affected men may agree that "[. . .] genital sexual activity is a prominent feature in the maintenance of masculine gender [. . .] Thus an impotent man [man with ED] always feels that his masculinity, and not just his sexuality, is threatened" (Person, 1980, p. 619).

Based on the explanations of evolutionary theory that holds a heteronormative view of sexuality, men are assumed to have fundamentally different reproductive strategies than do women (Buss & Schmitt, 1993; Plummer, 2005). These explanations and assumptions about male sexuality are translated into masculine norms (Epstein, 1994). According to explanations of evolutionary theory, men are assumed to be motivated to have many sexual partners and frequent intercourse, because such a strategy would bring men the highest possible number of offspring. Women, on the other hand, are assumed to invest more in their choice of partner, as they have only a limited number of gametes and have to invest more than men in their offspring (e.g., pregnancy). For this reason, women are assumed to be less concerned with the frequency of having intercourse. These assumptions explain the rationale that high sex drive and centrality of sex as definitions of masculine norms are given "in nature" (Plummer, 2005). Masculine norms, or what it means to be "a real man," are therefore based on the centrality of the penis (Potts, 2000) and the centrality of achieving ejaculation in a defined time framework (Johnson, 2010), as well as the number of sexual partners and sexual acts (Gross, 1978).

Some men are found to be concerned about their ability to conform with these masculine norms about sexuality during sexual intercourse (Lamb et al., 2017). Interviews among heterosexual male adolescents in Austria revealed that they believed that men's high sexual desire is given "in nature." In addition, they were worried about being sexually experienced, functional, and competent (Schmied & Reidl, 2008). Such ideas can prevail into adulthood. If they do, sexual intercourse becomes an outlet for performing and confirming one's own masculinity (Lamb et al., 2017). Loss of sexual functioning can diminish the sense of masculinity and may cause embarrassment and feelings of vulnerability (Bokhour, Clark, Inui, Silliman, & Talcott, 2001).

Thus, masculine norms are descriptions of behaviors, thoughts, or attitudes that are associated with male sex. These norms are socially defined and are changeable over time (David & Brannon, 1976). Some of the masculine norms are sometimes erroneously considered to be given "in nature" (Plummer, 2005). In this article, the "sense of masculinity" is understood as the degree to which a man regards himself to fulfill these norms, that is, to what extent he regards himself to be masculine (Kagan, 1964). Adherence to masculine norms can heighten a man's sense of masculinity. It can, however, also lead to gender role conflict. Gender role conflict results when a man chooses to behave in accordance with masculine norms, even though these norms and behaviors are incongruent with one's own sense of self. In such situations, choosing behaviors that are in accordance with masculine norms can be restrictive to the person and therefore limit "the person's ability to actualize their human potential" (O'Neil, 1981b, p. 203). These restrictions are experienced as negative and can have negative consequences on the person or on others (O'Neil, 1981b).

Experiencing gender role conflict concerning sexual behavior can be a result of an inability to perform according to masculine norms. Constant preoccupations and monitoring of whether one behaves according to masculine norms may, on the other hand, lead to sexual dysfunctions (Barlow, 1986). In the current study, the associations between sexual dysfunctions and the experience of gender role conflict were analyzed without implying any direction of causality.

Discussions About Sexual Health Issues With Physicians

Even though sexual dysfunctions are prevalent and associated with the sense of masculinity, relatively few men have ever had a conversation with a physician about sexual dysfunction. Only 22% of men in a U.S. study who experienced a sexual difficulty had talked to a physician about this difficulty (Laumann, Glasser, Neves, Moreira, & GSSAB Investigators Group, 2009). In Austria, the proportion of men with a sexual dysfunction who consulted a

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physician was also low (23%; Nicolosi et al., 2006). In contrast, 80.9% of men in a large-scale survey in Europe (including participants from Austria) indicated that they had had at least one health care visit in the previous year (Peytremann-Bridevaux & Santos-Eggimann, 2007). Thus, men seek out health care, but they are not likely to consult a physician about sexual difficulties or dysfunctions.

Not only are sexual dysfunctions related to masculinity, but also the issue of men's professional help-seeking is associated with masculinity. Masculine norms are seen to be in conflict with help-seeking behavior. Therefore, men who adhere to traditional masculine norms are less likely to seek professional help than are men who do not adhere to these norms. In several studies, men's tendency to restrict emotional expressivity was negatively associated with positive attitudes toward professional help-seeking (Vogel & Heath, 2016). Masculine norms are also negatively associated with medical help-seeking behavior after experiencing symptoms of cancer (Fish, Prichard, Ettridge, Grunfeld, & Wilson, 2015). For example, men's suppression of emotions or the wish to appear strong influenced men's self-referral behavior negatively after detecting symptoms caused by prostate disease (Hale, Grogan, & Willott, 2007). In general, the wish to appear strong and in control as opposed to appearing weak led many men who adhered to traditional masculine norms to delay seeking help after detecting symptoms of cancer (Fish et al., 2015).

