The “Sexual Dysfunction Treatment” on Men

Sexual dysfunction treatment

In any approach to a psycho-physiological process, treatment concepts vary measurably from school to school and, similarly, from individual therapist to individual therapist. The Reproductive Biology Research Foundation's theoretical approaches to the treatment of men and women distressed by some form of sexual dysfunction have altered significantly and, hopefully, have matured measurably during the past 11 years. There are founded on a combination of 15 years of laboratory experimentation and 11 years of clinical trial and error.

Sexual response

When the laboratory program for the investigation in human sexual functioning was designed in 1954, permission to constitute the program was granted upon a research premise which stated categorically that the greatest handicap to successful treatment of sexual inadequacy was a lack of reliable physiological information in the area of human sexual response.

It was presumed that definitive laboratory effort would develop material of clinical consequence. This material in turn could be used by professionals in the field to improve methodology of therapeutic approach to sexual inadequacy. On this premise, a clinic for the treatment of human sexual dysfunction was established at Washington University School of Medicine in 1959, approximately five years after the physiological investigation was begun. The clinical treatment program was transferred to the Reproductive Biology Research Foundation in 1964.

When any new area of clinical investigation is constituted, standards must be devised in the hope of establishing some means of control over clinical experimentation. And so it was with the new program designed to treat sexual dysfunction. Supported by almost five years of prior laboratory investigation, fundamental clinical principles were established at the onset of the therapeutic program. The original treatment concepts still exist, even more strongly constituted today. As expected, there were obvious theoretical misconceptions in some areas, so alterations in Foundation's policy inevitably have developed with experience.

Sexual therapy

A basic premise of therapeutic approach originally introduced, and fully supported over the years by laboratory evidence, is the concept that there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy.

Therapeutic technique emphasizing a one-to-one patient-therapist relationship, effective in treatment of many other psychopathological entities, is grossly handicapped when dealing specifically with male or female sexual inadequacy, if the sexually dysfunctional man or woman is married. Isolating a husband or wife in therapy from his or her partner not only denies the

concept that both partners are involved in the sexual inadequacy with which their marital relationship is contending, but also ignores the fundamental fact that sexual response represents (either symbolically or in reality) interaction between people. The sexual partner ultimately is the crucial factor.

If treatment is directed separately toward the obviously dysfunctional partner in a marriage, the theoretically "uninvolved" partner may actually destroy or negate much therapeutic effort, initially from lack of knowledge and understanding and finally from frustration.

Sexual Response

If there is little or no information of sexual import, or for that matter, of total treatment progress reaches the wife of the impotent husband, she is in a sincere quandary as to the most effective means of dealing with the ongoing marital relationship while her husband is in therapy. She does not know when, or if, or how, or under what circumstances to make sexual advances, or whether she should make advances at all. Would it be better to be simply a "good wife," available to her husband's expression of sexual intent, or on occasion should she take the sexual initiative.

During actual sexual functioning should she maintain a completely passive, a somewhat active, or a mutually participating role? None of these questions, all of which inevitably arise in the mind of any intelligent woman contending with the multiple anxieties and the performance fears of an impotent husband, find answers in the inevitable communication void that develops between wife and husband when one is isolated as a participant in therapy.

Of course, an identical situation develops when the wife is non orgasmic and enters psychotherapy for constitution of effective sexual function. It is the husband that does not know when, or if, or how, or under what circumstances to approach her sexually.

If he approaches his wife in a physically demanding manner, she reasonably might accuse him of prejudicing therapeutic progress. If he delays or even restrains expression of his sexual interest, possibly looking for some signal that may or may not be forthcoming, or hoping for stone manner of behavioural guideline, he may be accused of having lost interest in or of having no real concern for his sexually handicapped wife.

Not infrequently he also is accused (probably with justification) of being a significant contributor to his wife's sexual dysfunction. But if no professional effort is made to explain his mistakes or to educate him in the area of female sexual responsivity, how does he remove this continuing road block to his wife's effective sexual function?

Methods of therapy using isolation techniques when approaching clinical problems of sexual dysfunction attempt to treat the sexually dysfunctional man or woman by ignoring half of the problem, the involved partner. These patient-isolation techniques have obliterated what little communication remained in the sexually inadequate couple at least as often as the

techniques have returned effective sexual functioning to the distressed male or female partner.

It should be emphasized that the Foundation's basic premise of therapy insists that, although both husband and wife in a sexually dysfunctional marriage are treated, the marital relationship is considered as the patient. Probably this concept is best expressed in the statement that sexual dysfunction is indeed a husband and wife problem, certainly never only a wife's or only a husband's personal concern.

