

Intercourse type of situational anejaculation or inability to ejaculate intra-vaginally: three case reports from a conservative islamic community

Oguzhan Bekir Egilmez & Mehmet Hamdi Orum

To cite this article: Oguzhan Bekir Egilmez & Mehmet Hamdi Orum (2018) Intercourse type of situational anejaculation or inability to ejaculate intra-vaginally: three case reports from a conservative islamic community, Psychiatry and Clinical Psychopharmacology, 28:4, 473-476, DOI: [10.1080/24750573.2018.1468618](https://doi.org/10.1080/24750573.2018.1468618)

To link to this article: <https://doi.org/10.1080/24750573.2018.1468618>



© 2018 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 05 May 2018.



Submit your article to this journal [↗](#)



Article views: 3406



View related articles [↗](#)



View Crossmark data [↗](#)





Citing articles: 2 View citing articles [↗](#)

CASE REPORT



Intercourse type of situational anejaculation or inability to ejaculate intra-vaginally: three case reports from a conservative islamic community

Oguzhan Bekir Egilmez  and Mehmet Hamdi Orum 

Department of Psychiatry, Adiyaman University Faculty of Medicine, Adiyaman, Turkey

ABSTRACT

Anejaculation is defined as the inability to ejaculate semen despite sexual stimulation by intercourse or masturbation. It may result from organic or psychological causes and can be classified as orgasmic, anorgasmic, and situational. Situational anejaculation may be present in intercourse type. This means existence of ejaculation by masturbation, but not during sexual intercourse. Performance anxiety, hostility toward the partner, dysfunctional psychosexual development, and unconscious desire to avoid pregnancy are the possible underlying conditions. We herein report situational anejaculation in 24-, 26-, 34-year-old males who presented with inability to ejaculate intra-vaginally since they got married. All of them were the sole males in their family, had a childhood in a conservative community, and had arranged marriages. Due to the negative aspects of psychosexual counselling in rural societies, it was not possible to continue the follow-up and treatment of patients. Despite this, the authors conclude that this clinical course of situational intercourse anejaculation suggests a psychological problem in these patients.

ARTICLE HISTORY

Received 18 February 2018
Accepted 20 April 2018

KEYWORDS

Anejaculation; male subfertility; orgasmic disorder; psychosexual dysfunction; sexual intercourse

Introduction

Ejaculation is the discharge of sperm (ejaculate, semen) with the orgasm that is experienced in men after sexual intercourse. Ejaculatory dysfunction is one of the most common male sexual disorders. Ejaculatory dysfunction can be sourced from retroperitoneal lymph node dissection, multiple sclerosis, myopathic, neuropathic, metabolic, congenital, anatomic, infective causes, drugs or a psychogenic cause [1,2]. The spectrum of ejaculatory dysfunction includes premature ejaculation, retrograde ejaculation, delayed ejaculation, and anejaculation [3]. Problems with anejaculation can be classified as: orgasmic (organic) anejaculation, anorgasmic (psychogenic/idiopathic) anejaculation, and situational anejaculation. There are different types of situational anejaculation: clinic anejaculation (can collect semen at home, but has anejaculation in clinic), periovulatory anejaculation (unable to ejaculate at ovulation, but can ejaculate on other days), unexpected anejaculation (first time failure of ejaculation on day of ovulation), masturbatory anejaculation (ejaculates during intercourse, but not by masturbation), and intercourse anejaculation (ejaculates by masturbation, but not during intercourse) [4]. The factors possibly contributing to this entity are performance anxiety, negative affect (fear and hostility in attitude) toward the partner, dysfunctional psychosexual development, lack of awareness of one's body, psychological inhibition due to guilt, inadequate sexual arousal, previous

sexual trauma, and unconscious desire to avoid pregnancy. There is no sufficient evidence for these theories [5,6].

Intercourse anejaculation or in other words inability to ejaculate into the vagina is a rare situational anejaculation type. The majority of cases of this type anejaculation in the literature were reported from the communities which have strict upbringing [7,8]. According to our best knowledge, this is the first case study in Turkey about intercourse type of situational anejaculation. In this report, we aimed to describe the situational intercourse anejaculation of three adult patients, the only male child of their parents, who had grown up in rural areas and had strict rules of growth. This study contains cases that were seen in the last seven years (2011, 2016, and 2017).