The influence of masculine norms on help-seeking behavior for sexual difficulties or sexual dysfunctions is not conclusive. In the study by O'Brien, Hunt, and Hart (2005), men were more likely to embrace the prospect of help-seeking for sexual difficulties than for other symptoms. For symptoms not related to sexual functioning, the participants endorsed the view that men should not seek help. However, sexual difficulties were seen as a threat to masculinity. To "restore" or "preserve" sexual functioning men were readily acting against the endorsed view that men should not seek help (O'Brien et al., 2005, p. 503).

In another study, men were also interviewed about their help-seeking intentions. Generally, they held the view that men should not seek help. In contrast to the study by O'Brien et al. (2005), these men held the opinion that this norm also applied for sexual health issues (Ewert, Collyer, & Temple-Smith, 2016). Accordingly, in a sample of prostate cancer patients, the masculine norm of not being allowed to express weakness was negatively associated with the intention to ask physicians about sexual health concerns (Hyde et al., 2016). Thus, especially limited emotional expression and need for independence and control were barriers reported by men toward seeking medical help for sexual health concerns (Medina-Perucha, Yousaf, Hunter, & Grunfeld, 2017).

Current Study

In summary, currently only few publications report on prevalence rates of sexual dysfunctions except for the prevalence of ED among men in Austria. Furthermore, men's expectations about being asked by physicians about their sexual health are rarely addressed. The relationship between sexual dysfunction and gender role conflict was theoretically addressed (O'Neil, 1981a). To date few empirical quantitative studies exist that analyze this relationship. In addition, the association between masculinity and the reluctance to obtain professional help is well known. The association between patients' expectations about being questioned by a physician and masculinity needs to be determined. To close these gaps in the literature, the current study analyzes (a) the prevalence of sexual dysfunctions among male patients at a medical university hospital in Austria, (b) the frequency of men's previous discussions with a physician about sexual health, and (c) patients' expectations about being asked about their sexual health by a physician in future. Also examined were (d) the association between the self-reported prevalence of sexual dysfunction and gender role conflict as well as (e) the association between gender role conflict and the expectations about being asked by a physician about sexual health issues.

Method

Participants

This study drew on a sample of 133 in-patients at a medical university hospital in Austria. Patients were chosen randomly at the Department of Internal Medicine. Of the participants, 50.4% were in the hospital for treatment of either a renal disease, diabetes mellitus, a gastric disease, a liver disease, or dizziness. Of the interviewed patients, 41.4% were in the hospital because of a cardiovascular disease and the remaining 8.3% of patients were being treated for an infectious disease. The Department of Internal Medicine was chosen because it is known that diseases treated in this department and the treatment methods themselves are associated with sexual dysfunctions (Kandeel, Koussa, & Swerdloff, 2001). Therefore, it seemed reasonable to assess the prevalence of sexual dysfunctions in these patients and more importantly to study whether these patients wished to be asked about their sexual health.

The response rate was 52.6% ($N = 253$). Three participants did not complete the study. Thus, a total of 130 responses were analyzed. Participants' mean age was 59.4 ($SD = 14.6$; range 23–84) years. The majority (90.8%) of the sample had Austrian nationality. Participants also came from Germany (6.2%), Italy (3.1%), Turkey (0.8%), and other nations (2.3%). Of the men, 22.3% reported that their highest level of education was primary school, and 35.4% had finished vocational training. Nearly a fifth (22.3%) of the sample had a university entrance-level qualification, and 20.0% had a university degree. Most men (90.8%) reported having a heterosexual orientation. The sample included equal percentages of bisexual men (1.5%) and gay-identified men (1.5%). Three men (2.3%) reported that they did not feel any sexual attraction, whereas 3.8% of the participants did not respond to the question concerning their sexual orientation. Most men (74.6%) were sexually active, and most men (76.9%) were in a relationship.

Measures

The study used two methods for data collection. The first method was a structured face-to-face interview. This interview was conducted to assess the demographic variables and the prevalence of sexual dysfunction. An interview was used instead of a validated questionnaire (e.g., International Index of Erectile Function [Rosen et al., 1997] or Brief Sexual Function Inventory for Urology [O'Leary et al., 1995]) to be able to talk with patients about

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sexuality. In this way, patients were able to experience how it feels to be asked about their sexuality in a clinical setting. It was expected that with this experience they would be able to better decide whether they wished their physician to ask questions about sexual health issues in the future. The second part included a questionnaire dealing with previous discussions about sexual health with a physician, the wish to be asked in future about sexual health by a physician, and the validated questionnaire about gender role conflict.

