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Psychodynamic Psychotherapy

A case of compulsive masturbation in a patient with an obsessive-compulsive personality trait

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ABSTRACT

Purpose
The purpose of this article is to present the case of a patient suffering from a feature of obsessive-compulsive personality with accompanying compulsive masturbation, and to show the methods of therapeutic work with the patient in a psychodynamic approach.

Method
The main elements of the diagnostic interview and methods of work based on the psychodynamic approach are presented. The area of psychotherapeutic work focused on the problems of anxiety and guilt associated with sexual intimacy and compulsive masturbation and consumption of pornographic content.

Results
The patient succeeded in achieving some of the goals set with the psychotherapist. As a result of the therapeutic procedure to date, the man has gained better insight into the factors shaping his sexual functioning and sexual intercourse.

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Conclusions
The patient's early childhood psychological situation had significant influence on the development of his childhood sexuality, which was ultimately reflected in the construction of his personality and the sexual dysfunctions he faced in adulthood.

Keywords: sexual dysfunctions, masturbation, obsessive-compulsive personality trait, psychodynamic psychotherapy

Introduction

The term *masturbation* is derived from the Latin words *manus* 'hand' and *stupratio* 'soiling, contamination, spoliation' (Beisert, 2022). Masturbation has been treated as something undesirable throughout human history, but over the past recent years, its social stigma has diminished (Bancroft, 2009). Masturbation refers to all solitary forms of self-stimulation focusing on the genitals (Lehmiller, 2017). Masturbatory practices vary according to biological sex and personal preferences. Masturbation among women can include manipulation of the clitoris and labia, breast stimulation, or vaginal penetration with a sex toy. Among men, masturbation most often involves using one hand or both hands to stimulate the penis. Men also sometimes use sex toys. In individuals of different genders masturbation habits vary in terms of movement, speed, and force, as well as whether they are accompanied by pornography (such as erotic photos, videos or stories) (Lehmiller, 2018). Currently, there is an increase in masturbatory behavior among Poles and it is an important indicator of health (Izdebski, 2020).

Masturbation is a typical form of sexual expression in childhood and is a also a predictor of normal childhood development (Beisert, 2022). Masturbatory behaviors affect all phases of psychosexual development, however, their intense persistence in later stages of life may be an expression of a substitute form of satisfying sexual desire or reducing anxiety (Lew-Starowicz, 2001). Compulsive masturbation can also be described as pathological or anankastic autoeroticism, which represents habitual, compulsive sexual self-excitement, often without the occurrence of a sexual need (Smaś-Myszczyszyn, 2019). Any kind of tension will be relieved in such a case through compulsive masturbation.

According to psychoanalytic concepts, the unconscious mechanisms play the biggest role in the emergence of sexual dysfunctions. Psychoanalytic and psychodynamic therapies focus mainly on early childhood experiences and fears, inhibitions, and regressions (Cierpiałkowska et al., 2017). The causes of excessive masturbation can be traced to disorders of self-structure, early childhood deprivation, and childhood trauma and abuse (Smaś-Myszczyszyn, 2019). Sexual dysfunction can be a form of withdrawal from unconsciously experienced conflicts, and relational difficulties associate with patients' numerous defense mechanisms that cause sexual urges to be expressed in a compensatory form (Yakima & Malachowska, 2010). Psychodynamic psychotherapy of sexual dysfunction acts as a supportive treatment for people who cannot or do not want to use behavioral therapy, cognitive-behavioral therapy, couples therapy, or group therapy group therapy (Lew-Starowicz, 2022).

Problems of sexual dysfunction are sometimes revealed in the course of psychotherapy of personality disorders, and in such a case its purpose is: to develop an understanding of one's personality traits that influence the occurrence of sexual dysfunctions, shape motivation to undertake therapy for sexual disorders and integrate sexual dysfunction therapy with personality disorder therapy (Kokoszka, 2017). Because personality disorders affect the way a person perceives not only herself but also the world around her, it is clear that personality traits (and personality disorders as the most intense and visible forms of personality traits) affect the choice of sexual partners, sexual strategies and interpersonal relationships. People with certain personality disorders will have great difficulty ending a relationship, even if they are not are satisfied with it (e.g., dependent personality disorder), while others will tend to have short, very intense trysts (e.g., borderline personality disorder). Some patients will experience difficulties related to showing interest in a potential partner (e.g., schizoid or obsessive-compulsive personality disorder), while others will perceive relationships as more intense and intimate than they actually are (e.g., histrionic personality disorder) (Arbanas, 2021).

