Male Sexuality and the Problem of Identity

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emotionally involved with resultant impairment of both. Further, reality gratification of sexual urges in sexual intercourse at this stage of development would seem logically to interfere with the general maturational process, i.e., developing mastery of instinctual drives, abandoning the pleasure principle for the reality principle and investing energies in long term goals and delineating a workable self, a separate identity from the nuclear family.

I think that it is a serious mistake psychologically to assume that proper management for a sexually active child is contraceptive advice or a prescription for the pill and it is even worse medicine when separated from venereal disease control programs. Further, I believe the non-judgmental attitude of professionals dealing with this age group is open to misinterpretation as support and the non-judgmental attitude of the clergy, as endorsement, think that there is an important distinction between condemning an act and condemning an individual. A early adolescence, sexual gratification is not necessary nor conducive to mental health but the reverse, in fact, have not found chastity to be injurious to the health at any age, in addition to its fringe benefits for the soul.

REFERENCES

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John T. Dulin, Ph. D.

Physicians frequently encounter questions about sexual functioning, or dysfunctioning, in the course of routine practice. Not infrequently the patient's presenting complaint is related to concerns over sexual adequacy. How are such questions handled? Does the physician feel frustrated or embarrassed? Does he turn the patient off or does he listen and try to help him? If the physician has not studied and pondered the issues involved in sexual dysfunctions, it is likely that he will fail to grasp the psychological complications related to sexual problems. It would seem useful, therefore, to explore some of these issues so that the physician will feel more competent in dealing with sexual problems of his patients.

The theme of this article is limited to male sexuality, and my discussion will assume the context of twentieth century America. This is not the place to investigate the sexual practices and problems of our society, but I should comment about the ongoing “sexual revolution.” Adults in our society, as a recent magazine observed, read about, see and talk about sex more in a year than their parents did in a lifetime.

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Censorship has been fighting a losing battle in all areas so that by now there is a little left to the imagination. Yet with the increasing openness about sex and the increasing information available about sexual functioning there seems to be an increase in the number and severity of sexual problems. Now one may argue that there is no established relationship between the two phenomena or that people today are simply more open about expressing their problems. I have no objective material to counter such arguments, but my clinical experience in a variety of settings—general health as well as psychiatric—shows a significant increase in sexual problems over the past decade. And for every patient who is referred to the mental health professional I would estimate five or more who are seen by the physician in general practice.

Why is it that sexuality for the male is such an emotionally-charged issue? Why is so much shame or anxiety attached to sexual dysfunction and not to other kinds of dysfunction? It is my hypothesis that the emotions are more intense for the male with sexual problems because of the close relationship between these problems and the sense of identity. It is admittedly difficult to separate the psychological from the sociocultural aspects of this issue. The sexual openness and permissiveness of our contemporary society seem to be major factors contributing to the increasing number of sexual problems. Our society says to the male: you are a man to the extent that he must prove his masculinity, to himself and to others, by his sexual functioning. The male picks up this message and begins to evaluate his performance. If he fails to function according to expectation or desire, his own or his partner’s, he experiences some apprehension and anxiety, which in turn begin to affect his performance. I am thinking specifically of impotence and premature ejaculation. Such problems are not related to certain age, marital status, or economic level, although the younger male seems to be more open in discussing the problem.

I follow Masters and Johnson (1970) in distinguishing primary from secondary impotence and also in classifying premature and incompetence ejaculation separately. According to these authors, primary impotence is that in which the male has never been able “...to achieve and/or maintain an erection quality sufficient to accomplish successful coital connection.” (1970, 137). Secondary impotence is considered to be erectile failure after at least one successful intromission. Since impotence is such a widespread problem in our society, I will use this dysfunction to explore the relationship between male sexuality and the sense of identity. Let me begin by stating that I consider impotence to be a symptom of the problem rather than the problem itself. This physiological symptom is directly related to the psychological symptom known as anxiety, and most often there is a cause-effect relationship between these two symptoms.

Anxiety is that non-specific fear or apprehension experienced when a person feels threatened. The anxiety may be attached to a physiological function but investigation will generally reveal multiple underlying factors which contribute to the anxiety. Consequently, the first task of anyone treating an anxiety-related symptom such as impotence is to determine the primary etiological factors. These may be physiological, psychological, social, sociocultural, or ethico-religious. Masters and Johnson (1970, 161ff.) have done a signal service in discussing the most common etiological factors contributing to impotence. Anyone who finds himself treating patients with the problem of impotence would do well to acquaint himself with the Masters and Johnson discussion. Understanding of the various possible factors is particularly important in determining goals as well as limitations of treatment. Can impotence be treated as such when there is a prior or simultaneous problem of alcoholism? How far is the therapist able and willing to delve into the underlying personality structure to get at the roots of the alcoholism-impotence symptomatology? Often the therapist will find in such cases a passive-dependent personality with feelings of worthlessness and inadequacy. Such a person may feel increasingly unable to face and cope with the demands of adult life. This person may turn to alcohol to blunt the nagging self-doubt and to alleviate the continual anxiety, and the alcohol in turn may bring about impotence. More directly, his fear of losing his independence may be related to impotence through fear of closeness and deeper fear of castration.

Although fear of closeness is not age-specific, it seems more prevalent among the males from puberty to the mid-twenties. This would be expected if one takes as the primary task of this period the process of clarifying one’s sense of identity. I have found it helpful to use Erik Erikson’s developmental model to control and direct his growth toward adulthood. As the preparyory period, extended economic dependence involves extended emotional dependence, resulting in a retardation of the psychological growth process. The core of this process involves occupational identity as well as sexual identity, both of which contribute to one’s sense of personal identity. To the extent that either is undeveloped or distorted the individual will not only feel unsure of himself but will feel threatened by any kind of personal closeness.

At this point I would like to present and discuss a case which illustrates in a striking way the relation between impotence and identity. The patient was a 20 year old single, white male college student referred by a school counselor because his "lack of confidence" and his tendency to become absorbed in peripheral details was interfering with his academic
The Moral and Psychological Effects of the Sexual Revolution

Thomas L. Doyle, M.D.

It is clear that the world and society today are in a state of revolution. While rapid wide-sweeping change is evident to all, the implications of the phenomena are more readily observed by physicians and particularly psychiatrists. People are made insecure and anxious; they are baffled, for the values by which they once lived and measured their lives no longer apply. Yet along with the anxiety a certain sense of new hope and freedom, openness and honesty can be perceived as well.

The causes of this upheaval and revolution in all phases of our culture and in particular in the sexual area are complex and indeed multiple. Among these are the rapid advances in the past decade in the sciences and technology, the effect of the mass media particularly television bringing every event and discovery into the living room, and especially the effects of the new openness and flexibility brought into religion led off by Vatican II.

The world stands in a new place. People everywhere know that they...