Demographic variables. Participants were asked for their age, nationality (*Austrian* vs. *German* vs. *Turkish* vs. *Italian* vs. *other*), highest level of education (*primary school* vs. *vocational training* vs. *university entrance-level qualification* vs. *university degree*), marital status (*single* vs. *with partner*), sexual orientation (*heterosexual* vs. *gay-identified* vs. *bisexual* vs. *other*), and whether they were sexually active (*no* vs. *yes*). For the variable nationality, a dichotomous dummy variable was formed (*Austrian* vs. *other nationality*).

Sexual dysfunction. The structured interview was developed for the current study based on a literature search for sexual difficulties and sexual dysfunctions. The decision to assess five sexual difficulties follows other studies about sexual dysfunctions conducted in Austria (Nicolosi et al., 2006) and was based on the international definitions of sexual dysfunctions (APA, 2013; WHO, 2008). Patients were asked how often (*never* vs. *sometimes* vs. *often* vs. *always*) they experienced each of the following sexual difficulties: diminished sexual desire, pain during sexual activity, erectile difficulties, ejaculating sooner than desired, and diminished intensity of orgasmic sensations. Four answer categories for the frequency of experienced sexual difficulties were also offered in other studies about sexual difficulties and dysfunctions (Hendrickx et al., 2016; Nicolosi et al., 2006). If prevalent, patients were asked how much distress (*no distress* vs. *a little* vs. *considerable* vs. *much distress*) they felt in connection with each sexual difficulty. The questions about distress were developed based on studies conducted by Mitchell et al. (2015) or Hendrickx et al. (2016). For the sexual difficulties, a dichotomous variable was formed. Men were classified as having sexual difficulty when they reported experiencing a sexual impairment at least *often*. Sexual dysfunctions were defined as sexual difficulties that were experienced at least *sometimes* and that caused at least *considerable* distress. For the definition of sexual dysfunctions, a less strict frequency criterion was used than for sexual difficulties. In the definition of sexual dysfunctions, distress was weighted more strongly on the rationale that even men who sometimes experience distress would be helped by interventions to relieve even this infrequently experienced distress.

Discussions about sexual health issues with a physician. Patients were asked how often (*never* vs. *rarely* vs. *sometimes* vs. *often*) they had talked to a physician about their sexual health in the past. A dichotomous dummy variable was used to differentiate between men who had *never* talked to a physician about sexual health issues and those who had at least *rarely* talked with a physician about such issues. Moreover, patients were asked whether they would like their physician to ask them about sexual health issues in future (*no* vs. *yes*). A similar method was used by Sporn et al. (2015).

Gender role conflict. Gender role conflict was measured with the Gender Role Conflict Scale–Short Form (GRCS-SF; Wester, Vogel, O'Neil, & Danforth, 2012). GRCS-SF is a shortened form of the Gender Role Conflict Scale (GRCS; O'Neil, Helms, Gable, David, & Wrightsman, 1986). In comparison with the GRCS, the GRCS-SF has greater ecological validity and is applicable to a more diverse population (O'Neil, 2015, pp. 79–94; Wester et al., 2012). The GRCS-SF asks whether the person experiences distress, stress, or discomfort in situations in which behaviors prescribed by masculine norms are in conflict with more adaptive behavior or behavior that is more in line with the person's intention for a specific situation (O'Neil et al., 1986; Wester et al., 2012).

The GRCS-SF consists of 16 items forming four scales of four items each. The first scale called Success, Power, and Competition asks whether men continuously try to be more successful than other people. The scale Restrictive Emotionality assesses whether men avoid expressing their emotions in situations in which such expression would be adventurous (e.g., to an intimate partner). The scale Restrictive Affectionate Behavior Between Men assesses whether men avoid showing positive affection to other men and whether they disapprove of other men showing such affection to each other. Conflict Between Work and Family Relations is a scale that assesses whether men spend so much time at work that they do not find time for their family or leisure activities (O'Neil et al., 1986; Wester et al., 2012). Men can indicate the degree of experienced conflict on a 6-point Likert scale ranging from 0 (*strongly disagree*) to 5 (*strongly agree*).

The GRCS-SF has acceptable reported internal consistencies ranging from Cronbach's $\alpha = .77$ (Restrictive Emotionality and Conflict Between Work and Family Relations) to Cronbach's $\alpha = .80$ (Success, Power, and Competition; Wester et al., 2012). The current study also found acceptable internal consistencies (Cronbach's $\alpha = .66$–$.77$, see Table 1).

