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CASE REPORT

Psychosexual therapy in a cognitive--behavioural approach. A case of a patient with erectile dysfunction and masturbation conditioning

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Abstract

Introduction: *This article aims to present a case of a patient suffering from erectile dysfunction and therapeutic methods used with the patient in a cognitive-behavioural framework.*

Materials and methods: *The key elements of the diagnostic interview and techniques based on the cognitive--behavioural approach are presented. The therapeutic work focused on the patient's anxiety during sexual contact with his partner and reconditioning from masturbation to partner-based sex.*

Results: *The patient successfully achieved some of the goals set by the therapist. As a result of the therapeutic process, the client gained better insight into the factors shaping his sexual life. The client reports that he and his partner now rate their sexual life very positively.*

Conclusions: *Normalising the client's dysfunctional thoughts and beliefs allowed him to correct misconceptions about himself as a sexual partner and his partner's expectations. Based on his work, the patient learned to focus his attention on erotic stimuli and pleasurable bodily sensations, rather than on thoughts and anxiety-provoking stimuli.*

Keywords: CBT, erectile dysfunction, masturbation conditioning

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Introduction

In Poland, approximately 43% of women and 46% of men suffer from sexual disorders [1]. Considering the fact that psychogenic factors play a significant role in the onset and persistence of these disorders, the use of various methods in the treatment of sexual disorders, such as pharmacology, physiotherapy, surgery, education, and psychotherapy, seems advisable. According to Leiblum and Rosen [2], in the psychotherapy of sexual disorders, it is important to focus on reducing or eliminating the disorders, using behavioural methods, ensuring short-term treatment, and adopting an approach that involves both partners in the process.

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Erectile dysfunction is the most common sexual dysfunction for which men seek help from a sexologist. For many men, they are a distressing psychological issue. In recent years, the percentage of men experiencing erectile dysfunction (ED) at a younger age (under the age of forty) has significantly increased [3]. An increasing number of young men (around 30%) are currently reporting ED, which requires a comprehensive approach to treatment [4–6]. Studies confirm that ED seriously impacts the quality of life of men [7, 8].

The underlying mechanisms of erectile dysfunction may include: disorders of sensation, processing, and transmission of stimuli, disturbances in blood flow to the penis, and failure of the system responsible for initiating and maintaining an erection [1]. In the aetiology of erectile dysfunction, it is crucial to assess the patient's health status, and the medications they are taking, and to identify the psychogenic, biological, and mixed causes. Other factors affecting erectile reactivity include:

personality traits, sexual needs and preferences, self-esteem as a sexual partner, sense of worth, attitudes toward sex, insecurities, spiritual views, partner relationships, cultural conditioning, social norms, societal attitudes, proper psychosexual development, and early sexual experiences [9]. Psychological factors also include: lack of sexual education [10], mental disorders [5], family pressure and conflicts in relationships outside of marriage [11], insecure attachment in childhood, and feelings of guilt due to early sexual encounters [12].

Among individuals suffering from ED, a significant portion primarily experiences non-organic or psychogenic ED. Non-organic or psychogenic erectile dysfunction is a persistent inability to achieve or maintain an erection adequate to complete sexual activity caused by non-organic or psychological factors. Non-organic or psychogenic ED can be distinguished from organic ED if the problem appears suddenly, nocturnal erections are observed, and erectile dysfunction occurs only in certain situations or contexts [6]. It has been shown that psychological factors significantly contribute to the development of non-organic erectile dysfunction at a young age [6, 13]. Non-organic erectile dysfunction in young men is often accompanied by symptoms of depression or anxiety [14]. Anxiety causes stress in them and inhibits the proper sexual response, leading to ED. Cognitive factors play an important intermediary role in the development and maintenance of non-organic ED, such as maladaptive attitudes, dysfunctional beliefs, and negative automatic thoughts with an excessive focus on achieving an erection [15]. These, in turn, lead to the anticipation of sexual failure, reduced erection, and anxiety about failure [16].

