✓Treatments *That Work*™

SECOND EDITION

Enhancing Sexuality

A Problem-Solving Approach to Treating Dysfunction

Therapist Guide

John P. Wincze

Enhancing Sexuality

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About Treatments *ThatWork*™

Stunning developments in healthcare have taken place over the last several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit, but perhaps, inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and healthcare systems and policymakers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral healthcare practices and their applicability to individual patients. This new series, Treatments *ThatWork*™, is devoted to communicating these exciting new interventions to clinicians on the frontlines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses. But this series also goes beyond the books and manuals by providing

ancillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging healthcare system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral healthcare clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This therapist guide is designed to give mental health professionals the necessary tools to assess and treat sexual dysfunction. It focuses on the treatment of couples, but may also apply to the treatment of single clients. This comprehensive guide covers a wide range of sexual dysfunction in men and women, including problems with desire and arousal, problems with ejaculation and orgasm, and problems with pain and discomfort during sexual relations. Each topic-specific chapter gives an overview of principles underlying treatment and main concepts to convey to clients. Case vignettes provide excellent illustrations of key points. Atypical or problematic responses are also addressed in detail. The corresponding workbook provides information to correct misbeliefs about sex and offers practical suggestions for improving sexual relations. It includes exercises for couples, chapter review quizzes, and user-friendly worksheets to increase client understanding. Clinicians will find this an invaluable resource to help clients enhance their sexual functioning and their relationships.

David H. Barlow, Editor-in-Chief,
Treatments *ThatWork*™
Boston, MA

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Chapter 1 *Introductory Information for Therapists*

Background Information and Purpose of This Program

This guide is intended to give mental health therapists the necessary tools to assess and treat sexual dysfunction. It will be useful for psychologists, psychiatrists, social workers, marriage and family therapists, pastoral counselors, and nurse practitioners. The information in this guide is a product of the author's more than 30 years of continuous research, clinical practice, and teaching in the area of sexual dysfunction.

The majority of cases referred for professional treatment of sexual dysfunction require complex and sensitive handling. This guide is intended for clinicians who are familiar with the use of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR*; American Psychiatric Association, 2000) and who have clinical skills to deal with a variety of mental health problems. During the treatment of sexual dysfunction, issues of transference and countertransference often emerge. It is important, therefore, that therapists using this guide have skill in recognizing and dealing with therapy process issues.

Development of This Treatment Program and Evidence Base

The efficacy of specific treatment modalities for sexual dysfunction has been reviewed by Heiman (2002) and Heiman and Metson (1997). These reviews have identified that as a field, there are certain disorders that we can state with reasonable certainty are effectively treated. In general, sexual dysfunction problems that have been lifelong and are

generalized across all situations are difficult to treat, while those disorders that are acquired and specific to certain situations are more easily treated. This guide will identify the disorders for which we have efficacious treatments based on controlled research, and it will also identify those disorders for which treatment is promising but not empirically supported. Finally, it is noted that the therapeutic efficacy of manualized treatment for sexual dysfunction has been demonstrated in controlled research (Bach, Barlow, & Wincze, 2004).

This guide was developed from years of research on the development and refinement of treatment and assessment procedures (Barlow, 1972, 1973, 1977a, b; Caird & Wincze, 1974; Caird & Wincze, 1977; Carey, Wincze, & Meisler, 1993; Hoon, Hoon, & Wincze, 1976; Hoon, Krop, & Wincze, 1983; Hoon, Wincze, & Hoon, 1976; Hoon, Wincze, & Hoon, 1977; Malhotra, Balko, Wincze, Bansal, & Susset, 1986; Wincze, 1993, 1995; Wincze & Barlow, 1997; Wincze & Caird, 1976; Wincze & Carey, 2001; Wincze et al., 1987; Wincze et al., 1988) and the basic scientific understanding of sexual dysfunction (Abrahamson, Barlow, & Abrahamson, 1989; Abrahamson, Barlow, Beck, Sakheim, & Kelly, 1985; Abrahamson, Barlow, Sakheim, Beck, & Athanasiou, 1985; Balko et al., 1986; Barlow, 1986; Barlow, Abel, Blanchard, Bristow, & Young, 1977; Barlow, Becker, Leitenberg, & Agras, 1970; Barlow, Sakheim, & Beck, 1983; Beck & Barlow, 1984a, b; Beck & Barlow, 1986a, b; Beck, Barlow, & Sakheim, 1983a, b; Beck, Barlow, Sakheim, & Abrahamson, 1987; Beck, Sakheim, & Barlow, 1983; Bruce & Barlow, 1990; Cranston-Cuebas & Barlow, 1990; Cranston-Cuebas, Barlow, Mitchell, & Athanasiou, 1993; Freund, Langevin, & Barlow, 1974; Jones & Barlow, 1990; Lange, Brown, Wincze, & Zwick, 1980; Lange, Wincze, Zwick, Feldman, & Hughes, 1981; Nobre et al., 2004; Nobre, & Pinto-Gouveia, 2006; Sakheim, Barlow, Beck, & Abrahamson, 1984; Steinman, Wincze, Sakheim, Barlow, & Mavissakalian, 1981; Weisberg et al., 2001; Wincze, Albert, & Bansal, 1993; Wincze, Hoon, & Hoon, 1976; Wincze, Hoon & Hoon, 1977; Wincze, Hoon, & Hoon, 1978; Wincze, Venditti, Barlow, & Mavissakalian, 1980; Wolchick et al., 1980).

The author's clinical experience in treating sexual dysfunction comes from the variety of clinical settings, including a university-based clinic, a hospital, and private practice. Finally, the author's experience in

training clinical psychology graduate students, psychology interns, and psychiatric residents has helped to organize this material in a manner that is easy for the professional therapist to use.

Outline of This Treatment Program

The assessment and treatment strategies discussed in this guide are applicable to individuals and to couples with either heterosexual or homosexual orientations. The corresponding workbook for clients is divided into 13 chapters. Many chapters are followed by exercises, review questions, and worksheets that are designed to enhance the impact of each session. Use discretion regarding the amount of time devoted to each chapter. Table 1.1 provides a suggested outline for therapy sessions and the assignment of workbook chapters. This is intended as a guideline and should be flexibly adapted to each client's therapy needs. Some chapters can be covered very quickly, but others may require more time. Usually, the therapist will meet with the client every week until all of the basic information is covered and the assessment is complete. Once actual sexual activity is being worked on, sessions are often scheduled between one and three weeks apart to allow time for homework to be completed. Sessions scheduled 4 or more weeks apart may cause the continuity of treatment to break down.

Who Will Benefit From the Enhancing Sexuality Program

The individuals and couples who will do best with this program are those who are not overwhelmed by other nonsexual problems. Substance abuse and unstable psychiatric conditions will most likely interfere with attempts to treat sexual dysfunction. Although the presence of other disorders does not automatically interfere with this program (see Chapter 2), clinical judgment will help to determine whether or not these other disorders are of a magnitude that will interfere with the sex therapy process.

Individuals suffering from chronic medical conditions that contribute to sexual dysfunction, such as diabetes, may also benefit from this program. Clients with medical problems will find the information useful

Table 1.1 Outline of Treatment Program

Session	Summary of session content	Use of workbook
1	Introduction and therapy program outline. Assessment of one partner of a couple.	Review basic structure of workbook with couple. Assign Chapters 1–4.
2	Assessment of other partner of couple.	Ask partner how reading of Chapters 1–4 is proceeding. Respond to any questions.
3	Formulation of treatment strategy. (Chapter 2 of this guide will help determine therapy pathway.)	Review accomplishment of exercises, chapter reviews, and worksheets for Chapters 1–4. Assign reading from Chapters 5–8 if appropriate to the couple's problem.
4	Review progress for establishing priority time and identifying factors affecting sexuality.	Review accomplishment of exercises, chapter reviews, and worksheets for Chapters 1–6 (and 7 or 8, if assigned). Assign Chapter 9.
5	Review progress for understanding positive and negative factors in partner relationship. Review communication skills.	Review accomplishment of exercises, chapter review, and worksheets for Chapter 9. Assign Chapter 10.
6	Review progress to date and identify all goals established by the couple. Discuss principles of sensate focus and set up agreed-upon strategy.	Review accomplishment of exercises, chapter review, and worksheets for Chapter 10. Assign Chapter 11.
7	Identify all sources of sexual problems and solutions. Discuss details of sensate focus practice.	Review accomplishment of exercises, chapter review, and worksheets for Chapter 11. Assign review of Chapter 11.
8	Review progress in sensate focus and other treatment for specific problems.	Review additional questions for Chapter 11. Assign Chapter 12.
9	Troubleshoot any problems the couple is having with each goal and treatment procedure.	Review accomplishment of exercises, chapter review, and worksheets for Chapter 12. Assign Chapter 13.
10	Discuss relapse prevention and need for further or future therapy.	Review exercises, chapter review, and worksheets for Chapter 13. Discuss use of workbook after completion of therapy.

and clarifying. In addition, they will be given guidance about how to adjust to a condition in which sexual functioning is compromised.

The full benefit of this program can best be realized by married couples and single individuals with partners. Although individuals without partners will also benefit from this program, overcoming some sexual problems is best achieved by actual experience working with a

cooperative partner. The quality of a couple's relationship and the liabilities encumbering a person's sexual partner (e.g., hatred, lack of trust, lack of attraction, or medical infirmity) must be carefully weighed before embarking on treatment for sexual problems. Also, when dealing with a couple, it is important to determine whether or not they truly want to remain together. In cases in which there is severe anger, frustration, or disappointment, there may be "too much water over the dam," and no amount of therapy is likely to make a difference. Many couples enter therapy to legitimize a decision that they have already made.

Risks and Benefits of This Program

Risks

Although most participants in this program will realize benefits, there are some cautionary concerns and possible risks that clinicians should be aware of as follows.

Upsetting the Status Quo

Some couples whose sexual problem has existed throughout a long-term relationship may have adjusted to the problem and have an otherwise compatible and satisfying relationship. The quest for therapy may have been generated by newly acquired information about treatment possibilities. For example, a man who has had impotency problems for many years may have learned about Viagra® and want to give it a try. In such situations, undo anxiety may result if the expected goal is full restoration of intercourse and an active sex life. In such cases, it may be productive and less anxiety provoking to discuss increasing "intimacy" on a verbal and physical level rather than focusing on intercourse or a more active sex life.

