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SYMPOSIUM ON SEXUAL DYSFUNCTION

The Psychoanalytical Approach

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Modern psychodynamic formulations concerning the sexual dysfunctions stem directly from Freud's Three Essays on Sexuality (1905). Amplification and modification of psychoanalytical views since then have provided a further store of observation and clinical theory of personality development and the working of the unconscious mind, from which both behaviourally-, as well as psychoanalytically-orientated workers continue to draw. However, no single unified psychoanalytic theory of sexual dysfunction exists, nor should it at this stage of our understanding. Psychoanalysis continues to be the major source of psychodynamic principles in this field; there are three avenues down which progress is being made. The first, which forms the body of this contribution, is the application of psychoanalysis to the psychotherapeutic treatment of sexual dysfunctions. The second is the amalgamation of certain of the techniques and principles of psychoanalysis together with active behavioural practices based on the discoveries of Masters and Johnson and the behavioural therapists. [Singer (1974) in the USA; Robinson and Creed (1980) in the UK]. The third, no less interesting from a psychodynamic point of view is the way in which some modern behavioural learning theory psychologists are finding themselves facing psychodynamic complexities, such as transference, counter-transference, and a growing reliance on talking rather than manipulative procedures. Some behavioural sex-therapists see themselves as psychotherapists (Mackay, 1976). A knowledge of psychodynamics is therefore invaluable whatever one's final clinical approach.

The present symposium is timely in that the contributions of all therapeutic approaches require an airing before a general psychiatric audience, to determine their clinical usefulness, areas of overlap, and indications of how failures to respond clinically might be researched.

The point of view expressed here is based not on the experience of referrals to a sex clinic, but rather on cases referred for specialized psychotherapy or psychoanalysis. These tend to vary from those of a more complicated nature, to simpler cases who may respond well to a single interview. It is imperative, therefore, to span the spectrum of clinical presentation from simple to complex, in order to deal with the issues of assessment for treatment, principles of treatment and therapeutic outcome.

Statistics

Most difficult is the statistical evaluation of psychotherapy experience. The psychodynamic literature mirrors this dilemma. There are few papers detailing the results of psychotherapy of sexual dysfunctions. Predictably, the number of cases seen in reported series by all treatment disciplines are small, and the selection of cases is hardly comparable due to the high variation in clinical manifestation and psychopathology. The reported prevalence of sexual disorders in medical practice varies from less than 1 per cent to over 25 per cent (James and Lord, 1976). The need for careful selection is exemplified by the Bancroft and Coles (1976) study in a sexual problems clinic, where 59 per cent, 161 out of 275 referrals, were not taken on for treatment. What is evident from all studies is that a certain proportion of patients improve either in greater self-knowledge or sexual awareness wherever talking is used to promote better understanding of humal sexual psychophysiology, in the setting of a relationship. In all series a proportion of patients fail to improve symptomatically because they are held to be too complex in their dynamics or their mental and sexual pathology.

Personality and sexual dysfunction

The factor of complexity requires further elucidation. Complexity is due to the interdependence between sexual functioning and the personality as a whole. It is, therefore, important to evaluate this interplay in the individual case to arrive at the most appropriate treatment. Pathogenic factors arise mostly within the person (internalized conflict), or may be the result of environmental pressures (external conflicts). Complex factors arising external to the personality should be judged as to whether they spring from the environment of the family of origin, or from the sexual partnership. In principle, should the latter case prevail, marital sex therapy, either as a couple or in a group of couples, should then be considered (Skynner, 1976). Faulty sexual attitudes arising from the family or society attitudes may be helped by counselling techniques and re-education, or family or

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group therapy, see Crown (1976). Skynner and Brown (1981) discuss the relevant psychotherapeutic choices succinctly, but their opinion is too facile that a combined approach is superior to psychodynamic or behavioural methods used alone in sexual dysfunctions. Individual therapy may be more suitable initially for secondary disorders such as psychogenic impotence stemming from sexual incompatibility where the level of dissatisfaction with the partner lies beyond the individual's capacity to express this directly without further damaging the relationship, because the hostility is fed by unconscious sources stemming from earlier relationships with females, particularly the mother in childhood. For individual therapy of sexual disorders see Rosen (1977).