Case presentations

Case A

Twenty-six-year-old male patient who lives in a small, rural community of shepherds and agriculturalists in Adiyaman (Region of Eastern Anatolia, Turkey) was admitted to Adiyaman University Training and Research Hospital alone because of inability to ejaculate intra-vaginally since he got married (two years). There was no experience of sexual intercourse before marriage and he preferred heterosexuality. He was masturbating twice a week and had wet dreams. Any

CONTACT Mehmet Hamdi Orum  mhorum@hotmail.com

© 2018 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

anatomical or psychiatric problems were not reported related to his partner (wife). He reported no orgasm during coitus, despite normal erections or libido. He has sexual intercourse one time a week. Although the sexual intercourse lasted 20–30 minutes, he could not ejaculate during coitus. His partner said that he did not want to continue sexual intercourse due to vaginal dryness, and the patient took his penis out of her vagina and had orgasm with masturbation within 2–3 minutes. He had a avoidant personality. The patient had an arranged marriage. He was the only son of his family and strictly cultivated. There was no history of use of alcohol, cigarette, and cannabis before presentation. Family history did not indicate any findings of ejaculatory dysfunction. Her mother had a dominant personality and was pressuring her son to had a child. Physical examination revealed no pathology which could point to any reason for organic anejaculation. Neurological examination findings were normal. She was referred to the urology department, and no organic pathology was detected (Total testosterone, free testosterone, luteinizing hormone, prolactin, and oestradiol revealed normal levels. Genital and rectal examination and transrectal ultrasound showed normal testicles, prostate, penis, and seminal vesicles.). Sexual therapy was suggested the patient and wanted to come to the sessions with his partner. The patient missed the follow-up visits after that. The physician had felt subjectively that the patient was not willing to be treated.

Case B

Twenty-four-year-old male patient working as a farmer (vegetable and fruit) and lives in a rural community in Adiyaman (Region of Eastern Anatolia, Turkey) was admitted to our psychiatry outpatient clinic with a complaint of inability to conceive and ejaculate inside the vagina. This problem was primary and he had heterosexual preference. He was married for one year and had no kids. He had no premarital sexual encounters. He was masturbating three times a week and had wet dreams. There was no desire, arousal, orgasm, and sexual pain problems with his partner (wife), she was healthy anatomically and psychiatrically. Erection and nocturnal emissions were normal but no ejaculation during sexual intercourse (within 10–15 minutes). He has sexual intercourse twice a week. He had orgasms with masturbations (within 3–4 minutes). There was no obvious personality trait. The patient had strict upbringing, an arranged marriage and he was the sole son of family, had two sisters, both of whom were younger than the patient. His evaluation consisted of a detailed psychiatric, medical, substance abuse, and psychosocial history as well as relevant laboratory studies (especially including sex hormones). Family history did not indicate any findings of

ejaculatory dysfunction. Physical examination of systems was unremarkable. She was referred to the urologist, and no organic pathology was detected. Psychosexual counselling was suggested but the patient rejected our offer on the pretext that his partner would not come. Although it was stated that it would be more beneficial to come to the therapy with his partner, it was emphasized that the patient could continue the treatment alone in order to avoid the follow-up. The patient was never seen again. The physician thought that the patient was avoiding therapy.

Case C

A 34-year-old married male, assistant professor in a university in Turkey, with heterosexual orientation from a conservative community. It was second psychiatric admission with the complaint of failure of ejaculation into the vagina. There was no change after the first application. The patient was married for four years, had no children, had normal erection and libido, had ejaculation by masturbation (within 3–4 minutes), but had no orgasm during sexual intercourse (within 25–30 minutes). He had no experience of coition. There was no sexual dysfunction with his partner (wife), she had no problems anatomically and psychiatrically. He has sexual intercourse twice a week. He had anxious traits, had been brought up in a family that followed conservative Islamic traditions, had an arranged marriage and he was the sole brother of his three sisters. There was no history of substance use, psychiatric illnesses, penile trauma, or past family history related to ejaculatory dysfunction. His symptom was primary. Vital signs, laboratory findings (related to hormones, particularly) and results of physical examinations were within normal limits. After consulting a urology specialist, it is learned that there was no organic pathology. The first treatment option was sex therapy with his partner. In follow-ups, he did not come with his partner despite all my insistence and dropped out the therapy. The problem was ongoing, and indeed the patient was not persistent and willing to treat.

