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**SEXUAL FUNCTIONS
IN MEN AND THEIR
DISTURBANCES**

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Sexual Functions in Men and Their Disturbances

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Sexual Functions in Men and Their Disturbances

Separating male from female sexuality is an exercise in abstraction, perhaps even in frustration. Ordinarily one's sexuality is so much fashioned by the relationship between the sexes and its understanding so dependent on our appreciation of *the process of relating* that to study the sexual function of one's sex apart from the other is bound to be misleading. My assignment to deal with male sexuality requires me to concentrate my remarks on that sex, but of necessity constant reference will be made to the transactions between the sexes, especially since most sexual disturbances arise in the context of marriage or some other heterosexual relationship.

A frame of reference is necessary. Some general remarks about human sexuality will be followed by a discussion of the influence of culture on sexual behavior, after which sexuality as a system will be conceptualized and its components further defined in order to set the stage for a discussion of male disturbances in sexual functioning.

Introduction

Human sexuality, including sexual feelings and behavior, is so diverse and complex, its manifestations so protean, that its understanding requires the insights of artists as well as scientists and clinicians. Feelings include multiple bodily sensations, fantasies, emotions, and attitudes. Attitudes, in

turn, are composed of belief systems and their related values. Important facets of sexual attitudes are linked with the image of oneself as male or female, masculine or feminine, even combinations of these identifications and identities. Highly significant as well are other internal states such as sexual drive or interest and the capacity for erotic arousal and responsiveness. Sexual behavior goes far beyond “physical” sex, for it includes as well sex-typed behavior that not only varies enormously among individuals but also varies in different cultures, or in the same society in different historical periods.

Cultural Variations

Variations in sexual values and behavior in different historical periods in different cultures have been strikingly described by Marmor. Attitudes toward masturbation, premarital sex, infidelity, abortion, homosexuality, and the relations between men and women are so different that they may change the sexual “climate of opinion” drastically.

Even a cursory look at the recorded history of human sexuality makes it abundantly clear that patterns of sexual behavior and morality have taken many diverse forms over the centuries. Far from being “natural” and inevitable, our contemporary sexual codes and mores, seen in historical perspective, would appear no less grotesque to people of other eras than theirs appear to us. Our attitudes concerning nudity, virginity, fidelity, love, marriage, and “proper” sexual behavior are meaningful only within the context of our own cultural and religious mores. Thus, in the first millennium of the Christian era, in many parts of what is now Europe, public nudity was no cause for shame (as is still true in some aboriginal settings), virginity was not prized, marriage was usually a temporary arrangement, and extramarital relations were taken for granted. Frank and open sexuality was the rule, and incest was frequent. Women were open aggressors in inviting sexual intercourse. Bastardy was a mark of distinction because it often implied that some important person had slept with one’s mother. In early feudal times new brides were usually deflowered by the feudal lord (*jus primae noctis*). In other early societies all the wedding guests would copulate with the bride. Far from being considered a source of concern to the husband, these practices were considered a way of strengthening the marriage in that the pain of the initial coitus would not be associated with the husband, [Marmor, p. 165]

Malinowski, Devereux, Mead, Kluckhohn, Linton, DuBois, Kardiner, Opler, Ford and Beach were among the behavioral scientists who demonstrated that

sex roles were dependent on childrearing practices, which, in turn, were based on cultural institutions and their accompanying values.

An extraordinary variety in human sexual behavior exists. To quote Karlen, “there are societies where modesty calls for hiding body and face, others where it insists that the male hide only his glans penis; where widows commit suicide, and where women have several husbands; where girls commence coitus at 11, and where they and their lovers are put to death for premarital intercourse; where relatively few women masturbate, and where they do so with a reindeer’s leg tendon or with a live mink whose jaws are tied shut; where every male has experienced sodomy at some time in his life, and where one homosexual act may cause ostracism or even execution.” (p. 475).

Despite this, several generalizations are possible: (1) no society exists in which there is unlimited sexual access to most potential partners; (2) some form of incest barrier is always found, involving at least some members of the nuclear family; (3) heterosexual coitus is the standard pattern for adults everywhere; no society makes homosexuality, masturbation, bestiality, or any other noncoital form of sexual activity the dominant form for adults.

Sexuality as a System

If sexuality refers to the totality of one's sexual being, its essence is even more what one "is" than what one "does." One's sense of being male and masculine, female and feminine and the various roles these self-perceptions engender or influence are important ingredients of sexuality. Cognitive, emotional, and physical sex each contribute to the totality.

Sexuality may be described in terms of a system analogous to the circulatory or respiratory system. The components of the sexual system include:

1. Biological sex—chromosomes, hormones, primary and secondary sex characteristics, and so forth
2. Sexual identity (sometimes called core gender identity)—sense of maleness and femaleness
3. Gender identity—sense of masculinity and femininity
4. Sexual role behavior—(a) gender behavior, behavior with masculine and feminine connotations; (b) sex behavior, behavior motivated by desire for orgasm (physical sex)

Biological Aspects

Chromosomal Abnormality

In the vast majority of children gender based on biological sex is unambiguous. However, abnormalities of the sex chromosomal patterns (or of hormonal secretions) result in mixed internal reproductive systems and ambiguous genitalia. These problems of intersexuality, if not corrected early in life, may lead to conflicts in sexual or gender identity. The sex assigned is, with rare exceptions, more important in determining gender identity than is biological sex, and change in sex is usually unwise after eighteen months.

Some of these people and some without evident biological defect have grave difficulties in developing a core gender identity of the same biological sex. These are transsexuals, mostly biological males who think of themselves as “a female trapped in a male body” (Stoller).

Effect of Fetal Hormones

In the last decade particularly, evidence has been accumulating to indicate that fetal androgens, mainly testosterone, determine the organization of neural tissues that mediate sexual behavior. If fetal androgen is absent during a critical period of fetal development, the fetus will develop as a female. However, the presence of androgen in the proper amounts during the critical period masculinizes the individual, whether genetic male or female. The “organizing action of testosterone” establishes a neural system so that differential sensitivity and responsiveness are built into the controlling

mechanisms (Gadpaille 1972). The evidence seems to suggest that the hypothalamus plays a leading role in the control mechanisms. In normal development the genetic factors structure the endocrine environment, which, in turn, affects the psychosexual bias of the nervous system. Instead of having a bisexual constitution as theorized by Freud, the developing fetus, if there are no genetic or hormonal abnormalities, is organized in a male or female direction at very early stages of development. "The genetic code of XX or XY apparently determines only the differentiation of ovary or testes, after which fetal hormones from either gonad take over further differentiation."

As Stoller puts it, "The genital anatomic fact is that, embryologically speaking, the penis is a masculinized clitoris; the neurophysiological fact is that the male brain is an androgenized female brain."

Sexual Identity— Core Gender Identity

With relatively rare exceptions development of sexuality along usual developmental lines leads to a secure sense of maleness or femaleness that is generally complete by the age of three. If there are difficulties created by intersexuality and an ambiguous sex assignment, difficulties in sexual identity may be a consequence. Transsexualism, not always associated with known biological defect, is a special case of conflict over sexual identity. Even in ambiguous sexual development the sex of rearing can be established

independently of biological sex. In the vast majority of cases the assignment of sex during the first years of life will prevail, even overriding an opposed biological sexual identity. (In some rarer instances the opposite seems true; a disordered neural organization will lead to cross-sex attitudes and behavior despite unambiguous sex rearing.)

Of special interest is the implication from animal studies that “maleness and masculinity are more difficult to achieve and more vulnerable to disruption” than are femaleness and femininity (Gadpaille 1972). Among primates male copulatory behavior is inhibited more readily by extraneous stimuli and is more subject to the effect of previous experience. Males, more than females, have to learn to copulate, and this capacity among males is more readily destroyed by cerebral cortical ablation experiments. In the experiments conducted by the Harlows, the lack of peer group social and sexual play differentially affected the sexes, so that males, even more than females, failed to develop the capacity for adult sex behavior and successful copulation.

Gender Identity

Money and the Hampsons defined gender identity as “all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman respectively.” The unfolding of gender identity is

affected mostly by the cultural and familial factors provided by all the transactional experiences, explicit and implicit, planned and unplanned, encountered in childhood and adolescence. Indeed, the process of gender identity continues into adult life, creating modifications of self-image through a variety of nonsexual as well as explicitly sexual encounters.