Dual Sex Therapy

Definitive laboratory experience supports the concept that a more successful clinical approach to problems of sexual dysfunction can be made by dual-sex teams of therapists than by an individual male or female therapist.

Certainly, controlled laboratory experimentation in human sexual physiology has supported unequivocally the initial investigative premise that no man will ever fully understand woman's sexual function or dysfunction. What he does learn, he learns by personal observation and exposure, repute, or report, but if he is at all objective he will never be secure in his concepts because he can never experience orgasm as a woman. The exact converse applies to any woman.

Since it soon became apparent in the laboratory that each investigator needed an interpreter to appreciate the sexual responsivity of the opposite sex, it was arbitrarily decided that the most theoretically effective approach to treatment of human sexual dysfunction was to include a member of each sex in a therapy team. This same premise applied in the clinical study provides husband and wife of a sexually dysfunctional couple each with a friend in court as well as an interpreter when participating in the program.

By repute, report, observation, and by personal exposure in and out of bed, she too learns to conceptualize male sexual functioning and dysfunctioning, but she will never fully understand the basics of male sexual responsivity, because she will never experience ejaculatory demand or seminal fluid release.

For example, it helps immeasurably for a distressed, relatively inarticulate, or emotionally unstable wife to have available a female cotherapist to interpret what she is saying and, far more important, even what she is attempting unsuccessfully to express to the uncomprehending husband and often to the male cotherapist as well.

Conversely, it is inevitably simpler for any wife to understand the concerns, the fears, the apprehensions, and the cultural pressures that beset the sexually inadequate man that is her husband when these grave concerns can be defined simply, effectively, and unapologetically to her by the male cotherapist. The Foundation's therapeutic approach is based firmly upon a program of education for each member of the dysfunctional couple.

Multiple treatment sessions are devoted to explanations of sexual functioning with

concentration on both psychological and physiological ramifications of sexual responsivity. Inevitably, the educational process is more effectively absorbed if the dual-sex therapy teams function as translators to make certain that no misunderstandings develop due to emotional or sexual language barriers.

Sex therapist

If there are to be dual-sex therapy teams, what roles do the individual cotherapists play? What guidelines do they follow? What therapeutic procedures ensue? What should be their qualifications as professionals in this sensitive, emotionally charged area? These are all pertinent questions, and, as would be expected, in some cases they are difficult to answer.

The major responsibility of each cotherapist assigned to a husband and wife problem is to evaluate in depth, translate for, and represent fairly the member of the distressed couple of the same sex. This concept should not be taken to suggest that verbal or directive interaction is limited to wife and female cotherapist or to husband and male cotherapist far from it. The interpreter role does not constitute the total contribution an individual cotherapist makes in accepting the major responsibility of sex-linked representation. The male cotherapist can provide much information pertaining to male-oriented sexual function for the wife of the distressed couple; and equally important, female-oriented material is best expressed by the female cotherapist for benefit of the husband.

Acute awareness of the two-to-one situation frequently develops when a sexually distressed couple sees a single counsellor for sexual dysfunction.

For example, if the therapist is male and there is criticism indicated for or direction to be given to the wife, the two-to-one opposition may become overpowering.

Who is to interpret for or explain to the wife matters of female sexual connotation? Where does she develop confidence in therapeutic material she cannot express her concepts adequately to the two males in the room?

Exactly the same problem occurs if the therapist is female and contending with a sexually dysfunctional couple. Who interprets for or to the husband?

Dual Sex Team

Avoids the potential therapeutic disadvantage of interpreting patient complaint on the basis of male or female bias. Experience has established a recognizable pattern in the various phases of response by a female patient to questioning by a male cotherapist.

As a rough rule of thumb, unless the distress is most intense, the wife can be expected to tell her male therapist first what she wants him to know; second, what she thinks he wants to know or can understand; and not until a third, ultimately persuasive attempt has been made can she consistently be relied upon to present material as it is or as it really appears to her.

With the female cotherapist in the room, although the wife may be replying directly to interrogation of the male cotherapist.

During the first exposure to questioning she routinely is careful to present material as she sees it or as she believes it to be, for she knows she is being monitored by a member of her own sex. The inference, of course, is that "it takes one to know one." The "presence" usually is quite sufficient to remove a major degree of persiflage from patient communication.

When the sexually dysfunctional male patient is interviewed by a female therapist, it is extremely difficult to elicit reliable material, for cultural influence inevitably will prevail. Many times the male tells it as he would like to believe it is, rather than as it is.

Sexual dysfunction and male ego

His ego is indeed a fragile thing when viewed under the spotlight of untempered female interrogation. Not infrequently his performance fears, his anxieties, and his hostilities are magnified in the face of his concept of a prejudiced two-to-one relationship in therapy, when he presumes that his wife has the advantage of the therapist's sexual identity.

