

THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH PATIENTS WITH SEXUAL DISORDERS

LEON SALZMAN

Psychotherapy with Patients with Sexual Disorders

LEON SALZMAN

e-Book 2015 International Psychotherapy Institute

From *The Theory and Practice of Psychotherapy With Specific Disorders* by Max Hammer, Ph.D.

Copyright © 1972 by Max Hammer, Ph.D.

All Rights Reserved

Created in the United States of America

Table of Contents

[DUAL ROLE OF SEX](#)

[SEXUAL DEVIATIONS](#)

[ETIOLOGY](#)

[THERAPY](#)

[PREMATURE EJACULATION](#)

[REFERENCES](#)

Psychotherapy with Patients with Sexual Disorders

The therapy of the sexual disorders neither requires a distinctive approach nor a separate set of therapeutic tools or techniques. The same principles and technical procedures which are utilized in the psychotherapy of the neurotic disorders are applicable. The process of change may be complicated by the realistic limitations of the culture as well as the individual, but any valid therapeutic modality must clearly distinguish between adjustment and adaptation as well as between insight and alteration of behavior. We must not therefore attempt to make any artificial distinction between deep or superficial therapy or psychotherapy versus psychoanalytic therapy, as if some diagnostic categories or therapeutic modalities are outside the range of deep (meaning profound or basic) exploration because of lesser skills. There is no hierarchy of more intensive or more basic therapeutic modalities with psychoanalysis at the peak and psychotherapy at the bottom. It is beyond the scope of this chapter to examine this piece of mythological presumption. However there are variations in the methodology which includes the amount of time spent with the patient as well as the extent of utilization of such tools as transference or countertransference phenomena. Because our task is to comprehend the sexual disorder and attempt constructive changes, we should apply the best therapeutic techniques from all theoretical sources and technical modalities in order to adequately comprehend the underlying personality distortions which have produced the

deviant sex behavior.

The approach one uses, however, is inevitably related to one's theoretical conceptions of the development of the sexual function in man. Prior to Freud, sex behavior was almost entirely the concern of the theologian, philosopher and moralist. Sexual deviations were sinful, immoral or inhuman and therefore the province of the priest or the law. Therapy was either punishment or absolution. Classifications of sexual abnormalities such as described in *Psychopathia Sexualis* were merely descriptive; either anatomical or according to earlier legal categories. Since they had no etiological value they supplied no guidelines for therapy. Freud, while making tremendous contributions to the understanding of sex, was nevertheless limited by his own background and the cultural emphasis on biology and instinct theory.

Following the lead of earlier sexologists like Krafft-Ebbing and Magnus Hirschfeld, Freud tried to establish a separate causative factor for the large numbers of distortions and perversions in sex behavior based on his libido theory. Thus he considered each descriptive category as a separate disorder due to fixation, regression or faulty resolution of the Oedipus complex. There was another category of sexual deviations which was attributed mainly to castration fear. These ranged from fetishism to exhibitionism and impotence. However, while he catalogued many diseases, ultimately they appeared to be

due to a single cause, and the treatment was always psychoanalytic therapy without delineating any special areas of psychodynamic significance or isolating specific thwarts in that individual. In the past seventy years little has been added to his nosological scheme and the classical psychoanalytic treatment has been almost unaltered except perhaps in the major sexual aberrations like homosexuality.

In recent years there has been a tendency in some psychoanalytic circles to view the sexual deviations not as separate diseases but as symptoms of larger personality disorders. The sexual difficulties are therefore not treated as separate or distinctive issues but are dealt with under the greater therapeutic burden of resolving the individual's characterological problem. In other words, they are symptoms, not diseases, and the therapeutic task is to focus on the underlying defect and not on the sexual aberrations. However, because of the social and legal implications of these symptoms, it is difficult and at times impossible to institute ideal programs of therapy based on these formulations. Therapy in the sexual disorders must therefore not only take into account medical and psychiatric issues, but social and political issues as well.

To develop a rational and valid therapeutic program we need to comprehend the role which sex plays in human functioning. Sex plays a primary role in human affairs by virtue of its unusual capacity to fulfill major

psychological needs while performing its biological function. Any attempt to clarify the role of sex must take into account this significant and ubiquitous role in human behavior. What distinguishes sex activity from other physiological functions in the human? Sex activity is the only biological activity that requires “another person” for its complete biological fulfillment. As a result, it is most intimately associated with all the aspects of interrelatedness, both constructive and destructive, pleasurable and painful. It encompasses all the elements of interpersonal relationship, such as struggle, conflict, the satisfactions of tenderness and human closeness, and every maneuver, technique and dynamism of human behavior.

There is an hierarchy of our biological functions extending from the sympathetic functions which are entirely intrapersonal, to those which require increasing amounts of human cooperation. This is related to the development of man from his animal origins and involves those functions which operate independently of outside sources of stimulation (the autonomic functions) and those functions such as feeding, excretion, and sex, which, as man became socialized, impinged upon “others.” Sex activity is in the extreme position in that it not only prefers cooperation but requires “another person” for its complete fulfillment. To complicate its performance still further is the fact that it begins at a period in the individual’s development when his attitudes, patterns, anxieties and concerns about people of the opposite sex are already highly developed.

An aspect of its *major* role in interpersonal activity is involved in its capacity to dissipate anxiety and it is frequently called into action to deal with anxiety arising out of difficult interpersonal relationships. It is frequently used in this way, rather than to fulfill any lustful needs. Consequently the motivation for sex activity may be anxiety rather than lust or love. This fact helps us understand why it can be so easily given up as well as its widespread use under circumstances where intimacy is absent. This factor enters into the production of a great deal of deviant sex behavior.

DUAL ROLE OF SEX

The role of sex in the human being is twofold: First it relates to the problem of species preservation and can be called the pro-creative function. This aspect of the sexual function is most intimately related to the biological, physiological or organic functioning of the sexual apparatus. Its proper functioning is dependent upon adequate hormonal activity as well as other physiological factors. However, cultural issues, prejudices, customs and mores might dictate the modes of courting and mating. The other aspect of sex relates to man's other needs which are not essentially biological in nature but which result from his development from pre-human to human existence. This involves special needs such as the avoidance of loneliness, the need for love and intimacy.

