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SYMPOSIUM ON SEXUAL DYSFUNCTION

The Behavioural Treatment of Sexual Dysfunction

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The past 12 years have witnessed the establishment of behavioural methods of treating sexual problems based on the principles developed by Masters and Johnson (1970). Such methods, with some modifications, have proved to be well suited to the needs of our health service (Bancroft, 1975). It is an expedient time to take stock with regard to the current situation in this field, particularly the extent to which treatment facilities are meeting patients' needs, the type of methods being used, and how successful they are. In view of the rapid developments that have occurred in sex therapy it is also appropriate to consider what are now the oustanding clinical and research needs in this area.

Much of the work described in this paper is based on a sexual dysfunction clinic in a university department of psychiatry. The behavioural approach to treatment is largely typical of that used in other such clinics. After considering the extent of the need for sex therapy and the types of patients referred for treatment, the behavioural treatment of couples will be described. Subsequently the ways in which individuals without partners can be helped will be discussed. Finally, after briefly reviewing some of the adjuncts that have been used in treatment, the current clinical and research needs in this field will be considered.

Prevalence of sexual dysfunction

The precise extent to which problems of sexual dysfunction are prevalent in the general population is not known. If a survey were mounted to determine such prevalence, account would have to be taken of the difficulty of defining norms, which is always a doubtful exercise when sexual behaviour is under consideration, and of the extent to which individuals both regarded themselves as having sexual problems and of wanting help with them. The last point is the more relevant in terms of clinical practice.

Nevertheless, some attempts have been made to estimate the prevalence of sexual difficulties. Masters and Johnson (1970) made the surprising claim that 50 per cent of American marriages were affected by sexual problems. A study by Frank *et al* (1978) of 100 'normal' American couples provided evidence to substantiate this claim. However, the method of selection of their couples casts doubts on whether they were really representative of the general population. Estimates of the prevalence of sexual dysfunction in this country have been largely confined to circumscribed groups of patients presenting in medical clinics. Begg *et al* (1976) found on the basis of an interview study that one in ten women presenting in a family planning clinic had a sexual problem and wanted help with it. Twenty one per cent of men and 29 per cent of women presenting in a clinic for sexually transmitted diseases recognized themselves as having a sexual dysfunction, and virtually all of them would have liked help (Catalan *et al*, 1981). In a survey of newly referred, married, psychiatric out-patients, not referred primarily for sexual or marital difficulties, Swan and Wilson (1979) found that approximately 11 per cent had sexual or marital problems for which help could be provided.

A further guide to the need for sex therapy has been the fact that clinicians who have established sexual dysfunction clinics have usually had the experience of being inundated with referrals, leading to considerable delays before assessments and treatment can be carried out. Thus whatever the precise prevalence of sexual problems in the general population, there is clearly a considerable need for a clinical service.

Before describing the approach used in a clinic for the treatment of sexual dysfunction, it is important to note that the provisions made by the Health Service for such clinics are extremely limited. In some areas there are no facilities for the treatment of sexual problems. The low priority given to this work is questionable, especially in view of the likely contribution of sexual problems to marital disharmony (Frank *et al*, 1976), the consequences for the children of such marriages (Stuart, 1980), and the escalation in the divorce rate.

Source and nature of referrals to a sexual dysfunction clinic

The pattern of referrals to the clinic described here was previously reported for the three year period 1973–1975 by Bancroft and Coles (1976). During the next four years, referrals of couples and individuals

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were received from general practitioners (58 per cent), psychiatrists (19 per cent), gynaecologists (10 per cent) and a variety of other sources including family planning clinics, counselling services and social agencies (13 per cent). Some patients do not keep their initial appointment, although the number in this category has been reduced considerably by the introduction of a system whereby patients are required to provide, by a specified date, confirmation of attendance or else the appointment is automatically cancelled and offered to someone else.

All referrals are assessed by psychiatrists. This is simply a function of the setting of the clinic. It is questionable whether some form of psychiatric assessment is necessary in sexual dysfunction clinics. However, the small group of patients who have sexual problems as a consequence of, or in association with psychiatric illness suggests that in any sexual dysfunction clinic, whatever its setting, there should be easy access to psychiatric expertise. More importantly, in view of the high prevalence of organic disorders among patients referred with sexual dysfunction (Spark *et al*, 1980), is ready access to medical assessment.

In a series of 289 consecutive assessments, the sexual problems identified for the presenting partner or individual were as follows: *Women* (N = 152 or 53 per cent of the total): general unresponsiveness 51 per cent; orgasmic dysfunction 24 per cent; vaginismus 17 per cent; dyspareunia 3 per cent; and miscellaneous 5 per cent. *Men* (N = 137 or 47 per cent of the total): erectile impotence 53 per cent; premature ejaculation 15 per cent; ejaculatory failure 7 per cent; low libido 7 per cent; and miscellaneous (including sexual variations) 19 per cent.

