Incorporating Sexuality & Gender Concepts into Mental Health Practice

Treating Common Sexual Dysfunctions

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BHECN | BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

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- BHECN's webinar series designed to educate behavioral health trainees about practical topics in behavioral health
- Expert presenters provide a mixture of principles and case based application
- All webinars are free of charge
- Final webinar until Fall semester

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MISSION: BHECN is dedicated to improving access to behavioral health care across the state of Nebraska by developing a skilled and passionate workforce.

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Historical approaches to sex therapy

Multiple explanations and understandings

1. **Havelock Ellis**: all sexual dysfunction results from childhood masturbation: we have a limited number of sexual response cycles in a lifetime
2. **Freud**: biological result of being stuck in developmental stages; require psychoanalysis to determine (treatment for frigidity is 2 hrs/twice a week)
3. **1950's:** anxiety is the basis of all dysfunction
4. **Masters & Johnson**: a) cognitive performance anxiety spiral and b) skill deficient model
   - **Changed the way we thought about sexuality and dysfunction**
5. **Kaplan**: do sex therapy and then deal with resistance with psychodynamic therapy

Post modern model of sex therapy

- Resistance is not therapeutic failure
- To remain ignorant about sexuality now is a deliberate effort
- Media and self-help sources of information
- Cases that now present for therapy have generally tried self-help and failed
- Must look at underlying issues in the context of sex therapy
- Five factor model

Five factors of assessment

I. Cultural history of families of origin

Why does negative inoculation "take" with some women and not with others ?
What variables lead to negative/aversive attitudes?
What maintains belief systems?
Clinical sample vs. control group findings
Detailed information regarding early messages and experiences
LGBTQ experiences and messages

Systemic issues in the couple relationship

- In a genuine system, BOTH partners are involved in dysfunction
- Dysfunction is both causal and responsive
- Distortions in cognitive beliefs
- What is the value of the sexual dysfunction in the system?
  - Anxiety protection?
  - Distance/closeness regulation?
  - Power balancing?
  - Psychodynamic understanding

Operant issues in the relationship

- Day-to-day existence and functioning
  - Employment/education demands
  - Kids/care of aging relatives
  - Household management
  - Extended family
  - Recreational/sports commitments
  - Can't get in touch with sexual selves

  - Ask: How did sex get to be so low on your list of priorities?

Physiological and medical issues

- Mind/body connection
- Always begin with thorough medical examination to determine/rule out medical causes
- Impact of medication or substances, including supplements
- Chronic conditions

How to do therapy (generic model)

1. Dual relationship the most optimum; both partners contribute, both must invest in change process
   - Partner with higher desire may adjust downward for sake of relationship
2. Education and information component
   - Watch receptivity to the information; accept or reject? Why?
3. Attitudinal changes required; why should they believe you? Complex part
4. Eliminate performance anxieties for both partners

How to continued

5. Improve communication skills
   - Focus on abilities to express and receive information about self and relationship
   - How to discuss sexual concerns?
6. Jump into relationship issues:
   - Power and control, affectional needs, negative feelings, conflict resolution, trauma histories, etc
7. Physical and medical issues need attention, resolution

Common Sexual Dysfunctions (DSM-5)

- Premature ejaculation
- Delayed ejaculation
- Erectile disorder
- Female orgasmic disorder
- Female sexual interest/arousal disorder
- Genito-pelvic pain/penetration disorder
- Male hypoactive sexual desire disorder
- Substance/medication-induced sexual dysfunction

Treatment Protocols

- Talk, talk, talk……information first, education
- Sensate focus exercises
- Specific behavioral recommendations
- Use of medication
- Physical therapy
- Psychotherapy, individual and couple

How to begin

- Prior to the first session, have each partner complete an intake individually, either prior to or at the beginning of the session
- Examine the differences in perception between partners; how does each person view the problem
- Why each partner sees the issues differently is important
- No such thing as “the truth” in the problem

