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Medical Journal of Clinical Trials & Case Studies
ISSN: 2578-4838

# Psychogenic Erectile Dysfunction in Late Adulthood: A Case Report on Clinical Intervention and Intimacy Restoration

**Raju MVR[1]*, Mounika TSR[2] and Ramya Kosuri[3]**

[1]Head of the Department, Department of Psychology, Andhra University, India
[2]Research Scholar, Department of Psychology, Andhra University, India
[3]Guest Faculty, Department of Psychology, Andhra University, India

***Corresponding author:** MVR Raju, Senior Professor, HOD, Department of Psychology, Andhra University, India, Email: mvrrajuau@gmail.com

**Review Article**
**Volume 9 Issue 4**
**Received Date:** November 06, 2025
**Published Date:** December 02, 2025
DOI: 10.23880/mjccs-16000396

## Abstract

Erectile difficulties (ED) is a common condition in middle and late adulthood, with mental and emotional in origin causes accounting for nearly one-third of reports. The present report analysis presents a 56-year-old male who developed ED following bereavement and remarriage to a 26-year-old partner. Despite normal medical evaluations, the individual reported performance nervous tension, negative body image, unresolved grief, and relational strain, further influenced by cultural stigmatization of age-disparate marriage. Affecting an estimated 52% of men between 40 and 70, ED in this instance was primarily mental and emotional in origin, compounded by perceptions of inadequate penile size and nervous tension regarding sexual adequacy. Treatment consisted of a six-month mental and emotional program integrating cognitive-behavioural therapeutic guidance, mindfulness-based relaxation, psychosexual therapeutic guidance sessions, systematic desensitization, and spousal involvement. The clinical intervention led to marked improvements in self-esteem, intimacy, and spousal satisfaction, achieved without pharmacological support. Findings underscore the importance of a biopsychosocial model in addressing mental and emotional in origin ED, particularly when grief, relational factors, and cultural pressures interact. This report emphasizes the effectiveness of partner-inclusive, non-pharmacological clinical strategies in restoring sexual functioning and mental and emotional well-being in bereavement-related ED.

**Keywords:** Erectile Difficulties; Kamasutra; Late Adulthood; Cognitive Behavioural Therapeutic Guidance; Sexual Dysfunction

## Abbreviations

PTSD: Post-Traumatic Stress Disorder; ED: Erectile Difficulties; TCM: Traditional Chinese Medicine; CBT: Cognitive Behavioral Therapy.

## Introduction

Erectile difficulties, or the repeated failure to attain and sustain an erection adequate for satisfactory sexual function, occurs in about 52% of men between the ages of 40 and 70 and may be caused by organic, mental and emotional in

origin, or mixed etiology [1]. Psychogenic ED, as also seems to be the report here, is caused by mental and emotional conditions like stress, nervous tension, or trauma with or without underlying vascular, neurological, or endocrine disease [2]. Bereavement, especially loss of a long-term intimate partner, is an extremely notable life stressor that can disturb sexual functioning by means such as complicated grief, in which unresolved mourning presents as continuing yearning, emotional numbness, or avoidance behaviours, including sexual withdrawal [3].

Literature shows that traumatic or abrupt losses increase the risk for sexual intimacy challenges, possibly compounded by disorders such as post-traumatic stress disorder (PTSD) or prolonged grief disorder [4]. In widows, sexual dysfunction can arise from guilt at "betraying" the deceased partner, changed self-perception, or concern about being too vulnerable in a new partnership [5]. The individual's perceived 1-inch flaccid size of the penis—although within the range of normal anatomical variation (mean flaccid length 3.5–5 inches, but perceptions may drive body image disturbance)—almost certainly exaggerated performance nervous tension, a frequent cognitive distortion in ED in which expectant fear creates a failure cycle [6]. This conforms to the dual control model of sexual response, which holds that ED is caused by imbalances between excitatory (e.g., arousal) and inhibitory (e.g., nervous tension) neural systems [7]. In addition, the wide age difference in the remarriage (50 vs. 26 years) will bring relational stressors into play, such as mismatched libidos or societal judgment, although the report emphasizes ameliorative dynamics by way of shared therapeutic guidance sessions [8].