Sex therapists have taken the view that sexual dysfunctions should not necessarily be viewed in the context of the personality as a whole. However, the factor of increase in complexity based on the presence of personality factors is an admitted contributor to failure of behaviour and sex therapy. This ranges from couples selected for weekend sex-counselling courses, 'Long-standing sexual dysfunctions are not resolved as a result of group participation in self-help methods alone' (although) 'couple communication improves via the stimulus of new information, group discussions and permission to talk sexually', (Leiblum, S. R. and Rosen, R. C., 1979), to couples with the males suffering from chronic secondary psychological impotence. 'Sex therapy can improve sexual functioning. However it does not restore complete sexual health to couples with this complicated disorder' (Levine, S. B. and Angle, D., 1978).

Singer lists the factors militating against successful outcome of new sex therapy as follows:

(1) Age.
(2) Severity of associated psychopathology.
(3) Symbolic meaning of the sexual symptom and the extent to which it serves as a defence against underlying conflict.
(4) Quality of the relationship.
(5) Homosexual problems.
(6) Presence of significant anxiety and depressions in the symptomatic patient and in the partner.
(7) Presence of hidden medical problems.

Singer says that the prognosis of desire-phase problems is poorer than orgasm-phase dysfunctions. The course of inhibited sexual desire problems in treatment is stormier and more complex, even when successful. Only a small percentage of desire-phase dysfunctions respond to standard sex therapy.

All the above conclusions by Singer confirm the importance of personality factors in sexual dysfunctions. The factor of complexity regarding treatment methods is 'The need to pay proper respect to the complexities of human sexual function' as stated by Gelder (1979) warning against a purist use of behaviour therapy because of its limitations of theory and technique. In the context of sexual deviation, Gelder writes, "Attention must then be turned to wider aspects of sexual behaviour, and it is here that behaviour therapy has, so far, less to contribute. Some patients need to acquire social competence in their relationships with women. Behaviour therapy offers social skills training methods, but none has been evaluated fully. Until they have, reliance must still be placed on procedures that are the results of clinical experience—counselling, social work, or psychotherapy, individual or in a group". Gelder proposes that for the methods of developing heterosexual behaviour, systematic desensitization is more acceptable than aversion relief. "The commonsense presumption that it is most suited for patients who have specific anxieties about heterosexual intercourse is not supported by evidence, but is nevertheless an appropriate guideline. Patients will often also require counselling and training advocated by Masters and Johnson (1970)". Gelder plainly advocates linking different forms of treatment, psychotherapy, behaviour therapy and social and sexual learning skills, a view coming into prominence now. [See also Skinner, R. and Brown, D. (1981)].

The factor of complexity and the relationship of sexual factors to personality as a whole, is where the theory and technique of psychoanalysis and its derived psychodynamic therapies become prominent and significant.

Psychosexual development

The sex life of the adult undergoes a complex development, in a series of phases, originating in early infancy. Psychosexual development is liable to arrest in its progress and to an involvement in processes whereby infantile sexual conflicts are internalized within the personality which continue to exercise an effect on sexual and personality function in an unconscious manner. The subsequent behaviour of the individual could thus be said to be 'learned'. To denote a learning effect as such may mean to overlook the unconscious conflictual tendencies by which the learned effect was brought into being in the first place, and which by virtue of the dynamic functions within the unconscious, the behaviour, inhibition or symptom may be kept going. Psychodynamic treatment attempts to resolve the unconscious dynamic forces inherent in psychic conflict by making them conscious and acceptable to the personality. Analysis does not mean guessing at unconscious sexual or aggressive motivations, although these will have to be revealed during therapy. Rather

