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Helen Singer Kaplan's Sexual Response Models and Legacy

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Synonyms

Biphasic model; Founder; Helen Kaplan; Helen Singer; Helen Singer Kaplan; Pioneer; Tri-phasic model

Introduction

Helen S. Kaplan, MD, PhD, was perhaps the most influential sex therapist of the twentieth century. Kaplan was best known for her prolific writings, her successful sex therapy practice, as well as founding and directing the Sex Therapy & Education Program at the Payne Whitney Psychiatric Clinic of Weill Cornell Medical Center from the early 1970s until her death in 1995.

It was Kaplan's first book, *The New Sex Therapy* (1974), which adapted Masters and Johnson's program that had the greatest effect on society at large. She modified Masters and Johnson's 2-week intensive residential program into an outpatient treatment. While writing that book, she founded the Sex Therapy & Education Program at the New York Hospital, Cornell University Medical Center, the first medical school-based clinic of its kind. That program provided a template for subsequent training and treatment programs across the world. In 1974, she along with doctors Clifford Sager and Harold Lear established *The Journal of Sex and Marital Therapy*. Psychoanalytically trained as both a psychologist and psychiatrist, Kaplan recognized and brought to sex therapy and sexual medicine a respect for multi-determinism, multilevel causality, and multi-disciplinary participation. It was Kaplan (1995) who first described the "dual control elements of human sexual motivation," and identified sexual "inciters" and "suppressors" to sexual desire dysregulation, foreshadowing later dual and variable models of Bancroft & Janssen (1999), Bancroft et al. (2009) and Perelman (2006). She along with Harold Lief were first to draw attention to the importance of evaluating "desire" when treating sexual disorders. Kaplan's influence was profound, both directly and by training numerous next

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generation sex therapy and sexual medicine thought leaders.

History

The Beginning

Helen Singer was born in Vienna, Austria, on February 6, 1929. In 1940, she emigrated to the United States. Prior to her arrival in the USA, she spent time living in Paris where she studied art. Helen became a citizen of the USA in 1947. She received a Bachelor of Fine Arts from Syracuse University in 1951 and later studied clinical psychology at Teachers College, Columbia University in NYC where she obtained a PhD (1955) in clinical psychology. While married to the notable psychiatrist Harold Kaplan, Helen enrolled at New York Medical College and earned a medical degree in 1959. She later completed psychoanalytic training at that same institution (Wikipedia, 2022).

The seeds for the sex therapy and sexual medicine movement had been planted in fertile ground during the last half of the twentieth century. The world experienced a wave of explosive events and rapidly changing times during what became known as the "sexual revolution" of the 1960s and 1970s. The sexual revolution's demarcation point was in large part the postwar baby boom generation's widespread use of the newly developed birth control pill and other easily available forms of protection from unwanted pregnancy. Many concurrent, as well as subsequent events and issues totally changed the social landscape, which allowed for an ever-expanding public discussion and focus on sex. A partial but incomplete list would include the following: Alfred Kinsey's work; Hugh Hefner's Playboy magazine and enterprises; Masters and Johnson; the Vietnam War; and worldwide student protests and various emerging identity movements (e.g., feminism, etc.) from the late 1960s through the 2000s. Important changes would also include the impact of the majority of women entering the workforce, and numerous women's magazines and books that celebrated a new lifestyle (e.g., Helen Gurley Brown's *Sex and the Single Girl,* followed by *Cosmopolitan* magazine). Equally critical to societal change was the impact of not only the old media, but also emerging "social media." And finally, society's rate of change had been itself accelerating since World War II, a trend that (especially in technology) dramatically continues through this day.

For many mental health professionals, modern sex therapy and sexual medicine started with the publication of William Masters and Virginia Johnson's two pioneering works. *Human Sexual Response* (Masters & Johnson, 1966) delineated their laboratory studies of the physiological aspects of human sexual response. Subsequently, by codifying principles for improving sexual function and repairing dysfunction, their 1970 landmark volume, *Human Sexual Inadequacy,* birthed the field of sex therapy. They taught that the couple, rather than the individual, was the proper focus of therapy. That perspective was in distinct contrast to the intrapsychic developmental orientation of the reigning psychoanalytic paradigm. By comparison, sex therapy was relatively brief, problem-focused, and directive in theory and technique. Most important to the future of sexual medicine, Masters and Johnson, like Kinsey earlier, opened the subject of sexuality for ever greater public discussion.