Psychosexual treatment of sexual disorders consists of various approaches, including cognitive-behavioural techniques, interpersonal methods, systemic approaches, traditional sex therapy, behavioural exercises, mindfulness training, communication skills training, and psychodynamic interventions. Cognitive-behavioural therapy has proven to be an effective treatment strategy for psychological or non-organic ED in young men [17–19]. Recommended strategies and techniques in the treatment of erectile dysfunction include: psychosexual education for the patient, identifying the problem in the context of the patient, sexual role-playing exercises, restructuring sexual attitudes, Socratic dialogue related to sexual activity, building sexual communication skills, bibliotherapy, eliminating myths related to erections, addressing fears (of failure, intimacy, dependence, negative feelings), working on cognitive aspects, assigning homework, and encouraging spontaneous sexual encounters [1, 17, 18].

Case report

A 36-year-old man sought psychosexual consultation at the suggestion of his partner. During the first visit, he expressed that he did not know what to do to have "normal" (the patient's term) sex. When asked to describe the problem in his own words, he explained that every time he puts on a condom, he loses his erection and, as a result, is unable to engage in penetrative sex with his partner.

The patient was born at term, without complications during pregnancy, childbirth, or the postpartum period. He was his parents' first child. His parents were married and, since their wedding, lived in the same household as his father's parents. The patient described his father as hardworking, slow, and boring. From the patient's account, it appears that his father spent most of his life working and, after work, did not engage in family life—he rarely took care of the children and never had any household duties except taking out the trash and vacuuming. His hobby was working in the garden. According to the patient, his father never had the opportunity to become independent, as he lived his entire life in the same household with his parents, and after their death, with his wife and children. Among the typical behaviours of his father after work, he mentioned watching the news and reading newspapers. The patient's mother worked at the same industrial plant as his father. The patient described his mother as energetic, resourceful, and cheerful. She took care of the children and the household, and after finishing her maternity leave, she returned to work. From his childhood, the man remembers that his mother was in conflict with her mother-in-law, and his father often sided with his mother rather than his wife. The patient has one sister, two years younger than him, and when asked about his childhood memories with her, he replied that they were a normal sibling pair—they enjoyed playing board and logic games together, sometimes argued and fought, but generally, each of them had their own life and interests.

The patient assessed his parents' marriage as stable but characterised by ongoing conflict. He recalled how, after arguments, his mother would say that she was going to move back in with her mother. When the children were teenagers, the woman would sometimes pack her bags after an argument with her husband and go for a few days to stay with her mother, who lived in a different part of the same city. The man claimed that as long as his grandmother (father's mother) was alive, conflicts would occasionally arise in the household between the siblings, the parents, and within the

triangle of mother-in-law, mother, and father. At the same time, he believed that he received a great deal of love from his grandmother and mother during childhood, while his father encouraged his development by enrolling him in foreign language classes and swimming lessons. In childhood, the siblings were mainly cared for by their grandmother — she looked after them while their parents were at work, cooked for them, and took them on walks, to playgrounds, or the seaside. The siblings did not attend daycare or preschool. The upbringing involved the use of rewards and punishments, with a small inclusion of physical punishments, such as a slap. The family's financial conditions changed in the 1990s when the heavy industry began to decline, and the father's company stopped paying him regular wages. During this time, the mother changed her job and eventually worked in the administrative department, earning a modest income that allowed the family to make ends meet while the father was not receiving his overdue salary. The client fondly recalls his preschool and early school years, when he could carefree play outside with his friends. His darkest memory is the moment when upon returning home he found his grandmother deceased on the floor. He claims that during his childhood he did not engage in masturbation or sexual play. Sex and contraception were not discussed within the family.

