CASE REPORT

Prostitution use has non sexual functions - case report of a depressed psychiatric out-patient [version 1; referees: 1 approved, 1 approved with reservations]

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Abstract

Case: A shy, depressed 30 year old male discussed his frequent ego-syntonic indoor prostitution consumption in small peer groups. Several distinctive non-sexual functions of this paid sex habit were identified.

Design and method: The patient had 40 hourly psychiatric sessions in the private practice setting over 14 months. The Arizona Sexual Experience Scale was applied to compare the subjective appraisal of both paid sex and sex in a relationship.

Results: The paid sex consumption functioned as a proud male life style choice to reinforce the patients fragile identity. The effect on self esteem was a release similar to his favorite past-time of kick-boxing. With paid sex asserted as a group ritual, it was practiced even with frequent erectile dysfunction and when sex with a stable romantic partner was more enjoyable and satisfying.

The therapeutic attitude of the female psychiatrist, with her own ethical values, is put in to context with two opposing theories about prostitution: the 'Sex-Work-model' and the 'Oppression-model'. The therapist's reaction to the patients' information was seen as a starting point to understanding the intrapsychic function of paid sex as a coping mechanism against depressive feelings.

Conclusions: Exploring and understanding prostitution consumption patterns in young men can benefit the treatment of psychiatric disorders in the private practice setting. It is the psychiatrists task to investigate the patients hidden motives behind paid sex use to help patients achieve a greater inner and relational freedom.
Introduction
Paid sex behavior, either giving or receiving money, is a delicate matter for psychiatric patients. Patients rarely talk about this taboo subject spontaneously, and habitually psychiatrists tend not to ask about it. In contrast, prostitution use is frequent; 18% of American men paid for sex in their past, and 3% of them did so during the year before inquiry. 2% of American women have received money for sex during their lifetime.

We hypothesize that the personal and therapeutic attitude of health professionals towards paid sex is often ambivalent and leans towards the avoidance of the topic. There are multiple reasons for this such as the reduced importance of the topic in medical education and in psychiatry-training, a certain degree of idealizing the patient as not being prone to morally questionable behavior and, no apparent clues in the patient’s presentation and in his narrative.

We think that particularly in young men, asking actively about and understanding prostitution consumption may benefit their psychiatric and psychotherapeutic treatment. In our experience, investigating a patient’s hidden motives behind paying for sex can help patients to achieve greater inner and relational freedom.

The patient
Mr. A, a small and shy 30 year old male, was born in a north-western Portuguese village near an internationally renowned Casino-beach-resort and lived there until the age of 18. He is the only son of a working-class couple, who are both in paid employment. Mr. A attended a college in Lisbon, which was a three hour drive from his parent’s home. None of his peers from the village went to college; Mr. A was a driven individual and achieved his goal of furthering his education.

At home his parents always quarreled about his father’s infidelities, but despite this they stayed together to finance his studies. When they divorced after his graduation, he felt deserted and gradually developed a depressive state. His depressive symptoms lasted for 12 months before he came for a consultation to the F+F Gysin, Private Psychiatric Practice. As well as his parents’ divorce, he broke two toes during a kick-boxing session, which caused him to stop practicing his favorite sport. During this period he also started to date a girl who compared to him had a poor education and no fixed job. Because of this, she envied him for his higher income and thus she was unfaithful to him. The culmination of these reasons and a low mood, which stemmed from being resentful for not being promoted at work, a lack of motivation, social isolation and an irrational fear of being attacked in a familiar and secure night club. He had outbursts with friends, suffered from anhedonia, a lesser sexual drive, a fear of losing his hair and gaining weight. He was also particularly dysphoric of his small height of 1.59m. He wanted help but without medication.

He pays for sex
For Mr. A, paid sex was not a problematic issue, nor a direct motive for his consultation. When questioned about his sex-life he was comfortable talking about his experiences, and showed a degree of consumer pride in prostitution. At the age of 22, after breaking up a four-year relationship, out of curiosity and revenge, he purchased for the first time sexual services in a sex-worker’s apartment. This use of prostitution escalated when back in his native village, where a Saturday night ritual with a group of friends started. After dinner with their girlfriends, the group would take their partners home and then all the males would leave them to visit a brothel to have a drink, fun and sometimes have paid sex with prostitutes using protection. This kind of prostitution use became a peer group standard and, for Mr. A, it seemed to be an easy victory over his shyness.