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it means the verbalization of feelings or affects associated with tendencies about which there is fear or conflict as to the consequences to the self or the partner if they are given expression in physical reality. Work proceeds against a feeling of resistance within the patient's self. The more the sense of resistance or the more the person is unaware of any underlying causes or motivations for their sexual dysfunctions, the greater is there the presence of unconscious resistances and conflicts. Obviously such strength of resistances will have to be judged against the natural reluctance people have in discussing their most intimate sexual lives. Psychiatrists have an advantage in seeing patients referred to them because the referring agent, usually the GP, if well trained will already have explored the patient's sexual history, and some semblance of order will have been already induced, allowing for a more expert psychodynamic formulation to be made from facts already to hand.

One must, therefore, assess not only what is troubling the patient in terms of disorder of desire, potency or orgastic ability, but also faults in personality development plus the strength and quality of resistances or of defence mechanisms which protect the personality against conflicts and which serve to maintain the symptoms.

Comparison of psychodynamic and sex therapy approaches

Compared systematically the psychodynamic and 'new sex therapy' approaches to the assessment of sexual dysfunctions are as follows:

The psycho-analytical or psycho-dynamic approach

Many areas of functioning are assessed and may require to be explored. Among these are the following:

(1) The individual's maturity as a whole person.
(2) The capacity to form object-relationships with a partner.
(3) The presence of any specific resistances and anxieties stemming from externalized conflicts.
(4) Exploration of any specificity of sexual dysfunction.
(5) Does the sexual apparatus represent a 'target-organ'? Is the sexual dysfunction a symbolic means of expression of internalized conflicts, especially castration anxiety?
(6) The sexual dysfunction may be contributed to by many underlying conflicts or may serve as a defence against them.
(7) Are the repressed conflicts, affects and anxiety, analysable and by what means? Is the interference with love and desire compounded by massive unconscious aggression? Does the anxiety also express deeper fears of abandonment or merging with the object? Depending on the complexity of the clinical needs, the therapy may vary from a single session to a planned programme of weekly visits, to open-ended intensive transference analysis.

The Singer sex therapy approach

(1) Sexual dysfunctions are seen as the product of the physical concomitants of anxiety. The objective of treatment is to diminish this sexually related anxiety, thereby restoring genital functioning.
(2) Resolution of 'performance anxiety' and mild obsessive "spectatoring". (Masters and Johnson). These respond in a number of patients to brief separate treatment methods.
(3) Excitement and orgasm phase disorders should be viewed as separate syndromes. The 'new sex therapy' integrates a combination of structured sexual tasks with psychotherapeutic exploration of resistances.

General clinical considerations

What do these two approaches share in common and how are they different?

Both share a psychodynamic approach with the analysis of resistances to diminish anxiety; the accent being on the understanding of attitudes and conflicts interfering with interpersonal relationships. The success of these undertakings will depend on the trained expertise and analytic skills of the therapist. From the patient's point of view, what is ideally necessary is that the offending conflicts, desires and feelings are brought to the surface in adequate specificity and amount, to achieve subsequent freedom of function of the self, in terms of desire, the capacity to find and relate to another person sexually and with love, and to achieve satisfactory orgasm. In practice, only some degree of improvement in some of these qualities may be possible, but the gain in freedom and sexual pleasure is of immense value to the recipient, the partner and the family.

Where they differ formally is that the analyst does not actively participate in a planned programme of physical sexual retraining. The reason for this is as follows. The analytical approach believes that the patient should be the prime mover in their own successful functioning. Analysis of resistances means the removal of impediments which prevent the person experiencing their own inner desires and their fulfilment to satisfaction. The analyst has an equal regard for the reality factors and behaviour of the patient in every day conscious life, as well as in the workings of the unconscious past. Every encouragement is given judiciously to the attainment of inner desire and external achievement in relationships and sexual

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performance. In my experience, the treatment of sexual dysfunctions requires some modification of the analyst's traditional neutrality in favour of a positive attitude towards the patient's successful gain or recovery of their masculinity or femininity as expressed by real sexual behaviour, but also in every other avenue of masculine or feminine identity, such as employment and caring for others.