He remembered his biological maturation positively, feeling pleased when his pubic hair began to grow. As he got older, he started gaining weight and became dissatisfied with his body, but as he puts it, "he got his act together" — and began exercising, switched to a diet, and achieved a physique he was satisfied with. During adolescence, he was surprised by unexpected erections throughout the day, as well as nocturnal and daytime ejaculations. He shared that during his first nocturnal ejaculations, he felt disgusted because he would wake up feeling wet and sticky. He discovered that masturbation helped him control his erections and ejaculations, so after a few initial nocturnal ejaculations, he began masturbating regularly. He started masturbating at the age of 13–14. He masturbated with his hand, imagining girls, women, or pictures from pornographic magazines that his friend was buying second-hand in a nearby market. Masturbation was not associated with any emotions except pleasure and the fear of being caught by his parents or that his mother would find traces of his sperm in the laundry. He believed that masturbation was essential for controlling his sexual urges. As he put it: "Masturbation helped me relieve pressure". According to his account, at a certain point in his life (late high school and college), he masturbated several times a day, and in his opinion, that was too often. He remembered being sexually educated by his friends from the neighbourhood, and he gained more information from biology classes and his friend's pornography magazines. He described that sexual awareness was stimulating and exciting for him.

During the childhood and adolescence, he was attracted to women and girls. When seeing an attractive woman on the street or a tram, he would often get an erection, and on a few occasions, he also experienced ejaculation. He will recount that when he was 14, he had an erection during a medical examination at the sight of a pretty colleague of the examining physician. The doctor, who examined his penis and testicles at the time, said that „she sees that everything is fine down there", and left with a friend. The patient stated that although the encounter was a little odd, there were not any more intense emotions or memories associated with it. During his adolescence, he had erotic fantasies about women he met, and he also had a crush on several classmates and young teachers. In high school, he dated a girl from another class for a month. He did not have sex with her, did not kiss her, and they did not engage in any intimate touches. The man recalled that they held hands and mostly hugged each other. During his university years, he was not in a committed relationship nor did he engage in sexual contact with anyone.

The patient works professionally (he runs his own company) and has been in a relationship with a woman for the past two years. He met his current partner through his ex-girlfriend. They do not share a home, finances, or children. Neither of them had been previously married. They meet regularly every week and stay at each other's places several nights a week. This is the first long-term relationship in his life. The current partner is the patient's first sexual partner and also the first woman to whom he has confessed his love.

The client experienced his sexual initiation while being in a steady relationship with his current partner at the age of 36. The sexual intercourse took place in the room that the woman was renting at the time. The intercourse took place at the initiative of the client's partner. The man described that his motivation was curiosity and arousal. He had never had penetrative sex with anyone before. He felt that

he was in love with the woman and was eager to experience his first time with her. When asked how he would like to do it, he replied that he didn't know. The partner suggested two possible positions: the classic and her on the top, and the client chose the latter option. He admitted that he was so stressed that he preferred to lie down and let his partner take the initiative. After putting on a condom and applying the lubricant, the partner straddled and started kissing him, then grabbed his penis in her hand and massaged it on her vulva. For the patient, it was pleasant at first, although at some point he began to feel discomfort associated with friction. The patient mentioned that the moment of penis penetration was difficult for him. He did not know what to do and relied heavily on his partner. After penetration, his girlfriend began stroking and kissing him and then began to move slowly. The feeling was new, strange, and pleasurable for the patient. Unfortunately, after a few thrusts, the patient began to feel the pain, and after several more, the pain became so uncomfortable that they had to end the intercourse. Both became concerned about the man's pain. The man mentioned that the pain was related to the fact that his foreskin slipped very low. The patient usually masturbated with the foreskin covering the penis and never pushed it as far as it happened during intercourse. The woman suggested that he take a warm shower to relieve his discomfort. In case the pain didn't subside, she suggested a visit to a nearby hospital. After taking a shower and pulling the foreskin over the penis, the pain was somewhat alleviated and the man did not choose to see a professional. However, the pain was still noticeable the following day. In retrospect, the client evaluated his initiation as positive. If he could change anything, he would definitely use a different type of condom (since then, he discovered non-latex condoms, whose structure and lubricant he liked), have a little alcohol, and take a long, warm shower before intercourse.

After the first intercourse, the patient was afraid of subsequent encounters, so his sexual activities mainly consisted of manual stimulation, oral sex, and rubbing. At the same time, the man decided to „exercise" his foreskin. He noticed that during and after a shower, his foreskin is flexible enough that he can move it freely without experiencing pain. This was important because he had promised his girlfriend that if the pain reoccurred, he would go to the doctor. And he had no desire to see the doctor.