However, it was Helen S. Kaplan's first book, *The New Sex Therapy* (1974), which adapted Masters and Johnson's program that had the greatest effect on health professionals. She modified Masters and Johnson's 2-week intensive residential program into an outpatient treatment. In 1973, while writing *The New Sex Therapy* (1974), Kaplan established the first medical school-based sex therapy training and treatment clinic of its kind in the United States. As Kaplan's book became the standard text for most students and medical institutions, it had an impact on where and how people were treated for sexual problems around the world. In that same year, Kaplan, along with Sager and Lear, established the *Journal of Sex and Marital Therapy* (anticipating other multidisciplinary sexual medicine journals), which progressively obtained broader influence and distribution under the editorships of psychiatrists Schiavi and later Segraves.

As a psychoanalytically trained psychologist and psychiatrist, Kaplan brought to sex therapy the principles of multideterminism and multilevel causality. Kaplan's writings emphasized an integration of her psychoanalytic perspective, combined with the type of sex-oriented, behavioral "exercises" many of which were first codified by Masters and Johnson. In her practice, she demonstrated a therapeutic eclecticism that anticipated current sexual medicine approaches that combine appropriate selection of medical and surgical treatments integrated with sexual counseling (Perelman, 2005). In Kaplan's "Disorders of Sexual Desire" (1979), she presciently describes how the treatment of ". . . sexual disorders have provided a catalyst for integration and amalgamation of a wide spectrum of ideas and experiences. . ." Finally, Kaplan's ideas predate and anticipate the most current dual-control models (Bancroft et al., 1999, 2010; Perelman (2006, 2016) guiding sex therapy and sexual medicine, which are discussed later in this entry and elsewhere in this work.

The Early Days

This author first met Helen Kaplan during the summer of 1974 and became her first doctoral graduate student. She had just published The *New Sex Therapy.* As an alumna of Columbia University's Clinical Psychology program where Perelman was currently enrolled, Kaplan graciously agreed to meet with him at the suggestion of a mutual professor. Perelman sought to obtain Kaplan's supervision on his planned dissertation on ". . . Group Treatment of Premature Ejaculation," as Kaplan had just published a pilot study on that topic. With his abstract proposal and CV in hand (dressed in his only dark suit), Perelman entered the office suite which Kaplan then shared with Clifford Sager, MD. Kaplan was dressed in a sweater and jeans (atypical for senior professors then), and she quipped, "with a wall full of diplomas behind me Michael, I don't need to dress up for a meeting." They talked about her own years at Columbia before she became a psychiatrist. She described her plans for expanding Cornell's sex therapy training and research program. And with only a glance at his abstract, she directed him to show up at her case conference the following week at the Payne Whitney Clinic. "You will do your research there under my supervision, but my time is limited; so, identify a second outside reader." Fortunately, Ray Rosen, PhD (who later developed the International Index of Erectile Function for Pfizer), agreed to serve in that capacity. Interestingly, Rosen and Kaplan spent no time together and did not share a common theoretical perspective.

The Sex Therapy & Education Program's case seminar was an eclectic group, whose participants were mentioned in Kaplan's *Disorders of Desire* including ". . . Barbara Hogan, Merle Kroop, Arlene Novick, Avodah Offit, Harris Peck, Michael Perelman, Wardell Pomeroy, Raul Schiavi, Richard Symons, and Mildred Witkin."*

All of Kaplan's subsequent books were written over ensuing summers, from the copious notes she took from those weekly case conference discussions. The merits and limitations of the demonstration case Kaplan treated during the academic year were discussed and debated in those seminar format case conferences. One of the least known facts about Helen Kaplan was the extent to which her writings were influenced by the participants in those weekly case conferences. That seminar continues to this day under the auspices of Cornell Medicine's psychiatry department and is the longest enduring continuing education meeting of its kind in the world. Since Kaplan's death in 1995, it has been under the direction of this author and his colleague, Richard Kogan, MD.

