FORUM
PSYCHIATRY AND HUMAN SEXUALITY

Psychiatrists' role in the management of sexual disorders

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The considerable sociocultural changes concerning human sexuality over the past half century have had significant effects on the sexual attitudes and healthcare expectations of individuals and on the clinical scope and practice of psychiatry. This paper provides a brief background on the recent developments in views about nosology and the treatment of sexual dysfunctions and then focuses, specifically, on the role of psychiatrists when confronted with the increased number of patients seeking advice and help for their sexual concerns.

Historical background

The evaluation and management of sexual disorders had been the traditional province of psychiatrists among health professionals. Psychoanalysis was the prevailing theoretical model that oriented their clinical approach to sexual problems. Sexual and gender identity disorders were considered expressions of underlying unconscious psychological conflicts that required resolution by means of psychoanalytical exploration and treatment. Little attention had been paid to the nosological categorization of sexual disorders as illustrated by the American Psychiatric Association Diagnostic and Statistical Manual (DSM II) published in 1968 [1], in which all sexual dysfunctions were considered together with problems associated with micturition and menstruation under the rubric of psycho physiological genitourinary disorders.

The pioneering research of Masters and Johnson [2], based on psychophysiological recordings of sexual responses in the laboratory, broke new ground by structuring empirically derived observations in both sexes along a progressive sequence of phases: excitement plateau-orgasm-resolution, which they labeled the sexual response cycle. They later applied their physiological understanding to the treatment of excitement and orgasmic phase dysfunctions, reporting, in a 5-year follow-up study, considerable success in the rapid resolution of sexual symptoms after a 2-week daily therapy format. Their approach, by now well known, consisted of a male-female co therapist team treating couples by an amalgam of education, behavioral suggestions and relationship counseling. The book, Human Sexual Inadequacy [3], which summarized their clinical results, revolutioned therapeutic views about sexual dysfunction, opening the new field of sex therapy to clinicians with different orientations and training. Behavioral therapists, marital counselors and biologically oriented researchers contributed their unique perspectives, leading to more eclectic views about the pathogenesis of sexual symptoms. Helen Kaplan, a psychiatrists and psychoanalyst, exerted a significant conceptual influence by integrating behavioral, cognitive and interpersonal approaches with a psychodynamic understanding of the determinants of sexual dysfunction (4).

The 1970s were characterized by a rapid expansion of psychotherapeutic strategies aimed at the rapid resolution of sexual symptoms. The optimism that prevailed during those years was tempered, however, by the unfolding of outcome research. Although results from several studies indicated that sex therapy was effective, the relatively high number of patients who were treatment refractory and concerns about the stability of therapeutic gains raised challenging questions about the psychological treatment of sexual problems. The observation that for many of these patients

the primary difficulty was a deficit of sexual motivation led Kaplan to include a cognitive/motivational component in what she called the `trochaic' model of sexual desire, sexual arousal and orgasm, postulating that each of these phases is subserved by separate but interrelated physiological systems [S). This conceptual model oriented the classification of sexual dysfunctions in the 1980 Diagnostic and Statistical Manual of Mental Disorders (DSM III) [6], and remains basically unchanged in the currently revised version of the manual (DSM N, 1994) (7]. Although the validity of this model has been criticized, it has had important heuristic consequences, helping to orient treatment and research along clinically relevant dimensions.

During the 1980s and 1990s, important advances in knowledge as well as significant changes in attitudes about the evaluation and management of sexual disorders occurred. An explosion of information on the physiology of male sexual function was accompanied by an enhanced awareness of the deleterious effects of a wide range of medical and psychiatric illnesses and drugs on sexual behavior [8-IOJ. Although this vastly increased knowledge resulted in the development of valuable procedures for the diagnosis and pharmacological treatment of sexual problems, erectile dysfunction in particular, it also fostered dichotomous views about causation, with an unwarranted emphasis on medical solutions to sexual difficulties.

Sexual problems in psychiatric practice

With increasing frequency, sexually diseased individuals come to the attention of general practitioners, mental health professionals and specialists such as urologists and gynecologists. This development in health care is exemplified by the explosion of interest of men seeking help when an oral medication for erectile dysfunction became available. The prevalence of paraphilias and gender identity disorders in the community is not known but is likely to be as high as some of the more commonly recognized psychiatric illnesses. They are rarely identified in general clinical facilities, however, and are most frequently ignored as the focus of psychiatric research and treatment [11].

Evaluation

Although sexual difficulties may directly lead patients to see psychiatric help, more frequently, sexual problems and concerns underlie or are associated with other psychological, behavioral or medical difficulties, and remain undetected unless they are explored in a sensitive and non-judgmental manner as part of the assessment interview. Sexual problems and concerns, not classified as dysfunctional according to DSM IV diagnostic categories, are common, but their importance as a source of dissatisfaction and as determinants of help seeking behavior have been frequently ignored. Prevalent concerns center around the frequency and enjoyment of sexual activity, sexual orientation, unpredictability of sexual responses, body image, loss of sexual attractiveness, sexual boredom and distress about partners' loss of sexual desire. It is important, as part of the psychiatric evaluation, to define the history of the sexual complaint, identify the possible existence and nature of a sexual dysfunction, and explore the causes and contributing factors to the disorder. Equally valuable is information on the individual's and partner's reaction to the sexual impairment, the nature of their relationship, and their attitudes and expectations to possible treatment. Central questions are: is the sexual problem life-long or acquired?; is it generalized or limited to specific situations or partners?; is it associated with a general medical condition, or psychiatric disorders such as depression or drug use? Attention needs to be given to the neurological, cardiovascular and endocrine systems, to the deleterious effects of alcohol and tobacco, and to the side effects of psychoactive agents.

