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SYMPOSIUM ON SEXUAL DYSFUNCTION

Controversies, Methods, Results

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Background

The terminology of sexual dysfunction is ugly enough in all conscience—erectile impotence, orgasmic dysfunction and so on—but it has served a useful purpose by bringing these problems into clear focus rather than burying them within the general vagueness of terms such as impotence and frigidity.

Also because of the intimate relation between thought, language and action these concepts have led psychiatrists, psychologists, social workers and counsellors to delineate sexual dysfunction as an 'area' to treat and to develop appropriate techniques for doing so.

With apologies to Samuel Beckett the background to the therapy of sexual dysfunctions can perhaps best be classified as Before Masters and Johnson, Masters and Johnson, And after Masters and Johnson.

Before Masters and Johnson

In this phase the therapy of sexual dysfunction, as all other psychotherapy, was dominated by the two major depth therapies, Freudian psychoanalysis and Jungian analytical psychology. Sexual problems were viewed as part of an *individual's* general personality and neurotic problems. Thus not only was no special attention paid to sexual problems as such but the patient was treated in isolation with no attention paid to relevant and significant others. It seems very likely —although there is little recorded explicit information —that many peoples' general psychological functioning was improved but their specific sexual problems, in many cases, may well have remained.

Masters and Johnson

The second phase is closely related to the impact of Masters and Johnson's two books: *Human Sexual Response* (1966) and *Human Sexual Inadequacy* (1970). Sexual physiology joined the exploratory explosion in other bodily systems—respiratory and gastro-intestinal for example—this explosion relating to advances in technology permitting direct visualization of aspects of sexual functioning.

Masters and Johnson's (1966) physiological impact was three-fold: firstly, clinicians were provided with a framework within which, for example, to conceive the sequence of the sex act (arousal, plateau, orgasm, resolution); secondly, certain sex differences were objectified as in the capacity of the female compared to the male for multiple orgasm; and, thirdly, important details of sexual function became less the province of armchair speculation more of empiricism. Thus the psychoanalytic tendency to under-value clitoral as opposed to vaginal orgasm was put in its correct perspective.

Masters and Johnson's (1970) clinical contribution provided a framework and a terminology within which specific sexual problems might be conceived and treated. Sex 'specialists' of various sorts mushroomed, medical and non-medical. Many, perhaps most, worked within a two-phase Masters and Johnson model: first 'sensate focus', followed by a specific technique for a specific problem; for example, the squeeze technique for premature ejaculation. 'Sensate focus' is an attempt to alter the balance between sexual performance anxiety and sexual arousal in favour of the latter. Sexual intercourse is prohibited and sexual foreplay re-introduced in graduated steps. The 'squeeze technique' is a technique of re-training the premature ejaculator with the help of his partner, to learn how to delay orgasm.

In many senses the 1970's were a period of sexual therapeutic euphoria; certainly from the USA claims were made for success rates in the treatment of sexual dysfunction, especially by Masters and Johnson themselves which, to many struggling in this country seemed unconvincing. It should be noted at this point that investigators and clinicians from the USA have always tended to treat 'pure' sexual dysfunctions, to select these out, rather than to treat sexual problems as they present to psychiatrists and psychotherapists working in GB where sexual problems are frequently complicated by past and ongoing psychiatric, personality and relationship difficulties, or may be embedded within a related background of medical, surgical, gynaecological or social problems.

As well as this being a period of therapeutic euphoria it was also a period when skills models were used to analyse a number of human deficits both in the social (Argyle, Bryant and Trower, 1974) and sexual fields. Thus sexual skills, their timing and rhythm, are

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necessary such as the capacity to maintain penile erection and to control ejaculation in the male.

After Masters and Johnson

The third phase is perhaps echoed by the unconsciously naive remark in a recent textbook . . . "Human sexuality is far more complex than was anticipated a decade ago when Masters and Johnson's work was made public" (Zilbergeld and Ellison, 1980).

In particular what are the effective components in any therapeutic 'package', including those of Masters and Johnson, as opposed to the non-specific components such as a simple human relationship? It was realised that these questions needed to be looked at just as with the other psychotherapies (Garfield and Bergin, 1978). Also in GB a backlash effect began to appear. Wholly behaviourally orientated, programmed, packages to 'deal with' sexual problems began to be complained about by the clients who would see that, although sexual mechanics and their modification were important, they were not the whole story. A human context is needed for human problems. Kaplan (1974) in the USA echoed the need for specific sex therapies to remain within a general psychodynamic context.