The analyst's resistance to becoming directly responsible for planned physical sexual programmes depends more on the technical factor of transference however. During the analysis of the unconscious conflicts, the old anxieties and desires of the past become centred on the person of the analyst. This fact makes for a re-living in the present of old forgotten material.

By this means, a 'here-and-now' situation is fostered in which the patient is able to work-through painful affects, frustrated desires and over-whelming drives which threatened the self and the object in the past, and which continue to do so in the present in an unconscious symbolic way. Thus, any participation in the active directing of the patient's sexual behaviour may be reacted to unconsciously in a manner similarly to the past when the patient experiences untoward controls. The analyst tries to avoid any technical attitudes which may be used unconsciously by the patient in the service of a negative therapeutic reaction. That is to say, an apparent acquiescence with the demands and progress of the treatment, but which produces no essential changes.

Time-limited therapy may produce limited results because there has been insufficient opportunity for the working-through of old attitudes and feelings and their ramifications. Because analysis of whatever type always proceeds against the manifestation of resistances by the patient, the therapist must accept that interferences with desire may only be freed after repeated working over of the same material, seen in slightly different context and not put off by the patient's avowal that they have no more to say on the matter. This is particularly important when it comes to the verbalization of hostility. Sex therapists may be surprised at the storminess inherent in the analysis of disorders of desire. Analysts would find it remarkable if this were not so.

Snippets of interest concerning psycho-dynamic descriptions of therapeutic experience being discovered by sex therapists are increasing. For example, sex therapists now suffer from counter-transference problems in their own sexual behaviour, as might be expected unless they receive special training in psychodynamically examining their own sexual attitudes. Martindale, as reported at the IV World Congress of Sexology, Mexico (Eicher, 1980), revealed in one questionnaire study that "ten per cent of those (therapists) who worked with a co-therapist had a sexual relationship with the co-therapist starting after the beginning of co-therapy". Whether this is good or bad is not as yet scientifically decided! "Another 11.8 per cent had major problems in their private relationships as a result of co-therapy". It was concluded that "a clear majority of therapists were dissatisfied with the teaching of the dynamic aspects of sexual dysfunction and dissatisfied with 'behavioural' techniques". Also "that clients have personalities, emotions and relationships". Sex therapists now discuss "resistances", (Munjack and Oziel, 1978), but these are mostly clarified according to situational factors in therapy rather than as of unconscious origin. The resistance of 'positive reinforcement' is now equated with 'secondary gain', but there is a clear and valid reason to avoid unconscious factors as these will bring transference resistances more into play, which sex therapists are not qualified to interpret adequately.

In practice what counts is whether the expertise exists in the therapist for the clinical needs of the patient. Unfortunately shortage of trained psychotherapists and the costs of training and treatment, whether within the NHS or privately, are factors influencing availability. What is significant clinically is not so much *what* is said by a sex-behavioural or psycho-therapist but the ability to listen to the patient and to understand their communications and render them intelligible in a rational integrated way to the patient, approximating the patient's inner awareness of truth. Unconscious determinants require interpretation in the same manner.

Where patients have fixed aspects of sexual behaviour which do not respond to analytic interpretation, there is nothing to deter the patient being referred for specialized training by behavioural methods. Similarly, it is usual for behaviour and sex therapists to refer patients for more advanced transference techniques where the resistances offered are obviously beyond the scope of the practitioner.

From the point of view of the patient and the initial source of reference, which is usually the general practitioner, it is in the best interests of both to refer to the most suitable therapist from the outset. Everybody has their preconceived notions and preferences in this regard, but some general practitioners may feel the need for expert psychiatric opinion, and the task of choice of therapist may then fall to the psychiatrist.