Initially, the case conference met weekly for 90 min. The seminar group viewed Kaplan treating the patient(s) behind a one-way mirror for a 45-min session. A variety of international guests (a trend continuing until this day) visited to watch her work. The case was then reviewed by the entire seminar group, and Kaplan's work would be critiqued as well as praised. The history and psychodynamics were discussed at length. Once there was some consensus on etiology, a treatment formulation and potential sex therapy interventions were explored. Helen's notes on those discussions, when combined with her own insights, became the basis for all her books over

two decades. That reality was graciously acknowledged in her 1995 dedication to her last book: *The Evaluation of Sexual Disorders.*

Use of Videotaping

By the 1980s, the structure of the case conference changed, as Kaplan would video-record a case on Thursday morning that would be discussed in our conference later that afternoon. Helen and the patient(s) would enter a repurposed "frozen meat locker" deep in the third level basement of the old Payne Whitney building. The "meat locker" provided the needed silence for early use of primitive 1-inch videotaping at the Cornell Medical Center. Videotaping greatly improved the quality and specificity of the discussions as the "pause/play/rewind" features allowed for dissection of a particular remark, body posture, and extensive discussions of alternative interpretations of the session's material. While Helen would always conceptualize the case in psychodynamic terms (she frequently referred to herself as a "card carrying analyst"), in reality multiple conceptualizations could be applied to the brilliant and intuitive work she did.

By allowing others to view her videotaped work, Kaplan distinguished herself from most of her contemporaries, who simply reported case studies. Videotaping was also used as a "graduation test" from the training program as each trainee at the end of their fellowship would videotape a session, and then subject themselves to the scrutiny of their peers and a room full of supervisors and guests. While all who did this learned from it and did indeed graduate, it was certainly experienced as a "trial by fire." As Helen typically presented weekly, she progressively became more skilled and relaxed on camera, often quipping that "one literally forgets the camera was on." Following her death, this author presented an invited talk on the *"Use of Video in Sex Therapy Training,"* at the 1996 Annual Meeting of the American Psychiatric Association, discussing Helen's work and how her approach continued to be used in training. For almost two decades after, that became the standard approach for many sex therapy clinics worldwide.

Helen S. Kaplan Was Prolific

Kaplan wrote many books, and of course they had a highly determining effect on sexual therapy and sexual medicine. A few of them will be briefly summarized below with some commentary on their impact. Kaplan's second book *The Illustrated Manual of Sex Therapy* (1975) was essentially a supplement to *The New Sex Therapy,* which reviewed its main points, but also provided 39 illustrations that rendered the key exercises typically used in sex therapy to help resolve the most typical dysfunctions. Having been "hand-drawn" almost 50 years ago, that volume appears quite dated and almost quaint compared to what is now available on the Internet. But at the time, such illustrations were helpful to both patients and clinicians alike.

Kaplan's Triphasic MODEL

In *Disorders of Sexual Desire* (1979), Kaplan criticized the field of sex therapy for failing to address the importance of sexual desire disorders as a separate clinical entity. In the same year, Lief (1977) recommended that the diagnosis of "inhibited sexual desire" (ISD) be applied to those patients who chronically failed to initiate or respond to sexual cues. Recognizing the importance of "desire" as a motivating factor in sexual response, Kaplan reframed her "biphasic model" of sexual response (emphasizing a separation of excitement and orgasm) to a "triphasic model" that incorporated a desire phase. Kaplan's book's demarcation point was an earlier landmark article where Kaplan (1977) first suggested that sexual response should be considered "tri-phasic" with separate albeit overlapping phases of desire, excitement, and orgasm.

Kaplan had explored both her and the case-conference group's "failure cases" as opposed to those which remained successfully treated. Specifically, at Cornell, we had observed a trend that desire issues played a central role that was previously inadequately examined, with both our own initial failures and our cases that relapsed. This included a group of patients who were referred to our Cornell clinic who had previous sex therapies

from some of the other late 1970s centers using conventional Masters and Johnson sex therapy. The "desire" book then described at length how psychosocial and relational issues can lead to the loss of sexual desire, as can organic causes, including medical conditions, drugs, and aging. Strategies for solving these problems were offered and illustrated with more than 30 case studies.