The difficulty in objectively assessing the contribution of organic factors has resulted in a bewildering number of ancillary diagnostic techniques for the assessment of erectile problems, and in a tendency to diagnose patients into mutually exclusive psychogenic or organic categories. The

rapidly expanding information on sexual physiopathology has had the unintended consequence of neglecting psychological and relationship factors. Ideally, the assessment of erectile difficulties, particularly in older individuals or when suspecting organic involvement, is best implemented in multidisciplinary clinics with a balanced access to medical and psychological expertise, where it is possible to carry out a comprehensive step-wise evaluation with the minima) amount of testing required for treatment implementation [12].

Management

The treatment of sexual difficulties has evolved considerably since the pioneering work of Masters and Johnson. Their highly structured method has incorporated over the years panoply of concepts and techniques that reflect the wide range of psychological determinants and biopsychosocial conditions. Awareness of the contribution of medical and pharmacological factors to sexual disorders has stimulated important sexological research that has underscored the multifactorial causation of sexual problems.

The growing array of evaluation and treatment alternatives may be confusing to psychiatrists when addressing the sexual complaints of men, mainly erectile dysfunction. The primary aim of treatment should be the improvement of sexual satisfaction for the patient and his partner, and should not be limited to restoring erectile capacity. The overall therapeutic strategy is based on an integrated approach, with equal attention given to psychological and medical issues. Psychologically, it involves educational, cognitive, behavioral and interpersonal interventions; which may be combined on the basis of the patient/couple's characteristics, the therapist's theoretical orientation, and the treatment setting. Medically, it includes the diagnosis and treatment of underlying chronic disorders as well as reversible medical conditions such as endocrine disorders, medication effects, alcohol and tobacco use. Clinicians should allow patients to reach an informed decision by providing an unbiased view of the nature of the sexual difficulty, and discussing the advantages and limitations of appropriate" therapeutic options [12,13J. Currently, oral drugs, such as sildenafil, a selective 5phosphodiesterase inhibitor, are the patients' preferred choice for treatment of erectile failure [14), but their routine prescription without appropriate evaluation carries the risk of overlooking relevant medical or psychological factors and increases the probability of treatment discontinuation and symptom relapse. Practical considerations such as a lack of expertise or àme limitations frequently result in referral to specialized medical eenters, where patients may follow diverse evaluation pathways with a common emphasis on medical approaches. It is important, for psychiatrists, not to relinquish their clinical responsibilities by ensuring that patients' psychological and relationship needs and sexual expectations are taken into account.

Training considerations

Psychiatric training programs have not kept pace with evidence of the high prevalence of sexual disorders and the important consequences they have for social adjustment and personal satisfaction. Many mental health professionals find themselves ill prepared to address the sexual concerns of psychiatric and medically ill patients and the socially destructive effects of paraphilic behaviors and criminal victimization. The dramatic public health impact of HIV infection and the deleterious effects of psychoactive medications and other drugs on sexual function have contributed to focusing attention on sexual aspects in clinical practice. However, training programs are usually deficient in providing up-to-dace information on sexual pathophysiology relevance o medical and psychiatric illnesses, and offer limited supervised clinical experience with sexually disordered patients. The lack of familiarity with an interactive, multidisciplinary model that orients the psychiatric approach by integrating psychosocial and biomedical information has had the unintended consequence that some sexual problems, such as male erectile disorders, are falling within the exclusive province of other medical specialties. Although the rapid expansion of medical