The participation of both sexes contributes a "reality factor" to therapeutic procedure in yet another way. It lessens the need for enactment of social ritual designed to gain the attention of the opposite-sex therapist, an unnecessary diversion which often produces biased material in its effort to impress.

These hazards of interrogation and interpersonal misinterpretations can be bypassed through use of the dual-sex team. Certainly, during history-taking there is a session devoted to male cotherapist interrogation of the wife and female cotherapist interrogation of the husband, but in each instance within the method there is built-in protection to avoid the previously mentioned pitfalls.

First

The husband has had an extensive discussion with the male cotherapist the previous day (as has the wife with the female cotherapist); thus, the pattern for same-sex confrontation and information interchange has already been introduced, concomitantly establishing greater reliability of reporting.

Second

Both members of the sexually disturbed couple are aware that four persons are committed to a common therapeutic goal and that all parties will be brought together the next day for the roundtable discussion. Hence, any tendency of the patient to provide the cotherapist with inaccurate clinical material in the opposite-sex interrogative session usually is curbed in advance by the dual-sex team environment and the previously described progression of the treatment program.

Equal partner representation in a problem of sexual dysfunction is a particularly difficult

concept to accept for those patients previously exposed to other forms of psychotherapy. When either partner has been accustomed to being the principal focus of therapy, he or she finds it strange indeed that neither partner holds this position. Rather it is their interpersonal relationship within the context of the marriage that is held in focus.

An additional fortunate therapeutic return from the presence of both sexes within the therapy team is in the area of clinical concern for transference. There always is transference from patient to therapist as a figure of authority. There is no desire to avoid this influence in the therapeutic program, but, beyond both patients' and therapists' need to establish the authority figure, every effort is made in the brief two-week acute phase of the therapy program to avoid development of a special affinity between either patient and either cotherapist .

Instead of generating emotional currents, especially those with sexual connotation, from one side of the desk to the other, the therapeutic team is intensely interested in stimulating the flow of emotional and sexual awareness between husband and wife and encourages this response at every opportunity.

For example, if the team were to observe the wife becoming intensely attentive to the male cotherapist, directing all questions to him, accepting or even prompting answers only from him, in short, replacing the husband with the cotherapist as the male figure of the moment. The team would take steps to counteract this distracting, potentially husband-alienating trend.

The male cotherapist would begin to direct questions only to the husband, and all material pertinent to the wife (even including basic information pertaining to male sexual response) would be presented by the female member of the team until it was obvious that the wife's incipient tendency to establish special interpersonal communication with the male cotherapist had been counterbalanced by team intervention. Attempted recruitment of special rapport with the female cotherapist by the husband is handled in a similar manner.

To create further emotional trauma for either sexually insecure marital partner by encouraging or accepting such alignment, however deliberately or naively proffered, is not only professionally irresponsible, but also can be devastating to therapeutic results.

It cannot be emphasized too vigorously that the techniques of transference, so effective in attacking many of the major psychotherapeutic problems over the years, are not being criticized. The Foundation is entirely supportive of the proper usage of these techniques as effective therapeutic tools.

However, from the start of the clinical program, the Foundation has taken the specific position that the therapeutic techniques of transference have no place in the acute two-week attempt to reverse the symptoms of sexual dysfunction and establish, re-establish, or improve the channels of communication between husband and wife.

Anything that distracts from positive exchange between husband and wife during their

time in therapy is the responsibility of the therapeutic team to identify and immediately nullify or negate.

Positive transference of sexual orientation can be and frequently is a severe deterrent to effective reconstitution of interpersonal communication for members of a couple, particularly when they are contending with a problem of sexual dysfunction.

Sex therapeutic procedures

In therapeutic procedure involving the dual-sex teams, the control within the team rests primarily with the silent cotherapist during treatment sessions. The silent cotherapist is literally in charge of each therapeutic session. He or she, as the observer, is watching for and evaluating levels of patient receptivity to therapeutic concept and to the educative and directive material presented by the active cotherapist.

The silent cotherapist's role is to define, if possible, degrees of understanding, acceptance, or rejection of material and to identify immediate areas of concern in either member of the dysfunctional couple.

The silent observer really acts as the coach of the team. As soon as it is apparent that there is need for a situational change of pace, that the individual subject under discussion can be presented in a different, possibly more acceptable or understandable manner, or that it requires further clarification, the roles reverse and the cotherapist functioning previously as the observer, fortified and advantaged with the salient features of patient reaction to the on going situation, becomes the active discussant.

