Treating sexual dysfunction in general practice

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SUMMARY. A method of training general practitioners in the treatment of sexual dysfunction is described, using fortnightly seminars at which the doctors discussed the continuing care of their patients.

Doctors took on patients presenting in their practices and treated couples together, where possible, using a mixture of insight-directed and behavioural techniques similar to those used by Masters and Johnson (1970). Interviews were reported back to the group which gave advice and support. The doctors, all beginners in this type of work, were able to help substantially 72 per cent of 47 couples treated.

Introduction

The treatment of sexual dysfunction has in recent years been accepted as an important part of the service offered by general practitioners, and training for this kind of work is now included in the curriculum at many medical schools. Unhappily, few established principals have had any training in this work, and many have difficulty in giving effective advice to the increasing number of patients approaching them for such help.

Several general practitioners in the North-western region began two years ago to attend fortnightly seminars to discuss patients with sexual problems. The seminars were organised in the same way as those begun in London for the Family Planning Association about 15 years ago, first by Balint, and later by Main, the results of which have been reported by several authors (Friedman, 1962; Courtney, 1968; Tunnadine, 1970). In addition to the Balint approach emphasising the importance of the doctor-patient relationship, the seminars discussed the application of the Masters and Johnson behavioural techniques and investigated the feasibility of treating patients with these difficulties in the setting of general practice.

Method

There were initially two seminars of 12 doctors, but after the first year a number dropped out and the two seminars amalgamated into one of 11 with an average attendance of nine. The group met fortnightly during term time between October and May, and the meetings lasted two hours. Each doctor agreed to take on and treat a few couples from his or her own practice and report the interviews back to the group.

Cases were presented and discussed and on a number of occasions films demonstrating interview techniques were shown. Videotapes of couples during treatment with one of us (M.D.) were also shown. These were found to be much more helpful than simple verbal description of what went on in treatment sessions. As members gradually got to know each other, they were able to point out blind spots and begin to understand and use the doctor-patient relationship as a diagnostic and therapeutic tool.

Gradually ways were explored of using the behavioural methods of Masters and

Johnson in general practice. Usually the presenting partner was seen in a normal surgery and an appointment made for a longer assessment interview at which both partners were seen at first separately and then as a couple. This would usually take 30 to 50 minutes. Afterwards the couples attended together for weekly interviews which might last from five to 15 minutes. Few patients were seen more than six times.

At the assessment interviews the sensate focus technique was described, the patients being asked to refrain from intercourse and set aside three half-hourly periods when they could be warm and private. During these periods they were asked to experiment with stimulating each other using manual or oral techniques, whichever they preferred, taking it in turns to do the pleasuring. They were encouraged to voice their feelings, telling the partner which areas and which methods of stimulation pleased them. Usually stimulation of erogenous zones was forbidden, for at least the first week, then on the second visit this might be allowed, but an embargo placed on any definite attempt to produce orgasm or ejaculation. Gradually thereafter the techniques described by Masters and Johnson (1970) for the specific types of dysfunction were added.

The following is a brief description of the methods used.

Impotence

When impotence was the main problem, the wife was encouraged to stimulate her partner to erection and repeat this after erection had subsided on a number of occasions, thus giving her partner confidence that the erection could be produced again.

Premature ejaculation

Premature ejaculators were helped to gain control by using the Semans technique, the woman stimulating the man until he was aware of the feeling of inevitable ejaculation approaching. At this moment stimulation was stopped to prevent ejaculation, if necessary using the squeeze technique—firm pressure on the end of the penis with thumb on the frenulum and fingers on the opposite coronal ridge—to reinforce the inhibition. After repeating this two or three times ejaculation was allowed to proceed.

General sexual dysfunction

In cases of general sexual dysfunction in the female the partner was encouraged to provide more adequate stimulation first of non-sexual and later of erogenous areas.

Female superior position

In all cases the next step suggested was the female superior position, with the woman kneeling on top, but with no attempt at movement, giving the dysfunctional male confidence that the penis will stay erect in the vagina, and the dysfunctional woman a chance to recognise this as a pleasurable experience in itself. Movement was then encouraged, first of the female and then of both, but no actual directives to attempt intercourse were ever given, since these immediately raise the anxiety levels.

Treatment of the cases of non-consummation was similar, but where vaginismus was the main problem the woman was encouraged to dilate herself, to use tampons in menstruation, and when she was reasonably confident of the degree of dilation, she was encouraged to try the female superior position using the penis as a dilator.

Some patients found the female superior position difficult and unnatural and they were then encouraged to try a side-by-side position facing each other with one partner half on their back and with legs entwined. They usually were able to work out some variant of this position acceptable to themselves.

At each visit the couple were encouraged to report in detail how they had acted

and felt, and specific instructions for the following week were given. Frequently problems connected with the total marital relationship were uncovered and discussed, but the emphasis was directed as far as possible at treatment of the specific sexual difficulties.

Results

Seventy-five couples were seen by 19 doctors. The presenting partner was male in 26 cases and female in 49 cases.