The purpose of this article is to show the history of the therapeutic relationship, in which factors of abnormal psychosexual development are evident. Their presence resulted in a disordered habit in the sexual sphere (compulsive masturbation) and an abnormally functioning personality (obsessive-compulsive personality trait). The patient's early childhood psychological situation had significant impact on the development of his childhood sexuality (Freud, 1999), which was eventually reflected in his adult life. In addition, psychodynamic understanding of symptoms, the importance of supervision in the therapeutic process, as well as the difficulties that the therapeutic process, and the difficulties that can be faced in the work of a psychotherapist in the face of a patient's strong obscenity. To ensure the patient's anonymity, the names cited in the text have been changed. The psychologist in charge of the patient was a psychotherapist at the same time. The article concludes with a discussion, as well as reflections on the functioning of people with personality disorders in sexual relationships.

Method

The study used diagnostic interview methods and working techniques of a psychodynamic psychotherapy (mainly transference-countertransference analysis). The area of psychotherapeutic work was focused on issues of anxiety and guilt, related to sexual intimacy and compulsive masturbation, and consumption of pornographic content.

Study Procedure

The patient was qualified for insight-based long-term psychotherapy in the psychodynamic current without specifying the time of its completion. The goal of

psychotherapy was assumed to be symptom's reduction through the more constructive expression of emotions, working on self-esteem, and improving social relationships. Sessions were held once a week at the Mental Health Clinic.

Interview

A 21-year-old man, with no previous psychotherapeutic or psychiatric treatment, came in for a psychological consultation. He was persuaded for a visit by his partner, and the patient complained of "his struggle or defense against addiction," which consisted of compulsive use of pornography and compulsive masturbation.

The patient was delivered at term, with no complications during pregnancy or delivery. He was the second child of his parents. The first months of the patient's life coincided in time with cancer and the death of his grandmother, who was under the constant care of care of his mother. The patient grew up in a complete family with his mother, father, and sister who was eight years older. Both parents worked: his mother was a laboratory technician, and his father was a police officer and also worked as a cab driver. The patient slept in the same bed with his parents until he turned seven, occupying the central position there. During his childhood, obsessive-compulsive behaviors were present, such as touching a particular object with the fingers of both hands, counting, and preferring even numbers, doing things with two sides of the body, or tidying up in his room at night which prevented him from falling asleep. He had never been under psychological care before.

The patient attended kindergarten and then completed six years of elementary school. In the second year of junior high school, he was transferred to a sports school because of his achievements in basketball. However, this change was associated with difficulty in adapting to the new environment. The patient felt rejected by the close-knit class and had to prove his worth by showing his strength and masculinity in the form of numerous school fights. After graduating from middle school, he went to high school and later to full-time college, he did not move out from the family home. During high school, he had several relationships with girls (without emotional involvement or genital sex). The man was in an intimate relationship at the time he began therapy with a woman. At the time of reporting, he was a second-year student of applied linguistics in English and Arabic. During therapy, he began a second course of studies. In addition to his studies, he worked on a casual basis: first in a movie theater, later as an English tutor and referee of basketball games. In addition, he undertook casual summer jobs, including working at his brother-in-law's company (his sister became independent and started a family). The patient also mentioned regular and occasional smoking of marijuana over several years, which gave him an opportunity to relieve stress he was experiencing.

The man reported that, in his opinion, he masturbated very often (at least once a day) and used pornographic materials (videos, pictures, books). He felt the needed to refrain from these behaviors, as he perceived that they were beginning to turn into routine behaviors aimed at numbing his emotions. Those behaviors had