Although large numbers of mammals and possibly other animals maintain close relationships in family units, the arrangement appears based largely on biological considerations rather than on the basis of tender regard for the opposite sex. In the human, however, the association of male and female serves other than procreative purposes so that heterosexual intimacy as well as homosexual intimacy may occur with or without sexual contact or procreation. On the other hand, it is often very difficult to determine in a particular relationship whether the sexual activity serves the purpose of procreation, to alleviate loneliness, to alleviate anxiety, to prove one's manliness or to enforce some demand on one's partner. It is this varied and diverse use of sex that makes it so complicated and significant an issue in human behavior. Because so much of the human drama can be enacted in our sexual performances, they can illuminate the total personality structure of an individual most dramatically as it unfolds in an interpersonal context.

SEXUAL DEVIATIONS

Many sexual deviations not only involve major distortions in the sphere of sex but involve profound alterations of the individual affectional capacities and relationships. While Freud and others assumed that love and the tender emotions were derived from sexuality through a process of sublimation, sexual biological maturity has no direct relationship to love, since it is a purely physiological development which occurs uniformly in all of us who

have no biological or hormonal impediments. However, the presence of love which is a human development arising out of our “sociological” or post-animal needs is intimately involved in our sexual performances. The capacity to enjoy the sex act to the fullest is determined by the amount of intimate, tender regard one has for the partner. Maturity in a biological sense is not synonymous with competence or total capacity for utilization of the matured functions. This is particularly noticeable in the neuroses and psychoses, where there are striking limitations and impediments in performing physiological and psychological functions in spite of the presence of matured organic capacities for doing so. The presence of a physiologically matured sexual apparatus is no guarantee of a wholesome sexual existence. It is a necessary but not a sufficient precondition. The potentialities for pleasure and “happiness” (totality of satisfaction) in sexual activity are dependent upon the capacity to love and to be loved by another person. This is the reverse of the formula—sexual maturity implies love, since love or a tender regard for another human develops prior to maturation of the sexual function. There is some reason to believe that these affectional reactions derive from other sources, like the quality of the maternal relationship with the infant, and participate in the sex function to the degree that they are already present in the individual. The presence of love in a human relationship permits the maximum satisfaction in sexual performances. Whatever else is involved it is abundantly clear that every type, variety and

category of sexual deviation evidences a failure, deficiency or alteration in the individual capacity for tender, loving involvement with another human of the same or opposite sex or both. This is a constant and ubiquitous accompaniment of all distortions, perversions and deviations of the sexual life of man.

Concepts of normality and deviation would be simple if sex behavior in man were merely an instinctual performance with only a minimal of learned refinements. We could then proceed to label all sexual behavior not directly involved in the biological procreative function as abnormal, and we would be spared a multitude of disagreements and criticisms from legal, theological, sociological and psychological sources. However, an overview of the advances in the understanding of sexual behavior, both normal and abnormal, bears out the severe limitations of the original psychoanalytic conceptions of sex and its role in human behavior. Its deficiencies are particularly apparent in the area of sexual behavior involving the so-called perversions, deviations or abnormalities—or less pejoratively, the variations of sexual behavior.

What is normal and what is abnormal in sex behavior? This apparently simple yet complex question requires the combined efforts of sociologists, psychiatrists and public administrators to clarify. Normality is not simply a psychological or physiological determination. It involves definitions which evolve from the history, religious orientation and sophistication of a culture,

both in aesthetic and scientific matters. Normality in one sense is established by the prevailing theological and scientific attitudes toward sex behavior. Legal formulations of normality and deviance can and often do change with advances or changes in theological doctrine or scientific evidence regarding human physiology.

Thus the definition of normal sex behavior cannot be established in absolute terms. A workable formulation that can serve for many years to come asserts that normal sex behavior is largely a subjective determination and consists of sexual activity which is acceptable to both partners and which produces satisfaction and pleasure without damage, either psychologically or physiologically, to either partner or the community and broader culture in which they live. This formulation, however, requires the additional dimension that such behavior should not be contrary to public interest either because of the immaturity or incapacity of one of the partners to decide or resist the invitation or because public displays of such behavior tend to be offensive to others. This is analogous to concepts of normality with regard to other biological activities such as eating, urinating or defecating where peculiar, idiosyncratic or statistically unpopular practices are not considered abnormal or illegal unless they impinge on others. Social value judgments have no place in regard to variations in sex activity between freely consenting adult partners under circumstances of privacy. In view of the individual preferences and prejudices among people of various cultures, psychiatric

intervention or labels of deviancy arise only if anxiety accompanies the activity. We are referring here to variational behavior such as the positioning in the sex act or the orifices which may be used as well as the sex of the partners. These variations are qualitatively and quantitatively different from major deviations in the sex act which constitute serious social and psychiatric problems and have been minutely catalogued and described in the classic volumes such as Krafft-Ebing's *Psychopathia Sexualis*. It is these activities which will be dealt with in this chapter. The tendency, as I indicated earlier, however, to view such deviations as separate disease entities is neither theoretically nor therapeutically sound. Such classifications are holdovers of a nosology which predated present knowledge of sex.

Almost all of the sexual deviations are largely involved in processes which are not related to biological defects or faults but rather to interpersonal deficiencies. Where hormonal, constitutional or genetic factors are involved, the manifestations are not usually called perversions or deviations.

Most often sex serves no procreative purpose, whether in childless couples (through no design on their part), for whom sex can be the most intimate expression of their companionship and love, or when conception is not the goal. At these times it serves as a source of pleasure and expression of intimacy, but it can also be used to fulfill the neurotic needs of both partners.