During the relationship, the couple tried sex with a condom several times, but the client began to lose an erection during the intercourse — first during frictional movements, then at the moment or just before the penetration, and later even when putting on the condom. When asked about his theory regarding the situation, he replied that penetration itself is not very exciting for him, and additionally, the feeling of the condom on his penis is distracting. During subsequent intercourse, he no longer felt pain, especially after switching to a different type of condom.

The current situation of the patient

The man reports that the very idea of penetrative sex has become stressful for him. The patient feels pressure regarding maintaining an erection, but the more he cares about it, his penis is "less cooperative". He feels that his partner is disappointed because of this. He does not understand what the problem is, as he was previously able to have penetrative sex multiple times in a row. He admits that during penetration, at some point, his penis lost rigidity enough that it was necessary to stop the intercourse. The client believes that his penis "does not like" the condoms. He describes the sensation after putting it on his penis as "having a bag on the penis". And for him, this is frustrating and unnatural. When asked whether he had considered another form of contraception, he answered that he had not. He believes that hormonal contraception (pills, patches, IUD) is unhealthy and unnecessarily interferes with a woman's body. However, he does not feel ready to have children and therefore uses condoms. He is also considering having children in the future, which is why he categorically rules out a vasectomy. He evaluates his levels of sexual needs as normal. He would prefer to have sex once or twice a week, although he says there are weeks when they have it more often.

The patient regularly experiences morning erections. They occur most often every day, although there are rare days when they are absent or minimal. He notices that waking up with his partner is usually arousing for him and leads to strong morning erections, which last for a long time and prevent him from urinating or putting on his pants. He describes his sexual life as satisfying, except for erection problems after putting on a condom. He enjoys kissing his girlfriend, touching her, and rubbing against her. They bring each other to orgasm through kissing, caressing, and rubbing with hands, or other parts of the body. He

admits that when he masturbates by himself (alone or during sex with his partner), his erections do not disappear and he can always orgasm with ejaculation. He reports that during vaginal intercourse, the feelings of a penis are less stimulating than when masturbating and rubbing against a partner. He also describes that it is difficult for him to find where to insert the penis by rubbing it against the inside of the vagina, but with his hand, he finds the entrance without any issues. He also mentions that the height difference between him and his partner makes it difficult for him to find a comfortable position where he could experience pleasure without his penis slipping out of the vagina. He never managed to reach orgasm during penetration because he usually lost an erection before he reached that point. When asked how important penetrative sex is to him, he replied that he would like to be able to engage in it without problems, but he believes that this type of sex is overrated and less pleasurable than other forms of intimacy.

The interview suggests that the client masturbates once a week, sometimes while watching pornographic films. His favourite type of pornography involves women in swimsuits or nurse uniforms. He claims that sex with his partner is more pleasant for him than sex alone. He considers himself a good bed partner, believing that he quickly learns what works for his partner. For him, the purpose and meaning of intercourse with another person are closeness and pleasure. He believes that sex should be fun.

Diagnosis according to ICD-10

The patient was diagnosed with a disorder from the F52 category (sexual dysfunction not caused by an organic disorder or somatic disease), more specifically F52.2 (lack of genital response, erectile dysfunction in men). The indicated sexual dysfunction prevents the patient from engaging in sexual intercourse according to his desires for at least six months, although in certain situations, the dysfunction may not manifest. The patient experiences morning erections. Full erection occurs during foreplay, but it disappears or diminishes when attempting penetration, before ejaculation. Often, after putting on a condom, the erection is insufficient for intercourse.

Additionally, the patient exhibits a conditioning towards masturbation, described by Imieliński [20] as a syndrome of encoded sexual responses. The patient has fulfilled his sexual needs through masturbation throughout his entire sexual life. He has probably conditioned himself to a specific type of arousal associated with stimulating his penis with his hand, and the frictional movements in the vagina do not bring him the same pleasure. It should also be noted that the patient has never used condoms or lubricants during masturbation throughout his life, and as such, the presence of these products may distract him from sexual stimuli and contribute to the loss of erection.