Sex Problems as a "Smoke Screen"

It is certainly not unusual for couples who seek out sex therapy to have other problems such as communication difficulties or even basic value differences. In many cases, sex is easier to identify as a problem since

it is more observable and quantifiable. Although it makes therapeutic sense to focus on the nonsexual problems first, some individuals and couples may be so invested in the belief that the problem is only sexual that there may be resistance to a different conceptualization. Therapists must make sure that when the focus shifts away from sex, the couple or individual fully understands the rationale and agrees to the protocol change.

Benefits

The information contained in this program is based on empirical research. The organization and presentation of the material is based on what has worked best in the author's clinical experience. The manual-based structure of this program, which consists of this therapist guide and corresponding workbook, has several benefits.

Self-Paced Progress

It is rare that therapists and clients can schedule regularly paced sessions without interruptions. The *Enhancing Sexuality* program manual allows individuals or couples to slow down or speed up the pace of sessions, and accommodate irregular personal schedules.

Workbook as a Reference

The client may refer to the workbook when necessary. For one reason or another, clients with sexual problems often participate in therapy without their partners. Partners may be supportive but too embarrassed to attend therapy sessions. In such cases, clients often convey to their nonattending partner the essence of the therapy session. Note, however, that total reliance on this indirect communication may result in inaccuracies and confusions. Use of the workbook will help avoid confusion and miscommunication.

Even when both partners are present at a session, there is often disagreement following a session as to the exact nature of an assignment. Some

couples may do nothing rather than chance doing something wrong. Following the instructions and using the forms provided in the workbook can help couples clarify and complete homework assignments.

It is helpful for clients to review material covered in each therapy session and read relevant material in advance of their next session. This helps with continuity of treatment and often reveals problems clients may have with understanding concepts and communicating with their partners. Clients can be told to write down any areas of difficulty in their readings and discuss those issues with the therapist on their next visit.

As an adjunct to relapse prevention training, it is helpful and comforting for clients to have the workbook for reference after the program ends. In most cases, review of the workbook will help the client overcome the problem without an additional therapy session. If such a review does not help the client, the problem could be more serious and require a therapeutic review in a face-to-face session.

Use of the Workbook

The *Enhancing Sexuality* workbook is a companion product that may be used by clients involved in the therapy described in this therapist guide. The therapist guide is intended to help therapists structure a therapy program for clients seeking help for sexual dysfunction problems. This guide is valuable for therapists even if clients are not using the workbook, but use of the companion workbook is strongly recommended. The workbook contains information and practical suggestions to help men and women improve their sexual functioning. Specifically, it has educational material, corrections of myths and misunderstandings, and basic guidelines for understanding and overcoming sexual problems. Therapy skills are needed, however, to help clients pace their progress, judge their achievement of one step before moving to the next, recognize and deal with resistance, recognize and deal with partner-related issues, identify and deal with interfering nonsexual issues, and clarify issues that are poorly understood.

Table 1.1 on page 4 outlines the use of the workbook by session. Every client will benefit from reading Chapters 1–4 and 9–13 of the

corresponding workbook. Because Chapters 5–8 focus on specific problems, it is only necessary for a client to concentrate on those chapters applicable to his or her problem. However, encourage the client to read all of Chapters 5–8, even if these chapters do not directly apply. These chapters will give the client a better general understanding of all areas of sexual dysfunction experienced by men and women.

Chapter 2 *Pathways for Therapy*

Therapy for sexual problems works best when sexual partners are attracted to each other, are not angry with each other, and communicate effectively. Sex therapy also works best when neither partner has a comorbid Axis I or Axis II disorder, or a medical condition in need of immediate care. In many cases, however, conditions are not favorable for treating sexual problems because of the presence of a more emergent problem, or due to the presence of factors that interfere with treatment of the sexual problem. When such interfering variables are presented to the therapist, a decision has to be made regarding which problem to treat first. In some cases, both problems can be treated simultaneously. This chapter will help clarify the decision-making process. Figure 2.1 illustrates seven possible pathways following a comprehensive assessment.

This model assumes the therapist has completed a comprehensive assessment interview and has detailed information about the nature of the sexual problem, the quality and character of a couple's relationship, the psychological profile of a client and his or her partner, and the medical history of a client and his or her partner (Wincze, Bach, & Barlow, 2007; Wincze & Carey, 2001). This information or preliminary assessment should support a clinical determination of the primary problem and whether or not there should be treatment prerequisites to the sex therapy provided in this guide. The model outlines seven clinical pathways. The treatment pathways in Figure 2.1 will differ depending on whether or not there is a medical basis for the problem, the degree of the couple's distress, the presence or absence of substance abuse, and whether one partner has a more pronounced sexual or psychological problem. Once the clinical evaluation is made and diagnostic conclusions are reached, one of the following pathways is initiated.

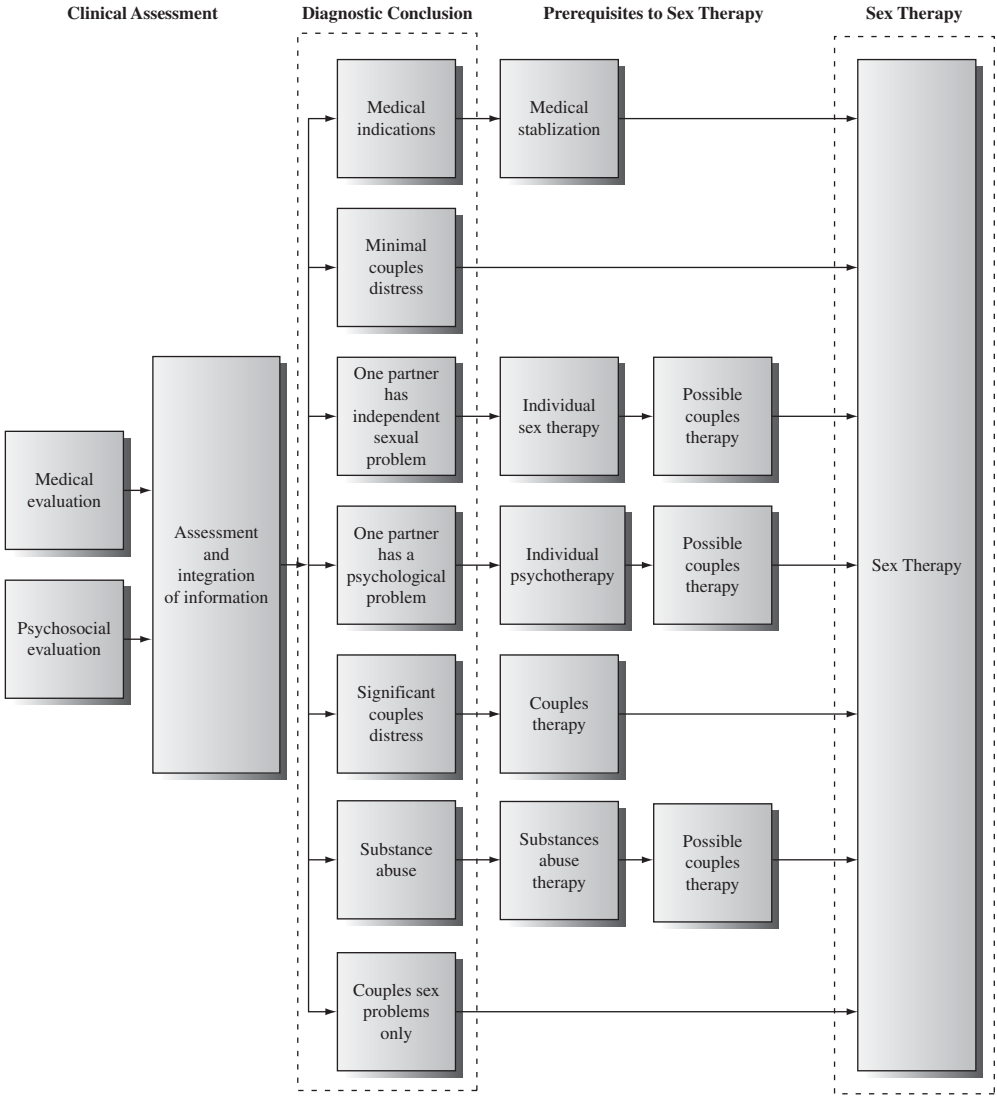

Figure 2.1

Clinical Assessment, Diagnostic Conclusion, and Prerequisites to Sex Therapy: Seven Critical Pathways.

Pathway 1: Medical Indications

If a client or his or her partner has not had a physical examination in the past year, a medical evaluation is needed. Early stages of undetected diabetes, cardiovascular disease, and neurological disease can all contribute to sexual problems (Wincze, Bach, & Barlow, 2007; Wincze &

Carey, 2001). Hormone levels for men should be obtained in cases where impotency or low desire seems to exist in all situations (i.e., partner sex, sex with a new partner, masturbation, or absence of sleep-related erections). However, if strong desire or full erections exist in at least one situation, it is less likely that the sexual problem is caused by medical factors.

If there is a strong possibility that medical factors contribute to a client's sexual problems, the options for a medical solution to the sexual problem must be explained. It is important to convey to the client that the presence of a medical factor that can cause sexual dysfunction is only an explanation for why the client is experiencing a sexual problem. The explanation does not necessitate action on the part of the client or the therapist. It is merely a starting point from which to discuss possible corrective action. A client may legitimately choose to do nothing at all about the sexual problem once he or she knows the major cause. However, the medical problem itself should be dealt with appropriately. Diabetes or cardiovascular disease, for example, must be controlled by medication or diet as fully as possible. Because these medical conditions are chronic, the client must get help adjusting to his or her disease. Some men who have such chronic diseases feel pressure to seek a medical solution for their sexual problem such as implant surgery or vasoactive injections. Some may choose to do nothing at all. The therapist's role is to be supportive, to discuss all of the options with the client, and show the pros and cons of how each option will impact him or her. It is essential to keep in mind and impress upon each client that positive conditions for sex and positive partner relations are important even when medical solutions for sexual problems are exercised. Many men have been disappointed following implant surgery, or when using vasoactive injections, because they find that unsatisfactory partner relations still exist. Therapists can play a significant role in helping clients improve overall sexual satisfaction by helping them improve the conditions under which sex occurs, regardless of whether or not medical solutions to sexual problems are exercised.

