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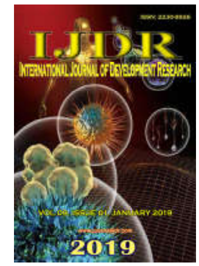

ORIGINAL RESEARCH ARTICLE

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MEMORY AND SEXUAL DYSFUNCTION AS AN EFFECT OR A SYMPTOM OF A TRAUMA OF SEXUAL VIOLENCE

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ABSTRACT

This paper presents results from research undertaken as a study of a clinical case which is both descriptive and investigative. From the outset, we are based on the assumption that, in their everyday practice, gynecologists should be knowledgeable about physiology and sexual pathologies in order to identify somatic disorders which may affect women's sexual response. We argue that a sexual anamnesis must be an essential component in a gynecologist's practice, and psychoanalytic listening is also a crucial step which allows for a better understanding of these problems. In the article, we try to establish to what extent patients with sexual issues who were victims of sexual abuse have had their sexual functions affected. Our hypothesis is that women's sexual complaints are associated to memory, in which sexual dysfunction derives from psychic confusion and conjunction. In order to give answers to the questions presented in our research, we will be based on concepts from psychoanalysis as well as from discourse analysis.

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INTRODUCTION

In this paper, we have tried to answer, among other things, to what extent patients with sexual complaints who were victims of sexual abuse have had their sexual functions affected. A comprehensive definition of health proposed by the World Health Organization (WHO), is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946)[1]. In this sense, sexual health, being part of the global health and well-being of men and women, incorporates somatic, emotional, intellectual and social elements. In our article, Pinheiro and Fonseca-Silva (2017), we recommend some studies that explore this subject. In one of them, Masters and Johnson (1970), pioneer researchers in this field, described men and women's physiological reactions through a four-stage model of the sexual response, which are: 1) excitement phase: a psychological and/or physiological stimulation for the intercourse; 2) the plateau phase: in which the individual is continuously excited; 3) orgasm, a phase where excitation reaches its peak, is followed by a sensation of pleasure, and later by relaxation and a decreasing sexual response; 4) resolution: a subjective state of well-being which follows orgasm. Kaplan (1977), in her turn, added a fourth phase to this cycle, the desire phase, which corresponds to the person's wish to have a sexual intercourse, which is triggered either from a sensorial stimulus or from memories of erotic experiences and fantasies. Kaplan's scheme was divided into these phases: 1) desire; 2) excitement; 3) orgasm; 4) resolution. This scheme provided the guidelines for the standard classification of the Diagnostic and Statistic Manual of Mental Disorders as well as for the American Psychiatric Association, from 1980 onwards. Basson (2002), in her turn, described the Circular Model of Women's Sexual Response, arguing that when the woman is stimulated by her partner, she reaches different levels of excitation, which may derive from intimacy, from the affectional bond that is established a by-product, or out of motivations unrelated to sexuality, and in which excitation precedes desire. According to this model, desire emerges as a consequence of the sexual intercourse, instead of being its cause. According to these researchers, the setbacks that may emerge during one of these phases of sexual

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[1] See webpage in Portuguese: http://www.direitoshumanos.usp.br/index.php/OMS-Organização-Mundial-da-Saúde/constituicao-da-organizacao-mundial-da-saude-omswho.html

response are called sexual dysfunctions. Kaplan (1977) defines such dysfunctions as psychosomatic disorders that prevent the individual either from having an intercourse or from reaching peaks of pleasure during the intercourse. Marthol and Hilz (2004) argue that the etiology of sexual dysfunctions is associated to psychosocial and physiologic factors, and may be related to: a) organic causes; b) psychological causes: individual, interpersonal and psychosexual factors. Additionally, according to Halvorsen and Metz (1992), Verit, Yeni and Kafali (2006) and Hatzimouratidis and Hatzichristou (2007), sexual dysfunctions fit into four categories, which are: a) dysfunctions of desire; b) dysfunctions related to man's excitation – erectile dysfunction; c) the orgasm phase; d) pain-related sexual dysfunctions.

Studies undertaken by Smith (2007) and Martinez (2008) indicate that, since the late 1990s women have been increasingly seeking medical solutions for problems that affect their well-being, particularly for issues related to their sexual health. Such studies indicate, however, that over 90% of the doctors, do not make further inquiries into their patients' sexual complaints, in spite of the fact the sexual dysfunctions are nowadays regarded as a health issue which affects women' quality of life in a meaningful way. Studies conducted by Basson et al (2000) also indicate that, even though women's sexual dysfunction has a high prevalence among other sexuality disorders, affecting from 20% to 40% of women, their complaints have barely been addressed. Doctors and researchers have been failing to address women's complaints either because of the lack of studies that might inquire into psychological and physiological aspects of sexual dysfunctions or due to the limited availability of therapeutic methods. Regarding this issue, in Pinheiro and Fonseca-Silva (2017), we point out that studies conducted by Abdo (2004) indicate that, among 3,148 women interviewed in 18 Brazilian cities, 32,4% have sexual complaints which they choose not to report to their gynecologists. On the one hand, this is caused by the patient's embarrassment in touching on this subject; on the other hand, this is due to the gynecologist's tactless approach in tackling the subject of sexuality, as it is noted by Costa and Rodrigues Jr. (1997). In these authors' view, medical education overvalues the technical aspects of each speciality, to the detriment of personal and psychological implications for their patients. We regard the gynecologist's clinic as an essential place for establishing a dialogue with women, a place where sexual dysfunctions, which are highly prevalent among other sexuality disorders, may be viewed as a woman's health problem. The psychoanalytic listening is essential for us to understand their problem. This led us to try and find out to what extent women who have been victims and traumatized by sexual violence are being affected in their sexual functions. Within this context, we argue that women's sexual complaints are associated to memory, in which sexual dysfunction ultimately derives from psychic confusion and conjunction which connects the individual to traumas, symptoms, and feelings of anguish and helplessness.

