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Current Concepts of Human Sexuality

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The last decade has witnessed intense activity and rapid development in the area of human sexuality. The intellectual and moral climate regarding sex has become increasingly rational, humane, and nonjudgmental to the point where the human sexual response has become a legitimate topic for scientific study. As evidence, people all over the world are openly seeking help for their sexual difficulties. This has led to the accumulation of extensive clinical experience, substantially changing traditional concepts about sexuality and sexual disorders. At the same time, clinical techniques have been greatly improved and extended.

The Triphasic Concept of Human Sexuality and Sexual Dysfunction

In the past, it was believed that human sexual response was a single entity beginning with lust and ending with a climax. But this monistic view is wrong and has hampered the quest for theoretical clarity and for the effective treatment of sexual problems.

Probably the single most important recent theoretical advance in this field has been the emergence of the *triphasic concept* of the sexual response, which is based on the discovery that the male and female sexual response is

made up of three interlocking, but neurophysiologically separate, phases: desire, excitement, and orgasm. This separation of the three phases, in addition to its theoretical importance, is also of great practical significance. Each of the phases can be impaired separately, and inhibitions of the specific phases produce the clinical dysfunction syndromes of orgasm phase, excitement phase, and desire phase dysfunction. Each of these phase dysfunctions is associated with related, but distinct and different, psychopathological patterns, and each responds to related, but specific treatment strategies. The new classification of sexual disorders as described in the DSM-III is organized according to this concept.

The Physiology of the Three Phases and the New Classification of Psychosexual Dysfunctions

The male excitement and orgasm phases were first clinically differentiated by James Seaman. In 1956, he developed a specific treatment for premature ejaculation, a condition that had previously been located, under the label of impotence, in the undifferentiated mass of male sexual difficulties. This distinction substantially improved the outcome for premature ejaculation, which had, until this time, a very poor prognosis. A similar distinction between the female excitement and orgasm phase disorders was proposed by the author in 1971. This met with similar results. When anorgasmia is differentiated from other forms of “frigidity,” the effectiveness

of treatment is significantly improved. Recently, a third and separate sexual phase has been recognized—the phase of sexual desire. The separation of desire phase disorders from the disorders of the phases of the sexual response has clarified some of the conceptual confusion between libido and genital reflexes; it also shows promise of contributing to clinical advances of comparable significance.

Desire

Desire in both genders is the experiential concomitant of specific neural activity in the brains "sex circuits." The generation of desire is analogous to the process that governs the other drives serving biological purposes; for example, the need for food. We feel hungry only when the "hunger circuits" of the brain are activated. The usual trigger for this is the need for nutrients. If these centers are not active; that is, if they are inhibited by satiety or by psychic conflict, or biologically by appetite suppressant medication, there is a loss of appetite or anorexia.

The sex centers of males and females normally are activated rhythmically by hormones, or they may be stimulated by an attractive sexual opportunity. When such neural activation occurs, we feel, in popular terminology, "sexy," "horny," or "hot," that is, sexually hungry.

If the sex centers are inhibited by psychic events or suppressed

biologically, we are not sexually receptive. We lose our “sexual appetite” or suffer from “sexual anorexia.”

The anatomy and physiology of the sex circuits of the brain have not yet been delineated with precision. However, enough is known to permit inferences regarding the general model of their structure and function. It is known that sexual circuits are located in the limbic brain and have important way stations or nuclei in the hypothalamic and preoptic regions. Both genders require adequate amounts of testosterone for the proper functioning of the sex centers and therefore for the experience of libido. Testosterone is the “the libido hormone” for both men and women. It is also known that the neurotransmitters serotonin (5HTP) and dopamine act in an inhibitory and excitatory capacity respectively.

Sexual desire may be inhibited by psychological and physical factors, presumably because of their inhibitory effect on the sex centers. In clinical practice, anger, depression, stress, psychological conflicts about sex, and certain illnesses and drugs are commonly associated with low libido states.

A person who suffers from a low level of sexual desire has little or no spontaneous interest in sex, and cannot easily be aroused. He does not masturbate, has no fantasies, and when approached sexually experiences little pleasure. He may react with extreme avoidance, repulsion, boredom, or

merely with tolerance and a mechanical genital response. Clinically, inhibited sexual desire (ISD) may be described along two axes, producing four clinical subtypes. ISD may be *primary,* or a life-long condition, in which a patient has never experienced much of a sex drive or interest in sex, or it may be *secondary,* occurring after a period of normal desire later on in life. The parameters of sexual desire can also be described as being *global,* referring to a complete loss of libido, or *situational,* meaning a loss of libido only in specific situations; for example, the absence of desire for a spouse or lover. The former is often seen in depression, while situational ISD is typical when the inhibition is based on psychological conflict.

Emergency emotions such as fear or anger have biological priority over the procreative drives. In physiologic terms, it may be inferred that the activity of the sexual centers and circuits of the brain (upon which the experience of sexual desire depends) is suppressed when brain mechanisms that subserve the "emergency" emotions and that insure personal survival are activated. In other words, fear and rage of sufficient intensity are incompatible with sexual desire, and attention to a dangerous situation will take priority over an amorous one. On a clinical level this means that when a person is sufficiently angry, anxious, in conflict, depressed, or under stress, his libido will be diminished. This can occur regardless of whether the source of stress is sexually related.