Once a client's medical options are addressed, the most appropriate treatment pathway for his or her situation should be followed. If no other major issues exist, sex therapy treatment can proceed. However, if substance abuse or severe couple problems exist, these issues should be

evaluated, and appropriate treatment options should be explored before sex therapy proceeds.

Pathway 2: Minimal Couples Problems

Some couples have difficulty getting along with each other although they feel positive toward and are physically attracted to each other. They may have inefficient problem-solving skills and poor communication skills. If the couple wishes to work toward staying together and strengthening their relationship, it is possible to address the mild relationship issues while simultaneously working on the sexual problems. Start by directing couples to follow these instructions:

1. Prioritize time for each other
2. Attend to the communication guidelines

Sex issues can be addressed and worked on while couples improve other aspects of their relationship. Only in cases where anger or discouragement interferes with progress should sex therapy be delayed while these issues are addressed.

Pathway 3: Individual Psychological Problems

In some cases, an individual may have such overwhelming nonsexual psychological problems that focusing on sexual problems is extremely difficult. Severe depression, post-traumatic stress disorder, acute adjustment reactions, and psychotic states are examples of psychological problems that may interfere with treatment for sexual problems. Good clinical judgment and diagnostic skills are important to determine the presence of a comorbid disorder, and in deciding how to proceed. In some cases, pharmacological intervention will stabilize a person enough to proceed, and in other cases, psychotherapy must be conducted to control the psychological problem.

It is not unusual for a client to overlook the impact of a nonsexual problem. The fact that a nonsexual problem preceded the sexual problem does not mean that it isn't contributing to the sexual problem. For example, depression symptoms may have been overridden by the newness of

a sexual relationship and only when a couple became more familiar with each other over time might the depression have begun interfering with sex. If this is confusing to a client, explain how the depression is interfering with sex now, and why it may require specific treatment. Once the comorbid psychological problem has been addressed and progress has been made, the sexual problem can be addressed, in most cases, without interference.

Pathway 4: Individual Sexual Problems

In general, it is best to approach the treatment of sexual problems as a "couple's" problem (if a partner exists). Following the intake assessment, both partners should usually be seen together, in order to reduce blame and facilitate communication. However, in some cases, an individual may have brought into a relationship such unique or overwhelming sexual issues that it is important to work with the client without his or her partner.

For example, a male client may have severe paraphiliac problems that interfere with a couple's sexual relations. As defined in *DSM-IV-TR*, a paraphiliac problem is one in which there are "recurrent intense sexually arousing fantasies, sexual urges, or behavior generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons." This condition must be present over a period of at least 6 months and involve distress or impairment in social, occupational, or other important areas of functioning. It may be important for the therapist to work alone with the male partner in order to understand the intensity and importance of the paraphiliac behavior. Once this is learned, a decision must be made to either control the paraphiliac behavior or integrate it in an acceptable manner into the sexual relations of the couple.

Another example of a specifically individual sexual problem might be that of a woman who has a history of childhood sexual abuse. Her fear or aversion to sex may have to be dealt with individually to address anger, shame, or guilt issues that are often present. Once these issues are satisfactorily put into perspective, her partner should

be included to help him or her understand the effects that the abuse has had.

Pathway 5: Severe Couples Problems

Couples often enter sex therapy with very severe relationship problems that pre-date their sexual problems. It is common for couples to focus on their sexual problem although relationship problems contribute to the sexual problem. It is sometimes easier for couples to identify sexual dysfunction as "wrong" and a source of "blame" than to identify complex communication or problem-solving deficiencies.

When unresolved anger or other negative feelings have existed for 6 months or more, these contributing factors must be addressed before sexual issues. Most couples readily agree with the strategy to delay addressing the sexual problems and initially address the couple's issues. Even when couples understand the reasons for this, it is important to periodically review with them the rationale for the strategy and the progress and goals achieved. Once couples have resolved relationship problems and positive feelings exist, therapy may proceed to directly addressing sexual difficulties.

Because many strategies helpful in overcoming relationship problems are also common to solving sexual problems, couples can use the workbook during this stage of therapy. Specifically, couples should review the sections on setting aside quality time and practicing communication skills.

Pathway 6: Substance Abuse or Dependence

When substance abuse or dependence is suspected in an individual seeking therapy, or in either partner of a couple, the substance problem must be accurately assessed and treated first. The author has never found it productive to delay treatment for substance problems, or to attempt to deal with these problems along with sexual problems. As a general rule, this program requires an individual to be "clean" for a minimum of 3 months before addressing sexual problems. The 3-month period

allows individuals to adjust to not abusing substances and to filling their time with more constructive activities. It is also a time for individuals to adjust to communicating and to solving problems without drugs or alcohol. This is often a stressful time and therefore a time when great energy has to be placed on staying sober. In the author's judgment, the 3-month sobriety period demonstrates the seriousness and steadfastness of a person's efforts and allows time to establish an environment conducive to working on sexual problems.

When at all possible, this program advises individuals to postpone sexual activity during the initial 3 months of sobriety. Often, when an individual discontinues substance use, sexual difficulties are exacerbated. This is usually due to an awareness and self-consciousness about sexual matters. There may also be anger issues that have to be worked through that may keep the other partner at a distance and away from intimacy.

Unresolved problems, anger, racing thoughts, and relationship issues come to the surface and are faced for the first time. Many therapists will find, at this point, that the unresolved relationship problems or individual psychological problems exposed by the abstinence period are severe enough to delay sex therapy until these other issues are dealt with.

Individuals and couples should be made aware of the possibility of increased sexual difficulties and be advised to approach sexual relations with a primary focus on establishing the right conditions for "intimacy." De-emphasize performance during the initial stages of abstinence. Therefore, when a client has a substance problem and follows your advice to seek help for this, inform him or her of possible difficulties during the initial stages of abstinence, and prepare him or her with a strategy to prevent exacerbating the sexual problems. The possibility of increased sexual problems during the initial abstinence period is most likely due to an increase in awareness and hypervigilence. Once abstinence has been in place for at least 3 months, sexual problems can be dealt with more directly. When therapy proceeds, it should be pointed out that preoccupation with these problems during the initial stages of abstinence can directly interfere with sexual functioning.

When assessment reveals a situation with no complicating medical, interpersonal, psychological, or substance abuse problems, sex therapy can begin. Such cases generally progress satisfactorily. The workbook offers a structural guide for clients during the sessions and can be used to facilitate the therapy process. The client can refer to the workbook to bridge the time between sessions (especially if there are unexpected delays between regularly scheduled sessions), and thereby stay on track.

Chapter 3 *Assessment and Treatment Planning*

Materials Needed

- Medical evaluation results (if appropriate)

Outline

- Introduce the therapy program (Session 1)
- Assess one partner of the couple (Session 1)
- Assess the other partner of the couple (Session 2)
- Formulate treatment strategy (Session 3)
- Review the couple's major issues and the components of the program (Session 3)
- Assign homework

Introduction of the Therapy Program (Session 1)

When either an individual or a couple presents for treatment, it is helpful to start with a brief informational introduction. This introduction should include a review of your basic credentials and years of practice. You should also emphasize that the structure and focus of therapy is dependent on the initial assessment. Finally, ask clients to give a brief summary of their problem and allow them to ask questions.

Following the introduction, the assessment protocol can then proceed. The remainder of the first session is spent with one of the two partners alone. The choice of which partner to see first is usually left up to the clients and often depends on their flexibility of schedules and availability for the next appointment.

The following case vignette illustrates how to approach the assessment. Clients entering sex therapy are often embarrassed and fearful that their problem is unique and makes them abnormal. You must help the client feel comfortable by stressing how common sexual problems are, and that sexual problems are not signs of serious mental illness.

Case Vignette

Use this dialogue key for all Case Vignettes—T = Therapist, C = Client, P = Client's partner (i.e., spouse or lover).

T: I want to begin by helping you understand what I'll be doing today. First of all, I want you to know that it is difficult for most people to discuss sexual issues. Sexual problems, however, are very, very common. Sometimes the cause of such problems is medical, and sometimes the cause is just due to a person's situation. What I will be doing today is reviewing both medical and nonmedical factors and seeing which factors apply to you. (At this point, explain to the couple that each will be interviewed alone on separate occasions.)

T: By the end of the assessment, I will be able to outline for you what the best course of treatment is for your problem. Do you have any questions?

C: How many sessions will this take? I know you probably can't tell me exactly, but what is the usual time?

T: You are right. I cannot give you an exact number of sessions. There are some people who move through the program more quickly, and in some cases, it is necessary to deal with other problems before working directly on sexual problems.

C: What do you mean by other problems?

T: Sometimes I work with people who are in a very stressful relationship. It is important that a person feels comfortable and positive toward his or her partner before working on sexual problems. Issues of anger and poor communication have to be worked on first. Other people I deal with have drinking or drug problems that need to be worked on first.

C: Oh, I see. So what do you want to know?

T: Well, please start by telling me about your current living situation. Who is living in your household?

(Generally, the therapist will proceed by obtaining basic background information before asking about the specific details of the sexual problem or psychosexual history.)

Areas for Exploration

Assessment of the sexual problem should include the following areas of exploration in the order they are usually addressed:

1. Basic demographics including age, composition of current household, job, length of time involved in the relationship, and educational background.
2. Brief description of the nature of the problem.
3. Medical and psychiatric history.
4. Psychosexual developmental history including childhood sexual experiences (if any), first intercourse experiences, significant messages or attitudes about sex from parents, and chronology of current or most recent sexual relationship.
5. Relationship with current partner, including feelings toward current partner, and nonsexual problems with current partner (if any).
6. Detailed description of the sexual problem including: frequency of problem, circumstances under which the problem occurs

(e.g., "with my wife but not my lover," "at home but not on vacation"), and history of the problem.

Confidentiality

Both partners should be told that confidentiality is assured. They should be asked to report in their separate interviews whether there is information that is not to be shared with their partner. If you learn information through one partner that could potentially interfere with therapy progress, this issue has to be resolved confidentially with that partner. For example, a client may disclose that he is having an affair and may feel that he is in love with this person. Such a situation is not automatically grounds for discontinuing the normal course of therapy. You must remain outside of moral or personal judgment, and review all of the pros and cons of the situation with the disclosing client. After such a review, a decision should be reached about whether or not to continue therapy, and whether or not to disclose information to the uninformed partner.