Some of these patients presented with sexual activities which were essentially normal, but were causing anxiety; the patients were seeking reassurance and responded to one interview. Others presented with sexual problems which would not respond to the techniques under discussion, and although their cases were studied to increase the group's own basic knowledge, there was no attempt at treatment by the general practitioner. These included homosexuality, cross-sexuality, and transvestism and are not included in the table.

Forty-seven patients were discussed in greater detail and accepted for treatment, the results being reported back to the group at intervals. The main diagnoses and outcome are shown in the table.

Orgasmic dysfunction in the female is used to denote a specific inability to achieve orgasm with normal desire for and enjoyment of intercourse, whereas general sexual dysfunction denotes disturbances in these other areas, and the patients may or may not be orgasmic. These are the definitions suggested by Kaplan (1974).

TABLE 1
RESULTS OF TREATMENT

Main diagnosis	*Improved*	*No change*	*Total number of couples*
General sexual dysfunction	12	2	14
Impotence	4	4	8
Non-consummation	7	1	8
Dyspareunia	5	1	6
Premature ejaculation	3	2	5
Orgasmic dysfunction	2	2	4
Retarded ejaculation	1	1	2
Totals	34	13	47

Criteria of success

Thirty-four couples were improved, the results varying from couple to couple, but being acceptable to both partners. In the case of an impotent male this might mean that although occasionally he still lost his erection, both partners were more relaxed and on most occasions intercourse could take place normally. In the case of premature ejaculation, enough control had been achieved to make it possible to carry on intercourse for a reasonable time, acceptable to both partners. In retarded ejaculation, ejaculation into the vagina was achieved on most occasions. In general sexual dysfunction the woman was able to enjoy intercourse, although not necessarily orgasmic, but where the main problem was failure of orgasm they were only counted as improved when actually orgasmic on most occasions.

Success in non-consummation was accepted when the marriage was consummated and intercourse enjoyable, although the woman had not always achieved orgasm. Dyspareunia was accepted as cured when most acts of intercourse were free from pain.

Failure to respond

Thirteen couples did not respond. Of these, two couples presented as a token just before separation, which they had previously agreed on; four partners refused to co-operate in treatment; one had a definitely proven organic lesion; one patient wished to be treated with his girl friend (although still living with his wife), a situation the general practitioner treating the couple felt he could not accept. Five were lost to follow up: two of these were complaining of impotence, one of premature ejaculation, one of ejaculatory failure and one of non-consummation. Of these the patient with non-consummation, the premature ejaculator, and one impotent patient probably defaulted because the partner refused to co-operate, and another patient with impotence moved from the area. The case of retarded ejaculation was associated with a spinal tumour, and although he still attended the surgery because of this, he refused to discuss any further the sexual problem.

Discussion

In the past, few general practitioners have taken a special interest in treating sexual dysfunction, and most patients presenting with these problems have been referred to psychiatric or gynaecological outpatient departments. Treatment there has been divided into three types: firstly, the physical treatment of any obvious lesion and the use of drug therapy for the dysfunction; secondly, treatment by analysis or psychotherapy; and thirdly, treatment using behavioural techniques.

Some therapists have seen only the presenting partner, and others both in the analytical and behavioural fields have seen couples together (Dicks, 1967; Masters and Johnson, 1970). Undoubtedly, the best results have been reported by Masters and Johnson, who see couples together, using a careful medical and psychological screening process, and treat them behaviourally.

Most of the couples reported in the seminars were seen together in an effort to increase communicaton between them. They were asked to carry out a series of behavioural techniques similar to those used by Masters and Johnson (1970), but instead of their intensive fortnight's treatment course this was reduced to a weekly interview in a general practitioner's consulting room, one therapist only being used, backed, of course, by advice from the group.

Great difficulties are always encountered in this type of work in finding a time when patients and therapists can attend regularly, but this may be easier in the more flexible general-practice setting than in hospital clinics. Another advantage in general practice is the ease of follow-up, although occasionally members felt that some patients disappeared from therapy and were then reluctant to see them at all, possibly consulting one of their partners afterwards for non-sexual problems.

The diagnoses listed in the table were not necessarily the presenting complaints, some patients coming with various physical symptoms in the first instance and only volunteering the sexual problems when given the chance to talk and, indeed, often only as the interview was terminating. As the doctors became more alert to these problems, they were able to detect slight cues offered by patients and some discovered a much greater incidence of sexual difficulty than had previously been apparent in their practices.

However, when they became over-enthusiastic and dragged symptoms from patients who were not really complaining of them, they often found the patients reluctant to accept help, and indeed not returning to treatment sessions arranged for them.

Results were surprisingly good, especially considering that all the general practitioners were beginners in this type of therapy and had few of the facilities of the special dysfunction clinics. Seventy-two per cent of cases taken on improved their relationship. In the past, doctors attending the seminar would have given these patients reassurance

and superficial advice only, or referred them elsewhere for help—referral they might well have been reluctant to accept.

