Quick Study: Sex Therapy

**Sexual Dysfunction:** Difficulty experienced by an individual or couple during the stages of normal sexual activity including physical pleasure, desire, arousal, or orgasm. Assessing performance anxiety, guilt, stress, and worry are important components to managing sexual dysfunction.

**Sexual Dysfunction in Women**
- **Female Arousal Disorder** consists of the inhibition of the arousal stage of sexual response so that vaginal lubrication and swelling develop minimally or not at all. In this case the woman may have diminished libido, or a lack of sex drive.
- **Orgasmic Disorder** consists of the inhibition of the orgasm phase of the female sexual response following a normal excitement phase.
  - **Primary Orgasmic Dysfunction** is when the woman has never experienced an orgasm.
  - **Secondary Orgasmic Dysfunction** is when a woman has had an orgasm through some form of sexual stimulation but currently experiences coital orgasms rarely, if at all.
- **Dyspareunia**, also called painful intercourse/sexual pain disorder, consists of postcoital vaginal irritation to severe pain during intercourse. This is more common in women than men and is more likely to involve psychological factors than in male dyspareunia.
- **Vaginismus** occurs when the vaginal opening closes tightly when intercourse is attempted, therefore preventing penetration. This is caused by an involuntary spastic contraction of the muscles surrounding the vagina.

**Sexual Dysfunction in Men**
- **Erectile Disorder** refers to when a male is unable to achieve or maintain an erection to the extent that he cannot engage in intercourse.
- **Ejaculatory Incompetence** occurs when the male suffers from delayed intravaginal ejaculation or the inability to ejaculate intravaginally.
- **Premature Ejaculation** occurs when the man ejaculates prior to or soon after inserting his penis into his partner’s vagina.
- **Dyspareunia**, or painful intercourse, is usually caused by organic factors in men.
Sexual Problems in Men & Woman

- **Compulsive Sexual Behavior** is a commonly debated term often used to describe hypersexuality. This is often treated with a 12-step program.
- **Paraphilias** are intensely arousing stimuli which include:
  - Non-human objects (fetishes)
  - Suffering or humiliation of oneself or one’s partner
  - Pedophilia or non-consenting adults
  - Exhibitionism

While these disorders can occur in both genders, they almost exclusively occur in men.

- **Performance Anxiety** is defined as excessive concern with sexual achievement and adequacy, often due to a fear of failure or may be due to a partner’s demand for performance.

- **Hypoactive Sexual Desire/Inhibited Sexual Desire** is a recurrent deficiency of sexual desires and fantasies. This can have organic or psychological causes.

- **Sexual Aversion Disorder** is a phobia defined as an aversion to, or avoidance of genital sexual contact with a partner.

Causes of Sexual Dysfunctions

**Emotional Factors:**
- Depression
- Sexual fears/guilt
- Past sexual trauma
- Interpersonal problems
- Anxiety

**Physical Factors:**
- Drugs
- Alcohol
- Nicotine
- Narcotics
- Stimulants
- Psychotherapeutic Drugs
- Premenstrual syndrome
- Pregnancy
- Postpartum
- Menopause
- Hormonal deficiencies
- Low testosterone
Interpersonal Factors:
- Partner performance and technique
- Relationship quality and conflict

Socio-cultural Influences:
- Inadequate sexual education
- Conflict with religious, personal, or family values
- Societal taboos

Assessment
The most common form is the sex history interview where each partner is interviewed separately. This phase allows for treatment goals to be identified by both the therapist and couple. This includes obtaining information about:
- Sexual history, including any sexual abuse
- Current sexual behaviors and practices
- Attitude towards sex
- Psychodynamic factors
- Systemic factors
- Psychiatric Status
- Biological Problems

Treatment in sex therapy often involves homework assignments to attempt to reintroduce positive elements into the couple's physical interaction. This often includes removing the focus from genital pleasure, and beginning to build a more satisfying relationship through less performance-oriented, sexual interaction.
Interventions include:
- **Insight and Education:** This is important because it involves helping the couple gain an understanding of the problem to remove any stigma or blame around the dysfunction. Dysfunctions may also be caused by a lack of information or misconceptions and therefore educating the client on patterns of dysfunctional sexual interaction can be useful.
- **Cognitive-Behavioral Techniques:** Focusing on the here-and-now symptoms.
- **Reducing Anxiety:** High levels of anxiety surrounding sexual performance can make problems worse. Treatment in this case involves starting with low anxiety exercises and moving to ones that cause greater anxiety.
- **Relationship Enhancement:** This is important when problems are interpersonal and embedded in the relationship. In this case, couples therapy is indicated.
Role of the Therapist:
- The therapist needs to be aware of maintaining a neutral ground and not siding with one partner or another. The therapist should be aware of any countertransference issues.
- Brief-therapy is usually used.
- The therapist generally takes a relatively directive role.

Approaches Used in Sex Therapy

Masters and Johnson
Prior to Masters and Johnson, sexual problems were treated in long-term psychotherapy with low success rates. Masters and Johnson stressed the role of education in treatment. The therapist needs to educate the clients on how their bodies work, as well as the role of past experiences, upbringing, and role models on sexual functioning. They divided the common pattern of sexual response cycle in both sexes into four specific phases including:
- Excitement Phase: Initial arousal
- Plateau Phase: At full arousal, but not yet at orgasm
- Orgasm Phase
- Resolution Phase: After organism

Sexual dysfunction is seen as disturbances in one or more of the sexual response cycles phases, or pain associated with arousal or intercourse.