Formulation of Treatment Strategy (Session 3)

After an assessment of both partners has been completed, a treatment strategy can be formulated. Chapter 2 of this guide will help determine the appropriate pathway to therapy. Medical stabilization, individual therapy, or substance abuse treatment may be first required. Couples therapy may also be needed to resolve relationship issues before beginning sex therapy. If a couple's individual or relationship problems are minimal, they can be addressed in conjunction with sex therapy.

Review of Major Issues and Program Components (Session 3)

Before beginning therapy, review with the couple the major issues to be worked on as indicated by the assessment. Discuss the overall treatment strategy and the plan for following the treatment program.

There are three main components to the treatment program. The first component focuses on understanding the importance of accurate sexual information and positive sexual attitudes. It helps clear up sexual myths and misunderstandings, which is important to establish the best conditions for a therapeutic process. The second component is an accurate assessment to help pinpoint the positive and negative factors that affect the individual or couple's sexual functioning. The third component works through the actual therapeutic process and builds relapse prevention.

Chapters 4 and 5 help the therapist guide the client through the first two components of the program. The first two components are covered in Chapters 1–8 of the corresponding workbook. The client or couple should complete these chapters during the first three therapy sessions. The exercise found toward the end of Chapter 2 of the workbook, in which couples set aside time for each other to discuss sexual beliefs, is fundamental for subsequent sessions.

Homework



- ✎ Have clients read Chapters 1–4 of the workbook (after Session 1).
- ✎ Have clients read Chapters 5–6 of the workbook (after Session 3).
- ✎ Have clients read Chapters 7–8 of the workbook, if relevant to the problem (after Session 3).

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Chapter 4 *Building Blocks to Understand and Assess Sexual Problems*

(Corresponds to chapters 1–4 of the workbook)

Materials Needed

- Sexual Myths worksheet
- Common Sexual Myths handout
- Influences on Your Sexual Development worksheet
- Substances and Their Effects on Sexual Behavior worksheet

Outline

- Introduce sexual problems (Chapter 1 of the workbook)
- Discuss sexual development (Chapter 2 of the workbook)
- Discuss medical and physical factors that affect sexual functioning (Chapter 3 of the workbook)
- Discuss common factors to consider for all sexual problems (Chapter 4 of the workbook)
- Assign homework

Overview

Principles Underlying Treatment

Two underlying treatment principles to help clients through the first two components are that sexual problems are extremely common in men and women, and that sexual problems do not make a person weak,

abnormal, or mentally ill. Emphasize that men and women can often enhance their sexuality by overcoming their sexual problems or learning alternate ways of pleasure.

Main Concepts Conveyed to Client

First, because sexual information is usually not taught in an open and comprehensive way, men and women are often subject to sexual misunderstandings that can interfere with sexual functioning. Clients learn that accurate sexual information can sometimes correct sexual difficulties and remove blame.

Second, men and women often react differently to their own sexual problems and to their partners'. It is usually necessary to understand these differences in order to overcome sexual problems.

Third, sexual attitudes and behavior are largely influenced by a person's learning history. Observed and experienced sexual information in childhood and adolescence strongly influences adult sexuality. Understanding this concept helps remove blame and the notion that one partner is right or wrong.

Finally, although medical factors can affect sexual functioning, it is usually necessary to conceptualize sexual problems as having possible contributions from medical and nonmedical (e.g., psychological, or interpersonal) factors to understand the full picture.

Introduction to Sexual Problems

Chapter 1 of the workbook introduces clients to the concept of sexual dysfunction, the different types of problems, and factors that can affect sexual satisfaction. The goal is for clients to begin understanding what sexual problems are and whether they have one.

Sexual Dysfunction Problems

Lack of desire is one reason couples enter therapy. Other types of problems commonly experienced by men and women include the following.

Common Sexual Problems for Men

- Erection problems
- Quick ejaculation
- Trouble having an orgasm

Common Sexual Problems for Women

- Emotional discomfort
- Physical discomfort
- Trouble reaching orgasm

Factors Affecting Sexual Satisfaction

Many factors can affect sexual satisfaction, and sexual problems are often caused by more than one factor. The types of factors are biological, psychological, and situational.

Biological

Biological factors that may lead to sexual problems can do so through direct or indirect paths.

- *Direct path*: disease, surgery, injury, or medicine that directly affects sexual functioning
- *Indirect path*: a physical factor that affects how one feels, which in turn affects sexual functioning (e.g., having a cold and therefore not being in the mood for sex)

Psychological

Psychological factors have to do with a person's learning history and include the following:

- Sexual experience and knowledge
- Emotions, fears, attitudes, and skills with regard to sex

Situational

Situational factors are outside a person and may involve the following issues:

- Time (e.g., different work schedules)
- Place (e.g., home environment not conducive to sex)
- Partner
  (e.g., one partner has medical problems that interfere with sex)

Understanding Sexual Dysfunction Problems

Reasons for the current sexual dysfunction may not be the same as the causes of the original problem. Men's and women's reactions to sexual dysfunction often create further problems. However, sexual functioning is a problem only if the couple is concerned or unhappy about it. Sexual functioning (e.g., frequency of sex, quality of erection, speed or lack of orgasm, and level of sex desire) is comparable only to the couple's expectations, not to the functioning of other people.

Understanding Sexuality

Chapter 2 of the workbook looks at the factors that influence sexual development. Understanding how sexual patterns and attitudes develop can help clients remove blame and recognize that everyone is a product of their learning history.

How Sexuality Patterns Develop

Genetic factors play a role in a person's sexual pattern, but most aspects of sexual behavior or preferences come from what a person has learned. Our sexuality is affected by our experiences as children, adolescents, and adults.

Childhood Experiences

During childhood, each of us has experiences that determine our

- Gender identity (i.e., identifying as a boy or a girl)
- Gender roles (i.e., behaviors or activities that are typical of a gender)
- Sexual direction (i.e., our attraction to those of the same or opposite gender)
- Sexual behavior (i.e., how we express ourselves in sexual activity)

Teenage Sexual Experiences

Puberty is an important stage during the teenage years, but can be a difficult time for many. The following are important points regarding adolescence:

- Insecurities, low self-esteem, and sexual performance issues can contribute to sexual problems
- Masturbation and sexual fantasies are a normal and safe way to practice sexual activities
- For many, first sexual experiences occur during the teen years and affect their sexuality into adulthood

Adult Sexual Experiences

People bring the sexual pattern they have developed during their childhood and teenage years into their sexual experiences as adults. Points for discussion include the following:

- Fears and misunderstanding about sex may cause problems in long-term adult partnerships
- Partners may have different beliefs and expectations about sex that cause conflict
- Adults cannot completely change their sexual pattern, but they can improve their skills and learn new behaviors within their set pattern

Men and Women's Reactions to Sexual Problems

Men and women may react differently to their sexual problems due to differences in cultural expectations.

Men's Reactions

Men may feel ashamed and devastated when not able to sexually perform (e.g., erection failure). They may avoid sex or isolate themselves. They may "test out" having sex in different ways. When they fail again, this makes them feel even more inadequate. Even if the "testing out" is a success, they don't think it "counts."

If a man's partner has a problem, he may not notice as long as he is able to complete intercourse. Other men may become angry or mistrustful of their partners.

Women's Reactions

If a woman has a sexual problem she may avoid sex. She may not initiate or respond to affection, believing once a man is aroused he must "go all the way."

A woman often reacts to her partner's sexual problem with hurt, anger, and mistrust.

Medical Factors That Affect Sexual Functioning

Chapter 3 of the workbook focuses on medical and physical factors. These include the following.

Diseases That Directly Affect Sexual Functioning

Diabetes, heart disease, cancer, and multiple sclerosis are the diseases that most often have a direct effect on sexual functioning. The effects of these diseases can vary, but most of the time, they appear slowly over time. Their impact may also be somewhat uneven, with sexual functioning normal at times and unsatisfactory at other times.

Therapist Note

■ *When a client searches for the cause of a sexual problem, he or she may rigidly adhere to a single explanation. This is especially true of men who are convinced that their problem is a result of medical factors. There is little comfort for the client, however, in telling such a man that he is perfectly healthy and that his problem is not medical. His hope is that the problem is medical (and therefore not the man's fault), and that it can be corrected with a pill or some other simple medical procedure.*

In such cases, it is important to point out that it is good news that there are no medical factors involved. All men are susceptible to interference in their sexual responding. It does not make them unusual or mean they have a psychological problem. It is also important to point out that medical factors affect a man in all situations and not just with his sexual partner. If a sexual response (e.g., arousal, erection, or orgasm) can occur during masturbation, with another partner, or during sleep, a medical explanation is unlikely and certainly not the only explanation. ■

Physical Problems That Indirectly Affect Sexual Functioning

Other diseases and physical conditions that do not directly affect sexual functioning may still "get in the way." Negative feelings caused by physical problems may take away sexual desire. Physical factors may also make a person feel unattractive or less confident.

Prescription Medications

Prescription medications are often connected to sexual problems; however, drugs affect everyone differently. Though we cannot predict which drugs will interfere with an individual's sex life, certain types of drugs are more commonly associated with sexual problems. However, some people who take these drugs see an improvement in their sex lives. These medications include the following:

- Antidepressant medication, specifically selective serotonin reuptake inhibitors (SSRIs), have been reported to cause sexual side effects in both men and women.

- Antipsychotic drugs used to treat mental disorders such as schizophrenia and paranoia have been associated with sexual problems in both men and women.
- There is a widespread belief that high blood pressure medication causes sexual problems in men, though there have been very few controlled research studies. Also, there are very few reports about the effects of these drugs on sexual functioning for women.

Therapist Note

■ *Clients who experience sexual problems after starting to take a drug should talk to their doctors before stopping their medication.* ■

Street Drugs

Many people think that street drugs make sexual functioning better, but in fact, they are more likely to interfere. Positive and negative reports about the effects on sexual functioning exist for marijuana, cocaine, and heroin (Yang & Donatucci, 2006).

Alcohol

The effects of alcohol on sexual functioning depend on the amount of alcohol consumed, the person's history of alcohol use, and how much alcohol a person can tolerate. Alcohol has both acute (short-term) and chronic (long-term) effects (Buffum, 1982; Laumann, Gagnon, Michael, & Michaels, 1994; Rosen, 1991; Yang & Donatucci, 2006).