The paraphilias may be regarded as special instances of situational ISD. Traditionally, the emphasis in these disorders has been placed on the variant object or aim, or on the content of the fantasy or fetish that arouses desire in these individuals. But perhaps the essential point involves the pattern of *inhibition* and not the nature of the arousing stimulus. For such patients only mature heterosexual expression represents a "danger," whereas the variant situation is symbolically "safe." Thus desire is inhibited only in the threatening heterosexual situations. But in "safe" circumstances, such as those created by the fantasy, fetish, or other paraphilic devices, which symbolically "circumvent" the threat of heterosexuality, the genital reflexes can function normally, and the conflicted individual is free to experience erotic desire and pleasure.

Excitement

Physiologically, excitement is caused in both genders by the reflex vasodilatation of the genital blood vessels. This produces a swelling which changes the shape of the genital organs to prepare them for their reproductive functions.

In the male the vasodilatation of sexual excitement is marked by erection. More specifically, erection is produced when the reflex vasodilatation of penile arteries increases the flow of blood to the penis, while

concomitant reflex constriction of the penile veins impedes the blood's outflow. This traps blood under relatively high pressure in the corpora cavernosii of the penis, distending that organ and making it erect and hard and capable of penetration.

In the female, analogous reflex vasodilatation of the genital organs occurs during the excitement phase. The female genital anatomy is simpler. Women do not possess specialized valves that trap the blood in the area, nor do they have special distensible caverns that produce erection. Therefore, vasodilatation of the female genitals produces a diffuse swelling around the vaginal and labial areas, which has been termed the *orgasmic platform.* This genital vasodilatation is also responsible for the characteristic deep coloration of the labia during excitement. In addition, transudate from the engorged tissues escapes into the vaginal cavity, producing lubrication.

The genital reflexes that subserve excitement (genital vasodilatation) and those that control orgasm (genital myotonic contractions) are controlled by separate spiral reflex centers. These are richly connected and receive inflow from various levels of the central nervous system (CNS). The multiple neural contractions provide the biological infrastructure that make it possible for erection and orgasm to be enhanced or inhibited by a wide range of experiences and emotions.

Penile erection in the male, and by analogy genital lubrication-swelling in the female, are primarily parasympathetic responses. The neural centers and circuits that govern penile erection are distributed on all levels of the CNS. All these influences finally impinge on two lower reflex centers that are located in the thoracolumbar portion of the spinal cord. One of these centers mediates psychogenic erection, while the other mediates erection attained on the basis of local tactile stimulation.-

The vasodilatory reflexes that produce the genital swelling of the excitement phase of males and females are subject to inhibitory influences from the higher brain. If the individual should become frightened or inhibited by conflict or even mildly startled, the penile blood vessels immediately constrict while the polsters and venus valves, which have retained the blood within the cavernous sinuses, relax. These reflex physiological responses to fear result in the instant drainage of blood from the penis, producing detumescence. When this occurs on a regular basis in appropriate sexual circumstances, the clinical syndrome of *impotence* (excitement phase dysfunction) results.

The patient's specific pattern of impotence will depend on which aspect of the sexual experience evokes anxiety of sufficient intensity to produce detumescence. Thus, some men have difficulty attaining an erection in the presence of a partner, some lose it at the moment of penetration, while others

become anxious and consequently impotent inside the vagina before they ejaculate.

Excitement phase inhibition of the female produces a clinical syndrome that in the past has been mislabeled *frigidity.* Such women feel sexual desire and may be orgastic, but they are unable to feel pleasurable sensations or show the physiological response of lubrication and swelling. Impotence is common, but excitement phase inhibition of females is a rather rare clinical syndrome.

Orgasm

Orgasm in both the male and female is produced by the reflex contraction (myotonia) of certain genital muscles. The experiential concomitant of these muscle contractions constitutes the pleasurable sensations of orgasm.

The male orgasm consists of two subphases: emission and ejaculation. After rhythmic stimulation of the shaft of the penis, which produces excitement, the orgastic threshold is reached. This triggers a discharge of the sympathic nerves to the internal male reproductive organs (which are of Wolffian origin): the vasa differentia, the seminal vesicles, and the prostate gland. This discharge stimulates the smooth muscles of the organ to contract and causes a bolus of semen to be deposited in the posterior urethra. This

response, which is mediated by the sympathetic nerves, is called emission. Emission is perceived by the male as a signal that ejaculation is about to occur. This phase of the orgasm response is not accompanied by pleasurable orgastic sensations. In the normal male, emission is followed a split second later by the 0.8 per second rhythmic contractions of the striated bulbo and ischio cavernosi muscles at the base of the penis. This contraction propels the semen through the urethra out of the penis in squirts. This phase is termed "ejaculation," and it is accompanied in the unconflicted and healthy male by pleasurable orgastic sensations. The male refractory period is associated with the first phase, emission; this means that after emission occurs a period of time must elapse before the male is responsive again. The second phase, the contractile or ejaculatory phase, does not seem to be associated with a significant refractory period.

Female orgasm lacks the first, or emission phase, because the female does not possess the Wolffian-derived internal male reproductive organs. However, female orgasm is clearly analogous to the second phase of the male orgasm. Upon tactile stimulation of the clitoral area, which is the anatomic and neurophysiologic analogue of the tip and shaft of the penis, the orgastic threshold is reached. This causes a discharge of nerve impulses to the striated muscles in the female perineum (the ischio and bulbo cavernosi muscles) producing rhythmic 0.8 per second contractions.-' In the normal female these contractions are experienced as the pleasurable sensations of orgasm.

