reprinted from
INTERNATIONAL JOURNAL OF PSYCHOANALYTIC PSYCHOTHERAPY - VOLUME 6
© 1977 International Journal Press

Lack of Timing and *Ejaculatio Praecox*

ENRIQUE GUARNER, M.D.

Underlying factors in *ejaculatio praecox* are investigated through excerpts from the analysis of a man who suffered from this symptom for many years. The literature is reviewed, and the symptom complex is related both to the patient's character structure and to the difficult resistances that he presented in analysis. The roles of the concept of time and of an inability to conceive completion are studied, as is the type of prevailing anxiety seen in these patients.

In *Inhibitions, Symptoms and Anxiety*, Freud said: "The sexual function is liable to a great number of disturbances, most of which exhibit the characteristics of simple inhibitions. These are classed together as psychical impotence. The normal performance of the sexual function can only come about as the result of a very complicated process, and disturbances may appear at any point in it. In men the chief stages at which inhibition occurs are shown by: a turning away of the libido at the very beginning of the process (psychical unpleasure); an absence of the physical preparation for it (lack of erection); an abridgement of the sexual act (*ejaculatio praecox*), an occurrence which might equally well be regarded as a symptom; an arrest of the act before it has reached its natural conclusion (absence of ejaculation); or a non-appearance of the psychical outcome (lack of the feeling of pleasure in orgasm)" (1926, pp. 87-88).

Sexuality depends on the interrelationship of psychic stimulation and physiological response. Any alteration of these coordinated reflexes may cause impotency in men; for this reason psychosomatic considerations are extremely important in regard to the sexual function.

I will present an unusual case—unusual in view of the difficulties from which the patient suffered and because he had defeated a great number of analysts in their therapeutic endeavors—and try to formulate a theory about *ejaculatio praecox*.

CASE HISTORY

When the patient called for his first appointment, his voice was shrill and he spoke rapidly. My secretary, who first answered the telephone, was unable to determine whether he was a man or a woman. The patient is short and robust with a spheroidal abdomen. His neck is short. His face is fair and round and he blushes easily. He wears a well-trimmed beard. His forehead is broad and his cheeks hang. He is almost bald, although he tries to disguise it with his side hair. His blue eyes are sunken under his eyebrows. He dresses well, without luxury; he has a certain imposing quality which provokes respect. What was most striking was that in spite of what seemed to be rather definitive characteristics, he still seemed nondescript.

He told me that he had suffered from absolute impotency since his marriage four years ago and that he had been unable, up to that moment, to deflower his wife. He added, however, that he loved her very much and did not want to lose her. He said that he knew his case was extremely difficult, insofar as he had seen many therapists. He acknowledged that he had never completed any treatment, but he hoped that I would be able to help him finally resolve his problems and relieve him of the burden of his tragedy.

He was forty-nine years old. Born in a small town in Germany, he came from a moderately wealthy Jewish family that had had to emigrate to South America in 1938 because of the Nazi persecution. The father was forty when the patient was born. He was described as having been able to achieve a modicum of financial success, but apparently he was a man who never found himself. He was also considered to be unaffectionate and distant from his family. Upon his arrival in South America, he stopped working. He was able to live off his investment in his brother's business. He stayed home reading, and punctually every day went for a walk in the park near the house he lived in. At the age of sixty-two, he suffered a coronary and died a few days later. The patient keeps very few remembrances of him. The father did not pay too much attention to his son and was concerned only that his homework be done well. Very seldom did he play with his children.

The mother was one year younger than the father. She had a strong, exaggerated, and domineering character. She always worried about feeding the children properly; she seldom let them go out on the street, and for that reason the patient was fearful of and cowardly in his relations with other children. He never participated in sports and even now has no interest in them. The mother died three years after the father, when the patient was twenty-five.

His childhood and adolescent memories in Germany are scarce although he had been fourteen when he left. He remembered anti-Semitism at school, on the part of schoolmates and some teachers. He received lower marks than

children with lesser capacities, but he had felt it futile to compete. In the beginning, there were still a few Jewish children, but when he arrived at the Gymnasium he was the only one left, because the other Semites had fled the country. His father was one of the last to leave Germany and did not do so until 1938.