The inevitable stages of psychosexual development (oral, anal, phallic, and genital) postulated by Freud are only gross approximations of the usual maturational processes, the nuances of which are very different in different individuals even in the same culture. For example, personality development during the anal stage is not related to an alleged anal eroticism, but, instead, is related to the nature of the interaction of the child with his parents and the conflict between submission to and defiance of parental demands for sphincter control. Similarly the latency period disappears in segments of society or in cultures where there is little sexual repression and perhaps even active encouragement of sexual, even coital, activity.

For the creation of the standard sexual identity, the child must have a parent or parent substitute of the same sex who is neither so punishing or weak as to make it impossible for the child to identify with him; a parent or parent substitute of the opposite sex who is neither so seductive, punishing, emotionally erratic, or withholding as to make it impossible for the child to trust members of the opposite sex; and parents who do not systematically

reject the child's biological sex and attempt to force him into behavior more in keeping with the opposite sex.

Sexual Role Behavior

Gender Identity

The stages of psychosexual development postulated in classical psychoanalytic theory have been criticized on these grounds:

1. The notion that the stages are an inevitable unfolding of an instinctual energy within the child, suggesting that the child has the initiatory capacities within himself, is erroneous. It seems more likely that the initiation of sexual transactions comes from his parent.
2. This formulation fails to take into account the enormous influence of culture and its institutions in modifying early sexual learning.
3. The assumption that all contacts with or stimulation of the child's end organs have either a protosexual or completely sexual meaning right from the start ignores the quite different motivations surrounding oral or anal behavior. These criticisms should not obscure the importance of Freud's discovery that the child's sexual activity and interests were "an essential precursor and component of the development of the character structure of the adult."(Gagnon 1965).

During the period three to seven years of age, the child gradually realizes that people are placed in two related categories, boys or girls, men or women, fathers or mothers. Certain cultural values and attitudes modifying masculine and feminine behavior are transmitted through clearly distinguishable cues including dress, bodily form and proportion, strength, distribution of hair, depth of voice, posture at the toilet, differential parental behavior with boys and girls, and characteristic sex-linked behavior in the kitchen, the garage, or the backyard. Physical differences between men and women, boys and girls, play a large part in the concept of masculinity and femininity learned at an early age; for example, a girl should be pretty and small, a boy large and strong. By the time the child is eight or ten, the primary sex-typed attribute for girls is having an attractive face, while for boys it is having a tall, muscular physique.

Although it is possible, as Margaret Mead has demonstrated, for a culture to instill aggression in females and passive dependency in males, most cultures, including our own, promote aggressivity in the male and a passive-receptive stance in females. Many studies have demonstrated the connection between maleness and aggression, and the evidence is almost as strong for a greater dependency, conformity, and social passivity for females than for males at all ages.

There are class variations. Sex-role differentiation is sharper in lower-

class families. Lower-class mothers encourage sex-typing more consistently than do middle-class mothers, and the difference between middle class and lower class is especially sharp for girls. More flexibility is afforded the middle-class girl than the lower-class girl in choosing toys and in undertaking activities of the opposite sex.

Therefore, despite the rapid shift in societal values with regard to masculine and feminine behavior, children still continue to act as if aggression, dominance, and independence are more appropriate for males and passivity, nurturance, and feelings more appropriate for females.

In the development of sex-linked behavior, it is of interest that the girl must acquire reactions from other people since she cannot know whether she is attractive or poised or passive without frequent feedback from her environment. This promotes her dependency upon other people. The boy, on the other hand, develops many important sex-typed behaviors while alone. He can perfect his motor or mechanical skills by himself (shooting baskets, fixing his bicycle), and these will strengthen his convictions that he is acquiring masculine attributes.

The pressures from society and from families for stereotyping sex-linked behavior are enormous. The studious or artistic boy and the mathematically inclined girl may suffer humiliation at the hands of his or her

family or peers. These stereotypic attitudes and values learned early in life generally persist into adult life and often come into sharp conflict with changing societal values, especially with regard to the role of women. Traditional masculine-feminine role behaviors, creating a sharp differentiation between men and women, are changing so rapidly that there is hardly a job or task that is completely absorbed by one sex alone. Sexual roles are now no longer assigned by tradition but are negotiated, creating a potent source of conflict between husband and wife. It is clear that efforts at reducing the perhaps excessive polarization of males and females have to start in the early stages of personality development.

Despite the changes, given our still current cultural emphases, by the time a boy is an adolescent a satisfactory sexual identity for him involves sexual experiences with girls. Thus, much sexual activity among males is as much motivated by the desire to strengthen a masculine identification as by strong erotic urges. For both boys and girls some concerns about their sexual identity and consequent inhibitions in sex-linked behavior seem inevitable. Whether this carries over to the area of physical sex itself depends on the intensity of anxiety, guilt, or hostility toward the opposite sex and on the types of reinforcing or extinguishing (corrective) stimuli the child receives during adolescence.

Sexual Behavior

Sexuality in Infancy and Childhood

Infants of both sexes seem to experience pleasure from the stimulation of the genitals and other areas of the body that are commonly recognized as erogenous zones. In the early weeks of life male infants respond to internal or external stimuli with erections, and even at the time of delivery erections in the newborn are seen. This indicates the presence of a built-in sexual reflex. In adult life the basic biological nature of the reflex sexual response is seen in penile erections (and vaginal lubrication) during REM sleep. Orgasmic experiences without ejaculation occur throughout the preadolescent period. A study of 700 four-year-olds in an English urban community found that 17 per cent of the children engaged in genital play at this age (Kirkendall & Rubin 1969). Curiosity leads most children to engage in exploratory activities involving themselves and other male or female children. When children are scolded or obviously distracted from such activities, children often experience their first deep-seated feelings toward sex, namely, that sex is threatening and that sexual expressions are to be regarded with guilt and shame.

Despite Freud's notion that there is a period of latency—a phase of the child's psychosexual life and development when sexual interest and behavior come to a halt—evidence clearly shows that there is a steady rise in sexual

activity involving nearly 80 per cent of preadolescent boys between 10 and 13. At most, between the ages of 5 and 11, there is a relative decline in protosexual or sexual interest. During this same age period there is an enormous broadening of the child's range of interests. As the child learns many things about the world in which he lives and as he increases his contacts with his fellows, curiosity about his family, including intense sexual curiosity, abates. He leaves the protective canopy of his family for the wider world, but his sexual interests are still there, somewhat masked by his involvement and commitment to the exploration of his milieu. If that environment is stagnant or punitive or otherwise inhibits his move outward to enlarge his horizons, the child's sexual curiosity and behavior may become active, even florid. (In a St. Louis housing project prepubertal children actively engaged in coitus or in attempts at coitus. All around them older children and adults were engaged openly in sexual encounters of all types, in the hallways, elevators, lobbies, laundry rooms. Mothers even encouraged children to engage in adultlike sex play, for it kept them off the streets and out of trouble with the police.) Broderick and others have demonstrated that there is no period in which the majority of boys and the great majority of girls are not interested in the opposite sex. Four out of five pubertal boys and even a larger number of girls have fantasies of getting married someday.

During the prepubertal period, approximately from the ages of 9 to 12, boys are commonly interested in their own sex. Many of them go through a

period of “hating girls.” This is probably a time in which they are consolidating their gender identity, and it is probably a mistake to call this a “homosexual stage.” There is a danger that parents will regard this same-sexed sexual activity as homosexual, creating a good deal of anxiety on the part of the boy who is participating in mutual sex.

Puberty

At puberty the increase in hormonal secretions brings with it the capacity for erotic arousal and responsivity, eventually leading to ejaculation in males. Preoccupation with sex causes many concerns at this time. Boys are concerned with masturbation or with what they assume to be a small penis.

Commonly puberty arrives for boys about two years later than for girls (11 to 18 for boys and 9 to 16 for girls). Whether the age of puberty has actually been getting lower for both sexes over the past half-century is still a controversial matter. There is a definite physical maturational sequence. In boys the order of pubescent phenomena is: (1) beginning growth of the testes and penis, (2) appearance of straight pigmented pubic hair, (3) early voice changes, (4) first ejaculation, (5) kinky pubic hair, (6) period of maximum growth, (7) auxiliary hair, (8) marked voice changes, and (9) development of the beard.