## Age-Related Factors

Age is a notable determinant in ED etiology and experience. Age-related decreases in testosterone or vascular compliance can cause organic ED in a 50-year-old man, but the individual's normal medical checkups (e.g., well-controlled diabetes, hypertension) indicate mental and emotional in origin causes [1,2]. However, age can compound mental and emotional susceptibilities, e.g., anxieties about reduced virility or attractiveness, especially in the context of a much younger partner [9]. Literature indicates that middle-aged men whose partners are younger report increased ED-related distress because they feel under pressure to "keep up" with youthful Vigor [10].

The individual's preoccupation here with flaccid penis size is perhaps an expression of age-related self-doubt regarding sexual adequacy and further exacerbated by his months-long sexual abstinence following bereavement [3,6].

## Social Stigma and Relational Stressors

The large age difference in the remarriage (50 vs. 26 years) brings with it possible relational stressors, e.g., incompatible libidos, divergent life stages, or social censure. Social stigma for age-disparate partnerships may enhance ED by creating external pressures or internalized shame, especially in cultures where such unions are against the grain [9]. For instance, the male can expect societal presumptions of inadequacy or being taken advantage of, while the younger partner can expect judgments regarding her motivation [11]. These social pressures have a tendency to raise the stakes for performance nervous tension, as the individual fears letting others down through failing to meet supposed expectations [2,6]. Furthermore, ED has a stigma, usually identified with emasculation or loss of status, that discourages help-seeking and entrenches avoidance [12]. The use in the report of supportive dynamics through therapeutic guidance sessions together indicates an attempt at reducing these stigmas, with open dialogue to counteract relational tension and societal judgment [8,13].

The choice to prioritize mental and emotional over pharmacological therapeutic approachs (e.g., no PDE5 inhibitors such as sildenafil) indicates a biopsychosocial model, as it acknowledges ED as complex [14]. Psychosocial consequences of ED include low self-esteem, depression, and relational conflict, which create a feedback loop exacerbating the condition. In bereaved situations, therapists find grief obstructs sexual reminiscence or re-engagement with sexuality, as clients avoid close partnerships to avoid painful memories [5]. Normal medical exams (e.g., supervised blood glucose and blood pressure in a diabetic individual) also corroborate a mental and emotional in origin diagnosis, since organic ED tends to accompany metabolic dysregulation [1].

## Eastern Cultural Perspectives on Sexual Dysfunction, with Special Emphasis on Indian Views

In Eastern cultural milieus, as in those grounded in Confucian, Taoist, or collectivist traditions, ED has extra complexities. Sexual well-being tends to be entangled with ideas of virility, harmony, and filial responsibility, especially where masculinity is linked to reproduction and lineage perpetuation. In Traditional Chinese Medicine (TCM), for example, ED could be understood as an interruption of qi (vital energy) or kidney yang deficiency and is usually associated with emotional stressors such as grief. Bereavement ED can therefore be understood as an energetic or spiritual imbalance and requires holistic therapeutic approaches such as acupuncture or mindfulness in addition to mental and emotional therapeutic guidance sessions. In addition, cultural reticence regarding open discussion of

sexual problems—based on shame or loss of "face"—may perpetuate help-seeking delays, thereby accentuating mental and emotional in origin ED through unresolved emotional burdens.

Human sexuality has long been a subject of fascination, veneration and exploration across civilizations, shaping nor only interpersonal relationships but also cultural values and religious ideologies. In the Indian context, sexuality has traditionally been regarded as an inseparable and natural dimensions of human existence, rather than a taboo or prohibited them. The concept of purusharthas- the four principles aim of human life in Hindu philosophy, namely Dharma (righteous duty), Artha (material prosperity), Kam( desire or sensual gratification), Moksha (spiritual liberation) – explicitly acknowledges Kama, or the pursuit of pleasure and emotional fulfilment , as ana essential element of a well-rounded life .Within this philosophical framework, sexual gratification is understood as a vital aspect of physical health, emotional balance , and interpersonal harmony.