Approximately two-thirds of the couples and individual patients who are assessed are taken on for sex therapy. Of the rest, some are not suitable for treatment (e.g. because of lack of motivation), a few are referred for marital therapy, others turn down the offer of treatment, and some require treatment for physical or psychiatric conditions. In addition, several patients simply require the kind of advice which can be given during the initial interview, and a few others are referred for an opinion only.

Although the majority of referrals are of couples, individuals without partners are also seen and help can be provided for many of them.

The management of couples with sexual dysfunction

The general approach to the management of sexual problems of couples will now be described. Subsequently the results of such treatment will be presented and the factors which determine outcome discussed.

Assessment

Each couple is thoroughly assessed before being offered treatment. At this stage the partners are interviewed separately. The main purposes of this assessment are the detailed clarification of the nature of the presenting problem(s), assessment of both long-standing and recent causes, and identification of factors which maintain the difficulty (including physical as well as psychological factors). In addition, assessment is made of the type of change that the partners hope to achieve as well as the motivation for treatment shown by each of them. Where indicated, a physical examination is carried out and hormonal (e.g. testosterone, gonadotrophins, prolactin) or other investigations (e.g. fasting blood glucose) arranged.

It is important to recognize that in many couples, both partners have problems. This was the case in 36 out of 100 couples offered sex therapy. Usually the partners' problems were inter-related. The most frequent association (39 per cent) was between female general unresponsiveness and premature ejaculation, both in cases where the female partner presented and in those where the male partner presented. For eight out of ten men who presented with premature ejaculation, their partners had a sexual problem and in six cases this was general unresponsiveness. Erectile impotence and vaginismus were less often associated with dysfunction in both partners.

Formulation

Before being given the initial treatment instructions, the couple is provided with a brief formulation concerning the nature of the problem(s) and the background variables, precipitants, and maintaining factors that may have led to the development of the problem and caused it to persist. The formulation is intended to give the couple a further understanding of their difficulty, to provide a rational basis for the treatment approach, and to provide the couple with a sense of optimism.

Treatment approach

Although treatment is highly eclectic, the principle components are behavioural task assignment, counselling and education.

Behavioural task assignment

A modified version of the Masters and Johnson (1970) approach constitutes the behavioural framework. This has two purposes. The first is to provide a method for the gradual establishment of a satisfactory sexual relationship. The second is to assist in the precise identification of factors that are contributing to the couple's difficulties. Thus, a gradu-

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ated series of tasks is provided, each of which has clearly defined limits. This allows the couple to tackle the problem one step at a time, frequently experiencing immediate success in the process and without feeling the pressure they faced before referral when attempting to overcome the problem as a whole. The stages are similar to those described by Masters and Johnson (1970), and include non-genital sensate focus, genital sensate focus and gradual progression to full sexual intercourse via the intermediate stage of containment.

Specific techniques are used to tackle certain dysfunctions such as the stop-start (Semans, 1956) or squeeze technique (Masters and Johnson, 1970) for premature ejaculation, finger exploration of the vagina by both partners for vaginismus, and masturbation exercises for orgasmic failure in the woman (LoPiccolo and Lobitz, 1972) or ejaculatory failure in the man (Masters and Johnson, 1970). In addition, in order to improve communication between partners, specific guidelines are provided to enable them to express their sexual needs and fears, and to help each learn how best to provide the other with sexual stimulation. For a more detailed description of the behavioural aspects of treatment the reader is referred to Jehu (1979).

Counselling

A therapist who approaches treatment with the belief that sex therapy only consists of a series of behavioural tasks will in most cases achieve disappointing results. Behavioural task assignment enables the rapid identification of causal factors, especially those that are maintaining the problem. At some stage during treatment almost every couple will encounter a block to progress. It is then that the therapist must assist the couple, by means of counselling, to identify the attitudes, beliefs or misunderstandings which prevent progress. Bringing such factors out into the open may be sufficient to enable progress to continue. However, usually it is not and the therapist has to provide further counselling to help the couple over the block. Although the components of this type of counselling still require precise elucidation, they would appear to include the following:

(a) helping the partners re-consider attitudes that they hold and have perhaps never questioned (e.g. that sexual activity should always be the prerogative of the male partner, with the woman playing a passive role; or, that a particular form of sexual behaviour is 'wrong'; or, that successful sex always leads to orgasm). The therapist must be careful not to impose values on patients, but should try to assist them to re-evaluate attitudes which are clearly obstructing progress towards their chosen goals.