The patient's past illnesses are not relevant to this case. The patient does not take any medications, does not smoke cigarettes, does not abuse alcohol, and does not use any stimulants or drugs. His body mass is within the normal range. The client regularly engages in sports and leads a healthy lifestyle. The client is not undergoing treatment in the fields of internal medicine, neurology, cardiology, urology, or endocrinology. The reported pain in the penis during the patient's first sexual intercourse suggests the need for a urological consultation, as the patient may be suffering from phimosis. The patient was advised to visit a specialist, but as of now, he did not go for the appointment.

Description of the patient's functioning, including problematic areas

The client came with the belief that his sexual failures are due to a physical or psychological defect. He was convinced that something was wrong with him. Unsure where these problems originated and suspected they might stem from his lack of experience and technique. He admits that at the very beginning of his sexual activity, he was filled with anxiety. He mainly did not know how to put on a condom, was unaware of lubricants, feared initiating penetration and where or how to insert his penis, and worried that stress might cause him to lose his erection. When his partner suggested oral sex, he was not sure how to respond. He was also frightened by the thought of ejaculation in someone's presence. The aspect of sex and his inexperience in this area were uncomfortable for him.

In his current relationship, the patient seems to function well. The patient's undeniable psychological strengths are his resilience and optimism. His account also suggests that his partner openly communicates her needs and fears, and makes a considerable effort in the relationship when it comes to initiating conversations about emotions and beliefs related

to their sexual life. Where the patient seems to feel comfortable in this environment. He admits that the stage of getting to know the woman, before officially entering into a relationship, was aimed at ensuring that he would be able to trust her also in the sexual sphere. From his account, it seems that he would never engage in sexual initiation with someone he was not sure about. This certainty was meant to ensure that, in case of a sexual failure, his partner would not ridicule him or share the incident with others. It seems that the man's empathy, openness, and high manners also work to his advantage. Moreover, from the patient's words, it is clear that he was looking for these traits in a woman, which also shows a significant insight into his needs or a tendency toward protective behaviours.

The only disadvantage for the patient is the lack of social support. He seeks information on the internet about how others have dealt with his situation, and cannot imagine having a conversation about this topic with his peers. Firstly, he believes that men do not talk to each other about sex with their long-term partners. Secondly, he is convinced that his peers have long since passed the initiation stage. Admitting that at first, he was very reluctant to talk to his partner about sex and that it was always her who initiated the conversation. This shows the patient's reluctance to confront difficult emotions and topics, as well as insufficient communication skills. This does not seem particularly surprising, given the patient's family history in the context of the lack of discussions about sex in his family home. It seems, however, that despite evident shortcomings in communication, the client is adapting to the new situation and learning to talk about his needs and fears. An area to work on is psychosexual education and learning to use "I" statements with the understanding of empathy for the other person.

Analysis of mechanisms shaping sexual disorders

The triggering factor of the problem is the intimate situation in which the patient is already past the stage of foreplay, and it is time for caresses, mutual touching of their genitals, and oral and/or manual stimulation. At this point, an automatic thought arises in the patient's mind that soon his partner may want him to put a condom on his penis (which the patient dislikes), then apply cold lubricant to his penis, and they will attempt penetration, which will, of course, end in failure due to the inability to maintain and the loss of erection for the rest of the evening, making him feel terrible due to the lack of sexual satisfaction for his partner.

As part of the emotions, feelings of fear, anticipatory tension, stress, doubt, shame, and guilt will arise. The patient will focus on putting the condom on as quickly as possible without losing his erection. In the presence of difficult emotional states, the patient's attention will shift away from sexual triggers and focus on non-erotic thoughts. These emotions, combined with non-erotic thoughts or the fear of failure (that it will not work again), lead to the physiological loss of sexual arousal and the loss of erection. The behavioural response will be the termination of the intercourse and withdrawal from the intimate situation, accompanied by feelings of sadness, shame, and doubt.

Over time, the client often avoided penetration sex during intimate situations — and told his partner that today he could not go on or that he was aroused for too long, he did not feel ready or he did not want to do it. A few times, he expressed that he preferred to have sex without penetration because it would be enjoyable for both of them, whereas if they chose penetrative sex, it would only leave them with an unpleasant memory of a lack of sexual satisfaction. He also admitted to drinking alcohol before intercourse, believing it would help him relax and stop worrying about his erectile issues. At one point, he also bought Sildenafil tablets after finding information online that taking an erectile dysfunction medication might help him overcome the psychological barrier preventing intercourse. He has not yet decided to take them. The patient also bought a masturbation egg because he wanted to see how this type of stimulation would affect him.

