Principles of Sex Therapy

Dr. Mrugesh D. Vaishnav

Sex therapy is designed to change certain patterns of sexual behaviour. Masters and Johnson gave new dimension to sex therapy. Today, we are entering into an era of reasoning, so what was once upon a time empirical is now being specific for each and every sexual dysfunction.

Therapeutic Options

1. Psychotherapy, education & counselling

2. Drug therapy

    - Anxiolytics
    - Antidepressants
    - Hormones
    - Vitamins & tonics
    - ICIVAD

3. Hypnosis/Narcotherapy

4. Yoga

5. Surgery and implants

Psychosomatic Concept of Sexual Dysfunctions

The sexual responses are delicate and can easily be disrupted by negative feelings or by psychological conflict and inhibition.

All biological functions which are controlled by the autonomic nervous system like digestion, respiration, cardiovascular functions and sexual functions are subject to impairment by emotional and cognitive factors. In other words these functional systems are also subject to psychosomatic disorders.

When a man is frightened, angry or tense during love making, his erectile or ejaculatory reflexes are likely to be impaired. For proper sexual functioning to occur a person must not only be free of intense negative feelings but must also be free of excessive cognitive control.

Changing Perspective in Psychological Approach

In the past it was believed that only profound neurotic conflict was capable of impairing the sexual responses. Severe pathogenic and repressive conflicts based on unconscious, delusional and infantile fears of injury were believed to be solely responsible for sexual dysfunction. Psychoanalysis was designed to clarify these issues and bring them in to conscious awareness of patient for resolution. Only the resolution of deep unconscious conflict was believed to be capable of curing sexual symptoms.

Masters and Johnson, Kaplan, suggested that roots of psychopathology often originate from:

- Anxiety born of misconceptions about human sexual response.
- Performance anxiety
- Tension arising from poor communications with spouse
- Superficial insecurities

Actually causality lies on a continuum from superficial anticipation of failure to the profound psychopathology. Hence effective intervention could be from sex education and counselling to sex therapy, brief psychotherapy and reconstructive psychoanalytic treatment.

In our sexually repressed society many sexual dysfunction's origin ate due to inaccurate information about sexual response and anatomy of sex organs. These curtain of ignorance results in spreading myths and misconceptions about male functioning, vaginal orgasms, mutual climax, masturbation, fantasy etc.

A great deal of anxiety and guilt is generated when there is discrepancy between real experience and unrealistic expectations leading to sexual dysfunctions. Anxiety and guilt may cause a person to avoid sex or restrict his or her-sexual behaviour. A person who suffers from ignorance about sexual techniques and misconceptions can often be helped with sex education and counselling.

In some patients sexual responses are impaired by the fear of sexual failure, by tendency to remain under conscious control during the sex act, fear of rejection if they fail to perform adequately. These groups of patients are highly amenable to brief sex therapy.

The next group of patients suffers from deeper insecurities and conflicts with fragile self-esteems. In these patients sex therapist should deal with psychodynamics' of relationship between unconscious conflict and sexual difficulty.

To treat sexual dysfunctions following, psychotherapeutic options are available.

1. Psychoanalysis

- Free association
- Transference
- Dream analysis

2. Behavioural approach

- Operant conditioning and token reinforcement
- Biofeedback
- Systematic desensitization
- Assertiveness training
- Aversion therapy

3. Cognitive restructuring

- Rational emotive therapy
- Do it yourself technique
- Encounter groups
- Marital therapy

4. Masters and Johnson model

5. New sex therapy - Kaplan

The type of therapy, which we can practice, is based on Masters and Johnson model and New Sex Therapy of Kaplan with certain modifications as per our socio-cultural set-up.

The Goals of Sex Therapy Can Be Broadly Defined As Follows

1. Helping the individual to accept and feel comfortable with his or her own sexuality.

2. Helping the individual to initiate and maintain sexual relationship.

3. Helping the couple to improve quality of their sexual relationships

Basic Issues in Sex Therapy

Sex therapy is a good example of behavioural psychotherapy. The basic issues of underlying elements of which are as follows:

1. Mutual Responsibility

   Sex therapy considers any sexual dysfunctions to be a mutual problem between the couple. Much time is spent on discussing husband-wife interaction.