The first session

- Allow at least 90 minutes to two hours
- Begin the session with both partners to discuss the overall issues and frame the process for them
- Allow equal time (30 min.) to meet with each partner individually
  - There is always something people feel uncomfortable saying in front of the partner
- Inform each person that information will be used in sessions unless flagged as confidential
  - Ok, this will be kept confidential
  - You need to get to the place where you can bring it up
  - Decide you can't do effective therapy with these secrets, and won't do therapy unless it can be effective

Male erectile dysfunction

- Greatest amount of attention paid to this problem, most due to medications now available and heavily advertised
- Cause is the lack of sufficient stimulation to produce arousal
- May be **generalized** (not limited to certain types of stimulation, situations, or partners) or
- **Situational** (only occurs with certain types of stimulation, situations, or partners)
- May be **lifelong** (present since the man became sexually active) or **acquired** (disturbance began after a period of erectile functioning)
- Strong age-related increase in prevalence, particularly over age 50
- Often associated with other medical or substance-related problems

Male erectile dysfunction

- Despite strong focus on medication, research suggested an integrated approach with therapy and medication use
- Combined medication and cognitive-behavioral sex therapy for best results
- Brief approach (4-6 weeks) with psychoeducation, homework assignments and combined medical and psychological approach most effective
- Use of sensate focus exercises with communication exchanges, visual arousal techniques (erotic videos)
- Therapist needs to be supportive and aware of frustration and potential early termination of treatment

Premature ejaculation

- Slow/fast techniques; begin with stroking, progress to penetration with intent to maintain control of arousal and ejaculation
- Squeeze technique may be used
- Modify behaviors during intercourse to take focus off orgasm and increase couple's sexual behavioral repertoire
- Man uses deep breathing techniques and abdominal muscle control to help regulate excitement level
- Some couples find techniques time and energy intensive; discuss thoroughly to avoid early termination of treatment

Female orgasmic disorder

- Marked delay in, or infrequency of, or absence of orgasm; or markedly reduced intensity of orgasmic sensations
- Not explained by nonsexual mental disorder, or the result of severe stressors (violence) or related to substance or medication use
- Lifelong or acquired; generalized or situational and causes distress (mild, moderate or severe)
- Most women require direct clitoral stimulation to reach orgasm; very few can orgasm with penile-vaginal intercourse alone
- May co-occur with sexual interest arousal disorder

Female orgasmic disorder

- Education and anatomy
- Self exploration
- Sensate focus exercises
- Use of vibrator
- Resolution of anxieties associated with sexual response
- Explore distractions
- Exercises to heighten sexual arousal transfer to partner
- Orgasm with intercourse if desired

Bridging techniques

- Have partner observe at various points
- Partner arouses self first , then mutual practice of masturbation
- She guides hand, gives feedback
- Have intercourse in positions that maximize clitoral stimulation
- Bridge from where you are to where you want to go

Female sexual interest/arousal disorder

- Lack of or significantly reduced sexual interest/arousal, including sexual activity, thoughts or fantasies, and reduced or no pleasure in sexual activities, with refusal of invitations for sexual activity
- Often associated with pain disorders, orgasm disorders, infrequent sexual activity, or relationship problems
- Evaluate for:
  - Partner factors: sexual issues, health status
  - Relationship factors: poor communication, conflict, discrepancy in sexual desire levels
  - Individual vulnerability factors: poor body image, history of sexual or emotional trauma or abuse, mental health conditions, or stressors,
  - Cultural/religious factors: attitudes about sexuality, prohibitions about sexuality
  - Medical factors: postpartum, fatigue, chronic pain conditions

Male hypoactive sexual desire disorder

- Persistent or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity
- Symptoms persisted for over six months and cause significant distress
- Sometimes associated with erectile problems or other sexual dysfunctions

Treatment issues

- Must be considered in relationship context
- Sexual history critically important to establish pattern
- Use of cognitive restructuring techniques helpful
- Bibliotherapy
- Discuss importance of physical/sexual connection in relationship satisfaction
- Address anger and anxiety issues of both partners
- Enhance affection and emotional bonding and reduce focus on intercourse as only goal
- Provide support and encouragement