The understanding of the physiology of female orgasm has made it clear that (1) female and male orgasms are highly analogous, and (2) there is no dichotomy between clitoral and vaginal orgasm. The affector arm of the female orgasm reflex is located in the sensory nerve endings of the clitoral area, while its effector expression is executed by contractions of the muscles surrounding the vagina. Thus all female orgasms are both "clitoral" *and* vaginal. The lower centers, which constitute the final common pathway for orgasm, are located in the sacral portion of the cord near the reflex centers that govern defecation and urination. They are close to, but definitely separate from, the nerve pathways and nuclei serving sexual excitement.

Again, the orgasm reflex is subject to multiple inhibitory and facilitatory influences from higher neural centers. Thus, when a person is in a negative emotional state, is frightened, angry, or ambivalent, the orgasm reflex may become blocked, or, conversely, escape from voluntary control.

Inhibition of the orgasm reflex is the most prevalent clinical complaint of females. *Anorgasmia* may be a part of general sexual inhibition or it can occur in women who feel strong sexual desire and who lubricate and function well during the excitement phase. Inhibition of the orgasm phase can occur with various degrees of severity. It is estimated that 8 to 10 percent of women in the United States have never had an orgasm at all. At the other end of the spectrum of orgastic threshold are those women who are easily orgastic

during coitus and who do not require direct clitoral stimulation. Between these extremes on the orgasm continuum lie various degrees of stimulatory intensity or thresholds for reaching orgasm. There is some controversy about where the clinical demarcation between the normal and the pathologically blocked female response should be drawn. Some authorities—particularly those influenced by Freudian concepts about vaginal versus clitoral orgasm—will define any woman who requires direct clitoral stimulation as suffering from an inhibition. More recent concepts and attitudes regard a woman as normal as long as she can experience a pleasurable orgasm together with her partner regardless of whether this requires direct clitoral stimulation.

This concept makes sense when it is recognized that coitus is not as intensely stimulating in the physical sense as is the direct stimulation of the clitoris. The orgasm threshold is multiply determined. Both psychic and physiological elements contribute to the final threshold. According to the classical analytic view, all woman who are free of sexual conflict should be able to reach a climax in response to the stimulation provided by coital thrusting alone. The need for clitoral stimulation is taken as evidence that the threshold has been elevated by inhibition. An alternate view holds that while psychic conflict can raise the threshold of the orgasm reflex, many unconflicted and normal women also need clitoral stimulation in order to experience orgasm; in other words, this pattern of orgastic release is a normal variant of the female sexual response.

There are two orgasm phase dysfunctions of the male, *premature* and *retarded ejaculation.* The syndrome of premature ejaculation, or *inadequate ejaculatory control,* is produced by a man's failure to learn voluntary control over his ejaculatory reflex, with the result that he climaxes reflexively and rapidly as soon as he reaches a high level of sexual excitement. Inadequate orgastic control is also occasionally seen in females, but does not represent a clinical problem.

The opposite orgasmic syndrome of males, *retarded ejaculation,* is analogous to female orgasm inhibition in that the ability to release the orgasm is inhibited. With males, as with women, the syndrome may occur with various degrees of severity. Men with mild retardation simply require an unusually long period of stimulation before they can ejaculate. Men who are somewhat more inhibited can reach orgasm on manual or oral stimulation but not within the vagina. Still more severely inhibited patients can only ejaculate upon masturbation by themselves, and in the most severe forms of this disorder males may not be able to ejaculate at all.

An interesting sub-variety of retarded ejaculation is seen in men who experience emission but not the expulsive phase of the ejaculatory response, which is specifically inhibited. Clinically, such patients experience a pleasureless seepage of semen, but not the 0.8 per second contraction of the perineal muscles nor the attendant pleasurable sensations.

Other Sexual Syndromes

Sexual phobias and psychophysiologic sexual problems associated with painful spasms of genital muscles are not related to the impairment of one of the three phases of the sexual response. They are included here because they share a similar etiology and respond to similar treatment strategies with regard to the psychosexual dysfunctions just described. Specifically all these disorders are associated with sexual anxiety and all are amenable, at least in some cases, to sex therapy methods.

Disorders Associated with Genital Muscle Spasms

In the female, the reflex spasm of the muscles surrounding the vaginal introitus, when severe, produces a syndrome called *vaginismus.* This condition accounts for many unconsummated marriages because penetration is impossible while the muscles are in spasm. Lesser degrees of vaginal muscle spasm produce various intensities of *dyspareunia* or pain on sexual intercourse.

A certain kind of *male dyspareunia* is also associated with spasms of the genital musculature. These patients experience acute ejaculatory pains, which may be caused by painful spasm of the cremasteric and perineal muscles or of the muscles of the internal reproductive organs at the point of ejaculation or a moment later.