(b) confronting patients with any discrepancy between their stated aims and their actual behaviour. For example, a couple may insist that they are keen to overcome their difficulties and repeatedly state their intention to carry out agreed tasks but then return week after week having made little or no attempt to do what was suggested.

(c) encouraging a couple to try out a new behaviour which they had not previously thought of, or regarded as taboo, but which is likely to help overcome their difficulty. Here the therapist is often playing a 'permission-giving' role.

(d) giving reassurance (e.g. concerning progress so far, or the fact that the couple will not be asked to proceed at a faster pace than they can tolerate).

(e) self-disclosure by the therapist. Limited self-disclosure concerning the therapist's experience can be helpful, particularly with regard to patients of the same sex. Clearly this tactic can only be used with a great deal of care and forethought.

After the reasons for a block to progress have been fully evaluated, it may become apparent that the task assigned to a couple is too much for them to manage at the present time and that it must be broken down into smaller steps.

Education

Many couples referred for treatment are poorly informed about sexuality. This lack of knowledge, or misinformation, often contributes directly to the sexual problem. One session early in treatment is therefore devoted to the provision of information concerning sexual anatomy and response; drawings and photographs are especially useful in this respect. Particular attention is paid to dispelling myths which often contribute to sexual problems (Zilbergeld, 1979). In addition, most couples are asked to read a suitable book, such as Delvin's (1976) *Book of Love*, which will provide them with sensible and accurate information.

General relationship problems

Many couple's sexual difficulties are closely linked to problems in their general relationship and the latter will often have to be dealt with before progress can occur in the sexual sphere (Lansky and Davenport, 1975). The approach involved in such marital therapy is usually based on the same principles as sex therapy, with emphasis on improving communication and carrying out mutually agreed tasks (Crowe, 1978; Stuart, 1980). Most couples offered sex therapy have been selected on the basis that their sexual difficulties are primary, and are not symptoms of general marital disharmony (such cases are referred for marital counselling). Consequently the therapist only gets

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involved in marital therapy insofar as it seems necessary in order to resolve a couple's sexual problem.

Frequency of treatment sessions

Couples are generally seen on a weekly basis. This seems to be in keeping with both the pace at which most couples wish to work and therapists' other commitments. However a couple may be seen more frequently if they encounter particular difficulties during treatment. Sessions are usually spaced out more towards the end of treatment when a couple will, hopefully, be consolidating on the progress made. All couples are offered a follow-up appointment three months after the end of the treatment period.

Therapists

Most therapists work individually. This is because there is no evidence that co-therapy is significantly better than individual therapy (Mathews *et al*, 1976; Barkla, 1977; Crowe *et al*, 1981). However, sometimes a male and female therapist work as a co-therapy team in order to broaden their experience, or to allow an experienced therapist to teach a less experienced one.

Therapists come from several professional groups, including psychiatry, psychology, general practice, social work, marriage guidance, family planning and nursing. Most couples are treated by trainee therapists who attend weekly training groups (Hawton, 1980a). Using the same approach, it has proved possible to train enthusiastic medical students to carry out effective treatment.

Results of treatment

Although proper evaluation of treatment can only be provided by comparative studies, systematic assessment of outcome is carried out on most couples who have received sex therapy in the clinic. Apart from providing an informative overall view of how effective the work is, it also helps the individual therapist to critically evaluate his or her own programme.

Of 100 couples offered sex therapy, 70 completed treatment, 20 dropped out, and in ten cases treatment was terminated by the therapist due to lack of progress. Those who completed treatment had a mean number of 14 treatment sessions (range 7–37), including the initial session of assessment.

The therapists made general outcome ratings for all the couples at the end of treatment and, for those who attended, at the three month follow-up (Table). It seems that approximately two-thirds of couples gain substantial benefits from treatment, which persist in most cases at least until the three month follow-up. The overall results for female and male problems are similar and are in keeping with those previously reported from Oxford (Bancroft and Coles, 1976) and from elsewhere in this country (Duddle, 1975; Milne, 1976). The results are particularly good for vaginismus and erectile impotence.

Determinants of outcome

There is a paucity of information about which types of couples are likely to be helped by sex therapy and those who will respond poorly. The presence of psychiatric disorder in either partner often seems to be one indication of poor prognosis (Myer *et al*, 1975; Lanskey and Davenport, 1975). Similarly, the outcome is unlikely to be good if there is evidence of extensive general marital disharmony (Mathews *et al*, 1976; McGovern *et al*, 1975; Fordney-Settlage, 1975). It is understandable that outcome is also related to the extent to which partners find each other 'sexually attractive' (Whitehead and Mathews, 1977).