In early adolescence masturbation becomes a central concern for most

youth, especially for the white middle-class male. Masturbation is part of the standard sexual pattern and becomes a problem only if there is guilt or anxiety associated with it. While masturbation is now accepted as a perfectly natural part of sexual development, for the first time its positive features are being stressed. Aside from the pleasurable release of sexual tensions, masturbation leads to increased information about the adolescent's bodily responses and to a developing sense of mastery over newfound sexual capacities, and it helps in preparing for heterosexual relationships.

The cumulative incidence of masturbation is more than 90 per cent for males and above 60 per cent for females. Most people who masturbate as adolescents continue to do so in adult life, at least occasionally. For many individuals masturbation constitutes virtually the only overt outlet.

In about three-fourths of males and about half of females, masturbation is accompanied by fantasies or daydreams, but with a difference between the sexes in the type of fantasy. Females usually fantasize about doing non-sexual things with someone who is admired, whereas males are more likely to have direct coital fantasies with someone of whom they are fond. Persons with more education fantasize more frequently; yet they are absent in about 12 per cent of college men and about 20 per cent of college women. Women are much less likely than men to fantasize having sex with a stranger or in a group. On the other hand, fantasies of being forced into sex are more common

in women (rape fantasies are a way in which the woman decreases her sense of responsibility and of guilt).

Although about one out of three adolescent boys has a homosexual experience leading to orgasm (and about half that percentage of girls), in the majority this is a transient stage in developing their own gender identity. About 10 per cent of males and about 4 per cent of females become preferentially homosexual. A great majority of adolescent boys and girls find their dominant push toward heterosexual activity. Working out their gender identity, gaining control over their impulses, and learning how their bodies function are more important in the early phases than release of sexual tension. In this culture girls are more interested in interpersonal relations than in sexual gratification. Embarking on sexual activity, boys and girls commonly go through a series of stages involving necking, light petting, heavy petting (petting below the waist), petting to orgasm, and finally coitus. The standard pattern for high school seniors of petting to orgasm gradually shifts to coitus sometime during their college years. A minority of high school boys and girls have coital experience (the differences among social classes are highly significant), but the majority have engaged in coitus by the time they finish college. Studying a representative sample of the population (not restricted to college youth), researchers at Johns Hopkins found that 44 per cent of 19-year-old unmarried girls reported having had sexual intercourse. The major shift over the past 30 years is in the sexual behavior of girls. A

generation ago about 30 per cent of senior college girls had premarital intercourse. Now over 50 per cent report "going all the way." The predominant sexual norm both for high school and college students is "permissiveness with affection." If affection is present there is little stigma attached to coital experience and behavior compared to the adolescents of a generation ago.

The complicated process of developing the capacity for intimacy, one of the major tasks of adolescence, involves the capacity for intimate sharing of pain as well as of pleasure with a loved person, in addition to the capacity to trust, to value fidelity, and to permit the loved person to develop his own unique style of living. With all the pressures impinging on the adolescent that involve his developing sense of self-reliance and sense of masculinity, it is often difficult for him to put aside his own satisfactions sufficiently long to develop genuine intimacy. This is a process that has its beginnings in early life, becomes a significant factor in adolescence, and continues with many vicissitudes into adult life. Although sex can be pleasurable in the absence of love or of intimacy, for most people sex is greatly enhanced in the presence of an intimate concern with another person who is returning affection and tenderness.

An intimate relationship usually leads to marriage. However, more and more young people are living together outside a formal marriage

arrangement. The number of people below the age of 35 remaining single has gone up significantly between 1960 and 1970. There is greater concern with fidelity than with permanence. Nonetheless, over 90 per cent of people eventually marry.

Masters and Johnson estimate that over half the married couples in the United States have a significant sexual problem, and they are referring only to sexual effectiveness and competence, not to conflicts over sex-linked behavior, conflicts over differing perceptions about what is appropriate for a husband and for a wife. The battle of the sexes more often involves battles over sexual roles than conflicts over foreplay and coitus. Nevertheless, as indicated above, difficulties in sexual performance are very frequent; indeed, they probably affect every couple at least at some point in their marriage.

Human Sexual Response

The four phases described by Masters and Johnson, excitement, plateau, orgasm, and resolution, appear to be similar in males and females. One important difference is that men have a refractory period in which they are unable to repeat the ejaculation without an interval of some minutes at least, whereas females can have orgasms following each other at intervals of a few seconds.

Prior to the initial stage of excitement is a preparatory stage of sexual psychic arousal, sometimes called “the sexual motive state,” a psychic readiness for sexual activity. It is affected by many factors such as the partner, the setting, the mood, and the positive or negative effect of emotion (love, anxiety). The details of the four stages of human sexual response have been described thoroughly by Masters and Johnson.

Sexual relationships not only can promote intimacy but also can serve as a means of satisfying nonsexual needs such as the need for reassurance, playfulness, companionship, and so forth. Unfortunately sex is often the setting for aversive feelings such as anger, revenge, dominance, and self-aggrandizement. Angry feelings may make sexual activities a veritable battleground for the expression and reception of enraged attacks. If these negative emotions are coupled with some degree of sexual incompetence, marital disharmony is assured. Thus, marital sexuality can be said to be

bipotential, since it can serve as the expression of the most significant, tender, affectionate, and intimate feelings between two people or it can serve to release feelings of hate, revenge, and punitiveness.

Generally, a decline in sexual interest and in frequency of sexual intercourse takes place through the life cycle. In the forties the average frequency is closer to two times a week, whereas early in marriage it is about four times a week. Nonetheless, as people get older they can continue to have an active and satisfying sexual relationship. Over 50 per cent of men in their sixties and at least 25 per cent of men over 70 continue to have satisfactory sexual experiences, even though the male has to depend much more on direct stimulation than on psychic stimulation as the threshold for his "sexual motive state" increases with age. Since his ejaculatory needs have diminished, he is better able to control his "staying power," slowing down his ejaculation far more effectively than at an earlier age. Sexual capacity in older people depends on continued sexual expression and interest through middle life and the availability of a willing and interested partner.

In middle age many couples report waning sexual interest. This is either a reflection of a lack of variety and the routinization of sexual behavior or a reflection of other aspects of their relationship. Sexual gratification is more often a barometer of the total relationship than a result of an insufficient variety of partners or sexual behavior. If open communication and mutual

participation in a range of interests have gone on throughout marriage, sex is likely to be fulfilling and enhancing. Clinics dealing in marital therapy report that about 75 per cent of couples coming for counseling have a significant sexual problem, but only 15 per cent have a sexual problem that is a primary cause of marital disharmony. In the other 60 per cent sexual problems are a consequence of disharmony in other areas of their relationship.

Areas of Sexual Dysfunction

Major disturbances of sexual functioning such as homosexuality, transvestitism, voyeurism, exhibitionism, fetishism, and sadomasochism are covered in other volumes of the *American Handbook of Psychiatry*. This chapter is meant to deal with more common vicissitudes of sexual functioning, most of which occur within the context of the marital or other sex- pair relationship. This chapter will contain discussions of impotence, premature ejaculation, ejaculatory incompetence, paradoxical orgasm, and, in addition, certain disturbances in relationships (created by ignorance or the influence of anxiety, guilt, or rage), conflicts over sex-linked behavior, difficulties in communication and perception, conflicts over frequency of sexual relations or choice of methods of sexual stimulation (such as oral-genital sex and coital positions), conflicts over the emotional components of sexuality, and infidelity. Finally this chapter will deal with special problems of the single male such as the fear of intimacy, the fear of marriage, and performance anxiety.

Comments on History Taking and Interviewing

Skills in history taking and interviewing are, of course, related to a person's general skills in interviewing. One must learn to be a good interviewer before one is competent to talk to a patient with a sexual problem. The usual dimensions of interviewing apply here as well as

elsewhere. The interviewer should follow the patient's leads and not unduly structure the interview so as to cut off information and the flow of affect. Generally he should try to use nonstructured questions and "bridges" when changing topics. Obviously, here as elsewhere, the greater his mastery of the field the greater will be his competence in taking a history and in interviewing during following sessions. In general, the interviewer must develop a style that fits his own personality.