The previous discussant then assumes the role of observer. And so roles change back and forth as indicated by patient responses or the immediate need for a particular sex-linked definition or explanation of material. Much of the patient's reaction can be identified by the observer that cannot be immediately apparent to any individual therapist simultaneously attempting to direct therapy and to evaluate levels of patient receptivity.

In the finite cooperative interaction between mutually confident cotherapists in any dual-sex therapy team, the currently dominant partner influence at any particular time is not being exercised by the one that is talking, but by the one that is observing.

Inevitably any sexually dysfunctional couple has, as one of its fundamental handicaps, insecurity in any and all sexual matters.

- How often have the sexual partners asked themselves if they are really "complete" as individuals?
- Has their functional efficiency been diminished in stressful situations other than in bed?
- How do their patterns of sexual response compare to those of their peers?

- How can a particular sexual situation or any confrontation with material of sexual content be handled without awkwardness or embarrassment?

The cotherapists encounter a multiplicity of these problems to which they can respond by holding up a professional "mirror" and helping the marital partners understand what it reflects. With the non-judgemental mirror available, constructive criticism can be accepted in the same non-prejudiced, comfortable manner in which it must be presented.

With this educational technique of reflective teaching, the distressed couple can be encouraged to take that first step that ultimately presages success in therapy for sexual dysfunction. The step consists of putting sex back into its natural context.

Seemingly, many cultures and certainly many religions have risen and fallen on their interpretation or misinterpretation of one basic physiological fact. Sexual functioning is a natural physiological process, yet it has a unique facility that no other natural physiological process, such as respiratory, bladder, or bowel function, can imitate.

Sexual responsivity can be delayed indefinitely or functionally denied for a lifetime. No other basic physiological process can claim such male ability of physical expression.

With the advantage of this unique characteristic, sexual functioning can be easily removed from its natural context as a basic physiological response. Everyone takes advantage of this characteristic every day as he rejects or defers untimely or inappropriate sexual stimuli in order to comply with the social requirements of the moment.

Religions have found dedicated support from those willing to sacrifice their functional physical expression of sexuality as a devotion to or an appeasement for their god or gods. If the natural physiological process of human sexual response did not encompass this completely unique adaptability, the sacrifice of denying one's sexual functioning for a lifetime could never have been made.

But the individuals who involuntarily take sexual functioning further out of context than any other are those members of couples contending with inadequacy of sexual function. Through their fears of performance (the fear of failing sexually), their emotional and mental involvement in the sexual activity they share with their partner is essentially nonexistent.

The thought (an awareness of personally valued sexual stimuli) and the action are totally dissociated by reason of the individual's involuntary assumption of a spectator's role during active sexual participation.

It is the active responsibility of therapy team members to describe in detail the psychosocial background of performance fears and "spectator" roles. This explanation is best accomplished by the cotherapist of the same sex as that of the individual whose performance fears are to be discussed. Again, education is the basis for therapeutic success, and the

dual-sex team can best present this information by following a sex-linked guideline.

Impotent and sexual performance

Regardless of the particular form of sexual inadequacy with which both members of the couple are contending.

Fears of sexual performance are of major concern to both partners in the marital bed.

The impotent male's fears of performance can be described in somewhat general terms. With each opportunity for sexual connection, the immediate and overpowering concern is whether or not he will be able to achieve an erection. Will he be capable of ¡ºperforming¡± as a ¡ºnormal¡± man? He is constantly concerned not only with achieving but also with maintaining an erection of quality sufficient for intromission

His fears of sexual performance are of such paramount import that in giving credence to or even directing overt attention to his fears, he is pulling sexual functioning completely out of context. Actually, the impotent man is gravely concerned about functional failure of a physical response which is not only naturally occurring, but in many phases involuntary in development.

To oversimplify, it is his concern which discourages the natural occurrence of erection. Attainment of an erection is something over which he has absolutely no voluntary control. No man can will, wish, or demand an erection, but he can relax and allow the sexual stimulation inherent in erotic involvement with his marital partner to activate his psycho-physiological responsivity. Many men contending with fears for sexual function have distorted this basic natural response pattern to such an extent that they literally break out in cold sweat as they approach sexual opportunity.

Impotence

Not only does the husband contend with fears of performance when impotence is the clinically presenting complaint, but the wife has her fears of performance as well. Her constant concern is that when her husband is given adequate opportunity for sexual expression, he will be unable to achieve and/or maintain an erection. She has grave fears for his ability to perform under the stress of the psychosocial pressure which both partners have unwittingly contrived to place upon this natural physical function.

Additionally, wives of impotent men are terrified that something they do will create anxiety, or embarrass, or anger their husbands. All of these crippling tensions in the marital relationship are gross evidence that two people are contending with sexual functioning unwittingly drawn completely out of context as a natural physical function by their fears of performance.