The present is a period of sober re-appraisal, of the realization that helping people with sexual dysfunctions is *often* difficult, although the relatively gratifying results justify the effort.

Prevalence of Sexual Dysfunction

The prevalence of sexual dysfunction in the community is difficult to assess. While the major epidemiological studies of neurotic illness in general practice suggest that from perhaps 15–30 per cent of patients suffer from psychoneurotic or psychosomatic disorder several more-difficult-to define areas of human unhappiness especially psychosexual difficulties have come into prominence only relatively recently.

Even theoretically it seems difficult to conceive of precise community prevalence figures. The major sexual dysfunctions such as male erectile impotency or premature ejaculation or female arousal problems or orgasmic dysfunction are not all-or-none phenomena but rather form a spectrum of dysfunction from mild to severe. Definitions such as that of premature ejaculation as inability to satisfy the partner on 50 per cent of sexual contacts, while useful for research, are arbitary. It also seems likely that psychosexual difficulties accompany many of the minor psychological difficulties assessed in previous epidemiological studies where they were not specifically asked about.

It also seems possible that some degree, often transitary, of sexual dysfunction may occur with couples who would otherwise be classed as, to use the American term, 'non-dysfunctional'. This is well illustrated in an unusual and valuable study by Frank, Anderson and Rubinstein (1978). They anlaysed the results of 100 predominantly white, well-educated and happily married couples to a detailed self-report marital questionnaire which contained a section, among a number of other sections, concentrating on sexual relations. Although over 80 per cent of the couples reported that their marital sexual relations were happy and satisfying and nearly 90 per cent of both sexes said they would marry the same person if they lived their life over again, nevertheless 40 per cent of the men reported erectile or ejaculation dysfunction and 63 per cent of the women reported arousal or orgasmic dysfunction. Also 50 per cent of the men and 77 per cent of the women reported what the authors define as 'difficulties' e.g. lack of interest, difficulty in relaxing, incorrect time, too little frequency etc. Further analysis suggested it was the overall relationship aspect of the marriage ('affective tone') that determined how most couples perceive the quality of their sexual relation.

Another related area that has recently come into prominence with the growth of interest in liaison psychiatry is that psychosexual problems may, and often do, accompany physical diseases of many types (Kolodny, Masters and Johnson, 1979; Crown, 1981a, b); as well as being related to medically prescribed drugs such as hypotensives, psychotropics and cytotoxics (Beaumont, 1976; Barnes, Bamber and Watson, 1979).

In a careful study Lester, Grant and Woodroffe (1980) examined sexual dysfunction in diabetic and non-diabetic hospital outpatients. Eighty-three consecutive male diabetic OP's, age 15–60 years, were compared with 50 non-diabetic patients of similar age range, attending other hospital OP's. A questionnaire was used and the patient's self-assessment accepted. A non-significant difference in sexual dysfunction was found: 23 per cent among diabetics, 20 per cent among non-diabetics. These authors did not differentiate between the types of sexual dysfunction but their findings underline the importance of control studies.

Catalan *et al* (1981) used information derived from a structured interview and Goldberg's 60-item General Health Questionnaire with patients attending a clinic for sexually transmitted diseases. Over 21 per cent of the males and 29 per cent of the females were experiencing sexual dysfunction problems.

These hospital studies suggest a possible basic prevalence of sexual dysfunction in perhaps 20 per cent of hospital attenders; in the community knowledge is uncertain but, even in basically good marital

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relationships, there may be transitory periods of sexual dysfunction whose disruptive effect or otherwise may relate to the general quality of the relationship.

Experience at The London Hospital

Our referrals are through two major sources, in the first instance from general practitioners. These referrals vary greatly in sophistication. Some are of the "impotency for two years . . . please see and advise" variety. On the other hand *pari passu* with the increasing sexual problems' training for medical students not infrequently patients are sent with a psychosexual problem well described and not infrequently already treated either by counselling, psychotherapy or behaviour therapy by the practitioner concerned. The social background of the patients is bimodal; the hospital itself is situated in a working class area so local patients are from this class. However the region stretches to Essex and Kent including a number of predominantly middle-class areas with referrals likewise. It is also clear that some group general practices, presumably known by their patients to be sympathetic to psychological and psychosexual problems, consistently assess and refer a large number of clients over the years.