approaches for evaluation and treatment have made valuable contributions, it has also given rise to reductionistic views about human sexuality. Psychiatrists, because of their medical training, are well positioned to integrate information from the medical history, laboratory and physical examination with psychological and relationship data, in order to reach informed judgments as to the relative contribution and interaction of causative factors. Considerable evidence demonstrates that psychological interventions contribute significantly to the treatment of sexual disorders, but the clinical diversity of sexual problems require familiarity and the flexible implementation of strategies derived from behavioral, cognitive, psychodynamic and systemic frames of reference. Multidisciplinary outcome studies need to be carried out, however, to assess the therapeutic efficacy of efforts to address this important and frequently neglected aspect of patients' lives.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 2nd ed. Washington, DC: American Psychiatric Association; 1968.
2. Masters WC, Johnson VE. Human sexual response. Boston: Little, Brown: 1966
3. Masters WC, Johnson VE. Human sexual inadequacy.Boston: Little, Brown; 1970.
4. Kaplan HS. The new sex therapy. New York: Brunner/Maazel: 1974.
5. Kaplan HS. Disorders of Sexual desire. New York: Brunner/Maazel: 1979.
6. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 3rd ed. Washington, DC: American Psychiatric Association: 1980.
7. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th ed. Washington. DC: American Psychiatric Association: 1994.
8. Bancroft J. Human sexuality and its problems. New York: Churchill Livingstone: 1989.
9. Schiavi RC. Impact of chronic disease and medication on sexual functioning. In: Sexuality across the life course. Rossi A (editor). Chicago: University of Chicago Press; 1994. pp. 313~39.
10. Schiavi RC, Taylor Segraves R. The biology of sexual function. In: Clinical sexuality. Levine SB (editor). The Psychiatric Clinics of North America; 1995, vol. 18, pp. 7-24.
11. Berlin FS, Malin HM, Thomas K. Nonpedophiliac and nontransvestic paraphilias. In: Treatment of psychiatric disorders, 2nd ed. Gabbard GO /editor). Washington DC: American Psychiatric Press. 1995. Vol 2, pp. 1941-1958.
12. Schiavi RC. Aging and male sexuality. Cambridge: Cambridge University Press 1999.
13. Schiavi RC. Male erectile disorder. In: Treatment of psychiatric disorders, 2nd ed. Gabbard GO (editor). Washington DC: American Psychiatric Press. 1995. Vol. 2, pp. 1867-1885.
14. Osterich I, Eardley I, Carson CC, Padma-Nathan H. Sildenafil: a selective phosphodiesterase 5 inhibitor for the treatment of erectile dysfunction. In: Textbook of erectile dysfunction. Carson C, Kirby R, Goldstein I (editors). Oxford: UK: Isis Medical Media: 1999. pp- 285-308.

Advances in the treatment of sexual disorders

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From the beginning of the century, scientific sexology has gone through several stages. We would not have our current level of knowledge without the contribution of Freud, who maintained that libido is one of the main forces structuring the personality and generating actions, motivations and behavior. The First International Congress for Sex Research that took place in Berlin in 1926 initiated the interchange of knowledge in the post-Victorian age. Despite the Nazi attempt to disrupt it, it was the base from which Alfred Kinsey developed his reports about sexual behavior in

men and women [1,2], which caused great controversy at the time. From that, Masters and Johnson emerged and, after their publications in 1966 and 1970 [3,4), the modern investigation of human sexual response and the treatment of sexual disorders actually began. Helen Kaplan then introduced the concept of the New Sex Therapy [5], combining the psychodynamic approach with behavioral techniques. Other significant contributions have been those by John Money, the Dutch School, John Bancroft, Gilbert Tordjman, Patricia Gillan, Richard Green, Gorm VVagner, Shere Hite and, in the sexual education area, those by Mary Calderone, Harold Lief, Patricia Schiller, and the Scandinavian School. Finally, the World Association for Sexology was created in Rome in 1978.

Diagnosis of sexual disorders

In the field of sexology, if a good diagnosis has not been made, treatment will not be beneficial. Up to the present time, the dilemma between organic and psychological etiopathogenetic factors has passed through many tendencies. We can now conclude that every patient who has a sexual disorder presents both factors. For that reason, it is fundamental that the sexological approach takes into account both causal possibilities.

Detecting organic causes, evaluating psychological causes, and studying the subject's personality determine the impact of the medicines that the individual uses: Analyzing the expectations and inhibitions in each case and studying previous traumatic experiences are the essential bases of a good diagnosis. We have to begin doing this. On the basis of our clinical experience we have elaborated a Classification of Sexual Dysfunctions, which we hope may represent a contribution to their good treatment [6].

Basic sexual education

Coherent and complete sexual education programs should be implemented by means of the triad composed by parents, schools, and the mass media. This is, however, almost a utopia. The myth that sexual education perverts children and adolescents is difficult to defeat. It has been proved that the more serious and scientific the level of education, the more the individual will be capable of making correct and firm decisions.

Pretending that ignorance must be prompted in order to allow Iater learning is a heresy in any area of knowledge. Nevertheless, some people advocate it in the area of sexuality.

Relaxation

Anxiety is a common element in every patient with sexual problems. Using any relaxation technique, therefore, is often useful: the techniques of Schultz and Jacobson, meditation, yoga, taichi, and (fundamentally) frequent, progressively intense and endorphin-generating physical exercise. These are basic tools in any program of sexual therapy. We can now rely on important anxiolytic medicines that, if properly prescribed, may be very useful, mainly ac the beginning of the therapeutic process.

Relaxation, of course, can be measured, and this will also lead to the measurement of the five phases of the human sexual response: desire, excitation, plateau, orgasm and resolution.

Psychotherapy

The best definition of psychotherapy comes from Cox [7]: helping the patient to make those things he cannot do by himself. Summarizing, every sexual therapist must know the bases and models of marital psychotherapy, group psychotherapy, cognitive-behavioral psychotherapy, assertive training, and self esteem reinforcement techniques.

The disclosure phenomenon deserves a special mention. It is particularly significant in cases of infidelity and homosexuality, which are frequently encountered in daily practice.

Pharmacotherapy

The Blue Revolution (sildenafil citrate, 1997) has consolidated the advances achieved with the administration of intracavernous drugs (1992). The field of sexology entered a new phase with these extraordinary advances.