Procedure

The study was conducted at [Innsbruck] Medical University Hospital and was approved by the medical university's ethics committee (ID: AN2016-0093 362/4.5). The study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013) and the APA standards (American Psychological Association, 2002). Male in-patients at the Department of Internal Medicine were approached and asked to participate in the study. Patients had to be male, older than 18 years, and they had to be able to speak and understand German. No other inclusion criteria were applied. All patients approached were verbally given

Table 1
Mean Scores, Internal Consistency, and Correlations Between the Gender Role Conflict Scale–Short Form Scales (N = 130)

GRSC-SF Scale	Cronbach's α	*M* (*SD*)	2	3	4
1. CBWFR	.663	2.3 (1.2)	.340**	.242**	.356**
2. RE	.732	1.6 (1.1)		.385**	.403**
3. RABBM	.773	2.0 (1.4)			.337**
4. SPC	.725	1.8 (1.1)			

Note. GRSC-SF = Gender Role Conflict Scale–Short Form; CBWFR = Conflict Between Work and Family Relations; RE = Restrictive Emotionality; RABBM = Restrictive Affectionate Behavior Between Men; SPC = Success/Power/Competition.
** $p < .010$.

information about the study. Patients were also informed that participation was voluntary and that they could withdraw their consent or refuse participation at any time. Withdrawal of consent or refusal to participate had no effect on their patient care or treatment. The interviewer was not involved in the patients' treatment. This also guaranteed that the patients felt free to refuse or withdraw from participation at any time. Written informed consent was obtained from all participants who agreed to participate. No reimbursement was offered.

Most of the questioned patients were in a private room. For patients who were not alone in their room, the interviewer offered them the opportunity to go to the interviewer's office for the interview. Patients who were not alone in their room, but who did not want to go to the office, or were not able to walk, had to explicitly consent to be interviewed in the room with other patients present before proceeding with the study. Responses concerning prevalence of sexual difficulties, $\chi^2(1) = 0.74$, $p = .390$, or prevalence of sexual dysfunctions, $\chi^2(1) = 0.16$, $p = .690$, did not differ between patients who were interviewed privately and those interviewed in the presence of other patients.

Statistical Analysis

Chi-square tests were used to analyze group comparisons, as these group comparisons comprised only categorical variables. The associations between patterns of gender role conflict and the prevalence of sexual difficulties, sexual dysfunctions, previous discussions with a physician about sexuality, and wishes with regard to future inquiries about this topic by a physician were analyzed by calculating correlations and logistic regression models.

Each regression model comprised two steps. The first step controlled for the effects of age, sexual orientation, education, and nationality. The GRCS-SF scales were entered in the second step of the regression model stepwise and only if they significantly contributed to the model. Even though the four scales of the GRCS-SF correlated significantly with each other (see Table 1), the analyses of multicollinearity supported the decision to enter each scale of gender role conflict separately in the regression models. In the regression analyses, no tolerance was below .20 (Menard, 2002, p. 76). The mean variance inflation factor was not substantially greater than 1. Collinearity diagnostics showed that the scales loaded on different dimensions (Field, 2009, pp. 297–300). Effect sizes (Nagelkerke R^2) are reported for each overall regression model. Odds ratios with a 95% confidence interval are reported.

The level of significance for all analyses was $\alpha = .050$. All statistical analyses were performed with the Statistical Package for the Social Sciences (SPSS) for Windows, Version 22.0 (IBM Corp., Armonk, NY).

Results

Prevalence of Sexual Dysfunction

The most prevalent sexual difficulty was low sexual desire (see Table 2). Nearly half (47.7%) of the patients reported that they at least sometimes experienced low sexual desire. The experience of at least sometimes ejaculating sooner than desired was reported by 36.9% of the patients. Not being able to reach a desired erection at least sometimes was reported by 33.1%, and the experience of poor orgasmic sensation at least sometimes was reported by 23.9% of patients. Pain during sexual activity was the least prevalent sexual problem. It affected 9.2% of patients (see Table 2).

Of those men who reported low sexual desire, 16.1% reported having experienced distress from this condition. Mostly men who did not reach a desired erection reported having been distressed by the symptom (30.2%). Of the men who reported poor orgasmic sensation, 16.2% were distressed by the condition. Around 10% (10.5%) were bothered by early ejaculation. Only one person (8.3%) who experienced pain during sexual activity was bothered by it.

Overall, ED was the most prevalent sexual dysfunction in the sample, followed by low sexual desire. Of the study sample, 4.6% were classified as having experienced PE, whereas 3.8% were classified as having an orgasmic dysfunction. One man in the sample reported having sexual pain disorder (see Table 2).

