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Sexual Anxiety in Sexual Dysfunction

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Sexual anxiety was examined in 98 patients presenting with sexual dysfunction and 68 of their partners at a psychosexual clinic using the SOMA questionnaire. All patients had raised values for heterosexual anxiety. Female partners had raised values while male partners did not. This provides further evidence for the role of heterosexual anxiety in the aetiology and treatment of sexual dysfunction.

Sexual anxiety has been implicated in the aetiology of sexual dysfunction by many writers. Masters & Johnson (1970) emphasised the role of 'fears of performance' (or performance anxiety) in both aetiology and maintenance of the problem. Psychoanalytic theory, learning theory, and theories underlying sex therapy have all emphasised anxiety as an aetiological factor (Kaplan, 1982).

Treatments described by various authors emphasise the alleviation of such anxiety. Psychoanalysis holds that the resolution of deep-seated conflicts may relieve anxiety and thus resolve sexual dysfunction (Rosen, 1982). Learning theory focuses on specific circumstances that evoke or maintain anxiety. Many patients show improvement with desensitisation (O'Gorman 1978), social skills training and other techniques that manipulate the negative reinforcement contingencies. Directive therapy involves minimising performance anxiety by avoiding all specific suggestion of goal-orientated sexual performance. This is achieved by taking the couple through a step-by-step programme towards mutually desirable sexual involvement. Kaplan (1982) discusses the use of tricyclic antidepressants and monamine oxidase inhibitors in treatment of women with sexual phobias. She reports improvement with the use of these drugs as "anti-panic medication". It appears that such medication reduces anxiety to the point where directive sex therapy may be of benefit.

The Sexual Orientation Method and Anxiety (SOMA; Patterson & O'Gorman, 1986) is a questionnaire designed to measure sexual anxiety in patients presenting at a psychosexual clinic and is based on the Sexual Orientation Method (SOM; Feldman *et al*, 1966), with additional items relating to sexual anxiety for which the scales were derived from the semantic differential (Marks & Sartorius, 1968). The test scores four components: heterosexual interest, homosexual interest, heterosexual anxiety, and homosexual anxiety. Internal consistency, test–retest reliability, and validity have been demonstrated. It has been shown that patients presenting with sexual dysfunction score high on the heterosexual anxiety component of the SOMA and have low scores on heterosexual interest.

We hypothesised that the partners of such subjects would show similar changes. We also wished to examine the relationship between heterosexual anxiety and the heterosexual interest score in heterosexual subjects. A low heterosexual score might be found in a homosexual subject, in an individual with transient loss of libido, such as might occur in depression, or in an individual with low sex drive.

Method

Ninety-eight consecutive patients presenting with sexual dysfunction at the Psychosexual Clinic in Belfast in 1980 and 1981 were included in the study. It was possible also to include 68 partners (all in heterosexual relationships). Each subject completed the SOMA at presentation. Four groups of subjects were examined: 46 dysfunctional men, 52 dysfunctional women, 41 male partners, and 27 female partners.

The dysfunctional groups included all patients presenting with any form of sexual dysfunction; in the case of men this included erectile and ejaculatory dysfunction as well as disorders of arousal, and in the case of women this similarly included disorders of arousal and orgasmic dysfunction.

Eleven dysfunctional women did not have partners available to complete the questionnaire: in eight cases this was because their partners were unwilling to attend the clinic or to participate in therapy, and in the other three the women had no current regular partner, despite having had at least one recent partner with whom they had attempted sexual intercourse. Nineteen female partners were unavailable to complete the questionnaire: in 12 of these cases the regular partner did not wish to be involved in therapy, in three the dysfunctional male did not wish his partner to attend the clinic and the remaining four had no current regular partner. Dysfunctional men and women whose partners did not complete the questionnaire did not differ statistically from those whose partners did complete the questionnaire on any of the four test scores.

Normal values for men and women have been established by Patterson & O'Gorman (1986).