Sexual Phobias

The previously described syndromes fall into the category of psychophysiologic disorders in that they represent disturbances of physiologic processes caused by psychological determinants. But often sexual problems are not psychophysiological; instead they are the products of sexual phobias and sexual avoidances. Patients may suffer from phobias of the entire sexual experience or of its various aspects. Kissing, touching, erotic feelings, intimacy, penetration, the genitals, semen, vaginal secretion, oral and anal sex, and so forth, may evoke anxiety and an attendant avoidance response. Instead of pleasure, such patients experience discomfort and panic in the sexual situation. The sexually phobic patient requires specific treatment. When the avoidance is based on a simple phobia, sex therapy can be modified to fit the requirements of in vivo desensitization. When sexual avoidance is a manifestation of an underlying panic or phobic-anxiety syndrome, appropriate medication combined with sexual therapy may be indicated.

Etiology

All the sexual symptoms described in this chapter, with the exception of the sexual phobias, can be caused by psychological conflict, or they can all result in part or entirely from depression, severe stress, certain medical illnesses, drugs, or substance abuse. Impotence in the male is especially likely to be caused by organic determinants such as the vascular and neurogenic

pathology associated with diabetes, arteriosclerotic vascular disease of the pelvis, endocrine deficiencies, antihypertensive medication, and alcoholism.. Such medical factors may be subtle and difficult to diagnose except with specialized procedures, which are not yet widely available. Consequently, the specific organicity may not be detected on a routine medical or urologic examination. Organicity must, of course, be ruled out before psychiatric intervention is planned. Also, sexual dysfunctions, especially the low libido states, are frequently secondary manifestations of primary psychopathological states such as depression and severe stress reactions. In such cases, intervention on the level of the underlying psychiatric condition is indicated, and not sex therapy. The following discussion of etiology applies only to primary psychogenic sexual disorders and not to sexual disorders secondary to medical factors or to primary psychopathologic states.

Past beliefs regarding the etiology of psychosexual disorders contained two major errors: (1) that all psychogenic sexual disorders are variants of a single psychopathologic entity, and (2) that these have only one cause: serious and unconscious sexual conflict that was acquired during early childhood, usually by the fifth year of life. This view, a derivative of psychoanalytic theory, had been until recently widely accepted in the field. Accordingly, the conflict responsible for sexual problems of males centers around the unconscious fear of injury or castration. Unconscious fear of injury was also thought to play an etiological role in female sexual problems, as was

unconscious competition with males and "penis envy." It was believed that conflicts acquired early in childhood were reactivated in the adult sexual situation, impairing the patient's sexual adequacy.

It followed from this theoretical position that the treatment of choice for sexual disorders of all kinds—prematurity, anorgasmia, the paraphilias, libido disorders, impotence, and so on—was held to be psychotherapy, which has the capability to foster insight into and resolve the presumed underlying sexual conflicts.

In the last decade this view of a serious and specific universal cause of sexual disorders has been challenged by the work of Masters and Johnson and also by some behaviorists. These clinicians demonstrated that sexual problems do not invariably originate in deeply unconscious neurotic conflict but are, in fact, frequently the product of superficial anxieties such as the simple fear of sexual failure; that is, performance anxiety. This "minor etiologies hypothesis" was supported by the high success rate of the brief Masters and Johnson treatment regime, which was designed essentially to modify the relatively minor forms of sexual anxiety.

The clinical experience of the past decade suggests that both points of view have validity. It appears that there is no specific etiologic agent associated with sexual dysfunction. Multiple factors can produce the same

sexual problems. Sexual conflict or sexual anxiety may be considered the ultimate cause of all psychosexual disorders. Anxiety evoked by sex is the "final common pathway" that leads to all psychosexual disorders. But the intensity and source of the sexual anxiety vary widely, even in those patients who display identical symptoms.

Clinical experience suggests that at this time the largest proportion of sexually dysfunctional patients suffer from the kinds of minor, superficial, or mild anxieties described by Masters and Johnson. These patients respond well to the brief sex therapies. But at the other end of the causal continuum there are patients, a smaller but substantial group, whose sexual symptoms originate in the more complex—the major or "deeper"— and usually unconscious kind of psychopathology postulated by psychoanalytic theory. Such patients, although their presenting symptoms may be identical to those of performance-anxiety sufferers, usually require more intensive and more psychodynamically oriented therapy for the relief of their problems.

A Psychosomatic Concept of Sexual Dysfunctions

The observation that the same sexual symptom can be associated with a broad spectrum of causal factors makes sense when sexual dysfunctions are conceptualized as psychophysiological or psychosomatic disorders. Such disorders are produced when the normal physiological processes are

disrupted by the physiological concomitants of emotional arousal, by fear, and by rage.

Multiple Levels of Causes

The disruptive effects of adversive emotion on the reflexes that comprise the sexual response are independent of their source or cause. In other words, the physiological concomitants of sexually disruptive anxiety are identical whether this anxiety is caused by a simple anticipation of failure to perform sexually or by an unconscious identification of the sexual partner with the mother. In either case, the penile arterioles will constrict, the polsters that impede the outflow of blood from the corpora cavernosii will open, and the patient will experience an involuntary and unwelcome detumescence. According to a psychosomatic conception the same symptom can result from a variety of causes as long as the anxiety reaches an intensity that is sufficient to impair the reflex in question. In some cases, this will result from simple consciously recognized stimuli, while in others deep unconscious conflicts may be responsible.

Specificity

The psychosomatic concept of sexual disorders does not answer the question of specificity or symptom choice, or why one patient with sexually related anxiety fails to learn control over ejaculations while another loses his

libido. While the question of specificity remains in many respects a mystery, some interesting hypotheses have been advanced.

