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TREATMENT OF SEXUAL PROBLEMS

Lode Wigersma[1], Gerard Roelofs[2], Willeke Bezemer[3], Jelto Drenth[4] and Harry Pomerantz[5]

In this review of sexological treatment in The Netherlands we summarized the services offered by general and specific care organizations and some of their research data. Unfortunately, most university and other out-patients clinics do not have enough time and humanpower to conduct research projects and hence to publish in scientific magazines. In spite of the relative scarcity of research data the scientific basis and the quality of the services rendered are sound enough, and a number of Dutch scientists working in the field of sexology play an important role in international sexology. This is underscored by the presence of the 10th World Sexology Congress on Dutch soil and by the active participation of many Dutch scientists in this congress.

Unlike The Netherlands, neo-Malthusian groups in Belgium hardly had a chance to grow into a fully developed movement. A general form of sexological help was provided from the early 1970s on in family planning centers, located in the major Belgian cities. Today, they remain a place were psychosexual counselling is provided, including short-term sex therapy. Besides, such provision in centers outside universities largely depends on the presence of individuals holding sufficient sexological expertise.

Historical overview

The treatment of sexual problems in The Netherlands is profoundly rooted in the **Neo-Malthusian League,** the Dutch planned parenthood movement (founded 1881).

Planning the number of children one wanted to raise became an acceptable topic for discussion, and then taboos on talking about one's sexual feelings gradually disappeared. In the League's consulting offices, sexual problems were treated by psycho-analytically orientated psychiatrists.

They were pioneers for a Sexual Reform movement, similar to the Berlin Institute. Amsterdam would have hosted the 6th Congress of the World League for Sexual Reform in 1934, had not political turmoil in Nazi-Germany brutally ended the League.

[1] L. Wigersma, MD, PhD. Dept. of General Practice, University of Amsterdam, The Netherlands.
[2] G.T. Roelofs, MD. Ambulatory Mental Health Care Institute, Parallelweg 43, 6221 BD Maastricht.
[3] W. Bezemer, MA. Rutgers Foundation, Groothertoginnelaan 203, 2517 ES Den Haag.
[4] J.J. Drenth, MD. Rutgers Foundation, Damsterdiep 65, 9711 SJ Groningen.
[5] H.B. Pomerantz, MA. Ambulatory Mental Health Care Institute, Parallelweg 43, 6221 BD Maastricht.

In Holland, as in Germany, sexual reform activities were almost impossible during World War II. Many of its leaders were jews, and some did not survive the holocaust. After the war the movement made a second start; euphemisms were unnecessary now. Its new name was: **Dutch Society for Sexual Reform (NVSH),** founded 1948. In the second half of the sixties, now referred to as the sexual revolution years, the NVSH began to grow, but its growth peaked as a result of the introduction of oral contraceptives. In '69, after lengthy deliberations, the decision was made to dissociate the consulting offices from the Society. Ideologically, the Society was moving to the progressive side (Marxism and feminism both having eloquent advocates), but people visiting the consultation bureaus most in need of this specific help were to be found in more conservative social groups. By leaving the Society, the threshold for the consultation bureaus was thought to be lowered, and potential governmental objections to financial support were circumvented. A new organization for the administration of the bureaus was founded: the **Rutgers Foundation.** In Amsterdam, a similar bureau was instituted: **MR'70.** For gay and lesbian people the **Schorer Foundation** provides specific services.

Another group of forerunners of sexology can be found amongst gynaecologists. The most famous, known all over the world, was **Theodor van der Velde.** With his book The Perfect Marriage (1925) he was the first to find himself a large general public. Fertility studies too inspired some gynaecologists towards sexological interest. All academic hospitals have a sexological out-patient department now, all within the gynaecology clinic, more or less multidisciplinary in staff composition. Unfortunately, these out-patients departments are much too small, except for those in Amsterdam and, more recently, Leiden.

In Flanders there is, besides a Federation for Planned Parenthood **(CGSO)**, only one center for treatment of sexual problems. At the end of the fifties a young genaecologist, dr. Renaer, succeeded in interesting the later Cardinal Suenens in the moral issues connected with Roman-catholic marriage regulations, as they were a heavy burden for a lot of Belgian families. This co-operation resulted in a series of conferences, and the founding of the **Center for Familial and Sexological Sciences** at the Leuven University. Affiliated with this center is the **Center for Communication** at Lovenjoel, providing, amongst others, a residential treatment program for sexual problems. In Belgium, ethical problems have gained much more attention from therapists than in Holland. The Flemish historian and moralist **Jos van Ussel,** coming from an essentially ethical starting point, was valued especially in The Netherlands as the man who inspired a lot of students to critically re-evalute the sexual revolution. In his opinion, sexuality still was not free, but the "don'ts" had been replaced by "musts", in an essentially masculine design of sexuality. His teachings have profoundly influenced a whole generation of sexology students.