From the sexual history, it is important to say that the patient has never masturbated. When he touches his genitals he feels fear and immediately washes his hands. He had his first sexual relation at twenty-one, an almost ritualistic act with a prostitute. His brother-in-law arranged everything, and although the patient experienced great anxiety, he also felt pleasure in his first sexual contact. When he returned to his home, there was a celebration because, at last, he was a man, and he felt a sense of completion.

The patient had occasional but infrequent relationships with prostitutes when he went to college. He did well in school and was able to win a scholarship to continue his studies at the postgraduate level. He went to two institutions in different countries, the last one in the United States. Although he was a very good student, he never succeeded in obtaining his doctorate, a fact that has haunted him up to the present time. During his graduate years, he first experienced *ejaculatio praecox* with prostitutes, a pattern which continues to persist.

He remained just a year in the United States and returned to South America to a job previously held and to his monotonous existence. Being a very peculiar and shy person, he had almost no friends and dedicated hundreds of lonely hours to reading. On holidays he had lunch with his sister and brother-in-law. Once in a while he found a prostitute, but she did not satisfy him.

One of his friends suggested to him that he go into personal psychoanalysis. He went to a therapist who at first helped him, but after three years, the sessions became monotonous and he decided to abandon the treatment. Later he started treatment with another doctor who gave him six LSD treatments, and he attended group therapy for two years. Deep inside, he does not have good memories of his experience and considers the therapist a "gabbler."

At the end of 1965, he met a very attractive prostitute and decided to establish a close relationship. He invited her once or twice a week to have dinner and they had sexual relations in his apartment. Nevertheless, he felt blackmailed by her, because she demanded great amounts of money. (He thinks that he gave her a third of his income.) His sexual relations were rudimentary because his erection did not last and he experienced premature ejaculation. He felt deceived, but with this woman, in contrast with previous ones, he felt the pleasure of possessing a beautiful body.

It is interesting to notice that the patient had never had a girlfriend although he was over forty years old. He had been in love with a librarian to whom he

never talked. Some years later he dated a colleague, but she soon married another man.

In his present position, he met a girl eighteen years younger who worked for the same organization. After a somewhat whirlwind courtship, they married. Yet, the marriage was never consummated. The patient could not maintain an erection. All attempts at intercourse failed because he ejaculated before he could penetrate.

Manifestations of his impotency varied from one occasion to another. Most frequently, he had premature emissions. With each unsuccessful attempt at intercourse his feelings of inadequacy intensified. For long periods of time, he would not be able to have an erection. If he were able to, he would ejaculate immediately, soiling his wife with his seminal fluid. At other times, his orgasm would be so rapid that it would occur without an erection.

Both the patient and his wife grew desperate. He sought all types of therapies, varying from hypnosis to such drugs as benzedrine and nupercaine. He felt dissatisfied with all of them and abruptly terminated each treatment attempt. Several years ago he was transferred to Mexico City. When he arrived he visited three analysts recommended to him, but he stayed with me because, as he stated, my office was just one block from his home.

In general, he is a very difficult patient, and shows practically no affect. He constantly compares me to his last analyst, saying that my interpretations would never have been made by him. When I confront him with his negative feelings toward me, he states that he is not certain he will continue with his therapy because he does not see any results. When I remind him that he is not my prisoner, he immediately pulls back and says that he will try for another six months, and that the same situation occurred with his last psychoanalyst.

He talks in a diffuse manner and almost completely ignores my existence, reducing all the sessions to the recitation of actual events. The tricks this patient plays on me are also noteworthy. Once in a while he introduces a new character into the therapy to see if I am listening, and if I ask about this person he states that he has mentioned him before on several occasions. Other times he brings a dream, which by the way are scarce, and when I start investigating it, he suddenly gives me clues that he had hidden from me to see if I were capable of interpreting his dream without them. Another typical characteristic is his constant questioning; he always asks about the origin of things.