An exactly parallel situation can be a factor in female sexual inadequacy. Fifty years ago in this country the non orgasmic woman was led (or under the pressure of propriety, forced) to believe that sexual responsivity was not really her privilege. Sexual pleasure was considered

an unnatural physical response pattern for women, and any admission of its occurrence was unseemly to say the least.

The popular magazines, with their constant consideration of the subject, have brought to the non orgasmic female a realization that in truth she is a naturally functional sexual entity.

Unfortunately they have also provided her with real fears of performance by depicting, often with questionable realism, the sexual goals of effectively responsive women.

Sexual stimuli

Her frequently verbalized anxieties when she does not respond to the level of orgasm (at least a certain percentage of time) are: "What is wrong with me? Am I less than a woman? I certainly must be physically unappealing to my husband," and so on. These grave self-doubts and usually groundless suspicions are translated into fears of performance.

It should be restated that fear of inadequacy is the greatest known deterrent to effective sexual functioning, simply because it so completely distracts' the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner.

Therapy concepts place major emphasis on the necessity for familiarizing the marital partner of a dysfunctional patient with details of the fear component. There must always be real awareness of the fears of performance by the marital partner attempting to support his or her mate in the distress of sexual inadequacy.

The husband of the non orgasmic woman may well have his own fears of performance. He worries about why he, as a sexually functional male, cannot give her the "gift" of response. Why is his wife non responsive to his sexual approaches? What really is wrong when he cannot satisfy her sexual needs?

The husband's fear of performance when dealing with a non orgasmic wife reflects anxieties directed as much toward his own sexual prowess as to his wife's inability to accomplish relief of sexual tensions. It is the influence of our culture, expressed in the demand that he "do something" in sexual performance, that gives the man responsibility for the woman's sexual effectiveness as well as his own.

If his wife is non orgasmic, more times than not he worries about his inadequate performance rather than lending himself with personal pleasure to the mutual sexual involvement that would lead to release of his wife from her dysfunctional status. Together, these frightened people manage to take not only sexual functioning from its natural context, but also keep it in its unnaturally displaced state indefinitely.

One of the most effective ways to avoid emphasizing the patient's fears of performance during any phase of the therapy program is to avoid all specific suggestion of goal oriented

sexual performance to the couple.

Regardless of the length or the intensity of the psycho therapeutic procedures, at some point the therapist usually turns to his or her patient and suggests that the individual should be about ready for a successful attempt at sexual functioning, immediately the fears of performance flood the psyche of the individual placed so specifically on the spot to achieve success by this authoritative suggestion.

Rarely is this suggestion taken as an indication of potential readiness for sexual function, as intended, but usually is interpreted as a specific direction for sexual activity. If there is a professional suggestion that "tonight's the night," the individual feels that he has been told by constituted authority that he must go all the way from A to Z, from onset of sexual stimulation to successful completion.

In many instances, regardless of the duration or effectiveness of the psychotherapeutic program, the fears of performance created by this authoritative suggestion for end point achievement are of such magnitude that sensate input is blocked firmly, and there will be no effective sexual performance regardless of the degree of motivation.

Removal of such goal-oriented concept, in any form or application, is necessary to secure effective return of sexual function. This can be achieved by moving the interacting partners, not the dysfunctional individual, on a step-by-step basis to mutually desirable sexual involvement.

Sexual Discussion

Four way verbal exchanges are maintained at an open, comfortable level during therapy. Communication is first developed across the desk between patients and cotherapists. Within a few days, verbal exchange is deliberately encouraged between patients.

The cotherapists are fully aware that their most important role in reversal of sexual dysfunction is that of catalyst to communication. Along with the opportunity to educate concomitantly exists the opportunity to encourage discussion between the marital partners wherein they can share and understand each other's needs.

If the therapy team functions well, its catalytic role in marital communication, which initially is of utmost importance, becomes a factor of progressively decreasing importance over the two week period. If the catalytic role is well played, the marital partners will be communicating with increasing facility at termination of the acute phase of therapy; by then communication between the marital partners should be well established.

Sexual intercourse

The ultimate level in couple communication is sexual intercourse. When there is couple complaint of sexual dysfunction, the primary source of absolute communication is interfered with or even destroyed and most other sources or means of interpersonal communication

rapidly tend to diminish in effectiveness.

Again, this loss of warmth and understanding is frequently due to fear and/or lack of comprehension on the part of either marital partner. The wife is afraid of embarrassing or angering her husband if she tries to discuss his sexually dysfunctional condition. The husband is concerned that his wife will dissolve in tears if he mentions her orgasmic inadequacy or asks for suggestions to improve his sexual approaches.