If a full psychiatric history on the Maudsley level is reckoned at six hours, what is there to be said for a full psychiatric and sexual assessment in a single consultation? Fortunately it is usually possible to

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recognize the type of problem and the level of qualitative and quantitative work required at initial consultation. If not, the psychiatrist should not hestiate to make further consultations to fulfil the assessment criteria. If the problem appears too difficult or complex, or the resistances too strong to even detect the psychological defences properly, advice should be sought from more experienced consultants in the field thought most appropriate.

Clinical Syndromes

Non-specific manifestations of sexual dysfunction

Probably the commonest sexual disorders never reach the level of seeking for help. These consist of a sexuality bounded by vague feelings of guilt, shame or disgust at the notions or impulses towards certain sexual practices. Such normal reaction-formations in the personality arise spontaneously at the age of five to eight years of age and later form part of acceptable social attitudes which help to self-govern infantile sexual impulses, and in particular assist in modifying masturbatory urges. However, such attitudes in one partner may be unacceptable to the other, whose preferred mode of arousal may include touching, showing, looking, kissing or licking genital or anatomical regions, which arouse resistances in the other to the point of refusal or resentment. Reaction-formations such as disgust which were formed in childhood may require to be re-assessed from the point of view of adult sexuality and notions of current social norms. Conversely it may be required to point out that some sexual demands are based on infantile experiences of gratification or defence, and that it is not particularly possible for the responding partner to acquiesce in such behaviour without doing violence to their own systems of self-valuation and natural defensive processes. Without the therapist having to take sides, the issues can be decided by reference to childhood versus adult meaningfulness and personality processes, and their interaction within a couple. The alleviation of guilt, shame and disgust leads to a diminution of sexual fears, anxieties and inhibitions in all cases by whatever techniques of verbal understanding through free discussion and education.

Masturbation guilt used to be designated a diagnosis in its own right some years ago, but now it is usually assessed as part of sexual development. Genital masturbation occurs in four well-defined phases. In the first year of life the genitals are discovered and handled as part of general bodily exploration. During the second year of life there is an early phallic awareness during the anal phase, and writers like Greenacre (1979) attribute later pathological castration manifestations when the child is exposed to threats of bodily damage at this early age. The phallic phase proper, from the age of four to six years, is when genital strivings and conscious masturbatory behaviour are at their height during infancy. A latent period lasting until puberty with lowered but not absent sexual feelings allows for curiosity about the world to be satisfied by learning. Puberty denotes the capacity for masturbation with genital orgasm. Faulty sexual knowledge in adolescents and adults is at times not so much the result of lack of education but is due to the inhibition of sexual curiosity and the impairment of learning due to infantile sexual conflicts. In another group are many of the emotionally immature young girls who fall pregnant though fully possessing adequate sexual education, and whose orgastic capacity is not yet established, but who use sexuality for self-esteem purposes.

Sexual education in a way which offers the individual information on sexual physiology, psychology and some resolution of their conscious infantile conflicts is vital for healthy development, but still an unconsummated wish devoutly to be desired.

Adolescent masturbation recapitulates in unconscious fantasy the earlier infantile sexual conflict. The associated guilt may not be about the practice itself but the unconscious fantasies which are oedipal in origin, or may refer to other family members, brothers or sisters in fantasy or reality. These guilts may later be transferred to adult sexuality or marital partners, and lead to inhibition and guilt.

Masturbation history and infantile sexual experience should always be enquired for as part of the sexual history in terms of attitude, fantasy, and the presence of strong reaction formations of guilt, shame, disgust or anxiety. The presence of actual sexual traumas in childhood and later should be explored for their effect on fantasy and conflict, particularly where children feel themselves to be the cause of whatever befalls them, or they may harbour resentment about otherwise loved parents or responsible adults who have failed to protect them. Infantile sexual traumas are pernicious occurrences beyond morality, because they may lead not only to increased personality defences which inhibit adult sexuality, but also to conflicts based on the unconscious wish to repeat the trauma in order to resolve properly the excessive stimuli. All the above non-specific factors may underly specific sexual dysfunctions. These are as follows:

Specific sexual dysfunctions

These may be simply classified as follows:

(1) *Disorders of male sexual desire*
Primary and secondary male impotence.