Short-term effects may include a loss of inhibitions (which in turn may increase feelings of desire). The more alcohol a person drinks, the greater the likelihood that sexual performance may decrease; men may not be able to get an erection and women may not be able to orgasm.

Chronic alcohol abuse can have long-term effects. Liver disease and damage to a man's testicles can cause testosterone levels to drop. This may result in a loss of desire and erection problems. If female hormones take over, a man may start developing breasts. Women who are alcoholic may have problems having orgasm, have irregular periods, and have problems becoming pregnant.

Sex Problems Upon Quitting Abuse of Alcohol or Drugs

Many men and women who stop abusing alcohol or other drugs often have sex problems due to increased awareness. They may focus more on performance; this focus decreases pleasure and so interferes even more with the process of sex. If the person used drugs to deal with sex problems, without the drugs the person becomes painfully aware that the problems are still there.

Therapist Note

■ *The sexual problems faced by someone recovering from alcoholism or other drug abuse usually are temporary. Also, the person can often work through the problems with a supportive partner. Specialized counseling by a physician or therapist can also help guide some people through the process.* ■

Aphrodisiacs

Humans have long searched for *aphrodisiacs* — foods, or drugs that are supposed to make a person want and enjoy sex more. There is no proof that any food, drug, or vitamin has a "booster" effect on a person's sexual desire (Rosen & Ashton, 1993).

There are, however, several prescription drugs that help men to obtain and maintain their erections. Viagra® (sildenafil citrate), Cialis® (tadalafil), and Levitra® (vardenafil HCL) have all undergone rigorous research testing and have been shown to have a positive effect for men experiencing erectile difficulties. These drugs, however, do not increase sexual desire; they only increase a man's ability to have an erection. Note that an erection when using any one of these drugs would only occur in a situation that would normally produce an erection such as sex with a stimulating sexual partner or during masturbation.

Therapist Note

■ *Although these drugs are generally safe to use, there are some side effects that occur in a minority of men using them. Facial flushing, headaches, nasal congestion, and bluish vision may temporarily occur. These are all harmless side effects, but may be distracting or annoying. A more serious side*

effect of lowering blood pressure too much can occur if any of these drugs are taken along with medication used for certain heart conditions. A medical doctor should always be consulted when using these drugs. ■

There are other nonprescribed (over-the-counter) drugs that claim to help men with erections but none of these claims have been supported by controlled research. Any positive effects of over-the-counter drugs or vitamins on erections are due most likely to a placebo effect.

Coping With Chronic Illness

A chronic illness may require a person to make changes in his or her sex life. A person may have to experiment with various approaches to sex before finding which approaches are most acceptable and satisfying. Most of the time, a person stops having sex until the pain and discomfort decrease to a level he or she can bear. The person not only has to adjust to living with a chronic disease, but must also deal with other lifestyle changes and issues such as depression and anxiety.

The impact that a chronic disease has on a person's sex life depends on many things, including how satisfying sex was before the disease and how flexible the person was in his or her approach to sex. For someone who did not have a good sex life or an open mind about sex, he or she will most likely take even less interest in sex or may avoid sex altogether. A person who has an open mind about sex will be able to cope better with medical factors, because he or she will be more willing to seek out sexual pleasure in a variety of ways.

Common Factors to Consider for All Sexual Problems

Most often when individuals are concerned about their sexual functioning, there is a focus on psychological (e.g., anxiety, depression, or anger), medical (e.g., disease), and relationship factors (e.g., compatibility, attraction). There are other factors that are often overlooked and may be important enough for some individuals and couples to tip the balance for a more positive outcome in a sexual relationship.

Feelings of Privacy

For many people, the feeling that someone else may hear, observe, or even know that he or she is having sex at the moment may interfere with sex. Relatives, children, or even pets in the home may create a lack of privacy and inhibit sexual approaches.

Comfort

A lack of comfort in the location where sex occurs can interfere with sex. A physically uncomfortable bed or backseat of a car may be a factor for some individuals and can contribute to a loss of erection or lack of orgasm. Discomfort can also be psychological, as in the example of a man who moved into his parents' bedroom upon their death and began to experience erectile dysfunction.

Novelty and Risk

While too much novelty and too much risk (unpredictability) may interfere with sex, the absence of novelty and risk (the same sexual routine every time) may also interfere with sex. Ideally, most men and women in long-term relationships find that moderate levels of novelty and risk improve sexual excitement and interest. Trying sex in a new location or with a different approach may add just the right ingredient for a rewarding sexual experience.

Sexual Interest and Excitement

As a relationship progresses and becomes more established, sex frequency and sexual excitement usually decline. In a long-term relationship, sexual interest and excitement can be maintained if a couple is:

1. *flexible* in their approach to sex
2. *not always available* to each other for sex

Flexibility means that a couple is willing to experiment and try new approaches to sex and vary what they do sexually as a couple. A couple that only has intercourse and only approaches intercourse in a routine manner is likely to experience a decline in sexual interest over time. Similarly, if a couple has sex on a predictable schedule and "never say no" to each other whenever sex is approached, they may also lose sexual interest over time. A general guideline for a long-term relationship is for couples to have sex only when both partners are feeling mildly to greatly interested in sex but not to have sex on those occasions when one partner is completely uninterested or greatly upset with the thought of sex.

Personal Space and Intimacy

Although intimate behavior and feelings of intimacy are the cornerstone of a close long-term relationship, there is also a need for personal space. Many couples have no boundaries with each other when it comes to nudity, personal hygiene, or toileting behaviors. Constantly seeing a partner nude may reduce sexual excitement and novelty is lost. Similarly, sexual excitement may be reduced if negative images are associated with a partner's lack of hygiene or open toileting behavior. Sexual interest can be maintained by mystery or elusiveness.

Planned Versus Spontaneous Sex

There are individuals who respond best to planned sexual encounters, while others respond best to unplanned or spontaneous sexual encounters. In *planned* encounters, a person can prioritize the time for sex and ensure that nothing will interfere. Planned encounters are often important strategies for couples with children who find their own interests often overshadowed by their children's needs and interests. *Spontaneous* sex, by its very nature, is unpredictable and novel and therefore more likely to be sexually exciting. One potential problem, however, is that while the concept of spontaneous sex is desirable, the reality is not always easy to achieve in couples with children or with demanding work schedules. Although there is no right or wrong, when it comes to planned versus spontaneous sex, most long-term relationships can benefit from a combination of both strategies.

Compartmentalizing Activities

Being able to "compartmentalize" means being able to focus on and enjoy the moment. Men and women who cannot compartmentalize usually have more difficulty with sex because their minds are often thinking of problems or responsibilities, and they are not thinking of pleasant sensations or sexually exciting behaviors. In extreme cases, a person will almost never be in the mood for sex because there are always other nonsexual issues to worry about or attend to. People who have difficulty compartmentalizing may benefit from "getting away" more often or setting aside specific blocks of time (with phones and TV shut off) for quiet time and possible romantic and sexual time together.

Worry Versus Fear or Anxiety

"Performance anxiety" as a cause of sexual problems is technically incorrect. It has been well established by sex researchers that fear and anxiety affect the body physiologically in the same manner that sex does, increasing heart rate, respiration, blood pressure, and skin sensitivity. In fact, it has been shown through research that if an individual is mildly scared or anxious, he or she will have an increased sexual response if a sexual encounter immediately follows the fear or anxiety. The real culprit that interferes with sex is not mild fear or anxiety, but worry. Successful sex involves focusing on the sensations and pleasures of the sexual moment and not worrying about the outcome or being preoccupied by nonsexual thoughts.

Homework



- ✎ Have the couple read Chapters 1–4 of the workbook and answer the chapter review questions.
- ✎ Ask each partner to complete the Sexual Myths worksheet in the workbook (Chapter 2).

- ✎ Instruct couple to read the Common Sexual Myths handout in the workbook appendix and to set aside a specific time to discuss it with each other.
- ✎ Ask each partner to complete the Influences on Your Sexual Development worksheet in the workbook (Chapter 2).
- ✎ Instruct couple to set aside specific time to discuss the past good and bad influences on their sexuality.
- ✎ Ask each partner to complete the Substances and Their Effects on Sexual Behavior worksheet in the workbook (Chapter 3).

Chapter 5 *Problems With Desire and Arousal*

(Corresponds to chapters 5–6 of the workbook)

Materials Needed

- Positive Factors Affecting Sexual Experiences worksheet

Outline

- Review any homework assigned in the previous session
- Discuss factors that affect sexual desire
- Discuss factors that affect sexual arousal
- Assign homework

Overview

Principles Underlying Treatment

The principle conveyed in this session is that sexual encounters provide varied experiences. Each sexual experience is affected by the balance between positive and negative factors.

Main Concepts Conveyed to Client

The main concept conveyed to clients is that sex is not an automatic biological function. It is affected by many factors, especially those relating

to a partner and the conditions under which sex occurs. Many clients I have treated have been operating under very adverse sexual conditions, yet the clients have been baffled as to why they have been experiencing sexual problems. Some clients experience a great deal of stress in their lives, or they attempt sex under nonerotic conditions, yet have full expectations that sex should occur unaffected. Emphasize that all men and women require "favorable" conditions for sex to occur successfully. The client's sexual problems under adverse conditions are common to anyone exposed to "unfavorable" conditions. "Unfavorable" conditions may be biological, psychological, environmental, or interpersonal. Such conditions can adversely affect sexual desire as well as sexual arousal in men and women. Keep in mind, sexual desire should not be measured solely by the frequency of sex with one's usual partner. Rather, sexual desire problems for men and women refers to a lack of "lust," "passion," or "desire" as measured by *all* sexual outlets including fantasy, masturbation, use of erotic images or written material, and sex with other partners. The *DSM-IV-TR* classifies such problems as "Hypoactive Sexual Desire Disorder" and includes symptoms of persistent absence of sexual fantasies and desire for all sexual activity. Furthermore, these occurrences are stressful or cause interpersonal difficulty.

Sexual arousal problems relate to actual physiological function. The *DSM-IV-TR* classifies such problems as "Female Arousal Disorder" and "Male Erectile Disorder." Symptoms include a lack of female lubrication response and a lack of male erection response. For both men and women, the symptoms also include personal or interpersonal distress. Female arousal disorder is very rare in premenopausal women and is not often encountered by therapists; for women, the focus is most often on desire and orgasm.