While such an enlightened perspective is obvious at this time, one must remember that not too long before, and for some time after Masters, Johnson, and Kaplan's early writings, the primary view of medical professionals and the public at large was to see sexual problems as limited to "impotence" and "frigidity." That view along with many psychoanalytic theories, especially those concerning women, came to be viewed as limited and controversial and ultimately were discredited (Barbach, 1975; Kaplan, 1974; Masters & Johnson, 1966, 1970). As mentioned, both Kaplan and (independently) Harold Lief were credited with identifying untreated desire as a major issue and this led to changes in DSM-III, which themselves later became controversial in DSM-5 and DSM-5-TR. That topic will be covered later in this entry.

In brief, Kaplan's participation in DSM-III (which began in 1974, with publication in 1980) heavily influenced the inclusion of a separate desire disorder category (Segraves, personal communication). Important differences in conceptualizations of the female sexual response cycle have, not surprisingly, led to a lack of diagnostic consensus and created contention in sexual medicine circles, resulting in continuous debate regarding diagnostic categories and their criteria. Lori Brotto, on behalf of the DSM-5 task force, successfully proposed that in women low arousal and low desire be combined into one category, "sexual interest–arousal disorder" or sexual arousability disorder (Brotto, 2010; Carvalheira, Brotto, & Leal, 2010). As of this writing, that is the current DSM nosology, although criteria for desire and erectile dysfunction remain separate and essentially unchanged for men. Clayton (2011) and others characterized the DSM-5's female sexual interest/arousal disorder as "a diagnosis out of thin air" and have expressed important concerns about how such a change is misguided and could have pejorative consequences for sexual medicine Balon & Clayton (2011, 2014). The rationale for collapsing the categories in women includes the fact that some women cannot distinguish between their own arousal and desire and that women's sexual desire may be more typically contextual than men's (Carvalheira et al., 2010). Some sex researchers hypothesized that men's sexual desire was spontaneous and initiatory, while women's sexual desire was said to be more receptive and/or reactive (Basson, 2000, 2006). However, sexual experience can be highly contextual and multidetermined for men as well as for women (Perelman, 2008). **The important take-home message is: Masters and Johnson's success attracted many to the field they pioneered, but their failure to recognize sexual desire explicitly as a critical aspect of sexual response was noteworthy. That omission was rectified when Kaplan updated her model to a "triphasic" one (desire, arousal, and orgasm), influencing (as did Lief) all clinicians who followed. It remains key to consider and evaluate desire, regardless of the pedantic arguments over diagnostic classification manuals.**

Multiple Causal Levels

Perhaps one of the most overlooked aspects of the *Disorders of Desire* book is Chapter Eight, *"The Concept of Multiple Causal Levels."* This chapter's ten pages identifies for this author the key to Kaplan's success in treating sexual disorders. Ironically, although still paying homage to her psychoanalytic training, Kaplan identified her key psychotherapeutic strategies as based on psychodynamic understandings, although Perelman (1980) later conceptualized her process as one better understood as a "cognitive behavioral sex therapy." Unlike a psychoanalyst's emphasis on understanding the patient's deep unconscious motivators, Kaplan advised addressing the immediate antecedents of the presenting symptom even when they may reflect "deeper" pathology. Kaplan suggested focusing on modifying the "immediate causes," and only when there was "resistance (obstacles)" to treatment, was there a need to address more hypothesized "remote"

causes of the disorder. That was a very modern view and was consistent with the initial approach of many behaviorists who later adapted a cognitive-behavioral approach to what Kaplan called "sex therapy strategy typology." Of course, the shift from a psychoanalytic to a broader dynamic or cognitive–behavioral view characterized most psychological writing in the later half of the twentieth century, not merely that of clinicians and researchers concerned with sexuality (Barlow, 1986; Lazarus, 1976; Wolpe, 1968).

The Cornell Method: Sex Status

In developing our "Cornell method," Kaplan labeled the technique for obtaining this information "taking a sex status" as a playoff from the then common "mental status" technique being taught to our psychiatry residents. It cannot be emphasized enough how "getting the details" of a recent sexual experience remains key to diagnostic success, but even by the late 1970s many professionals were still "uptight" and found explicit exploration (which is critical) uncomfortable. Indeed, what distinguishes sex therapists from other psychotherapists is our capacity to discuss sexual details comfortably and to put the patient at ease while exploring their current and past history. Kaplan was one of the first to do so and was masterful at it. This essentially remains one of her greatest contributions to the field of sex therapy, and such technique is an integral part of what beginning sex therapists are taught today (Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Perelman, 1998).