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TABLE I
Heterosexual anxiety and heterosexual scores

	No. of subjects	*Heterosexual anxiety score: mean (s.d.)*		*Heterosexual score: mean (s.d.)*	
Normal men	27	3.93	(3.15)	45.70	(2.45)
Dysfunctional men	46	6.26	(4.48)*	41.50	(6.36)*
Male partners	41	4.15	(3.84)	44.73	(3.22)
Normal women	20	2.30	(3.07)	41.75	(4.20)
Dysfunctional women	52	8.10	(3.94)***	30.90	(12.41)***
Female partners	27	5.81	(3.27)	37.15	(7.18)*

Level of significance compared with normal groups of either sex using Mann–Whitney U test: * $P<0.05$, ** $P<0.01$, *** $P<0.001$.

Results

Table I shows that the male partners of dysfunctional women had heterosexual and heterosexual anxiety scores which did not differ significantly from those of normal men. In contrast the female partners differed significantly from normal women in the heterosexual score. Dysfunctional groups of both sexes differ significantly from their normal counterparts on both scores.

In order to examine the relationship between heterosexual anxiety and heterosexual interest, scores for each subject were plotted (Fig. 1). It was postulated that the relationship would be linear, with heterosexual scores tending to fall as heterosexual anxiety increases. This would be in keeping with the aetiological theories discussed. In fact, both female groups had heterosexual and heterosexual anxiety scores which correlated highly. Spearman rank-order correlation coefficients were -0.81 for dysfunctional women and -0.65 for female partners. Both differences were significant at $P\leqslant 0.001$. The Spearman rank-order correlation coefficients for male partners at -0.13 was not significant and the value for dysfunctional men at -0.27 is significant only at $P\leqslant 0.1$. The plots yield more information.

In fact all individual scores lie at the upper right-hand portion of the graph. A line can be drawn in such a way that only two scores fall below it. This line represents the 98th percentile. The two subjects excluded in this way were both men who presented with sexual dysfunction, specifically primary erectile impotence. Both were married. One patient appeared effeminate and had mild gynaecomastia. His external genitalia were normal. Skull and chest X-rays were normal, as were the electroencephalogram, thyroid function tests, serum testosterone and oestradiol, and semen analysis. Chromosome analysis showed the normal pattern of 46XY. The other patient was noted to appear normal on clinical examination and had normal serum testosterone levels. Neither patient had a raised homosexual score on the SOMA and both denied any homosexual desire or behaviour.

Discussion

Two of the four scores yielded by the questionnaire, SOMA, are examined. The heterosexual component of the score is derived from the SOM, in which six adjectives were chosen from the list provided by Osgood (1957) for their sexual connotations. These are: interesting, attractive, handsome, (beautiful if applied to women), hot, pleasurable, and exciting. Concepts to which these are applied are, "men are sexually to me", and "women are sexually to me". The heterosexual anxiety component used two anxiety scales derived by Marks & Sartorius (1968). These are calm v. anxious and relaxed v. tense. These are applied to the concepts, "men make me feel sexually" and "women make me feel sexually".

Each subject is presented with 112 forced-choice comparisons, such as:

Women make me feel sexually
very anxious _____
quite anxious _____
Men are sexually to me
neither unpleasurable
nor pleasurable _____
very pleasurable _____

Patients are instructed to imagine themselves participating in sexual activity with an attractive member of the opposite sex. They are told to tick which of the two statements best describes their present response, and are told that although frequently neither statement will be true, they must mark the one that is closest to their feelings.

Validity of the heterosexual scale has been demonstrated by comparisons of heterosexual and homosexual groups, as well as changes with treatment (Feldman *et al*, 1966). Validity of the heterosexual anxiety scale has been demonstrated by comparisons of various patient groups and by showing improvement after treatment (Patterson & O'Gorman, 1986). In both scales internal consistency has been shown to be high. Eighty per cent of subjects have no or one inconsistency on any ten choice pairs of the heterosexual scale and 77% have no or one inconsistency on any ten choice pairs on the heterosexual anxiety scale. The scoring

