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Case Report

Intersystemic Assessment Approach for Psychosexual Therapy in Psychogenic Erectile Dysfunction with Ego Dystonic Sexual Disorientation

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Abstract

Anxiety is the most common cause of psychogenic erectile dysfunction (ED). Ego-dystonic homosexual in heterogenous married couples can induced this anxiety. Converting Ego-dystonic homosexual to heterosexual is still controversial. Currently, many cases of homosexuals are required to accept their identity and do not require conversion. We report 44-year-old man who has been married for six years complains of difficulty and decreased erection for 5.5 years. This man had a history of sexual intercourse with men during college but decided to become a heterosexual man and married his current wife. For the first six months, the patient performed oral sex with his wife. Then afterwards, the patient has difficulty getting an erection and even fails. The patient feels guilty toward his wife until their relationship becomes a crisis. The patient wants to commit to being a heterosexual man. We applied intersystemic assessment approach to the patient. There is progress in the patient's condition until now. Dystonic sexual orientation could cause a disturbance in the emotional and motivational parts of the brain responsible for erection. Behavioural therapy can be applied in patients with ego-dystonic homosexuals. Several steps needed to be taken in certain duration to improve the outcome. Many experts say that homosexuality should be accepted and should not be converted. But in the end, the choice is returned to the patient, whether to choose to convert or not. Physicians only need to support the patient's therapy and choices so that he does not experience any mental disorders that ultimately endanger his life. We followed this approach and this method seems efective to this patient.

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1. Introduction

Psychogenic erectile dysfunction is pervasive in young adulthood. The most common cause is certain psychological anxiety or fear. These anxieties can arise due to several aspects, one of which is the (history of) sexual disorientation in heterogeneous married couples such as homosexuals.1 Since the 1990s, homosexuality has been excluded from the DSM-III and is not considered a disorder.2 In some countries, sexual disorientation is still not accepted as usual, this raises a lot of controversies, ethical problems, and professionalism.3 What if a homosexual patient who wants himself to be heterogeneous leads to abnormalities such as erectile dysfunction? Is it still relevant to be treated or not? Will the choice continue to help the patient overcome his homosexuality or support him to accept his homosexuality? What kind of information that clinician needed in the era ease information and technology?

We conducted a literature review of the clinical cases we encountered at the Andrology clinic of Dr. Soetomo General Hospital.

2. Case

A 44-year-old married male, work as a property agent with high educational background, came to the Andrology Clinic with chief complaint of difficulty in getting and maintaining an erection in having a sexual intercourse with his wife. This complaint started around 5.5 years ago so in this period, he had difficulty in having a sexual intercourse with his wife. In the first 6 months of marriage, he usually had an oral sex with his wife, and they did not have any problem with this sexual pattern. Besides having an oral sex with his wife, he seldom had a penetration into the vagina. Patient stated that during oral sex and vaginal intercourse, he did not have another sexual fantasy beside his wife. In these 6 months period, he also did not have any erection problem (Erection Hardness Score = 4) and enjoying their sexual pattern. After six months, patient started to have a difficulty in getting and maintaining an erection.

Patient was having a quite long sexual history. From child to middle school, he said that he was close to both of his parents, but during childhood his father like to hold and carry on the shoulder. His friends were almost same in the number, between male and female. He denied any history of playing with dolls or any other girls' toys. In high school, he started to get interested in his dad's penis, but denied any desire to touch or explore it. Later his dad was passed away, and he lost his father and male figure in the family because later he was living with his mom and sister. He was dating a girl for 6 months in high school.

In college, he was not having any special interest in maintaining a friendship, he had the same amount of male and female friends and enjoy with everyone. But there was one male senior in his college asking for extra attention and getting close to him. At first the senior did not say anything about gay or any sexual orientation, but as time goes by, the senior started to show a sign of homosexual orientation. The senior asking him to do an oral and anal sex. At first, he did not want and denied it, but later he said that he was finally trying an oral and anal sex with his senior. He was given and got oral and anal sex together with his senior alternately. He said that he was feeling loved and cared by the senior, so he was enjoying this sexual activity. He was also feeling that same-sex sexual activity was comfortable and enjoyable, so they did it again several times. He was having a same-sex relationship during college. After college, he did not have any relationship anymore.