2. Information, Education and Permission

   Couples are educated in sexual anatomy and physiology, sexual myths and realities, sexual capacities and individual limitations. New sexual techniques are also taught and couples are permitted to try it out.

3. Attitude Change

   Much therapy time is spent in changing negative attitude towards sex and sexuality to healthy attitudes. This attitude change technique is based on rational emotive therapy of Albert Ellis.

4. Anxiety Reduction

Anxiety about sexual performance is usually dealt with by ban on intercourse during the initial sessions. Systematic desensitization can be used to reduce it.

5. Relationship

To understand and improve relationship between the couple following points should be looked in:

- To understand the, bond between them at superficial level and deeper level.
- Unconscious fears and angers will mobilize serious resistance to sex therapy may be resolved, prescription may be repeated or resistance may be by-passed.
- Person who is deeply angry cannot caress or please a partner.
- Man cannot be aroused by a female when he is fearful of intimacy and involvement with her.
- Security and stability of relationship should be reasurred
- When sexual dysfunction provides primary gain it is difficult to treat it
- Therapy should be aimed at eliminating negative relationship interfering with sexual dysfunction.

6. Communication and Feed Back

- Communication between the partners must be improved
- They should be taught and encouraged to give each other feedback during sexual activity.

7. Intervention

It should be carried out in destructive sex roles, to eliminate negative relationship.

8. Interpretation

To interpret relationship between sexual symptoms and neurotic conflict.

- Man's premature ejaculation may unconsciously express his hostility and rebellion against wife/mother.

- Woman's failure to respond to her husband may be a symbol of craving for a super daddy.

These conflicts should be resolved by understanding psychodynamics.

Principles of Sex Therapy

Sex therapy is designed to change certain patterns of sexual behaviour. To achieve this, specific behavioural prescription is given. The principles of which are as follows:

1. Clearly defined and appropriate behavioural goals are set, and the client is asked to attempt to achieve them before the next session.

2. These attempts and any difficulties encountered are examined in detail.

3. The attitudes, feeling and resistances that make behavioural goals difficult to achieve are identified.

4. Attitudes, etc. are modified so that achievement of the behavioural goals become possible.

5. Next behavioural goals are set and so on.

A basic feature of this approach is that the client or couple always has something to do between treatment sessions. Usually these tasks are small steps towards the final goals.

The therapist may devise graded hierarchy of situations, which the patient can behaviourally manage gradually up to target symptom. For example - a sexually frightened couple might be instructed not to do anything more erotic than simply lying close to each other during first week, remove articles of clothing during second week, kiss on the lips in the third week, fondle bodily parts in the fourth week, and so on until the two are eager to achieve their mutual requirements without likelihood of failure.

Throughout sex therapy the responsibility for chancre lies with the couple or individual.

Constructive use must be made of the help of therapist. Therapist can do little unless the clients are prepared to attempt the behavioural tasks recommended for their homework. However the therapist must ensure that the clients do have the time and opportunity to carry out the tasks. Some times treatment is deliberately delayed by the therapist until a job change or relative's visit is over before the therapy commences to make it free of distraction.

Sex therapy varies in duration but average 10 to 25 sessions are required depending on the type of dysfunction, couple's involvement, enthusiasm and response.

There are different approaches for sex-therapy sessions. Masters and Johnson advocated two weeks programme of daily sessions. While others like Mathews, Bancroft, Hackman etc. advocated once a week or twice a week session with structured sexual homework assignment. Some couple do better with less frequent sessions. Autonomy and self-confidence is perhaps enhanced by the reduced dependence on therapist.