This comprehensive understanding of sexuality found vivid articulation in ancient Indian texts and artistic traditions. The Kama Sutra of Vātsyāyana, composed around the 3rd to 4th centuries CE, is far more than a mere guide to erotic practices; it represents an elaborate discourse on love, intimacy, and the philosophy of harmonious living. It asserts that sexual relations extend beyond physical satisfaction, functioning as a means to cultivate mutual connections, confidence, and psychological as well as emotional balance between partners. Equally significant are the sensual cravings embellishing ancient Indian temples, which serve as symbolic of the society's liberal and accepting attitude towards sexuality. The architectural marvels of Khajuraho(Madhya Pradesh), Konark (Odisha), Modhera (Gujarat) and Padawali (Madhya Pradesh) exhibit intricate erotic imagery alongside depictions of divine beings, artists, warriors, and scenes from everyday existence, thereby portraying a holistic perception of human life and spirituality.Anything but obscene, these statues represent fertility, cosmic generation, and the divine marriage of male and female energies (Shiva and Shakti). They propose that intercourse was not a shameful or private act but a natural and sacred part of life necessary for the continuation of life and spiritual completion.

In spite of India's rich cultural and philosophical heritage, contemporary society continues to struggle with conflicting and ambivalent attitudes towards sexuality. Whereas ancient Indian thought integrated sexual expression with spiritual wellbeing, modern contexts often tend to pathologize or stigmatize sexual concerns, particularly during later adulthood. This contrast is well illustrated in the case of psychogenic erectile dysfunction, a condition primarily rooted in psychological and relational dynamics rather than biological or physiological causes [2,6]. Men affected by this condition frequently report feelings of inadequacy, performance anxiety, and diminished self- esteem, which are further intensified by the pervasive silence and cultural taboos surrounding sexual health [12].

## Interventions

### Initial Sessions

In the early sessions, Mr. X came across as anxious, hesitant, and somewhat guarded. He initially avoided addressing his sexual concerns directly, instead focusing on the grief and sense of loss following the death of his first wife. The early sessions were therefore centered on:

- Establishing a foundation of trust and a strong therapeutic alliance.
- Providing a safe space for emotional expression to process the pain of bereavement.
- Psychoeducation him on how erectile dysfunction can stem from psychological and emotional factors, particularly performance – related anxiety.
- Normalizing sexual difficulties to alleviate shame, guilt, and stigmatization.

### Subsequent Sessions

As therapeutic progressed, the client became increasingly engaged, cooperative and emotionally expressive. The focus gradually shifted towards the application of specific psychotherapeutic interventions aimed at addressing the psychological and relational components of his sexual dysfunction. guidance moved forward, the client became more engaged and open. We shifted our focus to specific psychotherapeutic techniques:

**1. Cognitive Behavioural Therapy (CBT)**

- Cognitive Restructuring: Together, we identified and challenged negative automatic thoughts that reinforced anxiety and self-doubt.
- Belief Modification: We worked on correcting distorted beliefs related to penile size, masculinity, and performance expectations.
- Behavioral Assignments: the client was encouraged to gradually engaged in non-demanding forms of intimacy, focusing on emotional connection rather than penetrative intercourse.

**2. Mindfulness and Relaxation Training**

- Progressive Muscle Relaxation: Techniques were introduced to reduce physiological arousal associated with anxiety.
- Breathing Techniques: practiced before and during sexual activity to ease tension and enhance bodily awareness.

- Mindfulness Meditation: Emphasized present- moment awareness to dimmish intrusive, anxiety- provoking thoughts during intimacy.

**3. Visualization and Guided Imagery**

- Positive Visualization: The client practiced imagining successful sexual encounters, replacing fear -based imagery with confidence- building scenarios.
- Desensitization Through Imagery: Gradually imaginal exposure to anxiety- inducing sexual situations was paired with relaxation responses to reduce anticipatory anxiety.