Masters and Johnson's books opened the sexological territory for social scientists. At the Utrecht psychology department, from '75 to '86, Everaerd and Schacht trained a generation of psychology students in the practical application of sex therapy (couples as well as groups), and made them co-operate in a steady line of scientific research projects on treatment results with these methods. Conceptually,

Everaerds enriched sexological theory with the terms interaction phase versus solo-phase, emphasizing surrender to one's feelings as essential during orgastic release.

The Society for Sexual Reform (NVSH), after having granted the consulting offices independence, stayed active as an ideological movement, paying much attention to society's weakest groups. Self-help groups were instituted for transvestites and transsexuals, pedofiles, exhibitionists and the handicapped. Its magazine's letter column "We Want to Know" was Holland's easiest accessible source of sexological information.

We also want to mention the **Foundation for Alternative Relation Mediation (SAR),** founded by some handicapped members together with non-handicapped volunteers, to give information on the special barriers the handicapped will meet in expressing their sexual desires, and to provide actual sexual services to this group.

In the eighties, medical specialists re-discovered impotence as their topic. Following international trends, a **Society for Impotence Research (NVIO)** was founded in 1986. In Flanders, especially at the Brussels university urological department, similar developments took place.

Unlike The Netherlands or England, the neo-Malthusian pressure groups hardly had a chance to grow in Belgium into a fully developed movement. In 1912, a 'Belgian League for the Regulation of Family Size' was created. It remained a small set of inspired and motivated individuals boycotted by Catholics, liberals and socialists alike. They moved into Flanders from across the Dutch border and emerged in a few circles in Wallonia. World War I put an end to their activities.

A family planning organization would re-emerge only in 1955 when the 'Belgian League for Sexual Advice' (= B.V.S.V.) was created. It mainly aimed to promote the spread of more reliable contraceptives and to contribute to the sexual well-being of the population. In the early sixties, two consultation centers were opened (Ghent, Antwerp) mainly providing contraceptive consultation. For many years, it had strong links with and relied heavily on the Dutch NVSH, for example by receiving its magazine free of charge for the membership in Flanders.

A general form of sexological help was provided from the early 1970s on in all CGSO-centers, located in the major cities in Flanders. A similar development took place in the French-speaking part of Belgium, be it obviously with more support from the French MFPF. The number of centers were also more numerous, partly reflecting the less dominant influence of Roman Catholicism in the Southern part of Belgium.

Today, the Centers of Fertility Regulation and Sex Education, the C.G.S.O.'s in Flanders and the C.P.F.E.S. in Wallonia, remain places were psychosexual counselling is provided, including short-term sex therapy. This practice however has never been submitted to empirical evaluation nor was it scientifically reported.

Throughout the seventies, they also served as a platform for the start of self-help groups, mainly aimed at the expression of sexual preferences labelled as 'deviant' (homosexuality, SM, transvestism, paedophilia). From the mid eighties on, help related to sexual abuse of women and/or children also emerged (similar to the situation in The Netherlands). In recent years, initiatives related to sex workers (prostitution) were launched in Antwerp (Payoke), Brussels (PSP), Ghent (PASOP) and Liège (Espace P).

Besides the centers affiliated to the planned parenthood movement in Belgium, psychosexual counselling is also provided in some 'Centers for Life- and Family Problems', as well as in 'Centers for Mental Health Care'. The fact whether provision is made or not, depends even more for such centers on the presence of dedicated individuals holding sufficient expertise in the domain of sexual treatment (Deven, 1986).

Clinical practice in Holland and Flanders

Professional sexological care in general practice, in the sexological out-patient departments at Academic hospitals, and in other sexological institutes will be highlighted below.

Prevalence of sexual problems in general practice

People in The Netherlands who choose to discuss their sexual problems with a professional usually go to their general practitioner (GP) first. An estimated 100.000 to 200.000 explicit sexual problems per year are presented to the 6000 Dutch general practitioners. The GPs refer about 10 to 15% of them to specialized care: sexology or psychiatry departments, social workers and psychologists (Wigersma, 1990).

Recent morbidity figures of sexual problems in Dutch general practice are provided by several large morbidity studies, of which we mention those conducted by Lamberts (1984, 1987) and Wigersma (1990). In a study of a different design, general practitioners were interviewed about the number of sexual problems they encountered during the previous 7 days (Frenken, 1988).

Table 1. Prevalence per 1000 patients per year of sexual problems in different studies in general practice

	Lamberts		Wigersma	Frenken
	1984	1987	1990	1988
Impotence				0.9
Orgasm disorder			0.7	0.9
Desire disorder			1.7*	3.2
Sexual preference problems	0.4		0.4	0.3
Other sexual problems				19.7**
Sexual problems	3.2	2.7		
Relationship problems with sex. problems	8.4		1.1	
Dyspareunia M + F			1.1	2.6
Non-psychogenic dyspareunia, female	0.8	1.0	0.3	0.9
Non-psychogenic sex. dysfunctions, male		0.7	0.3	
TOTAL	12.8	4.4	5.6	28.0

* Including impotence

** Including:
- Questions or anxiety about masturbation, contraception, penis size, secondary and tertiary sexual characters, unwanted pregnancy, sex during pregnancy and during menstrual period, sex after the menopause and coital position (prevalence 12.1);
- Sexual problems probably related to contraception (prevalence 3.4);
- Different sexual need than partner (prevalence 2.9).