been practiced by him since adolescence and i t was difficult for the patient to see the line when they became problematic. At the time he reported to the psychologist, he indicated that these behaviors were associated with feelings of shame, guilt, and disappointment. He saw that he was hurting both himself and his partner by doing so. He had a sense of loss of control in this area. As a result of the situation, the relationship between the partners, both sexually and emotionally, was also an area that was a source of dissatisfaction. The patient attributed the reasons for his behavior to frustration over the low frequency of sexual relations with his partner. In addition, he reported difficulties with his self-esteem, the sources of which he traced back to his childhood, particularly in the area of relationships with peers. Symptoms' intensification occurred in late adolescence and early adulthood, which was associated with making important life decisions and with sexual development, and entering into an intimate relationship with a woman. On the one hand, the patient saw himself as lost and in need of support, as well as anxious, insecure, and avoiding responsibility. He spoke of feeling tired, sad, and resigned. On the other hand, however, he felt a strong need to protect himself and others in dangerous situations. He was also able to see his resources: perseverance, language skills, or a clarified hierarchy of values that constituted his identity. He described himself as dependent on his parents, which made him unhappy. He valued fidelity, which, however, stood in opposition to his erotic fantasies with other women. The patient's mother was perceived as caring, warm, kind, and helpful, but at the same time overprotective and restrictive. The father, on the other hand, in the eyes of the man was always stronger than he was, which caused him to compare himself with him. The patient expressed a desire to be like his father. As a child he wanted to step into his grandfather's and father's shoes and to become a police officer. The images of his parents were ambivalent in complex.

The patient spoke little about his partner as if he was trying to protect her image within himself. He cared a lot about this relationship, loved her, and wanted to start a family with her in the future and live together, at the same time he was afraid of losing her. In addition, he dreamed of getting a good job in the future and building a house in a secluded place where he could find peace of mind.

Diagnosis according to ICD-10

According to the International Statistical Classification of Diseases and Health Problems ICD-10, a diagnosis of Other Habitual and Impulsive Disorders was made (impulses) – F63.8, which referred to constantly recurring maladaptive behavior. Compulsive masturbation fell into this category. The psychologist recommended that the patient should contact a sexologist before starting psychotherapy and consider taking strictly sexological therapy to integrate treatment of the disorder sexual with therapy for personality disorders. In addition, it was recommended that a psychiatrist ought to be consulted to consider the inclusion of pharmacological treatment due to the reported decline in mood and anxiety. The man, however, chose not to seek treatment along these lines – he was afraid despite considering these options.

Recognizing Personality Organization in O. Kernberg's Object Relations Theory

Kernberg's (1976) concept of personality is related to the concepts of psychoanalysts, at the same time, it goes beyond psychoanalytic theories. It is based primarily on the relationship with the object (Izdebska, 2015). The defense mechanisms used by the patient defense mechanisms were based on repression, and his identity was relatively consolidated. Rigidity and limitations in the patient's functioning mainly took the form of inhibitions on the realization of desires. Reality testing was intact and stable. The above observations suggested a neurotic level of personality organization. In addition, the patient believed other people were better than him, resulting in his lowered self-esteem and dissatisfaction with himself. He presented excessively strong impulse control. The above indicated a perfectionist superego (Izdebska, 2015), typical of the neurotic level of personality organization. The patient developed a very close relationship with his mother, while his father was perceived by him as a source of fear and apprehension: the patient admired his father on the one hand, but on the other was very afraid of him, which could be interpreted as a need to triumph over him, which at the same time was a source of the fear of retaliation. The specificity of experiencing his parents in this way reflected the Oedipal conflict present in his experiences. A typical sign of weakness in the patient's ego was a lack of tolerance for anxiety. The patient was afraid of his hostility, which resulted in the displacement of his sexual driver from his relationship with his partner to self-sustaining forms of sexual gratification. In addition, he experienced fear of excessive love associated with the person of his mother, manifested castration anxiety as a result of his relationship with his father, and feared the loss of objects important to him and the love of those objects. It seemed that the reports by the patient were egodystonic in nature and were a source of his suffering. It was difficult to see the secondary benefits of his symptoms.

Results

History of the Therapeutic Relationship

The psychotherapeutic relationship lasted 2 years and 3 months. Within it, three phases of work were distinguished due to the changes that were observed in the therapeutic relationship:

1) the phase of superficial exploration of the problem and resistance,
2) a phase of analysis and interpretation of symptoms,
3) the phase of strong development of transference, which occurred after the crucial moment in therapy.