By this I mean that sex activity does not necessarily arise as a result of lust promoted by tender feelings towards one's partner. It may frequently be precipitated by a need to overcome tension and restore amicable relationships during periods of stress, disagreements or following heated exchanges in basically friendly relationships. At other times it may express or convey feelings of strength, potency or hostility designed to reassure or overwhelm one's partner. It may be part of a competitive struggle in which one may perform or refuse to perform in order to fulfill some neurotic goal or else it may be a pseudo-manifestation of one's generosity devoid of true tenderness. There are endless possibilities in which sex activity attempts to deal with anxiety of one sort or another rather than as an expression of sexual need or tender regard. The sexual deviations are prime examples of sex activity where the motives for the behavior are rarely lustful needs but are expressions or manifestations of neurotic tendencies or attempts to appease or resolve some anxiety. In sex deviants of all sorts we find that except in the rare endocrine disorders, they are capable of functioning biologically. However, they avoid the sexual apparatus of the opposite sex for a variety of reasons, other than physiological.

Deviates always have problems in interpersonal functioning which involve aspects such as intimacy, closeness or the capacity to love and trust. Although they prefer sexual outlets other than genital intercourse, rarely is this outlet permanently interfered with. Their procreative functions are intact

even though their preference reduces such a possibility. It is very common to find deviates of all kinds being married and having children. The problems which are expressed or involved in the sexual deviation are almost always a part of their total personality structure and manifested in all areas of their living. For example, the exhibitionist who achieves sexual satisfaction through exposure of his genitals thus avoids an active and aggressive involvement with the opposite sex. In other areas of his living he is overtly shy, passive and timid as well. No two deviates are ever precisely alike either in their personality makeup or in the method of expressing the deviation. The deviation is specific to the individual personality makeup even though it can be categorized under broad headings.

ETIOLOGY

The issue of a biological versus interpersonal basis for the sexual deviations can be illuminated by the understanding of a common sexual difficulty. Premature ejaculation is a widespread phenomenon which has been variously interpreted as being due to biological deficits in the urethral stage of libidinal development or as the result of faulty interpersonal relationships. Since it is a condition which highlights the elements of participation in the sex act, it can illuminate the role culture plays in human sexual activity. Except for rare instances, there must be a maximum of mutual participation for the sex act to proceed to climax, and each participant must

perform the role dictated by his sexual organs. Consequently, both male and female are indispensable for a fully satisfactory sex experience and neither has any special or preferred status in the performance. In recent years, and closely related to the emancipation of the female, sexually and otherwise, the responsibility for the pleasure and orgasm in the female has been assigned to the male. It is his responsibility for orgasm to take place in the female. This requires that a sufficient duration of time transpire in intercourse. The anxieties and issues about an earlier ejaculation has brought the phenomenon of premature ejaculation to considerable prominence in recent years.¹

Premature ejaculation is a sexual disorder that has no counterpart in the female, although frigidity is often considered to be the female counterpart. Operationally, impotence is the masculine counterpart of frigidity in the female. Frigidity involves the inability to achieve a sexual climax, while premature ejaculation implies an exaggerated readiness to climax. Thus early orgasm in the female is never considered premature, since whenever it occurs it does not necessarily terminate intercourse. It is not equivalent to premature ejaculation and is often highly valued by the female and is flattering to the male. It is regarded as a desirable feminine trait in contrast to premature ejaculation, which is viewed as evidence of inadequate masculinity. Thus the sexual syndrome, premature ejaculation, cannot be understood without an elaborate analysis of gender roles and sexual expectations, as well as the social attitudes towards female rights and

privileges.

The sexual deviations can be classified in a variety of ways. Freud's classification was biological and was based on his libido theory. This classification was based on motivational concepts and involved a structural examination of the sex instinct into its partial components. Sandor Rado, in his adaptational view of sex behavior, classified sex behavior as being either standard or modified. The modifications were divided into three groups: (a) reparative, (b) situational and (c) variational. While the situational and variational modifications are sometimes called deviant, most deviations fall into the class of the reparative patterns. In this framework, Rado classified the patterns as either (a) replacement of sexual organs by other organs for example, anus, mouth, armpit; (b) sexual pain-dependence or masochistic or sadistic sexual patterns, (c) contact avoidance of partners for example, voyeurism, exhibitionism, etcetera; (d) patterns of solitary gratification for example, fetishism, compulsive masturbation; and (e) homosexuality. This classification had the advantage over earlier classifications in that the therapeutic goals were illuminated by a recognition of the dynamics of the behavior and its adaptive purpose. Another type of classification is phenomenological and is based on the elements of the sex act as an interpersonal phenomenon. This orientation includes the existentialist view of sex behavior which sees sex not as a collection of partial instincts or separate elements but rather as a total performance in which the individual

expresses his involvement, participation and commitment to another person. The sexual deviations are therefore manifestations of failures in commitment and involvement.

We can also view the sex act in terms of (a) preliminary behavior and (b) the act of sexual intercourse. Thus voyeurism, fetishism, exhibitionism and so forth can be viewed as deviations preliminary to intercourse, while sadism or other organ contact or intercourse with animals could be viewed as deviations involving intercourse.

There is a miscellaneous group of perversions and deviations that do not fit into categories and are merely descriptive. They include coprolalia (use of obscene language during sex), mixoscopia (pleasure from witnessing sex acts)and oosphresiphilia (love of odors as a sex stimulant). Others involve extremes of behavior such as pedophilia (sex with children), necrophilia (sex with dead bodies) and troilism (sex involving three people). The broad categories of sexual excesses which can become disruptive and therefore pathological include (a) nymphomania and promiscuity, (b) Don Juanism and satyriasis; (c) pederasty (sodomy); (d) fellatio and cunnilingus; (e) prostitution, pandering, prudery, rape and sexual apathy.

The genesis of a sexual deviation can be derived from the following:

1. Primary genital phobias. Such genital avoidances result from the early

conditioning in which the genital is viewed as a dangerous, dirty and disgusting organ to be shunned and avoided. They may produce a wide variety of sexual difficulties in later life involving the avoidance of the individual's own genitals, thereby eliminating sexual contact. The existence of the genital may be denied or its presence an embarrassment thereby shortening the sexual contact resulting in premature ejaculation. It may also produce frigidity and the whole range of deviations in which genital contact is avoided such as voyeurism, exhibitionism or fetishism. Such phobias may involve avoidance of the genitals of the opposite sex due to persistent fears of the genital as dangerous as in the notion of a dentata vagina. When the genitals are viewed as unclean, diseased, etcetera, they will also be avoided in oneself and the opposite or same sex.