Mr. A became hooked and hyper-seduced by a specific prostitute, and he fantasized about living with her in what he described as an ‘exotic land’. However, to have or to maintain a full erection during paid sex he needed to think and imagine that he was making love to a romantic partner. The patient referred to exclusive heterosexual orientation and sexual desire, however revealed that he would suffer a loss of erection when either nervous or stressed.

Tests and scales
The Arizona Sexual Experience Scale is composed of five questions. As we can see in Figure 1, for Mr. A, paid sex (red circles) is less exciting and less intense compared to romantic sex (green circles).

The informal Social Atom is a drawing that the patient was asked to create, drawing circles to represent his most important relationships and favorite past-times (see Figure 2). The proximity to the subject (the middle circle) indicates the importance of these to him. Mr. A’s social atom showed close relationships to his parents, friends and pets and also confirmed his problematic affective intimacy with women.

Mr. A’s relationship-cycle
We can describe Mr. A’s relationship dynamics by the means of anamnestic data and through his behavior in the therapeutic setting. We followed the Operationalized Psychodynamic Diagnostic-procedure.

Mr. A felt that he was not being recognized in his efforts to fulfill or please others. Often arriving late to dates with girlfriends, he not only refused to apologize, but also expected them to listen supportively to his complaints. He implicitly asked too much of others without being aware of it, and then found himself surprised by the negative responses he would receive, and found this negativity unjustified and rejecting. He felt an imbalance between giving and receiving, which reinforced his fears of intimacy (see Figure 3).
1. How strong is your sex drive?

1. extremely strong 2. very strong 3. somewhat strong 4. somewhat weak 5. very weak 6. no sex drive

2. How easily are you sexually aroused (turned on)?

1. extremely easily 2. very easily 3. somewhat easily 4. somewhat difficult 5. very difficult 6. never aroused

3. Can you easily get and keep an erection?

1. extremely easily 2. very easily 3. somewhat easily 4. somewhat difficult 5. very difficult 6. never

4. How easily can you reach an orgasm?

1. extremely easily 2. very easily 3. somewhat easily 4. somewhat difficult 5. very difficult 6. never reach orgasm

5. Are your orgasms satisfying?

1. extremely satisfying 2. very satisfying 3. somewhat satisfying 4. somewhat unsatisfying 5. very unsatisfying 6. can’t reach orgasm

**Figure 1.** Mr. A’s Arizona Sexual Experience Scale reveals that paid sex is less intense compared with romantic sex.

**Figure 2.** Mr. A’s Social Atom shows problematic affective intimacy to women.

With his paid sex encounters, he tried to escape from this cycle. After sex for money, he felt that afterwards, nobody is in debt with anyone. He looked for a “girlfriend experience” free from any affective claims. His internalized couple model is characterized by infidelity, hostility and matrimonial warfare.

For Mr. A, paid sex had many simultaneous non-sexual functions, which follow Willy Pasini’s list of Non-sexual Functions of Sex⁶: sex as tranquilizer and antidepressive for his symptoms, as identity-support and socializer in his peer group as well as power-tool and object of exchange with women. The intrapsychic function of paid sex seems to be a narcissistic first-aid kit.

**Diagnosis and clinical evolution**

Mr. A was diagnosed with depressive episode, moderate to severe, with mild psychotic symptoms (ICD-10: F33.2)⁷ and failure of genital response (episodic erectile dysfunction in a paid sex setting) (ICD-10: F52.2). Paid sex activity in general may hide the aspect of a disorder of impulse control⁸, however this was not present with Mr. A. Addictive and obsessive traits in his paid sex behavior were
ruled out. A weekly psychotherapeutic treatment was proposed and started in monotherapy, without anti-depressive medication. The patient showed high therapy-motivation and good compliance. He accepted the therapy-program and during a period of 14 months, Mr. A attended 40 hourly sessions.

The patient gradually improved without psychotropic medication and took three weeks off work as sick-leave and three weeks off work for overdue vacations. He quickly changed to a more challenging and better rewarded job and started up kick-boxing again. Socializing better in his new job, he continued to be solitary in his private life and started to commit time to his newly adopted dog (which coincidently was his mother’s favorite activity).

Moreover, he reduced his peer-group paid sexual activities but still dissipated his energy by regular night-life, drinking and paid sex consumption. His sentimental life still revolved around his problematic girlfriend, whom he had chosen when he was depressed.

Theories of prostitution
To understand the patient’s pattern of paid sex consumption and the therapeutic attitude and reaction of the therapist, it is important to understand the actual positions and knowledge about prostitution. There is general agreement that one should distinguish clearly between street and indoor prostitution. Street prostitution is seen as implying frequent health-risks for workers with a high degree of victimization and oppression, while indoor prostitution subject to much debate.