Discussions With a Physician About Sexual Health

Approximately half (50.8%) of the participants had never talked about a sexual health subject with their physician in the past. Men with a sexual dysfunction (53.8%) spoke with their physician about sexual health as often as did men without a sexual dysfunction (48.1%), $\chi^2(1) = 0.28$, $p = .599$.

Nearly half (49.2%) of the participants stated that they would like their physician to ask them about their sexual health. Mostly men with a sexual dysfunction (80.8%) wanted their physician to ask them about sexual health issues. Nevertheless, a considerable proportion of men with no sexual dysfunction (41.3%) also wanted their physician to ask about sexual health issues during clinical

Table 2
Prevalence of Self-Reported Sexual Difficulties and Sexual Dysfunction (N = 130)

Sexual difficulty	SDi sometimes %	SDi often %	Distressed %	SD %
Erection	16.2	16.9	30.2	10.0
Low desire	38.5	9.2	16.1	7.7
Premature ejaculation	30.0	6.9	10.5	4.6
Low orgasmic sensation	23.1	0.8	16.2	3.8
Pain	9.2	0	8.3	0.8

Note. SDi sometimes = sexual difficulty reported to be experienced sometimes; SDi often = sexual difficulty reported to be experienced often or more frequently; SD = sexual difficulty that was distressing and was classified as sexual dysfunction.

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visits. This proportion was significantly lower, $\chi^2(1) = 0.28$, $p < .001$, Cramer's V = .32.

Gender Role Conflict

Overall, men reported experiencing low levels of gender role conflict (see Table 1). The GRCS-SF scales all correlated significantly with each other to a small or moderate (Cohen, 1988) extent (see Table 1). This indicates that the four scales of the GRCS-SF measure similar but still different constructs, for example, the four patterns of gender role conflict.

Sexual difficulties and sexual dysfunctions. The prevalence of sexual difficulties was not associated with experienced gender role conflict. No significant correlations between the patterns of gender role conflict and any of the sexual difficulties were observed (see Table 3). Further, no significant logistic regression model resulted in the analyses, all $\chi^2(4) < 9.15$, $ps > .057$.

Significant correlations between patterns of gender role conflict and ED or PE were observed. Sexual desire disorder was only weakly associated with one scale of the GRCS-SF (see Table 3).

While controlling for age, education, nationality, and sexual orientation, restrictive emotionality (RE) was predictive for ED. As men reported experiencing more difficulty in expressing their emotions, they were more likely to report ED (see Table 4). The same relationship was observed for sexual desire disorder. As men reported experiencing more difficulty expressing their emotions, they were more likely to report sexual desire disorder (see Table 4). The regression model for PE was calculated without entering nationality or sexual orientation in the model in the first step. Only men with Austrian nationality and heterosexual men reported being affected by PE. Entering nationality and sexual orientation in the regression model would have resulted in high error terms in the model. When controlling for age and education, restrictive affectionate behavior between men (RABBM) was positively associated with the prevalence of self-reported PE. As men reported experiencing more difficulty expressing positive affection toward other men, they were more likely to report PE (see Table 4). No other experienced gender role conflict was predictive for prevalence of ED, sexual desire disorder, or PE (all $ps > .138$). For the other sexual dysfunctions, no significant regression models were obtained for predicting the particular sexual dysfunction by experienced gender role conflict.

Table 3

Correlations Between the Gender Role Conflict Scale–Short Form Scales and Sexual Dysfunctions, Previous Conversations About Sexual Health With a Physician, and Wish to Be Asked About Sexual Health Issues by a Physician (N = 130)

Variable	CBWFR	RE	RABBM	SPC
Difficulties with erections	−.035	.090	.034	.025
Difficulties with desire	.006	.057	.022	.089
Difficulties with ejaculation	−.130	.106	.073	.020
Erectile dysfunction	.038	.180*	.136	.130
Low desire disorder	.043	.160†	.023	.101
Premature ejaculation	−.039	.134	.205*	.090
Orgasmic dysfunction	.069	.111	.052	.084
Previous conversations	.211*	.024	−.051	.050
Wish to be asked	.026	−.095	−.059	.032

Note. CBWFR = Conflict Between Work and Family Relations; RE = Restrictive Emotionality; RABBM = Restrictive Affectionate Behavior Between Men; SPC = Success/Power/Competition.
† $p < .100$. * $p < .050$.

Discussions with a physician about sexual health. Conflict between work and family relations (CBWFR) correlated with previous conversations (see Table 3). No significant logistic regression model could be obtained when predicting previous conversations with a physician about sexual health, $\chi^2(6) = 10.47$, $p = .106$. However, RABBM and CBWFR were significant predictors in the model (see Table 4). Men with higher RABBM were less likely to have talked with a physician about sexual health than were men with lower RABBM. Participants with high CBWFR were more likely to have talked to a physician about sexual health issues than were men with low CBWFR (see Table 4).