In taking a sexual history or in interviewing a patient with a sexual problem, special skills are required. Since sex evokes so many highly charged feelings, and anxiety and embarrassment are such frequent occurrences, the interviewer's attitude and manner are all-important. If he is uncomfortable he will communicate his discomfort to the patient whose embarrassment will increase. Conversely, if the interviewer is comfortable and relaxed, the patient will soon overcome his own anxiety. If the patient is clearly inhibited about discussing sexual matters, the therapist must take the initiative. Sometimes the decision whether to probe or wait until the sexual material comes up in a more appropriate context after the patient has worked through some of his resistances is a difficult one, and the interviewer will have to depend on his experience to make such a judgment. More often than not, gentle and tactful questioning turns out to be the most effective means of eliciting information and associated feelings.

In the opinion of many psychiatric educators, residents in psychiatry are not exempt from the almost universal anxiety and embarrassment found in other house officers in dealing with sexual problems of patients. Most of them have never learned this kind of interviewing when they were medical students, and little is done during residency training to teach the management of patients with sexual problems. As a consequence anxiety about one's lack of competence ("competence anxiety") occurs frequently. The only cure for this anxiety is to carry out interviewing under close supervision until the psychiatrist's growing skills make him more confident of his ability.

Sexuality is an area in which the physician's own unresolved problems can create particular countertransference difficulties. For example, he may be inhibited about questioning because of his own unconscious voyeurism, or his guilt about certain facets of sexuality may create much discomfort. Anxieties about potential homosexual behavior may create a blind spot in dealing with related aspects of sexual attitudes and behavior. Anxieties about his own sexual performance may lead either to inhibitions in interviewing or to a counterphobic brusqueness and aggressivity. His own sexual standards and life style may be in contrast to those of his patient, yet he has to learn not to be unduly influenced by his own sexual morality and preferences. One should not impose one's values on the patient. Condemnatory feelings about premarital or extramarital relations will certainly damage the relationship

and interfere with communication between doctor and patient. Attempting to “liberalize” a patient before he is ready for the suggested behavior may be just as injudicious. As in any psychotherapeutic encounter, timing is all-important—timing of questions as well as of suggestions.

In general, there are certain technical maneuvers or “gambits” the interviewer can follow. He can move from less to more highly charged areas—for example, from a discussion of marital relations to sex within marriages; from a discussion of wet dreams to masturbation; from a discussion of dating to petting to intercourse. He can discuss the ubiquity or normalcy of behavior as a way of broaching the subject—for example, “The majority of married people engage in oral-genital sex, so tell me your feelings about this.” One can assume normalcy when asking about masturbation or other facets of sexual behavior. Instead of asking “Did you ever masturbate?” it is more effective to ask “How young were you when you first masturbated?” Another help in sexual interviewing is to ask about attitudes before behavior. The physician may say, for example, “Research tells us that the majority of married men have one or more extramarital relations. What are your feelings about that?” It is usually easier for the patient to talk about his attitudes than about his personal experiences. Another general technique is to learn what expectations the patient may have entertained before actually undergoing certain experiences. “What were your expectations on your honeymoon?” followed by “How did your actual experiences match your expectations?”

The content of a sexual history can be subdivided into the following categories: identifying data, childhood sexuality, which should include family attitudes about sex, learning about sex, childhood sex activity, primal scene and childhood sexual theories or myths, the onset of adolescence, orgasmic experiences before and after marriage, feelings about oneself as masculine (or feminine), sexual fantasies and dreams, dating, engagement, marriage, including premarital sex with partner, the wedding trip, sex in marriage, extramarital sex, sex when divorced or widowed, sexual deviations, certain effects of sex activities such as venereal disease or illegitimate pregnancy, and the use of erotic stimuli. It may be helpful to use a structured questionnaire such as the Sexual Performance Evaluation, a form developed at the Marriage Council of Philadelphia. This questionnaire permits the patient to answer questions about his own and his spouse's perception of a variety of sexual behaviors.

There are special advantages to interviewing husband and wife together, a technique called "conjoint interviewing." The physician has the opportunity of observing their interaction firsthand by the way they look at and talk with each other as well as by their bodily movements. In these cases he gets important information about their feelings and attitudes toward each other. Facial expressions and movements of the body may indicate concern, protectiveness, disdain, anger, and so forth. The physician is able to watch how a husband and wife attempt to control their relationship. If a wife

complains that her husband gives her little affection, one can observe very directly whether the husband has the capacity to express affectionate feelings or even angry feelings.

In every marital situation there is a perceptual system with eight dimensions. The husband has a perception (1) of himself, (2) of his wife, (3) of his wife's perception of him, (4) of the marital relationship. This is likewise true for the wife, who has the complementary perceptual system. The interviewer is able to check this perceptual system and get immediate feedback. To take one example, the therapist may ask the wife, "How do you think your husband feels about the way you respond to him in bed?" (Her perception of his perception of her.) She will respond and the interviewer can then turn to the husband and say, "How does this fit in with the way you feel about her sexual responses?" (His perception of her.) In this fashion one can get immediate feedback about any of these perceptual areas or about communication in general. It is sometimes helpful to have a spouse repeat back what the other one has just said in order to make certain that one of them is not being "tuned out" by the other.

When one therapist is working with both the husband and wife, the usual format is to take a short sexual history from the husband and wife together to get some notion of their interaction and then to interview each of them separately, either on the same occasion or at the next interview. If a dual

sex therapy team is doing the interviewing, as recommended by Masters and Johnson, it is customary to have the husband interviewed by the male therapist and the wife by the female therapist separately and then switch at the next session so that each marital partner is being interviewed by the therapist of the opposite sex. Conjoint interviewing then takes place at the third session.

The use of a dual sex therapy team has many advantages. Better understanding is assured by the identification between the therapist and the patient of the same sex. Often the therapist of the same sex can articulate the feelings of that patient far more effectively than the two members of the opposite sex in the room. As in any group therapy situation, the co-therapists can aid each other in multiple ways such as clarification of points, making observations that the other therapist has missed, checking misdirected interventions by one therapist, and so forth. In addition, both transference and countertransference responses are diminished by dual sex conjoint interviewing.

Diagnosis or Appraisal

The therapist needs to define the sexual problem as precisely as possible. More than that, he must be able to appraise how the sexual problem fits into the fabric of the patient's life. The man who comes in complaining of

impotence and wants treatment for this dysfunction presents a different problem to the therapist than does the patient who comes in for treatment of his depression, but who discloses occasional episodes of impotence when he suffers a blow to his self-esteem.

Because one's sexuality is so interwoven with one's interaction with others, it is rather difficult to categorize sexual problems without diminishing the unique and subtle aspects of an individual's life style. Yet some gross categories are aids to conceptualization. Sexual problems are either overt and out in the open in the initial interview or soon after, or they may remain masked by a variety of other symptoms such as depression, phobia, anxiety attacks, obsessive ruminations, and bodily complaints. Sexual problems may be a consequence of difficulties in the relationship, or they may have arisen almost entirely from difficulties prior to the relationship, especially influenced by early life experiences. Of course, the relationship may augment or exaggerate potentialities for dysfunction that the patient brought into the relationship. With some patients the sexual problem is critical in the sense that not only does it serve as an important source of unhappiness and lowered self-esteem, but also it is a significant threat to an important relationship. With other patients the sexual problem seems to be less significant and takes second place to other difficulties in adaptation and relationships. Further complications are created by different perceptions of the problem by the partners. A 37-year-old schoolteacher came for help

because of impotence. Indeed, there had been no satisfactory coital experience for seven years. When his wife was interviewed, it turned out that she was less concerned about the sexual dysfunction than about her husband's lack of interest in her needs, his "selfishness" and passivity. It is usually impossible to treat the sexual problem without dealing with the total marital or sex-pair relationship.

In making the appraisal, the history can be organized around the following considerations : (1) the circumstances under which the symptom first occurred, (2) the patient's reaction to the symptom, (3) the wife or partner's reaction to the symptom, (4) the nature of the marital interaction, (5) situational components (the symptom may appear only at times or may occur only with the wife or with a mistress).

Based on the appraisal, the therapist must decide whether the patient requires conjoint marital therapy or individual treatment. These considerations will be taken up more thoroughly in the section on Therapeutic Considerations.

Impotence

The impotent man cannot achieve and/or maintain an erection sufficient for him to penetrate the vagina and maintain successful coitus. In *primary impotence* the man has never been able to complete coitus satisfactorily because of his failure to achieve an erection. In *secondary impotence* the male's rate of failure to complete successful sexual intercourse approaches 25 per cent of his opportunities, according to an arbitrary definition of Masters and Johnson.