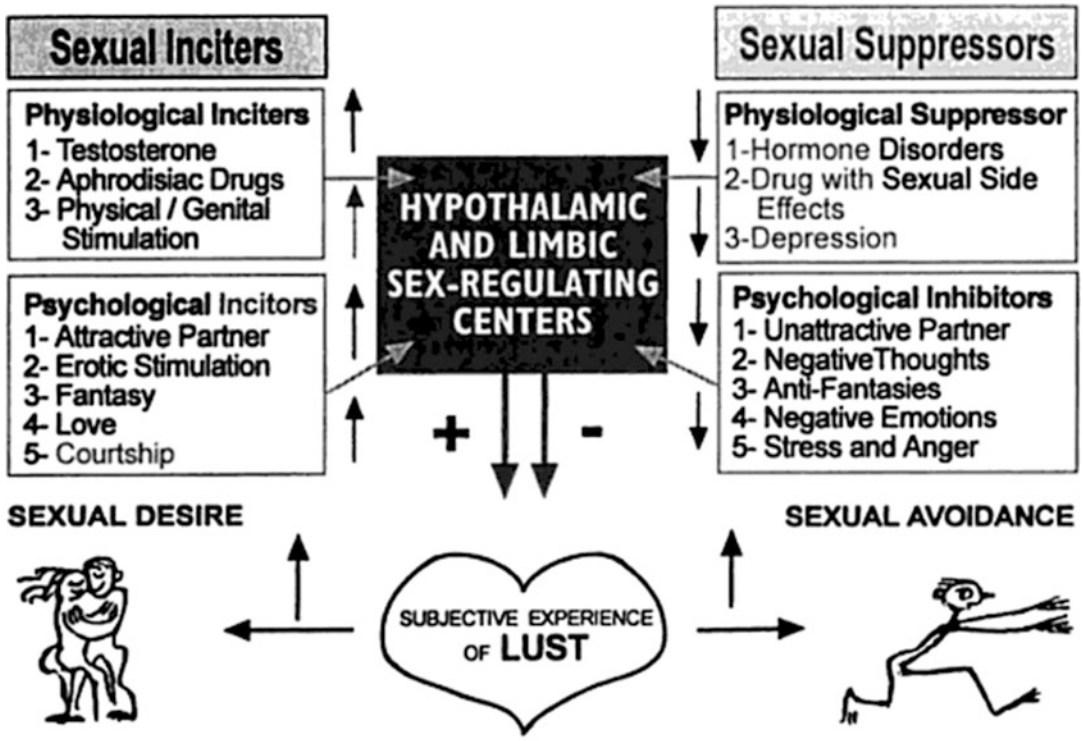
Anticipating the Development of Dual Control Models

It is Kaplan's (1995) last book, *The Sexual Desire Disorders,* that remains of greatest interest to this author as it foreshadowed both his own and notable psychiatrist Bancroft's dual-control models of arousal (Bancroft & Janssen, 1999; Perelman, 2006). Kaplan had intermittently collaborated this author beginning in 1979 (Kaplan & Perelman, 1979; Kaplan, 1985), and in 1994 over coffee Helen sketched an illustration for him while they discussed Kupferman's hypothesis that, "All examples of physiological motivational control seem to involve dual effects—inhibitory and excitatory... (1991)." They recognized that "control of sexual motivation is no exception, and also operates on such a 'dual steering' principle (Kaplan, 1995)." Kaplan's sketch became Fig. 1 in that book and continues to inspire Perelman's efforts to refine his Sexual Tipping Point® model as a visual heuristic, as well as to illustrate how sexual counseling can be integrated with current and future treatments to provide optimized patient risk/benefit (Perelman, 2005, 2009, 2018a, b).

Cultural Backdrop and Context

The 1970s and 1980s were the heyday of sex therapy.

