EXPERIENCE OF A CLINIC FOR SEXUAL DISORDERS

by

J. T. QUINN, P. JOAN GRAHAM, J. J. M. HARBISON, H. McALLISTER,

Departments of Mental Health, Social Studies and Psychology,
Queen's University, Belfast.

THE PURPOSE of this article is to describe a service which has been developed in the Department of Mental Health, Belfast City Hospital, over the last two or three years. The service is devoted to the investigation and treatment of a wide variety of sexual disorders.

Selection of Cases

Some idea of the work of the clinic can be gained from the Table which summarizes the details of the patients seen in the last calendar year. The clinic is "family" orientated and when a patient is married the spouse is investigated as intensively as the person who presents with the problem. This emphasis on assessment of spouse considerably increases the work undertaken by the clinic, but we feel the extra effort is justified both by own experience and the emphasis placed upon the importance of spouses in sexual disorders by other workers (Graham, 1971; Cooper, 1969; and Feldman, 1971).

A number of comments on the Table appear appropriate. Firstly, the rather high number of impotent patients without spouses is due to the fact that, in our sample, twelve of the patients were not currently married (either being divorced, widowers, or single).

Table

Number and diagnosis of patients and spouses seen at a clinic for sexual problems over a one-year period

Diagnosis	*Patients*	(%)	*Spouses*
Homosexuality	20	(22)	—
Frigidity	15	(16)	12
Impotence	37	(40)	22
Other	14	(15)	4
Uneventuated	6	(6)	4

Secondly, in the period from which we have drawn our sample, there has been an unusually low referral rate for homosexuality. Thirdly, it will be noted that only one female homosexual presented at the clinic during this time. This is in line with our own experience from previous years and agrees with the reports in the literature which indicate a low referral rate of female homosexuals. Fourthly,

the "other" group includes trans-sexuals, trans-vestites, exhibitionists and a few unusual sexual disorders.

INVESTIGATIONS

The following investigations are carried out in the clinic:

(1) The patients have detailed psychiatric and physical examinations and the spouse is interviewed by the psychiatric social worker who is a member of the clinical team.

(2) Psychological investigations. Both patient and spouse are assessed, using four kinds of psychological tests:
   (a) standard tests of personality.
   (b) specific tests of sexual interest, orientation and sexual anxiety
   (c) tests of attitude to sexual behaviour and to other important social functions
   (d) measures of marital interaction and adjustment.

(3) Psychophysiological investigations. A number of psychophysiological investigations are also carried out. These involve monitoring the patient's physiological responses to a standard test situation. Heart rate, respiratory rate, skin resistance, E.M.G., and (in males) penile blood flow are monitored, using an 8-channel polygraph, while the patient is either listening to a standard auditory alerting signal or looking at slides of sexual material. From these investigations, two kinds of information are extracted:
   (a) measures of general sexual arousal, orientation and sexual anxiety
   (b) psychophysiological tests of general neuroticism (this test uses the rate of habituation of the altering or orientating reflex).

The psychophysiological tests provide information similar to, but at a different level from, the paper and pencil tests described above. An important theoretical aspect of our work is to investigate what relationships, if any, exist between these two levels of measurement.

It is not intended in this paper to present details of the results of our investigations. The conclusion of our work with homosexuals have been reported elsewhere (Quinn et al, 1973a), but a brief outline of the general results appears appropriate to illustrate the usage of tests which may otherwise be unfamiliar to some readers.

Sexual orientation measures

The Sexual Orientation Method (Feldman et al, 1966) discriminates well between homosexual and non-homosexual groups (such as patients suffering from impotence). Perhaps a useful practical conclusion from this is that homosexual interest as measured by this test is not raised among patients with other sexual disorders.

Personality measures

It would appear from our results that some aspects of personality distinguish between the groups of patients and patients' spouses which we see at the clinic; and that when measures of sexual orientation and personality are combined, using multivariate statistical techniques, the differences between all the groups of patients we see become quite marked.

Psychophysiological assessment techniques

These techniques are much more complicated than the paper and pencil methods, and our confidence as to their clinical use is more limited; however, the psychophysiological measure of sexual orientation described above does discriminate well between homosexual and non-homosexual groups. Again it would appear that at this different level of measurement there is no evidence that people with sexual disorders other than homosexuality have substantial homosexual interest.