Psychoanalytic theory postulates that unconscious psychodynamic conflicts related to disturbances of specific developmental periods produce specific symptoms. For example, premature ejaculation has been related to the disturbances of the urethral substage of development, and retarded ejaculation to unconscious hostility toward women deriving from oedipal and preoedipal conflicts. However, experimental and clinical support for these interesting hypotheses is lacking.

From a physiological perspective one determinant of symptom choice is "physiologic response specificity." This hypothesis holds that people have a highly individualistic physiologic response to stress. A person's characteristic physiologic response pattern is evident from infancy. Accordingly, some vascular responses in an individual are particularly reactive to emotional arousal. These individuals will tend to develop hypertension or impotence or vascular headaches in response to various stresses. Persons with a different pattern might respond to the identical stressor with anorgasmia, another with a loss of libido, and still another will develop peptic ulcer or an allergy. Experimental and clinical evidence supports this hypothesis; and it is likely that such individual response patterns constitute one determinant of specificity.

Observations of the specific and immediate experiences of patients who suffer from sexual dysfunctions have yielded some additional insights regarding the determinants of the various specific sexual symptoms. More specifically, three variables can play a role in the "choice" of the sexual symptom: (1) *intensity* or depth of the underlying anxiety; (2) the precise *time* at which this anxiety is evoked during the lovemaking experience; and (3) the *specific adaptation* to or *defense* against this anxiety employed by this individual.

Quality of Conflict

It is difficult to define the intensity or depth or quality of anxiety in a clinical situation with any degree of precision. However, despite this unfortunate ambiguity, there is consensus among clinicians who have experience with sexually dysfunctional patients that their underlying anxiety encompasses a wide range of intensities or complexities. Some patients suffer from minor anxieties that can be diminished, to a point at which sexual functioning will resume, by simple reassurance and training in sexual and communication skills. Others suffer from severe and major marital and/or intrapsychic problems that require extensive and complex therapeutic intervention.

The clinical study of the sexually dysfunctional patient population

suggests that the severity of sex-related anxiety is not evenly distributed among the various sexual syndromes. As a group, but with many exceptions, patients who suffer from orgasm phase problems (that is, those who have desire and erections but whose orgasms are either blocked or uncontrolled) tend to suffer from the mildest and most easily modifiable sexual anxiety. Such patients, as a group, have the best prognosis with the brief sex therapy methods. They often have no other discernible psychological problems, enjoy good marital relationships, and frequently improve without gaining significant insight into underlying problems, if, in fact, these exist.

By contrast, dysfunctional patients with the severest and most tenacious types of sexual conflicts and relationship problems tend, again with individual exceptions, to develop ISD. These patients have the poorest prognosis with brief therapy, and treatment tends to be stormy, with resistances arising even when the outcome is eventually successful. Severely conflicted patients generally do not improve merely in response to counseling or educational and behavioral methods. Usually they must gain at least some measure of insight into underlying conscious intrapsychic and/or relationship difficulties before improvement occurs. Such patients usually require longer and more insight-oriented therapy than is provided by the standard fourteen-session, behaviorally focused treatment that is the traditional Masters and Johnson mode.

Impotent patients (that is, those with excitement phase problems) as a group fall in between. Some, who suffer from secondary impotence, are clinically like the premature ejaculators and anorgastic females in that they harbor minor or superficial, and often consciously recognized, performance anxiety. Such patients have an excellent prognosis with rapid sex therapy. Others, usually those with life-long potency disturbances, are more like the typical ISD patient in the complexity of their underlying sexual conflicts. They will have a poorer prognosis and more difficult course of treatment.

It should be emphasized that the preceding conceptualization refers only to trends and not to individual patients. There are many anorgastic patients who suffer from severe and complex intrapsychic and/or relationship problems; while some low libido patients need only relief of performance anxiety or improved communication with their partner in order to regain their desire.

Timing

The time at which anxieties are evoked during lovemaking also influences the nature of the symptom. When anxiety occurs near the end, after considerable pleasure has already been experienced, orgasm-phase problems tend to occur. When anxiety disrupts the sexual experience during the excitement phase, the patient is likely to develop impotence. When negative

affect is evoked early on, at the time when lovemaking is just contemplated or initiated, then desire tends to become suppressed.

Specific Defenses

It has been emphasized that the source of the sex-related anxiety that produces sexual symptoms is not specific. Such anxiety may derive from intrapsychic and/or relationship difficulties, and it may be "minor" or "major." Its genesis could be found in any or all stages of early development or else it might be the product of current stress. The patient or couple may be perfectly aware of what is upsetting him or her in the sexual situation, or the sexual conflict may operate entirely on an unconscious, deeply defended level. In this sense, the remote sources of sexual dysfunctions are not specific. On the other hand, the *immediate antecedents* of sexual symptoms appear to be highly specific. The study of the immediate and specific experiences of sexually dysfunctional patients suggests that the different dysfunctional syndromes are associated with specific defenses against, or adaptations to, the anxiety that emerges during the sexual experience. And it is the interaction of the specific defenses or adaptations to anxiety with the physiologic process of the sexual response that produces the specific sexual symptom.