Table 1 shows the results of these studies. The studies are not consistent in method and classification; hence the different figures. Frenken's study is based on subjective data. The general practice morbidity surveys are registration studies, in which the doctor records the complaint or the diagnosis or both, as presented in the encounter. Frenken's terminology is entirely sexological, whereas in the course of time the classification used in general practice has become less sexological and more general. This development is compatible with the fact that people present their sex problems to the general practitioner in "rough" categories, not in specific terms. Moreover, not every disease or reason for encounter that includes sexuality or sexual (dys)functioning can and should be classified as a sexual problem **per se**, according to general practice research standards (Wigersma, 1990).

In spite of these methodological differences a reasonable analysis of sexual morbidity in The Netherlands can be presented here. The first morbidity study by Lamberts (1984) was conducted in 12 general practices in and around Rotterdam during 1979-1981, the second one (1987) in 14 practices in Amsterdam, Rotterdam and the eastern part of the country during at least one year. Both are studies in which all morbidity has been registered, which means that there was no special attention given to sexual morbidity. The sexual problems figures of these studies show one marked difference. The 1984 study included an 8.4 per 1000 prevalence of relationship problems with a sexual aspect, a category not mentioned any more in the 1987 study. Obviously this has become part of the general category "relationship problems". Wigersma (1990) conducted a study in 11 Amsterdam practices during one year, focused on sexually transmitted diseases and sexual problems. The classification system used here was a little bit more specific than the one used by Lamberts. The participating doctors were interested in these problems and could be expected to be attentive. However, the prevalence found by Wigersma is only marginally higher than in Lamberts' 1987 study. And even this small difference may partly be attributed to the fact that the prevalence of sexual problems in medical practice is higher in Amsterdam than elsewhere in the country. We may therefore conclude, that a keen awareness of sexual problems among general practitioners partaking in morbidity surveys does not lead to a substantially higher recorded prevalence.

Reporting from memory, the method used in Frenken's study, usually results in serious overestimation of the prevalence as seen by general practitioners, because of the respondents' tendency to give desirable answers. Above this, a large part of the problems included in the prevalence and mentioned in the table 1 legend should not be classified as sexual problems. The conclusion is that, although some of his figures correspond with those from the GP morbidity studies, Frenken's study as a whole may not be considered a reliable reflection of sexual morbidity in general practice.

Other sexual morbidity studies conducted in The Netherlands are interview and questionnaire surveys among (groups in) the population. It goes without saying that such surveys unveil a far greater sexual morbidity than is presented to institutions of health care. Their value lies in assessing the way people deal with sexuality, not in the prediction of prevalence in health care practice.

Interventions in general practice

Table 2 shows the interventions performed by general practitioners in answer to newly presented sexual problems, as studied by Wigersma (1990). The emphasis clearly lies on problem clarification, education and counselling. Only with dyspareunia (90% females) are laboratory tests (microbiological examinations) performed in a substantial number of cases. This is compatible with the possibility of vaginal pathology as a cause of dyspareunia. The total referral rate (19% for all sexual problems) is high compared to the 7% found by Lamberts in 1987, but that may be related to the fact that Amsterdam has numerous specialized institutions in this field, contrary to the regions where Lamberts conducted his study. In about 25% of newly presented sexual problems the patient returned for a second visit, in 6% for a third time. In nearly all new encounters the doctor and the patient had agreed upon a follow-up encounter. Obviously many patients simply do not return to their doctor with sexual problems, although the doctors find it necessary.

Table 2. Interventions in sexual and relationship problems in % of diagnosis (Wigersma, 1990)

	Desire problem	Dyspa-reunia	Orgasm problem	All sex. problems	Relation-ship probl.
n:	31	19	19	79*	22
Phys. exam.	32	84	26	41	18
Microbiol. exam.		38	5	11	5
Blood exam.	3		5	3	9
Problem clarification	84	100	79	86	95
Education	45	68	11	47	59
Medication	6	11		8	
Counselling	35	53	11	32	50
Referral:					
social work	6			3	
psychology					9
sexology	10	5	11	8	
psychiatry	3		5	3	5
other specialist	3	11	5	5	
other					5

* Including sexual preference problems

A reliable figure of the prevalence of sexual problems in general practive is given by several GP morbidity studies. The management of sexual problems by general practitioners emphasizes clarification, counselling and education. Sexual problem episodes in general practice are often dealt with during a single visit of the patient, which indicates that the short term prognosis is favorable, or that there is no cure, or both.