Although vaginismus nearly always responds well to therapy (Masters and Johnson, 1970; Duddle, 1977), for other sexual problems it appears that the specific type of disorder is less important in determining outcome than the nature of a couple's general relationship. Problems which develop in the context of a serious deterioration in a couple's general relationship are likely to do badly, usually because the partners have lost affection for each other. Unfortunately this sometimes does not come to light during the initial assessment, but only later when the couple are unable to carry out their tasks.

In addition to the lack of difference in effectiveness between single therapists and co-therapists (Mathews *et al*, 1976; Barkla, 1977; Crowe *et al*, 1981), there seems to be no interactive therapeutic effect between the sex of therapist and that of the presenting partner (Crowe *et al*, 1981). Clinical experience suggests that therapists who consistently obtain good results are those who are systematic and adhere as far as possible to the therapeutic programme outlined earlier.

Treatment of patients without partners

One of the most important developments in sex therapy since Masters and Johnson (1970) first introduced their treatment approach for couples has concerned the treatment of the individual patient who either currently does not have a partner, or whose partner refuses to be involved in therapy. This has been developed most extensively for helping women who are unable to achieve orgasm. LoPiccolo and Lobitz (1972) introduced a directed masturbation programme which consists of a graduated series of exercises through which patients are helped firstly to become comfortable with their own genitalia, secondly, to improve tone in the pelvic musculature through the use of Kegel's (1952) exercises, thirdly, to locate and

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TABLE

Outcome of treatment according to problem of presenting partner (%)

Problem	End of treatment				Three month follow-up				
	Presenting problem resolved/ largely resolved	Some improvement but problem largely unresolved	No change	Worse	Presenting problem resolved/ largely resolved	Some improvement but problem largely unresolved	No change	Worse	Not known
Females									
General unresponsiveness (N = 35)	22 (63)	4 (11)	9 (26)	0	18 (51)	5 (14)	3 (9)	1 (3)	8 (23)
Vaginismus (N = 14)	11 (79)	0	3 (21)	0	9 (64)	0	1 (7)	0	4 (29)
Orgasmic dysfunction (N = 5)	3 (60)	1 (20)	1 (20)	0	3 (60)	2 (40)	0	0	0
Other (N = 6)	2 (33)	3 (50)	0	1 (17)	1 (17)	3 (50)	0	2 (33)	0
Total (N = 60)	38 (63)	8 (13)	13 (22)	1 (2)	31 (52)	10 (17)	4 (7)	3 (5)	12 (20)
Males									
Erectile impotence (N = 26)	21 (81)	1 (4)	4 (15)	0	18 (69)	2 (8)	0	0	6 (23)
Premature ejaculation (N = 10)	6 (60)	2 (20)	2 (20)	0	6 (60)	0	1 (10)	0	3 (30)
Ejaculatory failure (N = 3)	0	1 (33)	2 (67)	0	0	0	0	0	3 (100)
Other (N = 1)	1	0	0	0	1	0	0	0	0
Total (N = 40)	28 (70)	4 (10)	8 (20)	0	25 (63)	2 (5)	1 (3)	0	12 (30)
Both sexes									
Total (N = 100)	66 (66)	12 (12)	21 (21)	1 (1)	56 (56)	12 (12)	5 (5)	3 (3)	24 (24)

stimulate sensitive genital areas and, finally, to become orgasmic through masturbation. A woman may be encouraged to use sexual fantasies or read erotic material in order to enhance arousal, and where difficulty is still experienced in achieving orgasm this is usually possible with the assistance of a vibrator. When orgasm can be obtained through masturbation, the woman is encouraged to show her partner how to stimulate her effectively. The results with this approach are good (Lobitz and LoPiccolo, 1972; Kohlenberg, 1974). It can be successfully incorporated into a conjoint treatment programme for couples (Munjack *et al*, 1976; Riley and Riley, 1978).

The use of directed masturbation has been developed further in the treatment of women in groups (Barbach, 1974). This is an extremely economical approach, each group consisting of between five and seven women and two female co-therapists who meet for ten occasions on a weekly or twice weekly basis. Group treatment may have particular advantages because of the sharing of problems and mutual encouragement that occurs. In Oxford a success rate of 60 per cent has been obtained using such treatment.

Therapeutic approaches have also been developed for men without partners. Thus it is possible to offer help for premature ejaculation, erectile impotence, and ejaculatory failure, through a programme in which suggestions are made concerning prolongation of masturbation, the use of fantasy, and, for premature ejaculation, the stop-start technique (Semans, 1956). Individuals with such problems have been treated elsewhere in groups with considerable success (Zilbergeld, 1975; Lobitz and Baker, 1979).