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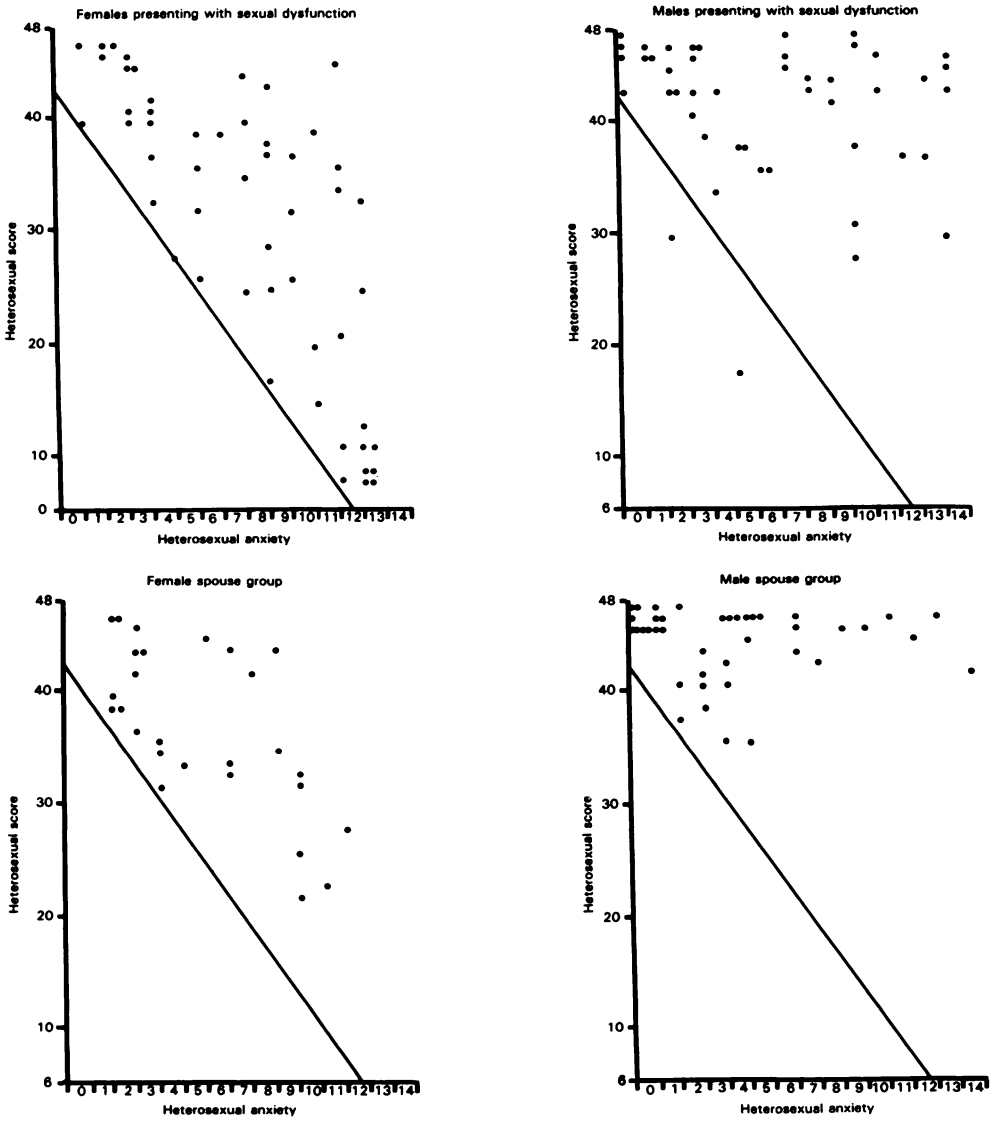


FIG. 1 Heterosexual anxiety and heterosexual scores for the four subject groups.

programme accounts for inconsistencies and can 'correct'. Feldman *et al* (1966) showed that heterosexual inconsistencies tend to decrease after treatment, although this effect was not marked. McCafferty (1984), using a questionnaire of similar construction, showed that subjects with a high number of inconsistencies before treatment tended to have a poorer outcome after treatment. Results must be interpreted bearing in mind the limitations of semantic differential techniques, and the forced-choice procedure.

Figure 1 demonstrates that heterosexual individuals with reduced heterosexual scores on the SOMA invariably have increased heterosexual anxiety. The converse is not true: subjects with increased homosexual anxiety may have normal or slightly reduced heterosexual scores, not falling below the diagonal line shown in Fig. 1. There are three possible

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reasons why such a definite, linear cut-off occurs on this plot.