**4. Psychosexual Counselling**

- Addressed myths and misconceptions related to sexuality, masculinity, and aging.
- Introduced Sensate focus exercises, progressing from non- demand physical touch to more intimate contact
- Explored emotional intimacy, and relational satisfaction, reinforcing the idea that sexual fulfillment extends beyond penetrative intercourse.

**5. Sexual Dysfunction Therapy / Desensitization Techniques**

- Systematic Desensitization: Combined graded exposure to sexual situations with relaxations training to alleviate performance- related anxiety.
- Behavioural Rehearsal: Practiced alternative sexual behaviours to shift the emphasis from erection achievement to shared pleasure.
- Arousal Control Strategies: Focused on redirecting attention from performance outcomes to mutual enjoyment and connection.

**6. Spousal Counselling**

The client's wife participated in approximately 20 parallel sessions, which focused on enhancing communications, empathy, and relational adjustment.

- Communication Skills Training: Practicing assertive communication and active listening to express needs constructively.
- Empathy and Support Strategies: Reinforcing emotional support and reassurance over performance pressure.
- Psychoeducation: Normalizing sexual and emotional adjustments associated with remarriage, emphasizing presence and rebuilding trust.
- Couples Exercises: Engaging in structured home assignments aimed at increasing closeness, reducing anxiety, enhancing intimacy.

## Outcome

By the end of six months, Mr. X reported significant improvements in self-confidence, sexual functioning, and overall marital satisfaction. He experienced a marked reduction in performance -related anxiety and found it easier to initiate and sustain intimacy. His wife observed enhanced emotional closeness, empathy, and mutual understanding within the relationship. Importantly the couple did not require pharmalogical intervention, highlighting the effectiveness of the integrated therapeutic approaches that combined cognitive behavioral therapy (CBT), mindfulness practices, relaxation training, psychosexual counselling, and desensitization techniques.

## Case Formulation

Psychogenic erectile dysfunction is best understood through a biopsychosocial model, which integrates biological psychological and social factors influencing sexual functioning.

From a biological perspective common element such as age-related physiological changes, the history of diabetes, and body image concerns particularly regarding perceived penile size may significantly contribute to erectile difficulties.

Anti psychological dimensions, factors such as performance anxiety negative beliefs about masculinity and self-worth and unresolved grief following the loss of a first spouse can play assembly l role in the development of symptoms. The social dimensions further compound the problem, with influences such as marrying much younger partner relationship expectations and communication barriers acting as a significant stressor. A dynamic case formulation takes into account the interaction between conscious and unconscious process including repressed grief self-doubt, defence mechanisms in bracket example avoidance and a fear of rejection. This process can create a self-perpetuating cycle of anticipatory anxiety avoidance of intimacy, in reinforcement of negative self-beliefs which maintains the dysfunction.

Risk formulations is an essential aspect of assessment, and it considers both the persistence of symptoms and the potential for relational or psychological distress if left untreated. In this case, risk include marital strain avoidance of intimacy, and the possible emergence of secondary depression or low self-esteem postop nevertheless, the presence of protective factor Satya strong motivation for therapy spousal support coma in the absence of other psychiatric comorbidities mitigates this risk and enhances the livelihood of a favourable therapeutic outcome.

Globally erectile dysfunction act effects approximately 20 to 40% of women aged 40 to 70 years with relevance increasing with age making it a notable public health concern although organic ideologists including vascular metabolic

neurological cases are common in older men, psychogenic erectile dysfunction ans accounts for an estimated 25 to 30% of all cases epidemiological studies further reveal that psychogenic erectile dysfunction is particularly relevant among young and middle aged men, but may also occur in older individuals who experience psychological stress and resolved brief, relational discord or performance related anxiety.

In the present case the patient's history of spousal Bree recent prolonged sexual run activity and remarriage to a younger partner emerged as a clear psychosocial risk factors aligning with a psychogenic origin. Cultural and societal influences further shape how Ed is perceived and addressed. Globally stigma surrounding male sexual health and reluctance to seek professional help contribute to substantial under reporting in India. It is estimated that 10 to 20% of men over 40 years' experience some form of erectile dysfunction, though the actual prevalence is likely higher due to cultural taboos that discourage open discussions of sexual difficulties.