Treatment in university departments

In order to bring about a better understanding of the present circumstances within the university medical centers, we provide a short history of the establishment of out-patient sexological services. If one considers how sexological thought has

developed in medical practice in The Netherlands, it is possible to point out a number of relevant facts which have had great impact on the present situation.

At the end of the 1940s, several medical sexologists founded the Dutch Society for Medical Sexology. It was led by three prominent sexologists of varying religious backgrounds. Unfortunately, the time was not yet ripe for sexology to be accepted in traditional medical circles. Their plea for acceptance of medical sexology as a medical specialization fell on deaf ears. At that time, sexology was not taught in any of the medical faculties in Holland. In order to remedy this situation, the NVSH established two chairs in sexology, the first of which, in Amsterdam, was occupied in 1969 by Dr. C. van Emde Boas, who, from 1971, also filled the second chair, in Leiden.

Then the university activities in medical sexology quickly spread. Both in Utrecht and in Rotterdam, psychiatrists and gynaecologists showed interest in sexology. In 1977 the medical faculty in Utrecht founded a chair in medical sexology to which Dr. H. Musaph was appointed.

At first, the sexologists worked mainly in association with gynaecological out-patient departments. The association between medical sexological and urological out-patient departments only began in the 1980's.

Sexological services in University clinics traditionally included a psychoanalytic approach to human heterosexual sexuality. "Perversions", including homosexuality, received special attention. This viewpoint has long since been replaced by a far more liberal and enlightened view of the normal variations in human sexuality, which is now the basis for sexological practice in University departments.

There are large regional variations in both content and size of sexological services in University departments.

Table 3. University medical sexology departments or treatment units, connections with other departments, and special competence

The Netherlands	Department of	Connections with dept(s)	Special sexological competence
Acad. Medical Centre (chair) Amsterdam	Gynaecology	Psychiatry, urol., psychology	Psychosomatic; Somatic Psychoendocrine
Free Univ. Hospital (chair) Amsterdam	Interdepartmental gender group		Gender dysphoria Transsexualism
Utrecht (chair)	Gynaecology	Psychology	Somatic; Relationship
Groningen	Gynaecology		Ilness and sex
Leiden (chair)	Gynaecology	Non-medical sexol.	Women; Sexual violence
Rotterdam (chair)	No own dept.; part of gynaecol.	Physiology, Urology	Chronic illness Erectile dysfunction
Maastricht	No own dept.; part of urol. and gyn.	Ambulatory Mental Care	Incontinence Psychosomatic
Nijmegen	Gynaecology	Psychiatry, urol., psychology	Impotence
Belgium			
Leuven	Gynaecology	Urology	Psychosomatic Psychoendocrine
Antwerp	No own dept.; part of gynaecol.		
Brussels	No own dept.; part of urol.		Erectile dysfunction

The one existing gender team will be described in some detail. The differences can partly be ascribed to the historical development and are partly due to the lack of involvement of medical specialists. Resistance to comprehensive sexological services can occasionally be met in certain hospitals in Holland. The type of services which are now offered in each of the University Hospitals will be described below, with the emphasis on the treatment modalities found there (table 3). Almost all departments offer general consultation and treatment for women and men.

The Netherlands

The department of sexology and psychosomatic gynaecology of the **Academic Medical Center in Amsterdam** is the successor to the first outpatient sexological service in The Netherlands. This service, which was established in the 1950s, further expanded in the 1970s into the field of psychosomatic gynaecology and counselling on psychosexual problems of contraception. The department also is involved in training and research. The approach can best be described as multi-disciplinary with a strong emphasis on the multi-causal background of sexual dysfunction. The high level of specialization has led to a selection of the incoming patients. Problems suitable for classic (psycho)sexual therapies are left to be treated by other organizations. The work in the clinic is concentrated on strict medical sexological problems (combination of somatic pathology and sexual dysfunction) and problems of a psychosomatic gynaecological and urological nature.

Research is carried out in cooperation with the department of clinical psychology on topics such as the efficacy of treatment for chronic focal vulvitis, and sexual and relational consequences of oncological gynaecological treatment. Also evaluation of erectile dysfunction is being carried out within the framework of inter-departmental research.

The first clinic to specialize in the area of gender dysphoria is the **Academic Hospital of the Free University, Amsterdam.** In 1972, the Dutch Gender Center Foundation was instituted. After several years of informal contact with the Free University Hospital, the ethical committee gave its approval to the medical treatment of transsexuals. This innovative clinic which started in 1976 offered therapy consisting mainly of the endocrinological treatment of transsexuals with a small number of operative corrections by private plastic surgeons. In 1982 a multidisciplinary gender team was formed. It works according to the guidelines for treatment of the Harry Benjamin International Gender Dysphoria Association. Medical treatment for transsexuality is covered by health insurances and there are few legal barriers to the sex change. Up to now, nearly 1500 transsexuals have been treated by the gender team since 1976 (Gooren, 1990). Approximately 150 patients have undergone sexual reassignment surgery, This team which is presently located within the division of endocrinology also carries out research and training activities. In 1988, the Free University founded a special chair for transsexology which was awarded to Dr. L. Gooren.