A Phase of Superficial Exploration of the Problem and Resistance

Pornography and masturbation. Most of the initial sessions focused on the patient's monitoring of the frequency of use of pornographic materials

and related masturbation. The man tried to refrain from the aforementioned behaviors because he saw its devastating effect on his romantic relationship. He claimed that it was causing him to lower his sexual self-esteem, as well as lowering his partner's self-esteem. The father of the patient's partner also used pornography, which caused the patient to feel a double burden on the woman with experiences that were difficult for her. The patient brought up the subject of expressing his anger in the form of self-destructive behavior (hitting himself in the head), thus also showing the possible punitive mechanism of masturbation. He manifested resistance to dealing with his difficulties in various ways. For six months he contemplated the legitimacy of therapeutic work, occasionally missed sessions, and tried to limit the content he brought in. He decided to treat separately pornography use and masturbation, permitting himself to masturbate while refraining from watching pornography. Such a solution aroused ambivalent feelings in him. Moreover, during the exam session, he rationalized his behavior with the tension he felt. On more than one occasion, the man wondered if he had to give it up. He reported an apparent sense of control, which was verified in subsequent sessions. On more than one occasion, he admitted that for a week or even longer period, he managed not to watch pornographic material or masturbate, however, the day before psychotherapy, he often failed to keep his assumptions. In response, the psychotherapist focused on the reported problems, trying to seek solutions with the patient. The man had difficulty accepting the psychologist's interventions, hence the therapist did not engage in a deeper exploration of the problems. He even considered ending the therapy after a few months of its duration, as he was afraid of dealing with topics that were more difficult for him.

Partnered sex. Over the holiday period, the patient often went out with his partner Zosia (they were at a music festival, among other things), but he was constantly accompanied by fantasizing about other women. As the frequency of masturbation decreased, he reported an improved sex life. He was very keen to please his girlfriend sexually. He remembered a party he organized for her at the time, which he wanted to end with sex, but the experienced pressure and stress derailed his plans. The patient searched the Internet for prostitute services, reporting that in all likelihood his brother-in-law was using this type of service. He looked at his desire with a moral dilemma. The turning point of the work was the contribution of the patient's desire to bring the person of his partner into the therapeutic relationship: "I thought that maybe it would be better if Zosia was here with us, after all, this is partly our common problem." He thought this would prevent him from going further and deeper into therapy, as in the patient's perception, the reported symptoms were no longer a key difficulty in his life. By bringing in content regarding Zosia and the need to end the relationship, the man showed the mechanism in which, by bringing in a third party, he could relieve the tension. Identifying this situation made it possible to end addressing the topic of ending therapy and start a relatively stable work. The use of supervision at this stage of treatment enabled the psychologist to see

her difficulties within the exploration of thoughts, fantasies, and imaginings concerning the erotic sphere, which was related to the fear of her perversity. In addition, the psychotherapist's attitude towards the patient (stepping into the role of counselor and educator) showed a certain analogy to the relationship with the mother. The psychologist was encouraged to address the countertransference in the form of a discussion rather than playing it out in action and to discuss the relationship with the partner and parents. In addition, the psychotherapist assumed a controlling role, which prevented the topic of drive and sexuality from being brought into the session and also protected her from feeling obscene. The realization of the above and the permanent overcoming of resistance made it possible to begin the actual work.

The Phase of Analysis and Interpretation of Symptoms

Childhood problems. The patient reported that he often stayed in his life passively, which ultimately aroused his disagreement with such an attitude. He perceived himself as uncertain. He cited an incident from his childhood where he was beaten by another boy and could not reciprocate, so he was helpless. In addition, the man cited situations from his adolescence when he was afraid of taking responsibility, even during a team game. He associated his dissatisfaction with life with his mother's overprotectiveness and inability to experience satisfaction with his actions. He declared that his mother was the most important person in his life, but apart from the love he felt for her, there was a strong fear, that his mother is overstepping his boundaries. The patient's first memory of his experiences concerned his stay in kindergarten. The man remembered that together with other children, they examined each other's intimate places and was punished by the teacher. He was also caught in the act of a sexual play by his mother.

Problems of adulthood. The patient repeatedly reported a compulsive need to improve his computer games' design. Believing not to be masculine enough, he wanted to avoid premature ejaculation through masturbation in order to satisfy his partner more. He reported fears related to adult life, independence, and responsibility. He had to cancel his visit twice because of college exams. A break in therapy caused the patient was waiting for the meeting and felt that he needed it. But he was glad he didn't stay in contact with a psychotherapist, he managed to make the right decisions on his own.