At the time of seeking advice, the patient believed that the problem with maintaining an erection negatively affected his well-being and the functioning of his relationship. He believed that his girlfriend was disappointed and would like to have sex more often. After the last conversation with his girlfriend, which took place after the failed sexual encounter, the patient cried for two hours. Upon returning home, he got drunk and played video games. He said that a joke made by his partner at a delicate moment for him caused a slight breakdown. On the other hand, his partner felt guilty afterwards for hurting him. The client believes that both of them are tired of this topic and would rather just enjoy closeness with their partner.

Therapy/assessment plan

In the process of formulating goals, the example provided by Cysarz [9, 21] was used. The main goal of therapy was to reduce the patient's anxiety in sexual contact with his partner. The specific goals were:

a) Psychoeducation in the cognitive model of a human being,
b) Psychoeducation on emotions with particular emphasis on anxiety and fear,
c) Psychoeducation about the sexual response cycle according to Masters and Johnson,
d) Psychoeducation on the concept of "good enough sexuality",
e) Psychoeducation focuses on common myths and misinformation about sex,
f) Learning to recognise and analyse automatic thoughts,
g) Learning to recognise his emotional states by the patient,
h) Learning to identify cognitive distortions,
i) Identification of the patient's beliefs about themselves and their partner,
j) An attempt to modify the patient's dysfunctional beliefs, encouraging the patient to test their beliefs when they arise in their thoughts,
k) Training in partner communication,
l) Sexual training focused on reconditioning from masturbation to partnered sex.

The planned form of therapy is working with models that have proven effective in the treatment of psychogenic erectile dysfunction:

a) Cognitive-behavioural model (to challenge negative thoughts and maladaptive beliefs),
b) Good enough sex model (to shift focus away from perfectionist views of sex towards a more realistic understanding of sexual acts and their components),
c) Work with training elements mindfulness (to help him focus on sexual stimuli and the pleasure coming from them).

Additionally, as part of the therapy, there will be training aimed at reconditioning the patient from focusing on masturbation to focusing on stimuli associated with partner sex. The sessions will take place once a week or once every two weeks in the office and will be on a one-to-one basis. The patient's partner will be invited to participate in a selected session; however, due to administrative reasons (the clinic is funded by a grant, and only individuals specified in the agreement are eligible for therapy), couple therapy, psychosexual training for the couple, or individual psychotherapy for both partners will not be possible.

The course of therapy

Below is a brief description of the main objectives of each session and their key elements. The description of the sessions was based on the example provided by Bilejczyk, Bilejczyk, and Pogorzelska [22]. In selected places, notes were also added about important life events of the patient relevant to the therapy.

Sessions 1–2

The goal of the sessions was to establish a therapeutic rapport and gather a detailed interview from the patient — including a general interview and an interview regarding the reported issue. The patient's anxiety level was measured using the Depression, Anxiety, and Stress Scale (DASS). The patient scored 19 points (range from 0 to 38) on the stress severity scale, indicating moderate stress levels; 4 points (range from 0 to 36) on the depression severity scale, suggesting a normal level (no depression); and 14 points (range from 0 to 34) on the anxiety severity scale, which suggests moderate anxiety levels. During the interview, it was revealed that the patient has gaps in anatomical and physiological knowledge related to sexual activity, and some of his beliefs and thoughts may be counterproductive in his sexual life.

Psychoeducation was proposed as part of the therapy to address the gaps in knowledge. The gaps in the patient's knowledge included:

a) A lack of knowledge about the anatomy of female genital organs, which was related to the difficulty in locating the clitoris and the entrance to the vagina in his partner,
b) The belief that women primarily achieve orgasm through penetration,
c) The lack of awareness that the pain associated with the unveiling of the acorn of a penis that occurred during relations with a partner could be associated with the presence of phimosis,
d) Lack of knowledge about the existence of lubricants and different types of condoms,
e) The belief that hormonal contraception is harmful to women.