Format for Behavioural Approach to Sex Therapy

1 Initial meeting with couple -

a Proper history taking

b Brief psychiatric examination

- to evaluate mental status and psychopathology
- to assess quality of relationships and intrapsychic dynamics
    - Sex therapy is contraindicated if either partner is suffering from schizophrenia, mania, paranoia, manic depressive psychosis, major depression etc.
    - Treat psychiatric condition first even in well-compensated psychiatric patients, sex therapy requires special skills.
    - Neurotics and persons with personality disorders will make up a large bulk of patients in sex therapy clinics. They have guarded prognosis.

c Medical survey should be carried out to investigate as appropriate -

- generally debilitating or painful conditions
- Endocrine disturbances
    - Glucose Tolerance Test (GTT)
    - Serum testosterone
    - Serum oestrogen and progesterone levels.

        - Thyroid function test

- Rule out circulatory disturbances, neurological illness and surgical problems.

- Drug survey - Antiandrogens, narcotics. Sedatives, alcohol etc.

2. Evaluation of couple's sexual experiences.

    - Encourage and reinforce openness

    - Pursue gently but firmly

    - Get clear and detailed picture of their sexual activity

    - Assess prior sexual experiences

    - Formulate problems

    - Use problem oriented questions

3. Physical examination should be carried out. This can serve following purposes:

    - to provide educational experience in physiology and anatomy of genitalia.

    - to get them acquainted with one's own body

    - to clarify concepts about size of genitalia

    - to check genital organs and their response

- specific exercise e.g. kegel or start stop may be explained

- Identify genitalia with correct anatomical name which can create openness between the partners

- to elicit vaginismus, dyspareunia.

4. Round table discussions

5. Audio visuals - slides about sexual anatomy & physiology of male-female - counselling to remove sexual myths and misconceptions.

6. Body imagery assignment: look at your naked body in mirror.

7. Sensate focus - I, touching and caressing - written instructions are given.

8. Sensate focus - II, genital pleasuring - written instructions are given.

9. Mutual bathing assignments.

10. Non-demanding coitus - written instructions are given - slides and photographs may also be shown.

11. Assignment - Male active/Non-demand technique - female back against male chest.

12. Assignment - Female active/Non demand technique - squeeze technique.

13. Assignment - Male active/Non demand technique - female supine male pleasuring vagina.

14. Slides of coital positions are to be shown.

15. Steps showing how to become orgasmic by slides.

16. Relaxation technique/or hypnosis - when indicated.

17. Specific exercise - Masturbation - use of fantasies, bridge manoeuver - stimulation to distraction - as per dysfunctions.

18. Assessment of negative reactions, which may be resolved, exercise may be repeated or negative reactions may be by passed.

Road Blocks for Sex Therapy in Our Set-up

1. Large number of ignorant single male is seeking help for desire, erectile and ejaculatory dysfunctions. They are interested in medicines, sex tonics, massage oil etc. They are suffering from pill and tonic complexes. It is difficult for them to accept any treatment without drugs.

2. India is a male dominated society; hence people with low educational level and conservative attitude are not ready to bring their wives for sex therapy. They are secretive, fearful and insecure if they have to inform their spouse about their problems.

3. Wives are also reluctant to visit doctor " there is nothing wrong with me, why should I go to the doctor?"

4. There are also newly married couples and about to marry individuals moving from pillar to post for magic cure. Th may not like the idea of a treatment programme for 3 - 6 weeks duration.

5. As ours is an inhibitive society with 'joint family system' couples are many times tense and guarded. They do not disclose that they are visiting a sex therapist. Hence, long term follow-up result in dropouts.

6. The serious limitation for sex therapy in our country is that, it requires participation of two co-operative individuals. The prescribed exercises, which are crucial ingredients of sex therapy, are essentially structured interactions with sexual partners. They simply cannot be conducted alone.

When a dysfunctional patient who has no partner, or reluctant to bring the partner, or if partner is not co-operative for therapeutic procedure seeks help, do psychosexual evaluation and formulation with the patient. Also carry out educative audiovisual session with the patient individually or in a group. Explain the behaviour modification treatment plan as do it yourself programme, which might be helpful in some cases. Some times psychotherapy and group therapy is offered as reasonable alternative to sex therapy. It is likely that patient is not cured with this kind of counselling and brief therapy approach. But he is given rational understanding of his problem and also the hope of resolution when he forms a suitable relationships.

