Sexual Counseling in Medical Practice

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Sexual problems and marital discord are aspects of emotional difficulty in living that have been relatively neglected by the medical profession. There has been little recognition of the profound role that family life has on the physical and emotional health of the individual. Physicians tend to treat the individual without recognizing that family interactions may play an important part in the efficacy of the therapeutic program prescribed. When confronted directly with a patient's marital or family conflict, most physicians feel overwhelmed, become defensive, and make perfunctory attempts to give advice that is usually banal and inane. ("You ought to spend more time at home. Why not cook his favorite dishes? Stop drinking. When are you going to stop beating your wife?") If the difficulty is sexual incompatibility, the doctor is frequently as embarrassed as the patient. Although the anatomy and physiology of the genital organs are studied in great detail in medical schools, little has been taught on the functional, social, and emotional use of these sexual organs. Therefore, the physician's handling of the subject of sex will depend on his own sexual experiences, on the cultural concepts and taboos learned in his own upbringing, and on his observations regarding sex in his clinical practice. The result is that his advice is limited, his prescription of drugs is ineffectual, and he or the patient beats a hasty retreat. The patient may, or may not, be referred to a psychiatrist or a family agency. Sometimes even the psychiatrist is at a loss and he, too, passes the buck to a family social agency.

Psychosexuality

The following summary of psychosexuality can serve as a frame of reference for the physician in evaluating the sexual complaints of those who consult him. The physician needs to become knowledgeable about the factors that affect sexual behavior, for it is particularly in the area of sexological information that the physician's education has been neglected. (Several excellent texts are available on the latest understandings and techniques; a bibliography is included at the end of this article.)

Sexual relationships in human beings involve two factors: the biological need for lustful gratification and the emotional need for intimacy and physical closeness. The healthy fulfillment of one's lustful needs not only involves the specific behavior leading up to sexual intercourse, but also includes the assertive expansiveness of the individual's masculinity or femininity—his sexual identity.

Sexual Identity

Sexual identity is determined by an admixture of the following biological and social factors:

1. *Biological sex.* This is determined by chromosomes, external genitalia, and hormonal status.

2. *Gender identity.* This is determined by the perception and conceptualization of the roles of maleness and femaleness. Gender identity is social, and studies have shown that parental attitudes toward the infant's gender, attitudes which are unambiguous and clearly delineated from birth until the age of two or three, fix the gender identity for life.

3. *Child-parent relationships.* These are important in developing healthy sexual attitudes. The conditions necessary for normal heterosexual development are:

a. The child's identification with the parent of the same sex. The parent must not be too weak, nor so punishing that the child rejects the parents as a model for adult attitudes and behavior.

b. The child's trust in the parent of the opposite sex. This parent must not be too seductive, punishing, or emotionally inconsistent, or the child will develop a fear of the opposite sex.

c. The child's acceptance of his biological sex. The child must not feel that his biological sex is unacceptable, inferior, or rejected. The parents must manifest acceptance of the child's sex, and they must not attempt to teach or influence the child to adopt the opposite sexual role.

4. *Cultural value systems.* These are most significant in our society, because it promulgates certain models as the social ideals for masculinity and femininity. The tall, broad-shouldered, slim-waisted athletic man with the features of Adonis epitomizes masculinity. The five-foot-five, shapely legged, slen-

der-waisted, ample-bosomed, delicately featured woman represents the American feminine ideal. Unathletic boys or masculine-looking girls sometimes embrace the roles of the opposite gender, in reaction to others and because of their own distortions of their identities, in acceptance of the dominant social values of their environment. Intellectually precocious boys or scientifically oriented girls may be labeled sissies or unfeminine by their peers or the adults in their environment and may assume that they lack appropriate sexual abilities. Acceptance of value orientations may be covert and unspoken, implied by social attitudes of those around them. The segregation of the sexes in schools may affect the person's gender role, particularly at the preadolescent and adolescent levels when sexual curiosity and development are most rapidly occurring.

