Contemporary Themes

Three years' experience in a sexual problems clinic

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The demand for help with sexual problems appears to be increasing, but there are very few clinics in Britain that deal specifically with such problems. We report here our experience of such a clinic in the Oxford area and hope to provide some guidance about the work load and other problems that have arisen in such a service.

The clinic

The clinic is organised by a consultant psychiatrist with a special interest in sexual problems and working within a university department of psychiatry. The clinic takes up one session a week at which the staff—the consultant, a lecturer and a senior registrar in psychiatry, and two part-time women psychiatrists—see three to four new patients and also provide continuing treatment for other patients. These five people each contribute one to one and a half sessions a week to the clinic, in some cases seeing patients at times outside the regular clinic session. Each new patient or couple is given one and a half hours for initial assessment. All married patients are asked to attend with their spouses and unmarried patients with sexual partners are asked to bring their partners with them if the referring agency had indicated that this would be appropriate. During each clinic the staff members meet for half an hour to discuss the new referrals and decide what treatment should be offered.

There is also a pool of other health professionals who have asked for supervised experience in treating sexual problems. During the past two and a half years 30 professionals have gained this training; they have included psychiatric trainees at registrar and senior registrar level, clinical psychologists, general practice trainees, social workers, medical students, and one nurse.

These trainee therapists are allocated patients or couples from the waiting list, arrange treatment in their own time, and attend one of two supervision groups held fortnightly by the consultant psychiatrist. Some selection is exercised in this allocation, those cases presenting more obvious difficulties being given to therapists with more experience. Treatment in most cases is based on a modified Masters and Johnson method.[1 2] The supervision groups are used to deal with practical management along these lines so that each therapist can learn not only from his own experience but also from that of others in his group. In most cases a therapist will remain in the group while treating one or two couples. Some stay on to gain more extensive experience. In some cases therapists work in co-therapy pairs, though most work individually. In addition to this form of treatment brief counselling and, when appropriate, drugs are also provided by members of the clinic staff. A treatment research project has been in progress during the past 18 months, and this has absorbed some of the treatment load.

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Referrals

The numbers of referrals have increased over the past three years, from 151 in 1973 to 227 in 1974 and 273 in 1975. The 50% increase between 1973 and 1974 no doubt reflected an increased awareness of the clinic's existence rather than an increased incidence or need. Referrals have also tended to come from an increasingly large area.

To assess local service needs we therefore took a defined area around Oxford within about a 12-mile radius and consisting of both urban and rural areas (this area was used originally for a different research project and is described precisely elsewhere[3]). The area has a population aged over 15 of about 219 000 (1971 census). Referrals from within this area were 135 in 1974 and 139 in 1975, which suggests that the number of referrals from the local area is stabilising. Over the past year the waiting period for the first assessment has been about three months.

The patient population

Details of 200 consecutive patients or couples assessed in the clinic between 1 January 1974 and 21 April 1975 were analysed. These 200 were from a total of 275 patients referred during that period (73%). Of those not seen 52 cancelled or did not keep their appointment and 23 were not accepted because they lived too far away.

Of the 200 patients seen 98 were men and 102 women (in the case of a couple the sex of the partner with the principal sexual difficulty was recorded). The sources of referral are shown in table I. The types of sexual problem, mean age, and numbers of patients with a sexual partner are shown in table II. It was rare for a woman without a current sexual partner to seek help, whereas almost a quarter of the men were without partners.

TABLE I—*Source of referral of 200 patients*

	General practitioner	Psychiatrist	Gynaecologist	Family Planning Association clinic	Other
No of men ..	77	12			9
No of women ..	60	19	12	6	5

Treatment

The proportion of patients who have received treatment is shown in table III. In 86 cases treatment was either offered and rejected or considered inappropriate. Reasons for the latter included one partner not prepared to participate, no suitable place for regular love making (in the case of some unmarried couples), language difficulties, or the problem being secondary to psychiatric or physical illness which was to be treated elsewhere. In the absence of such reasons and when both partners were prepared to accept our method of treatment it was unusual for treatment not to be offered. Rejection of the offer usually reflected ambivalence in one or both partners, either about the relationship continuing or about changing the sexual status quo, or difficulty in accepting the conditions of our treatment approach, which demanded, for example, regular visits, both partners being involved, and "home assignments."