Written informed consent was taken from the patients in order to publish their data.

Discussion

Anejaculation is the inability of the ejaculation, despite the stimulation of the penis by sexual intercourse or masturbation. The term “anejaculation” (true impotentia ejaculationis) is used by Steeno et al. to describe all cases of nonejaculatory intercourse [9]. Anejaculation may be primary or secondary, total, selective, or occasional. Patients having primary selective anejaculation can masturbate but cannot ejaculate intra-vaginally and this situation is called by some authors as intercourse anejaculation. This disorder stems from

unconscious conflicts or abnormal beliefs about intravaginal ejaculation [5,6].

We presented three cases of situational intercourse anejaculation in this study. Penetrating sexual intercourse lasted 15–30 minutes, but no ejaculation occurred. Outside the vagina, there was orgasm with masturbation in a few minutes by hand. Some characteristics of these patients were similar. The most obvious thing in common was the fact that they were the only male sons of their families. They grew up in rural areas and their families were conservative. The ancestors were predominant and there was also significant family and societal pressure on the couple to have a child. All three patients had an arranged marriage. They have been married for at least one year. There was no experience of sexual intercourse premarital. The patients' partners were able to achieve multiple orgasms during sexual contact. They did not seem interested in psychiatric treatment. They answered negatively to our proposal to come with their partners. These characteristics were consistent with other cases in the literature. The cases related to anejaculation reported from Israel are frequent. It is stated that Jewish orthodox population is at risk because of strict religious regulations [7,10]. More rarely, there are cases reported from other communities and religious groups. Gopalakrishnan et al. [11], from a psychiatry clinic, reported a case who had been brought up in a family that followed orthodox Hindu traditions. There was a pressure on the couple to have a child. They suggested that resolving relationship issues, reducing anxiety by cognitive behavioural therapy, and altering masturbatory techniques, and increasing the level of information about the sex can help the patient overcome his ejaculatory dysfunction. In another study [8] in a Muslim society (Egypt), two situational psychogenic anejaculation cases were transferred. These patients were from urban population and one of them was the sole boy in the family. These cases were reported from a department of urology. The patients applied to a physician to have a child. One of the cases succeeded to get sperm from masturbation-induced ejaculate and the other one got sperm after doing conventional testicular sperm extraction. The use of the retrieved sperms succeeded to attain pregnancy in both cases. However, the anejaculation did not revert in either patient. They also stated that men from Islamic communities with strict religious upbringing have the possibility to have psychogenic anejaculation. According to the author, men with this type of anejaculation were resistant to improvement even after their concern to conceive dissipates.

One of the aims of the present case study was to report the existence of situational intercourse anejaculation in Turkey. As far as we know, the current study is the largest series of cases that clearly documents the existence of situational intercourse anejaculation in

Turkey, Islamic communities, and even in the world in terms of the number of patients it contains. In the vast majority of cases reported, the main application cause was childlessness and therefore, a big number of the cases were reported by the urology departments. Psychosexual counselling was not welcomed and even rejected by patients with situational anejaculation. The main concern of these patients or couples was to conceive as soon as possible, but the counselling may take a long time. Also, in rural societies, psychological consultation means they were mentally unsound. This is another reason why treatment is delayed. Another important aim of this study was to convey the similar features of the patients. All of them had a childhood in a conservative community, were the sole son of their families, and had arranged marriages. They were not interested in psychosexual counselling and had family pressure to have a child. Our subjective thoughts on these cases are related to interpersonal, parent, and couple relationships, that is, psychological. Three cases were the sole male and there was a great pressure of having a child on them. In rural societies, ensuring the descent is an important demand and at the same time is a matter of honour. According to those living in the countryside, the lineage continues over the boy. This thought may cause a performance concern on men. Sometimes, when a person does not want to have a child or does not want to give a grandson to the family, this can lead to unconscious sexual problems. Another possible psychological problem with our cases is that the patients are married to people they do not want. This may have contributed to the sexual problems of the people. Although the relationship of our patients with their mothers cannot be elaborated, it is thought that the mother-son relationships may be related to the sexual problems. It is thought that the relationship between the mother and the married person may be related to performance problems.