2. Fixating experiences in which sexual pleasure becomes associated with traumatic or other pain-induced stimuli. Fixating experiences may also involve non-painful stimuli in connection with other organs such as repeated enemas or fetishes involving clothing or any other symbolic object. This may be the explanation of many fetishistic practices where pleasure is intimately connected or conditioned with either accidental or coincidental occurrences. Silk clothing, pleasant or unpleasant odors, or pain produced by whipping or physical contact which produces or is associated with an unexpected genital discharge may produce a lifetime pattern of sexual deviant behavior.

3. Early activities tied directly to the genitals producing pleasurable or exciting experiences. This may be due to deliberate stimulation or accidental stimulation of irritating clothes or bed sheets. This usually produces deviations involving the patterns of intercourse rather than foreplay. This may often be the early experience of the homosexual where direct contact began as exploratory or nonsexual, playful behavior. It could also account for some deviations involving animals, compulsive masturbation or other solo sex outlets.

4. Character structure in which sex is implicated—self-effacing or aggressive character manifesting these traits in the sexual behavior, as with Don Juanism or a display of strength played out in sex, but having no necessary relation to sexuality.

THERAPY

Since the variations in sex behavior are derived from multiple sources and are the outgrowths of the interactions of the biological gender substrates with the culture both immediate and more distant, the therapy of such variations or deviations must take these factors into account. Only rarely will operative procedure, hormones, gonadal influencing drugs or other manipulative procedures prove to be effective. A broadly based therapeutic approach based on the recognition of the influence of psychological forces on

physiological functioning will be required. Therefore, we cannot simply trace the libidinal development of the individual in the traditional zonal or epochal framework and discover where the fixation or regression occurred. Instead, we must use the techniques that have been derived from an analysis of character structure in which a flexible approach to the traditional concepts of free association and the revival of early experiencing is emphasized.

In order to comprehend the character structure of an individual, it is necessary to know how he functions and adapts in the present. This calls for a detailed presentation of his current experiencing in order to identify areas of anxiety and the way he deals with these anxieties. Consequently, the therapy proceeds in a more directed fashion with immediate goals that are clear to the patient. The therapist is generally more active and may direct the patient to areas which he feels may be illuminating. Such activity is manifested by more frequent questions and interpretations and a variety of techniques both verbal and nonverbal designed to encourage the patient to see how his present patterns of behavior are contributing to his difficulties in living. For example, it is most important in the treatment of the exhibitionist to demonstrate his prevailing patterns of immaturity and passivity in all areas of his living. We would, however, need to explore this issue in some detail with regard to the opposite sex involving his mother, early and later girlfriends and particularly in a detailed exploration of the actual exhibitionistic acts. His fear of contact coupled with need for some recognition without challenge to

his fantasies of a powerful, successfully aggressive male must be clearly exposed in therapy. This same situation may be present in the case of the voyeur with some additional elements of early fixating experiences as well as the safety and security of being physically uninvolved with the partner. For example, a 24-year-old exhibitionist lived with his mother and was an ideal son. He brought home flowers, was always on time for dinner and was a “good boy” in every regard. On his dates he rarely tried to kiss his girl friends or go any further than holding their hands. He was a good boy, respected by all his girlfriends, even while he was having sex relations with prostitutes. Even though his girl friends would have been interested in intercourse, he was very reluctant to suggest it. His greatest sexual satisfaction came in exhibiting himself to young girls when he could proudly display his penis and prowess without fear of humiliation or rejection. In therapy he came to recognize the purpose of his compulsive need to exhibit himself. This involved profound doubts about his acceptability as a man. He felt certain of himself only as a little boy who was always good and who never disturbed mother. As puberty approached, he was intensely afraid of being rejected if he made any sexual gestures at all towards the girls he liked or admired. He could only have sex with prostitutes, which proved nothing to him, or else expose himself to strangers where it was safe in the sense that he could sustain his grandiose fantasies about his competence. If the observer was frightened away, it proved how successfully potent he was. If he stayed to

look, it proved how fascinating he must be. This became clear only when we explored in detail those occasions on which he exhibited himself. A minute scrutiny of his feelings and associations in connection with such events enabled us to elucidate the dynamics of his behavior. The same issue, in which the total personality of the individual was revealed in the deviation, was manifested in a severe obsessional girl who would achieve orgasm only when she fantasized an extensive whipping while being subdued by bandits who had intercourse with her from the front and behind at the same time. Her inability to allow herself to enjoy sex by her own choice since it was dirty and indecent made it necessary for her to be overwhelmed and forced beyond her control to submit. This is a very common picture in the pain-dependent deviations. This patient could become aware of the significance of this fantasy only as she became aware of her overall obsessional need to be in control at all times including during the sex act. Since orgasm in the female requires that the female “let go” and give up control, she required a fantasy of being overwhelmed and out of control before she could let go. As her personality structure unfolded and she no longer needed to be in absolute control all the time, sex activity became more of a game and less of an exercise in control. She became increasingly able to have orgasm without her typical fantasy. In other deviations such as sadism or masochism we will discover similar patterns of response in which the necessity to inflict or endure pain is associated with the broader personality structure in which receiving or

producing pain is the requisite price for pleasure of any sort. Calvinist doctrine was very influential in this regard and often this philosophy participated in the sex function either by some accidental or coincidental fixating experience in early puberty.

Thus in most of the deviations once we discover the adaptive or symbolic meaning of the act we attempt to relate it to the total personality picture and try to demonstrate how its beginnings may have set up a pattern of behavior that is no longer necessary. If we can help the patient see that there is no danger of being physically hurt or emotionally humiliated or that his or his partner's genitals are not dirty or diseased and that the pressures of sexual needs can be satisfied directly with equal if not greater pleasure, then we have opened up the way for some alteration of the deviated sex pattern.