At present, an important therapeutic arsenal exists, including fentolamine mesilate, apomorphine, derivatives of estrogens and testosterone, and PT-14. The effort to find a medicine that has similar effects in women is the objective of a high-speed race. Likewise, complex medicaments that act at central and local levels will appear soon.

In addition, we know that many depressed patients have sexual problems. On the other hand, every patient with sexual problems may become depressed. However, antidepressant drugs often produce sexual side effects that may lead the patient to stop using them. The fact that the side effects of antidepressant drugs on the sexual response are usually given scarce attention (when they are actually mentioned) demonstrates the persistent difficulty in focusing on aspects that are related to sexuality.

Hormonal replacement therapies, as well as the use of yohimbine and bromocriptine, constitute another area of study.

Sexual therapy

Describing the sexual therapy conceived by Masters and Johnson as an art or amalgam of capacities and abilities that deserves all the respect of the scientific community is not easy. However, the basic techniques can be listed as follows: (a) teaching to touch and caress; (b) kissing; (c) masturbation (a word that generates rejection because of its previous implications, but a first order tool to achieve good sexual learning. We successfully use this l, 2, 3 technique in order to defeat resistance, which is greater in women: the couple observes first the masturbation in the man, then in the woman and finally practices mutual masturbation. Maybe using the term `auto-exercise of the sexual function', or any other similar term, would be preferable to defeat the huge resistance to the use of this practice with the purpose of achieving sexual satisfaction); (d) training of the pubococcigeous muscles in men and women; (e) erotic massages; (f) developing skills to facilitate intimacy; (g) oral sex; (h) anal sex; (i) sexual positions that allow learning the movement, as well as dancing successfully; (j) the Stop and Go Technique, introducing pauses to defeat the penetration anxiety or the immediate search of the orgasmic response; (k) the squeeze technique, to control premature ejaculation; (l) the bridge maneuver, to achieve in women a progressive gradient of excitement in the clitoris through the coitus; (m) the use of vibrators to reach a high level of relaxation; (n) clarifying fake conceptions that look for simultaneous orgasm or multiple orgasms, thinking that the level of satisfaction would be higher that way; (o) techniques to generate and communicate sexual fantasies; (p) visiting a sex shop, as a way to release tensions and defeat fears; (q) analizing the individual or the couple's quality of life by the use of standardized scales; (r) discussing sexual variations; (s) using our VESTAF scheme (Void routine: travel any time you can; Exercise your body; Satisfactory sexuality; Time, to be controlled; Abide hunger: eat in a balanced and healthy way; Fantasies, induction, recreation and communication).

Surgery

Three aspects should be mentioned in the area of surgery. The first is the use of prostheses to solve nonreversible organic erectile dysfunctions. These are improving all the time, and have very good results when they are indicated. The inflatable types are things of the past, because semi-rigid models, in which complications are less significant, have substituted them. We definitely believe that putting a definitive prosthesis in patient, who do not require them is unethical, but it is also unethical not to use them in persons who require them at a given moment. A multidisciplinary medical committee must approve this type of surgery.

The consequences of prostatectomy, a frequent surgical intervention that often impairs ejaculation, generate severe psychological consequences. Regrettably, doctors, do not inform the patient about this consequence, and this subsequently causes intense conflicts in the doctor/patient relationship.

Phalloplasthia is particularly important in the case of change of sex and in traumatic cases of partial or total amputation of the penis.

Conclusion

I would like to conclude this short paper by emphasizing the concept of interdependence in the couple relationship, described by Parra ~t a!. [8], which is becoming more and more useful in order to solve the different types of marital problems which, in the past, led to the `battle of the sexes'.
According to the World Health Organization [yj, 'sexual health is the integration of the somatic, emotional, intellectual and sexual aspects of the sexual being. in ways that are positively enriching and that enhance personality, communication and love'. The right to sexual information and education, and the right to give and get sexual pleasure, are fundamental to this concept. To this purpose, the World Association for Sexology has adopted a Declaration of Sexual Rights [10J, which must be summarized in a new definition of sexual health to be discussed promptly.

There are indeed many areas of interest for sexologists and psychiatrists. The new WPA section on Psychiatry and Human Sexuality has an enormous cask in promoting the knowledge and understanding of sexual issues. A survey conducted by Mezzich and Hernandez-Serrano [ll] showed clearly the need for continuous sexual education, even among the leaders in psychiatry and sexology. Some of the issues open to research include domestic violence, rape, childhood sexual abuse, treatment of sex offenders, paraphilias and compulsive sexual behavior, adolescence crisis, cross-cultural issues, pregnancy, abortion, female mutilations, gay-lesbian and sexual life-styles. We have the duty to face these issues. We must do it.