More specifically, anorgastic women and men who suffer from retarded ejaculations become anxious at high levels of sexual excitement. At the

moment when abandonment is appropriate they tend to “put on the brake.” Such patients deal with their anxiety with an obsessive form of self-observation: “Will I come?” or “Is it taking too long?” In this manner the orgasm reflex becomes inhibited, just as any reflex that is under voluntary control can become inhibited when scrutinized obsessively. Again, the underlying source of the anxiety that arises as the patient makes love is highly variable and may involve unconscious hostility toward the partner, guilt, fear of loss of control, oedipal transferences, fear of rejection deriving from preoedipal issues, unrealistic expectations about sexual functioning, and so on. And if the patient deals with his anxiety obsessively (what Masters and Johnson call “spectatoring”), the orgasm reflex will be inhibited and the syndromes of retarded ejaculation or anorgasmia will result.

Similar specific antecedents may be observed with the other psychosexual disorders. Vaginismus and the functional dyspareunias of males and females are associated with painful spasms of the genital muscles. Again, this involuntary spasm is the specific final cause of the syndrome and represents the response to the sexual anxiety, which may have a variety of origins.

The syndrome of premature ejaculation is produced when a male becomes anxious at high levels of sexual pleasure to the point of total distraction or denial of these pleasurable sensations. This distraction is a

perceptual defense against erotic pleasure. It interferes with the normal process of sensory integration, the process by which voluntary control over all biological reflexes that are subject to such control is learned.

Excitement phase disorders, or impotence, represent the inhibitory effect of undefended anxiety on the delicate parasympathetic genital vascular reflexes. The source of this anxiety is highly variable. Frequently it involves the anticipation of sexual failure, "performance anxiety." Some impotent males will unconsciously conjure up such performance fears in the service of deeper and unconscious conflict about sexual adequacy; for others, performance anxiety is "pure," that is, not associated with deeper sexual difficulties.

The specific and immediate antecedents of inhibited sexual desire are not yet completely clear. The study of the specific and immediate sexual experiences of such patients suggests that many, if not most, ISD patients unconsciously and involuntarily focus on depressing, frightening, and frustrating thoughts and images when they are in a potentially erotic situation. These "anti-erotic" mental processes may include focusing on negative aspects of the partner, recalling stressful events in external life, or evoking derogatory and depreciatory thoughts about themselves. In this manner, such persons upset themselves to a point where sex is avoided. They tap into the natural physiological mechanisms that suppress sexual desire in

an adaptive manner, much as a person does who finds himself in a dangerous or sexually inappropriate situation. Such patients typically have no insight into their active sexual self-sabotage.

Multiple Levels of Etiology

In some clinical situations no discernible pathology underlies the immediate causes just discussed. For example, a woman has simply acquired for no discoverable reason a condition spasm of her perivaginal musculature. No underlying trauma or sexual conflict can be detected. When the spasm is desensitized or extinguished, the patient functions normally, or is cured. In other clinical situations, however, a variety of underlying or remote causes are clearly operative. For example, the woman has acquired her vaginal spasm because the prospect of coitus evokes unconscious guilt about pleasure, or because of oedipal taboos, or because penetration has acquired the infuriating symbolic meaning of submission to the male. Where such remote causes exist, resistances to the removal of the symptom tend to be mobilized during rapid treatment. These have to be circumvented or resolved for a successful clinical outcome.

Among the remote etiological elements commonly seen with sexually dysfunctional patients are guilt, or superego conflicts regarding sex, competition, and pleasure. Unconscious fears of romantic success and

intimacy are also highly prevalent in these patients, as is unconscious rage at the partner. Finally, severe psychopathology and serious difficulties in the relationship may also produce sexual dysfunctions. This group of patients does, in fact, suffer from severe problems. These are the deeply neurotic patients whose early pre-sexual (preoedipal) and sexual (oedipal) development was substantially pathological. Couples engaged in severe contractual misunderstandings and power struggles, especially when these have their genesis in primitive parental transferences, are also in this severe or major group. Sometimes these deeper problems can be bypassed with behavioral means that modify only the immediate antecedents of the symptom. In such cases the patient is left with his major psychological problems, but his sexual functioning is improved. Frequently, however, such severe underlying problems give rise to tenacious resistances to behavior modification and are not amenable to brief treatment methods.

Current Concepts of Treatment

Historical Perspective

In the past, insight therapy, that is, psychoanalysis (or one of the modifications that falls under the rubric of psychoanalytically oriented psychotherapy) was considered the appropriate modality for sexual disorders. This judgment was based on the traditional premise that sexual

problems are reflections of unconscious conflict, and it was expected that resolution of this conflict would result in the cure of the sexual symptom.

Marital or couples therapy approaches have also been employed for treating sexual problems. Conjoint treatment presumes that conflicts and problems in the marital system are responsible for some sexual problems. It is thought that both partners participate in the genesis and maintenance of these relationship problems and that, to some extent at least, the dynamics of the struggle is usually beyond either partner's conscious awareness. By fostering insight into, and hopefully resolving, such interactional issues, the therapist attempts to improve the couple's sexual experience.

Patients undergoing individual insight therapy often appear to derive considerable benefits in terms of insight, growth, and improvement in other aspects of life. But even when significant unconscious conflict is resolved, the actual sexual symptom is cured in only a relatively small portion of patients.