His inability to differentiate between impulses, affects, body sensations, and his incapacity to postpone discharge causes a bizarre transference reaction. It seems to me that he has submitted to analysis because he is unable to break off treatment. Coming punctually to the appointed hour magically avoids a crisis. He does not respond to any interpretation, but tries to carry out his role as a patient, never developing an observing ego. His prolonged dependency on a parent has facilitated this situation. He does not want to

remember his dependency on his mother; at the same time we can infer that a profound hostility toward her took place in childhood. A major resistance in transference feelings is the denial of the hate he felt for his mother, the ànalyst acting as a surrogate.

A defect in the development of basic ego functions stems from a disturbance of early object relationships and thus of early identifications. The Nazis were frightening and he could not establish any close relationships in Germany. All these factors make any working alliance impossible. On a conscious level, this patient has no realistic hope of alleviating his neurotic misery and shows a lack of mobility of cathexis for displacement, which makes him mistrustful of all therapists. He clung tenaciously to a number of psychoanalysts in the past but had tremendous difficulty sustaining a transference relationship. Although in certain areas he seems to function reasonably well, he maintained only a fragile equilibrium with all his previous analysts.

Each session is similar to the previous one. He spends considerable time in superficial monologue. There is a marked absence of dreams and much silence. The only difference between my technique and that of his other therapists is that I focus upon his seemingly defensive lack of emotions.

When the patient talks about real events, he habitually brings up problems with his wife. Very often he presents an "emergency." Because of the lack of sexual activity, his wife flirts with several men. At the beginning of treatment, it was her painting teacher; on another occasion, an attractive neighbor. In general these emergencies are minor because, at nonsexual levels, he believes his relationship with his wife is good. However, he suffers intense anxiety due to his general insecurity. He lives depending on his wife's arrival at home. He watches her constantly and feels persecuted if any man comes close to her.

At the same time, the continuous demands made on the therapist, and the bizarre transference manifestations, provoke a disturbed countertransference reaction. This patient, whom we could call either a severe character disorder or a borderline, is in a way a heavy emotional burden for anyone who cares about him. I feel that almost none of my interpretations are accepted because he cannot identify with me. He provokes a great deal of frustration on my part, since I have no satisfaction or sense of accomplishment. On the other hand, I feel that I can understand this patient in a better way than his previous therapists, because I suffered a certain persecution in my own childhood and also had to leave the country I was born in.

In all, this patient creates a most difficult analytic experience for himself and his analyst; there is a persistent sense of frustration and disappointment in both participants. An inner state that appears related to his *ejaculatio praecox* creates a comparable interaction between himself and his wife. The basic factors in this symptom appear clinically as his impaired masculine identification, his unresolved aggression toward his mother, and a number of

ego dysfunctions which make it difficult for him to deal with his underlying primitive sexual and aggressive fantasies.

DISCUSSION

Abraham postulated (1917) three mutually dependent causes for impotency: (1) a basic feminine orientation, (2) a sadistic attitude toward women, and (3) an increase in urethral eroticism that makes the patient equate urine with sperm as children do.

Wilhelm Reich (1928) related *ejaculatio praecox* to certain forms of hysteria. The emission would be a reaction to the prohibition to masturbate: The penis should not be touched. According to this author such cases would have a more favorable prognosis than those stemming from pregenital problems.

Stekel (1927) wrote of the desire "to become impotent," a last effort to make sexual relations impossible. This could be provoked by: (1) fear of losing independence (patients would equate sexual relations with marriage and loss of freedom), (2) fear of venereal disease (this is equated to castration panic, but he also mentions vaginismus and the captive penis), and (3) fear of death (this can be related to guilt about the committed sexual act).

Gutheil (1959) emphasizes pregenital elements in which oral and urethral phases are predominant; at the same time he emphasizes a passive, feminine orientation toward sex. This author describes the frequency of enuresis in patients with *ejaculatio praecox* as the result of an infantile attitude that substitutes urine for the depositing of semen.