References

1. Kinsey A. Sexual behaviour in the human male. Philadelphia: Saunders;l948.
2. Kirmey A. Sexual behavior in the human female. Philadelphia: Saunders; 1953.
3. Masters W. Johnson V. Human sexual response. Boston: Little, Brown: 1966
4. Masters W, Johnson V. Human sexual inadequacy. Boston: Little. Brown; 1970.
5. Kaplan HS. The new sex therapy. New York: Bnunner Mazzel; 1974.
6. Hernandez-Serrano R, Parra C. A. Clasificacion de las disfunciones sexuales. Presented at the 1st International Congress of Sexology. Rome, October 1988.
7. Cox M. Personal reflections after 3000 hours in terapeutic groups with sex offenders. Cropwood Conference Series no. 12. West DJ (editor). Cambridge; 1980.
8. Parra CA, Devries R, Hernandez Serrano R. Interdependence. Presented at the 11th Symposium IIOnternacional Educacion Sexual. Caracas, February 1995
9. World Health Organization. Education and Treatment in human sexuality: the training of health professionals. Geneva: WHO; 1975.

10. World Association for Sexology. Declaration of sexual rights. WCS. Hong Kong, August 1999.
11. Mezzich JE, Hernandez Serrano R. The international survey on human sexuality. Presented at the 11th World Congress of Psychiatry. Hamburg. August 1999.

Commentaries

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During the past 100 years or so, important advances have been made in our understanding and treatment of sexual disorders. If we compare the progress in this area with that in general psychiatry or other branches of medicine, however, it falls sadly short.

The classification and diagnostic criteria of sexual disorders are plagued with inconsistencies and ambiguities. In orgasmic disorders, for example, the criteria are psychologically based for females, but physiologically or functionally based for the males [1,2]. The diagnostic term `vaginismus' is also a misnomer, because the core symptom of the condition is the fear of vaginal penetration, and not the vaginal muscle spasm [3,4). In the group of sexual preference disorders (paraphilias), many of the inclusions (e.g. incest or rape) are understood more generally as crimes or just socially unacceptable sexual behaviours, rather than as diseases. With all of the `advances' of the past 100 years, so far only homosexuality has had the good fortune to become excluded from this ridiculous grouping. To rectify the problems, new ways of classifying sexual disorders have been proposed [2,5), but they still have a long way to go before they are accepted into the established international diagnostic manuals.

There is little to boast about with regard to treatment either. The Masters and Johnson type of behavioural exercises is only slightly more systematic than those recommended by the Chinese classical sex manual SuNui-jing of around 1 century B.C. or by the Indian Kama Sutra of around 1-4 centuries A.D. Vaginal muscle training and progressive dilatation of vagina to treat female sexual dysfunction or improve sexual satisfaction have been practiced by the Chinese for at least 1000 years [6J. Yoga, meditation, Chi-kung (Chinese breathing exercises), Tai-Chi-Chuan (Chinese boxing or movement exercises) and possibly some traditional exercises of different cultures could all serve as relaxation exercises for sexual improvement. There is no evidence to show that they are less effective or more difficult than, say, the Schultz and Jacobson method. Psychotherapy or psychoanalytic techniques are useful accoutrements for the management of all psychiatric conditions. Refining their application in treating sexual disorders is a logical path for academic psychiatrists, and could hardly be considered a breakthrough. New surgical techniques and new medication for sexual disorder, such as sildenafil, might be more novel, but the credits go more to the surgeons or pharmacologists than to the sexologists or psychiatrists.

The reasons for this slow progress on sexual disorder treatments might be the same as those that made psychiatry difficult during the l9th century. We have thoughts and ideas regarding sexuality psychiatry, but if this subject, like psychiatry at its infancy, is publicly marginalized as a taboo, with the patients stigmatized as deviants or sinners, major advances cannot be made. The first marginalization effect would fatl on research funding. In nearly every country, sexuality research has had difficulties in attracting public funds. For example, according to Gladue and Ludwig [7],

from 197L to 1996 in the USA less than 1% of the research funding from the National Institutes of Health went to sex research. Shortage of money undermines research quality and makes the discipline less attractive to researchers, setting up a vicious cycle of obstacles and deterioration.

For major and further advances in sexuality psychiatry, therefore, the crucial battle to fight is a sociopolitical one, to remove the prejudices against sex in general, or, as Hernandez-Serrano heeds in his paper, to promote the concept of sexual rights. The Declaration of Sexual Rights by the World Association for Sexology [8] defines what sexual rights should cover, but some strategy is needed to impress the importance of such sexual rights in social leaden and policy makers. A promising strategy is to define sexual health through sexual rights, that is, to make it clear that satisfied sexual rights is one essential condition for sexual and mental health [9]. Such a definition of sexual health is perfectly legitimate and not new, and may be the only proper one. All that is required is to emphasize the importance of sexual rights and to educate the public to realize the linkage between rights and health, and that any infringement of one is an assault on the other.

It is common knowledge that there were two sexual revolutions during the 20th century; the first one, from around 1920s to 1930s, was fuelled by the women's emancipation movement, and the second, from around 1960s to 1970s, was fuelled by medical advances such as the invention of antibiotics and oral contraceptives. Each revolution contributed to advances in the treatment of sexual disorders (e.g. the beginning of sexology as a scientific discipline in the first, and the beginning of sex therapy in the second). Although it is hardly recognized, we are entering a third sexual revolution [10] that is fuelled by the media revolution and increased mobility and affluence of people. These changes have elevated the recognition and acceptance of diversity and hence the attention on human rights to a new height. Sexuality psychiatry is being offered a golden opportunity to put its message across, and to build up an image as respectable and worthy as all other medical scientific disciplines. It is from such a consolidated platform that I anticipate many breakthrough advances in the treatment of sexual disorders during the 2lst century.