(2) *Disorders of male sexual orgasm*
Premature ejaculation.

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Lack of sexual pleasure during orgasm.
Ejaculatio retarda.

(3) *Disorders of female sexual desire*

(4) *Disorders of female orgastic capacity*
Primary and secondary.

In both sexes, sexual dysfunctions may be classified according to disorders of desire or of orgastic competence. No specific psychopathology exists for these disorders. Predisposing, precipitating and maintenance factors must be explored. Patients may of course react similarly in a homosexual situation.

Males: Disorders of desire

Primary impotence: Where successful heterosexual intercourse has never taken place due to lack of erection.

Secondary impotence: Where previously successful or apparently satisfactory intercourse is now interfered with due to failure of erection.

The predisposing factors in primary as well as secondary male impotence must be considered from a developmental point of view. Genital functioning and the genital organs have become sensitized in the patient's mind as a target for damage. Such castration fantasies may derive from threats or actual bodily damage during the phases of greatest phallic awareness and masturbation. Acting in concert with such fears of castration are fantasies that intercourse or the female sexual organs are dangerous, based on infantile sexual experiences or fantasies. Childhood exposure to adult intercourse, menstruation or physically damaging sights may result in later psychosexual disorders (Greenacre, 1979; Rosen, I., 1979a).

Hostility against the female, conscious and unconscious, is invariable in male impotence. However, it cannot be said to be the cause of the condition. Unconscious repressed hostility may have arisen from a host of causes, including the defensive attitude of guarding against loving which is perceived as overwhelming or the loved one being in danger of being lost after attainment. The complexity of underlying psychopathology in male impotence, makes perfunctory nonsense of Kilmann and Auerbach (1979) assessment of Depth Therapies. In a review of the literature they suggest future investigators 'examine the impact of treatment on homogenous samples and conduct controlled comparisons of different treatment methods'. Such asking for the moon is better suited to space-research, than inquiring into human inner strivings.

Apart from elucidating the unconscious fantasy material together with the repressed affects, the progress of psychotherapeutic treatment of male impotence contains some noteworthy aspects. This clinical account must necessarily be sketchy in a symposium presentation of this kind. Patients require initial and repeated reassurance based on observable clinical physical examination that there is nothing wrong with their genital apparatus beyond an interference with function. Requests for pills and physical treatment for potency are expressions of resistance.

Because of the symbolic nature of the symptoms of impotence, any material pertaining to masculine functioning and identification may be used to resolve the underlying conflicts and fears of lack of success. The presenting symptom of anxiety about performance becomes reduced, and growing success in work and social life is used to reinforce the self-determination to resolve deeper fears. Therapeutic omnipotence or nihilism should be avoided. Psychotherapy implies the therapist's expectation for change (Greben, 1981). That the therapist must work hard to achieve change is essential in treatment of sexual dysfunction.

Young males with externally derived inhibitions gain confidence in courtship and sexual prowess step by step with encouragement and the strong positive transference which develops. Among the factors making for therapeutic success is that of an unconscious communicative interaction between patient and therapist (Langs, 1981). Correct assessment of the treatment possibilities for the patient, and the correct handling of the therapeutic situation are therefore essential for a beneficial therapeutic relationship and positive outcome for the patient.

Impotence resulting mainly from internalized conflicts require much working through of material, but the gains in erectile capacity accrue in almost magical dimensions as early sexual and aggressive fantasies and the defences against them are resolved. There is not necessarily a one-to-one relationship between removal of cause and evidence of gain in potency. Often there are layers of defensive psychopathology which require analysing, such as guilt arising from current sexual failures, earlier adolescent masturbation practices and fantasies, homosexual fears and conflicts, rivalry in reality or on an oedipal basis with the father, castration fears based on actual physical threats in childhood, conflicts over close loving relationships with the mother and evidence of being frustrated by the mother at crucial periods of development.