Kaplan, Masters, and Johnson were among the brightest stars of the 1970s and 1980s, which were the heyday of sex therapy as its concepts were widely disseminated. Sex therapy programs were emerging in academic centers, and private practitioners were incorporating sex therapy techniques into their office practice. For instance, the Stony Brook program, under the direction of Joe LoPiccolo, in early collaboration with Gretchen Lobitz and later with Julia Heiman (former Kinsey Institute director), produced influential behaviorally oriented research on sex therapy (Heiman, LoPiccolo, & LoPiccolo, 1976; LoPiccolo & Stock, 1986; Morokoff & LoPicolo, 1986). Behavioral approaches became a predominant part of the sex therapy literature, with all manner of and variation in treatment format and paradigm being used, including groups, video, audio, bibliotherapy, and later the Internet (Annon, 1974; Hawton, Catalan, Martin, & Fagg, 1986; Wincze & Carey, 2001; Zilbergeld, 1978), while also expanding the types of interventions (e.g., directed masturbation training; Barbach, 1975; Perelman, 1980). Much research was conducted and published at the University of Medicine and Dentistry of New Jersey (Rutgers) group under the leadership of psychologists Sandra Leiblum and Ray Rosen (Leiblum & Rosen, 1989). Other American contemporaries of Kaplan and additional influential early USA centers included some of the following locations and individuals:



Helen Singer Kaplan's Sexual Response Models and Legacy, Fig. 1 Helen S. Kaplan's (1995) dual-control elements of human sexual motivation: a psychosomatic model. From The Sexual Desire Disorders: Dysfunctional Regulation of Sexual Motivation, by H. Kaplan, 1995, New York, NY: Brunner/Mazel. Copyright 1995 by Brunner/Mazel. (Adapted with permission)

Brown University: David Barlow and John Winze; Case Western Reserve University: Stan Althof, Steve Levine, Candace Risen, Taylor Segraves, and Kathy Segraves; Columbia University: Gene Abel and Alexander Levay; Downstate-Brooklyn Hospital: Robert Dickes and Marian Dunn; Hartford Hospital: Alan Wabrek; Institute for Rational Therapy: Albert Ellis; Jewish Family Services of New York: Cliff Sager; Johns Hopkins University: Len Derogatis; Lenox Hill Hospital: Avodah Offit; Long Island Jewish Hospital: Sallie Schumacher, Leon Zussman, and Shirley Zussman; Mt. Sinai Hospital: Raul Schiavi and Pat Schreiner-Engel; New York University Medical Center: Virginia Saddock; Thomas Jefferson University: Ida Fisher, Bernie Fishkin, and Arlene Goldman; University of California, Los Angeles: Joe Golden; University of South Carolina: Oliver Bjorksten; University of Colorado: Carol Lassen; University of California, San Francisco: Harvey Caplan, Bernie Zilbergeld, Lonnie Barbach, Carol Ellison, and Linda Perlin Alperstein; University of Hawaii: Jack Annon and Craig Robinson; and University of Minnesota: James Maddock and Eli Coleman (Perelman, 2014).

Professionalization of Sex Therapy and Sex Research

While Kaplan (as noted earlier) had initiated a journal which greatly added to the creditability and professionalization of sex therapy as a discipline, that process was expanded upon in the late 1970s and 1980s. The *Archives of Sexual Behavior* became the journal of record for the new International Academy of Sex Research, and other journals also emerged. Spearheaded by Kolodny, two ethics meetings with published results were held at the Masters and Johnson Institute to establish standards (Johnson, Masters,