Usually the failure of communication in the bedroom extends rapidly to every other phase of the marriage. When there is no security or mutual representation in sexual exchange, there rarely is freedom of other forms of marital communication.

It should be made abundantly clear, in context, that Foundation philosophy does not reflect the concept that sexual functioning is the total of any marital relationship. It does contend, however, that very few marriages can exist as effective, complete, and ongoing entities without a comfortable component of sexual exchange. With detailed interchange of information, and with interpersonal rapport secured between marital partners, the dual-sex therapy team moves into direct treatment of the specific sexual inadequacy brought to its attention.

After roundtable discussion, the team anticipates that both partners in the distressed couple will have become reassured and relatively relaxed by the basic educational process and will have established a significant step toward effective communication. Treatment approaches to specific sexual dysfunctions will be discussed separately under appropriate headings in subsequent individual case.

Sexual Advice

From a professional point of view, formal training contributes little of positive value if a specific discipline is emphasized to a dominant degree in the treatment of sexual dysfunction. It is current foundation policy to pair representatives of the biological and behavioural disciplines into teams of cotherapists.

From a purely practical point of view, there is obvious advantage in having a qualified physician as a member of each team. This disciplinary inclusion avoids referring embarrassed or anxious couples to other sources for their vitally necessary physical examinations and laboratory (metabolic function) evaluations. The behavioural member provides invaluable clinical balance to each team with his or her particular contribution of psychosocial consciousness.

Many combinations of disciplines should and will be used experimentally as representative individuals are available, complying with the Foundation's basic concept of a member of each sex on each team.

The Foundation is constantly looking for professionals with the individual ability necessary

to work comfortably and effectively with people in the vulnerable area of sexual dysfunction. There must be an established research interest; this requirement is peculiar to the Foundation's total research program but is unnecessary for purely clinical programs.

There also must be an expressed interest in and demonstrated ability to teach, for so much of the therapy is but a simple direct educational process. Not a negligible requirement is the willingness to make a commitment to a seven day week or its equivalent.

Most important, the individual must be able to work in continual cooperation with a member of the opposite sex in what might be termed a single standard professional environment. Team dominance by virtue of sex-linked or discipline-linked status by either cotherapist would tend to dilute their mutual effectiveness in this particular psychotherapeutic design.

Finally, individual members of any dual sex therapy team, if they are to concentrate professionally on the distress of the couples complaining of sexual inadequacy, must be fully cognizant and understanding of their own sexual responsivity and be able to place it in perspective. They must be secure in their knowledge of the nature of sexual functioning, in addition to being stable and confident in their own sexuality, so that they can in turn be objective and unprejudiced when dealing with the controversial subject of sex at the fragile level of its dysfunctional state.

Many men and women who are neither personally secure in nor confidently knowledgeable of sexual functioning attempt the authoritative role in counseling for sexual inadequacy. There is no place in professional treatment of sexual dysfunction for the individual man or woman not culturally comfortable with the subject and personally confident and controlled in his or her own manner of sexual expression.

The possibility for disaster in a therapeutic program dealing with sexual dysfunction cannot be greater than when the therapist's sexual prejudices or lack of competence and objectivity in dealing with the physiology and psychology of sexual functioning become apparent to the individuals or couples depending upon therapeutic support.

If the therapist is in any way uncomfortable with the expression of his or her own sexual role, this discomfort or lack of confidence inevitably is projected to the patient, and the possibility of effective reversal of the couple's sexual dysfunction is markedly reduced or completely destroyed.

Sexual health

At onset of the program, couples were requested to devote three weeks of their time to the therapeutic program. This concept of time commitment was maintained for the first two years of this clinical research program.

Evaluation of sexual experience made clear that three weeks was simply too long for a couple's comfortable commitment of time away from home and, from the stand point of therapy demand also was an unnecessarily extended period. Therefore, the outer limit of time demand became two weeks and has remained so for the last nine years.

An important clinical contribution to effective therapy in sexual dysfunction can be made by scheduling husband and wife partners on a continuum; all units in the acute phase of the treatment program are seen daily (seven days a week) during their two weeks in the foundation's intensive educational program.

One of the therapeutic advantages inherent in the two-week phase of rapid education and/or symptom reversal is the isolation of the husband and wife partners from the demands of their everyday world.

Approximately 90 percent of all couples treated by the Foundation are referred from outside the St. Louis area. These people are regarded and treated as though they were guests. Every effort is made to insure their enjoyment of a "vacation" during time spent in the city.

Care is taken to familiarize them with the geographic area and supply up-to-date information regarding restaurants, areas of interest, amusement, educational potentials, etc.