References

1. Kothari P. Orgasm, new dimensions. Bombay: VRP Publishers: 1989.
2. Kothari P. Orgasmic dysfunction - a new classification. Abstract, 14th World Congress of Sexology, Hong Kong, 1989, P.68.
3. Ng ML. Vaginismus-a disease, symptom or culture-bound syndrome? Sexual Marital Ther 1999; 14:9-.13.
4. Ng ML. Towards a bio-psychosocial model of vaginismus: a response to Janice Hiller. Sexual Relationship Ther (in press).
5. Hernandez-Serrano R, Parra CA. Clasificacion de las Disfunciones Sexuales. Presented at the 1st International Congress of Sexology, Rome, October, 1996.
6. Ng ML. Treatment of a case of resistant vaginismus using modified Mien-ling. SexuaI Marital Ther 1992 7:295-299.
7. Gladue BA. Ludwig K. Funding patterns in sex research - U.S. National Institute of Health, 1972-1996. Presented at the 24th Annual Meeting, International Academy of Sex Research, Sirmione. Italy, June, 1998.
8. World Association for Sexology. Declaration of Sexual Rights. 14th World Congress of Sexology, Hong Kong, August, 1999.
9. Kontula O. The future of sexual health. Presented at the 24th Annual Meeting, International Açademy of Sex Research, Sirmione. Italy. June, 1998.
10. Coleman E. Revolutionary changes in sexuality in the new millennium: sexual health, diversity and sexual rights. In: Sexuality in the new millennium. Ng EML, Borras-Vals JJ, Perez-Conchillo M, Coleman E (editors). Bologna: Editrice Compositori: (in press).

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The thoughtful overview papers by Schiavi and Hernandez-Serrano on the evaluation and management of sexual disorders present a number of questions and recommendations to make clinical care more effective in the important field of sexuality psychiatry. They speak on the need to consider, in addition to sexual disorders *senso stricto*, any coexistent mental and physical disorder, adaptive functioning, partnerships and interdependence, attitudes and expectations about treatment (including broad sexual satisfaction and quality of life, not only restoration of narrowly defined performance). They also brought up an encompassing concept of sexual health from a World Health Organization programme in this area.

The need for a comprehensive approach to evaluation and diagnosis is, of course, not restricted to the case of sexual disorders. Such need has been articulated, in fact, for a number of disorders, and even for the whole of psychopathology and human disease [1]. The first comprehensive diagnostic models were termed multidimensional or multiaxial, and were applied to general medicine [2] and psychiatry [3]. They attempted to encourage the clinician to pay systematic attention to key informational domains by organizing the evaluation and diagnostic formulation along axes such as syndromes, aetiology, adaptive functioning, stress and supports. Eventually, with various degrees of visibility, multiaxial models have been incorporated within contemporary classification systems such as the International Classification for Oncology [4], the mental health component of ICD-10 [5], the American Psychiatric Association's DSM-IV [6] and the Cuban Glossary of Psychiatry [7].

More recently, a comprehensive diagnostic model has been designed at the core of the World Psychiatric Association's International Guidelines for Diagnostic Assessment [8]. This diagnostic model encompasses a standardized multiaxial formulation (I, illness; II, disabilities; and III, contextual factors) and an idiographic or personalized formulation.

As part of the development of a World Psychiatric Association Educational Program on Sexual Health, An International Survey on Human Sexuality [9] was conducted in 1999, with the participation of 187 qualified psychiatrists and SI qualified sexologists from 75 different countries. Among its most prominent findings was the need for more professional training, as well as patient and public education. Also, importantly mentioned as key factors for dealing with sexual health were the comorbidity of sexual disorders, relationship issues, cultural, social and environmental factors, and ethical concerns.

From the findings of this International Survey and the informed judgment of expert panel meetings in New York and Buenos Aires in 1999, the need emerged for a comprehensive diagnostic approach to the evaluation of individuals experiencing sexual disorders. The main components of such a comprehensive diagnostic model are as follows: standardized multiaxial formulation, including sexual disorders (sexual dysfunctions, paraphilias, and sex identity disorders), other mental and general medical disorders, interpersonal and general social functioning, partnership, cultural and other contextual factors and quality of life; and idiographic or personalized formulation (i.e. what is unique and meaningful as perceived by the clinician, the patient, the couple and the family). More specifics on the content of this model and a related training package are being

worked out within the framework of the World Psychiatric Association Education Program on Sexual Health.

A comprehensive diagnostic model for sexual health that covers sexual disorders, their mental and general medical comorbidities, relationship and contextual factors, quality of life, and a complementary idiographic or personalized formulation is under development. It is hoped that it will enhance scientific accuracy, therapeutic effectiveness and ethical aspirations in this crucial area of human health.