In **Utrecht,** a strong accent is placed on the treatment of sexual problems with (suspicion of) a direct or indirect somatic etiology. The treatment modality can best be described as short, directive and behaviour-oriented. When necessary, however, a psychodynamic approach can be taken. In research Utrecht concentrates on the development of an instrument for detection and screening of sexual problems and disorders of patients within the medical setting. Beside research and clinical activities, there is a wide range of training activities on pre- and postgraduate levels.

The Utrecht group is one of the very few to scientifically report on their population. In 1981 van Bilderbeek-Lankester gave figures on 5 years of personal experience. Of 162 patients/couples, 42% completed treatment, 14% were still continuing treatment at that time; 21% were referred, mostly to psychotherapists, 16% were drop-outs. The problems they sought help for (in order of frequency): vaginismus (47), female anorgasmia (31), loss of libido (23), dyspareunia (19), erectile failure (19), sexual aversion in the female (9) and ejaculatory failure (6, not specified).

The former Utrecht Department of psychology sexological research was famous for its sound methodology. To evaluate outcome the investigators mainly relied on Frenken's Sexuality Experience Scale (Frenken, 1981). Their research subjects were:

- a comparison of sex therapy (ST) with communication therapy (CT) in couples complaining of female orgasmic dysfunction (Everaerd and Dekker, 1981).
- a comparison of efficacy of ST versus systematic desensitization (SD) for couples consulting for secondary orgasmic dysfunction (Everaerd and Dekker, 1982) and couples complaining of male sexual dysfunction (Everaerd and Dekker, 1985).
- a long-term follow-up study of the couples participating in the three studies mentioned before.
- an evaluation (Everaerd et al., 1982) and an attempt at predicting outcome in individual cases (Dekker et al., 1985) of male-only groups for mixed sexual dysfunctions (sexual orientations in these groups were mixed, e.g. heter-, homo- and bisexual). In these groups masturbation training, RET and social skills training were important elements.

The **Groningen Academic out-patient department** distinguishes itself from the others through its research program in sexuality related to illness and disability. This program had led to a large number of publications in various journals, both national and international. The fundamental research questions deal with the effects of illness and disability on sexual functioning of patients and the effects of therapy on sexual dysfunction of the patient and the partner. This has resulted in sexological intervention programs/strategies for a number of disorders, such as gynaecological cancer treatment, ostomies and coronary bypass surgery. The staff is involved in the pre- and postgraduate training of medical students, medical interns and psychologists.

At the **Academic Hospital in Leiden,** the department of gynaecology has been an important example in Holland of work in psychosomatic gynaecology and obstetrics for many years. A chair in (non-medical) sexology helps to contribute to the development of this specialization. A specific accent regarding women's health care has

served as a beacon for developing programs in sexology and (psychosomatic) gynaecology. An example of this quality of life approach is the group-therapy method for women who have undergone oncological gynaecological surgery and the work done with women suffering from chronic pain in the lower abdomen.

At the moment, plans are being finalized for the opening of a sexological out-patient clinic. Next to general services, research and training, this clinic will offer specific treatment to women and men who have been victimized by sexual violence or have undergone other sexual traumas.

At the Dijkzigt **Academic Hospital in Rotterdam** there is no independent out-patient clinic for medical sexology. The sexological services have been delivered since 1985 in the gynaecology and urology out-patient departments and serve patients referred from other departments as well as by general practitioners. Besides general medical sexological therapy, mostly for women, patients with chronic illnesses, such as multiple sclerosis and diabetes are treated for sexual dysfunction.

A special feature in Rotterdam is the work which is done in medical physiology. In this setting psychophysiological assessment is made of men suffering from erectile dysfunction (Slob et al., 1990).

Otherwise, much as in the other hospitals, the sexologists contribute to university training and research. Noteworthy are the studies which are done in comparative biology and physiology.

After several years of negotiations between the Institute for Ambulatory Mental Health Care (RIAGG) in Maastricht and the **Maastricht Academic Hospital** a provisional facility for medical sexology was opened in the fall of 1988. In Maastricht, the sexological services are offered in both the department of urology and the department of gynaecology. Important work is the psychosomatically oriented treatment of patients suffering from intractable urinary incontinence.

Referrals are only accepted from the other hospital departments. Lack of funds do not allow of the development of a research program. Occasionally, residents in gynaecology and psychiatry are coached in medical sexology.

At the **Radboud Academic Hospital in Nijmegen** there is a long tradition of attention on sexological matters in the department of gynaecology. Medical sexological consultations are given by the gynaecologists and are supported by a psychiatrist/sexologist from the department of psychiatry.

