Dialogues in Philosophy, Mental and Neuro Sciences

Crossing Dialogues Association

ORIGINAL ARTICLE

The meaningfulness of short interpretation in brief clinical encounter

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This case study deals with failure to ejaculate intravaginally during sexual intercourse. The causative factors were thought to be unconscious in nature. The patient showed significant improvement after only one session, when these unconscious factors were interpreted to and accepted by the patient. We discuss briefly the application of psychodynamic theory in sex therapy and possible implementations in training settings.

Keywords: erectile dysfunction, unplanned pregnancy, sexual dysfunction, psychosexual therapy

DIAL PHIL MENT NEURO SCI 2014; 7(1): 21-24

We are reporting the case of a 22-year-old male who came to our clinic complaining of difficulty in ejaculating intravaginally. The man is a university student who has lived with his current girlfriend for the last 5 months. He is the middle of two other full-siblings, and has two half-siblings. He has been dating his current girlfriend for the last 3 years and they started having intercourse 5 months ago. He reported the relationship to be going well except for the sexual part. He came to our clinic after his girlfriend confided to him that it was bothering her that he was not able to ejaculate intravaginally. She felt that it was part of her satisfaction to make him "satisfied", and she urged him to seek treatment. The patient felt shocked by his girlfriend's comment as he always "put her needs before his", ensuring that she achieved orgasm during intercourse. He further explained that he had had difficulty ejaculating in her vagina since the relationship started. He would have intercourse lasting up to 20 minutes with her and she would be able to achieve orgasm but he would not. After the first 2 months, he would fail to maintain his erection after about 20 minutes of intercourse and then he would stop.

On each of these occasions, ejaculation would be achieved after intercourse by either oral sex or by masturbation done conjointly with his girlfriend. He reported no problem with erection or orgasm during masturbation or oral sex.

The patient described his personality as always caring about others, thinking about others' needs before thinking about his own. He was raised in a middle-class secular Canadian family. He does not recognize any rule of organized religion in his life, but he feels he has a strong sense of morality.

Something intriguing came out in the course of pursuing the patient's personal history with him. The patient's father had two children from a previous marriage which did not last long and was followed by divorce shortly after the birth of the second child. His father regretted that relationship, and felt he had "rushed into it" with the consequence of disturbing the lives of his children, who had to live in two separate homes. Although his father had not wanted to commit himself to the relationship, he felt it was "too late to leave" and he felt "stuck". Frequently, his father reported that he had wasted many years in that "fruitless relationship". Our patient got the story from his father, but his mother often reiterated it to him and cautioned him "not to make the same mistake your father did", meaning to be careful about committing himself to a relationship that he might regret.

The patient was conservative with dating and starting relationships; he became sexually active at 19, which was somewhat late compared to his peers. He reported he dreaded having sex and felt extremely anxious about it. His first sexual

experience was with a girl at a party, as a one-night stand. He was drunk at the time; he drank intentionally to "break his anxiety around having sex". He failed to maintain his erection on that occasion and did not ejaculate in the end. He continued to have one-night stands but never committed himself to a serious relationship as that would be something to be "thought hard about". In all of his sexual encounters, he failed to ejaculate intravaginally, and he achieved orgasm in the same manner as with his current girlfriend. The intercourse would last about 10 to 20 minutes.

After we made a full assessment we gave the patient our feedback. Our thinking was that the patient was dreading the idea of impregnating his partner, especially since it was as yet unclear whether the relationship would last. We interpreted the patient's behavior as identification with the father. We explored with the patient the unconscious conflicts related to the messages he got from his parents about being ultra cautious and careful about sexual relationships. Although the patient was conscious about many aspects of his sexuality, that particular insight had not occurred to him. He did not respond with an "aha" experience but seemed to be engaged fully in our discussion. He further revealed that he always uses condoms, but said he was not consciously afraid of impregnation, although interestingly enough he reported trying to ejaculate not even close to his partner's genitalia as he was afraid the semen might get into her vagina and cause unwanted pregnancy.

The patient came two weeks later for a follow-up appointment. He reported he had succeeded in ejaculating intravaginally every time he had intercourse with his girlfriend, and that he felt liberated by this. When he was asked about what might have helped him, he said, "I thought your explanation made sense to me and now I can understand why I had this problem".