Chapters 5 and 6 of the workbook are important for all clients because they help clearly identify positive and negative factors that may be affecting sexual desire and arousal. Thus, although these chapters address specific problems, the content is applicable to other disorders as well. All clients, regardless of their problem, should read Chapters 5 and 6.

Definition of Sexual Desire

Sexual desire is a psychological state in which a person has an interest in masturbating or in participating in sexual activity with another person. Men and women can have problems with low or absent sexual desire as well as with high or constant sexual desire. Low sexual desire is referred to as a sexual dysfunction, while excessively high sexual desire is often referred to as sexual addiction. This guide deals only with sexual dysfunction and not with sexual addiction.

Situational Versus Generalized Sexual Desire Problems

A true measure of low sexual desire is determined by looking at all possible sources of sexual behavior including: masturbation, sexual fantasies, sexual activity with one's usual sexual partner, and sexual activity with all sources or individuals other than one's partner. The lack of sexual desire with only one partner or set of circumstances is referred to as a *situational* sexual desire problem, while the lack of sexual desire under all circumstances and with all partners is referred to as a *generalized* sexual desire problem. It is important to know this distinction because it will determine how a desire problem is treated.

Causes and Treatment of Situational Low Sexual Desire

There are a number of possible causes of situational low desire. The following are treatment strategies for the most common causes of situational low sexual desire:

1. *Couples conflict*. Couples whose sexual problems are caused by conflict or lack of love may benefit from couples therapy with a professional therapist. Couples who are most likely to benefit from couples therapy are couples whose problems have been more recent (within the past 5 years). Conflicts for most couples are caused by poor communication skills and poor problem-solving skills. If this is the case, refer clients to Chapter 9 of the workbook.

2. *Lack of attraction*. If lack of sexual attraction toward the individual's partner is the problem, have the client start with trying to identify what possible changes in his or her partner's appearance or behavior might help to increase his or her sexual desire. In approaching this topic with the partner, it is most helpful for the individual to state his or her concerns in a positive way rather than a negative way. Every effort should be made to approach this in a collaborative and loving way to avoid blame and defensiveness. For example, if the partner is overweight, the individual can identify that exercise would be beneficial to them both and suggest working out together.

3. *Boring or routine sexual patterns*. When a couple participates in sex in a routine manner with little variation or enthusiasm, change is highly possible if a couple has the spirit of working together to improve their relationship. It is important to remember that there are individual differences in sexual behavior and there should be no blame or right versus wrong. In experimenting with what might be helpful for them, couples will need to express levels of comfort and enjoyment with new approaches. In this way, communication about sex will improve and some variety to the couples usual approach to sex will most likely be added. Couples may be helped by reading illustrated sex manuals that can suggest and guide them with new approaches to sex (e.g., Hooper, 2003).

Causes and Treatment of Generalized Low Sexual Desire

There are both medical as well as psychological causes of generalized low sexual desire in both men and women.

Severe depression interferes with sexual feelings for most people. Effective treatment for depression can improve sexual desire in most cases if psychological causes are also dealt with. However, depressed men and women who take medication that is classified as a selective serotonin reuptake inhibitor (SSRI), often report the side effect of low sexual desire.

Men with below normal levels of testosterone will also experience low sexual desire. The effects of low hormone levels in women have not been

as clearly established as it has been for men. The determination of testosterone levels and the treatment of below normal testosterone levels must be determined by a physician. The age and health of a man will be considered when supplemental testosterone is used. In men with prostate cancer, giving additional testosterone may make the cancer progress. For most men with below normal testosterone, however, taking additional testosterone is safe. Supplemental testosterone can be administered by a pill, in an injection, in a patch, or in a gel usually applied to the shoulder. The administration of testosterone to men with below normal levels of testosterone usually improves sex drive.

Problems With Sexual Arousal

What is Sexual Arousal?

In both men and women, "sexual arousal" is the term used to describe the physiological and psychological changes that we experience when we prepare to have sex. For men, the physiological change is getting an erection, and for women, the physiological change is vaginal lubrication or "wetness," and for some women, hardening of the nipples. For both men and women, the psychological changes that happen during sexual arousal include focusing attention on erotic stimulation and feelings of pleasure.

When men are having difficulty with sexual arousal, they may have trouble getting an erection or maintaining an erection during sexual activity. This is referred to as erectile dysfunction (ED). The loss of an erection can cause further worry to the point that every time a man is in a sexual situation, he thinks about failure. This is often referred to as "performance anxiety" and can become a vicious cycle (erection loss leads to worry and worry about erection loss leads to continuing erection loss).

Women who experience problems with arousal have difficulty with lubrication. This leads to lack of pleasure and may even cause pain during intercourse. ED in men is actually somewhat common, while problems with arousal in women before menopause are actually very rare.

How Does Sexual Arousal Happen?

In both men and women, sexual arousal is a combination of two things: strong psychological attraction and physical stimulation. Most of the time, the physical sensations cause a man to get an erection. In a woman, they cause vaginal wetness. Sexual arousal is not an automatic process, but occurs when there are enough good, or positive, factors for sex.

Therapist Note

■ *A person can be aroused physically during sex even when he or she does not want to be, for example, during sexual assault or abuse. This does not mean that the victim is enjoying the experience, only that there is enough stimulation to arouse the victim's body. The fear and anger that often go with sexual abuse may even make the arousal stronger. This is so because fear, anger, and sexual arousal all increase heart rate, blood pressure, and breathing rate. The signs of physical arousal during something that frightens and repulses may be confusing for the victim.* ■

Factors Affecting Sexual Arousal

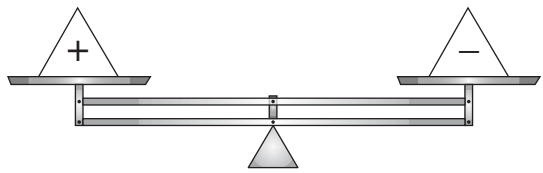
Many factors can have an effect on sexual arousal. In general, they fall into three categories: biological, psychological, and interpersonal.

Biological Factors

Physical factors that can have an effect on arousal include diseases that affect sexual functioning, physical conditions that affect how one feels, the effects of certain prescribed drugs, and the abuse of alcohol and other drugs. How a disease, medicine, or drug affects sex cannot be predicted for any one person. Some factors, such as certain prescribed drugs, block the sex drive in the brain. Other factors affect how the body works. Though biological factors may hinder the process of sex, they do not have to stop it all the way.

Figure 5.1 illustrates how positive and negative factors can affect sex. In sexual encounters, these factors can tip the scale *for* or *against*

sexual functioning. The balance of these factors can change, sometimes leading to satisfying sex and sometimes leading to sex that is not very satisfying. Certain negative factors may be so severe that no kind of sex is possible regardless of how many positive factors there



	Successful Sexual Functioning	Dysfunctional Sexual Functioning
Psychological Factors	Good emotional health	Depression or PTSD
	Attraction toward partner	Lack of partner attraction
	Positive attitude toward partner	Negative attitude toward partner
	Positive sex attitude	Negative attitude toward sex
	Focus on pleasure	Focus on performance
	Newness	Routine, habit
	Good self-esteem	Poor self-esteem
	Comfortable environment for sex	Uncomfortable environment for sex
	Flexible attitude toward sex	Rigid, narrow attitude toward sex
Physical Factors	No smoking	Smoking
	No excess alcohol	Too much alcohol
	No medications that affect sex	Antihypertensive medication (heart)/drugs
	Good physical health	Poor physical health
	No heart and blood-flow problems	Heart and blood-flow problems
	No diabetes	Diabetes

Figure 5.1

Positive and Negative Factors That Affect Sexual Functioning.

are. For example, in a man with severe diabetes, very little blood flows to the penis and the man cannot get an erection even if he is very aroused.

Therapist Note

■ *A sexual encounter should not be thought of either as all good or as all bad. Remind clients that sex can be satisfying even if it is not perfect or amazing.* ■

Psychological Factors

Psychological or *personal* factors can also have an effect on the process of sex. These factors include a positive attitude toward sex and being "in the mood." Another factor is self-esteem and feeling good about oneself, including liking one's body. Feeling unsure of oneself or uneasy about sex can interfere with sexual intimacy. It is also important to be able to focus on pleasure and sexually pleasing thoughts and not on how one performs (e.g., whether one will be able to get an erection). Having thoughts about sex that are upsetting or thoughts that are not sexual (e.g., worrying about work) can take away from a person's enjoyment of sex. The physical setting (e.g., noise level), the timing of sex (e.g., the hour of day or night), and the degree of privacy (e.g., guests or relatives in the house) may also interfere with sexual arousal.

Psychological factors such as depression may get in the way of sex. Feeling depressed makes most men and women have little or no desire for sex and may also interfere with arousal. Being depressed can also have physical effects that make it harder for the body to respond sexually. Post-traumatic stress disorder (PTSD) may also interfere with sexual desire and arousal. Being overly vigilant, or always "on guard," can keep a person from focusing on the pleasant thoughts needed for sex.

Interpersonal Factors

Many interpersonal factors can have affect a person's sex life: how well the person gets along with his or her partner, how attractive the person finds his or her partner, how comfortable the partner is with sex, and

how the partner approaches sex. Men seem to be less aware than women of how important partner factors can be and seem to think having an available partner is all that counts. Many men expect to get aroused even when there are very clear, adverse partner issues. A partner's put-downs and lack of interest can surely interfere with sex, even if the person is not aware of his or her own reactions.

Physical Attraction

Basic physical attraction to one's partner is another important factor that has an effect on arousal for both men and women. Just because a person's partner is available and the person loves and respects the partner does not mean the person will be aroused. Arousal for a man (erection) and for a woman (vaginal wetness) depends on having a high enough level of erotic excitement. Each person in a relationship should always try to look his or her best; this is important for self-esteem as well as appeal to one's partner.

Understanding the Reasons for Sex

Most men and women do not think much about why they have sex. They may say they have sex "because it feels good" or "because I am in love." Reasons for sex, however, may differ greatly and depend on whether a partner is a "new" or a "familiar" one. With a new partner, one involved with for 6 months or less, the two important reasons for sex are physical attraction and newness. With a familiar partner, one known very well, other reasons for sex come into play from time to time. This may include having children, to show their love for each other, to make up after an argument, or just to have fun. No matter what the reason for sex is, there still must be sufficient erotic excitement for sexual arousal to occur. The reasons for having sex also have an effect on how satisfying the sex is. One reason for having sex may make the sex very good physically, while another reason for having sex may make the sex very good in an emotional way.