Primary Impotence

This condition is relatively rare. Masters and Johnson treated only 32 males with primary impotence over an 11-year period. The dominant feature in these men is the association of sex with sinfulness and dirtiness. Guilty fear is the "emergency" emotion found most frequently. There may have been frequent sexual, although not necessarily coital, experiences with the mother during adolescence or intense restrictions may have been placed on the adolescent boy during his dating and courting period, resulting in an almost complete absence of sexual encounters with girls. When some encounters take place, there is such a feeling of awkwardness resulting from his fumbling efforts at sexual contact that anxiety about his competence is added to the underlying feeling of wrongdoing. For their mates these men tend to select virginal wives whose own inexperience augments the male's awkward efforts.

In some men a homosexual predilection, either overt or covert, leads to a failure in erection with a heterosexual partner. Humiliating and degrading experiences with prostitutes during the initial attempts at sexual intercourse are other contributing causes. Occasionally initial coital efforts under the influence of alcohol or drugs leaves a highly vulnerable young man with the impression that he is totally incompetent sexually. Initial failures, whatever their underlying cause, are then intensified by the strong anxiety about adequate performance.

Secondary Impotence

Over 90 per cent of cases of secondary impotence are psychogenic, yet the therapist must be aware of the possibility of some defect in the machinery of the body. The differentiation can be made readily. If a patient is able to have an erection from any source, whether from foreplay or during masturbation, or if he wakes up with morning erections or is aware of erections during nighttime dreaming, it is clear that there is no neuromuscular or circulatory disorder affecting his capacity to have an erection.

Systemic Disease

Of all the systemic diseases that are associated with secondary impotence, diabetes mellitus is the most frequent. Occasionally secondary

impotence is one of the earliest symptoms of diabetes. The reasons for the relationship between impotence and diabetes are not clear, since one does not always find neuropathy in such cases. Other systemic illnesses in which impotence occasionally occurs are syphilis, multiple sclerosis and other degenerative diseases of the spinal cord, and even more infrequently endocrine dysfunction such as hypopituitarism and hypothyroidism. Infections and intoxications may produce temporary secondary impotence. Weakness and fatigue seem to be the significant factors.

Local Disease

Local disease such as phimosis may, by its associated pain on erection, cause secondary impotence. The effects of castration are variable, although most adult males will not be troubled by impotence following castration. The effects of prostatic disease and prostatectomy are also variable, although again the vast majority of patients following prostatectomy do not demonstrate impotence. The specific method of prostatectomy does play some role in that there are more cases of impotence following the perineal method. However, impotence is not an inevitable consequence of even radical surgery.

Drugs

Many drugs taken in excessive quantities may cause impotence. This is

particularly true of alcohol and the opiates. Even sedatives and tranquilizers may be implicated. While small doses of amphetamines may delay ejaculation in some men, larger doses may cause either impotence or ejaculatory abnormalities. The same is true of the psychoactive tranquilizers such as Mellaril.

Aging

As has been indicated earlier, aging is not an inevitable cause of impotence. If an active sexual life has been maintained through middle age and there is a willing and cooperative partner, men are often capable of having adequate erections in their seventies or even eighties. Because of the decrease in ejaculatory need, premature ejaculators in early years find that this disturbance disappears in midlife. The decreased need to ejaculate also affects the arousal state of the male. He is more dependent on local stimulation than he was in his early years, and psychic factors have less capacity to bring on quick arousal. A man may have satisfactory sexual intercourse without ejaculation, and if his partner understands this and does not demand ejaculation as part of a “normal” coital experience, the man’s increased control may result in highly satisfactory coital experiences.

History Taking and Interviewing

The precise details of secondary impotence must be elicited. The

difficulty may be situational, occurring at certain times in certain situations or with certain partners. It may follow a pattern in that the occurrences may follow some competitive defeat in work or in athletic competition. They may occur following angry encounters with the partner, and the anger itself may be a consequence of a specific pattern of interaction between the man and his wife. If it occurs, for example, almost every time the wife has been flirtatious at a cocktail party, this factor and its psychodynamic significance needs to be clarified. Sometimes impotence occurs only with ingestion of too much alcohol or drugs.

After establishing the pattern the history taking should be organized around the topic suggested earlier.

Circumstances under which Secondary Impotence First Occurred.

The first episode of impotence often occurs after excessive ingestion of alcohol or attempted coitus when the patient is excessively fatigued, preoccupied, or distracted by some interruption of sexual activity such as children's voices, unexpected telephone calls, and the like. Other important causes in the first episode are anger at his wife, the failure of his wife to respond, or guilt toward his wife, perhaps for some extramarital relationship, real or fantasied. Occasionally the first episode occurs because of something that has nothing directly to do with the patient's sexual life. It may have followed a failure in work or in social life. Some humiliating experience

outside the home may be responsible for the first episode. The interview should be directed toward determining as precisely as possible the circumstances surrounding the first episode.

The Patient's Reaction to the Symptom. The degree of embarrassment this causes varies from man to man. Sometimes it is so intense that the man's entire life is affected. He may become seriously depressed and unable to function. At any rate the most common response is a redoubled effort to perform properly, which in itself augments the problem since one cannot will an erection any more than one can control his breathing for any length of time. The more the man concentrates on his performance, the less able he is to have an erection or to maintain it. The other frequent response is an increasing avoidance of sexual encounters in order to avoid embarrassment.

The Wife's Reactions. Sometimes the wife is understanding, sympathetic, and supportive. This makes treatment much easier. However, more frequently the wife is frustrated and angry. She may increase her demands on the husband perhaps thinking that she is losing her attractiveness and wishing reassurance, or she may withdraw from sexual activity in order to avoid the frustration or to protect her husband from his own embarrassment and humiliation. At any rate an expression of disappointment or frustration on her part adds to the man's sense of

humiliation. He may redouble his efforts to please his wife; the increased demand for performance can only have an adverse effect on his sexual competency.

Nature of the Marital Interaction Including the Sexual Relationship.

In the majority of cases secondary impotence is a response to other difficulties in the marriage. Interviewing should be aimed at elucidating the nature of conflict areas in the marriage as well as those affiliative forces that may improve the prognosis. A detailed history of the marital couple's sexual interaction will be helpful to put the present difficulty in its historical context. The degree of responsivity of the wife is an important factor. Whether premature ejaculation preceded the development of impotence is another factor.

Situational Impotence. As has been indicated, a man may be impotent with his wife but fully potent with a mistress or the reverse may be true. Sometimes a man is potent with only one type of woman, such as one from a different ethnic background or social class. Misidentification of wife and mother is the most frequent instance of this. Because of repressed incestuous impulses toward his mother, he separates passion from love. Passion is evoked by a woman who reminds him least of his mother. Since sex is also associated with sinfulness and wrongdoing, he is most often passionate with a female whom he views as degraded, such as a prostitute. Women are put into

two polarized categories, Madonnas or prostitutes, angels or whores, or as someone has said, Marys or Eves.

It is probably true that all men have some anxiety about maintaining potency especially with the advance of age. Most highly vulnerable are those men with a deficient sense of masculinity (gender identity) in whom castration anxiety is particularly strong. In these men the anxiety that follows the initial failure to achieve or maintain an erection is so intense that the fear of failure (performance anxiety) plunges the man into repeated episodes of impotence. In this connection I am indebted to Jules Masserman for a differentiation between “anxiety” and “panic.” Anxiety occurs when for the first time a man is unable to achieve an erection twice, and it is panic when for the second time a man is unable to achieve an erection once.

Case Illustrations of Secondary Impotence

Case 1: Guilt over an Extramarital Relationship. A man in his mid-forties had been impotent for two years. Although occasionally troubled by premature ejaculation, he had had little trouble achieving or maintaining an erection in more than 20 years of marriage. Two years prior to his seeking help, influenced by stories of his business partner’s extramarital adventures, on two occasions he had attempted intercourse with a young woman. He was impotent on both occasions. Feeling great remorse over his ineffectual

attempts to be “one of the boys,” he became impotent with his wife as well. Treatment ultimately involved both marital therapy and individual treatment for him.

