It is also important that the therapist remembers at the end of each interview to ask if anything has been discussed which should not be revealed to the partner. If information about a current affair has been revealed the therapist will have to explain that this precludes sex therapy for the present. Should a partner have revealed some other confidential information which might be important in treatment (e.g. a long history of faking orgasm), the therapist must agree to the person's request to keep this from the partner. However, the therapist should explain that if it becomes apparent during treatment that sharing this information with the partner is necessary in order for progress to occur, this will be discussed again outside a conjoint session.

Conjoint assessment

After interviewing both partners separately the therapist should then see them together again. If there was some important discrepancy between their individual accounts of the problem, this conjoint interview allows the therapist to explore this further, and, hopefully, to clarify it. However, the main purpose in seeing the partners together is to gain an impression of how they relate to each other. The therapist can assess how they discuss sexuality; whether they appear supportive of each other, and whether one partner views the other as having the sexual problem, or whether they share responsibility for the problem.

Finally, the therapist should explain the conclusions that he or she has reached concerning further management. This includes the couple's suitability for sex therapy, or, for example, indications for marital therapy or physical investigations.

Cultural problems

An increasingly important issue concerns the management of couples from different cultural backgrounds from that of the therapist, especially those from other ethnic groups. Some understanding of the sexual values of the particular culture is usually essential. For example, many Asian men find totally unacceptable the suggestion that their partners should have an equal opportunity to initiate sexual activity. In such situations, therapists are advised to find, or supervise, another therapist who is familiar with the sexual values of the particular culture. Should this prove impossible, the therapist should explain the difficulty to the couple and then try to help them, modifying the sex therapy programme in whatever way is necessary to accommodate their value system. In spite of these cross-cultural difficulties, sex therapy can be applied with reasonable success in clinics dealing with mixed racial communities (Christopher 1982).

Assessment schedule

The details of an assessment schedule that has been found useful in clinical practice are given below. In working through such a schedule, one should not simply ask a long series of questions and record the answers; the information should be organized in the therapist’s mind in order to establish a clear picture of each partner and the relationship. Apart from clarifying the precise nature of the presenting problem, the therapist should also try to identify any factors in the partners' backgrounds which might have predisposed them to develop a sexual problem later in life, possible precipitants for the problem, and factors which may be maintaining it. If, at the end of the assessment, it is difficult to put together a formulation of the problem, the therapist should consider whether any important questions have been omitted, or whether there has been any misunderstanding. However, while the assessment should be thorough, in many instances important aspects of the aetiology will for the present remain obscure. Important causal factors which have not yet been revealed will often become apparent during therapy, although successful therapy may occur without the full aetiology ever being revealed.

The assessment schedule is summarized in Table 6.1 at the end of this chapter and discussed in detail below. For the sake of clarity this is largely in note form.

1. The nature and development of the sexual problem

This includes detailed clarification of the nature of the problem (or problems), including when and how it began, how it subsequently developed, any factors that have made it worse (e.g. stress at work, general disharmony, medication), and any that
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Let's start by understanding the concept of sexual Francisco, or the desire to engage in sexual activity. This is a common question in sexual therapy, and it is important to identify the underlying issues that may be contributing to sexual difficulties.

(i) Premature ejaculation or retrograde ejaculation: Does the problem occur only with the partner or also with strangers? How do you feel about the frequency of occurrence?

(ii) Premature orgasm or ejaculatory dysfunction: How do you feel about the frequency of occurrence?

(iii) Non-erotic sexual fantasies: Have you noticed any changes in your sexual fantasies?

(iv) Vaginismus: How do you feel about the frequency of occurrence?

(v) Sudden loss of sexual desire: How do you feel about the frequency of occurrence?

(vi) Vaginal dryness: How do you feel about the frequency of occurrence?

(vii) Vaginal pain: How do you feel about the frequency of occurrence?

(viii) Vaginal infection: How do you feel about the frequency of occurrence?

(ix) Vaginal bleeding: How do you feel about the frequency of occurrence?

(x) Vaginal discharge: How do you feel about the frequency of occurrence?