DISCUSSION

This case example illustrates the power of interpretation of the unconscious, and how basic intervention on a key issue of the patient's life might have a substantial positive impact. In this case, the patient was suffering from delayed orgasm; which is one of the most poorly understood sexual dysfunctions. Despite the wide literature that examined the issue of premature ejaculation and its treatment with pharmacological and non-pharmacological interventions, the literature on delayed or retarded ejaculation is still scarce. Delayed orgasm is defined as "the persistent or recurrent difficulty, delay in, or absence of attaining orgasm after sufficient sexual stimulation, which causes personal distress" (Mulhall et al., 2014). Some psychological factors have been examined for association with delayed ejaculation like what Michetti et al. (2013) reported ; they looked into alexithymia as an important psychological process and they did not find it related to this disorder, despite the fact that it was reported to have high association (30 %) with other male sexual dysfunctions.

In general, retarded ejaculation is regarded as rare in the literature with reported rate of around 3 %. Since the beginning of sex therapy, it was seen as a clinical rarity, with Masters and Johnson only reporting 17 cases (Perelman and Rowland, 2006).

The most useful strategies for understanding retarded or delayed ejaculation will integrate rather than isolate the various biogenic and psychogenic aspects of this dysfunction. Evidence based evaluation and treatment protocols for this disorder are lower than for other sexual dysfunctions, but reports suggest better treatment efficacy when the etiology is predominantly psychogenic (Perelman and Rowland, 2006).

Although this report focuses on deep and unconscious factors in contributing to sexual dysfunction, simple contextual factors like lack of privacy during sexual intercourse should not be overlooked (Boddi et al., 2014). Moreover, during assessment and counselling, the implications of sexual disorders on the partners ought to be emphasized; there are usually two patients when sexual problems are presented (Renshaw, 2000).

Although long-term therapy is the standard when it comes to resolving conflict issues in the psyche, the wisdom of psychodynamics should not be neglected simply because of time limitation. We believe every patient could benefit from psychodynamic exploration tailored to the

patient's needs, as in this case. With the increasing biological focus in sexual medicine in recent years, the realm of psychodynamics in sexual medicine has, unfortunately, been put at risk of being forgotten or neglected because it is sometimes thought "too complex" to be utilized. Our case example emphasizes the importance of continuing to include psychodynamic therapy in the sex-therapy curriculum, and to use it in sexual disorders either along with medications or as a standalone.

The approach in sexual dysfunction should not be based on narrow understanding of human biology without taking into consideration the complexity of human behavior. The former may lead to a very erroneous reductionistic approach towards common clinical conditions that could be resolved if more holistic approach is taken.

The social challenge for sex in the new millennium is at once to clarify the separate harms and benefits of impregnation, of reproduction, and of having sex with someone, (Jansen, 1999) but increasing knowledge about sexual function has enabled many people to be more natural and at home with their own body and that of the other (Moulton, 1977). Renshaw (2000) suggested that fear of impregnation needs to be checked by asking: Do you feel, at this time, prepared to become a father emotionally and financially?

The suffering of our patient could be also understood along the lines of heterosocial anxiety, since it was apparent from the history he provided that he had related to the other sex with considerable difficulty since an early age. Leary and Dobbins (1983) demonstrated that heterosocial anxiety (anxiety experienced in social interactions with members of the other sex) lead to engagement in sexual activity less frequently with fewer sexual partners. Moreover, McCabe and Connaughton (2014) surveyed 331 Australian men from the general population and reported that 'Performance anxiety' seems to be an important issue when it comes to male sexual dysfunction. However, in females they suggested that the emphasis is more on relationship issues.

Increased anxiety and depression in patients with delayed ejaculation was put under empirical testing in a study by Xia et al. (2013) that compared clinical characteristics in 24 patients who suffer from primary delayed ejaculation matched with 24 controls, and they found significant increase in anxiety and depression for the former group ($p < 0.001$).

We know that males and females with a history of sexual abuse report higher sexual risk taking than those without a history of sexual abuse (Raj and Silverman, 1999), but little is known about the opposite phenomenon of extra-cautious sexual behavior and how it links to sexual inhibition.

Freud made only passing references to the subject of pregnancy, mostly in relation to the fear of pregnancy and without making a clear distinction between fantasies about pregnancy and the real fear of impregnation prior to effective contraception. Considering the reproductive function in general, Freud accepted that its purposes are served by human sexual life, which consists essentially in an endeavor to bring one's own genitals into contact with those of someone of the opposite sex (Lester and Notman, 1986).

Fear of impregnation could be extremely complex in the unconscious, and it has been seen as a sign of neurosis. Fear of impregnation is a crucial issue in both genders but, unfortunately, little light has been shed on it in the literature. We hope that our case example helps to attract more interest in the subject.

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