MATERIALS AND METHODS

The survey results here presented are the outcome of a clinical case study which is both descriptive and investigative. For data collection, the technique of a semi-structured interview was employed. As an ethical procedure, this study was undertaken with the participants' agreement, in compliance with Resolution 196/96 from Brazilian National Health Council (CNS), which states: "One of the several methods employed in Bioethics is the Principialist Model. Such model provides the groundwork for several international protocols and, in Brazil, for Resolution 196/96 from the Brazilian National Health Council (CNS), which establishes the rules for research conducted on human beings in this country (Manso, 2004)". In order to give answers to the questions presented in our research, we will be based on concepts from psychoanalysis as well as from discourse analysis.

RESULTS AND DISCUSSION

Marthol and Hilz (2004) argue that the etiology of sexual dysfunctions is associated to psychosocial and physiologic factors, and may be related to a) organic causes; b) psychological causes: individual, interpersonal and psychosexual factors. Regarding the psychological causes, our attention is focused on the trauma. According to Laplanche and Pontalis (1991, p. 523), and based on Freud's studies, trauma may be understood in the terms of a 'psychic economy' and may be defined as 'an event in the subject's life, defined by its intensity, by the subject's incapacity to respond adequately to it and by the upheaval and long-lasting effects that it brings about in the psychical organization'. According to Uchitel (2011), Tutté (2006) and Boheleber (2007), psychic trauma is the response to an unexpected event which caused feelings of fear, panic, anguish, shame or psychic pain to the subject affected. This experience relates to what Freud called helplessness, a general condition in the psychic functioning of a person which consists of a feeling of inability to defend oneself or acting without help in their psychic life, and which may emerge during a traumatic event or in a situation of accumulated excitation, whose origin may be external or internal. Therefore, trauma is associated to the subject's condition of impotence and helplessness. According to Freud (1926), affective states, such as anguish, are seen as sediment of very old traumatic experiences. When relived in similar situations, such experiences are recalled as mnesic symbols of the original traumatic experience. In Freud's view, anguish always emerges when there is a real and threatening danger or, at least, when this is experienced as real by the subject. Additionally, he states that anguish also works as a signal, whether danger is caused by an external event (realistic anguish) or by pulsional motions (neurotic anguish), as it is shown in the cases of the people described below by their names' initials, M.L.A. and M.J.J.N.: M.L.A. a 68-year-old housewife, has finished high-school, catholic, stable economic conditions, married to F., a 71-year-old accountant. She had 4 children in natural childbirth. She is in menopause, already had her uterus removed and is nowadays using hormones to improve vaginal lubrication. My husband wanted me to talk to the gynecologist, because he thinks I am a sort of 'fridge' when it comes to sex.

'When I was 17, my husband locked me up in a room and raped me. Since I was poor, had no father and no loving affection and I got pregnant, I had to get married to this man, in a hurry. Then, I became a cow: I had children, over and over and over again. I never received any affection, never got a French kiss […] I miss that… I never feel desire… I haven't been excited… for over 20 years… sexual relation is always a rape to me…' (our emphasis, in bold).

M.J.J.N. – a 51 year-old Nurse Technician, married, has been in menopause for 5 years, got pregnant twice, in use of

hormones nowadays. She's been feeling piqued and in absolute sexual dissatisfaction with her husband. But she says she no longer cares about "that", given that things have been this way since she started a relationship with her first husband.

'I was a virgin when I got married, at the age of 28. Doc, my honeymoon was a rape, a gall moon, a real aggression. My whole body was swollen, I cried all the time. Three months after the marriage, I got pregnant. In my seventh month of pregnancy I found out letters that revealed my husband's cheating on me. He had several lovers, he'd come back home he had the smell of other women's sex and signs of lip biting in his mouth. Six months after my marriage, we split up. Four years later, I got married again to a man who was 10 years older than me… I've been married for 10 years now. He's an evangelical, just like me… in our very wedding night, I realized I'd made a blunder, for he was rude, he'd bite my nipples in the middle of the night, there was no affection at all… I get upset, and want to put an end to all that quickly. I know that hormones won't be able to fix it… I get resigned… I hate him… I'm used to it, let it be…' (our emphasis, in bold)

The significant materialities of these two complaints about a sexual dysfunction evoke reminiscences of the times when M.L.A. and M.J.J.N. were victims of rape and relived their trauma. Within these memories, the original feelings of helplessness and repulse are recreated. Freud (1926) argues that an original traumatic experience becomes the ground for the emergence of anguish throughout the rest of the human being's life.

In the significant materialities of M.L.A and M.J.J.N.'s complaints, we can identify the displacement of anguish: from its origin in the person's situation of helplessness onto the situation of danger and "next, there are subsequent displacements, from the situation of danger onto the determinant of the danger-loss of the object and the changes caused by such a loss" (Freud, 1926, p. 192).

Therefore, only from each subject's narrative can a trauma be identified. Through such a narrative, something from the subject's original experience, in its radical exteriority, may be subjectified and become a symptom.

CONCLUSION

The cases analyzed above make it clear to us that sexual dysfunction is the way through which the unconscious brings the trauma back. Sexual dysfunction has the effects of a symptom, something that updates trauma, in an attempt to dissolve it. Therefore, the effects of a symptom are the solution found by each subject to deal with the traumatic encounter with sex, or, in Freud's words (1926), the traumatic encounter with his/her desire.

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