Although systematic outcome studies are lacking, the same is probably true regarding the outcome of conjoint treatment. With the resolution of contractual disappointment, power struggles, communication problems, mutual transference, and other difficulties in the couple's interactions, the relationship often improves, but it does not automatically follow that concomitant sexual improvement will also occur. Often the couple gets along

much better, but he still climaxes too rapidly and she does not climax at all.

Sexual problems have also been treated by various behavioral methods, based on the concept that sexual symptoms and sexual anxiety are learned and can be unlearned. Accordingly, it is held that if the contingencies are constructed so as to extinguish sexual anxiety and to foster the learning of sexual skills and improved attitudes, sexual problems can be cured.

Some successes have been reported with the behavioral treatment approaches, but these have been limited. There have been no reports of large-scale successes comparable to the Masters and Johnson outcome study with behavior therapy. It is my impression that strictly behavioral approaches to sexual symptom are successful for only a limited patient population.

The most impressive results thus far reported are those of Masters and Johnson, who reported an 80 percent cure rate. Extensive clinical experience, accumulated since their study, has by and large confirmed the original finding, and has made it clear that sex therapy represents a genuine and significant advance in the treatment of sexual problems. Therefore sex therapy, either in its classic form or in one of the modifications in current use, is widely regarded as the treatment of choice for psychosexual dysfunctions, with the possible exception of severe disorders of sexual desire. Of course, sex therapy is indicated for the psychosexual dysfunctions only when no contraindications

exist in the form of organic etiologic factors, substance abuse, depression, the presence of significant stress or crisis, active and serious psychopathology in either partner, or severe problems in the relationship.

Sex Therapy

It is interesting to speculate on the possible reasons for the efficacy of sex therapy as compared to the other forms of treatment. Possibly the limited success of the insight therapies that rely exclusively on verbal interchange between the therapist and the patient or couple is due, at least in part, to the neglect of these modalities as the specific antecedent or immediate cause of the sexual symptom, in favor of focusing on the underlying deeper or remote causes. Most psychoanalysts and couples' therapists typically do not clarify the details of the patient's or couple's sexual interaction or immediate erotic experience, nor will they give suggestions regarding sexual corrective experiences. Instead, the therapist will work to clarify and resolve the underlying intrapsychic and/or interactional conflict in the hope that such insight might be curative. However, clinical experience suggests that the resolution of unresolved unconscious intrapsychic or marital conflict, will frequently not *per se* result in relief of the sexual symptom. In many clinical situations, specific sexual difficulties persist even after excellent insight has been attained and will only improve after the patient or couple's sexual experiences are specifically and adequately modified in addition to insight.

Behavioral techniques have an obvious advantage in treating sexual dysfunction because these methods are exquisitely designed to illuminate and modify the immediate and specific contingencies that ultimately produce the sexual symptom. But these techniques are helpless in dealing with resistances that typically appear during the rapid modification of sexual behavior, except in those patients where the underlying causes are minor. Since the concept of unconscious motivation has no place in behavioral theories, no behavioral techniques exist for dealing with unconscious sexual conflict and with the tenacious resistances to which they give rise.

Perhaps the great advantage of sex therapy lies in the fact that it is *integrated.* It intervenes on both levels: at the level of the immediate sexual symptom, and, when it is necessary, at the level of deeper psychopathology. Integrated techniques employ an amalgam of behavioral and psychodynamic modes. Sexual tasks designed to modify the sexual symptom are integrated with the psychotherapeutic sessions, permitting the therapist to deal with resistances and with the underlying emotional conflict from which these arise.

Recent Modifications of Sex Therapy

The original sex therapy procedure that was described by Masters and Johnson in 1970 has been extensively modified by many of the clinicians who have been working in the field in recent years. The purposes of these

modifications have been to streamline treatment, that is, to eliminate those features that are not necessary for therapeutic efficacy, and to extend the range of therapeutic effectiveness to a greater and more troubled patient population, that is, those who suffer from deeper conflicts and resistances and who tend to fail to respond to classic sex therapy.

All modifications retain the two essential features of sex therapy: (1) The focus on relief of the sexual symptom to the exclusion of other problems, which are only dealt with to the extent that is necessary to improve sexual functioning, and (2) The employment of an integrated combination of corrective sexual tasks and psychotherapeutic sessions that are usually conducted conjointly with both partners.

Procedural Modifications

Masters and Johnson originally felt that that the use of a dual gender co-therapy team was essential to the success of their method. However, no solid evidence has been presented attesting to the superiority of co-therapists over a single therapist. Many therapists are currently working alone, and clinical experience suggests that a single well-trained therapist, who is sensitive to the sexual experiences of both genders, is as effective as a team.

The original Masters and Johnson format required that the couple isolate themselves from the stresses and distractions of ordinary life, check

into a motel, and see the therapist intensely for daily sessions for a period of two weeks. After this time, the patients were discharged regardless of treatment outcome, with the assumption that if cure had not taken place by this time, the couple was not amenable to the method. Although some clinicians and programs still operate according to this model, most have modified this procedure so that the couple remains at home and visits the therapist in their own community.

The time frame of treatment has also become more flexible in most programs. Masters and Johnson employed a fourteen-session treatment format for all their patients—once a day for two weeks. In other programs, patients are typically seen once or twice a week and length of treatment varies from three sessions to as many as thirty. Clinical experience suggests that these modifications have a more positive outcome for a wider range of patients.