Gender role conflict was significantly associated with a patient's wish to be asked about sexual health issues by a physician only when controlling for age, education, nationality, sexual orientation, and having at least one sexual dysfunction. Namely, RE played a significant role. Men with stronger RE were less likely to want to be asked about sexual health issues than were men with weaker RE (see Table 4).

Discussion

The current study aimed to assess the prevalence of sexual dysfunctions among men in an Austrian sample. It also examined whether sexual health issues were covered in patient–physician conversations in the past and whether physicians were expected by the patient to initiate the topic of sexual health during clinical visits. The association between gender role conflict and sexual dysfunction as well as between gender role conflict and patient's expectation to be asked by their physician about sexual health issues was analyzed.

Sexual Difficulties and Sexual Dysfunctions

In the current study, one of the most prevalent sexual difficulties, thus sexual impairment without the consideration of accompanying distress, was ejaculating sooner than desired. This result is in line with the high prevalence of this sexual difficulty reported in the literature (McCabe et al., 2016). However, in the literature the sexual difficulty of ejaculating sooner than desired is often labeled as a sexual dysfunction. It is called PE, and it is often discussed as the "most prevalent sexual dysfunction" (Simões Paço & Jorge Pereira, 2016, p. 87). However, such conclusions may overestimate the number of people affected by PE. Hendrickx et al. (2016) cautioned against overestimating sexual dysfunctions by neglecting the distress criterion of sexual dysfunctions (see also Mitchell et al., 2015). This overestimation of PE would also have occurred in the current study if the accompanying distress had not been assessed.

When considering the distress caused by a specific sexual difficulty, ED was the most prevalent sexual dysfunction in the current study. The second most frequent sexual dysfunction in the current study was low sexual desire. These two sexual dysfunctions were associated with experienced gender role conflict. Men who tried to restrict their emotions were more likely to report having ED or low sexual desire. The association between ED or low sexual desire and masculinity is not surprising, as both erec-

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Table 4
Association Between Gender Role Conflict and Sexual Dysfunctions, Previous Conversations About Sexual Health With a Physician, and Wish to Be Asked About Sexual Health Issues by a Physician (n = 125)

Variables in logistic regression model	ED	Low desire	PE	Previous conversations	Wish to be asked
Model	$\chi^2(5) = 11.90^*$	$\chi^2(5) = 12.14^*$	$\chi^2(3) = 9.49^*$	$\chi^2(5) = 10.47$	$\chi^2(6) = 24.87^{***}$
Nagelkerke R^2	0.13	0.23	0.23	0.11	0.24
Age[a]	0.99 [0.95, 1.03]	0.99 [0.95, 1.04]	1.09 [0.99, 1.20]	1.01 [0.98, 1.03]	0.98 [0.95, 1.00]
Education[a]	1.67 [0.87, 3.21]	2.01 [0.92, 4.41]	0.91 [0.37, 2.13]	0.85 [0.59, 1.23]	1.25 [0.85, 1.84]
Sexual orientation[a]	2.08 [0.80, 5.36]	1.32 [0.24, 7.16]	—[c]	0.62 [0.29, 1.32]	0.92 [0.42, 2.03]
Nationality[a]	3.07 [0.60, 15.62]	4.76 [0.83, 27.39]	—[c]	0.79 [0.26, 2.40]	0.56 [0.16, 1.99]
Sexual dysfunction[a]	—	—	—	—[b]	9.75 [2.84, 33.45]***
RE[a]	2.17 [1.18, 4.00]*	2.27 [1.12, 4.56]*	—[a]	—[b]	0.54 [0.35, 0.83]**
RABBM[a]	—[b]	—[b]	1.99 [1.00, 3.95]*	0.74 [0.55, 1.00]*	—[b]
CBWFR[a]	—[b]	—[b]	—[b]	1.65 [1.15, 2.38]*	—[b]
SPC[a]	—[b]	—[b]	—[b]	—[b]	—[b]

Note. ED = erectile dysfunction; RE = restrictive emotionality; PE = premature ejaculation; RABBM = restrictive affectionate behavior between men; CBWFR = conflict between work and family relations; SPC = success/power/competition.
[a] Odds ratios are reported. [b] Not in logistic regression model because of stepwise forward procedure and nonsignificant contribution to the model improvement. [c] Not in the logistic regression model because only men with Austrian nationality and heterosexual sexual orientation reported this sexual dysfunction.
$^*p < .050$. $^{**}p < .010$. $^{***}p < .001$.