Adjuncts to treatment

Written material

There is no doubt that reading material can greatly assist in the treatment of sexual problems. As already mentioned, it can be used to provide information for patients with inadequate knowledge about sexuality. Secondly, self-instruction material may be a useful adjunct to treatment. Thus in a study by Zeiss (1978), instruction manual combined with limited therapist contact proved successful in the treatment of couples in which the male partners had premature ejaculation. Mathews *et al* (1976) found that postal instructions combined with monthly contact with a therapist were successful in the treatment of some couples with sexual dysfunction although not as effective as a more orthodox Masters and Johnson approach. Thirdly, some patients may respond to self-help written material alone. In the investigation of couples where the men had premature ejaculation, Zeiss (1978) found that totally self-administered treatment was not successful. However, McMullen and Rosen (1979) reported that treatment by written material alone proved highly effective for individual women with primary orgasmic dysfunction. Finally, erotic reading material may help facilitate sexual arousal for an individual patient or couple where difficulty in becoming aroused is contributing to the sexual problem (Gillan and Gillan, 1976).

Mechanical aids

The usefulness of vibrators in the treatment of orgasmic dysfunction has already been mentioned. Although there is a large range of other 'sexual aids' on the market (Rhodes, 1980), they appear to have little or no role in the treatment of sexual dysfunctions in the able-bodied. However, some aids are certainly of help for disabled patients (Hamilton, 1980).

Hormones

The role of hormonal treatments in the management of sexual dysfunction remains extremely uncertain. This largely reflects the currently rudimentary understanding of how sex hormones influence sexual interest and performance, and of the role of hormonal abnormalities in the aetiology of sexual problems. Rarely does testosterone administration improve erectile impotence (Cooper *et al*, 1973; Benkert *et al*, 1979) except where hypogonadism is marked (Skakkebaek *et al*, 1980). Bromocriptine treatment is useful for the rare case of erectile impotence secondary to hyperprolactinaemia (Thorner and Besser, 1977).

The use of androgens in small doses in the treatment of female unresponsiveness has recently attracted attention (Carney *et al*, 1978). Unfortunately androgens have not proved very effective in clinical practice. This is an area which requires further investigation.

Research and clinical needs

Since Masters and Johnson (1970) revolutionized the treatment of sexual dysfunction more than a decade ago, there have been considerable further developments in sex therapy (Hawton, 1980b). However, this is a field in which clinical developments tend to be rather too far ahead of research work, with the result that there are several important gaps where systematic investigation is required to provide a firmer basis for the current widespread clinical enthusiasm. There are nevertheless some areas for further clinical development. Among such research and clinical needs the following seem to be particularly important:

(a) more information is required to enable treatment to be tailored to patients' needs. Some patients

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only require very brief treatment, including problem definition, advice, reassurance, permission-giving and educational procedures (Annon, 1974). As has already been noted, others seem to respond well to self-help treatment described in the form of manuals, or to this combined with brief contact with a therapist. Many patients seem to require more intensive treatment. At present there is little information to guide the clinician about which sorts of patients are likely to respond to each approach.

(b) information is needed about the characteristics of couples or individuals which are predictive of outcome of treatment. Couples who do badly often receive prolonged treatment. If such couples could be identified early then considerable therapeutic time would be saved.

(c) much more information is required concerning the hormonal basis of sexual interest and performance, and the interaction between hormonal and psychological factors in both the causation and treatment of sexual problems. Such information should lead to more effective hormonal treatments, possibly in combination with psychological treatment.

(d) patients with sexual problems associated with physical disorders, such as diabetes and multiple sclerosis, can often be helped a great deal by counselling, and the therapeutic strategies described above. Clinicians need to become more aware that such patients can often be helped to adapt to their sexual difficulties and continue their sexual relationships.

(e) we remain relatively ignorant about the long-term durability of gains from sex therapy, and the extent to which couples who do badly with treatment eventually manage to overcome their difficulties. Good maintenance of treatment gains after a five year follow-up was reported by Masters and Johnson (1970). No major difference was found by Crowe *et al* (1981) between post-treatment and one-year follow-up results of therapy of couples with a range of sexual problems. However, an investigation by Levine and Agle (1978) suggested that in the case of erectile impotence the outcome after only one year may be considerably worse than at the end of treatment. Systematic studies of long-term outcome of sex therapy are clearly required to substantiate the widespread enthusiasm for our current clinical approach to the management of sexual problems.

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