5. *Sexological knowledge.* This involves learning the appropriate use of the genitalia and the processes involved in lustful fulfillment, which are important determinants of sexual identity. Because lustful desires are biological, it is often assumed that human beings are reflexively knowledgeable in the art of making love. It is an interesting commentary on our culture that we recognize the need to teach our youth proper eating habits and to train them to use their muscular prowess athletically; that we have charm schools, beauty and barber schools, dancing schools, schools for making friends and influencing people; but that nowhere do we teach human beings the elementary techniques for the skillful fulfillment of a basic, biological process. Many men and women have questioned their sexual identity because they lacked knowledge of the mechanics of making love. This involves not only a lack of knowledge on how to satisfy the partner, but also a lack of knowledge on what is involved in gaining full satisfaction for the self.

The second factor in sexual relationships, the need for physical and emotional closeness and intimacy, is equally important in the full gratification of the human being's sexual needs. Sex can be enjoyed on a purely lustful basis, as a sporting activity, but a more intense gratification occurs when it is integrated with our need for mutual emotional closeness. We can enjoy a meal with a relative stranger and generally would prefer the company of someone, rather than dine alone. Our enjoyment is infinitely increased when the meal is partaken with someone whose interests we share and with whom we feel free to express our innermost feelings. Love, a feeling for another person to the degree that his satisfactions in living are as important as one's own, enhances the pleasure of any human activity, whether it be eating, walking, or sex. A subfactor in human sexual behavior is our need for physical contact with others, an aspect frequently overlooked. Human beings have a need to touch other human beings physically. (Try going 24 hours without touching another person. It is possible to do so, but you will find that you have a strong urge to put your hand on someone's arm, to shake hands, or to just rub shoulders.)

Sexual Problems

In general, sexual problems are due to: 1) ignorance of the sexual facts of life, or 2) contamination of the sexual area by other desires, wishes, needs, or fears on a childish level, e.g., considering sexual intercourse to be a criterion of worthwhileness, control of the other person, physical hurt, and so on. Two examples best illustrate these factors.

a. A woman patient confided that she had no interest in sexual intercourse, did not receive any pleasure during the act, and reluctantly had intercourse out of a sense of duty to her husband. Inquiry revealed that she was not sexually frigid, and that she masturbated two to three times a week by clitoral stimulation with orgastic satisfaction. When asked why she could not reach the same satisfaction during intercourse, the patient revealed that, throughout the 20 years of her marriage, she had thought that gratification during intercourse resulted from the penis touching something deep inside her vagina and that clitoral stimulation and excitement were only for masturbation. The final irony is that this college-educated woman is married to a doctor of clinical psychology.

b. A man in his 40's complained of impotence of approximately two years' duration. Prior sexual relationships with his wife had been highly satisfactory. The marital relationship had always been somewhat strained, but two years earlier the conflicts had become more severe. Due to the intensification of the conflicts, he completely lost his erection one night in attempting intercourse. He became concerned as to whether he had lost his manliness, he experienced intense anxiety whenever he attempted intercourse, and he either failed to have an erection or lost the erection at the time of penetration. The lustful activity was contaminated by his concern about his sense of identity as a man, which he equated with the ability to have intercourse. Intercourse became a trial to determine his worthwhileness, rather than a pleasurable gratification of a lustful need. In this marital conflict, the loss of emotional closeness and feelings of mutuality initially diminished the desire for sexual intercourse; and the husband's subsequent questioning of his own virility and worthwhileness completely blocked the sexual relationship. The reestablishment of communication with the wife, the resolution of the marital conflicts, and the resolution of the husband's anxieties regarding his own worthwhileness

and identity restored the mutually satisfying sexual relationship. In most situations there is some overlapping and intertwining of both factors.

Sexual Counseling

A prerequisite to successful sexual counseling is the physician's attitude about sexual matters. He must not only be aware of and accept his own sexual impulses, but also must recognize that his sexual concepts are only one among many patterns of sexual adjustment. If he wittingly or unwittingly assumes that there is only one right pattern of sexual behavior, he will be judgmental rather than understanding of the patient's problem, and he will tend to be condemning, rejecting, or disdainful of the patient's difficulties. On the other hand, he may feel benevolent and, with missionary zeal, decide to rescue the poor soul and show him the right path. He might, because of his own sexual fantasies, encourage or privately admire the patient's sexual adventures or misadventures. There are other overt and covert forms which this judgmental attitude may take, but, regardless of the form, the attitude interferes with the physician's friendly, interested objectivity.