Father theme. When the topic of the father came up, the man pointed to his similarity to him in the sphere of depressiveness. One day he found pornographic materials that belonged to his father, so he noticed in this respect as well resemblance to him, however, he wanted to be better than his father. The father was seen by the patient as a source of fear and danger. He had fantasies about killing his father that triggered fear. A conversation about his father was difficult for

him, he was even happy when the time of session ended what prevented him from exploring the subject further. However, he returned to the subject of his father on the next visit. He admitted that his father was a key person in his life. Evaluating himself as inferior and weaker was dictated to a large extent by the father stories of him being quiet strong, brutal, and aggressive. The father's goal was to motivate his son to similar activities, which occurred to be counterproductive. The patient saw himself as weak and passive in comparison. Perceiving himself in context father may have contributed to the development of low self-esteem. In childhood, the patient rarely received gifts, however, the memory of superhero toys made him very emotional. He thought the father could feel guilty for his weaknesses. He even wanted to tell him that, though fearing his grandfather's anger towards his father, he was anxious to talk after his grandfather's death. The very close relationship of the mother with the children, especially with the patient, meant that the father was separated from the mother. The patient said: "Mother treated us as a shield against the father." The oedipal conflict was interpreted on the level of fear of castration and the need to prove one's masculinity through compulsive masturbation.

Sexual fantasies. The patient did not remember being the observer of the intercourse of his parents, but he often fantasized about their sex, placing himself in the role of an observer. He noted that his close relationship with his mother may have affected his relationships with women. He often fantasized about other women, including prostitutes. In one session, he shared his fantasies about a woman who is shorter than him, talks to him openly about the sexual sphere, and is physically attractive and intelligent for him, which has been interpreted in the context of a therapeutic relationship. He used to fantasize about his partner's sex with other men. The current partner topic was poorly explored by the patient. She was the first woman with whom the patient had a close emotional relationship. At the beginning of their relationship patient's sexual behavior was aggressive and authoritative, and he behaved in a dominant manner. During his therapy, the patient's partner suffered from pain during intercourse. Even though the partners craved for intimacy, it seemed impossible and forbidden to act on their feelings. At times the patient could be a caring and protective partner, at other times the man tended to treat his girlfriend in a cold, offhanded manner. He admitted to being aroused by the feeling of being loved and desired and dominating. However, his and his partner's orgasm or the sight of his cum made him feel guilty.

Patient's concerns. In discussions with the psychologist, the patient returned to the topic of masturbation, seeing it as a result of anxiety and stress. He had a history of self-harm (hitting himself in the head), which was a mechanism for displacing the anger from his punitive and harsh father and other men to himself. The patient declared a strong need for independence and self-reliance, but he was very anxious about the graduation stage, had a problem finishing his thesis, and had a fear of becoming a professional. At one of the sessions, the man brought

a fantasy in which he saw himself as naked, stepping into a rushing river with its current guiding him. The image reflected what was going on between the patient and his parents. They were imposing on him to take a master's degree in the field, in which he had completed his first degree, which he did not want to do. He feared his parents' disappointment because previously he had always followed their will. As a result, he took up two majors: one he pursued himself, the other for his parents. The realization of his parent's expectations and the difficulty in opposing them showed the patient's limitations within ego autonomy. Only the sexual sphere was an area in which he felt seemingly free.

The patient's relationship with the psychotherapist. The patient brought in information with difficulty, sometimes setting up ready-made scenarios in his head, which he was later unable to utter. He said, he felt a burden after the sessions. Sometimes he seemed surprised, and even frightened by his reactions and statements, which were previously beyond his awareness. He admitted that he didn't bring all the content to the session because he would lose his sense of secrecy in such a situation, felt a sense of inhibitions, and was embarrassed. Absences were much less frequent than in the previous phase of therapy, the patient tried to justify them. It happened, that he forgot about the psychotherapist's planned vacation. The use of supervision at this stage enabled the psychologist to see that in her counter-transfer, she was still functioning like an overprotective mother, which was associated with the transfer of the complementary. Patient's sexual arousal was highly noticeable during sessions. The man described his sexual arousal as "strange emotions", which was ultimately ignored by the psychotherapist and replaced by interpretations of the patient's symptoms. The man in this phase of the work even brought his desire to make an appointment with the therapist "for a beer" which was ignored by her and did not become an area for exploration. As a result of the supervision, it was suggested that the patient should be allowed more space for his activity and relating to the therapeutic relationship, rather than just understanding of the symptoms, which the psychotherapist found difficult as a result of the perverse content.