TABLE II—*Types of sexual problems in men and women*

Male problems	No of men	Mean age (years)	No with partner	Female problems	No of women	Mean age (years)	No with partner
Erectile impotence	41	42·1	32	General unresponsiveness	63	30·1	63
Premature ejaculation	23	35·8	12	Orgasmic dysfunction	18	30·4	18
Ejaculatory failure	9	32·8	6	Vaginismus	12	24·9	12
Homosexuality	12	30·1	6	Deviant sexuality	3	24·3	1
Other deviance	9	37·0		Miscellaneous	6	32·5	6
Miscellaneous	4	41·5	3				
Total	98	37·8	68	Total	102	29·5	100

TABLE III—*Stage of treatment in 200 consecutive patients according to presenting problem*

Problem	Treatment completed*	Still receiving treatment	On waiting list	Given advice only	Offer of treatment refused or inappropriate
Women					
General unresponsiveness	30	5	1	1	26
Orgasmic dysfunction	11				7
Vaginismus	8	1			3
Others	2	2			5
Men					
Erectile impotence	15	1	2	1	22
Premature ejaculation	9	1			13
Ejaculatory failure	5				4
Others	17	2			6
Total	97	12	3	2	86

* This includes those who dropped out (see table IV).

TABLE IV—*Outcome and duration of treatment in those with certain problems who completed treatment or dropped out*

	Successful outcome		Worthwhile improvement		No worthwhile improvement		Dropped out	
	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions
Women								
General unresponsiveness	12 (40)	8	11 (37)	13	5 (17)	13	2 (7)	3·5
Orgasmic dysfunction	3 (27)	5·5	5 (45)	14			3 (27)	3·5
Vaginismus	6 (75)	17			1 (13)	14	1 (13)	3
Men								
Erectile impotence	5 (33)	9	2 (13)	9·5	3 (20)	5	5 (33)	3
Premature ejaculation	1 (11)	18	4 (44)	10·5	1 (11)	11	3 (33)	3·5
Ejaculatory failure	2 (40)	9	2 (40)	6			1 (20)	6
Total	29 (37)	10	24 (31)	12	10 (13)	10·5	15 (19)	3·5

Outcome

Assessing the outcome of treatment is a complex matter which can be done adequately only in a research setting. Here we report very crude assessments made by the therapists, who were asked to assign each couple to one of the following categories: (*a*) presenting problem largely resolved, treatment successful; (*b*) some problems continue, but sufficient improvement to make treatment worthwhile; (*c*) insufficient change to make treatment worthwhile; (*d*) problems deteriorated or worse; (*e*) relationship came to an end; (*f*) dropped out before treatment had chance to make any impact.

The outcome categorised in this way is shown for the principal types of sexual dysfunction in table IV, together with the mean number of treatment sessions in each category.

Discussion

Although this clinic has not dealt with all the patients referred for specialist help with sexual problems in our area, it has certainly seen most of them. The work load appears to be stabilising. Two factors may have contributed to this: firstly, a three-month waiting list before the first appointment may have discouraged some patients, and, secondly, the clinic's setting in a psychiatric department may have discouraged others. The best place for such a clinic is not in a psychiatric hospital but either in a community health centre or in a general hospital.