Our second referral service is internal, from medical and surgical colleagues. Thus psychosexual problems may be embedded in a whole range of other problems. These include other psychiatric problems; medical, gynaecological and surgical problems; problems characteristic of particular clinics such as dyspareunia and vaginismus characteristic of the sub-fertility clinics or worries and concerns about the genitals from the urology clinic.

New patients are seen by medical students who take a full psychiatric and sexual history. They are then seen by the consultant who attempts to formulate the problems and establish a plan of management. This may, and often does, involve referral to a psychological colleague with a view to assessment for specific sex therapy.

Methods of Treatment

Our methods of treatment derive from the conceptual structure within which we evaluate the cases, which is similar to that of H. S. Kaplan. Thus we embed our behavioural approaches firmly in a psychodynamic attitude. The major techniques we use to help clients are those of psychotherapy, contract and compromise and behavioural modification.

These treatments may be used in varying combinations as appropriate together with adjunctive measures where necessary such as psychotropic medication, and sex aids especially prescribed reading.

Overall we have found no method by itself *especially* effective but behaviourally and contractually orientated methods seem more successful with poor outcome problems and a psychodynamic approach more acceptable with basically good outcome problems. Certainly many clients seem to like to be able to have discussion, counselling and psychotherapy in addition to anything else they are offered. However, scientifically valid it might be to employ a purely behavioural approach patients ask for more, possibly as a backlash to the behaviour therapy euphoria of the last ten years.

We usually work with one therapist rather than a dual sex team. As research emerges (Crowe, Gillan and Golombok, 1981) those studies that have formally investigated the question of the number of therapists and the sex of the therapist seem to demonstrate that it does not contribute materially to therapeutic efficacy. In relation to economy and convenience therefore we continue with the single therapist.

Results

One of us (S.C.) who works mainly within a psychodynamic and contractual framework regrets that he has never systematically investigated his results. Later comments therefore on problems that seem easier or more difficult to modify are clinical impressions. We are, however, able to present P.d'A.'s objective analysis of problems treated by her over the last three years.

Fifty-one patients or couples were seen by P.d'A. and/or her students between February 1978 and February 1981. Seventy-four patients were referred; of these 23 cancelled or did not keep their appointment or were given a resource closer to their own homes. (Table I).

Assessment

The majority of patients (i.e. 60) had received a full psychiatric assessment prior to referral. The minority who had not, had in all cases seen a professional person and the particular sexual problem had been discussed in detail on at least one occasion. They were then referred directly to the psychologist who would offer treatment on the same basis as the majority with the proviso that the GP was kept informed and was deemed medically responsible for the patient. Where couples were referred they would be assessed separately and then conjointly. Psychological assessment consisted of a more detailed psychosexual history and over the last eighteen months, the Marital Happiness Scale (MHS) (Azrin, Naster and Jones, 1973) was administered before and after treatment and at 12 months.

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TABLE I

Original patient population

	Source of referral				
	Psychiatric	Direct GP	Gynaecological	FPA	Other
No. of men	28	2	–	–	–
No. of women	32	3	6	1	2
(Total 74)	60	5	6	1	2

Treatment

In all cases a modified form of Masters and Johnson treatment was offered, and it was made clear to patients that our approach was based on new learning with emphasis on successful task completion. Of the total of 51 patients, 13 had already attempted other kinds of treatment and 4 had previously received a treatment similar to that of the clinic.

After the initial assessment, a therapy contract would be offered to the couple/patient. In all but 6 cases the couple were seen throughout conjointly. The average length of contract was 6 sessions although as can be seen in Table II) this was frequently extended until the treatment goal was attained. The 'Drop out' column was arbitarily fixed at those who failed to keep two or more consecutive appointments in the first contract.

All patients were given specific sexual assignments in treatment starting with a programme of sensate focus. They were given a detailed text by John and Judith Bancroft to assist them, together with pictures, diagrams and verbal instructions. The assignments were varied and were pertinent to the specific dysfunction e.g. the 'squeeze' technique for premature ejaculation. Patients were further instructed in the use of other psychological techniques for appropriate dysfunctions e.g. deep muscle relaxation and systematic desensitization in treating vaginismus. Patients were asked to record their behaviour between sessions and to rate on a simple seven point scale, using their own subjective criteria for success or failure. The purpose of recording was to provide ongoing feedback to therapists and patient(s) to increase rewards for successful assignments and to give an immediate guide as to the motivation of the patient. Of the four patients who dropped out, only one had undertaken behaviour recording.