The Phase of Strong Development of Transference

Sexualization of the psychotherapist's person. After the psychotherapist's leave of absence, the patient confronted with the psychologist's name change, he did not comment on it and seemed offended. He reported satisfaction with his mental functioning during the psychotherapist's vacation, after which he missed the next two sessions, and contacted her on the phone. He confessed that the limited availability made people more attractive to him. Illustrating these desires was a picture, which the patient brought to the session with difficulty, shame, inhibition, and shyness: "I imagine you and myself naked lying on your desk. You are lying on your back, and I cuddle into your chest. I feel so safe and warm." A few sessions later, the man offered to give his session to a colleague,

which would have the effect of bringing a new person into contact and again creating a triangular relationship to reduce tension. The patient was repeatedly concerned with creating triadic relationships, which on the one hand reduced anxiety and on the other centered around competition. Shortly afterward, he admitted to forgetting about the sessions, he did, however, arrive. He associated this with the image of his mother, which he experienced it strongly emotionally, but could not explain.

Fulfilling one's own needs. The patient became involved in university project involving the creation of computer games and organized a university event on the subject, which was a huge success. However, he did not accept congratulations in the end, having the conviction that fulfilling his own needs would lead to disaster. He designed computer games – created characters, with whom he identified himself (a wolf, a child, a young man). Their interpretation made it possible to see the patient's needs again: freedom, fearlessness, and aggressiveness. The man became interested in groups of preppers. He became increasingly bold in expressing anger toward his parents and he was anxious to move out from their house. He decided to drop out of college, which was his parents' choice. He feared being kicked out of the house but was surprised by his father's acceptance of the decision. His mother, on the other hand, felt offended, according to him. The patient had trouble remembering the new psychologist's name, found it difficult to talk about the therapeutic relationship, and compared her to his partner. He often spoke of his mother, whom he saw not only as a caring and loving person but also as a stiff, closed, and inaccessible person. Arriving at the session in poor physical condition (after an all-night party) caused a patient's regression and revealed his need to be cared for, which was consequently met with his feelings of shame. The patient looked at women with strong sexual desires. He recounted a dream in which he retaliated against his parents. The patient said: "I was with Zosia at my house, in the kitchen, we were doing it and my parents saw it. I was happy that they saw it." The patient proved his masculinity in this way and felt satisfaction at his parents' embarrassment. He admitted that he wanted to be questioned by the psychotherapist and did not reveal certain contents so that she would solicit him. As time passed, there was more frequent and satisfying sexual contact with his partner. However, this was accompanied by irritation at his partner and thoughts of separation. The man had a fantasy in which his father had intercourse with his partner. The patient reported an improvement in mood, reduced anxiety in his relationship with his father, and greater self-efficacy in his relationship with his mother. However, there were still difficulties in terms of defining one's own needs, feeling of lack of freedom, and failure to acknowledge the experienced emotions, which in his perception was a sign of weakness. The patient wanted to be free, independent, and self-reliant, but at the same time, he was very afraid of this.

Abandonment of therapy. After another month's leave of absence from the psychotherapist, the patient did not return contact, only in a telephone

conversation did he explain the absence. He got a job in Warsaw and decided to move there. As a result, psychotherapy was discontinued and there was an indication to continue with another psychotherapist in Warsaw. At this stage of work, the psychologist benefited twice from supervision to receive support and guidance for further work with the strong countertransference accompanying the process. The patient's further fate is not known to the psychologist.