Therapist Note

■ *Some people who seek help for a sex problem have the unrealistic expectation that sex will be intense and amazing every time. They may become*

unhappy or angry when this does not occur, or want to withdraw and to shut off their desires for sex entirely. Remind clients that the reasons for sex may differ from time to time, and that sex will be more or less intense and great from one time to the next. Also, the firmness of a man's erection and the amount of wetness in a woman will differ from time to time. All of these things are normal. ■

Understanding Positive Factors for Sex

For most people, the two environmental conditions that are important for sex are privacy and a setting that is free from distraction. Beyond these two, the ideas about good conditions for sex vary from one person to the next. Every person has conditions that make sex more or less appealing. Everyone has likes and dislikes that differ. Some people like candles and mirrors. Some like the lights off. Some want to have sex in the morning, others at night. Some people want to take a shower before, and some do not. All of these factors are personal preference and are not right or wrong.

Many people think that sex will be great in spite of the situation or conditions. However, just having a willing and able partner does not guarantee good sex. Most couples can improve their sex lives by bring together the right conditions for both of them or by alternating conditions to suit each other. Serious problems develop when couples are not flexible enough to negotiate their sexual preferences and differences.

Understanding Negative Factors for Sex

Conditions that are not favorable for sex are anything that does not make the setting comfortable or that keeps a person from getting aroused or gets a person "out of the mood." This includes factors that take away a person's attention or that create worry, for example, a crying baby, a barking dog, a disagreement with a partner, or a ringing phone.

It makes good "sex" sense to increase the factors that enhance sex and to decrease the factors that interfere with sex. Though this guideline

seems like common sense, couples often have problems because they try to have sex under the worst of conditions. For example, they have sex when they are not in the mood, or when they feel pressured.

Aging and Sexuality

Men and women often ask about the effects of age on sexual functioning. The most common age-related question is "Does sex stop at a certain age?" Another frequent question is "Does sex peak at a certain age?" The answer to both of these questions is "no," but age does affect sex to some degree for both men and women. There are factors that are far more important than age for making sex great or disappointing, for example, how good the relationship is and how attracted partners are to each other. Worry and other negative factors can interfere with sex at any age.

Changes With Age for Men

For men, the most notable change with age has to do with erections. As a man ages, he has fewer erections just from thinking about sex or seeing something sexy. Some men think they are impotent because they no longer get such erections, but it only means that as they get older, they may not respond as strongly to some types of sexual stimulation such as erotic or pornographic pictures. Most men notice a change in their late thirties or forties. In general, as a man ages, he needs more direct touching of the penis to get an erection.

Another change for most men is the older they get, the longer it takes to become aroused again after an orgasm. The *refractory period*, or the time it takes after an orgasm before a man can get another erection, may be only minutes for a man in his teens or twenties, but an hour or more for a man in his sixties.

Finally, the time that a man takes to ejaculate changes as he gets older. As a rule, young men ejaculate very quickly. In general, older men take longer. Other factors that affect the time that it takes a man to ejaculate are discussed in Chapter 6.

Changes With Age for Women

Aging also produces some changes in sex for women. As with men, women may also need more direct touching of the genitals to become aroused. Also, it may take longer to become aroused. As women enter menopause, they may notice a sharp decrease in vaginal wetness during sex. Intercourse may become less comfortable and may even cause pain. Lubricants may help.

The changes that occur for both men and women are normal and should not stop sex at any age. There are more important factors than age, such as the circumstances under which sex occurs. What usually interferes with sex as a person gets older is a decline in health.

Case Vignette

Clients entering sex therapy often look for a single explanation to their sexual problem. Clients often overlook obvious factors such as negative feelings toward one's partner. It is easier, and perhaps more acceptable, to identify a single medical problem than to face the complexity and unknown characteristic of a psychological or interpersonal problem as the source of sexual dysfunction.

T: Please tell me when you first started to experience erection problems.

C: It all started about a year before my wife and I decided to get a divorce.

T: You were married for about 15 years. When did you and your wife start having trouble getting along?

C: When I think about it, it had been the last five years that we hadn't gotten along. It became very nasty and we fought a lot. It seems like we were always angry at each other.

T: Did you and your wife attempt sex during the last year of your marriage?

C: Yes, we would try every once in a while. When I tried though, I would lose my erection and she would get furious. She would say, "Why do

you bother to get me involved in sex when you can't follow through?" I felt awful and got angry and depressed.

T: Since your divorce, have you been with other women?

C: Yes. And this is what I can't understand. I met a very attractive woman and on the third date I tried to have sex, but failed. I thought that my wife was the problem, but now I know it is my fault.

T: How did this new woman react when you lost your erection?

C: Well, at first she seemed to understand, but soon she started to say things like it wasn't her job to arouse me, and that she never had this problem with other men.

T: What do you think is causing your problem?

C: I don't know, but there must be something wrong with my body, because it happened with two different women. The new woman I was with was attractive and wanted sex, but I couldn't perform. I wanted to, but it just didn't work.

T: Are there any other times that you do experience erections? It is normal for men to experience erections when they sleep, or when they wake up in the morning. It is also normal for men to experience erections during masturbation, or when looking at sexually explicit pictures. What is your experience?

C: Well, I get full erections at those times, but not when I need it. Is there a pill you can give me to help with the erections? I heard that some men take pills to give them erections. Are there vitamins or stimulants of some sort?

T: It is a very positive sign that you can get erections at night or when looking at sexually explicit pictures. This means that your body is functioning normally. There are many different factors that can interfere with a man's sexual functioning, and what we have to do is figure out what is affecting your situation. There also may be different reasons at different times, so that factors that affected you with your wife may be different than the factors that affected you with the new woman.

There are no vitamins that can help you with erections, but in certain cases some medications may be helpful. First, however, let's look at some possible factors that may have affected your sexual response with your wife and with the new woman. Let's start by reviewing the situation with your wife. You said you were very angry at your wife. Did you really feel like having sex when you were angry?

The important point of the preceding therapist–patient dialogue is that a problem of performance anxiety was created by the original experience of ED and was responsible for maintaining the ED problem with a new partner. The first experience of ED for this patient was caused by strife in the marriage and the experience of ED with the subsequent partner following the divorce was most likely caused by performance anxiety (i.e., worry about failure).

Atypical or Problematic Responses

It is often difficult for clients to identify certain current factors as problematic when these same factors did not previously inhibit sex. For example, a man who consumes three or four drinks of hard liquor a night may disconnect the liquor as a contributor to his impotency, because he always drank as much in the past and did not experience sexual problems. The balancing scale in Figure 5.1 may help a client conceptualize why the liquor could be a factor now and was not a factor in the past. The therapist can help the client identify positive facilitating and negative inhibiting factors in the past and present.

Usually, factors such as age, stress level, physical condition, and partner relationship are relevant for such a discussion. The relevant point of your discussion should be that moderate to heavy drinking of alcohol is a negative factor because of its physiological inhibiting properties. The importance of this inhibition may manifest itself only when other negative factors are present, or when positive factors are absent.

Homework



✎ Have the couple read Chapters 5 and 6 of the workbook and answer the chapter review questions.

✎ Ask each partner to complete the Positive Factors Affecting Sexual Experiences worksheet in the workbook (Chapter 6).

✎ Ask the couple to set aside time to talk about each partner's likes and dislikes. They should try to compromise if there are too many differences.

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Chapter 6 *Problems With Ejaculation and Orgasm*

(Corresponds to chapter 7 of the workbook)

Materials Needed

- Factors Affecting Sexual Experiences worksheet

Outline

- Review any homework assigned in the previous session
- Present useful information about ejaculation
- Present useful information about orgasm in men and women
- Assign homework

Overview

Clients should understand at this point that their sexual problem is a result of the presence of various inhibiting factors or the absence of sufficient facilitating factors. In all cases of sexual dysfunction, there is also the strong possibility that myths and misunderstandings are present. This is especially true in cases of male ejaculation. The most common misunderstanding is that men can "last" for as long as they want. I have had both male and female clients endorse this misunderstanding. In such cases, it is helpful to provide normative information and explain that most men "last" in the range of 1–8 min during active thrusting. Several factors such as age, arousal, and time since last orgasm affect the speed of ejaculation in men. It may also be that differences in speed of ejaculation are largely determined by physiological factors such as the

threshold of sensitivity to tactile stimulation. This possibility should be presented to men and their partners in cases of rapid ejaculation in order to help normalize their problem. For men or women who are experiencing delayed or absent orgasm, this chapter will explore medical factors and consider the possibility of low desire, lack of erotic stimulation, and lack of sexual skills as concomitant problems.

Men and women vary widely in the type and intensity of stimulation that triggers orgasm. The intensity and pleasure of orgasm also varies widely within each individual depending on numerous facilitating or inhibiting factors, such as length of the relationship. The therapist should explain all of these dimensions to clients reporting orgasm problems so clients can formulate realistic expectations regarding their orgasmic experience.

Even with realistic expectations and sufficient erotic stimulation, there are still many men and women who do not achieve orgasm. The etiology of orgasmic dysfunction in such cases may be related to insecure or stressful partner relations. In these cases, therapy should focus on couples issues first, then on sexual dysfunction issues. Once couples have achieved a sufficient level of comfort and compatibility in their relationship, orgasmic problems can be focused on. In addition to the guidelines that follow and the sensate focus strategy from Chapter 10, open-minded couples may derive a great deal of pleasure and orgasmic success with the use of a vibrator. Few individuals think of using a vibrator, yet vibratory stimulation has been shown to be a reliable elicitor of arousal and orgasm for both women and men (Turner & Rubinson, 1993).

Another pleasure and orgasm enhancer is lubricant jelly. Suggesting the use of a vibrator or lubricant should be carefully approached so as not to offend or frighten the client. The therapist should present such suggestions as *options that some clients have found helpful*. Clients who are interested in exploring such options may need guidance as to where to purchase vibrators (usually department stores or large chain drug stores) or lubricant jelly (over-the-counter at drug stores) and may need instructions on use. Instruct clients that there is no right or wrong use, but that direct stimulation with a vibrator on the clitoris or glans (the sensitive tip of the penis) may be too intense and uncomfortable.