Case 2: Impotence as a Result of a Wife’s Bitter Reproaches. A man in his mid-thirties had been impotent for seven years. Raised in a family in which the males were given complete care and attention by the females, very little was asked in return except to be breadwinners. When he married he didn’t have the faintest notion that he would have to give his wife any emotional support. He married a woman who had been previously married and divorced. She had had two difficult pregnancies and deliveries, fraught with considerable danger because of eclampsia. When she became pregnant for the third time (the first in his marriage), the husband became even more indifferent and virtually left her alone all during the labor. Her feelings of isolation were heightened by some careless and inconsiderate nursing care. She never really forgave her husband for his neglect. Consequently she began to withdraw from him emotionally, while she reproached him for his passivity and lack of concern. From premature ejaculation he began to ejaculate with semierections, and then finally he developed a complete case of secondary impotence. Conjoint marital therapy was the treatment of choice.

Case 3: The Man Who Liked Nymphets. A retired businessman in his late thirties had frequent episodes of impotence. Raised by a domineering

mother, he fantasized that the vagina was a huge hole that would engulf him. As a consequence he preferred nymphets whom he could fondle and caress but with whom he avoided coitus. He enjoyed foreplay with his wife but would try as much as possible to avoid sexual intercourse. On the other hand, his wife's idea was that any kind of sex that did not quickly move on to coitus was perverse. Both of them were highly frustrated by this interaction. Again marital therapy was employed to resolve this dilemma.

Case 4: Impotence Resulting from a Fear of Marital Entrapment. A man in his late forties had been married for less than a year almost 15 years earlier. He had had no difficulty with potency prior to his marriage and during the first three months following the wedding. When his wife became pregnant she announced that this was all she wanted out of the marriage and refused him any further sex. Within the year they were divorced. Following this trauma, the patient had a phobia that he would impregnate a woman and then be trapped into another unfortunate marriage. He did not trust any contraceptive method. He had been impotent with scores of women during the ensuing years. On only one occasion was he potent. This followed his partner's discovery that his condom, into which he had ejaculated with a semierect penis, was still in her vagina. The patient began to tremble, to sweat profusely, and to feel faint, but within 20 minutes he had the best erection he had had in 17 years and was able to have successful coitus for the first and only time. Discussion of his feelings during this episode revealed that

his fear of pregnancy had been completely relieved by the fact if he were going to impregnate the woman, he had already done so and no further harm was possible. By the time he came for treatment his phobia of impregnating a woman was so intense and so impervious to reason that he would not even consider the possibility of vasectomy.

Case 5: A Bisexual with Fear of Women. A man who had had extensive homosexual encounters in adolescence and early adulthood was married to a nonorgasmic female. Coitus had never been consummated. The patient had previously been married to a woman with whom he had had no erectile difficulties until he discovered that she was having an extramarital relationship. His mistrust of women, which had been submerged during his first marriage, came to the surface. He selected a woman who had a violent misconception of sex and who unconsciously sabotaged any possibility of overcoming the husband's fear and mistrust of women. This vicious cycle necessitated marital therapy.

Case 6: Revenge through Impregnation. Years ago, long before the pill, a man of 40 came for consultation because of impotence. By his count he had impregnated 14 women by putting holes in his condoms. His story was that at age 13 he had discovered his mother, to whom he had been closely attached, in bed with his father's employee. He chose a unique method of gaining revenge on all women by "knocking them up." The only way he could

have intense sexual excitement was when there was the danger of impregnating his female partner. It was with great glee that he would receive the news that the girl was pregnant. As a crude jest he called himself "Jack the Dropper." Over time his pleasure had begun to wane, and he no longer got an intense thrill from his vindictive triumphs. Ultimately, in a somewhat unusual example of the law of the talion, "an eye for an eye and a tooth for a tooth," he became impotent. His depression was so intense that he required psychiatric hospitalization.

Premature Ejaculation

Premature ejaculation is difficult to define. If a man characteristically ejaculates prior to vaginal penetration, almost everyone would agree that this behavior is abnormal. When he ejaculates within one to two minutes after entrance, the pathological nature of his behavior is much less certain. Kinsey reported that this is the average time; hence he found nothing abnormal about it. Since rapid ejaculation is found among animals of diverse species including the primates, Kinsey held that in the human rapid ejaculation was a natural expression of a biological phenomenon. Assuming this to be true, if the male is interested in bringing his partner to a climax, he must learn how to control ejaculation, for only a small minority of women seem to be able to respond within one or two minutes following intromission. (Highly responsive women can masturbate to orgasm within two to three minutes, but even these women are not usually that quickly responsive to coitus.) Whether a man is a premature ejaculator therefore depends on two factors: (1) the nature of the interaction between himself and his sexual partner, and (2) the norms established by society. It is clear that female satisfaction is a cultural demand in our society. Presumably far fewer men were labeled as premature ejaculators in Victorian England.

Given these two factors, an arbitrary and historically time-bound definition is inevitable. Presumably the one set forth by Masters and Johnson

is as workable as any. They consider “a man a premature ejaculator if he cannot control his ejaculatory process during intravaginal containment for time sufficient to satisfy his partner during at least 50 per cent of their coital exposures.” However, they immediately point out that this definition is absurd “if the female partner is persistently non- orgasmic for reasons other than rapidity of the male’s ejaculatory process.”

It is impossible to ascertain the prevalence of premature ejaculation. For every male who presents himself to a therapist for treatment, presumably there are thousands who try to deal with their failure to control the speed of ejaculation as best they can without professional help. Since cultural expectations play a role, it is probable that there are important social class differences. Among many people in the lower social class, there may be no recognition that such a malady exists. If the husband is intent only on his pleasure and sheds responsibility for his wife’s pleasure and if the female takes little pleasure in coitus and would just as soon get it over with, then neither will complain about premature ejaculation. Furthermore, it is probable that premature ejaculation is an almost ubiquitous phenomenon during adolescence. The cultural demand for speed, especially when sexual activity is being carried out in situations where the couple may be “caught” as in the back seat of a car or in the living room of the girl’s parental home, predisposes the adolescent to the development of premature ejaculation. Anxiety about being caught is superimposed on anxiety about performance,

which in itself is well-nigh universal. If, on top of this, there is also fear of impregnating the girl, along with the feeling that one is doing something wrong anyway, the combined anxiety will almost certainly produce premature ejaculation.

It is difficult to separate psychological from physiological factors; the intense erotic arousal in young males, especially when there has been infrequent contact with the opposite sex, and the heightened excitement of a new or relatively new experience, coexist with the anxieties cited previously. It is little wonder that premature ejaculation occurs so frequently. What is more remarkable is that the majority of men seem able to learn to control ejaculation either before or during marriage.

Essential to this control is a desire to please one's partner and the ability to recognize the subjective sensation just prior to ejaculatory inevitability. If this ability to recognize the penultimate subjective sensation is absent, there is nothing the man can do to prevent ejaculation. But if he learns to recognize this internal signal, he can stop thrusting or otherwise signal his partner to modify their pelvic movements in order to decrease excitement. This is the rationale for the "squeeze technique" developed by James Semons and elaborated by Masters and Johnson. This will be discussed under Specific Forms of Treatment in Sex-Oriented Therapy.

In marriage or other close sex-pair relationships, feelings of resentment toward the partner may in themselves cause premature ejaculation. However, probably many thousands of men enter marriage with a marked fear of performance and fear of their partner's scorn and ridicule and continue the pattern of premature ejaculation for many years. Some of these men learn that frequent coital experiences will help them gain control since their ejaculatory demand is decreased. Similarly the decrease in ejaculatory demand with aging produces greater control.

The typical case coming to the therapist is that of a man in his late twenties or early thirties who, after five to ten years of marriage, has had a fairly constant pattern of premature ejaculation. His wife is also nonorgasmic at least through coitus, although she may be fully responsive with other methods or partners. The pattern of sexual disappointment and angry reproaches has heightened the demands for performance that only increase the man's anxiety and failure. This vicious cycle requires marital therapy for its solution.

Ejaculatory Incompetence

Ejaculatory incompetence is defined as the inability to ejaculate in the vagina during coitus, despite a good erection. Occasionally one finds a male who is even unable to masturbate to ejaculation, but most men who have ejaculatory incompetence have no such difficulty. The condition is rather rare. Masters and Johnson report having seen only 17 males with ejaculatory incompetence in an 11-year period. It probably is not as rare as the literature would lead one to believe. I have seen five cases in the past two years.