Inevitably they rekindle, in part, their own communicative interests when there is no child crying, no secretary reminding of business commitments, or no relatives or friends inadvertently intruding. With this isolation from social demand, opportunity develops for closeness or a unity that almost always is missing between marital partners facing crises of sexual dysfunction.

This arbitrary social isolation certainly is an important factor supporting the effectiveness of the therapy program. Under these circumstances protected from outside pressures the marital partners frequently accept for the first time the Foundation's basic premise that "there is no such thing as an uninvolved partner in any marriage distressed by a complaint of sexual inadequacy."

Sexual Interest

Yet another advantage of the social-isolation factor is its effect upon the sexual interest of both marital partners. With the subject of sex exposed to daily consideration, sexual stimulation usually elevates rapidly and accrues to the total relationship. This specific psycho physiologieal support is indeed welcome to the cotherapists dealing with the blocking of sexual stimuli in individuals distressed by sexual inadequacy.

To help develop a level of sexual interest:

For the couple which is realistic to their life style, vacations from any form of specific sexual activity are declared for at least two 24-hour periods during the two weeks, in a system of timely checks and balances. However, daily consideration of sexual matters and social

isolation continue to give maximum return to this facet of the psychotherapy.

It might be held as part of this therapeutic concept that patients must have the opportunity to make those mistakes which reveal factors contributing to their particular distress. This means of learning is particularly important in reversing sexual dysfunction. In this interest, the patients are told that the cotherapists are not interested in a report of perfect achievement when they are following directions in the privacy of their own bedroom.

The cotherapists are interested in couple's making their usual errors of reaction and interaction as they involve themselves in situations that provide opportunity for natural response to sexual stimuli. If the mistakes then are evaluated and explained in context, the educational process is infinitely less painful and more lasting. There are significant advantages in this technique.

When mistakes are made, they are examined impartially and explained objectively to the unit within 24 hours of their occurrence. Additionally, they are discussed within the context of the misunderstanding, misconceptions, or taboos that may have led to or influenced their occurrence initially.

There is yet another specific advantage in daily conferences. If the distressed unit waits a matter of days after mistakes are made before consulting authority, the fears engendered by their specific episode of inadequacy or mistake in performance increase daily in almost geometric progression. In such a situation, alienation between partners is a common occurrence. By the time the next opportunity for consultation arises, a great deal of the effectiveness of prior therapy may have been destroyed by the takeover of the fears.

Fears of performance do not wait a few days or a week until the next appointment; in the meantime, the couple, separately or together, must use their own methods of coping. Most often this will be withdrawal of sexual or total communication, which places them further away from altering the sexual distress than before therapy was initiated.

When patients do not make mistakes during their acute phase of treatment, the cotherapists arrange for them to do so. It is inevitably true that individuals learn more from their errors than from their ability to follow directions effectively on the first attempt.

If marital partners reverse their sexual dysfunction and fully understand, through comparison with episodes of failure, why and what made it possible for them to function effectively, the probability of reduplicating the success in the home environment is increased immeasurably.

As evidence of the advantage to the therapeutic program of the unit's social isolation, those couples referred from the St. Louis area require three weeks to accomplish symptom reversal rather than the standard two weeks for those living outside the local area. It is difficult to isolate oneself from family demands and business concerns if treatment is being ear tied out

in the environment in which the couple lives.

For this reason it has been found more effective to see patients referred from the St. Louis area on a daily basis for the first week, there after five times a week, and to assign a total of three weeks to accomplish reversal of symptomatology. Partners in sexually distressed marriages who cannot or do not isolate themselves from the social or professional concerns of the moment react more slowly, absorb less, and communicate at a much lower degree of efficiency than those advantaged by social retreat.

The Foundation's request for two weeks' withdrawal from daily demands, at first rather an overwhelming suggestion to most patients, pales into insignificance when compared to the isolation demands engendered by necessary hospitalization for acute surgical or medical problems. When the couple's presenting complaint is one of sexual inadequacy, it should constantly be borne in mind that there is not only the equivalent of two distressed people but also an impaired marital relationship to be treated.

Sexual function

In order to establish at least a minimum of patient screening, at onset of the clinical treatment program no units were accepted in therapy unless the complaining partner in the couple (e.g., the impotent male or the non orgasmic female) had a history of at least six months of prior psychotherapeutic failure to remove the symptoms of sexual dysfunction. Very soon this proved to be a poorly contrived standard, of little screening value.

As should have been apparent at onset, there was no secure way of establishing the functional effectiveness of the prior therapeutic program. How determined and well oriented was the therapist, how cooperative or fully responsible was the patient? After two years this original standard was abandoned in favour of that currently in effect.

Sexual Screening

A reasonably effective method of screening has been substituted by requiring that no patients be accepted at the Foundation unless they have been referred from authority. As authority, the Foundation accepts physicians, psychologists, social workers, and theologians.