The therapy course suggested working on the following maladaptive beliefs and thoughts. The maladaptive beliefs and thoughts included:

a) The belief that a man should be capable of having sexual intercourse and achieving an erection in every situation,
b) Thoughts about anticipated failure (i.e., according to the patient, the loss of erection and the inability to climax during penetration),
c) Worrying that the patient will not be able to initiate sexual contact,
d) The belief that anxiety will arise during intercourse, preventing him from maintaining an erection,
e) The belief that he is failing his partner and is an incomplete man (because a real man should always satisfy his partner).

Session 3

The goal was to explore the client's expectations regarding therapy and the course of his own sexual life (including beliefs about himself and his partner). An additional goal was education in the cognitive model and teaching the identification of automatic thoughts and cognitive distortions. The patient was encouraged to keep a diary of automatic thoughts along with the emotions accompanying them.

Session 4

The goal was sexual education regarding the anatomy of both women and men, the physiology of sexual intercourse, and the sexual response cycle according to Masters and Johnson. During the session, the patient gained a better understanding of the physiology of sexual responses and the importance of immersing himself in sexual sensations during intercourse. The patient came up with the idea that his partner should put the condom on his penis, so he wouldn't have to distract himself with this task.

Session 5–6

The goal was psychoeducation about emotions, with a particular focus on anxiety and fear, and teaching the patient to recognise his emotional states. *Mindfulness* techniques were introduced. It turned out that the experience of having his partner put on the condom had positive effects — although the patient still lost his erection, it was not immediately after the condom was put on his penis.

Session 7

The goal was training in partner communication. The patient's partner attended the session. The woman admitted that it bothers her that she most often has to initiate the conversation about unsuccessful intercourse or the loss of an erection. She shared that she doesn't want to be a slave to erections and would be very willing to explore other forms of sexual expression with her partner. When asked if she was considering a form of contraception other than condoms, she replied that she definitely was. She expressed concern that she had previously taken contraceptive pills, which worsened her underlying condition (at the time, mixed depressive-anxiety disorders) and likely caused her to be unable to treat recurrent vaginal and vulvar fungal infections.

Sessions 8–10

The goal was to change negative automatic thoughts and modify the patient's dysfunctional beliefs about himself, his partner, and sex. The client admitted that before session 7. He was not aware of some of his partner's views on their shared sexual life. He conveyed that the couple had agreed that his partner would not initiate vaginal intercourse for now and would leave the initiative in this regard to the man.

Sessions 11–12

The goal was psychoeducation about good enough sexuality — celebrating the positive aspects of sex, emphasising the relational aspect of sex, focusing on pleasure, and learning a flexible approach to sex. During the meeting, the client confided that he had recently allowed his girlfriend to caress his penis until ejaculation. Previously, he either did not orgasm with her or would bring himself to orgasm on his own.

Session 13

The goal was to introduce sexual training aimed at reconditioning from masturbation to partnered sex. Techniques aimed at deepening intimacy with the partner were introduced (Masters and Johnson behavioural training). During the meeting, it was revealed that the client had started masturbating with a condom to help his penis get accustomed to the sensation. He also purchased an egg-shaped sex toy, to try a different type of stimulation. The therapist suggested to the patient that he allow his partner to stimulate his penis while he is wearing a condom.

Sessions 14–15

The goal was to continue the sexual training aimed at reconditioning from masturbation to partnered sex. The topic of Masters and Johnson's behavioural training was continued. During the session, the

patient shared that he and his partner are practising mutual masturbation with a condom. He also shared that he is increasingly enjoying oral sex. In the past, he did not allow his girlfriend to stimulate his penis for too long because he was afraid he wouldn't be able to prevent ejaculation. When asked if he orgasms during oral sex, he replied that "he doesn't want to ejaculate on his girlfriend's face". When he is on the verge of orgasm, either his partner stimulates him by hand, or he rubs against his partner's body until ejaculation.

