often not applied because of lack of organisation[9]; and one study found that 11% of a series of hospital deaths after road accidents could have been prevented by more attention to breathing and the circulation after arrival.[14] And, finally, the consultant must create a caring department. Medicolegal troubles, it has been said, can be avoided not only by awareness of the risks and by tidying up routine procedures but, above all, by "showing the patient that we care."[2] These principles are as important for the shaping of an effective and humane department as for avoiding specific disasters.

I am deeply grateful to all the people in accident and emergency departments and elsewhere who have been so generous with their help.

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Introduction to Marital Pathology

Management: Sexual counselling

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Sexual difficulties are commonly associated with marital pathology.[1] A counsellor who sees a patient with a sexual problem should discover whether the patient is married, living with a partner, or living alone. He must also assess the quality of the relationship. Sexual problems are much more easily helped when a couple are willing to help each other. If the relationship is good and the problem is only sexual then the couple are more easily helped. Sexual problems are difficult to treat when they reflect a poor or deteriorating relationship; attention must be directed towards improving the relationship. A couple experiencing conflict, hostility, and indifference may have a poor sex life, but their relationship is the primary problem; indeed, one or both may have a successful sexual relationship with another partner.

Common sexual difficulties

NON-CONSUMMATION

Sometimes when intercourse is attempted the woman's pelvic muscles contract and make coitus painful, which may ultimately prevent it altogether. A woman who experiences this often marries a gentle and unassertive man who does not press for intercourse if he causes his wife pain. The counsellor can help the couple to relax by examining their attitude to sex, contraception, and having children. The wife is then encouraged to use progressively larger dilators, which may eventually be inserted by her husband and restore confidence in intercourse.

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DYSPAREUNIA

Dyspareunia is painful or difficult intercourse. Vaginismus may cause discomfort at the entry of the vagina. Pain deep in the vagina may be caused by a retroverted uterus with the ovaries trapped in the pouch of Douglas. Lesions in the pelvis such as endometritis or sepsis may be the cause. All these physical causes may be corrected after making the right diagnosis. Psychological causes of dyspareunia may be anxiety, apprehension of pain, and previous trauma; the patient can be desensitised to these factors.

ANORGASMIA

Primary—Primary anorgasmia, when a woman has never experienced orgasm, is rare. Kinsey found that 10% of women had never experienced orgasm by the fifteenth year of their marriage.[2] It is generally believed that primary anorgasmic women have never masturbated and feel extremely apprehensive about sexual contact. Current treatments aim at overcoming this anxiety by encouraging the development of body sensitivity and the ability to masturbate.[3] Primary anorgasmia needs specialised help.

Secondary—Women with secondary anorgasmia have been able to experience an orgasm and then gradually or abruptly lose the ability. The woman may have become anxious or lost sexual interest after the birth of a child, or her marriage may have deteriorated. Sexual arousal and response may always have been poor and may have been finally lost. Treatment may

be psychological, or libido may be increased by giving 10 mg of testosterone daily sublingually for three months.[4]

SECONDARY IMPOTENCE

A wife's ability to experience an orgasm depends on her husband's capacity to maintain an erection long enough to arouse her. Secondary impotence, the failure to obtain or maintain an erection having done so in the past, is a common problem. Physical causes should be excluded. The doctor must assess whether the problem is occasional or continuous and deteriorating. Occasional episodes may be due to stress, fatigue, alcoholic excess, or depression. A man may experience an episode of impotence, become anxious, approach his next coitus with increased apprehension, and then fail again because of anxiety. The wife should offer reassurance and encouragement and possibly additional penile stimulation. The intervals between intercourse should not be allowed to become progressively longer as sex may become increasingly unfamiliar. A persistently low or deteriorating libido may be improved by erotic arousal through fantasy, reading, films, and audio-visual material, which may lead to masturbation; eventually the partner should be present and replace the alternative forms of stimulation.