He met his wife first time after college; their families introduced them. He was having and intense communication and relationship with her, so they decided to get married after one year. They lived together with his family together with his mother and sister. His wife did not enjoy it, as his sister was too superior in the family. They planned to live by themselves, but their financial situation did not make it possible. During their first 6 months of marriage life, as mentioned earlier, they enjoyed their sexual life together. But time after time, especially after 6 months, he had no passion for his wife so he sometimes secretly watching gay porn. Later, his wife caught him watching gay-porn and mad at him. Because he had no interest with his wife, he could only get an erection early in the morning. He asked his wife to have a sexual intercourse in the morning, but his wife always refused him because she wanted to go to work. When trying to have a sexual intercourse at night, his wife always fell asleep. After this sexual problem arise, in the last 3 months his wife was living with her family even though they always communicate to each other every day. His wife asked and wanted to divorce him, but he insisted and committed to continue their marriage life. They decided to regularly go to church for counseling, to psychologist and andrologist.

Past Medical History

His first wet dream is when he was 13 years old. Both patient and his wife were on their first marriage, have been married for 6 years and have no child. The patient denied any past medical history of any chronic disease.-He also denied any history of trauma or operation. He did not smoke and did not on certain routine medication.

Before he came to our Andrology clinic, he had checked himself to other doctors, but he felt that there were not any significant differences. In the past few weeks, he consulted his condition to psychologist and priest at the church and feel that there was a little improvement, so he decided to have another try to go to Andrology Clinic to make it better.

Psychological history found that he has a psychological relationship problem with his wife. His wife unlikely to have a sexual intercourse with him; always denied him when he wants to have a sexual intercourse. He was still sexually attracted with his wife and did not have another partner. He thought that this erectile dysfunction condition was caused by his past sexual orientation.

Sexual History During His Marriage Life

He said that his libido was good and still sexually attracted to his wife, but when he was having a sexual intercourse with his wife, he hardly maintains his erection because he had not forgot his past sexual activities with his male seniors; but when he had another sexual activity (such as masturbation) he can easily maintain his erection. During masturbation, his fantasy is his wife.

Nocturnal Penile Tumescence positive and easily having an erection during masturbation. IIEF-5 score was 8. He did not have ejaculation problem.

His predisposing factors were age, sexual, childhood memories and personality. His precipitating factors were personal and interpersonal conflict, decreasing income during pandemic and coping mechanism, whereas his perpetuating factor were metabolic syndrome, decreasing income and separation with his wife.

Physical Examination and Laboratories

His vital sign was within normal limit, while his height is 169 cm and weight 85kg, with BMI 29,8 kg/m^2 (fall under obese classification for Asian subgroup). Abdominal examination shows central obesity. Genital organ within normal.

Based on anamnesis and physical examination, we diagnosed this patient with moderate erectile dysfunction et causa psychogenic cause, ego-dystonic homosexual, and obesity grade I. Patients bring his laboratories examination (within normal).

For the first visit, we educate the patient: about the possible diagnosis for the patient and early psychosexual treatment (few sessions for psychotherapy), that his case was multidiscipline, with doctor, psychologist and church counselor involved in this case, promoting the patient to continue his couple therapy with psychologist and church counselor, early assessment involving motivation, expectation, and bio psychosexual background of the patient, and still lifestyle modification.

Table 1. Laboratories Results of The Patients.

Parameter	Results	Normal Value
Hemoglobin	14.4 gr/dL	13.3 – 16.6 gr/dL
Hematocrit	44.8%	41.3 – 52.1 %
Fasting blood glucose	106 mg/dL	<100 mg/dL
Total Cholesterol	212 mg/dL	<200 mg/dL
Triglyceride	126 mg/dL	30-150 mg/dL
HDL	36 mg/dL	40-50 mg/dL
LDL	155 mg/dL	<99 mg/dL
Prolactin	133 uIU/mL	54-340 uIU/mL
Testosterone	2.54 ng/mL	2.2-10.5 ng/mL
PSA	0.29 ng/dL	≤ 4 ng/dL

Therapy Plan

We plan some of the therapy sessions that we describe in Figure 1. We conduct an intersystemic assessment approach in this patient. Identification of the main problem and condition that influence his erection process was done. We also explored the patient's current sexual experience and the quality of his relationship with his wife. We assess a lot of things about his psychological problem that may alter his condition. Psychological approach by using cognitive behavioral therapy was done in this patient. We also advise this patient to do a regular exercise and balanced rest as the lifestyle modification. We did not give any medication related to the psychological condition of this patient. Periodic evaluation was recommended and this patient follow our recommendation. After several therapy session, patient stated that his communication with his wife were getting better. He picked up his wife every day from her office, but they still lived separately. They had finished his counseling at the church, and they felt that every day they were getting better. They planned to live together again by finding house/apartment that is available for rent. Based on his laboratory's

examination, the diagnosis of obese was changed into metabolic syndrome.