There are conferences of staff members of the departments of urology and gynaecology about patients with impotence. Several departments of psychology play an important role in the sexological services in Nijmegen. There are plans to establish shortly an out-patient sexology clinic in Nijmegen.

Belgium

The only Academic center for medical sexological treatment is in the city of Leuven. At the Academic Hospital Gasthuisberg, under the auspices of the department of

gynaecology, a wide range of services is being offered. The medical sexology itself is integrated into a psychosomatic unit, which has developed a broad research, training and clinical program. Patients with various sexual problems are treated.

If necessary, counselling in the legal aspects of the problems can be given. Gender dysphoria can also be diagnosed and treated.

The strength of the unit in Leuven lies in its integration into a general setting of psychosomatic gynaecology and obstetrics. This means that a number of significant areas which are strongly related to sexology are included in the expertise. We mention psychosomatic aspects of contraception and sterilization, psychosomatic and psychosexual aspects of adoption, donor insemination and in vitro fertilization, psychoendocrinological aspects of infertility, and psychosomatic aspects of chronic pelvic pain and urinary incontinence, as well as psychosexual aspects of breast cancer.

Furthermore, Leuven is well known for its scientific work in psychosomatics and sexology as well as its excellent reputation as a training center for specialists in this field.

In 1984, Vansteenwegen et al. reported on 10 years of residential (3 weeks intensive therapy) and ambulatory (weekly) sex therapy for couples at the Lovenjoel center. Total number of couples: 192. One third of treatments were performed in co-therapy. Patients complaints were: female anorgasmia (48), vaginismus (37), premature ejaculation (20), secundary erectile failure (18), anejaculation (17) and primary erectile failure (15). The dropout rate was 23%, with no specific problem producing higher dropout rates; sexual aversion and anejaculation were the problems most likely to defy treatment. Residential therapy, as well as co-therapy, resulted in better treatment outcome. If the couple's primary aim was to improve general aspects of the relationship, results were disappointing.

At the **Academic Hospital in Antwerp** there is a limited capacity for consultation in medical sexology. These consultations are given by a gynaecologist who is specialized in sexological therapy and operates under the auspices of the department of gynaecology.

In the **Academic hospitals in Ghent and Brussels,** no medical sexology is offered as such. The department of gynaecology appears to offer counselling services for patients seeking andrological treatment such as *in vitro* fertilization and artificial insemination. In **Brussels** there is specific expertise available in the area of erectile impotence in the department of urology.

Treatment in the Rutgers Foundation

In 1969, at the founding of the Rutgers Foundation for family planning and sexuality, the treatment of sexual problems was a very small part of its activities, but the need for this type of help soon proved to be large. Moreover, Masters and Johnson's works had generally led to optimistic expectations of the treatment possibilities of sexual problems. The Foundation decided to organize their sexological departments in a multidisciplinary fashion: physicians, psychologists and social workers were co-operating in teams, on the same level of professional responsibility.

Besides sexual dysfunctions, the sexological teams were soon confronted with other problems: paraphilias, gender dysforia, emotional reactions after sexual violence. In handling these problems, Rutgers Foundation therapists have often led the way for others. The recent discussion on professional codes against sexual contact between therapists and clients was started by this group.

Frenken (1985) presented Rutgers Foundation material from the years 1980-1983: 6310 women, men or couples came to the Foundation. No less than 41% of the men complained of erectile problems. A disparity in sexual desires (frequency or/and ways of lovemaking) was the main problem in 19% of the men; 18% complained about premature ejaculation. Retarded or absent ejaculation accounted for 9% of the men who sought help.

In women, inhibited sexual desire was the most frequent complaint (28%); anorgasmia and vaginusmus were both mentioned by 19%, dyspareunia by 10%. 14% had desire discrepancies as their main complaint. No further analysis is given, and this paucity of information no doubt reflects a general lack of time for reflections on their work that most sexological departments suffer from.

Specific care

Specific care for women

In The Netherlands the **Health Care for Women (HCW)** movement has a highly significant presence, not least because of governmental support. In HCW the social status of females as well as their socialization are considered to be possible causes of physical and mental problems. The professional help should be concentrated on that starting point. HCW is particularly found in about 300 projects of the so-called autonomous professional help. The Ambulatory Mental Health Centers have recently been obliged to organize their support along these lines of specific help for females. Nevertheless, more traditional views still play a dominant role. In the medical profession the effects of women-centered help are less perceptible.

Methodically speaking HCW is positioning itself between self-help and professionalism. Important topics for therapy are agression, autonomy and sexuality. During therapy a balance of power between therapists and client is pursued as much as possible, so female therapists are preferred, as well as group treatment modalities, and the use of clear, concrete interventions. It is obvious that during the therapeutic process complaint and treatment have to be adjusted to each other, but it is the responsibility of the therapist to decide on the autonomy of the female client.