There are two main prostitution theories which explain and deal with indoor prostitution: the “Sex-Work model” and the “Oppression model”. The first proposes legalization of prostitution as a way to earn a living, and for harm reduction, minimizing risks for sex workers and consumers. The second focuses on exploitation, victimization and abuse of women and is usually adopted by feminist movements and right-wing conservatives for different reasons.

Portugal does not criminalize prostitution, but linked economic activities are illegal, like renting an apartment for prostitution work. There is no regulation, and sex workers are without legal protection and do not benefit from systematic harm reduction strategies. In general, prostitution does not seem to be on sexological or political agendas and very few studies about prostitution-users are available.

Discussion
Although the patient suffered from a moderate to severe depressive episode, with mild psychotic signs, no medication was given in response to the patients’ wishes and following the tendency of psychiatrists to follow a “watchful waiting” approach. Official therapeutic recommendations in Germany and Switzerland state: “When a unique therapeutic approach is planned in patients suffering from moderate to severe acute depressive episodes, treatable in outdoor-setting, exclusive psychotherapy should have the same importance as exclusive medication when the method of treatment is chosen.”

The attitudes of psychiatrists and psychotherapists to paid sex are rarely examined. With the clinician, a professional tolerant and neutral position may coexist with a private negative sensibility about prostitution. Unintentionally, this may result in a negative judgment of paid sex and avoidance of the patient’s narratives of paid sex behavior.

Fátima Gysin (the therapist of Mr. A) specialized in sexology and psychosomatic consultation at the University of Geneva headed by Willy Pasini. In Portugal, in the private practice setting, she has treated an up-scale sex-worker for depression and anxiety unrelated to her professional activity. The patient valued her work and was determined to continue indoor, top-level prostitution. In this context, exploitation, misery and victimization are absent or less visible and sex-work appears to be frequently a free choice of profession.

One question is the degree of communication of the therapist’s personal moral, ethical or political stance to the patient. Sometimes the therapeutic process is better served by the therapist’s auto-disclosure, while generally non-disclosure is recommended.

Conclusion
Although it wasn’t a reason for consultation nor was it presented as a symptom, it was essential to Mr. A’s psychiatric treatment for his depressive disorder to open up his paid sex habits. The therapy helped him to make sense of and give meaning to his struggle with intimacy. The change from his depressive mood was probably facilitated by the interest given to the significance of his paid sex experience. On different levels, prostitution use can be simultaneously a symptom, a free choice and a cultural pattern. In depressed men seeking psychiatric or psychotherapeutic help, an active exploration of any existing paid sex experiences can be useful.
Consent
Written informed consent for publication of the clinical details was obtained from the patient. Permission has been solicited by e-mail for publishing the results of the Arizona Sexual Experience Scale (ASEX).

Competing interests
No competing interests were disclosed.

References
7. WHO – ICD-10 Classification of Mental and Behaviour Disorders. 1994. Reference Source
Open Peer Review

Current Referee Status: ?  

Version 1

Referee Report 17 April 2013

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It is only one clinical case and so I think it has a medium interest. Although it is present in a clear way I think the discussion should be more consistent. Anyway, it deserves to be published.

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Competing Interests: No competing interests were disclosed.

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This is a complete case report, where all the necessary information has been extensively provided. Overall, the report is valuable, but we have few reservations. We suggest to the Authors to:

- Explain more clearly some of the clinical considerations in order to facilitate the reader’s comprehension of this case. For example, they could better specify the sentence; ‘which coincidentally was his mother’s favorite activity’, on page 4;
- Within the text, if possible, comply with paragraphs’ name used in the abstract;
- Add in the abstract (section: Design and method) the informal Social Atom and the Operationalized Psychodynamic Diagnostic-procedure;
- Specify in the section ‘Tests and scales’ the important results emerging from Arizona Sexual Experience Scale, as it has been done for the Social Atom;
- Add to the ICD-10 nosography also the DSM classification: in some Countries this is more used than the other one and so it could be more comprehensible;
- The reference list could be improved with some recent international articles supporting your theoretical assumptions. For example we can suggest two important publications concerning different motivations to sexuality and the importance to talk about sexuality during the therapeutic process:

Meston CM, Buss DM (2007), Why Humans Have Sex
Archives of Sexual Behaviour 36(1): 477-507
• Meston CM, Buss DM (2007), *Why Humans Have Sex*, *Archives of Sexual Behaviour*, **36**: 477-507

We have read this submission. We believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.

**Competing Interests:** No competing interests were disclosed.