Some of the practical difficulties and feasible solutions offered are described in following cases.

Case - 1: Abdul and Shabana

Abdul twenty-six year old was brought by his relatives. He was married to Shabana, 22 year old. Since last 3 months, Shabana had left him because he could not perform She blamed his potency. The poor young man was stamped as "Namard". The relative wanted to certify his potency.

Abdul had normal early morning erections and erection during masturbation, but he admitted that he could not perform with Shabana. The poor young man blamed masturbation for that and took help from a so-called quacks who dispensed drugs to make his weak penile vessels potent and powerful even though he failed miserably with Shabana.

The serum testosterone and GTT were normal and ICIVAD of 15 mg papaverine resulted in complete erection. Sex education to remove myths and misconceptions, reassured him with brief supportive psycho-therapy but that was not enough for that man to perform with Shabana at her residence to prove his potency.

Abdul was suffering of performance anxiety, insecurity of marital relationships, family pressure, and social pressure of labelled as impotent. Antianxiety and antidepressants helped Abdul. He was ready for sex therapy programme. But Shabana and her relatives declared, "There is nothing wrong with the girl, why should she visit a doctor?" After family therapy Shabana's relatives agreed upon proposal that she would visit hospital for one day and would co-operate with Abdul as per instructions. If Abdul would succeed then she may co-operate for

further treatment. The proposal was accepted and during their stay injected ICIVAD - of 45 mg of papaverine. Abdul successfully penetrated but Shabana expressed lot of fear of injury. It was later on detected that she had also functional vaginismus. Now the couple was ready and they were taken for sex therapy programme.

Case - II

Deepali a 32-year-old housewife was married to Sohan - a thirty five-year-old sales representative. She was a slim, tall and beautiful woman dressed expensively and fashionably. They were married for last ten years and had one daughter seven years old.

Chief complaint

They wanted a male child. The couple's love making frequency was irregularly irregular for last five years, it was three to four times per year during which she was least responsive and he performed poorly. Both had sexual desires, which were channelized by either self-masturbation, mutual masturbation or sometime orogenital sex.

The couple's interpersonal relations were cordial. She was a loving, caring, dutiful and charming wife as he narrated, and he was loving, caring and over protective husband as she described.

The psychosexual evaluation revealed that Deepali had several attacks of unconsciousness - which were diagnosed as "Hysterical conversion reactions", immediately after marriage, which prevented the couple from establishing a regular pattern of sexual intercourse. Sohan, a loving and caring husband, was petting Deepali for hours together when she had such attacks. As Sohan was over protective and was fulfilling dependency need of Deepali, she became more and more attention seeking and demanding. She was getting erotic pleasure when he was petting heavily during attacks of unconsciousness. Such attacks were routinely precipitated at the time of intercourse. Thus she was using such attacks as unconscious defense to her intrapsychic conflict. Narcoanalysis was carried out, during which premarital affair of Deepali was explored. She was emotionally and sexually involved with a boy, who according to her - cheated her, which developed hatred for men and sex in her mind. Initially she visualised Sohan through her transferential eyes as traditional man, but gradually she

realized that he was all-together a different man. Sohan's loving attitude developed lot of guilt, shame, self-hatred, and anger towards herself in her. She felt that she was cheating him by offering second hand body, this intrapsychic conflict resulted in to recurrent attacks of conversion reaction and avoidance of sex. But she used to please him with oral genital sex.

Sohan's problem was different. He had experienced failure during premarital sex and was doubting his potency. Her convulsion attacks prevented him from performing and he was enjoying petting. He was also helping her with cunnilingus. The couple had sexual life for some time and she delivered baby girl. But sex developed guilt and insecurity. She felt that he may leave her after enjoying her.

Thus in this couple avoidance of lovemaking was as a result of defense to deep intrapsychic conflict.

