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Sex Therapy Compared with Placebo in the Treatment of Impotence

By A. S. El Akabawi and A. Idarous

ABSTRACT

Two groups of patients fulfilling criteria of Secondary Functional Impotence were studied. Two models of therapy were used : A classical drug therapy regime with prostatic massage sessions, and a "talk" therapy model. In the latter approach, patients were seen for 15 brief psychotherapeutic sessions twice weekly in which M & J pleasuring instructions were given to them combining a behavioural and non-directive expressive psychotherapeutic interventions. Results showed no differences in the high rate of improvement. Implications of the experiment using M & J instructions without involving the female partner in a non-western culture are discussed. Conclusions favour the use of the classical medical model with placebo amplifiers and M & J instructions as an educational desensitizing factor in therapy.

INTRODUCTION

Most treatment given to impotent patients by general practitioners and venereologists in Egypt relies on the placebo response. Vitamins, androgen hormones, aphrodisiac preparations and courses of prostatic massage are widely prescribed in university and state hospital OPDS as well as in private practice.

Placebo effect accounts for improvement in impotent patients given drug therapy inspite of the fact that there are usually no definite indications for their use (Frank, 1982, Beecher, 1955).

The past twelve years have witnessed the establishment of behavioural methods of treating sexual problems based on principles developed by Masters & Johnson (1970). The sensate focussing or pleasuring technique of M & J forms the basis of the behavioural interventions, to which may be added the more specific techniques. It can be viewed as a means of desensitizing the "Performance Anxiety" which maintains the psychosomatic pattern or alternatively as a means of enhancing and extending non-verbal communication and understanding. Though behavioural methods are directive in nature, it is possible and often necessary to combine them with non-directive interventions characteristic of psychotherapeutic methods of treatment (Frank, 1982).

Modifications of the original M & J instructions to suit cultures other than the American were developed and documented (Gillan, 1978; Lobitz and Le Piccolo, 1972). Crown and D'Ardenne (1982) suggest that no significant therapeutic impact has been made in the treatment of psychosexual problems presenting within a transcultural setting and that this is an important problem area for research.

The present study reports observations of treatment outcome using two models of therapy for impotent patients in Egypt, one is the often used drug therapy, the other a combination of modified M & J instructions together with non-directive interventions in brief psychotherapeutic sessions. Cultural factors necessitated treating patients without involving their female partners.

SUBJECTS AND PROCEDURES

Thirty patients presenting with a complaint of impotence were randomly selected from patients attending the out-patient department of the Venereal and Skin Diseases department, Al Hussein University Hospital in Cairo, during April and May 1981. Each had a routine history taking, general physical and neurological examinations. Routine urine analysis and prostatic discharge analysis were also done. In all patients, no organic cause was detected and the thirty patients were

included in the study satisfying diagnostic criteria of secondary functional impotence used by M & J (1970).

Both workers together met with each patient in an interview where patients were offered the choice between two types of treatment; a drug therapy or a "talk therapy", without giving details of either. According to self selection, patients were divided into two groups. All patients in the two groups did not have previous treatment for impotence by a physician or a traditional healer.

NON DRUG THERAPY GROUP

This consisted of 14 patients with age range 24 – 52 years (mean 35.5 $\pm$ 9.2). All were married for an average of 9 years. Duration of the complaint ranged between two months and two years.

Table 1 shows information about age, occupation, education, length of marriage and duration of complaint. All patients were seen by both therapists together, without their wives for 15 therapy sessions. Sessions were 20 minutes each, held twice weekly.

The therapist (A.A.) and Co-therapist (A.I.) used a combination of M & J instructions and non-directive expressive interventions aiming at identification and expression of feelings related to the symptom. Instructions began with a prohibition of attempting intercourse, followed by instructions to practise with their wives a graded pleasuring technique, from sensate focussing and talking about feelings with their partners to genital sensate focussing and non-verbal communication exercises, to sexual intercourse. Monitoring of home work, specific behavioural instructions and talking about feelings and minimal interpretations formed the content of each therapy session.

THE DRUG THERAPY GROUP :

This comprised 16 patients. Table 2 summarizes information about age, education, length of marriage and duration of complaint. Age ran-

ged between 26 and 53 years (mean 35.7 $\pm$ S.D. 10.5). Each patient was prescribed polyvitamin tabs., a depot testosterone 100 mg I.M. injection once weekly (7) and prostatic massage course once weekly for 15 sessions. Patients were told that they have to complete the course of treatment irrespective of improvement. All patients completed 15 prostatic massage sessions allowing for follow-up notes to be recorded weekly, till the end of the study period (8 weeks). Tables 1 & 2 show outcome of treatment in each group.

RESULTS

Experimental Group (No Drug Group):

13 of the 14 patients improved, recording successful intercourse at and after the time of specified session. Timing of improvement varied, with the majority (10) taking place by 13 th session.