The therapist's role becomes more than a mere facilitator to reliving the past; it becomes that of a collaborating partner in examining the neurotic structure and the particular symptom complex and recognizing the defenses which serve to produce or encourage failures in the patient's present-day interpersonal relations, sexually and otherwise. Through such maneuvers the patient is assisted in recognizing the sexual distortions and how they relate to his transference attitudes. This means that we try to establish the relationship and similarity of his emotional attitudes towards sex and other persons and his attitudes towards nonsexual relationships and his therapist in particular.

This matter was strikingly illuminated in a 37-year-old patient who came to therapy because of his phobias of open spaces. As therapy regarding his phobia unfolded, he related his obsessive fear of molesting little girls. He had great difficulty in maintaining an erection in his sex activity with women his own age and invariably ejaculated prematurely when he managed to sustain an erection. Our relationship was characterized by his putting me into the role of the idealized father who was perfect and whom he had to overwhelm and defeat. His need always to be right and never less than perfect led to a number of grandiose expectations of himself. His pride and fear of being humiliated if he were less than a superman led to many transference “tugs of war.” During one such engagement he revealed that his preference for little girls came from the necessity of not looking inadequate or less informed than others. He was then involved with proving how he knew more than

Through associating the need to know everything and perform perfectly in sex, he could see that his present sexual patterns were incongruent with these demands. However, with little girls he could clearly dominate the relationship and be their teacher and master. This was a most illuminating insight which served to remove most of his horror and his intense anxiety about the possibility of attacking young girls. In the course of therapy this problem was entirely resolved and he could finally attempt a continuous sexual relationship which culminated in marriage. He has managed not only to sustain an erection with his wife but also to prolong the sex act not

infrequently. While he still feels uncertain about whether his wife is comparing him unfavorably with her first husband, his security is sufficiently adequate that no longer has he any fears or doubts about molesting young girls. Used in this way, transference becomes more than a mere revival of infant-parent relationship; it is viewed as a collection of distortions or a set of characteristic attitudes toward a variety of people who have played meaningful and determining roles in the patient's life. Irrational attitudes are examined in terms of their historical development as well as an understanding of their current adaptive value.

Transference is a major tool of therapy since it allows for the most direct observation of the distorted attitudes developed in the course of maturing. The exhibitionist tends to develop a relationship of extensive passivity with a parent figure transference, while the homosexual may become involved in a typical seductive relationship with a therapist of the same sex. At the same time the sexual masochist or sadist will tend to relate to the therapist in a way which clearly conveys their need to be hurt or to be cruel and hurtful. Thus the transference attitudes will reveal details about the individual's sexual behavior which will help elucidate the origins and present adaptive values of such behavior.

In the relationship of the "here and now," the patient is forced to acknowledge that some of his attitudes toward the therapist do not arise out

of a response to the therapist as he is, but to the therapist that the patient personifies. This opens up a broad avenue for exploration of the function and history of this distortion. This view of transference goes much further than the classical view which limits the distortion to that of a parental figure. A patient's irrational hatred of his therapist arises not only from a hatred of his father, for example, but also because of a series of relationships in which the patient has been abused and mistreated by authority figures which leads him to expect malevolence also from the therapist. This will certainly include fixating experiences or a prevailing atmosphere of pain-related incidents if the individual has some sadistic deviation or variety of a masochistic sexual perversion from the minor needs of being pinched, bitten or merely roughly treated to the severe beating that some masochists require for sexual satisfaction. This data will unfold as the transference relationship is examined in detail. On such occasions the patient will find malevolence in the multitude of opportunities offered in any close relationship like therapy. The clarification of the transference can reveal the background for a variety of sexual disturbances ranging from impotence and frigidity to coital infrequency and sexual avoidance.

A young lady whose father was a severe alcoholic during her early years came to know him as a dangerous and disgusting man whom she had to put to bed and care for during his hangovers. She sought therapy because of concerns about being homosexual and her intense anxiety about sexual

activity. She had had a few boyfriends, some intercourse, but no homosexual activities whatsoever. She avoided intimate relationships because she expected that they would produce mutual dependencies which she feared but wanted. Her expectations of total dependency, which she visualized as exceedingly dangerous, clashed with her demands to be completely independent and in this way she was prevented from establishing any deep involvements with her boyfriends. These issues became clearly manifested in her transference attitudes with me and her fears and expectations of being overwhelmed and taken advantage of if she became too trusting and devoted. Her hatred for her father was largely an expression of her resentment and disappointment in not having established a loving relationship with him. The exploration of this attitude towards men enabled her to acknowledge her femininity without shame or fear of being taken advantage of. She began to experience and enjoy her sexual activities and ultimately married a man many years older than herself. What began as almost total frigidity and fear of homosexuality was resolved into a satisfactory marriage with extremely enjoyable sexual contacts.

Transference becomes more than a mere repetition and transferring of feeling; it becomes a dynamic process which represents and reproduces the effect of early experiencing on present behavior as a current, active functioning issue in a patient's life. The activity and lack of anonymity which characterizes such a therapeutic approach arises out of the theoretical

conception that transference attitudes are more meaningful and revealing when they are produced through contact and experiencing than in a vacuum of pure fantasizing. The therapist should not limit his activity or avoid revealing facets of his own personality. Face-to-face encounters with the patient sitting up rather than on the couch is frequently more productive than the traditional procedures. In addition, since we now know a great deal about mental operations we can be more energetic in using shortcuts and not always be cautious about our interpretations. All these innovations tend to produce stronger transference relationship which permits a sharper and more convincing awareness of the personality factors which have led to the sexual distortions.

Because of our growing conviction of the validity of our concepts of mental functioning, we should not be too wary about actively intervening and encouraging productive areas of inquiry while discouraging endless and fruitless meanderings and distractions of patients. Thus the free association technique, while undoubtedly useful, can be abused and therefore should be limited at times. This is particularly relevant in the treatment of the sexual deviations, since we can go far afield unless we are aware of the constant necessity to tie our observations and associations to the issues involved in the sexual deviation. This notion has been supported by most ego analysts who use the free association technique with caution and judgment.