Since the patients in our study do not continue their follow-up regularly, there is no detailed data on the treatment. If we look at the literature, a detailed anamnesis and sexual history should be taken from patients who have complaint of anejaculation. They should be asked to come in pairs. The quality of the three phases of the sexual response cycle, including desire, arousal, and ejaculation, should be assessed. The subjects other than the psychological conditions that may lead to problems related to this topic should be examined in detail by being directed to the departments such as urology and gynaecology. Whether the ejaculatory disorder has occurred in all conditions, or whether it is in certain situations, should be investigated whether it has just started or not [3]. Various therapeutic regimens have been advocated for the management of anejaculation. While Masters and Johnson [10] advise sex therapy aiming at the production of

ejaculation by the partner, Geboes et al. [5] use sexual education, hormones, psychotherapy, and the electrovibrator. Some studies indicate that situational anejaculation is treated with counselling services, while others say it is useless [8].

Conclusion

Previous reports have indicated limitedly the instructions about heterosexual vaginal intercourse anejaculation. But we believe this is the first report of the patients with intercourse type of situational anejaculation in Turkey, and the first three-case study in the world. Again, this study has a notification function, follow-up feature is insufficient due to the negative opinions of the patients on the psychosexual counselling and the low demand for treatment. Further psychiatric research should be conducted with respect to situational intercourse anejaculation to provide a greater understanding of prevalence, aetiology, course, and treatment.

Disclosure statement

No potential conflict of interest was reported by the authors.

ORCID

Oguzhan Bekir Egilmez  <http://orcid.org/0000-0002-6303-1758>

Mehmet Hamdi Orum  <http://orcid.org/0000-0002-4154-0738>

References

- [1] Giuliano F, Clement P. Neuroanatomy and physiology of ejaculation. *Annu Rev Sex Res.* 2005;16:190–216.
- [2] Kaplan SA. Re: metabolic syndrome does not increase the risk of ejaculatory dysfunction in patients with lower urinary tract symptoms and benign prostatic enlargement: an Italian single-center cohort study. *J Urol.* 2018;199(2):320–321.
- [3] Rowland D, McMahon CG, Abdo C, et al. Disorders of orgasm and ejaculation in men. *J Sex Med.* 2010;7:1668–1686. doi:10.1111/j.1743-6109.2010.01782.x
- [4] Meacham R. Management of psychogenic anejaculation. *J Androl.* 2003;24(2):170–171.
- [5] Geboes K, Steeno O, De Moor P. Primary anejaculation: diagnosis and therapy. *Fertil Steril.* 1975;26:1018–1020. doi:10.1016/S0015-0282(16)41418-4
- [6] Shull GR, Sprenkle DH. Retarded ejaculation reconceptualization and implications for treatment. *J Sex Marital Ther.* 1980;6:234–246.
- [7] Hovav Y, Shotland Y, Yaffe H, et al. Electroejaculation and assisted fertility in men with psychogenic anejaculation. *Fertil Steril.* 1996;66:620–623.
- [8] Salama N. Achieving pregnancy in situational psychogenic anejaculation in an Islamic community – two case reports and literature review. *Am J Med Biol Res.* 2015;3(6):149–151.
- [9] Steeno O, Geboes K, DeMoor P. Male impotence: diagnosis and therapy. In: Hafez ESE, editor. *Techniques of human andrology.* Amsterdam: Elsevier-North Holland; 1977. p. 431.
- [10] Masters WH, Johnson VE. *Human sexual inadequacy.* London: Churchill; 1970.
- [11] Gopalakrishnan R, Thangadurai P, Kuruvilla A, et al. Situational psychogenic anejaculation: a case study. *Indian J Psychol Med.* 2014;36(3):329–331. doi:10.4103/0253-7176.135393