Undoubtedly this type of treatment is time-consuming, but where the problem was presented as primarily sexual, occurring in the context of a reasonable total marital relationship, most doctors found that after the initial assessment interviews the behavioural techniques used could be presented in a number of weekly five or ten minute interviews. However, when the doctor was seduced into allowing long discussion of the general relationship and lost sight of the active behavioural techniques, treatment tended to be long drawn out and results unsatisfactory. Indeed, in some cases the sexual component was merely the presenting symptom of a more fundamental problem in the marital relationship, producing resistances in treatment, and many of these cases had to be passed on for specialist therapy because of the need for greater skill than most of the general practitioners possessed, and because of the time required.

Value of physical examination

There was some discussion of the need to use medically qualified people in the treatment of these cases, and undoubtedly some could have been helped by trained non-medical staff. However, we felt that doctors have a valuable asset in their ability to carry out physical examinations as part of treatment. Giving an impotent man the assurance that his genital apparatus is normal is a valuable beginning to persuading him of the psychological nature of the problem, without which belief effective therapy is difficult to start.

With the sexually dysfunctional woman it is even more important to be able to do a vaginal examination; quite apart from the reassurance of normality, many women appear able to bring out deep underlying fears and fantasies while it is being carried out (Tunnadine, 1970). In cases of vaginismus it seems particularly important that the therapist can also examine the patient, even though examination be no more than inserting the tip of the finger. The dramatic clamping together of the thighs can then be discussed and used as an illustration of the shutting down of the vagina by the patient. If necessary, the doctor can help the patient to insert dilators which she and her husband can use later in their own home.

Although general practitioners must in the future have sufficient knowledge to be able to recognise these problems, not all will wish to take them on for treatment, and it seems appropriate for a few doctors to specialise in sexual dysfunction, perhaps in addition to contraceptive and subfertility work with, ideally, one such doctor in each group practice. These doctors could also form a trained pool from which to staff special sexual dysfunction clinics for patients who need more time than the average general practitioner can give, or who would prefer not to discuss their problems with someone they will have to see again (Duddle, 1975).

The members of the seminar felt that they gained in several ways by regular meetings. Firstly, they were soon able to overcome the initial embarrassment still felt by most of the members of our society when discussing sexual problems. Secondly, they were able to enlarge their knowledge of sexual norms by discussion with others, and thirdly, were able to share the anxiety felt by most people when beginning this type of work. Many of them felt at first they would be quite unable to help these cases which in the past they had shied away from treating, and they needed a good deal of group support to carry on if they did not immediately achieve success.

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REFERENCES

Courtenay, M. (1968). *Sexual discord in marriage.* London: Tavistock Publications.
Dicks, H. V. (1967). *Marital Tensions.* London: Routledge and Kegan Paul.
Duddle, C. M. (1975). *British Journal of Psychiatry*, **127**, 169–170.
Friedman, L. J. (1962). *Virgin Wives.* London: Tavistock Publications.
Kaplan, H. S. (1974). *The New Sex Therapy.* London: Baillière Tindall.
Masters, W. H. & Johnson, V. E. (1970). *Human Sexual Inadequacy.* London: Churchill.
Tunnadine, L. P. D. (1970). *Contraception and Sexual Life.* London: Tavistock Publications.

GENERAL PRACTICE IN CANADA

The general practitioners, feeling the pressure, metamorphosed into family doctors, developed a hopefully prestigious college of their own, and lobbied for departments of family medicine in the teaching centres and in the large community hospitals. One beloved euphemist in the wild west advertised to the public that he was a " general specialist ".

As a result, general practice, particularly out of hospitals, is now more than holding its own. As always, the reasons are economic. Firstly, the public, tired of being bounced from specialist to specialist, demanded an entry into the health care system through their very own family doctor. Secondly, the provincial fee schedules were manipulated to make general practice fiscally rewarding as well as just hard work. The schedules were also altered to pay consulting fees only for work referred by family doctors, thus discouraging the specialists from providing direct personal service " off the street ".

REFERENCE

Banks, P. J. (1976). *British Medical Journal*, **1**, 702.

WOMEN IN MEDICINE

As the proportion of women entering the medical profession has been rising in Western countries, it has now reached nearly 40 per cent in Britain and will reach 50 per cent by the 1980s if current trends continue. We are still, however, a long way from the female domination of medicine found in the Union of Soviet Socialist Republics and some other communist states.

In the past far too many women doctors have dropped out of medicine within a few years of qualification in order to look after their husbands and children, and relatively few ever return to full-time work. If this pattern were to persist, its cost to society would soon rise with the rising number of women doctors and soon become unacceptably high. . .

'. . . One of the National Health Service's unsolved problems is the disparity between the numbers of training posts needed in the hospital service and the numbers needed to staff the junior grades. Part of the solution could come from more and better use of the pool of medical women willing to work part-time. The recent legislation about equal opportunity gives an impression of politically motivated window-dressing rather than real reform. What is wanted in the National Health Service is practical provision for the needs of women who wish to combine medicine with marriage without damage to the standards of either'.

REFERENCE

British Medical Journal (1976). Editorial, **1**, 56.