Discussion

Obsessive-compulsive personality occurs in only 25% of patients with obsessive-compulsive disorder (Pozza et al., 2021) and affects 3 to 8% of the general population (Diedrich & Voderholzer, 2015). When working with people with personality disorders personality, it is important to assess the personality type or disorder of patients and partners, as these can affect their communication skills, attitudes toward therapy, adherence to the therapy plan, expectations of the therapist, and their sex life. In interpersonal relationships, people with personality obsessive-compulsive are aloof and may have trouble showing feelings, and their perfectionism, control, and rigidity in relationships may dominate over spontaneous displays of affection. Due to these reasons, it is not surprising that these individuals are less likely to engage in sexual activity (Cogan, Cochran, & Velarde, 2007). Sexuality is inhibited in them because they use many neurotic defense mechanisms (i.e., reactive formation, isolation of affect, intellectualization) (Gabbard, 1994). Men (more often than women) with obsessive-compulsive personalities say they suffer from marital dissatisfaction, possibly because they experience too many emotions coming from female partners, which overwhelms them (Porcerelli, Cogan, & Hibbard, 2004).

When people with personality disorders have sexual dysfunctions, they are treated sexologically in the same way as people without personality disorders (you will not find specific techniques for individual personality disorders in the literature). It is important to remember that people with personality disorders will perceive the therapist, the procedures offered, and the entire therapeutic process through the lens of their personality disorder. For this reason, sex therapy for people with personality disorders can present many difficulties. To obtain the best results in the case described above, it would be advisable for the patient remaining in the process to benefit not only from the services of a psychotherapist but also from a sexologist and a psychiatrist. Unfortunately, despite the psychotherapist's suggestion, the patient did not seek consultation with the indicated specialists.

The psychotherapeutic process was dominated by complementary transference, in which the man directed desires related to his mother toward the psychotherapist (Caligor et al., 2017). The triumph over his father (and even exclusion of him on some issues) generated fear of retaliation. This unresolved. Oedipal conflict, the constant struggle with sexuality and aggressiveness, and the inability to realize urges when confronted with sexual intimacy generated massive

anxiety and guilt in the patient, as well as an inability to associate sexuality with tenderness and love. The abnormal course of the practice phase within separation-individuation (Mahler, 1972) prevented him from the constructive resolution of the oedipal crisis and resulted in the development of the following traits: indecisiveness, hesitation, shyness, and timidity. Oedipal desires were intensely revived again in the early adulthood phase when the patient entered into an intimate relationship with a woman (Freud, 1999). The man was concerned with creating triadic relationships centered around competing with someone to get someone desired by both parties. His mother's depressiveness in the face of her illness and the death of his grandmother may have resulted in a form of disregard for him on the one hand, while on the other hand causing an inability to withstand even a minimal frustration and over-reactivity to any patient activity (Chrzan-Detkoś, 2017). The early mother-child relationship requires, among other things, an appropriate dose of stimulation (Stern, 2015), mentalization (Fonagy, 1997), as well as the ability to read the child's signals and needs (Beebe et al., 1997). In the development of the patient, an important aspect of the resolution of the Oedipus complex (Freud, 1999), which is the desexualization of the relationship with the object. He was characterized by a very punitive and demanding superego. The defense mechanisms he used were based on repression (displacement, isolation of affect, rationalization, neurotic projection, posited reaction, and intellectualization), his identity was relatively well consolidated, intact and stable testing of reality, however, the rigidity of reactions, obsessiveness within intrapsychic conflicts and compulsivity in the area of sexual behavior were noticeable.

The diagnosis made earlier was questioned, as certain issues remained unclear, especially after the patient's dropout. The man's stories revealed an overprotective and aggressive theme of early childhood experiences, which were undoubtedly important for the consolidation of his identity (which was, after all, still developing), world image, modulation of affect, impulsivity, or integration of conflicting desires (Kernberg et al., 2018). The goal of the process was to strengthen the ego and achieve a mature identity. Although one can see some consistency in the patient's actions, discontinuing psychotherapy may foster the idea that his personality was borderline in nature. Such a diagnosis may be fostered by interpreting the patient's behavior as the result of paranoid transference paranoid. In addition, the very strong and resistant to change countertransference of the therapists and the patient's anxieties, which could be interpreted as preoedipal, could support the hypothesis of a borderline organization of his personality. In the patient's picture patient, however, was dominated by inhibitions, erotic transference (not eroticized, typical of BDP), ever-present conflicts that were much more pronounced than his deficits, and the techniques ultimately applied, involving the interpretation of transference and countertransference resulted in a moderate improvement in symptoms.

Diagnostic difficulties within the organization of personality, both among psychotherapists and researchers (Cierpiałkowska & Marszał, 2013), testify to the immense complexity of the individual's functioning, especially when patients are in the process of healing or decompensating.

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