Interested objectivity permits the physician to understand the patient's problem, and understanding is what the patient is primarily seeking. "The patient who is troubled needs understanding and clarification of his difficulties, and the doctor is in a unique position to bring this about. The patient does not need moral persuasion or censure, which he can obtain in abundance from other sources; it is unfortunate if the doctor fails to recognize this opportunity and instead, like others before him, promotes a particular solution or deplores another." (Wahl, 1967, p 242.)

Unfortunately, many physicians have the mistaken idea that understanding psychological problems requires a different type of thinking than understanding physical problems. The same processes and techniques that are involved in obtaining a medical history and in understanding the presenting complaints are applicable in psychological counseling. The difference is that, in the former situation, the physician is attempting to conceptualize physical morphological processess and, in the latter, he is conceptualizing psychological attitudes and emotional patterns.

Specific Procedures

The specific procedure in sexual counseling is, first, to give the patient a chance to state the problem. Patience is required, because this will probably be the first time he has ever discussed his problem with anyone. He may be embarrassed, anxious, and concerned as to how you will react to what he has to say. An interested, matter-of-fact, non-judgmental attitude implying that he cannot tell you anything you have not heard before is immensely helpful. Simply communicating his difficulty to an understanding, nonprejudiced person is a tremendous relief to the patient. The doctor has already helped him. He has exposed himself—laid himself bare—and nothing has happened. If the physician now follows through with the same matter-of-fact understanding manner by asking pertinent questions to elicit further details of the problem, the patient will generally collaborate.

The procedure is the same as that carried out if the patient complained of a pain in his chest. How long has he had the problem? How frequently does it occur? Under what circumstances is it more or less severe, and so on? The physician is not being sadistic or morbidly curious; he simply needs to know the full picture so that he can understand the difficulties the patient is experiencing. The patient may protest or may be embarrassed, but, knowing that the doctor is attempting to understand him, he will cooperate. It is important to obtain the full picture, not only of his present sexual problem, but the history of his sexual experiences. This should include his exposure to sex as a child—the manner in which he discovered the difference between the sexes. Did he see either of his parents nude? What degree of modesty existed in the family? What was the parents' attitude toward sex? Did he learn about sex at home or on the street? How old was he when he first masturbated? When did he begin to date? When did he first have intercourse? What type of girl or boy was involved, and what kind of an experience was this? Did he enjoy the experience? What subsequent sexual experiences have occurred up to the present time? Has he ever had any homosexual experiences? All of these questions and many more permit the physician to make the necessary differential diagnosis as to the particular type of sexual problem that may be involved. Most errors in medicine are caused by lack of a thorough examination and evaluation of the components of the problem. This is equally true on a psychological level. Thorough investigation and evaluation are the keystones of successful sexual counseling. Such a procedure permits the physician to determine what the problem actually is and to ascertain whether the difficulty lies in an ignorance of the sexual facts of life or a contamination of the sexual area by other emotional needs, conflicts, or desires.

Steps in Counseling

The physician is now in a position to assist the patient in handling his problem. Notice that the phrase is "assist the patient in handling his problem." In contrast to the practice of physical medicine, the physician cannot do something to or for the patient, but can only

assist him in doing something for himself.

First, he can clarify the problem for the patient. The aforementioned example of impotence is a situation in which the problem was not impotence but a problem of marital conflict. Patients of both sexes have appeared in my office with the presenting complaint of fear that they were homosexuals. This was based on either an erotic fantasy about, or a feeling of affection toward, a person of the same sex. In some cases, the patient has interpreted his or her inhibited, shy behavior toward the opposite sex as an indication of homosexuality. After all, what more clearly expresses one's doubts about one's own sexual identity than being homosexual. These patients are usually lonely people with little or no sexual contact with either sex, who equate their thoughts, feelings, or fantasies with actual behavior. Clarification of the presenting problem can be of infinite help to the patient, eliminating many pseudo problems and decreasing anxiety.