When the therapist becomes more active it becomes more apparent that not all the patient's attitudes toward the therapist could be viewed as irrational responses. Some of the patient's attitudes represent realistic and rational attitudes in response to the kind of person the therapist really is. While this is considered an artifact in orthodox analytic therapy, it is apparent that the most stringent efforts of the analyst to remain incognito are largely impossible to achieve. In spite of all the safeguards the patient can discover many important pieces of data about the analyst through his verbalizations as well as information about his public life, which is available if one is interested. The office habits and practices of the therapist can stir up responses which are related realistic issues. Thus we must distinguish between the true transference responses and the realistic responses. This can serve the important function of increasing the patient's convictions regarding the significance of his transference reaction. Indirectly, this distinction can lessen the authoritative atmosphere of the analytic situation and permits a realistic appraisal of the analyst, which is a vital need for the neurotic, who is already overburdened with distorted conceptions about others.

This is particularly apt in dealing with the sexual deviations, since these individuals are already overwhelmed and overburdened by the cultural taboos and restraints and the authoritative family situations in which they grow up. The deviations generally arise in an authoritative, restricted and inhibited family structure where restraints and prohibitions led to all sorts of

distorted ideas about the sexual apparatus. Whether primary phobias or fixating experiences have occurred, a continuation of the authoritative situation in the therapeutic atmosphere will only complicate or prevent the resolution of the patient's distortions. The authoritative atmosphere of the therapeutic situation is also lessened by the use of chairs instead of having the patient lie on a couch, which encourages the child-parent interaction.

Since our current view of the origins of the sexual deviations does not require a genetic reconstruction of the past as essential to the elucidation of a patient's character structure, the use of the couch cannot always be justified in theory. It can even become an obstacle and encourage regression and dependency as in the exhibitionist or sexual masochist where it may strongly reinforce current character trends and serve as a resistance to therapy.

A most significant outgrowth of the increase in activity by the therapist is to encourage the exploration of the role of countertransference in the therapeutic process. Early in his therapeutic work Freud recognized the potential influence of the therapist's own personality on the therapeutic process. This led to the requirement that every therapist be analyzed himself in order to become aware of his own distortions and neurotic difficulties. However, the personality of the therapist can never be entirely eliminated from the process. While being attentive to this matter, the therapist's moralistic responses to some of the more extreme responses such as rape,

sexual sadism or his horror at necrophilia or the like must be taken into account. He must also be aware of the subtle and at times successful activities of the homosexual to attempt to seduce and the therapist's covert encouragements. Likewise he must be particularly cautious about fulfilling the masochist's need for some critical denunciation or the exhibitionist's effort to be taken care of as a child. All the reactions cannot be avoided nor is it entirely useful that they should be. It has become most apparent that countertransference elements in the therapeutic process can be utilized to great advantage in the process of therapy.

The therapist's attitude toward the patient can be a very powerful tool in elucidating the character structure of the patient. When the therapist is free, flexible and willing to become involved in the therapy his reactions can be most useful in learning about the subtleties of his patient's performances. This is particularly true in the behavior of many exhibitionists, fetishists and voyeurs who expose their immaturity in the therapeutic relationship. The therapist must be free to convey his reactions to these manifestations in order to bring them into the open and thereby get them into the therapeutic work at the earliest possible time. It can open up major lines of inquiry, since the patient's effect on others can be examined in the "here and now" as it affects the therapist. Such reactions on the part of the therapist can infuse new meanings to the therapeutic process and are often invaluable in overcoming resistances and stalemates. It is obvious that the therapist cannot

like all his patients equally, or at all. With some he recognizes stronger interest and attachments than with others. Such a variety of attitudes does not necessarily offer any clues to the possibilities of successful therapy. It does, however, offer many opportunities to the keen and competent therapist to make rapid and fruitful formulations about his patient's patterns of operation. The utilization of countertransference feelings can be equally detrimental to the therapeutic process if used in ill-advised ways or as poorly timed interpretations. For example, the inclination to tell a patient how irritating he might be or how seductive her behavior is, must be tempered by the strength of the relationship and the readiness of the patient to accept unflattering or uncomplimentary statements. This is particularly apt in the treatment of homosexuals or other seductive heterosexual problems such as nymphomania, satyriasis, etcetera. The time must come if the therapeutic work is proceeding well, when the patient will make sexual demands on the therapist, which must be met with a firm, definitive and clear-cut refusal without increasing the patient's feelings of being rejected or chastised. The distinction must be clearly made between rejecting the request and rejecting the person. This is a crucial distinction in the disease process and the ability to convey this difference to the patient will be an essential ingredient in his ultimate care.

Not only is the manner, tone and attitude of the therapist crucial to this maneuver, but the timing is equally important. One must select the proper

time to inform the exhibitionist that he is passively aggressive and that his behavior represents a childish attempt to achieve his desires without assuming any responsibility for his activities. At one point it could open up profitable lines of inquiry while at another time it can produce resentful criticism of the therapist's envy.

The responses of the therapist to the subtle clues of the patient's behavior are generally difficult for the patient to acknowledge because he is genuinely unable to recognize them himself. It probably has not been brought to his attention before and therefore to really make an impact on him requires not only the proper timing but an example which will be clear and indisputable rather than one which is too shrouded in confusing ambivalences. It takes considerable skill to decide when it is safe to make an observation which might produce a significant response from the patient. When used wisely it can accelerate therapy and inaugurate a contact with the patient which becomes invaluable for the further progress of therapy. The utilization of countertransference reactions is becoming more widespread and an essential part of current psychotherapeutic practice.

It is essential in the therapy of the sexual distortions to get a complete and detailed account of these difficulties at the outset. In view of the widespread confusion of definitions, it is necessary to identify the patient's label of his behavior with some more meaningful or causal conceptions of the

disorder. For example, the patient may complain of being impotent because he occasionally fails to perform sexually or because he cannot meet his wife's demands. However, in these cases we may not be dealing with impotency, but with a variation of the extreme expectations of the partner. Similarly, the frequent complaints of unsatisfactory sexual adjustment, whether it is a failure to achieve orgasm, frigidity in the female or premature ejaculation or inadequate potency in the male, often has more reference to unawareness of the physiological spectrum of sexual potentialities and the excessive expectations of the partners than a valid sexual difficulty. This problem is particularly important in the looseness with which the terms "homosexuality," "sexual masochism," "nymphomania" and others are used. Often the patient applies this label to himself out of ignorance, guilt or moral condemnation and it does not really apply to him.