Mile medical conditions such as diabetes hypertension and cardiovascular diseases are frequently linked to erectile dysfunction normal blood pressure and the Blood glucose levels observed in the patient reduce the likelihood of organic cause underscoring the significance of psychogenic factors as independent contributors to sexual dysfunction.

Furthermore, researchers highlight the importance of Patna involvement in achieving positive therapeutic outcomes studies consistently show that couple-based interventions yield mould favourable results than individual therapy alone emphasising that relationship dynamics, communications, and mutual emotional support play critical roles in both the onset and resolution of psychogenic erectile dysfunction.

## Epidemiological Considerations

Erectile dysfunction Ed is a widespread condition affecting approximately 20 to 40% of men between the age of 40 and 70 with prevalence increasing steadily with age. While many cases in older adults are associated with physical health factors such as vascular metabolic or neurological disorders, and estimated 25 to 30% of cases are primarily psychological or emotional in horizon.

This psychogenic form of Ed is more frequently observed among younger and middle-aged men, though it can also manifest older individuals particularly in the context of bereavement relational stress or performance related anxiety. For example, loss of spouse an extended period of sexual inactivity and remarriage to a younger partner have been identified as a significant psychosocial trigger contributed to the onset of erectile Difficulties.

On the global scale the relevance and impact of EB are strongly influenced by sociocultural factors including stigma, cultural taboos Mama and reluctance to seek professional help which often dazzles in under reporting. In the Indian context it is estimated that 10 to 20% of men over 40 years' experience erectile difficulties though the actual relevance is likely higher due to persistent silence and discomfort surrounding discussions of sexual health.

While chronic medical conditions such as diabetes and hypotension are commonly linked with erectile dysfunction in this particular case normal clinical findings ruled out organic causes coma barby emphasizing the psychological and emotional determinants of the problem. Moreover, evidence from recent studies underscores that Patna involvement in therapeutic intervention tend to yield more favorable outcomes than individual therapies alone highlighting the relational and interpersonal dimensions of psychogenic erectile dysfunction.

## Ethical Considerations

One addressing psychogenic erectile dysfunction, several ethical principles warrant careful attention particularly confidentiality, informed consent, in partner involvement given the highly sensitive nature of sexual health concerns maintaining strict confidentiality essential to reduce stigma, froster trust, and encourage claims to disclose their experiences openly.

In this case, informed consent was obtained prior to both individual and couple based therapeutic guidance sessions, ensuring that all participants clearly understood the nature, purpose, and non-formal logical orientations of the intervention. Tatha involvement, while therapeutically beneficial, required balancing individual autonomy with the share responsibilities of the relationship karma emphasising mutual respect and clear communication regarding privacy boundaries.

Shins must also remain aware of their own biases and assumptions surrounding topics such as sexual performance, ag grief and partner age differences. Holding a non-judgemental, culturally sensitive, and empathetic approach is vital to ensure ethical integrity and therapeutic effectiveness the decision to prioritise therapeutic guidance over medication in this case underscores these ethical principles, highlighting respecting for patient autonomy, holistic care, and psychosocial wellbeing.

## Summary and Future Directions

In this report highlights the significance of psychological commotion and interpersonal dimensions in the etiology and management of erectile dysfunction while biological courses are well established among older men, these reports demonstrated that psychogenic factors such as grief prolong sexual inactivity and performance anxiety then independent contribute to the condition. Structured counselling and therapeutic sessions for the individuals and his partners proved effective in addressing emotional distress rebuilding self-esteem and promoting relational adjustment in the absence of pharmacological treatment future investigations could include longitudinal research on the sustained outcomes of therapeutic counselling, comparative analysis between individual and couple based interventions in the integration of culturally tired therapeutic models across diverse population. Expanding the evidence base for non-pharmacological interventions can further improve accessibility and reduce the stigma associated with sexual dysfunction therapy.

## Conclusion

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