Second, the physician can supply the correct sexual information when the patient is misinformed. A large proportion of sexual counseling cases can be handled at this level, despite evidence that a deeper personality problem may be present. The degree of ignorance about sexual matters, even among intelligent, well-educated people, is amazing. The lack of appropriate sex education has resulted in a lack of knowledge about elementary sexual physiology and psychology and the perpetuation of old wives' tales and superstitions. Many marital crises have occurred because one or both partners lacked knowledge about foreplay, techniques of arousal, frequency of intercourse, and what constitutes an orgasm. Many persons have questioned their sexual identity because of misconceptions about the size of their sexual organs, secondary sexual characteristics, or the degree of their responsiveness to erotic stimulation. The physician himself should explain these matters to the patient rather than refer him to a sex manual. No sex manual can answer the specific questions that a patient might have and, not infrequently, the patient does not understand what he has read. In addition, reference to a sex manual reinforces the implication that these are matters not to be openly discussed but only to be read about privately. Sometimes, a patient will request reading material. This request should be met, but only after a face-to-face discussion and arrangement of a follow-up interview to ensure a proper understanding of the reading matter. That is particularly important in premarital counseling. The romantic haze of the forthcoming nuptial event may temporarily block out the importance of a satisfactory and successful wedding night. The emotional excitement of being married obscures the realities of marriage.

Third, the physician can assist a number of patients whose problem is primarily a contamination of the sexual area by emotional problems of a more general nature. Many emotional problems of recent origin and mild degree can be helped by an understanding physician. Cases involving premature ejaculation, loss of sexual desire, impotence, and frigidity are often the result of the spilling over of concerns about one's health, acute anxiety regarding economic factors, worry and concern about members of one's family, reaction to marital conflict and strain, and mild agitation or depression. The sexual symptoms frequently disappear when the real problem is pinpointed and dealt with.

Fourth, there will be some cases in which referral to a psychiatrist will be necessary. Some cases of premature ejaculation, impotence, frigidity, promiscuity, and so on are deep-seated problems of long-standing and require the assistance of a skilled and experienced psychotherapist. The physican's role in these situations is to help define the problem, to clarify the need for therapy, to explain what is involved in therapy, and to refer the patient to a psychiatrist. Naturally, the patient himself must feel that he has a problem. If he is satisfied with his particular sexual adjustment, he will lack motivation to seek correction. There is an old adage "You can lead a horse to water, but you cannot make him drink." This aspect frequently occurs with homosexuals, who claim they are "happy" in their sexual adjustment. Although some experts in the field feel it is best not to cast doubts on a pattern of sexual adjustment which the particular patient does not see as a problem, it is, in my opinion, equally a disservice not to confront him with the possible consequences. Frequently, these situations can be handled by suggesting a consultation with a psychiatrist to evaluate the problem and confirm the physician's findings, rather than to initiate therapy.

There are other phases of sexual counseling which cannot be discussed here due to the time limitation. Among others, the problem of premarital contraceptive advice, the unmarried mother, the menopausal state, aging, adolescence, the handling of sexual problems in childhood are specific problems that warrant detailed discussion.

In summary, sexual relationships involve two factors: lustful gratification and emotional and physical closeness. Lustful gratification involves sexual identity which is determined by: 1) biological sex; 2) gender identity; 3) child-parent relationships; 4) cultural value systems; and 5) sexological knowledge. Sexual problems are due to ignorance of the sexual facts of life and/or to contamination of the sexual area by other needs, wishes, or fears. A detailed understanding of the presenting complaints and the sexual history of the patient will enable the physician to make a differential diagnosis. The physician

can then clarify the problem and assist the patient in eliminating pseudo problems. He can supply the necessary information regarding sexual functions about which the patient is misinformed. He can also assist those patients for whom the sexual area is contaminated by other emotional problems of a more general nature. Finally, the physician renders a service to the patient by defining and pointing out the existence of a serious sexual problem which should be referred to a psychiatrist for evaluation and/or therapy.

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