Beyond screening the patients for appropriate referral to the Foundation, the referral source further is asked to provide available details of psychosocial background relevant to the husband and wife sexual dysfunction.

A telephoned report is made to the referring authority describing husband and wife progress (or lack of it) during or immediately following the acute phase of treatment at the Foundation. Well-informed authority then can provide a most important reinforcement for newly acquired patterns of sexual interaction for the couple once removed from the Foundation's direct control by termination of the acute phase of therapy.

In many instances, patients in established psycho therapeutic programs have been referred for removal of symptoms reflecting a somewhat broad area of distress in which sexual inadequacy is only a part. After their two weeks at the Foundation, these couples are, of course, returned to referring authority to continue their established treatment programs.

Obviously, the referring authority, before continuing in therapy with his patient, is briefed in detail as to the couple's response to its Foundation exposure. The screening process as currently constituted has several aims, all obviously selective in nature.

Symptoms of Sexual Inadequacy

Primarily, control which prevents referral of major psychopathology is presumed. In other words the psychoneurotic is acceptable, but not the psychotic.

It should be emphasized that the reversal of symptoms of sexual inadequacy in psychoneurotic patients is indeed a significant portion of the Foundation's objectives. Acceptance of this role by the Foundation is based on the premise that the reversal of particularly troublesome sexual symptoms may speed the progress of a psychoneurotic patient within the greater context of his established and broader-based psychotherapy.

However, the majority of the couples contending with sexual dysfunction do not evidence psychiatric problems other than the specific symptoms of sexual dysfunction. Socio-cultural deprivation and ignorance of sexual physiology, rather than psychiatric or medical illness, constitute the etiologic background for most sexual dysfunction.

Therefore, when a couple is properly educated in sexual matters, and their specific symptoms are reversed, there is no need for further psychotherapy, unless extensive duration of the distress has created psychosocial complications no longer directly related to the sexual dysfunction.

Other areas of selective screening for information vital to the therapeutic program center on such questions as:

1. Are both members really interested in reversing their basic dysfunctional status? If one member of the unit simply has no interest whatsoever in reversing the symptomatology of sexual dysfunction in the marital relationship, the unit probably needs legal rather than medical or behavioural advice. The chances of reversing the sexual dysfunction under the circumstances of total disaffection for a marital partner are negligible.

2. What, if anything, is known of the couple's adjustment or maladjustment to its social community?

3. Do the referred members of the couple understand the programs, procedures, and policies of the Foundation? If not, it is suggested that the local authority, quietly

briefed in advance by the Foundation's professional staff, present the information in more specific detail to his patients.

4. What is the couple's basic financial picture? Should the Foundation offer the patients an adjusted fee scale or free care?

Sexual Therapy Commitment

The original research premise emphasized the fact that positive reversal of symptoms of sexual inadequacy during the acute phase of the treatment program was not of great import. If there were to be any clinical claim for positive effect in the Foundation's concentrated approach to symptom reversal, the clinical results would have to be judged in retrospect over a significant period of time, not at the termination of the acute phase of therapy.

Therefore, the policy of five years of follow-up for couples after termination of the rapid-treatment phase of the program became an integral part of research standards. Failures to reverse symptoms are, of course, considered most significant.

Little of clinical value can be established for any therapeutic program, regardless of length of its ongoing treatment phase, if the results are not evaluated in long-term follow-up after termination of the acute phase of therapy. The abiding guide to treatment value must not be how well the patients do under authoritative control but how well they do when returned to their own cognizance without therapeutic control.

This result finally must place the mark of clinical failure or success upon the total therapeutic venture.

Individual members of couples seen in treatment must agree to cooperate with five years of follow-up after termination of the acute phase of the therapy program. They fully understand.

The Foundation's basic premise that success in reversal of the symptoms of sexual dysfunction means little during the two weeks of intensive treatment, unless the symptom reversal is maintained for at least the first five years after separation from direct Foundation influence.

Success in maintenance of symptom reversal for this length of time does provide some sense of permanency in the continuing effectiveness of the couple's sexual functioning.

Those couples whose acute treatment phase was judged inadequate or a failure arbitrarily have not been placed in the five-year follow-up program. This type of follow-up would indeed have been a study of major importance, but such continuing interrogation certainly could have interfered seriously with other clinical approaches designed to relieve the unit's problems of sexual dysfunction.

The therapy concepts and clinical procedures depict basic methodology of cotherapist

interaction, first, between team members, and second, directed toward husband and wife of the sexually dysfunctional marital, unit. Jules Masserman has so aptly described psychotherapy as "anything that works." This "works" in a healthy percentage of cases.

Writers:

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