A treatment success was based on self reports, reports from GP's and the Marital Happiness Scale when a treatment goal had been met fully. Where the goal had been partially met or there was disagreement between partners, this was rated as some improvement. (Table II).

Eighty-two per cent of female clients achieved a positive change or some improvement after therapy. Vaginismus was both the most common complaint and the complaint that responded best to treatment.

The results from male clients are less clear. Although 64 per cent (13 cases) showed total or partial improvement, the remaining failures included a 14 per cent drop out rate. Premature ejaculation was more successfully treated than impotence.

Discussion

This is based both on P.d'A.'s objective analysis using behavioural methods and S.C.'s clinical experience with a psychodynamic and contractual approach.

Good outcome problems

Psychosexual problems with the best outlook seem to be those that are secondary to a poor relationship provided that the couple are prepared to work on their relationship. In this respect the psychotherapy of psychosexual dysfunctions links with psychotherapy in general. Increasing the client's insight and helping the couple to take charge more effectively of their own lives seem increasingly invoked as factors in all effective psychotherapy.

Of specific problems treated behaviourally, vaginismus and premature ejaculation show the best results. The sample is, of course, small and the success bias towards the female population may reflect the therapist's greater competence with her own sex. However, the figures are encouraging. This group was not free of psychiatric disorder or marital disharmony and yet responded to sex therapy in a conventional Masters and Johnson framework.

Poor outcome problems

Low sex drive

Psychosexual problems resulting from low sex drive seem particularly difficult to help. It seems likely that

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TABLE II

Breakdown of three years of sexual problems at The London Hospital 1978–1981. Fifty-one cases

	Positive change	%	x̄ no. sessions	Some improvement	%	x̄ no. sessions	No change	%	x̄ no. sessions	Drop out	%	x̄ no. sessions
30 ♀												
General sexual unresponsiveness	6	20%	8	3	10%	8.5	1	3%	9	1	3%	2
Orgasmic dysfunction	2	6%	7	3	10%	7	2	7%	8			
Vaginismus	10	33%	11	1	3%	7	–					
Others							1	3%	6			
Female total		59%			23%			13%			3%	
21 ♂												
Impotence, primary and secondary	2	9.5%	7	1	5%	6	5	23%	7	2	9%	3
Premature ejaculation	6	28.5%	4	3	16%	4				1	5%	2
Ejaculatory failure				1	5%	6						
Male total		38%			26%			23%			14%	

Table represents the breakdown of all cases of sexual problems seen between 1978 and 1981 where a contract for sex therapy had actually been established and undertaken. The 'drop out' column is defined by those who failed to keep two or more consecutive appointments.

the sexual drive varies from person to person relating both to inborn factors and to life experience. If two people with different sexual needs marry a psychosexual problem ensues. Assessing appetite on past desire and past and present masturbatory and sexual performance is relatively simple. What is difficult is to treat the condition.

Arousal problems

Given a stated 'normal' sexual desire, arousal problems in both sexes are not easy to treat. Females whose problem is described as 'frigid', 'switched-off', non-responsive even to masturbation either by herself or by her partner are difficult. While techniques of 'super-stimulation' as suggested by Gillan (1979) may be effective not all clients nor all therapists can work comfortably with the techniques she suggests. Sex aids need to be 'tailored' to the social background age and sensitivities of the clients. Thus to many clients especially in the older age groups, e.g. sexual problems following hip surgery (Currey, 1970), personal contact and discussion of sex is difficult and a distance technique such as a written hand-out is preferred. On the other hand the majority of clients with sexual dysfunction, whose average age may be similar to the average age of other psychiatric outpatients, i.e. in the mid-thirties, can tolerate discussion and may like sex aids prescribed whether visual or mechanical. Some sex therapists consider that a sexually dysfunctional couple should be sexually aroused by any means in order to get their sexuality re-started. However it is our view that both client and therapist sensitivities should be respected.