(xi) Vaginal itching: How do you feel about the frequency of occurrence?

(xii) Vaginal abscess: How do you feel about the frequency of occurrence?

(xiii) Vaginal swelling: How do you feel about the frequency of occurrence?

(xiv) Vaginal discharge: How do you feel about the frequency of occurrence?

(xv) Vaginal pain: How do you feel about the frequency of occurrence?

(xvi) Vaginal itching: How do you feel about the frequency of occurrence?

(xvii) Vaginal abscess: How do you feel about the frequency of occurrence?

(xviii) Vaginal swelling: How do you feel about the frequency of occurrence?

(xix) Vaginal discharge: How do you feel about the frequency of occurrence?

(xx) Vaginal pain: How do you feel about the frequency of occurrence?

(xxi) Vaginal itching: How do you feel about the frequency of occurrence?

(xxii) Vaginal abscess: How do you feel about the frequency of occurrence?

(xxiii) Vaginal swelling: How do you feel about the frequency of occurrence?

(xxiv) Vaginal discharge: How do you feel about the frequency of occurrence?
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Does or did the man masturbate rapidly? Was guilt associated with masturbation?

(vi) Retarded ejaculation. Can the man ejaculate under any circumstances (with his partner, during masturbation, in his sleep)? If not, has he ever been able to ejaculate? Is ejaculation pleasurable?

2. Family background and early childhood

Parents' and siblings' ages. Family deaths and dates of deaths. Nature of parents' relationship, including whether they appeared to show each other affection.

Childhood: happy and unhappy aspects. Nature and closeness of relationships with parents; was affection received from them? Nature of relationships with siblings. Attitudes of family to sex. Was sex discussed in the home? If so, in what context and what impression did this have on the person? Family history of physical illness (e.g., diabetes) and of psychiatric disorder.

3. Early sexual development and experience

Age of puberty (development of secondary sexual characteristics). Was this about average for the person's peer group, or did he or she develop earlier or later than peers? If earlier, or later, did this cause embarrassment, anxiety, or sense of inferiority? General attitudes to early sexual development.

For female partner: age of menarche; had she received prior information? Reaction to first menstruation. Any upsetting sexual experiences that occurred during childhood. Age at which first developed sexual interest in opposite sex. Masturbation. Ask "when did you find out about masturbation?" This allows people to tell you when they began to masturbate, or, if they have not, when they first heard about it. Attitudes to masturbation. Age at which had first boyfriend/girlfriend. Nature of early relationships with opposite sex. Age when had first sexual experience (if before met current partner). Nature of this experience and attitude towards it.

Subsequent heterosexual relationships: the nature of these and whether there were any problems in either the general or sexual aspects of the relationships. Any history of homosexual interest/behaviour. Has such interest/behaviour persisted, or was it a transient (e.g., adolescent) phase?

4. Sexual information

Source of sexual information (parents, friends, jokes, books, experience).

Does person think that knowledge about sexuality is adequate? (The therapist should also make an assessment of the person's level of sexual knowledge on the basis of responses to questions throughout the interview.)

5. Current relationship

When and how met partner. What attracted person to partner? How relationship developed.

Sexual relationship: when first began. How it developed. Was it at any time satisfying to the person/were there problems early on and, if so, what were they? Effect of marriage on sexual relationship (if began before marriage). Partners' ability to communicate about sex.

General relationship: affection, friction, interest, social activities, friends, communication. Effect of marriage on general relationship.


What form of contraception, if any, is being used? Attitudes to future contraception.

Infidelity: any affairs during this relationship? Have there been problems in other sexual relationships? Is there a current affair?

Commitment: how committed is the person to this relationship? Any thoughts of separation? Likely consequences if sexual problem persists?
6. Schooling and occupations

Brief account of schooling, achievements, and occupations. Details of current occupation. Is it particularly stressful or tiring? Is it satisfying? For housewives: how demanding is housework; any help available?

7. Interests

Hobbies and interests. Are these shared with partner?

8. Religious beliefs

Has the person ever held strong religious beliefs? Do these affect the person's attitudes to sexuality? Are religious beliefs shared by both partners?