Psychodynamically, ejaculatory incompetence is related to premature ejaculation, even though physiologically they are the converse of each other. In many cases marked guilty fear seems to be the most prominent emotion. Severe reprisal for masturbation and even for nocturnal emissions may result in a marked fear of ejaculation. Ejaculation may mean a successful and pleasurable completion of masturbation that increases the guilt, or it may simply mean that detection is that much more possible since the soiled clothes or bed sheets may be a cue to repressive parents. On occasion a fear of impregnating a woman is also implicated in the etiology. Many cases turn up striking examples of psychic trauma. Masters and Johnson report the case of a young man who was caught at the point of ejaculation by the police while parked in a lover's lane. In another case they cite, children burst into the room just as the husband was ejaculating. Since these experiences must

happen to thousands of people without the development of ejaculatory incompetence, it has to mean that the groundwork for ultimate dysfunction has been laid prior to the traumatic event.

Of special interest in some cases is the fantasy that the male will either soil or be soiled in the process of ejaculation; either the vagina is seen as a dirty hole, contaminating the penis, or the ejaculate itself is seen as a contaminant of the female partner. In a number of men the symptom merely indicates a "holding back," an inability to give of oneself to a partner who is either despised or hated. Either out of hostility to the woman or the fear of impregnating her, some men deliberately stop thrusting when they are about to ejaculate. If this is done over a period of time, unconscious mechanisms take over and the man becomes unable to ejaculate even if he consciously wants to.

An unusual case of ejaculatory incompetence was discovered in an 18 year old who could not masturbate to ejaculation. He had started to masturbate at about 11 but never could ejaculate. His first seminal emission occurred when he was 14. He masturbated frequently during the three-year period before the first seminal emission and established a pattern of masturbation without ejaculation, probably on a physiological basis to begin with. He also was intensely frightened by the first wet dream and thought that he had developed a serious illness. In three sessions a member of my staff,

with reassurance and education, was able to cure a symptom that had been present for seven years.

Paradoxical Orgasm

This is a very rare condition in which male orgasm, generally with a semierect penis, occurs in inappropriate places and circumstances. Unlike the midstage between premature ejaculation and impotency in which ejaculation occurs with a semierect or flaccid penis, but in which the circumstances are highly appropriate to erotic arousal, paradoxical orgasm occurs in situations in which sexual arousal is entirely out of place. In most cases studied, orgasm takes place in a competitive situation, such as the conference room of a corporation during a business meeting or an argument over the telephone. On occasion paradoxical orgasm will take place in symbolic enclosures like a phone booth. But even here the conversation during the phone call is usually of a competitive, aggressive nature. Psychodynamically these men have markedly aggressive impulses, unconsciously murderous in nature, while at the same time they have a strong fear of retaliation. Symbolically they want to “put it out” but are afraid it will be chopped off. These men usually have pseudohomosexual anxieties, if not latent homosexual impulses. They are usually incompetent with their wives or sex partners, having either severe premature ejaculation or impotence.

Relationship Problems

Since the majority of sexual problems within marriage or other close sex-pair relationships arise out of conflict in nonsexual areas, with the sexual problem being a manifestation of these other areas of dysfunction, it is important to at least take passing notice of the kinds of problems that frequently create sexual difficulty. Inner conflicts in the male between passivity and self-assertion or between dependency and self-reliance lead to difficulties in assuming the masculine role. As compensation for passivity and dependency, the male may be overassertive, making his wife feel she is an object for use and manipulation rather than an equal co-partner. However the man may directly act out his passivity and dependency by being markedly underassertive, giving his wife the feeling that she has a baby to care for instead of a man to lean on when she needs him. All of these problems can lead not only to the difficulties cited above, but also to conflicts over frequency of sexual intercourse and arguments over types of foreplay or coital positions. Inner and interpersonal conflicts over the expression and control of emotions or words—in general, over communication—are almost invariably found in evaluating a marital unit with sexual difficulties. Feelings of resentment about the failure to communicate feelings or to express sufficient sexual interest are other frequent complaints. All of these can lead not only to dissatisfaction with the sexual aspect of the marriage, but also to infidelity.

Infidelity

The incidence of extramarital sex is increasing. Recent figures from the Institute of Sex Research at Indiana indicate that about 60 per cent of husbands (35 per cent of wives) have had at least one episode of extramarital sex by midlife. The number of people involved alone would tell us that not all of them are reacting to neurotic conflicts. Extramarital sex may result from a search for variety, sometimes even sanctioned by the spouse, who may be engaging in parallel affairs. In many cases no lasting harm is done to the marriage and on occasion it may be beneficial. If the wife is not available sexually because of physical or emotional handicaps, or is simply not interested in sex, extramarital sex may satisfy the man's erotic interest without endangering the marital relationship. This may be true as well if the wife is interested in sex but not responsive. The lack of response may diminish the husband's interest in marital sex while it awakens his interest in extramarital sex. Without outside interests the marriage would be threatened. Infidelity may be an alerting signal that something is wrong with the relationship, and it is possible for the partners to react constructively when both are aware that the marital difficulties have reached a point of crisis.

Since most people are acculturated to believe not only in permanency but in fidelity, extramarital sex is often destructive of the relationship.

Diminished self-esteem, a consequence of feeling less preferred than the mistress or lover, may lead to depression or rage, with frequent marital quarrels, withdrawal from the relationship, or retaliative extramarital sex. Even when one partner seemingly accepts the situation with resignation, passive-aggressive techniques may eventually sabotage the marital relationship.

If the therapist is consulted because of infidelity, marital therapy is almost always the treatment of choice. If, however, it is a repetitive pattern, apparently indicative of neurotic conflict, individual psychotherapy may be preferable. Some of the frequent inner anxieties or conflicts leading to infidelity are an intense search to prove one's gender identity, the Madonna-prostitute complex, and a fear of intimacy.

Nontraditional Relationships

Cluster marriages in which two or three couples live together, a ménage à trois, and group sex are the most frequent types of nontraditional sexual styles found among married people. However, few people come for help because of living in a nontraditional relationship. Of these newer forms group sex has been the only one studied extensively, and that has been studied by participant observation rather than by clinical experience with the participants. In group sex the emphasis is on sexual pleasure, not on the relationship; indeed, intimate, affectionate relationships are a threat to the lustful enjoyment of sex for its own sake. One of the striking findings in group sex is the marked increase in homosexuality, especially among females, that seems to take place in this setting. Group sex (swinging) either attracts people with the potential for homosexual or bisexual behavior, or it releases impulses that are widespread in the population but are held under check within traditional relationships. The former explanation is more likely than the latter.

Special Problems of the Young Man

The adolescent and young adult male frequently is torn by internal sexual conflicts. On the one hand, he has to manage intense feelings of sexual arousal, demanding release and gratification, augmented by the need to prove his masculinity. On the other hand, even if he does not have to deal with moral anxiety based on some association of sexuality with sinfulness, almost always he has to cope with the fear that he may not be a competent sexual performer. As has been indicated previously, these anxieties provide the basis for premature ejaculation and, occasionally, impotence.

The capacity to develop intimate relations develops slowly over a number of years, and the fear of intimacy is omnipresent. This may take the specific form of fearing to make a girl pregnant and the consequent premature commitment to a permanent relationship. Young men's frequent fear of marriage slows down the development of a capacity for intimacy and occasionally interferes with sexual competence itself. Another problem seen fairly often is the misconception of sex as an act of violence. This leads to a fear either of hurting the female or of being hurt in return. The fear of genital damage or diminution commonly referred to as castration anxiety may be highly significant in interfering with sexual performance. Any of these anxieties inhibiting appropriate dating and courtship behavior, compounded by a perceived personal rejection by the opposite sex, may create the fear that

one is homosexual; this, in turn, augments the underlying fears about one's heterosexual competence and sets up a vicious cycle increasing the loss of pleasure and decreasing effective heterosexual adjustment.