(a) Heterosexual anxiety may influence the heterosexual score, tending to cause it to decrease. The degree of such an influence would depend on other factors.
(b) The heterosexual score as it decreases causes the heterosexual anxiety to rise. This effect always operates, but other factors may also cause the heterosexual anxiety to rise.
(c) Some other factor may influence both heterosexual anxiety and the heterosexual score so that as it causes a decrease in the heterosexual score it must cause an increase in the heterosexual anxiety. Other factors may also cause heterosexual anxiety to rise.

The authors have favoured the first of these reasons, as it reflects current theory in that heterosexual anxiety is a strong aetiological or maintaining factor in sexual dysfunction. It is of interest that additional factors must operate to determine the amount of influence that heterosexual anxiety may exert on the heterosexual score. It is possible that time may be one such factor; in other words heterosexual anxiety may be present in an individual for some time before it produces a decrease in the heterosexual score.

Plots of the four diagnostic groups indicate different patterns for each group. The scores for male partners fall in only the upper portion and mostly to the left-hand side of the graph. This group has heterosexual and heterosexual anxiety scores which do not differ significantly from those of normal men (Table I). Dysfunctional men show a wider spread of scores, with a higher proportion falling towards the lower, right-hand portion. This group differs significantly from normal men on both heterosexual and heterosexual anxiety scores.

Dysfunctional women show the most disturbed scores, some scoring the lowest value possible on the heterosexual range. These low heterosexual scores indicate low levels of heterosexual interest but do not imply homosexual orientation. In fact this group, despite having low heterosexual scores, does not have high homosexual scores. These individuals invariably have high heterosexual anxiety scores and probably correspond to the group of phobic patients described by Kaplan (1974). Female partners have heterosexual scores which differ significantly from those of normal women. This difference is in the direction of dysfunctional, although scores are significantly less disturbed than for dysfunctional women. Differences between the dysfunctional women and female partners reach significance levels of $P \leqslant 0.05$ for heterosexual anxiety and $P \leqslant 0.001$ for the heterosexual score.

Masters & Johnson (1970) have described a phenomenon whereby the female partner of a dysfunctional man may develop a high amount of sexual anxiety despite her own apparently normal sexual functioning. The interest in these changes in the direction of dysfunction in female partners lies in the fact that such changes do not occur in the male partners of dysfunctional women. It appears that men are unaffected by dysfunction in their partners, while women react to dysfunction in their partners by developing changes of a dysfunctional nature.

It may be that sexual dysfunction originating in the female partner is an aetiological factor for dysfunction in the man, who eventually presents as the disordered partner. It is difficult, however, to explain why this happens in these cases while the male partners are so remarkably unaffected in their scores by the presence of dysfunction in their partners. One explanation might be that early identification of the sexual difficulty as a problem specifically of the female partner protects the male from sexual anxiety and prevents secondary loss of his sexual interest.

It is of interest that women in a sexually dysfunctioning couple, with dysfunction in either themselves or their partner, tend to have significant decrease in their heterosexual scores. Men in a similar situation have scores much closer to normal values. Feldman *et al* (1966) report lower scores among normal women than normal men in this item of the SOM, but differences do not reach statistical significance. A temporal variant might account for differences noted between dysfunctional men and women: the women might present for treatment at a later stage, thus allowing a greater fall in heterosexual score. However, differences between male and female partners cannot be accounted for in this way. Men may have some inherent factor which prevents a drop in heterosexual interest, even in the presence of dysfunction and heterosexual anxiety. This could be due to a greater capacity of rehearsal of the heterosexual situation in fantasy, allowing sexual interest to be maintained, while not preventing heterosexual anxiety in the real situation. An alternative explanation for this phenomenon is that women tend to remain sexually active despite sexual dysfunction. In this case the woman may learn that sexual activity is unrewarding and may develop loss of heterosexual interest.

The SOMA is of value as a diagnostic tool for dysfunctioning subjects and their partners. It may indicate those patients whose heterosexual interest is decreased in the absence of raised heterosexual anxiety. These patients are unusual and do not appear

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to respond to standard methods of treatment. The SOMA may enable a better understanding of the nature of heterosexual anxiety and its relationship with heterosexual interest.

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