Case Report

Integrating Cognitive Restructuring Within Psychodynamic Therapy for Erectile Dysfunction

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Abstract

The behavior of a human being in sexual matters is often a prototype for the whole of his other modes of reaction in life.[1] Erectile dysfunction due to psychogenic cause has been a highly researched area. Psychoanalytically, it has been seen as a symptom of an underlying conflict due to early developmental experiences. The attitude of parents especially at the time of a child's emerging sexuality is considered important in perpetuating sexual inhibition and symptom. Sexual dysfunction has been found to be closely linked to anxiety and guilt and fears of punishment. This pattern of disturbance permeates into other areas of a person's life and may continue to perpetuate his symptoms. Negative body attitude and shame have been found closely linked to sexual dissatisfaction. In this paper, a case is discussed where a patient is undergoing psychodynamic psychotherapy for depression reported along with erectile dysfunction. Distorted cognitions related to his and the partner's body were addressed along with both current and past conflicts related to his current symptomatology.

Keywords

Sexual dysfunction, psychodynamic psychotherapy, cognitive restructuring, body image

Introduction

Erectile dysfunction has been an area of much research and debate. The psychogenic cause continues to be a contributing factor in a majority of younger population presenting with the problem. Studies have shown that the relationship between body shame and sexual pleasure and problems was mediated by sexual self-consciousness during physical intimacy.[2] The problem when experienced in relationships can encompass all other areas of functioning of a person's life as well. Cognition as well as conflicts both are known to contribute toward perpetuating the problem. Therefore, cognitive restructuring in therapy aimed at improving relationship difficulties may help to improve sexual dysfunction in men.

Negative Body Attitude and Shame

Body image self-consciousness during physical intimacy indicates an internalized process where people are consequently prone to heightened awareness of how one's own body appears to others.[3] A mechanism through which negative body attitudes might be linked to sexual dissatisfaction can be found in Fredrickson and Roberts' objectification theory given in 1997. Objectification is the experience of being treated as a body, predominantly valued for one's usefulness to others. Shame is a distressing emotional state that arises out of negative evaluation of oneself when compared with a personal or societal ideal.[4] Sexual traumatization, such as childhood sexual abuse, seems particularly relevant to one's attitude toward one's body.[5]

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Cognitive Interference and Sexual Dissatisfaction

Initial research focused on the relationship between cognitive distraction and sexual dissatisfaction, and found that sexual dissatisfaction was positively related to cognitive interference.[6] Subsequent studies looked closely at cognitive interference to differentiate between performance-based cognitive distraction and appearance-based cognitive distraction, though both were positively related to sexual dissatisfaction.[3]

Case Vignette

A young male, married for 2 years with no prior history of any psychiatric illness enrolled in therapy for depression. He stated that he was losing opportunities at work as others at his office were more outgoing and dynamic and he wasn't. He felt defeated and unmotivated and kept thinking of quitting his job. He claimed that though his colleagues treated him well, he found he would get angry over a lot of things. He also found himself procrastinating. He felt worthless and sat the whole day doing practically no work. He complained of backache on and off for over a year.

His wife had recently joined him after taking a transfer to the same city. He complained of occasional arguments with his wife though he reported that she was quite accommodating. He complained of erectile dysfunction for the past 6 months. Although initially he had taken pharmacological treatment and observed an improvement, it did not sustain and he currently experienced the same symptoms. No organic cause was reported. When asked what he would like to work upon, he stated that it was his anger and depression.

During the fifth session, he looked uninterested and tired. As is customary, the therapist asked him what was the problem, and if he would like to work upon? He said that he was not planning to come but came nevertheless. Also, given that he is tired he finds it difficult to be emotionally present for any therapeutic work. Noticing the aggravation of his symptoms in the therapy room, the therapist began to work toward handling the resistance.

Therapist: I notice you look tired and distracted (pointing out the resistance).

Patient: Yes, I felt like calling you today to cancel the session, but then I came.

Therapist: I see. So, you didn't call me or talk to me, but bore the difficulty (showing how he suffers alone by not sharing). Why did you not call me?

Patient: I thought you would be disappointed by me (projection).

Therapist: What kind of a relationship will it be where you have to hide what you want and continue to suffer, to please others (showing him the price of his defense of avoidance and silence).

Patient: A bad one. Actually, that's what happens at work too (gaining awareness). I have been put into a new project and my team lead keeps telling me that I should discuss my problems with her, but I don't. Later I can't figure things out because it is new to me. Then she reprimands me in front of others. Actually, she told me on multiple occasions to approach her to discuss any problems.

Therapist: What is the reason you don't ask for help?

Patient: She will judge me. She will think I pretend to be good, but I am a failure (projection).

Therapist: And here with me there is a thought that you might think I will be disappointed by you (moving into the transference to work through the resistance).

Patient: Yes, and that I have so many issues.