Therapeutic Considerations

The selection of appropriate therapy is of prime importance. A patient should not be placed in a given modality of therapy merely because the therapist is skillful in that form of treatment. This means that the therapist has to become competent in a variety of forms of therapy or, failing that, he has to be able to refer patients to another therapist who possesses the requisite skills in the appropriate method of treatment. The modalities in the treatment of sexual problems fall into three main groups: (1) individual therapy, (2) marital therapy, or (3) a combination of these. Individual therapy may consist of reconstructive psychoanalysis, individual psychotherapy (psychotherapy with more limited goals than the reconstruction of personality), or behavior therapy. Elsewhere in the *American Handbook of Psychiatry* various forms of therapy are discussed in detail. Essentially behavior therapy has three basic techniques: (1) gradual desensitization, (2) flooding, (3) the assignment of tasks outside the treatment to overcome inhibitions. Another form of behavior therapy less frequently used is aversive therapy. Marital therapy may consist of conjoint therapy, the modality in most frequent use at this time, seeing the husband and wife separately, or a combination of the two. Conjoint marital therapy requires specialized training since the skills required are quite different from those involved in individual therapy. If marital therapy is generally the treatment of choice in problems of sexual dysfunction, as I believe, it means that relatively few psychiatrists have

been sufficiently well trained to be competent sex counselors. Although 50 per cent of departments of psychiatry now claim that they teach some form of marital therapy, less than a handful have organized formal courses or programs in marital therapy apart from family therapy. A combination of individual psychotherapy or behavioral therapy and marital therapy is sometimes indicated.

What are the factors that determine the selection of treatment? The expectations of the patient are important. If he comes in for individual therapy and sees himself as the primary recipient of psychiatric care, this may either preclude marital therapy or the patient may require persuasion that marital therapy is the better choice. Put briefly and concisely, the issue is whether the relationship between the husband and wife or the intrapsychic conflicts of the patient will be the focus of therapy. If the relationship is to be the focus, the spouse's cooperation is mandatory. If the husband and wife come in together to deal with the problem, there is an explicit expectation that the relationship will be dealt with. Even in this situation one spouse may consciously or unconsciously sabotage the efforts of the therapist. If the patient has come in alone and the spouse's cooperation is required, efforts will have to be made to obtain her commitment to the therapeutic process. Most spouses can be brought in willingly if they are asked to cooperate in the treatment process by aiding the therapist to overcome the patient's difficulties. If the wife has any commitment to the marriage at all, this appeal

generally is effective.

When marital therapy is the treatment of choice, the therapist has to decide whether his primary approach will be a “sex-oriented” therapy or a “marriage-oriented” therapy. In sex-oriented therapy the emphasis is on the sexual adjustment, and the various forms of marital disharmony are worked through as they form resistances to the treatment of the sexual dysfunction. In marriage-oriented therapy the emphasis is on the total relationship, and the sexual adjustment is a secondary consideration until enough of the problems in the marriage have been worked through so that the therapist can tackle the sexual problems directly. In the former approach the hostility of one spouse to the other might manifest itself as a refusal to follow the regimen set forth by the therapist. If coitus is interdicted in the first phase of treatment, he or she might attempt intercourse out of an unconscious wish to prevent the treatment from becoming successful. One partner may go through the motions of acting in accordance with the suggestions of the therapist and still fail to respond emotionally to the change in performance. When the marital relationship is the focus rather than the sexual problem, problems of communication, mutual hostility, and so forth are dealt with first in order to increase the motivation of the couple to try to work more effectively on the sexual problem.

Specific Forms of Treatment in Sex-Oriented Therapy

Impotence

For a full description of the technique developed by Masters and Johnson, the reader is referred to *Human Sexual Inadequacy*.³⁰ Basically their program involves three stages: (1) nongenital pleasuring, (2) genital pleasuring, and (3) nondemand coitus, in which the less involved spouse acts as “co-therapist.” The essential ingredient of the treatment of all sexual dysfunctions is avoidance of the demand for performance. The impotent patient must be protected from the demand for penetration both from his spouse and himself. This decreases the fear of being incompetent. As a method of treating impotence, the need to avoid sexual intercourse and to decrease the patient’s own demand for successful penetration has been known for a long time, at least since the time of John Hunter over 200 years ago. He claimed that he was able to treat impotent men successfully by insisting that they “refrain from coitus during six consecutive amatory experiences.” This principle has been thoroughly developed by Masters and Johnson.

After the couple has learned the pattern of mutual pleasuring that Masters and Johnson called the “sensate focus,” erotic arousal has been increased, and the male has had a series of successful erections, the wife (or partner surrogate), in a superior (on top) coital position in a place and at a

time when she can control the decision for penetration, places her mate's penis in her vagina until the man can appreciate the sensation of vaginal containment without ejaculation. In this fashion his confidence is built up until he can generally last for 15 to 20 minutes before ejaculation. If his penis becomes soft, the woman withdraws, repeats the stimulation until erection is secured, and once again mounts him. This process is repeated until impotence is overcome altogether.

If the male is not married or has no partner whom he can bring in for sex-oriented marital therapy, individual therapy is the only form of treatment that can be applied. The therapist then has to choose between psychoanalysis, individual psychotherapy, or behavior therapy. Behavior therapists have concentrated their efforts on frigidity rather than on either impotence or premature ejaculation, yet there are isolated reports of the successful behavioral modification of both conditions. Desensitization, with or without the assignment of tasks outside of therapy to overcome inhibitions, is the prevalent mode of behavior therapy of male sexual dysfunction. If, for example, the hierarchy of feared situations involves anxiety about telephoning or making contact with a female, the patient may be assigned the task of carrying this out in addition to desensitization in the therapist's office. In successive stages the patient is brought through finding a partner, hand holding, petting with clothes on, undressing and light petting, heavy petting, and finally, coitus. In psychotherapy the decision to deal with the total

personality or to deal primarily with symptom removal is critical. The approach may be primarily historical, dealing with psychic traumas and their effect on present functioning, or therapy may emphasize the anxieties in the patient's current life, hoping that a cognitive technique may decrease inhibitions sufficiently so that the patient begins to carry out in real life what he has thus far been unable to do.

Premature Ejaculation

A special sex-oriented technique to treat premature ejaculation has been devised by Masters and Johnson based on a technique for the individual male originally formulated by Semons. The "squeeze technique" involves the female placing her thumb and two fingers at the coronal ridge of the penis when she has been signaled by her mate or realizes through other cues that he is about to ejaculate. Firmly squeezing the penis in this fashion will prevent ejaculation and cause partial flaccidity. This is repeated many times until the male senses the sensation just prior to ejaculatory inevitability. Since he can stop stimulation at this point, this gives him greater control. Eventually he learns to signal his mate when he senses that he is about to ejaculate, and both of them can stop or decrease their efforts at mutual stimulation. In this way the patient acquires the necessary control to continue intromission for 15 to 20 minutes. The individual male who does not have a partner can learn to apply the squeeze technique himself (the original recommendation of Semons).

Ejaculatory Incompetence

Masters and Johnson suggest that the wife masturbate her partner to ejaculation. When this is successful it is rare that the patient fails to be able to ejaculate in the vagina. Ejaculating in the presence of the female seems to be the first necessary step in the process of overcoming this difficulty. In my experience inhibiting attitudes toward the mate have to be worked out. These almost invariably are feelings of hostility, sometimes deeply buried beneath a facade of agreeableness and a desire to please the female.

Special Forms of Marital Therapy

If marriage-oriented therapy is the treatment of choice, the relationship is dealt with until sufficient motivation is developed to begin the treatment of the sexual problem. When this motivation is high and the interfering emotional factors have been reduced, then the sex-oriented therapy just described can be used effectively. The dual sex therapy team, recommended by Masters and Johnson, has many advantages, some of which have been described earlier in this chapter in the section on Interviewing. Since most therapists do not have access to another therapist of the opposite sex, they should be reassured that they can handle these problems effectively although perhaps over a somewhat longer time than when a dual sex therapy team carries out the treatment.

A special form of treatment of sexual problems is the treatment of groups of couples with sexual problems. When this is done the use of audiovisual aids is very helpful. Showing groups of couples explicit pictures of sexual encounters developed by the National Sex Forum interwoven with small-group discussions, in which partners are separated, has been very useful in overcoming inhibitions and increasing the ease in communication between the husband and wife. In a similar fashion audiovisuals may be used with individual couples.

The psychotherapist who wishes to treat sexual dysfunction

competently should learn a variety of techniques so that he can select the appropriate one for a particular patient. Since many of these techniques are not taught in residency or graduate training, some postgraduate training in the more specific treatment modalities described in this chapter seems necessary. Since sexual problems arise most often in the context of a marital relationship, and since, furthermore, in over half the couples the partner of the “presenting” patient also has a form of sexual inadequacy, marital therapy is the most important of these modalities.

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