References

1. Engel GL. The need for a new medical model: a challenge for biomedicine, Science 1997; 196:129-136.
2. College of American Pathologists. Systematized Nomenclature of Medicine (SNOMED). Skokie, IL; College of American pathologists: 1977.
3. Mezzich JE. Patterns and issues in multiaxial diagnosis. Psychol Med 1979; 9:125-137.
4. Percy C, van Hoken V, Muir C. International Classification of Diseases for Oncology. Geneva: World Health Organization; 1980.
5. Janca A, Kastrup M, Katschning H, Lopez-Ibor JJ, Mezzich JE, Sartorius N. Multiaxial Presentation of the ICD-10 for Use in Adult Psychiatry. Cambridge. UK: Cambridge University Press; 1997.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Diesorders. 4th ed. Washington, DC: American Psychiatric Association; 1994.
7. Otero AA (editor). Tercer Glosario Cubano de Psiquiatria. Havana, Cuba: Hospital Psiquiatrico de La Habana: 1989.
8. Mezzich JE, Berganza CE, von Cranach M, Jorge MR, Kastrup MC, Murthy RS et al International Guidelines for Diagnostic Assessment. (in preparation).
9. Mezzich JE, Hernandez-Serrano R. The International Survey on Human Sexuality. Presented at the 11lth World Congress of Psychiatry, Hamburg, August 6-11, 1999.

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Schiavi and Hernandez Serrano provide comprehensive overviews of the diagnosis and treatment of sexual disorders. This commentary deals with a condition which is only briefly mentioned in the latter overview, but is increasingly attracting clinical and research attention: compulsive sexual behaviour (CSB). There has been considerable debate about the nomenclature regarding this condition. It has been called hypersexuality, hyperphilia, paraphilia, paraphilia-related disorder, hypereroticism, erotomania, perversion, nymphomania, satyriasis, Don Juanism, Don Juanita-ism and, more recently, sex addiction and sexual compulsion. In DSM IV, the paraphilias are well defined as 'recurrent, intense sexually arousing fantasies, sexual urges or behaviours involving I) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons ... The behaviour, sexual urges, or fantasies cause clinically significant distress in social, occupational, or other important areas of functioning' [1]. There are eight categories of paraphilias, and these are generally considered to be the most common: pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, transvestic fetishism and frotteurism.

These labels suggest that CSB is an exotic or rare phenomenon, but in fact, many men and women experience periods of intense involvement in sexual activity. Some of these periods may be short-lived or may reflect normal developmental processes. Also, the behaviour often does not involve unusual, exotic, socially nonconforming behaviour. Many times the obsessive or compulsive behaviour involves consensual, normophilic sexual behaviour. There is no clear category for this type of clinical syndrome, however. The authors of DSM do give an example under the category of Sexual Disorders Not Elsewhere Specified. The authors describe :an example of `distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used'. I have identified other forms of non-paraphilic CSB including five subtypes: compulsive cruising and multiple partners, compulsive fixation on an unattainable partner, compulsive autoeroticism, compulsive multiple love relationships and compulsive sexuality in a relationship [2,3]. Nonparaphilic CSB involves conventional and normative sexual behaviour taken to a compulsive extreme.

Thus, I believe that there are many manifestations of CSB that can be subsumed under two basic types: paraphilic and nonparaphilic CSB. Whatever the term used, there are many people who have recurrent and intense sexually arousing fantasies and sexual urges, which cause clinically significant distress in social, occupational, or other important areas of functioning. Although the nosology has not been resolved nor clearcut clinical diagnostic criteria formulated, it is important for clinicians to recognize both paraphilic and nonparaphilic types of this problem.

Unfortunately, there are no good epidemiological studies to estimate how many people suffer from CSB. It is only recently that we have been able to conduct good population studies regarding the estimates of sexual dysfunctions (lack of sexual desire, orgasmic problems). Questions about CSB are often feared by funders of sexual surveys to be too sensitive and intrusive. We are left with estimates, and these are complicated by simultaneous under- and over-reporting. The best estimate is that the problem occurs in approximately 5% of the population.

The aetiology of the CSB is fiercely debated and is probably multi-dimensional. We know that there is a high psychiatric comorbidity of CSB with other psychiatric disorders. In some cases it could be a function of an anxiety, depressive, or impulse control disorder. There is much debate regarding whether it should be classified as an impulse spectrum disorder or an obsessive-compulsive spectrum disorder. Others see this as an addictive disorder. In any event, anxiety does seem to play a role in triggering the behaviour. Also, contrary to naïve understanding, the behaviour is not necessarily driven by sexual desire alone. It seems that anxiety triggers an anxiety reduction mechanism. The obsessive thoughts and compulsive behaviours reduce anxiety and distress, but they create a self perpetuating cycle. The sexual activity provides temporary relief, but it is followed by further distress. In addition, an individual engaging in CSB puts himself/herself and others at risk for sexually transmitted diseases, illnesses and injuries; often experiences moral, social and legal sanctions; and endures great emotional suffering. This creates more distress, especially when the behaviour is felt to be out of control.

There seems to be a clear neurobiological mechanism associated with CSB. In some cases, CSB can be caused by a neurological disorder such as epilepsy or Alzheimer's disease. In many cases, however, it is speculated that there is a neurotransmitter dysregulation somewhere in the erotic pathways of the brain. We can see evidence for this suggestion when individuals are treated with pharmacological agents that affect specific neurotransmitter action (in particular the newer selective serotonergic antidepressants).