Therapist: Is it not what we are here to do? To work together so that we can share the burden of your problems and help you with them (inviting collaboration).

Patient: Ah yes, of course! If I don't tell my problem it is pointless coming here (more awareness).

Therapist: So, what is the problem you find difficult to take help for?

The patient then stated that the problem of erectile dysfunction for 6 months was the major reason he felt demotivated and depressed.

A detailed assessment was done regarding emotions, anxiety, and cognitive interference during sexual activity. He reported thoughts significantly related to body image and cleanliness, both pertaining to himself and his wife.

He reported that his thoughts of himself were "having a belly, not a fit body, bad breath, smelling of sweat."

His thoughts about his wife were "unsmooth skin, patches on skin, too much weight on the sides."

Distracting thoughts were also fantasies related to other women with perceived smooth skin. He stated feeling angry toward his wife at these moments and losing interest.

Differentiating Reality From Thoughts and Fantasy

Therapist: Could your fantasy and thoughts be hurting you. It seems that every time you want to get close to your real partner, this fantasy partner pops in. Obviously, since it is fantasy you can only have a fantasy relationship with her but then your real relationship will suffer, and you and your wife will never be able to get close to each other.

Patient: That's true. Since a very long time I dreamt of a women with a smooth skin. My parents were very orthodox, and when most friends were interested in girls, I was expected to study. I used to watch my friends talking so easily to girls and it felt like failure. My cousins used to call me "shorty." My mother compared me to my elder cousin who was a better personality and it made me feel I had a weak body. I started thinking I am unattractive.

Therapist: So what words describe you?

Patient: Failure, weak, bad, underachiever, unattractive.

Therapist: If these are the thoughts that come to your mind to describe you, how are you going to feel (showing him how he punishes himself)?

Patient: Depressed.

Therapist: So how true are these words (exploring syntonic reaction)?

Patient: Not true really. I have always done well and achieved much. My wife thinks I am attractive. I can see I have been beating myself up, because this is what is stuck in my mind since childhood. Possibly, I did not even try for a relationship because I feared failure (displaying good insight).

Therapist: And so a fantasy became your best relationship when you did not have a real one. But now you have a real partner, and you say she is accommodating, but looks like you still have the fantasy partner between the two of you.

Patient: Looking perplexed that means I have to give up on my fantasy?

Therapist: The good news is that there is no law which says that you have to give up on your fantasy. You can hold on to the fantasy, but every time you open the door, reality will pop up to disappoint you. Or you can accept the reality and have a real relationship.

Patient: That makes sense. Actually, my wife is quite accommodating and fulfills a lot of my requests. She must be feeling so bad, and it makes me guilty. In fact, she was very patient and understanding about my problem.

Therapist: So what do you feel toward her?

Patient: A lot of love for not judging me. I feel a lot happier now.

The patient reported no erectile dysfunction at the next session. He felt he could talk more openly to his wife and she was happy that he had begun sharing with her.

Discussion

In approaching a case of psychogenic erectile dysfunction multiple variables come to play. These include body consciousness, cognitive distortions, cognitive distractions, sexual fantasies, shame, and guilt. Distortions of beliefs and convictions about sexuality are established in childhood as a consequence of adverse influences on sexual development. Destructive attitudes are usually exerted by not only parents but also other power figures in and outside the family.[7] These attitudes may continue to affect other areas of his adult functioning perpetuating his distress. These may also add an element of resistance to intimacy in real relationships.

Conclusion

The role of psychodynamic therapy in working through these conflicts may continue to be an adjunct to the cognitive behavioral approach or other therapies in treating erectile dysfunction.

A very significant factor also includes the attitude of the partner in handling the shared sexual disturbance. Since intimacy shared between partners is both sexual and emotional, a compassionate attitude from the partner may be vital in treating erectile dysfunction.

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References

1. Freud, S. *Sexuality and the Psychology of Love*. New York, NY: Simon and Schuster; 1997.
2. Sanchez DT, Kiefer AK. Body concerns in and out of the bedroom: implications for sexual pleasure and problems. *Arch Sex Behav*. 2007;36:808-820.
3. Dove L, Wiederman MWN. Cognitive distraction and women's sexual functioning. *J Sex Marital Ther.* 2000;26(1):67-78.
4. Cohen TR, Wolf ST, Panter AT, Insko CA. Introducing the GASP scale: a new measure of guilt and shame proneness. *J Pers Soc Psychol.* 2011;100:947-966. doi:10.1037/a0022641.
5. Beiber I. The psychoanalytic treatment of sexual disorders. *J Sex Marital Ther.* 1974;1:5-15.
6. Beck JG, Barlow DH, Sakheim DK. The effects of attentional focus and partner arousal on sexual responding in functional and dysfunctional men. *Behav Res Ther.* 1983;21(1):1-8.
7. Beiber I. The psychoanalytic treatment of sexual disorders. *J Sex Marital Ther.* 1974;1:5-15.