& Kolodny, 1980). The early sex therapists formed new professional societies such as the Eastern Association of Sex Therapists, which became the Society for Sex Therapy and Research in 1982. Many sex researchers joined the Society for the Scientific Study of Sexuality. The American Association of Sex Educators and Counselors (AASECT) expanded its name to include and "certify" sex therapists. Perelman as Chair of AASECT's Awards Committee presented Kaplan with their Award for Excellence in 1983 at a joint meeting of AASECT and The World Association for Sexology. The latter organization (now the World Association for Sexual Health) was founded in 1978 by a multidisciplinary, worldwide group of nongovernmental organizations (many of the aforementioned societies) with the aim of promoting sexual health and sexual rights throughout the world. All of these societies supported a biopsychosocial viewpoint; however, their small membership rosters, volunteer administration, modest treasuries, and splintered interests limited their ability to thrive in the manner of the later sexual medicine societies (e.g., SMSNA), which benefited from indirect pharmaceutical company marketing guidance and financial support. Although some individuals who were part of sex therapy history became active and important lecturers, clinicians, consultants, and researchers, the number and impact of self-identified sex therapists began to decline's urological hegemony over the treatment of sexual complaints emerged by the close of the twentieth century. However, the number of individuals indicating affiliation with sexual medicine has exploded exponentially over recent decades (Kleinplatz, 2012; Perelman, 2014; Schover & Lieblum, 1994).

Urology Gradually Achieves Hegemony

The ubiquitous presence of sexual medicine's message, with pharmaceutical commercials replacing cigarette advertising as a major source of television and Internet network revenue, may seem an overnight sensation. However, the ascendancy of urology over other specialties (psychiatry, psychology, and gynecology, which traditionally managed sexual issues) was more than two decades in the making. No doubt the worldwide attempt to medicalize and "pharmaceuticalize" sexuality accelerated that process.

Urology's Influence and Gradual Dominance of Sexual Medicine

Beyond testosterone, other early treatments for sexual dysfunction were used by urologists, including James Semans, who first developed the behavioral model that Masters and Johnson and Kaplan adapted to treat premature ejaculation (Semans, 1956). During the 1980s, there was a progressive attitudinal shift away from a psychological etiological and treatment view within medicine and the public at large to one emphasizing an organic understanding and, subsequently, surgical and medical solutions. For many urologists, the sexual medicine modern era began with the new diagnostic and surgical procedures, including penile arterial revascularization, the rigid penile implant, the first hydraulic penile prosthesis, pudendal arteriography, and dynamic cavernosography (Porst & Buvat, 2006). Use of these sophisticated procedures, although not necessarily improving treatment, added scientific credibility and imprimatur to the importance of organic pathogenesis yet regrettably initiated a period of time where psychosocial factors were not appreciated by most urologists.

Kaplan recognized this shift in public and medical professional focus as an opportunity. Earlier, as a psychiatrist, she capitalized on her ability to both treat anxiety and panic pharmaceutically. She was early in advocating for the use of a combination of medication and sex therapy. In her book, *Sexual Aversion, Sexual Phobias and Panic Disorder*, she reported that a significant number of "sexaphobic" patients had a dual diagnosis of sexual and panic disorder and recommended as needed use of psychoactive drugs to treat anxiety, panic, and phobia, along with counseling (Kaplan, 1982). The book was not a particular commercial success, but the concept had a huge impact. Kaplan's model provided some of the blueprint for pharmaceutical companies' (Pharma) marketing of sexual pharmaceuticals. As multiple drugs

for male and female disorders were launched, an ever-expanding sexual medicine movement emerged. However, there is little doubt that Helen Kaplan' work helped lay the groundwork for that success.

As urologists began establishing dominance in the "public marketplace" with the successful use of various intracavernosal injections (Caverject, Pharmacia, Peapack, NJ) and intraurethral systems (Muse Vivus, Mountainview, CA), Kaplan attempted to maintain her own "ownership" of an expanding sexual medicine, in part, by writing an article herself (1993) and simultaneously publishing a book with the prominent Danish physician Gorm Wagner (of "Physiological Changes in Sexual Response" film fame) on the use of these new approaches, called *New Injection Treatment for Impotence: Medical and Psychological Aspects* (Wagner & Kaplan, 1993). Kaplan presented five cases where patients did not benefit from ICI therapy because of hidden emotional and marital relationship difficulties. She argued that brief psychodynamic techniques to manage the resistances to ICI could help some of the couples adjust to and enjoy the pharmacological restoration of potency. More important to Pharma, however, the treatment efficacy of these products and their economic success was offset by their intrusiveness into the patients' body and the reduction in spontaneity their use patterns required. Pharmaceutical companies were inspired to pursue oral treatments with the goal of less intrusiveness and even greater profits.