Identification Of the Main Problem and Cognitive Adjustment

• Create a comfortable atmosphere for the patient to talk and share his story, build communication between doctors and patient
• Exploring and excluding organic cause and other psychopathological conditions
• Exploring the background and identify the patient's problem (male) starting from childhood, adolescence, young adults to marriage
• Exploring the patient's sexual experience: sexual experience from childhood, the most enjoyable of all sexual experience. Highlighted every pleasure derived from the experience and the reason behind it. Including exploring the presence or absence of gender conformity
• Exploring the quality of the relationship with his wife, including sexual relations, fantasies during intercourse, as well as the patient's wife's response to it
• Ask the patient's expectations with current treatment and their motivation
• Continue to encourage the patient to communicate regularly with his wife
• Ask the patient to bring his wife together; to identify his wife's problems

Periodic Evaluation and Restructuration

• Facilitates the emotional expression of the patient and his wife every session
• Evaluate the results of commitments from previous meetings, including with other counselors, such as communication and love language between couples (how, what factors contribute to success and failure), including minimizing the predisposing, precipitating, and perpetuating factors
• Educate about emotional management when failing to fulfill the commitments
• Educate the nature of simple sex such as "sensate focus"

Consolidation, Training and Maintenance

• Periodic evaluation of each assignment and exercise that has been taught before
• Start to advise the patient to slowly start having a sexual intercourse with his wife. For the first time, advise to use the start-stop technique to harmonize the rhythm with his wife.
• Evaluate other issues that are still developing and decide the final commitment for further therapy and decision

Figure 1. Therapy Plan for Several Sessions

After several months of therapy sessions, both with the consular at church. The patient lives at home with his wife. He has started having intercourse with his wife, although sometimes it fails, but the patient's wife accepts the shortcomings and continues to support the patient. The patient's mental condition is more stable and got with his condition. The patient said the support from his wife, family, and the patient's closest community helped the patient better. Information that patients share with us via telecommunications. His married life is now much better with his wife.

3. Discussion

Psychogenic erectile dysfunction defined as the persistent inability to achieve or maintain an erection during sexual intercourse caused by psychological and interpersonal factors; while organic erectile dysfunction was due to organic problems (vascular, neural, or hormonal factors). 4,5 Main factor which causes erectile dysfunction in this patient were his dystonic sexual orientation and his bad relationship with his wife. From the physical examination and laboratory parameters

such as testosterone within normal, so testosterone decline induced erectile dysfunction can be excluded.6 Based on this factor, we diagnose this patient with psychogenic erectile dysfunction.7

In this patient, we hypothesize that there were disturbances in the emotional and motivational parts of the brain that interfere with the erection process in these patients. The anamnesis that plays an important role is the history of sexual development in the past, where he lost his father figure when he was young and his senior who invited to have a same-sex sexual relations in college.

The first time he had sex was having same-sex relationship with his seniors in college, which was fun for him, while when he was with his wife, it was difficult for him. When he grew up, he didn't find any sexual passion for his wife as high as his past sexual history. His wife had to join and live with his families which made her even more uncomfortable. These difficulties causing him to start remembering the past and started watching gay porn videos, things he can enjoy from his past.

The diagnosis of psychogenic erectile dysfunction is established through a thorough history and physical examination. Intersystemic assessment approach is needed in the treatment of psychogenic erectile dysfunction (Figure 2).