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tion (Potts, 2000) and sexual desire (Plummer, 2005) are important defining features for masculine norms, also in Austria (Schmied & Reidl, 2008). According to masculine norms, sexuality is focused on the functionality of the penis (Potts, 2000). Applying evolutionary theory to explain why strong sexual desire in men is given "in nature" also gives considerable weight to this component when defining masculine norms (Plummer, 2005). In a qualitative study, men reported that the loss of sexual functioning caused them embarrassment and feelings of vulnerability (Bokhour et al., 2001). Genuine expressions of such emotions stand in conflict to traditional masculine norms (David & Brannon, 1976). In the current study, men who experienced sexual difficulties as distressing were also more likely to experience a gender role conflict, specifically conflicts while restricting their emotions. Distress caused by gender role conflict may be (further) attributed to sexual difficulties. This conclusion was supported by the current finding because the association with gender role conflict was found only for sexual dysfunctions, but not for sexual difficulties where distress is not considered.

It may also be possible that men who try to adhere to masculine norms are more likely to monitor their sexual activity more closely and compare their "performance" to masculine norms concerning sexuality. This monitoring may lead to the so-called "performance anxiety" that can lead to sexual dysfunctions (Barlow, 1986). Therefore, the direction of causality, whether gender role conflict can cause or/and is caused by sexual dysfunctions, cannot be determined without further research that applies methods that go beyond correlational analysis.

It is important that current classifications of sexual dysfunctions (APA, 2013; WHO, 2008) be aware of the close association between masculine norms and the classifications of sexual dysfunctions. The focus on the erect penis (Potts, 2000) and the focus on vaginal (heterosexual) intercourse as well as the "ejaculation imperative" (Johnson, 2010, p. 238) foster many of the traditional masculine norms. It is important to reflect on whether classifications of sexual dysfunctions are sensitive for men experiencing a sexual dysfunction or whether they are more likely sensitive for men who especially try to adhere to the masculine norms of sexuality.

Related is the fact that most research on sexual functioning is based on heterosexual men (Sandfort & de Keizer, 2001). The International Classification of Diseases and *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, definitions of PE, for example, are based solely on heterosexuality (vaginal intercourse) and heteronormative expectations of sexuality (APA, 2013; WHO, 2008). Further, Puppo and Puppo (2016) argued that PE is not a sexual dysfunction, as the physiology and organs are not impaired in people diagnosed with PE, and that the category of this sexual dysfunction advocates masculine norms of heteronormative sexuality. This argument is supported by a study that showed that especially heterosexual men report being affected by PE (Peixoto & Nobre, 2015). In the current study, sexual orientation was not associated with a prevalence of sexual dysfunctions. However, especially men, who tried to act out heteronormative sexuality by restricting expressions of positive affection toward other men to avoid being perceived by others as gay-identified men, were more likely to report PE than were men who had no restrictions on showing positive affection toward other men.

Physicians should be aware of the way in which masculine norms are "[. . .] limiting what counts as enjoyable male sexual experience" (Potts, 2000, p. 89). Physicians should become aware of their own and their patients' assumptions about sexuality that are based on masculine norms for sexuality. The assumption that "[s]exual prowess, not intimacy, is the primary means through which one proves oneself to be masculine" (Robbins, Wester, & McKean, 2016, p. 390) should be challenged. It may be adventurous also in clinical settings to apply a "broad" definition of sex (Fileborn et al., 2017). Such a definition would be inclusive of other sexual behaviors and not rely on solely (heterosexual) vaginal penetration as being the only "real" sex. The focus could shift from the penis to the aspect of being intimate with another person and to other forms of bodily sensations that are outside the traditional masculine norms (Fileborn et al., 2017; Potts, 2000).

However, another explanation can be offered for the association between RE and ED or low sexual desire. As sexual interactivity can also be used to exchange touch as a way to experience intimacy or to communicate affection (Fileborn et al., 2017), men with a sexual dysfunction may "lose" this means of conveying intimacy and communicating affection to their partner. Men who avoid verbally expressing emotions may be affected by this loss of the opportunity to communicate intimacy more than are men who also have other ways to express emotions. Therefore, these men may experience sexual difficulties as distressing, and sexual dysfunctions become evident.

Patient–Physician Conversations About Sexual Health Issues

Gender role conflict was not only associated with a higher prevalence of sexual dysfunctions in the current study. Gender role conflict was also associated with patients not wishing to be asked by a physician about sexual health issues. These results are in line with other studies that report that masculine norms can be experienced as a barrier to help-seeking (Vogel & Heath, 2016).