Cognitive restructuring and rational emotive psychotherapeutic approach helped the couple and after resolving intrapsychic conflict couple was taken for behaviour therapy. Non-genital pleasure, genital pleasuring exercise and non-demanding coitus helped the couple. And they were asked to proceed for intercourse after he was relieved of performance anxiety and she was relieved from guilt of cheating him. The outcome was successful follow-up after three months revealed satisfactory progress.

If the conflict is at deeper intrapsychic level having its roots in childhood, with transference for either parents it is difficult to resolve.

Case - III

The husband was 43 year old, postgraduate medical doctor - and wife was a non-practising medical graduate - occasionally assisting husband in his nursing home. The couple had been married for last 18 years and two issues.

Chief Complaints

Couple was not involved in sexual activity for last three years. Suketu had lost sexual desire for his wife Priti but did have interest in erotic feeling, which were channelized by masturbation. Priti complained of total loss of sexual desire. Priti

was under treatment for recurring depression while Suketu joined later with problem of inhibited sexual desire.

History

The couple had a love marriage. Priti was an outstanding scholar while Suketu was a sportsman and above average medical student. When they met he was immediately attracted to her. She was initially shy but later on surrendered to his love. The wife delivered a son, when she was in first year of residency. Hence she had to sacrifice her career. She delivered another child after two years, which prevented her, even from setting private practice.

They had a disturbed relationship after birth of second child. Priti had post partum-depression, which went on recurring, at regular intervals. The family history of depression was also present. The affective disorder was not treated by a psychiatrist. Priti was occasionally taking sleeping pills.

Suketu was brought-up in a family, which was dominated by his demanding mother, who was probably a case of histrionic personality disorder. As a child he was trying to please demanding mother and had relieved himself of that responsibility after he moved to hostel for his further studies. Priti's depression evoked similar response. He felt herself responsible for her depression and at the same time had hostile impulses towards her. His defensive and angry responses to her demand for help caused her to see him as insensitive, self centered, and uncaring.

In addition to these emotional issues their sexual life had never been satisfactory. During the early marriage days she was trying to avoid love making, as she was afraid of conceiving. This inhibited, fearful and insecure circumstances resulted in lengthy stimulation before she could climax. They were always quarreling on issues of either she should use contraceptive pill or he should use Nirodh, either she should go for tubal ligation or he should get vasectomy done. She preferred clitoral stimulation for longer period which he found boring and became angry perceiving her as demanding as his mother!

Despite all these love hate games they had deep feeling for each other. When they moved emotionally too far apart they both felt anxious and moved close again.

Aetiology

The immediate cause of this couple's problem was her recurrent depression, which was based on biological and psychological ground. The situation was complicated by their infantile transferential reactions.

Treatment

Priti's depression was treated with drugs - fluoxetine and psychotherapy. Priti was also made engaged with general practice during evening time, which she took over from busy retired practitioner. After her mood was normal sex therapy was started.

Initially the prescribed sexual exercise evoked strong resistance in husband, who avoided the prescription. He was still angry and used old resentments to suppress his sexual response. At this juncture therapy was focussed on resolving neurotic conflicts. His anger and his need to suppress his sexuality diminished only when worked on his relationship with mother. He was taught to be assertive rather than becoming angry or avoiding sex. He was made aware that he became sexy while alone but evoked negative thoughts while they were together-.

After that, pleasuring exercises evoked positive response. When both of them felt comfortable and eager they were asked to proceed for genital stimulation. Gradually they were able to stimulate each other to orgasm. During therapy session their fear of intimacy and sexual success was identified. They developed insight into it hence therapy helped in increasing closeness.

When the couple began to resume intercourse Priti resisted. The loss of career and Suketu's mechanical sex prevented her of sexual involvement with husband. However such resistance could not hamper the progress in sex therapy.

On follow-up, couple reported improvement in sexual desire. But sexual functioning and frequency of intercourse increased gradually. Both of them learnt to overcome their anger and frustration.