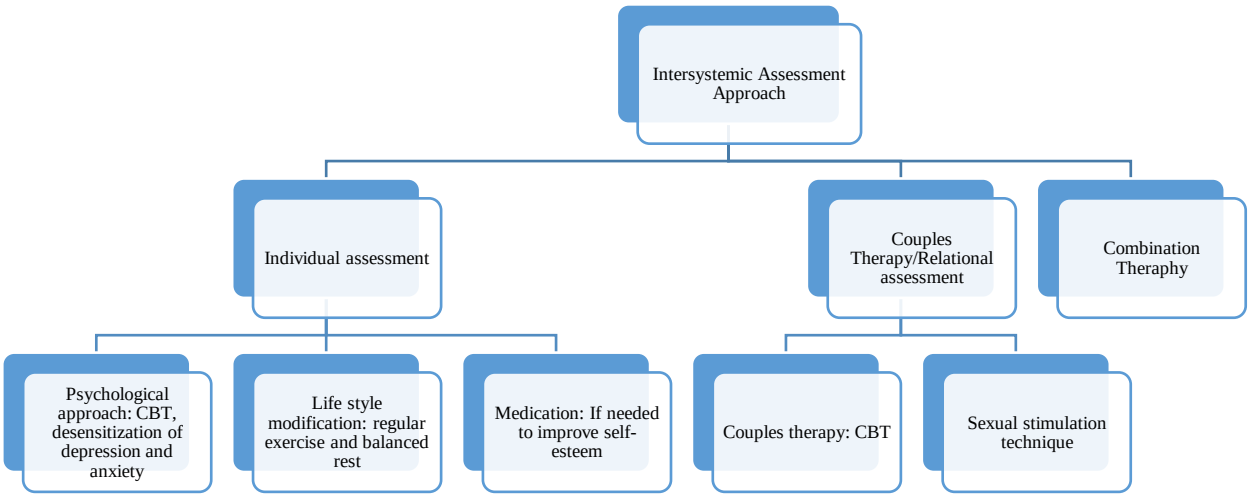

Figure 2. Intersystemic Assessment Approach in Psychogenic Erectile Dysfunction

*CBT: Cognitive Behavioural Therapy.

The principle of the treatment in patients with psychogenic erectile dysfunction is to understand the cause, understand the cognitive and the patient's fear, understand the patient as well as teach the patient to be able to control the fear, then determine the action. Sexual therapeutic approach is one of the main treatments of psychogenic erectile dysfunction.[7]

Ego-dystonic sexual orientation described as gender identity or sexual preference that is not in doubt, but the individual wishes it were different because of associated psychological and behavioral disorders and may seek treatment to change it. This patient can be classified into ego-dystonic homosexual because: (1). Realize that his sexual orientation is not normal, (2). Hiding his sexual orientation because he worried about stigmatism and social pressure from others, and (3). Married because he thought that heterosexual is the only normal sexual orientation.

Ego-dystonic homosexual and erectile dysfunction is related to one another. The prevalence of erectile dysfunction is between 13.2%-25% in homosexual.[8] The mechanism of how ego-dystonic homosexual affect the erection is that impaired sexual preference, past sexual trauma, misunderstandings about normal sexual function, depressed feelings about sexuality and wrong pleasures will cause feelings of depression, guilt, anxiety, and fear. This condition will cause GABA, noradrenaline and serotonin became the dominant neurotransmitter. The dominance of this neurotransmitter will cause disturbances in the erection process.[9,10]

Therapeutical approach in ego-dystonic patient is still debatable. One suggests that the aim of the treatment is to evaluate the sex orientation; but it is

still controversial and experimental. Cognitive behavioral therapy and pseudo heterosexual are several provided to relieve dysphoria in male patients with ego dystonic homosexuality.[11] Another treatment approach in patients with ego dystonic homosexuality were also intersystemic approach and sexo-analytical model.[12] Claude Creult in his paper described the steps taken in behavioral therapy and factors that support the success in the therapy. First step is sexo-analytical model, followed by early assessment (motivation, gender confirmation, sexual fantasies, family support and heterophobia), sexual analysis (individualization of sex in patient) and the last step is defining the therapy sessions and durations. Factors supporting the success rate in this therapeutical approach are motivation to change, minimal gender inversion, homosexual who are free from other psychopathologic condition, enable to create a heterosexual sex fantasies and support from families and communities.[12] We did this intersystemic assessment approach and therapy systematically to this patient. First we identified what is the main problem. It turns out that the main problem affecting his erection was his anxiety caused by sexual dystonia. This conclusion is taken after exploring the patient's background and past sexual experience. We did not find any significant organic cause of his DE. We followed this patient as what he wished; to ease his ego-dystonic homosexuality. Periodic evaluation and assessment was conducted and yields a good outcome. This intersystemic assessment aproach and cognitive behavioral therapy method seems effective to this patient. Things that must be adhered to by a doctor when handling any case, including cases of sexual dysfunction with (without) sex disorientation, are the basic principles of ethics, autonomy, beneficence, non-maleficence, and justice.

4. Conclusion

Although the treatment of homosexuality is still debated then there are still very few studies related to similar cases (because they may be considered unethical), in our opinion, the decision still depends on the patient's choice. Physician only helps patients to be as comfortable as possible with their choice. We followed this intersystemic assessment approach in this patient; as this patient chose to convert his sexual dystonia to become a heterosexual. After several follow-up discussions, his condition seems improving and we hope that this patient will stick to the choice that he made.

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Author's Contribution

All authors have contributed to the final manuscript. The contribution of each author as follow: collected the data, drafted the manuscript and designed the figures, devised the main conceptual ideas and critical revision of the article. All authors discussed the results and contributed to the final manuscript.

Conflict Of Interest

The Authors State There Is No Conflict Of interest.

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