In the field of the sexological help HCW has a growing influence, e.g. in the development of group treatments, more for ideological than economic reasons! In these groups women can share their sexual problems (libido problems, vaginism, surviving incest), and discover that these problems are less related to their individual personality than to 'women's life'. Some Dutch female sexologists have a real feministic profile, but even without this profile quite some sexologists appreciate the pre-orgasmic women's groups which operate according to a treatment modality of Lonnie Barbach. Another instance of a slowly growing acceptance of the influence of

the specific HCW is the objective of the treatment of vaginism. Coitus as the aim of therapy is not any more taken for granted. Instead, harmony between the client's non verbal (physical) no and a verbal yes is aimed at. That harmony can be yes, I want and can have a coitus, but could also be no, I don't want a coitus. Also the choice of Artificial Insemination with partner's semen by vaginistic women is gaining ground. Without 'solving' the vaginism, the woman can become pregnant. From a Women's Mental Health Care point of view, vaginism is no longer considered to be caused by fear of men of the penis, or as sexual aversion or aversion from being an adult woman, but as a possible (conscious or unconscious) dynamics of power and powerlessness between men and woman.

The interest in the development of therapies for survivors of incest, rape and sexual assault, and the awareness of possible sexual contacts between helpers and clients also mirror an interest in Women's Health Care.

Helping victims of sexual violence

One and a half decade ago, feminist women's groups started to accuse professional helpers of bad help or non-help for victims of sexual violence. Their major charge was that women were not believed if they talked about sexual violence, and that the treatment by police and health care professionals led to secondary victimization. These feminist women started with women-centered help to victims/survivors. From that time the quantity of voluntary and professional help has boomed. It must be said that quality has not always held pace with quantity.

An adult woman who now becomes the victim of rape or another form of sexual abuse, can go to one of the autonomous women's projects like 'Against Her Will' or 'Women Against Rape' (Tegen Haar Wil, Vrouwen tegen Verkrachting). Helpers are mostly (female) volunteers. In big cities female general practitioners have organized a network for medical care and investigation after rape, in cooperation with the police who refers women to them. Most police forces also cooperate with a volunteer's organization called 'Victims Help' (Slachtofferhulp). Further help and therapy for victims of sexual violence is offered by autonomous women's groups, Ambulatory Mental Health Centers (Riagg) and the Rutgers Foundation. The Ambulatory Mental Health Centers and the Rutgers Foundation offer different types of help: individual, systemic, family and group treatment. The Rutgers Foundation is specialized in giving help for sexual problems after violence.

Victims of incest can also go to the above mentioned organizations. Apart from these a strong national organization, called 'Organization Against Sexual Abuse of Children' (Vereniging tegen Seksuele Kindermishandeling) should be mentioned. Most sexologists of the Rutgers Foundation work along the lines of specific Mental Health Care for Women. Some bigger cities have networks of professional and voluntary helpers in which the police participates.

In cases of ongoing incest, another practice is followed. In The Netherlands we have the institute of the Vertrouwensarts ('trusted representative doctor'). Suspected sexual child abuse or incest can be reported to this 'trusted representative doctor', who investigates this, and coordinates the help. The general practitioner of the family

can be involved in the helping process, as well as the Community Mental Health Care for Children and the Society for the Protection of Children (Kinderbescherming). The police is rarely involved: no one is obliged to inform the police. Nowadays schools play an active role in signalling physical and sexual child abuse.

The awareness of more forms of sexual violence is growing, such as the sexual abuse of mentally and bodily handicapped children and adults, and the topic of sexual harassment/abuse by therapists is no longer concealed. Measures are taken by different professional help organizations and by the Government.

The growing interest in the treatment of offenders of sexual violence is remarkable. Of course it is important to help the offenders too. But it is precarious that the interest in helping offenders seems to grow at the cost – in energy, money and professionalism – of the interest in helping victims.

Women and AIDS

Women are vulnerable to the immunodeficiency syndrome (AIDS) and are now contracting this disease at a faster rate than men (in fact twice as fast). In The Netherlands 5% of all AIDS patients are females, the actual number being 60 in June 1990.

Looking at the care provided for HIV infected women, test practices, prevention programs, scientific publications and the interest of the media, it becomes clear that far more attention is being paid to women as infectors than to women as infectees. This is noticeable from the interest taken in prostitutes, female IV users, and in pregnancy of HIV infected women.

Prevention

In 1985 a platform 'Women and AIDS' was established. This platform criticizes e.g. the way 'safe sex' – the use of condoms – is propagated by the Dutch Commission on AIDS Control as a means of preventing contamination. Reasons mentioned for this criticism are: in Holland the use of condoms was never much accepted as a way of contraception, 'the pill' is far more popular; the use of condoms requires equality in relationships, which is not always the case; when something goes wrong with the condom (or when the male partner refuses to use it), the risks for the woman are greater than for the man; quite a few women like to make love, but don't like to have intercourse. Another complaint of this platform is, that lesbian women are never mentioned in the context of AIDS prevention. Most prevention campaigns have been mass media campaigns. Women's groups now demand target specific campaigns directed to women. The Rutgers Foundation is preparing the strategy for such a campaign.