It would be possible to present further data about impotent and frigid individuals, but, at the time of writing, the analysis of the data with these groups is less complete and it appears appropriate not to present details of these results.

Treatment Methods

We will now briefly describe some of the treatment methods used in the management of patients referred to the clinic.

Homosexuality

A number of techniques are used in the management of homosexuality. It is not possible in the space available to give more than a cursory outline of the methods available.

Aversion therapy

This is the best known and most controversial method of treatment. Numerous aversion techniques exist, all based on learning principles derived from animal experiments. In general, such techniques set out to form an association between homosexual arousal and a noxious stimulus (such as electric shock). A review of these treatments may be found in a recent book by Rachman and Teasdale (1969). The most extensive series of cases is reported by Feldman and MacCulloch (1971) who claim that over sixty per cent of homosexuals will respond to aversion therapy. However, they emphasise that patients who are exclusive life-long homosexuals do not respond well to aversion therapy. In contrast, we have a particular interest in the use of methods for producing heterosexual interest in exclusive homosexuals, and in fact we rarely use electrical aversion therapy, at least as a treatment of first choice, with any of the patients referred to our clinic.

Desensitisation

This technique is widely used for the treatment of many conditions such as homosexuality, frigidity, impotence and simple and complicated phobias. Its use in homosexuality is described by Bancroft (1970) who claims that about a third of homosexuals respond favourably to desensitisation. It is interesting that Bancroft found no differences in outcome between groups of patients treated with aversion and desensitisation, and his overall treatment results would be therefore less optimistic than those of Feldman and MacCulloch (1971).

Desensitisation attempts to reduce anxiety associated with situations which the patient is assumed to be afraid of. Its use in homosexuality is based on the hypothesis that many homosexuals fear heterosexual relationships (are 'heterophobic').

Techniques for conditioning heterosexual arousal

Two techniques have been developed in this department (Quinn et al, 1973b). One procedure produces or increases heterosexual interest by Pavlovian conditioning; the second is a complicated technique which attempts to 'reward' physiological responses in the presence of heterosexual stimuli. A trial supported by the Medical Research Council is under way, comparing the efficacy of these two techniques. While the results are not complete, it is clear at this stage that some exclusive homosexuals can develop heterosexual interests when treated by either of these two methods.

In view of recent editorial comment (World Medicine 1973), it is useful at this stage to state our policy with respect to the treatment of homosexuality. We do not approach homosexual behaviour with any particular value judgement. Obviously, we have no interest in coercing individuals to change their sexual orientation; but in distinction to some, we believe that there are individuals who find life in their own particular society too difficult because of homosexuality. We believe that these people have the right to be offered an opportunity to learn a new sexual orientation, particularly as methods are now available which do not involve aversion therapy.

Frigidity

We have been treating frigid patients for over eighteen months. The small number appearing in the current figures can be explained by the fact that a colleague, Dr. E. O'Gorman, has seen quite a number of these patients outside the clinic. Her work, however, has been carried out in close association with us and frigid patients are now routinely included in the sexual problems clinic.

Treatment methods in frigidity depend upon the use of one or other of the varieties of systematic desensitisation. As we have already indicated, great emphasis is laid upon involving the spouse in the investigation and treatment. One interesting method used is the desensitisation of the patient in a group setting (O'Gorman et al, 1972). This procedure appears to be very efficient, and appears to be effective in managing some patients with frigidity.

Impotence

Impotence is the most difficult to treat of the three problems discussed in this paper. Two main techniques are under investigation at the moment—the desensitisation of heterophobic responses and positive conditioning of heterosexual interest (using the technique already mentioned above with respect to homosexuality). Our own experience supports the literature in sugesting that approximately one-third of impotent patients are helped by desensitisation. It is too early to say whether or not other procedures – such as positive conditioning – will prove to be more effective than desensitisation in the management of this difficult condition.

SUMMARY

This paper attempts to describe a relatively new clinical development in Northern Ireland. Cases have been referred from all over the province, and by organizing a clinic system, it has been possible to keep waiting lists down to a very short time.

The clinic has also proved very useful for teaching medical students, clinical psychology students and social work students. We hope that, in the future, it will be possible to extend this service, which appears to be valuable in helping people with sexual disorders and also provides a setting for the collection of extensive data for research into these problems.

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