Other pregenital zones are occasionally referred to in the literature, but I would like to discuss an aspect of *ejaculatio praecox* not previously mentioned. During orgasm one discharges a substance and simultaneously feels excitation. In general, there is a close relationship between semen and excitation. The prolongation of the sensation of pleasure is important. In the majority of animals precopulatory patterns are brief, and so is copulation itself. In baboons, for instance, the time from mounting to ejaculation is no more than seven to eight seconds, with less than fifteen pelvic thrusts, often fewer. The human being, however, has a copulatory phase of several minutes before the male reaches the consummatory act of sperm ejaculation. In humans, the aim of sexual activity is to prolong the act as long as possible in order to achieve maximum excitation with the emission of semen. *Ejaculatio praecox* would cut off the mounting excitatory crescendo by interrupting the process of summation of erotic sensations. Emission occurs before completion and semen is ejaculated with a relative lack of sensation or feeling. Thus, the sex act does not progress along its natural course. It is incomplete.

In *The Self and the Object World*, Jacobson (1964) states that in the second year the changes in the nature of the relations of the child with the object

world, introduce in the psychic organization a new category: time. She is obviously referring to the maturity of the locomotor apparatus, sphincter control, and the ego's capacity to discharge instincts in a graduated fashion. One acquires the ability to make judgments in terms of *now* or *after*. In contrast to the oral stage, the *now* is not the instant of satisfaction, and the acceptance of delay can bring the pleasure *after*. We see therefore the importance time acquires during anal and urethral phases.

My patient was always preoccupied with time. He was constantly concerned with his wife not coming home on time. He persistently focused upon being punctual, early, or tardy. His sexual development took place rather late, and up to this day he has never masturbated, being unable to discharge instinctual excitation. He married at forty-five; again his timing was late. He has never completed any treatment, and he has never been able to consummate the sexual act with his wife. His life has been punctuated by imperfect timing, being late in his sexual development, or being early within the confines of sexual activity as in *ejaculatio praecox*. The latter is associated with his inability to achieve completion.

The following orientation seems characteristic of this patient's *ejaculatio praecox*, one which may be fairly common in patients suffering from structural problems.

First, as stressed, he could not bring any act to completion and this extended into the sexual area. Completion was equated with commitment, and the patient was terrified of a close relationship. The latter could lead to dissolution of his identity sense, or at a deeper level, to annihilation.

Next, the patient's anxiety was primitive; more precisely it was an anxiety characteristic of early phases of development. This type of ego constellation antedates the firm establishment of the sense of time and continuity which is part of a good time differentiation. He demonstrates how such poorly developed functions manifested themselves in the sexual act and contributed to the formation of the symptom of *ejaculatio praecox*.

CONCLUSIONS

The analysis of this patient appears to confirm the importance of pregenital traumas and problems in the development of *ejaculatio praecox*. Other pertinent factors, some of which have been described in the previous literature, include a feminine orientation, a variety of ego dysfunction, a dread of closeness and a fear of losing one's independence, incestuous fixations, and extensive unresolved aggressive conflicts. Of particular additional importance is the patient's dread of the passing of time and of the completion experience. Underlying these factors was a primitive anxiety with fears of annihilation and dread of merger, anxieties intensified by the patient's failure to establish a firm sense of time.

REFERENCES

Abraham, K. (1917). Ejaculatio praecox. In *Selected Papers on Psycho-Analysis*, pp. 280-298 New York: Basic Books, 1957.

Agoston, T. (1949). Horror vacui. *Psychoanalytic Review* 37:438.

Erikson, E. (1963). *Childhood and Society*. New York: Basic Books.

Federn, P. (1953). *Ego Psychology and the Psychoses*. New York: Basic Books.

Freud, S. (1926). Inhibitions, symptoms and anxiety. *Standard Edition* 20:77-175.

Gutheil, E. (1959). Sexual dysfunctions in men. In *American Handbook of Psychiatry*, ed. S. Arieti, chapter 36. New York: Basic Books.

Jacobson, E. (1964). *The Self and the Object World*. New York: International Universities Press.

Morris, D. (1967). *Primate Ethology*. London: Weidenfeld and Nicolson.

Reich, W. (1928). The genital character and the neurotic character. In *The Psychoanalytic Reader*, ed. R. Fliess. New York: International Universities Press, 1948.

Stekel, W. (1927). *Impotence in the Male*. New York: Liveright.

Solomon, J. (1964). *A Synthesis of Human Behavior*. New York: Grune and Stratton.