9. Medical history

Nature of any past/current illnesses/operations. (For women) any problems with menstruation? Current and recent medication.

10. Psychiatric history


11. Use of alcohol and drugs (including smoking)

12. Appearance and mood (i.e. mental state)

It is rarely necessary to carry out a formal examination of mental state as is often done in psychiatric assessments. However, the therapist should assess each partner's appearance and mood throughout the interview. In particular, the therapist should look for signs suggesting depression (e.g. sad or dishevelled appearance, crying, pessimism) or anxiety (persistent apprehension, trembling, pallor, hesitations). If there is any suspicion of such disorder the therapist must enquire specifically about the person's mood, sleeping pattern, appetite and weight, energy, concentration, and memory. If the person is depressed, the therapist should always ask about attitudes to the future, and suicidal ideas.

A full psychiatric assessment must be carried out if it appears that the person has a moderate or severe psychiatric disorder. If the therapist is not appropriately qualified to do this, a psychiatric opinion should be sought.

13. Goals and motivation

At the end of the assessment interview with each partner the therapist should try to establish the precise changes in both the sexual and general relationship the person would like to achieve through treatment. Accurate assessment of motivation is often difficult as it may only become fully apparent once treatment begins. Nevertheless, the therapist must assess each partner's motivation as far as is possible. This includes determining to what extent responsibility for the problem is shared, who sought help, the consequences of any previous attempts at solving the problem (either with assistance or through self-help), and the couple's primary goal in seeking help. Couples who seek help with fertility problems (e.g. non-consummation, retarded ejaculation) and for whom conception is the only goal are often very difficult to help.

14. Physical examination and investigation

In some sex therapy clinics a physical and sexual examination of both partners is carried out routinely for both diagnostic and therapeutic purposes. This is inappropriate in non-medical settings and is in any case often unnecessary. Because of the highly intrusive nature of such a procedure when there is no obvious indication for it, a physical examination of this kind is probably best restricted to those partners for whom it may be therapeutic, and those whose histories suggest the possibility of an undetected physical cause for their problem. Women with vaginismus, and people with anxieties about the size, shape or some other characteristics of their genitals are examples of the first category. A physical examination for diagnostic purposes is indicated for men with erectile dysfunction and women with dyspareunia, and is appropriate for some people with impaired sexual interest.
### TABLE 6.1
Areas which should be covered during the assessment of each partner

1. The nature and development of the sexual problem
2. Family background and early childhood
3. Early sexual development and experiences, including homosexuality
4. Sexual information
5. Relationship with the partner
   - Development
   - Sexual relationship
   - General relationship
   - Children and contraception
   - Infidelity
   - Commitment
6. Schooling and occupation
7. Interests
8. Religious beliefs
9. Medical history
10. Psychiatric history
11. Use of alcohol and drugs (including smoking)
12. Appearance and mood (moral state)
13. Goals and motivation
14. Physical examination and investigations (if necessary)

### TABLE 6.2
Aspects of the physical examination and some investigations which may assist in the differential diagnosis of sexual disorders of men

1. **General physical examination**
   - General signs of illness: diabetes (e.g., retinopathy), thyroid disorders, adrenal cortex disorders
   - Hair distribution
   - Gynaecomastia
   - Blood pressure
   - Peripheral pulses (limbs)
   - Reflexes (limbs)
   - Sensation (limbs)
2. **Genital examination**
   - Penis: congenital abnormalities, size, symmetry, tenderness, retractability of foreskin, pulses, signs of plaques (Peyronie's disease), infection, urethral discharge
   - Testicles: size, symmetry, texture, sensation
3. **Blood tests**
   - Testosterone
   - LH
   - Glucose-fasting (glucose tolerance test if abnormal or diabetes strongly suspected)
   - Prolactin (if testosterone abnormally low)
4. **Special investigations**
   - (i) Nocturnal penile tumescence
   - (ii) Penile pressure
   - (iii) Corpus cavernosography
   - (iv) Arteriography of genital blood supply
   - (v) Sacral cord evoked potentials
   - (vi) Visual stimulation and penile tumescence