MF&ST

Sexual Disorders: Assessment & Treatment

Historical:

- 1960's and 70's Sexual Revolution
- Birth Control Pill: Emphasis away from procreating
- Added option of spontaneity.
- Attitude of openness and freedom.
- Publication of literature & research on sexual behavior
  - Pioneers in the field:
    - 1966 Masters & Johnson: Human Sexual response
    - 1977 Helen Kaplan: Disorders and Sexual Desire
    - Harold Lief, J. LoPiccolo, R. Rosen & S. Lieblum

- Women's movement
- Gay liberation movement
- 1980's and 90's another shift in attitudes about sex
  - unwanted pregnancies
  - sexually-transmitted diseases
  - AIDS

Etiology & Background:

- Sexual desire disorders on the increase in presenting problems for therapy.
- 40% of sex therapy patients present with ISD (inhibited sexual desire) Defined: (Kaplan) people who chronically fail to initiate or respond to sexual stimuli. DSM IV definition: Persistent and pervasive inhibition of sexual desire.

Gender Differences:

- More women than men are given the diagnosis- according to the authors males and females experience similar levels of desire. Differences reported represent differences in socialization, experiences & societal norms.
- The one difference: desire seems to be experienced more continuously by men across the life cycle; women's desire is more variable depending on hormonal, interpersonal, & other contextual factors.

Evaluation:

- Reasons for decreased desire are many & complex- diagnosis needs to consider:
  - **Global vs. Situational**: Person lacks any interest in sexual activity or lack of desire only for a particular partner or activity.
  - **Primary vs. Secondary:** (secondary includes medical, psychiatric, or sexual dysfunction) i.e. low sexual desire secondary to specific performance difficulty viz erectile dysfunction.

Specific Models for Assessment:
Levine Model for Sexual Drive:

1. Bio Drive
2. Cognitive & Attitudinal Component (sexual wish) Expectation or belief (sex is dirty).
3. **Affective interpersonal component (most important according to Levine)**

Relationship conflicts are perhaps the most central & pervasive issue for treatment.

Sexual desire is also influenced by:

- Depression: both clinical and sub clinical.
- Sexual abuse-Trauma
- Most common among survivors of sexual assault
- Fear of vulnerability
- Loss of control
- Inability to establish intimate relationships
- Conditioned aversion to all forms of sexual contact
- Parental attitudes
- Conflict about sexual preference/Identity
- Overdose of religious orthodoxy during upbringing.
- Obsessive compulsive personality disorder & aversion to bodily contact/fluids
- Fear of pregnancy

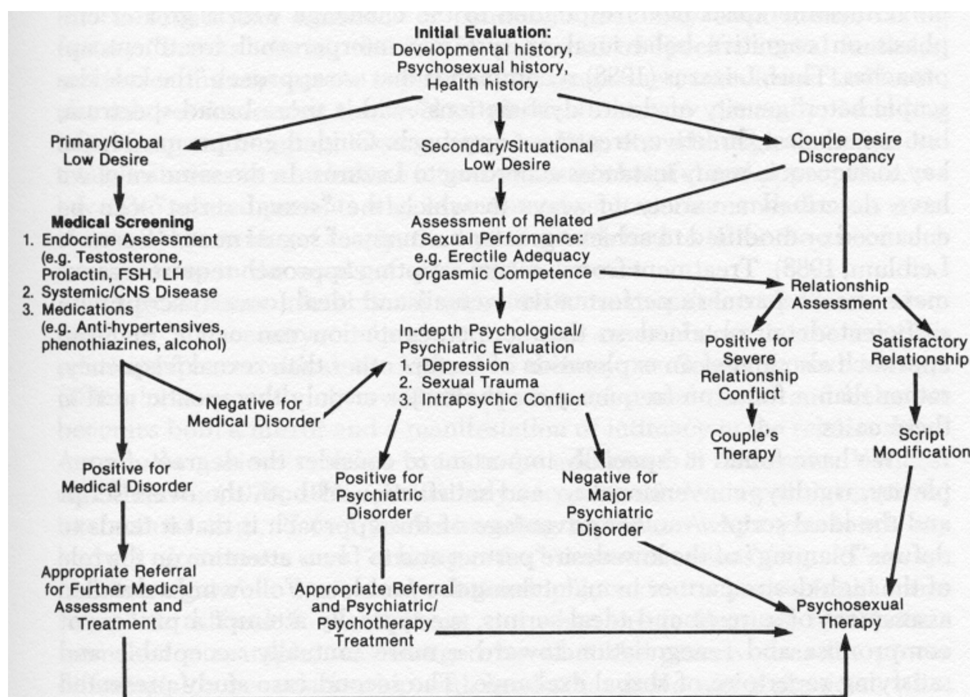

FIGURE 2.1. A flow-chart model for evaluation of low sexual desire. From "Current Approaches to the Evaluation of Sexual Desire Disorders" by R. C. Rosen and S. R. Leiblum, 1987, *Journal of Sex Research*, *50*, p. 152. Copyright 1987 by the *Journal of Sex Research*. Reprinted with permission.