Only one patient (case 8) did not improve, he showed a clinical syndrome of depression. Causative factors in all problems were related to interpersonal behavioural aspects of sexual activity except in 3 cases where intrapsychic aspects were more prominent : Case No. 1 (expressed feelings of guilt over remarrying), Case No. 8 (depressed mood and thought content) and case No. 10 (depressed mood and thought content consistent with a grief reaction).

TABLE I

Non Drug Therapy Group

SERIAL	AGE In YEARS	OCCUPATION	SCHOOLING	DURATION OF COMPLAINT IN MONTHS	DURATION OF MARRIAGE	TIME OF IMPROVE-MENT	PROBABLE CAUSATIVE FACTORS OF IMPOTENCE.
1	52	Merchant.	Preparat.	6	6 m	10,12 s	Guilt over remarrying after death of lst wife.
2	30	Civ.Serv.	Second	5	5 y	9,10 s	Fear of pregnancy. Coitus interruptus.
3	25	Civ.Serv.	Second.	2	2 m	8,9, 10 s	Honeymoon Bleeding, fear of hurting wife.
4	45	Grocer.	Illiter.	7	22 y.	13,13, 15 s	Wife had an operation for fibroid. He lost interest and she fears bleeding.
5	39	Laundry.	Illiter.	12	2 y.	10,11, 12 s	Marital discord since his mother came to live with them. Wife uses sex to punish him.

6	50	Waiter	Illiter	12	26 y	13,14 s	Fear of pregnancy. Coitus interruptus.
7	34	Driver	Preparat	24	1 y	12,13 s	Honeymoon failure. Sexual inhibitions all his Life.
8	35	Driver	Illiter	12	15 y	No IMPR.	Neurotic depressive Syndrome.
9	28	Teacher	Univ.gr.	6	5 y	9.10 s	Coitus interruptus.
10	38	Merchant	Preparat	4	18 y	11,12 s	Grief following son's death.
11	28	Student	Univer.	4	2 y	14 s	Culture-bound belief of being a victim of spell cast by an enemy.
12	35	Technician	Preparat	3	6 y	13,14 s	Occasional failure followed by performance anxiety.
13	24	Civ.Ser.	Second.	6	6 m	12 s	Sexual ignorance. Bleeding of wife on defloration fear to try.
14	45	Vendor	Illiter	8	25 y	14 s	Marital discord. Problems at work.

TABLE II

The Drug Therapy Group

SERIAL	AGE	OCCUPATION	SCHOOLING	DURATION OF COMPL-AINT IN MONTHS	DURATION OF MARRIAGE	IMPROVEMENT AT END OF STUDY PERIOD.
1	48	Mechanic	Prepar.	6	7 yr.	IMPROVED
2	39	Guard	Illit.	12	13 yr.	IMPROVED
3	30	Drive	Illit.	10	25 yr.	NO IMPROVE-MENT
4	36	Peasant	Illit.	7	8 yr.	IMPROVED
5	24	Recruit	Prepar.	6	4 yr.	IMPROVED
6	53	Mechanic	Primary	18	30 yr.	IMPROVED
7	40	Civ.Serv.	Univ. Graduate	9	12 yr.	IMPROVED
8	22	Recruit	Primary.	9	2 yr.	NO IMPROVE-MENT
9	36	Worker	Prepar.	4	7 yr.	IMPROVED
10	51	Worker	Illit.	12	33 yr.	IMPROVED
11	34	Recruit	Illit.	12	9 yr.	IMPROVED
12	24	Policeman	Prepar.	18	3 yr.	NO IMPROVE-MENT
13	27	Civ.Serv.	Univ. Graduate	4	4 m.	IMPROVED
14	35	Driver	Primary.	6	7 yr.	IMPROVED
15	28	Tailor	Prepar.	24	2 yr.	IMPROVED
16	24	Recruit	Primary	9	9 m.	NO IMPROVE MENT

Control Group (Drug Group)

11 of the 16 patients improved. Cases which didn't improve (3, 8, 10, 12. 16) were not suffering from an associated psychiatric disorder to warrant a psychiatric diagnosis other than impotence : 307.2 (I.C.D. 9). Search for causative factors was not feasible as the explorative interview might have become in itself a therapeutic factor. X a test was applied and results showed no statistical significance. The size of the sample and deficiencies in the design are obviously inappropriate for statistical analysis of value.

DISCUSSION

Though tests of statistical significance failed to show intergroup significant differences, the direction of improvement seemed biased in favour of sex therapy. Confirmation will require a larger sample and better design to demonstrate statistically significant differences relating to intragroup factors as age, duration of complaint or education. Only one case (Case No. 8) in the experimental group did not improve. The patient had other symptoms of a neurotic depressive illness. In contrast, all patients in both groups did not have symptoms to warrant a psychiatric diagnosis. This patient's complaint of impotence seemed to him of secondary importance. Actually, he did have some improvement of other depressive symptoms. Maintenance of the symptom of impotence was the patient's "offering" to the therapists to keep the "healing cycle" going beyond the original contract (15 sessions) (Balint, 1957 & 1961). Probably, this patient's impotence would have improved if therapy continued longer. It is suggested that improvement with brief psychotherapy occurred in two phases (Uhienhuth and Duncan, 1968). In the first phase, patients with higher initial level of depression showed greatest improvement in affective factors. In the second phase, all types of symptoms improved.