Treatment of CSB usually involves a combination of psycho- and pharmacotherapies. It is important to recognize the continuum of behaviours. Not all sexual behaviour that causes

problems necessarily reaches a clinical threshold. Many patterns of behaviour can simply be described as `problematic' or `subclinical'. Often, these problematic behaviours can be more readily addressed through brief psychoeducation or cognitive behavioural therapy. In the more extreme, it is more likely that a combination of pharmacotherapy and psychotherapy would be necessary.

It is important that the clinicians understand the wide range of normal sexual behaviour and be careful not to impose their own or societal values and thereby pathologize it. The behaviour should meet the afore mentioned clinical criteria, which have been described and based on research that has demonstrated the clinical pathology associated with the behaviour. Also, some individuals easily pathologize themselves when they exhibit behaviours that do no conform to societal, family or religious constrictions. We must use science and an international consensus of what constitutes CSB and carefully distinguish between the conflicts over values and the clinical syndrome.

In conclusion, CSB is a serious psychosexual disorder that needs to be identified and appropriately treated. CSB does not always involve strange and unusual sexual practices. Many conventional sexual behaviours become the focus of the individual's sexual obsessions and compulsions. New advances in the understanding and treatment of CSB have given us a new direction and hope for better treatment of individuals suffering from this disorder. New pharmacotherapies combined with traditional psychotherapies have been shown to he effective in treating the various types of CSB.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders~ 4th ed. Washington. DC: American Psychiatric Association: 1 A84.
2. Coleman E. Compulsive sexual behavior: new concepts and treatments. J Psychol Hum Sexuality 1991: 437~2.
3. Coleman E. Is your patient suffering from compulsive sexual behavior? Psychiatr Ann 1992: 22: 320-d25.

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During the 1980s and 1990s, with the explosion of information on the physiological aspects of male sexual function and with the increasing demand for care by sexually distressed individuals, the role of general practitioners and specializes such as urologists and gynecologists has become important. The evaluation of sexual difficulties still needs proper psychiatric assessment, however, to explore the nature of sexual dysfunction, as well as medical evaluation to identify the presence of medical disorders or drug side effects. Schiavi rightly warns against the neglect of psychological and relationship factors as a consequence of the increased emphasis on psychopathological aspects. He also points to the inadequacy of psychiatric training programmes and the lack of a multidisciplinary model. The expansion of medical information has given rise to reductionistic views about human sexuality, whereas psychiatrists, through their medical training, have a more integrative approach.

Schiavi's paper emphasizes the role of psychiatrists versus other medical professions (general practitioners, urologists, gynecologists), but there are other mental health practitioners

(psychologists, social workers, nurses) who work as well in sex therapy. Although they provide their contribution in psychosocial approaches, they lack dramatically. the proper medical training that is needed in the evaluation of sexually disordered patients. This again stresses the role of the psychiatrist as a leader of a team, having diverse training in medical and psychosocial approaches [l]

The paper by Hernandez-Serrano discusses some of the historical steps that contributed to the recent progress of our knowledge of human sexuality. As a past president of the World Association for Sexology, he points to the role of that Association in the wide acceptance of sexology as a medical and psychological profession.

For Hernandez-Serrano, basic sexual education is a must for the coming generations. He believes that relaxation (as a vital remedy to combat anxiety), erotic stimulation (to enhance human sexual response) and various modes of psychotherapy should be known by every sexual therapist. Passing through the various pharmacotherapeutic tools, he emphasizes the role of sildenafil as a revolution from intracavernous agents, and describes the pros and cons of the use of antidepressants and other drugs such as hormones and dopaminergic agents. He devotes much attention to sex therapy, pointing that the different tactics, starting from touch and care through to analyzing the couple's quality of life and discussing sexual variations. He criticizes the use of prostheses for non-reversible organic erectile dysfunction, indicating when to use them and when not to approve their use. He concludes his paper by emphasizing the concept of interdependence in the couple's relationship and mentioning the Declaration of Sexual Rights.

Other aspects that also deserve emphasis are the recent data on the epidemiology of sexual disorders, which are important in realizing their significance [2-4), the prevention strategies; either primary (on a societal and individual level) or secondary (early diagnosis and intervention), which are essential to reduce the risk of sexual disorders and their economic costs; and the impact of culture on both diagnosis and treatment of all categories of sexual disorder {5).

References

1 Abdel Azim S. Integrative approach in the management of vaginismus. Presented at the International Congress of Psychiatry, Cairo, 1987.
2 Spector IP, Carey MP. Incidence and prevalence of sexual dysfunctions: a critical review of the empirical literature. Arch Sex 8ehav 1990; 19:389-408.
3 Abdel Arim S. Sexual disorders among Egyptian psychiatric patients. PhD thesis, University of Cairo, Egypt 1974.
4 Osborn M, Hawton K, Gath D. Sexual dysfunction among middle aged women in the community. Br Med J 1988; 296:959-962.
5 Davis DL. Cultural sensitivity and the sexual disorders of DSM-IV: review and assessment. In: Culture and psychiatric diagnosis. Mezzich JE, et al. (editors). Washington, DC: American Psychiatric Press; 1996.

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