Treatment Approaches

1. Psychodynamic: psychoanalysis & early childhood issues
2. Cognitive/Behavioral: broad spectrum, directive approach, cognitive restructuring (unrealistic and irrational beliefs are confronted, cpoing and positive self-statements are prescribed).
3. Sensate Focus:
   - Behavioral exercise by Masters & Johnson
   - Heightens sensuality & arousal while minimizing performance demands
   - Progresses from non-genital touching that includes stimulation of genitals, but no intercourse, to penetration without thrusting,to intercourse w/o any prohibitions.
   - Case study (pg. 260-2) focuses on Day I and Day II tasks. Developed by Masters and Johnson. Day I entails pleasuring the partner but no genital touching is allowed. Day II focuses on breast and genital stimulation.
4. Sexual Scripting: gap analysis between present functioning and the "ideal state"
5. Transactional Analysis:
   - Playful child role instead of judgmental parent or frightened child roles.
   - LoPicollo "fantasy breaks" during the day for rehearsal of specific sexual fantasies.
   - Increasing exposure to explicit books, magazines, videos
   - Increased level of physical intimacy i.e. hugging, kissing, handholding.
6. Systemic Approach:)territorial interactions, dominance and "ranking-order" communications, attachment interactions) sexual desire and behavioral refelction of intimacy in the relationship.
7. Seduction rituals
8. Pharmocological Agents
   - Not very successful for ISD

Case Study:

- James & Diane O'Neil, different backgrounds (sociopolitical). He had some difficulties, became discouraged with sex. Drinking, too much work, needed relaxation.
- Bill and Alice Sharp: Hip, young, master and servant, gained weight, lost weight, he wanted it she didn't. Not completely succesful.

Orgasmic Disorders in Women

* Not a problem until this century because the purpose of sex was for procreation only and women were not particularly to enjoy sex.

Women can have an orgasm in about the same amount of time as a man. When they can't it is usually a result of one of the following:

- Personal history
- Relationship issues
- Lack of education/information about sex

Problems:

- Primary: Never had a orgasm
- Secondary: Infrequent orgasm

* Clinical studies show that 20-90% of women report arousal problems. Cause: No clear pattern emerges (Fisher's 1973 study).

Highest Correlations (not necessarily related)

- Sexually abused women
- Early love objects (fathers) undependable
- Fear of abandonment (Kaplan 1974/ Masters and Johnson, 1970)
- Anxiety

Treatment:

- Cognitive/Behavioral Approach
- Directed masturbation (80% success for orgasm and 20-60% w/ partner)
- Partner stimulation
- Kegel exercises (contraction of the pubococcygeus (PC) muscle.

Dyspareunia: Painful intercourse or coital discomfort. *Dys*: ill, difficult, bad, painful, or disordered *pareunia*: greek: "lying beside in bed" free translation: "badly mated". For women the etiology falls into three categories:

1. Developmental factors: guilt/shame, religious taboos
2. Traumatic factors: rape and other sexual assaults
3. Relational factors: resentment and antagonism against partner, personal upsets.

Vaginismus: Involuntary, spasmodic contraction of the pubococcygeus and related muscles controlling the vaginal opening making intercourse difficult or impossible.

Erectile Dysfunction

Refer to a urologist & treat only if it is not physiological and related to ewrpformance anxiety.

- Sensate focus
- Relaxation techniques

Chapter 11

Impact of sexual abuse on sexual functioning

- Must assess sexual abuse issues w/ couple presenting sexual problems
- Ask about unwanted sexual acts
- Age during abuse occurrence
- Duration
- Nature of the act
- How the client felt about the behavior
- Emotional/sexual impact of abuse

Treatment:

- Gently explore with client in an individual session any possible connection between abuse and the current problem.
- Depending on specific problem, one of the following approaches may be helpful:
    1. Sensate focus
    2. Relaxation
    3. Self-talk
    4. Focusing exercises