A difficulty in establishing the number of sexual problems in a given population is that there is a very wide range of severity of such problems, and indeed few sexual relationships do not have scope for some improvement with better awareness and improved communication. Various factors will determine whether a couple consider a problem sufficiently important to seek professional help, in particular referral to a specialist clinic. Severity is one factor, the social implication of referral is another, and the efficacy and acceptability of the help offered is a third. Therefore if the clinic was made more available and acceptable there might be some increase in the number of referrals. Nevertheless, our experience represents a fair guide to the work load that would arise in a specialist clinic in any other comparable area. The 200 cases seen during the 16-month period studied generated 1100 to 1200 hours of clinical work. Assuming that treatment involves one rather than two therapists, such a work load should be manageable with six or seven sessions of counsellor/therapist time a week. It is important that both a male and a female therapist are included in the clinic team and that appropriate medical and gynaecological skills are available. Nevertheless, the clinical commitment could readily and appropriately be provided either as small parts of full-time contracts or on a part-time sessional basis.

The distribution of types of problems reported here is probably representative of the range of sexual problems presented to clinicians. The older age of the men presenting,

particularly those with erectile impotence, is similar to that reported by Milne[4] in a comparable clinic. There is no evidence that this is associated with a longer duration of the problem in the couples with a male presenter, and this raises the possibility that different aetiological factors, related in some way to aging, are operating among men. Categorisation on the basis of the type of sexual dysfunction, though traditional, is probably of limited value as it may exclude patient characteristics, such as the degree of performance anxiety or the amount of resentment in the relationship, which are more relevant to assessing the response to treatment. The high proportion of people rejecting or not being considered suitable for counselling indicates the complex nature of and the high degree of ambivalence associated with many of these interpersonal problems. Any treatment which requires a high degree of commitment from both partners should be expected to meet with a high rejection rate in such a clinic population.

Substantial benefits for two-thirds of those receiving treatment is an encouraging outcome, given that much of the treatment was given by therapists using the treatment method for the first or second time. With greater therapeutic experience this outcome should be improved further. The treatment approach has also proved to be both readily accepted by most therapists and easily taught and supervised. While the behavioural component is relatively straightforward, however, the psychotherapeutic element does require therapist skill and will be more important in those cases in which complex interpersonal or attitudinal factors are operating.

The negative association between the number of sessions and outcome suggests that those who do well with this method do so with relatively few sessions. Those who drop out of treatment usually do so after three or four sessions. This stage of treatment is generally a good time to appraise the likely outcome, and in those cases in which the prognosis is uncertain a limited contract of three or four sessions can be made in the first instance.

We hope that our experience with this clinic will encourage health authorities in other areas to establish such a service, which would demand only limited resources and yet help to solve problems that have widespread and long-term repercussions on family health.

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References

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Clinical Topics

Attitudes and advice after myocardial infarction

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Summary

While medical opinion increasingly favours an active approach to rehabilitation after myocardial infarction, interviews with 40 patients and their relatives showed a low degree of understanding of medical advice and information. There was general satisfaction with treatment, but communication was seen as often being inadequate, vague, and conflicting.

Introduction

Medical opinion increasingly favours an active approach to convalescence from myocardial infarction, and current textbooks and reviews[1] emphasise the value of initiating such treatment from the earliest stages. The problems in communicating information to patients[2] and the cautious and pessimistic lay views of heart disease lead to the expectation that it will be difficult to convey positive views about convalescence and exercise. It is important, therefore, to take into account the beliefs and attitudes of patients and their families. While their descriptions cannot be taken as valid accounts of what actually happened, presumably the patients' understanding and interpretation of information and advice, rather than what was actually said, determine their attitudes, satisfaction, and behaviour.

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Methods

During the pilot and early stages of a larger study 40 patients (aged 34-69) were interviewed using a semi-structured schedule during the first week after myocardial infarction and again at home a month after discharge from hospital. Spouses were similarly interviewed at home at the time of the hospital admission and separately at follow-up. Interviews were tape-recorded. Medical notes were scrutinised.

Results

PATIENTS

Patients (see table) found it difficult to recall the early stages of illness. At the initial interview most were satisfied and indeed very grateful for the quality of their care, in both the coronary care unit and the general wards, but seemed to have very little understanding of diagnosis, the nature of hospital treatment, or longer-term implications. Most accepted this, saying, "The doctor will tell me if there is