Care

In 1989 the Rutgers Foundation started to organize short term groups for HIV infected women, like the gay community did for itself. So far three group courses have been held in Amsterdam (where also most seropositive women live), a fourth group will shortly start in Utrecht. Main topics in these groups were the prejudice against a

prostitute or IV drug user in case of an infected woman, pregnancy and (the impossibility of) motherhood, sexual relations and safe sex, the specific disease profile in women and the frustration around the ignorance of medical doctors and other health care workers.

In december 1990, on World Aids Day which was dedicated to women, it was observed that women should be the target for more and better campaigns for the prevention of AIDS, and that care for HIV infected women should be improved in quantity as well as in quality.

Homosexual men and AIDS

Since the onset of the AIDS epidemic in western Europe (1982-83) an elaborate system of care and prevention for homosexual men has been developed in The Netherlands. The gay community took the initiative for the first nationwide AIDS education campaign (1983), which was mainly aimed at homosexual and bisexual men. Also in 1983, an ambulatory venereal disease and AIDS clinic for homosexual men was established in Amsterdam: the "Stichting Annvullende Dienstverlening" (StAD, supplementary services foundation). The clinic renders services supplementary to the general STD care institutions. This foundation, together with other gay organizations, the Amsterdam municipal health department and the Ministry of Health constituted the first national AIDS policy committee in 1984.

In 1984, as the AIDS epidemic spread further among gay men, the StAD started a small scale primary prevention course for gay men, aimed at altering sexual habits in the AIDS era. The course was modeled after an American example and was successful throughout the country. The foundation has organized and still organizes numerous other prevention programmes aimed at gay and bisexual men, such as safe sex workshops, video workshops, shows in gay bars and activities in gay cruising areas (parks, public toilets). All these programmes are aimed at altering sexual habits and presenting gay men with the tools they need to maintain safer sexual behaviour.

Next to this and in association with a number of general practitioners in Amsterdam who have a lot of AIDS patients, the StAD produces postgraduate education programmes and material on AIDS for Dutch general practitioners (Hochheimer, 1988). Doctors employed by the StAD actively support some of the general practices in Amsterdam with the heaviest burden of AIDS- and HIV-patients by taking over office hours and home visits. Most AIDS patients in these practices are gay men.

Another important gay health care institution is the Schorer Stichting, a foundation named after an early gay activist in The Netherlands. In the AIDS field, the foundation has been offering psychosocial care for gay men and their friends and families since 1984. It also initiated and now coordinates the "buddy" home care projects all over the country. This project offers AIDS patients free volunteer support at home. The Schorer Stichting, on the basis of its expertise, produces education programmes and training courses for workers in psychosocial health care.

Although these gay organizations are important care providers, most gay men with HIV-disease and related problems make use of general health care institutions such as general practitioners, district nurses, hospitals, psychiatrists and social

workers. It is therefore important that gay (and other) life style elements are included in postgraduate education about AIDS for all professionals and volunteers. After all HIV has no precedent as an extremely serious health and culture problem in the gay community. Through our education programmes we try as hard as we can to prevent communication problems between patient and health care provider about homosexuality and life style.

Home care is provided by regular institutions: general practitioner, district nurse, home care organizations. In the case of gay men, buddies are often present. Health care for gay men has not been evaluated through scientific study. HIV-studies among gay men include seroprevalence research, HIV-morbidity surveys from the StAD gay clinic and several practices in Amsterdam, and sexual behaviour studies.

Heterosexual men and AIDS

Most heterosexual men with AIDS or HIV-infection in The Netherlands are either hemophiliacs or (former) intravenous drug users. Many of them make use of the general health system in case of complaints and diseases. About 17% of all Dutch hemophiliacs are HIV-infected. The very active national hemophilia patients association has set up extensive education campaigns and support systems for its members, by which patients can profit greatly.

The municipal health centers in the big cities, together with general practitioners and local clinics for the addicted, monitor a substantial percentage of intravenous drug users in the country. Monitoring usually includes health education, education about HIV prevention, assessment of the physical condition, and often also the prescription of methadone, a substitute for heroine. In case of HIV-disease care is often complicated by aggravated addiction behaviour, which often makes these patients difficult to deal and make appointments with. Because of this, the establishment of special care units for addicted AIDS patients in hospitals and nursing homes is considered, as well as hospices and buddy projects with specially trained staff for ambulatory patients. Regular home care, which is provided by the general practitioner, the district nurse and home care organizations, can only be organized effectively when the patient leads a more or less regular life.

There has been no systematic assessment of the care for HIV-infected intravenous drug users. The only studies conducted are seroprevalence studies.

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