However, the results of the current study seem to be in contrast to findings made by O'Brien et al. (2005) that report that men wish to obtain professional help for sexual problems to restore their valued sexual functioning in the manner defined by masculine norms. In their study, men admitted that they might be embarrassed to seek help for sexual concerns. In the current study, only RE was associated with men's wish to not be asked about sexual health issues. They might expect that such conversations could bring them into an embarrassing situation that would force them to show weakness, vulnerability, and worries. All these emotional expressions stand in conflict to traditional masculine norms (David & Brannon, 1976).

Even though the overall regression model did not reach significance, it showed that CBWFR was positively associated with the frequency of previous patient conversations with a physician about sexual health. It seems that men who focused on control and self-efficacy may also try to see health issues as an aspect they can take control of. This may have led to the greater likelihood of conversations with physicians about sexual health issues among patients with high CBWFR in the past. This result supports the recommendation that some men would be helped if the health care environment were supportive for maintaining men's masculinity that is beneficial for health (Sloan, Gough, & Conner, 2010). Some men may profit if health care environments also framed sexual health issues as something that men are able to take control of and that men can approach as an informed and responsible health care consumer (Sloan et al., 2010).

In the current study, a considerable proportion of men are affected by sexual dysfunctions. Especially these men with a sexual dysfunction wished to be asked by their physicians about their sexual health. For these reasons, the authors agree with other studies and recommendations that sexual health issues are an important and relevant topic that should be routinely addressed by physicians in health care settings (Althof, Rosen, Perelman, & Rubio-Aurioles, 2013).

Strengths and Limitations

The current study is not without its limitations. First, the sample size is relatively small for a study assessing the prevalence of sexual dysfunctions. Further, the sample consists of in-patients at the Department of Internal Medicine. This sample may have special experiences and needs that are not applicable for or representative of a larger population. The current sample mostly consisted of heterosexual men. Therefore, the study may be underpowered to find differences in sexual difficulties and sexual dysfunctions or in the wish to be asked about sexual health by a physician across sexual orientation. Further studies with more diverse samples are needed (Sandfort & de Keizer, 2001).

Second, no validated questionnaire was used to assess the prevalence of sexual dysfunctions. Therefore, the results will be difficult to compare with those of other studies of prevalence rates. The current approach was chosen to permit patients to experience how a discussion about sexual health feels before stating whether they want their physician to ask them about such topics. Furthermore, there are few validated measurements of sexual dysfunction that assess distress for each sexual difficulty. Failure to assess accompanying distress would have resulted in overestimation of the prevalence of sexual dysfunctions (see also Hendrickx et al., 2016; Mitchell et al., 2015). Therefore, the current approach seemed most appropriate.

The chosen method of face-to-face interview could have impacted patients' responses. Patients could have been reluctant to disclose sexual difficulties or dysfunctions to the interviewer. Nevertheless, face-to-face interview also has advantages. Nonresponse rates are higher with self-administered study methods than with face-to face interviews (Christensen, Ekholm, Glümer, & Juel, 2014).

Third, the focus of this study was to determine negative associations with masculine norms. There are many known negative associations of such adherence (O'Neil, 2015, pp. 165–206). However, adherence to masculine norms can also have positive associations. As also seen in the current study, some masculine norms are positively associated with the likelihood of obtaining medical help for sexual health issues. Consequently, negative as well as positive associations between masculine norms and help-seeking behavior could be considered in future studies (Kiselica, Benton-Wright, & Englar-Carlson, 2016).

Conclusion

Currently, few data are available on the prevalence of sexual dysfunctions in Austria. The current study highlights the fact that sexual dysfunctions are a prevalent problem at a medical university hospital in Austria. The study also shows that without applying the criterion of distress for the definition of sexual dysfunction, the prevalence rate, especially for PE, would have been overestimated. The close association between gender role conflict and sexual dysfunction revealed that especially men who adhere to masculine norms and feel gender role conflict as a result may attribute this distress to their sexual difficulties. The close association between masculinity and sexual dysfunction should also be reflected in international classifications of sexual dysfunction. Which aspects of the definitions and classifications are based mostly on traditional masculine norms of sexuality must be given consideration. By reinforcing masculine norms, men may experience potentially

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fulfilling and enjoyable sexual interactivity as distressing solely because they are not able to adhere to masculine norms. The issues of masculine norms for sexuality can also be addressed by physicians during a patient's clinical visit. Physicians should address sexual health issues with their patients, because patients expect their physicians to do so. A gender-sensitive approach should be applied. Physicians should be sensitive to men's reluctance to show emotions, and this may help shape an environment that defines concerns about sexual health as something that men are able to take control of and something that men can approach as informed and responsible health care consumers.

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