Masters and Johnson developed a short-term (2 weeks) psychotherapy treatment program with couples. They discovered that performance anxiety, or spectatoring was the most common reason for most problems. Spectatoring is when a participant is critically watching his or her sexual performance rather than giving into the pleasure of being with a partner. Treatment included:
- Medical, psychological, and sexual histories.
- Couples were given specific instructions based on these assessments and were expected to complete homework between sessions.
- **Sensate Focusing:** A desensitization technique where the goal is to lower anxiety levels in couples through a series of exercises by replacing anxiety with pleasure. Couples are encouraged to take steps toward sexual intimacy through sensual exploration and massage. Feedback and communication is encouraged regarding what feels good.
  - Step I: The partners are instructed to avoid the genitals or breasts.
  - Step II: The partners may include erotic areas but not to the point of orgasm.
  - Step III: The partners may include orgasm.
Cognitive-Behavioral Sex Therapy
● Exercises are used with the aim to overcome negative, self-defeating feelings and images regarding sexual experiences.

Techniques Include:
● Sensate focus
● Systematic desensitization: A client creates a hierarchy of anxiety provoking situations and/or images. Each situation is then gradually faced until the level of anxiety no longer interferes with pleasure. This can be done by imaging stressful situations at first, and then gradually moving toward actually engaging in such activities.
● Bridge maneuvers: First temporarily increasing, and then with time gradually withdrawing direct clitoral stimulation during intercourse when the female is unable to have an orgasm with intercourse alone.
● Coital alignment technique: Slow, rhythmic back and forth gliding movements so the penis and clitoris stimulate each other during intercourse.
● Masturbation or self-stimulation: Most commonly used technique to treat inhibited female orgasm. Can include genital stimulation, erotic stimuli, vibrators, and lubrication. Self or partner stimulation may also be used during intercourse.
● Stop-start Technique: Used in treating premature ejaculation. The partner engages in a progressive cycle of stimulating the penis until he begins to feel early sensations of orgasm, then stops, pauses, and begins again.
● Squeeze Technique: First developed by Masters and Johnson for the treatment of premature ejaculation. The partner stimulates the penis until he is aware of the early sensations of orgasm. The partner then grips the penis between the thumb and first finger just below the ridge. The partner holds it for about 3-4 seconds, then repeats the stimulation-squeeze cycle in a progression towards intercourse.

Helen Singer Kaplan
● Followed after Masters and Johnson.
● Integrated early sexual traumas, guilt, shame, and repression with behavioral methods.
● Her psychosexual therapy addresses personal and interpersonal processes that interfere with sexual functioning such as a lack of information, fear of failure, early sexual trauma, lack of trust, and repressed sexual thoughts and feelings.
• Believed anxiety plays a large role in sexual problems.
• Used sensate focus, systematic desensitization, and relaxation in combination with cognitive techniques such as cognitive restructuring.
• Believed sexual desire was another problem in particular with female sexual arousal disorder.
• Treatment for sexual dysfunction included drawing attention to both physical causes and psychological causes.

Leslie and Joseph LoPiccolo
• Most noted for developing directed masturbation training which is a treatment for primary inorgasmic or preorgasmic dysfunction in women.
  ○ The woman is encouraged to increase her acceptance of her body by gaining an awareness of her body, particularly her genitals, and to discover what gives her pleasure.
  ○ Once the woman has an understanding of what gives her pleasure she teaches her partner what gives her pleasure.
  ○ Initially the couple engages in non-genital mutually pleasurable experiences and gradually increases their genital contact.

David Schnarch
• Shifted away from behavioral interventions in treating sexual problems but rather encouraged couples to become more autonomous which in turn develops greater emotional intimacy and a better sexual life.
  ○ Based on Bowen’s ideas about differentiation of self: Developing a sense of self allows greater involvement with a partner without losing oneself in the process.
• Tolerating and managing one’s own anxieties rather than depending on a partner’s approval helps to foster intimacy and sexual development.
• Believes sexual intimacy is feared because it is too dangerous to be vulnerable and reveal oneself to one another. Thus differentiation of self is important.

Talmadge and Talmadge
• Combined systems and object relations theory with Gestalt and experiential therapy techniques.
• Emphasized married couples with psychogenic sexual problems.
• Treating sexual dysfunction is done by exploring the emotional relationship of the couple.
  ○ Involves the consideration of the partners’ physical health, overt
sexual behaviors, relationship issues, intrapsychic issues, and sexual attitudes, knowledge, and values.

- Assessment tools (Marital Satisfaction Inventory) can be used to make differential diagnoses and to develop treatment plans.
- Believed that being too independent threatened the connectedness of marriage, however, being too dependent threatens the sense of self.
- Each partner brings a set of expectations to the relationship that result from the family or origin, personality structure, and social contexts. The therapist helps the partners see both of these sets of expectations as being acted out in the sexual relationship.
- Views there as being 3 clients in therapy: the marriage and each partner.
  - Each partner is viewed individually and as part of the couple. This helps the focus be on the individual and to take personal responsibility rather than blaming the other partner.
- The therapist takes on a parental role that is affectionate, nurturing, and supportive in order to model different ways of relating. This helps the partners learn to engage with one another similarly.