PREMATURE EJACULATION

In premature ejaculation, which may also cause anorgasmia, the man reaches orgasm or ejaculation, or both, before or immediately after penetrating the woman. Anxiety is important in this disorder and should be reduced with drugs. The squeeze technique developed by Masters and Johnson may be used: before ejaculation the woman puts her thumb on the frenulum and her first two fingers on either side of the coronal sulcus and applies pressure until the desire to ejaculate is lost. This technique may be used as often as desired, and gradually the man may learn better control.

Reducing sexual anxiety

Poor sexual performance is often related to anxiety; modern sexual treatment following the techniques of Masters and Johnson[5] uses methods to reduce this.[5 6] This advice may be given without specialised training to a co-operative couple. A couple experiencing persistent sexual difficulties can be advised as described subsequently before they are recommended to seek specialised help. The difficulties may be infrequent or absent intercourse, non-enjoyable intercourse, episodes of impotence, or gradual sexual alienation in the absence of marital difficulties. The couple are advised to stop attempting to have intercourse: their sexual life must start afresh. They must first become relaxed when feeling each other. When relaxed, perhaps when on holiday, they can concentrate on feeling each other's bodies. They must aim through touching, caressing, and stroking to give pleasure. All this contact must be non-genital. When the couple are relaxed and happy with this non-genital contact, they proceed to genital play with intercourse still forbidden. Then the couple choose a sexual position that is easy for both of them and allow penetration but no thrusting. Finally full intercourse is achieved.

The aim is to achieve considerable relaxation and allow the partner to tell the other what gives him or her pleasure. The accent is removed from the genitalia. The couple learn how much relaxation they need, what parts of their bodies give them extra pleasure, the secure feeling of touching each other physically and genitally, the pleasure of being inside each other without hurrying to the climax, a small number of coital positions that they are at home with, and the right pacing to experience mutual orgasms or at least mutual pleasure.

SEXUAL VARIATIONS

A wide variety of objects, words, pictures, fantasies, coital positions, and activities may arouse erotic excitement. The couple should be able to use their aids without guilt, and neither partner should coerce the other to do what they do not want to do. The couple must feel that they themselves matter more than the variation. When incompatibility is considerable then expert help is needed, particularly if the variation becomes the only form of sexual activity.

Sex and marital problems

Sexual problems are often the first sign of a deteriorating relationship. The counsellor must assess the quality of the marriage before starting sexual therapy. This does not mean that sexual therapy may not proceed simultaneously, but sometimes marital counselling should precede it.

MARRIAGE WITHOUT COITUS

Sexual therapies have made considerable progress in the last decade and a sexless marriage should now be rare, but it does exist. The sexual life of a couple who never have intercourse may take alternative forms of physical and genital stimulation depending on what they find acceptable. Sometimes even this alternative sexual stimulation will not be available. The counsellor must establish if a third person is providing the missing sex needs. The counsellor may be put into difficulties if asked not to divulge this information. He or she is obliged to treat this information as confidential. Telling the partner may be disastrous or essential: the counsellor can choose either to desist or to continue until change is possible. Nevertheless, he or she must avoid deliberately deceiving. But if neither intercourse nor other sexual variations are possible then the couple need to reinforce their affection for each other in alternative ways. Sexual intercourse is a powerful means of uniting a couple and needs adequate compensation when missing.

The doctor and sex

Doctors reflect the society in which they live and work, and, despite the greater freedom that exists in discussing sex, not all of them are either comfortable with the subject or familiar with the advances made. Doctors must become aware of their own sensitivities and limitations for they are often the first port of help for those who experience sexual difficulties. Doctors must only treat the problems that they feel capable of tackling and should refer others to marriage-counselling centres or to other departments that treat sexual problems. Sexual problems form a large part of marital difficulties and an effective early response may make a great difference to the outcome of a marriage.

This is the last in a series of eleven articles; reprints will not be available from the author.

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