Female anorgasmia

Anorgasmia in the female often presents a difficult problem. Techniques of dynamic psychotherapy seem unhelpful unless the anorgasmia is secondary to an obvious traumatic cause revealed in the history or in the marital relationship. Techniques of gradual inspection of the genitals through masturbation to mutual masturbation and sexual intercourse (Lobitz and Lo Piccolo, 1972) although they seem neat theoretically are not always easy to 'package' acceptably for relatively conventional couples.

Transcultural problems

Transcultural problems should have special mention. In clients where there is a language difficulty as with Pakistani or Indian immigrants the sexual problem is often embedded in an apparently physical problem. It is difficult to get such persons to switch their attention to the marriage and even harder to get them to bring their spouse into the couple therapy. In groups in whom there is no language problem, but a culturally conditioned sexual problem, as in men from the West Indies, there is often so much invested in sexual performance that they find it impossible to acknowledge that either they have a sexual problem or to tell their partners that they have.

Liaison problems

Another difficult group of psychosexual problems possibly seen more in a department based in a general hospital than in a specialized psychosexual clinic are problems with a background in physical disease. These are the psychosexual problems that have originally presented to specialized clinics such as urology, gynaecology, general surgery, many subspecialities within medicine (cardiovascular, respiratory, gastrointestinal etc.), or sexually transmitted diseases (STD). This latter group of problems, for example, often present with a psychosexual problem embedded in a background of excessive guilt. Other examples of this type of problem are the sexual problems of the disabled and sexual problems intrinsic to certain forms of physical disease, for example, those relating to diabetes mellitus.

A number of patients referred from non-psychiatric clinics include people who conceive all problems in physical terms. These have been called 'alexithymics' (Nemiah, Freyberger and Sifneos, 1976). They are those who tend to somatize their problems rather than to psychologize them. With these clients one seems to be trying to swap one form of concept for another. If such a person is convinced that his sexual problem is 'physical' nothing on earth seems able to persuade him to think in terms of a psychogenic aetiology. At one border this group merges into the hypochondriacal neurosis; another interface is with the neurotic group of dysmorphophobias for example women who are convinced that their tummy or their breasts are unattractive. Another border is with the monosymptomatic psychoses with one single apparently limited 'notion' or delusion such as that the tip of the penis is 'damaged' (Munro, 1980).

Conclusion

Wright, Perreault and Mathieu (1977) indicate in a review of the treatment of sexual dysfunction up to the end of 1976 that neither the psychodynamic approach nor the directive approach allow firm conclusions to be drawn on their efficacy because of basic methodological limitations. Many studies are based on unsystematic case reports. Success rates vary widely from study to study; definitions of cure vary. While at the most stringent critical level these criticisms still apply, in GB there appears to be some

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considerable agreement about methods and outcomes. Our own clinical impressions and our results from specific sex therapy of a modified Masters and Johnson type seem to correspond with others.

Crowe *et al* (1981) in a careful study used three techniques: modified Masters and Johnson techniques with one or two therapists and a technique involving discussion of marital problems with emphasis on relationship, relaxation techniques, contracts and efforts to improve communication. All approaches led to statistically significant improvements lasting at least till the one-year follow-up in couples with impotence, anorgasmia, loss of libido; there was no significant difference between techniques.

Bancroft and Coles (1976) also using a modified Masters and Johnson technique recorded a 'successful outcome' or 'worthwhile improvement' in 68 per cent of 78 patients with sexual dysfunction, (erectile impotence, premature ejaculation, ejaculatory failure, female general unresponsiveness, orgasmic dysfunction, vaginismus).

In general therefore sex therapy as practiced at the moment seems to lead to improvement in around two-thirds of patients of either sex presenting with sexual problems to out-patient clinics known to have a special interest in their treatment. It is interesting that this success rate is very similar to that for psychotherapy applied to areas other than the psychosexual (Garfield and Bergin, 1978).

Research

There seems little doubt that the area that most needs researching is to continue to seek out what is genuinely therapeutic in the various therapies for sexual dysfunction and what is not. Crowe *et al* (1981), for example, suggest that several of the accepted components of the Masters and Johnson technique may possibly not be contributing.

So far as groups of clients are concerned we suggest that no significant therapeutic impact has been made in the treatment of psychosexual problems presenting within a transcultural setting and that this is an important problem area.

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