Kaplan Dies Prior to the PDE5I's Revolution

No doubt had Kaplan lived past 1995, she would have participated in Pfizers' launch of Viagra. Kaplan was better positioned than most mental health professionals to deal with the "Viagra Revolution." She did attend the critical 1992 National Institutes of Health consensus conference that marked a turning point in the treatment of "impotence," through its redefinition as "erectile dysfunction" (ED). That conference helped predetermine who Pfizer selected for its urology-based sildenafil trial sites, and there is little doubt Kaplan could have found a consulting position within that juggernaut of activity. Worldwide, both physician and nonphysician scientists were funded to perform fundamental preclinical research using animal models, biochemical experiments with human products, new devices, instrumentation, and/or surgical procedures in advance of formal clinical trials. Because reliable and valid measurement is fundamental to sound research, a few sex researchers were recruited to develop the clinical trial methodologies and outcome end points. By that time, Kaplan's breast cancer had returned, and she had withdrawn from her academic life and private practice. Helen S. Kaplan, MD, PhD, died on August 17, 1995, in New York City.

Limitations of Kaplan's Work and Critiques

Kaplan practiced a very strategic and directed sex therapy, yet she continuously described her work in psychoanalytic and dynamic terms. Notable behaviorists, who themselves were beginning to dominate the psychotherapy landscape, presented their own work as research based and empirical. They criticized Kaplan throughout her career for what they felt was a gratuitous allegiance to an aging analytic viewpoint. Additionally, Kaplan, like Masters and Johnson before her, failed to provide any serious reliable and valid measurement of her treatment's outcomes, and that was an additional critique of her work (Zilbergeld, 1983).

Linear Models Versus Circular Feedback Models

Theoreticians, clinicians, and researchers raised questions about female and male sexual responses being different, and many stated that the female sexual response is not linear. Basson's circular model was first published in 1999, with minor refinements during the subsequent years in many different journals including the New England Journal of Medicine (Basson, 2000, 2005). She emphasized subjective sexual arousal as well as genital congestion and suggested female desire was typically evoked, rather than spontaneous. For over a decade, Basson and her advocates

contrasted her PowerPoint-illustrated circular feedback models with those of Masters, Johnson, and Kaplan, which they believed were mistakenly oversimplified as a linear progression of phases. However, that argument naively compared late-century PowerPoint illustrations with midcentury hand-drawings. Such a juxtaposition ignores the technological differences between what can be done on a computer versus the difficulty and expense of commissioning complex illustrations in the early 1960s and 1970s. As someone who knew Masters, Johnson, and especially Kaplan well, this author can assure the reader that all three of them were more than aware that arousal could trigger desire, and that interaction and feedback between the various phases was typical. The controversy that ensued for the first decade of this new millennium over "linear" versus "circular" models has eased as additional research demonstrated how different women may identify with each of these models (Sand & Fisher, 2007). Clinical experience suggests individual phenomenological experiences vary on the basis of individual determinants rather than gender alone. Of course, not only women, but also men vary as well in a similar manner when asked to identify a model with their own experience.

Conclusion

Kaplan's work continues to have a lasting impact on sex therapy and sexual medicine. As both a psychologist and psychiatrist by training, Kaplan recognized and brought to sexual medicine a respect for multideterminism, multilevel causality, and multidisciplinary participation.

Kaplan foreshadowed today's various dual-control biomedical-psychosocial and cultural models that provide a conceptual framework for understanding the complex and dynamic intrapersonal and interpersonal variability of both sexual function and dysfunction. Kaplan's treatment. Typology recommended the clinician modify the "immediate causes," and only directly address (although remaining mindful of) potential "remote causes" when obstacles to progress occurred. Kaplan's therapeutic eclecticism left a most important and critical legacy, in being one of the first sexual medicine specialists to both conceptualize and utilize a treatment that combined the use of pharmaceuticals and sexual counseling, all within an approach that recognized the value of multispecialty cooperation. Hers was an elegant paradigm that should continue to help guide the future of sexual therapy and medicine!

* By 1980, The Sex Therapy & Education Program's name was shortened to the "Human Sexuality Program."

Cross-References

- ▶ Dual Control Model
- ▶ Female Sexual Interest/Arousal Disorder
- ▶ Masters and Johnson
- ▶ Sexual Tipping Point

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