Technical Modifications

Masters and Johnson's original treatment program encouraged the exchange of sensuous pleasure between the partners, deemphasized performance pressures during sex, fostered open and authentic communication, promoted attitudes of mutual respect and caring, and provided training in sexual skills. This same treatment format was used for all

the dysfunctions and for all couples.

The recognition of three physiologically separate phases of the sexual response, which ultimately differentiates between the three types of dysfunctional syndromes, has led to the recognition that each syndrome is associated with specific psychopathologic antecedents. Within this theoretical framework, more specific and rational treatment strategies have been developed. Thus many clinicians now employ different therapeutic techniques for each specific syndrome. Descriptions of these are available in literature.

Basically, it is assumed that in order to cure the sexual symptom, it is necessary to modify the immediate antecedents that gave rise to it. Thus, the behavioral aspect of treatment is designed to modify the specific antecedents or immediate causes of the sexual symptom. Since these are different for the various syndromes, the "sexual exercises" or behavioral tasks assigned to the couple are different and specific. For example, in anorgasmia of females and retarded ejaculation in males, the exercises are designed to maximize genital stimulation and at the same time reduce the obsessive self-observation by which orgasm is retarded. Focus on erotic fantasy or on physical attributes of the partner may be used in the service of this intervention. By contrast, premature ejaculation is treated with techniques that help the patient focus on the sensations premonitory to orgasm and to accept the pleasurable sensations concomitant with high level of sexual arousal. Both the "squeeze"

and the "stop-start" methods have proved effective in accomplishing this objective. By these means it is hoped that the patient's distraction, or tendency toward perceptual defense against erotic pleasure, will be modified to the extent that he can attain voluntary control of his ejaculatory reflex. Potency disorders, which are frequently associated with performance anxiety, are often successfully dealt with by structuring the couple's erotic interaction so that it is reassuring and free from performance pressures. In this manner the fear of sexual failure can often be diminished. The improvement of desire disorders generally requires that the patient gain some insight into his or her tendency to evoke or focus on negative images or "anti-fantasies" when in an erotic situation. This is the hypothetical immediate cause of ISD. To this end the tasks are structured: to help the patient confront his or her defenses against sexual pleasure and the tendency to turn off.

Tasks may be also modified in order to meet the specific and individual dynamic requirements of the patient or the couple. Also, the pace of treatment can be adjusted to accommodate the particular level of anxiety and the patient's tolerance for anxiety. Within such a flexible therapeutic framework, sensitivity and creativity must be used to devise the specific tasks. These should be structured so that they will enable the patient to make progress, while at the same time these experiences must not evoke anxiety of sufficient intensity to mobilize counterproductive resistances to treatment.

Thus, for example, a highly anxious couple may not be able to tolerate the rapid tempo of standard treatment, and tasks can be assigned at a slower and more gradual pace without sacrificing an eventual favorable outcome. Or, if it appears that a specific sexual experience has acquired some threatening symbolic meaning to the patient (and for this reason evokes resistances), alternative tasks may be employed that will "bypass" this obstacle. For example, if the female superior position, which is usually employed during the treatment of premature ejaculation, female excitement phase disorders, and some potency disturbances, is threatening on some symbolic level (perhaps evoking fears of passivity and helplessness in the male, or concerns with aggression or sexual responsibility on the part of the female), the therapist has two choices. He may attempt to resolve the unconscious threat evoked by this position during the therapy sessions, or he may decide to substitute a side-by-side position or some other one that will still enable the patient to carry out the appropriate and crucial exercise without having to deal explicitly with the anxiety generated by the unconscious meaning of these exercises.

Psychodynamic Emphasis

Masters and Johnson did not make reference to unconscious conflict or motivation in the description of their treatment procedure. They relied on education, training in sexual and communication skills, in vivo desensitization

of sexual anxiety, and on the construction of stimulating and reassuring sexual tasks. These methods have helped numerous patients, and many competent therapists still adhere to this essentially non-dynamic therapeutic model. However, others, including this author, feel that sexual pathology gains clarity and that the therapeutic process becomes effective for a greater range of patients when sexuality and therapy are conceptualized in psychodynamic terms with reference to multiple levels of etiology, including those that occur on an unconscious level. This is especially true when dealing with patients whose symptoms have deeper roots, symptoms that are the product of more serious conflict than those produced by minor performance anxieties and lack of communication. With minor problems such as the fear of sexual failure (particularly when this disturbs only the orgasm phase), cure can often be obtained, without insight, on the basis of behavioral modification alone. But this is not true of more complex problems such as those seen with the more serious potency disorders and with the majority of desire-phase problems. In such cases, more emphasis needs to be placed on fostering insight.

The insight-promoting aspects of sexual therapy are emphasized during the therapy sessions. These sessions may be conducted conjointly or with either partner, as resistances arise.

In the attempt to develop more effective treatment procedures for the more difficult dysfunctions, a variety of treatment styles or variations are

currently in use. In general, these can be thought of as modifications of brief active crisis intervention forms of psychotherapy that have been especially adapted for working with sexual problems. This author's own method employs a fine balance between support of the patient's pleasure functions and active confrontation with his resistances to the development of sexual adequacy. These new approaches are promising and make sense from a theoretical perspective. However, they still need to be objectively evaluated and compared to other treatment approaches.

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