The precipitating factor in the formation of the symptom of male erectile impotence is often some external happening which alters the balance of self-esteem based on the patient's sense of masculinity. Thus one man who had been dominated like his father by an authoritative passive-dependent mother, married a woman who used her religious affiliation to dominate their sexual lives and who was otherwise quite emotionally dependent on the patient. In his

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business life he was active and successful, and he was a pillar of the community. After his wife's death he fell in love with a woman who determined to free him from his need to serve others. She went too far in describing him vehemently as a workaholic, and this disturbed his balance of self-esteem. His sexual life had never been satisfactory but adequate, but now he became impotent, depressed and his work suffered. In therapy this happy, friendly, outgoing man soon recognized a long-standing antipathy against all women, together with a fear of involvement emotionally. The impotence expressed his conflicts in a body-language way; punished his sexual partner and protected her against possible damage simultaneously. Denial was the prominent defence employed against affects, while he referred to his penis as 'he' in the third person, as a split-off part, not quite integrated with his sense of self. The integration of the various denied and split-off and repressed parts of the self during therapy is what promotes an increase in available libido, which fused with aggressive strivings in a neutral safe manner, leads to the experience of normal desire and the spontaneous attainment of erection. Self-esteem is enhanced and its balance rests on stronger more integrated, less fragile, determinants. For an account of normal development of self-esteem and its regulation by sexual deviation, see Rosen (1979b).

Disorders of male orgasm

Premature ejaculation is often the result of faulty earlier masturbation practices together with fears of being overwhelmed by sexual excitement, and fears of the symbolic significance of intercourse as a merging experience. Such men have a concentration of their libidinal interest invested on the penis itself. This is technically known in psychoanalysis as a high cathexis of the penis with libido. In psychotherapy, the highly charged emotional and sensual investment of the penis becomes lessened and the emotional and libidinal pleasure becomes more widely spread to involve the patient's own body and the emotional relationship with the female partner as a whole person.

In the context of a loving relationship, brief methods of retraining such as the Semans squeeze technique (1956) may prove valuable between understanding sympathetic partners (see Singer, 1970). However, psychosexual maturation through psychodynamic procedures should be added for the most satisfactory result, especially as premature ejaculation may derive from anxiety between the partners (Salzman, 1972) as cited by Singer (1974) p 338.

Ejaculation retarda is where the male fails to have an orgasm given ordinary sufficient female orgastic response. Such cases are difficult and complicated to treat and relate to early developmental conflicts of bodily control which may link with other symptoms such as prolonged enuresis in childhood. The solution lies in resolving the early control conflicts, or as advised by behaviour therapists, in teaching new methods of masturbation. Difficulties in letting go may be based on a lowered sexual arousal, but where other psychosomatic elements are simultaneously present, adequate subjective relief may not be possible without deep individual transference-therapy.

An early case treated by behaviour therapists is instructive. At the Maudsley in the mid-1950's I treated a young man who suffered from nocturnal enuresis and ejaculatio retarda. After months of weekly psychotherapy his enuresis was reduced from nightly to once a fortnight. The ejaculatio retarda still gratified his lady friend, but was unchanged. Ending this tour of clinical duty, I thought he might be finally transformed by the newly arrived behaviour therapy. After months of behaviour therapy, my now distinguished colleague, Professor Gwynne Jones, reported sadly that as the patient only wet the bed once a fortnight he was beyond conditioning, but proudly confided that he had been taught a new method of masturbation. The ejaculatio retarda remained—as a tribute to the need for prolonged analytical treatment of his unconscious conflicts of control.