The patient is a young, intelligent person and easily grasped most elements of the cognitive-behavioural model of erectile dysfunction. The discussion on case conceptualisation was fruitful. The patient was able to provide several examples from his own life that were consistent with the conceptualisation of erectile dysfunction and conditioning related to masturbation. A strong therapeutic alliance was established between the patient and the therapist, and the man repeatedly demonstrated high motivation in controlling and modifying his automatic thoughts and beliefs. The patient sees benefits for himself in opening up the communication channel with his partner and in practising mindfulness. He also clearly wants to recondition himself from masturbation to partnered sex. He is very eager to familiarise himself with psychoeducational materials in his free time. From his account, it appears that he and his partner approached the Masters and Johnson training with great enthusiasm.

Results and conclusions

At the very beginning, it should be emphasised that the patient suspended further sessions due to professional commitments that required him to relocate outside of Poland for six months. According to the patient's account, his decision was discussed and accepted by his partner. As a result, it is not possible to summarise the therapy, reinforce its effects, or conduct a final evaluation. As a result of the therapeutic process, the client gained better insight into the factors shaping his sexual life. The patient notices that the sexual functioning of both him and his partner is largely connected to their current life situation. He observes that during periods of overwork, fatigue, stress, accumulating responsibilities, or everyday life problems, neither of them feels motivated for sex, or the sex they have is not as satisfying as it could be. He reports situations in which sex, influenced by a good mood, a pleasant evening, alcohol, and lit candles, was extremely satisfying. He claims that in those moments, both of them reach the appropriate level of arousal and experience orgasm. He also mentions that sex "especially feels great" after being apart and on weekend mornings when they can afford to stay in bed longer. He appreciates it when his partner cleans the apartment, prepares something good to eat, dresses nicely, and does her makeup for his arrival. He sees how much she tries despite being tired, and he also makes an effort to look good before meeting her again. He mentions that he is also turned on when his partner comes to him during a break from remote work (since they both work remotely) and flirts with him. A few times, in such situations, they ended up "in bed for quick sex", which both of them enjoyed.

The client reports that he and his partner now rate their sexual life very positively. Thanks to psychoeducation, the patient felt more confident in the sexual relationship. He also believes that his partner is a very good lover. When he was able to focus on the sensations during intimacy, he stopped worrying about whether he would have an erection. The man discovered that he enjoys oral sex — both as a passive and active partner. At the time of closing this report, the couple was undergoing training and had not yet engaged in sexual intercourse. However, the client's sense of well-being and confidence in the sexual sphere had significantly increased. The patient assessed that after some time he would be happy to try penetration sex and mentioned that he began to look for information materials about what positions favour lovers, and in which relationship there is a large height difference.

It seems that the most important healing factor was normalising the thoughts and emotions of the patient and his partner. The couple did not feel that their sexual problems were related to their relationship or the psychological defect of one of them. It also seems that the fact of establishing a therapeutic relationship was a great support for the patient. He did not have to deal with his problem alone and could talk about it with someone other than his partner. The partnership and the improvement of communication also turned out to be extremely helpful. The patient's partner seems to be very supportive. A big advantage is also the freshness of their relationship, as they both find each other very sexually attractive. Among the psychological factors, the openness of both partners to explore their bodies and engage in sexual training also proved to be important.

The main limitation of the presented case is the fact that the therapy was suspended by the patient and was not completed. This prevented the remeasurement of the anxiety level, the reinforcement of its effects, and the final evaluation. Another limitation was the fact that the client chose not to visit a urologist, sexologist, or andrologist, which could have helped address the concerns related to the pain symptoms during the first penetrative intercourse. Another limitation was certainly the fact related to the clinic's regulations, which prevented the couple's therapy and the partner's psychotherapy from being conducted. The author personally believes that both in the Warmian-Masurian region and in Poland, there is a lack of centres where people in need of help could receive comprehensive diagnosis and treatment in an interdisciplinary team consisting of doctors, physiotherapists, psychologists, psychotherapists, and sexologists, either free of charge or for a relatively small fee.

Article information and declarations

Author contributions

Ewelina Kamasz is the sole author of this article. She wrote it herself.

Conflict of interest

The author declares that there was no conflict of interest.

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