A patient considered her husband to be sexually inadequate because he was unable to have intercourse every time she desired it. She took no account of the necessity for sufficient rest periods for the male or the difference between the availability of the male and female for sexual activity. The failure to understand this simple physiological fact produced exaggerated expectations which could not be fulfilled. The resulting anger, frustration and disappointment produced a vicious circle which then truly incapacitated her husband for adequate sexual performances. He began to feel impotent and incompetent and each attempt at intercourse was accompanied by great

anxiety producing either premature ejaculation or failure to maintain an erection. His wife's anger increased his anxiety and stirred up great anger towards her. Thus the vicious circle grew larger and more destructive until the wife came for some assistance.

Another patient considered himself to be homosexual in spite of his never having had a homosexual experience. He did have numerous heterosexual contacts but never felt that they came off adequately or that he had produced an orgasm in the women. This, coupled with his prior analyst's interpretation that his passive attitudes were evidence of his latent homosexual trends, focused his obsessive preoccupations on his masculinity. He began to scrutinize his behavior for evidences of homosexuality and if he stopped for a hitchhiker, he wondered if it was for homosexual purposes. The fact that he had many male friends, that he liked dancing and so forth, all became "evidence" of his homosexuality. This preoccupation, produced largely by the theoretical preconception of his earlier therapist, took the focus away from his real difficulties which revolved about his pervasive needs for magical control of every element in his living as well as his phobic avoidances of every situation in which he could not see himself immediately as the "master." He was not homosexual at all but a perfectionistic, grandiose person who had to excel at everything. Since he did not excel at lechery he began, with the assistance of psychological theorizing, to attribute homosexual tendencies to his already overburdened compulsive neurosis. In this example,

the failure to distinguish homosexuality as an actual distortion of sexual object choice from homosexuality used as an obsessional distraction and a pejorative label would put the therapeutic focus in the wrong place. Unfortunately, this is a very common occurrence in the treatment of obsessive patients with homosexual doubts.

Thus the definition of prematurity in ejaculation, homosexuality, frigidity, etcetera, must be clear and delimited if any useful therapeutic benefits are to take place. For example, we cannot leave the definition of homosexuality so wide open that it includes any behavior that is discrepant from conventional gender behavior. It should be called homosexuality only when the person foregoes and avoids any interest or attempt to integrate on a heterosexual level and establishes his life in exclusive, compulsively preferred relationships with the same sex. The label should not include those people whose living is integrated with people of the opposite sex, whatever the degree of deficiency or distortion of this relationship there may be, and it should certainly not include those sexual experimenters who dabble in every deviation or who remain celibate for reasons other than true homosexuality.

Many sexual deviates come to the therapist, either directed by the courts, one's mate or one's own guilt or need to improve one's living. While the symptoms must be explored, the investigation of the total personality and the role the symptom plays in the total character structure must be

completely understood. There are particular problems in the treatment of the specific deviations. For example, the passivity of the exhibitionist or the anger of the rapist and sadist create technical problems that cannot be anticipated entirely. However there is no special dynamic constellation that characterizes one deviation as opposed to another, even though we can make general statements about some of them. For example, the avoidance deviations like voyeurism, exhibitionism or fetishism all involve some feeling of danger in genital contact that would be called castration fear. Impotence could be viewed as total avoidance of any sexual involvement, while satyriasis, nymphomania or Don Juanism are all efforts to overcome doubts of one's masculinity or femininity. Aside from these general statements, however, every deviate must be studied and understood in terms of his own past and personality development. His avoidance of adult sexual contacts can only be understood in terms of his own idiosyncratic life history. Therefore, it is misleading to describe the therapeutic handling of each of the labeled deviations. Since they do not have a separate etiology, there is no specific therapy that applies to them. Therefore I will close the chapter by showing in some detail how the understanding of the total personality is the method of choice in treating all the deviations. It also demonstrates how the distorted sexual behavior is only a symptom of a broader personality disorder rather than a disease in itself.

PREMATURE EJACULATION

Premature ejaculation is an extremely common symptom and seems to be intimately related to the obsessive-compulsive dynamism and to sub serve the operation of power.

The symptom occurs only in relation to a specific person and in specific situations. Unlike other mental phenomena, it cannot occur in the absence of the sexual object. This is the reason why premature ejaculators masturbate without ejaculating prematurely. It occurs only with real people as opposed to fantasized partners. It probably occurs on some occasions in all people, since it is essentially a response to anxiety. Although premature ejaculation can occur in fatigue states, hyperactive drug states, prolonged abstention or excessive excitement, it is primarily an anxiety-provoked phenomenon which occurs in relation to a conflict situation in which the individual is involved. The symptom results from this conflict but does not solve it. It produces instead further anxiety since the sexual performance does not improve while the conflict continues. The brief case history which follows will illustrate some of the points discussed above.

Patient A had an active and successful sex life during the first year of his marriage. During the second year some difficulties arose, and although the relationship appeared to be working out, he began to notice that he was ejaculating prematurely. The ejaculation would occur after a few strokes and

under very special circumstances. It occurred only when intercourse was stimulated and precipitated by his wife, who was an aggressive, domineering individual. During the first year of marriage the patient was active and energetic in his marital affairs. As he slowly relinquished this role to his wife, quarrels became more frequent and the patient always felt subdued by his wife. Premature ejaculation invariably occurred when he was angry with her. In this way he punished her and indicated his indispensable role in the marriage. Although there was some guilt about his supposed inadequacy, there was at the same time a secret satisfaction and a lack of real impetus to eliminate the difficulty. He did not recognize any problem, and it was his wife who had pushed him into treatment. The symptom was a relatively minor problem in a severe obsessional character structure. The occasions for premature ejaculation became less frequent as the tug of war and power struggles lessened in the patient's living.