Factors which maintain sexual dysfunctions are often due to irreconcilable reality difficulties between partners. The breaking of old relationships, or the fear of bonding with new partners, cannot be tolerated by many individuals, and arouse anxiety. The sexual symptom may be a way of preserving family or relationship ties by avoiding new sexual and emotional intimacy. Patients may decide that they prefer to keep their symptoms, and they must be allowed to resist or break treatment. Preferably, such decisions and their consequences should be understood, but such insights may also be intolerable.

Female sexual dysfunctions

Disorders of female orgastic capacity

All sexually mature humans deserve the right to experience sexual orgasm. The nature and quality of orgasm in the female still constitutes one of the most controversial and unresolved areas of modern female psychology. For reasons of brevity I refer readers to current psychoanalytic viewpoints on female sexuality: *Female Psychology* (Blum, 1976), *Female Sexuality* (Panel discussion, 1968), Sherfey (1972), Chasseguet-Smirgel (1976), Moore (1976); *Female Orgasm*, Fisher (1973).

It would be correct to say Freud never denied the

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capacity for clitoral orgasm. He was concerned to discover how vaginal orgasm developed as a maturational capacity. Physiologists may deny the presence of the vaginal orgasm and maintain that all female orgasm is clitoral in origin. Nevertheless it remains a fact that there is a qualitative experiential difference between vaginal heterosexual intercourse and clitoral masturation. It has been on this point of difference that the analysts have taken issue with Masters and Johnson and their followers. Whatever the physiological differences in these two experiences, it remains an undisputed fact that there is a wide variation in the psychological degree to which the sense of self may be attached and expressed in different qualities of orgasm. In Freudian psychology, the quality of female as well as male orgasm depends on several factors apart from the relative absence of conflict and anxiety. These are the quantity of libido or desire drive with which the genitals and the whole body is invested; the investment of emotional interest one partner has for the other, in other words, how much love is present; the involvement of the sense of self in the actual bodily experience and the meaningfulness of the sexual act with the person concerned. Psychoanalytical techniques aim to enhance or restore these qualities. In contrast, the teaching of masturbatory techniques now constitutes one of the mainstays of sex therapy for female orgastic incompetence.

With regard to primary versus secondary orgastic dysfunction in women, a review of the literature by Kilmann (1978) reveals that it is possible to teach women masturbatory techniques by various methods to a high percentage of positive gain of orgastic ability. Secondary non-orgastic women seem to reflect more marital discord and psychopathology than primary non-orgasmic women, who show a lesser response to masturbatory training and a higher need for treatment of their anxiety in relationships with their partners.

Conclusion

Sex therapy is being subjected to more critical scrutiny by psychiatrists. As Wilson (1980) insists, "there is reason to be sceptical about the widely advertised success of behavioural therapy techniques. Although patients report being pleased with therapy and gaining substantial benefit, objective behavioural and physiological measures reveal that no real change in their sexual arousability or performance had taken place—a girl's chances of orgasm are much more strongly connected with who she *is* than what she *does*". I agree. In my clinical experience, gain of, and enhancement of, female sexual orgasm is always associated with improvement in the sense of self based on the acquisition of adequate bodily cathexis and a feminine identity free of conflict. This area remains, however, one of the most difficult in which to attain the highest levels of quality of orgastic life. Is this the reason for the theory that genetic influences largely determine orgastic capacity? More research is needed.

Simply put, the therapeutic tasks do not vary depending on the sexes. Dysfunctions of desire require the removal of inhibitions and anxieties based on conflict. Disorders of orgasm require that libidinal cathexis of the genitals be established so that sufficient arousal can occur for orgasm. Quality of orgasm depends on the involvement of the self and the emotions in a meaningful way.

The psychiatrists' task may be to discover and provide directly or by referral the most appropriate therapy for sexual dysfunctions. A working-knowledge of psycho-dynamics is an essential ingredient for understanding and treatment.

A wide range of individual or group psychotherapy exists, and should be selected for the patient's needs. If necessary, a linking of psychodynamic and behavioural methods may be indicated.

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