Both groups were biased towards the type of treatment they had, but the drug therapy group had the advantage of familiarity with me-

dical model therapy. There were strong amplifying factors in the treatment ritual, i.e. pill taking, injections and intimate prostatic massage (Shapiro and Morris, 1978).

Subjects in the experimental group were blind to the nature of treatment. In a sense, their choice was an indirect expression of therapeutic nihilism or non seriousness at best, towards the presenting problem.

In the experimental group, responders were those whose impotence was reflecting "performance anxiety" due to ignorance, temporary interpersonal difficulties of superficial emotional changes. "Talk Therapy" offered educational and emotional expressive factors that effected change of sexual behaviour, when given simultaneously.

CONCLUSION

Comparing results in both groups, one might, however, venture to state the following :

1. Behavioural instructions are important additions to the armamentarium of practitioners in Egypt treating impotence.

2. Involvement of the female partner does not seem essential in sex therapy.

3. Brief psychotherapy sessions seem to be as good as drug therapy in a developing country, where the majority of the population are illiterate and traditions pertaining to sexual behaviour are generally repressive.

4. Medical model therapy of impotence seems more suitable in developing countries. Cultural attitudes towards illness and the dependent position of patients on doctors make it mutually attractive.

5. A possible approach that might be suitable seems to be a combination of the most economic and culturally acceptable "medical" treatment with modified sex therapy aiming at alleviation of per-

formance anxiety and sex education. Placebo amplifiers might be more rewarding in results than explorative efforts.

6. Direct psychotherapy for impotence with some patients may not be desirable. Patient orientation, cost, lack of trained personnel and nonspecificity of therapeutic factors are possible reasons (Strupp, 1970). A study showed that improvement curves for both brief insight psychotherapy and placebo were remarkably similar (Frank, 1974).

7. The study alerts educationalists to specific requirements in training of practitioners dealing with impotence. An understanding of and skill in using the psychotherapeutic potential of ordinary doctor-patient encounters is an important curricular requirement in medical education.

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AUTHORS

Ahmed S. El-Akabawi, M. B., B. Ch., D. P. M. & N., M. R. C. Psych., Lecturer in Psychiatry.

Ali Idarous, M. B., B. Ch., M. Sc. Psychiat. & Neur. Attached Registrar. Department of Neuropsychiatry, Alazhar University School of Medicine, Cairo, Egypt.

الموجـــــــز

مقارنة العلاج الجنسى بالعلاج الموه فى الضعف الجنسى

تمت الدراسة على مجموعتين ينطبق عليهم تشـــخيص العنة الثانوية الوظيفية ، وقد استعملت طريقتان فى العلاج .

الأولى : العلاج الدوائى الكلاسيكى مع تدليك للبروستاتا .

الثانية : العلاج الكلامى ، حيث تم تطبيق ١٥ جلسة نفسية قصيرة مرتين أسبوعيا مع تعليمات وارشادات حسب طريقة ماسترز وجونســون بالاضافة الى التدخل السلوكى والتعبير غير الموجه .

ولم توضح النتائج فروقا واضحة بين الطريقتين وقد نوقش احتمـــال تطبيق طريقة ماسترز وجونسون دون وجود الطرف الانثوى فى الحضارات غير الغربية .

وينتهى الباحثان الى تفضيل الطرق الطبية الكلاسيكية مع مســـاعدة العلاج المهوه وارشادات طريقة ماسترز وجونسون كوســـيلة تحصينية فى العلاج .

ABSTRAIT

Une Thérapie du Sex comparée

avec un Placebo

dans le traitement de l'impuissance

Deux groupes de malades présentant les critères de l'impuissance ont été étudiés. Deux modèles de thérapiefonctionnelle ont été employés. Un régime de chimiothérapie classique associé à des séances de massage prostatiques et une sorte d'entretien thérapeutique. Dans cette dernière façon d'aborder le problème, les patients ont été entretenus pour 15 brièves séances thérapeutiques deux fois par semaine où des instructions-comme décrites par Masters et Johnson pour arriver au plaisir sexuel-leur ont été donnée. Ceci était associé à une intervention psychothérapeutique du comportement expressive et non directive. Les résultats n'ont pas montré de différence dans la proportion d'amélioration. Les implications de cette expérience employant les instructions de Masters et Johnson-sans entraîner le second partenaire (femelle) - dans une culture non occidentale ont été discutées. Les conclusions sont en faveur de l'emploi du modèle médical classique avec un placebo amplificateur et les instructions de Masters et Johnson comme des facteurs éducateurs et désensibilisateurs dans la thérapie.

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