What transpires in the man who suffers the discomforts of premature ejaculation? The situation is approximately the following: from the outset of his sex life or during the course of it, he has the distressing experience of either ejaculating before penetration or after a few strokes. He is left anxious and ashamed and behaves as though he were a disgraced male. Consequently, at the next attempt, he is very anxious lest he again ejaculate prematurely. He senses the woman's anxiety and concern, and in his earnest desire to perform well, he tends to exaggerate the effect he is producing on the female. At this

point, he becomes caught in the sociological and cultural attitudes towards the male, such as the equation of prolonged intercourse with potency, and conceives of his partner in the sex act as being dissatisfied, distraught, tense and angry. He must eliminate the prematurity, and in this tense atmosphere, it either gets worse or continues unabated. With increasing concern and anxiety, it becomes less and less possible to overcome it. After a short while, his partner complains, threatens and possibly denies him any contact. He is miserable, and thinks of himself as a failure, unmanly, impotent, weak.

What goes on covertly is quite different. As the wife becomes more angry, she also begins to recognize the importance of her husband in his potential capacity to afford her some gratification. He has become more essential to her existence and through his inadequate performance has managed to control her pleasure and affect her living. If she becomes more tender, concerned and interested and the husband temporarily feels victorious, his anxiety diminishes and premature ejaculation may disappear. However if it continues, his partner may become more vitally concerned and encourage him to see a psychiatrist. If it is only temporary, we may see recurring episodes, for as his orgasm improves, his partner demonstrates less interest, concern and tolerance for him. Premature ejaculation returns and the cycle begins over again.

This is perhaps an oversimplified version of the involved and

complicated interchange that occurs, but it does demonstrate some aspects of the power struggle involved in this symptom. The problem is often initiated in marriages where the partners are prudish, uninformed and uncommunicative in sexual matters. They may have secret expectations with regard to their sexual activity and hesitate to voice their disappointments. Although they appear resigned to unsatisfactory sexual relationships, they covertly resent and demand more from it. This often produces premature ejaculation in the male and increases the tension in the relationship. In these instances, the problem, which may originally have been due somewhat to ignorance or prudery, now becomes a matter of demand, control and manipulation of the partners.

In this symptom we can notice most clearly the element of power as utilized by the sexual function. The very presence of the symptom serves to put the male in the role of the generous, giving person who in his generosity may or may not give pleasure to the female. The variations and fluctuations in the appearance of the symptom coincide most clearly with this element in the relationship between man and woman. It provides a most sensitive weapon for vindictively punishing or graciously satisfying the woman. The patient's problems may involve fear of feminine aggressiveness, unconscious jealousy, injured feelings, expressions of contempt, fear of women's genitals, concern over conception, etcetera, but operationally it is used as an instrument of power and manipulation in interpersonal relations.

This helps us understand those instances where premature ejaculation may occur with one's wife but not with other women or with prostitutes. The power struggle which may be producing it in the wife is absent with the prostitute or the other woman.

There is no dependent relationship with the prostitute, and one's ability to dominate, control and manipulate the situation is amply satisfied. The seduction and winning of the girl other than one's wife often satisfies the power element, and since there are few ties and tensions, the struggles are minimal and prolonged intercourse can occur. Although the individual may have many obvious problems with regard to women, the prostitute or paramour does not stir them up, and so there is no premature ejaculation, although other sexual deviations may be present, reflecting these other problems.

This symptom is often seen in homosexuals who are capable of some heterosexual contact. In these cases one can clearly see the role power, control and manipulation play in the symptom. It does not represent the feminine component in the personality—quite the contrary. It represents the attempts at more masculine expression of the aggressive need. The homosexual who is capable of heterosexual contact frequently suffers from delayed ejaculation (*ejaculatio tarda* as contrasted with *ejaculatio praecox*). It has been noted also that in heterosexual marriages, the homosexual partner

has had premature ejaculation, which serves the purpose of shortening the contact, disappointing his wife and “showing her who’s boss!”

Premature ejaculation is probably present much of the time in the obsessional dynamism, where there are elements of obscure power operations directed at maintenance of control over everything that happens.

Some sexual deviations run afoul of the law and the therapy is complicated by the intervention of the courts and the public attitudes toward such disorders. It must be recognized that the public attitude towards some deviations does not alter our theoretical understanding, even though it might greatly influence the practical limitations imposed on the technique for dealing with them. Neither should this fact distort the emphasis of the psychological significance of the deviations. Thus, while voyeurism, fetishism, masochism, sadism and other forms of sexual deviation may result in legal action, they have no other significance as neurotic symptoms than any other distortions of human activity which is private and outside of legal sanctions. The particular symptoms must be understood in their own right as part of the total personality structure. Consequently, the general techniques that apply to the therapy of the neurosis can be applied to the sexual disorders. A search for separate etiology with a distinctive therapy for each category is not only misleading but probably invalid.

REFERENCES

- Krafft-Ebing, R. Von: *Psychopathia Sexualis*, 12th ed. New York, Phys. and Surf., 1922.
- Hirshfield, M.: *Sexual Anomalies and Perversions*, London, Encyclopaedic Press, 1944.
- Freud, S.: Three essays on the theory of sexuality. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, vol. 7.
- Salzman, L.: *Developments in Psychoanalysis*. New York, Grune & Stratton, 1962.
- Money, J. (Ed.): *Sex Research*. New York, Holt & Rinehart & Winston, 1965.
- Salzman, L.: Premature ejaculation. *Int J Sexology*, 3, 1954.
- Rado, S.: *Psychoanalysis of Behavior Collected Papers*. New York, Grune & Stratton, 1956, vol. 1.
- Salzman, L. *Obsessive Personality*. New York, Science House, 1968.
- Freud, S.: New introductory lectures on psychoanalysis. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, vol. 22.

Notes

- 1 Krafft-Ebing in his classic work *Psychopathia Sexualis* does not even mention premature ejaculation, while Forel, the author of a very popular and widely disseminated book *The Sexual Question* published in 1922 does not include it either. I have had no success in finding any reference to this disorder in any publications prior to 1900. In pursuing the matter I wrote to Dr. Ernest Jones who replied in a personal communication in 1962 that "My impression is that hardly anything was written on that subject prior to Freud."