Clients should be encouraged to explore these options over a number of occasions, and not give up after one try. There is some skill acquisition involved.

One other possible explanation for delayed ejaculation in men that is worthwhile to explore is the method used for masturbation. I have had a number of male patients who have complained of delayed orgasm who, upon enquiry, have reported atypical masturbation methods. Most commonly, I have encountered men who have masturbated their entire lives by rubbing their penis on a pillow or bed sheets while lying on their stomachs. Men, in such cases, have greatly benefited from "retraining" by instructing them to practice masturbation using their hands and a lubricant. This more closely simulates the sensations of intercourse with a partner.

Premorbid sexual aversion may be an additional cause of orgasmic problems. This is related to a negative sexual history that includes fear or an aversion to sex. These issues must be addressed and worked through in individual therapy before proceeding with the preceding suggestions for enhancing orgasm.

Some people purposely hold back from letting themselves orgasm because of either fear of fainting, fear that the orgasm will make them look foolish, or fear that the orgasm will lead to an out of control response. In such cases, individuals can benefit from discussion about the orgasmic experience as a normal, healthy response. Addressing myths or misunderstandings about orgasm, and reviewing the physiology of orgasm, may be helpful.

Principles Underlying Treatment

The important therapeutic principle in treating ejaculation or orgasmic problems is to avoid increasing the pressure to perform. If a therapist focuses on ejaculation or orgasm, and teaches skills to improve them, therapy may fail because it feeds into performance anxiety. A more successful approach is to focus on general pleasure and enjoyment of sexual encounters. Ejaculation and orgasm should be viewed as part of a whole sexual experience. The psychological value, pleasure,

and meaning should be emphasized along with sensual pleasure. By emphasizing psychological satisfaction along with more general sensual pleasure, there is less likelihood that a client will feel increased performance anxiety created by the therapist.

Therapists may unwittingly put performance pressure on their clients with orgasmic problems by directly asking a client if orgasm was experienced during the practice. Remember, the goal is increasing pleasure, and the therapist should ask about pleasure. Clients will spontaneously report if orgasm was experienced.

Main Concepts Conveyed to Client

One concept to convey to clients is that ejaculation and orgasm are only part of the total pleasure possible from a sexual exchange. The defining criteria of sexual success should not be ejaculation or orgasm alone. By helping a client focus on all aspects of a total sexual experience, pressure is removed from the focus on ejaculation and orgasm.

A related concept is that, in most cases, orgasms do not have to occur at a specific interval of time or in both partners simultaneously for sex to be pleasurable or "successful." Emphasize to clients that orgasms may occur before or after one's partner orgasms, or that orgasms may not occur at all on some occasions, but that sex can still be pleasurable and satisfying. Such instructions tend to increase the overall likelihood of sexual pleasure and remove the focus from sexual performance.

Ejaculation in Men

It will help clients to know some basic things about the process of ejaculation. The process is really very hard for men to control. Many factors can affect the timing with which a man ejaculates during sex, including age, frequency of sex, and degree of arousal.

Chapter 7 outlines methods that may help some men gain better control of ejaculation. However, the best way to deal with concerns about

ejaculation is for men and their partners to learn and share the facts. In this way, both partners can have realistic expectations.

Factors Affecting Ejaculation: Age, Frequency of Sex, and Degree of Sexual Arousal

In general, the younger a man is, the more quickly he will ejaculate. This pattern likely has to do with many factors, such as good physical health, the newness of sex, and fewer chances for sex when a man does not have a steady partner. The link between how often a man has sex and his control of ejaculating is open to debate. Research about this has not given clear results, but it seems the more often a man ejaculates, the longer he may "last" (keep an erection) during sex. For instance, a man who has had sex twice in the same night or has masturbated to orgasm before having sex with his partner will likely have more control during the second time. A man who has not had sex for a week or more may not have as much control as one who has had sex three times a week. Also, the more intense a man's arousal is, the more quickly he will ejaculate.

Differences in Speed of Ejaculation

The factors just discussed may surely have an effect on the speed of a man's ejaculation. However, like most human behaviors, the pattern of ejaculating will differ from one man to the next. Differences in physical makeup will cause one man to ejaculate sooner than another man in spite of other factors being the same. Often men and their partners do not understand this fact and the result is anger, blame, and anxiety. When a man ejaculates "too soon," it is common for either the man or his partner to think that something is wrong. The same is true when the man takes "too long" to ejaculate. Many people have unrealistic ideas about how long a man should be able to last. These ideas often come from "locker-room bragging," folklore, and porno movies. Research has been done on the time a man takes to ejaculate after penetration, and the results show that the average time is between 2 and 8 min for most men (Crooks & Baur, 2004; Wincze & Carey, 2001).

Drugs and Ejaculation

Many drugs used to treat mental problems can affect the speed of ejaculation (Meston & Gorzalka, 1992; Yang & Donatucci, 2006). For instance, some drugs used to treat depression can slow down ejaculation. Such drugs are for the treatment of other problems, not for slowing down ejaculation. Since the effect of slowing down ejaculation is a side effect, its use for this purpose cannot be predicted. Ointments that deaden the sensations in the penis have been used to treat men with ejaculation problems. However, the benefits are open to debate. The ointment may decrease pleasure rather than give the man more control.

Orgasms in Men and Women

The orgasm for both men and women is an emotional experience as well as a physiological experience. Subjective descriptions of orgasm are the same for men and women and usually include words describing "a building of tension or sensations," "extreme excitement and pleasure," "feelings of warmth, calmness, and relief once it is over," and many similar phrases. The physiological experience involves muscle contractions and heightened sensitivity in the genital area. The intensity of an orgasm varies from experience to experience and can be very intense and explosive to very mild. For men, the orgasm and the ejaculation usually occur at the same time, so there is usually no doubt as to the experience of orgasm, even if it is very mild. When a woman, however, has a very mild orgasmic experience, she may be in doubt as to whether or not the orgasm occurred. When a man or a woman has difficulty in achieving an orgasm, or infrequently achieves an orgasm, or never achieves an orgasm in spite of adequate stimulation, then that man or woman is said to have an orgasmic disorder.

Useful Information About Orgasms in Men

For men, orgasms most often occur at the same time as ejaculation. However, a man can ejaculate and not have an orgasm. Also, a man can have an orgasm and not ejaculate. Even if a man does not have an erection, he can still ejaculate and have an orgasm. Factors that interfere with sex can keep a man from ejaculating and can also keep a man from

having an orgasm and getting an erection. They can also disturb the common sequence of response.

Intensity of Orgasms

Some men think that every orgasm should be very intense and are surprised, upset, and worried when it is not. A man can have very mild to very intense orgasms depending on how aroused he feels. The more aroused a man is, the more intense the orgasm will be. Other factors that affect orgasm most are age, how well the man knows his sex partner, and state of mind. In general, the younger a man is, the more intense his orgasm will be. As we said before, the age of a man may also affect the pattern of ejaculation.

In general, if a man is with the same partner for a long time, the intensity of his orgasm may decrease. Making some changes may make the sex more exciting and increase the intensity of orgasm—for example, having sex in a new setting, like a hotel on vacation, or trying a new approach, such as a new sexual position. If a man is depressed or worried, then his orgasm may be very mild or even be stopped entirely. The opposite is also true. If he is happy and free of worry, he may have a more intense orgasm during sex.

Drugs and Orgasms

The drugs that have an effect on ejaculation also seem to hinder orgasm. There is no prescribed or street drug that can guarantee more intense orgasms. Some prescribed drugs such as antihypertensives, antidepressants, antipsychotics, and anticonvulsants may decrease the intensity of a man's orgasm. Fortunately, there are many drugs available for treating specific problems. Thus, switching from one medication to another for treating a specific problem may improve sexual functioning. This should only be done under a physician's care.

Useful Information About Orgasms in Women

Just as in men, orgasms in women can range from very mild to very intense. The factors that work for or against orgasm for men also work

the same way for women. Orgasms for women, however, may also differ from those of men.

First, women generally do not reach orgasm as easily as men do. It seems the more experience with sex that a woman has, the more likely she is to have an orgasm during sex. Experience seems to help a woman to learn what type of stimulation is best for her. The way a woman reaches an orgasm may be a matter of learned behavior or it may simply be a matter of preference. One way is not more right or more wrong than any other. It is very common and normal for a woman to achieve orgasm through hand stimulation or oral sex before or after sexual intercourse.

Second, women are able to recover more quickly than men after an orgasm. In general, men need a period of time to recover between orgasms (refractory period). Women are physically able to have many orgasms in a row—called multiple orgasms. Though some young men have reported having multiple orgasms, they are more common in women. However, while women are capable of multiple orgasms, only a minority of women have experienced them.

There may be a third difference between orgasms in women and those in men. Some researchers believe that there are two distinct types of orgasms for women. One type comes from stimulating the clitoris. The other type comes from internal stimulation during intercourse (Laumann et al., 1994).

Fourth, women do not always have to have an orgasm during sex to feel satisfied. For most men, orgasm tends to be the goal of sex and when orgasm does not occur, they may feel unfulfilled or a sense of failure. This is less frequently true for women, as having an orgasm is not necessarily their only goal. Sharing, touching, and being desired are also very important to women. Men sometimes do not understand this and think they have failed if their partners do not have an orgasm, even when the partners say they feel satisfied.

Case Vignette

T: You stated that your problem is premature ejaculation. I deal with a lot of men who also state they are experiencing premature ejaculation, but

I've found out that people's definition of this problem varies quite a bit. Some men I see consider it premature ejaculation because they consistently ejaculate before they enter their partner. Other men feel that they are premature if they ejaculate before 15 min. What is your definition? What has been your experience with ejaculation?

C: Well, I don't ejaculate before intercourse, but I only last a minute or two.

T: And what happens when you ejaculate? How do you feel, and how do you react?

C: I get very angry, and I usually apologize to my wife.

P: He gets so upset that he completely ruins the mood. I'm getting to the point that I don't even want sex because we both get so upset. He makes me upset because he is upset. I tell him it doesn't matter, but he doesn't listen.

T: I think part of the problem is the way you are reacting. Sex should be pleasurable and something that is enjoyed. It shouldn't be a performance. What I will try to do in therapy is help you learn to enjoy your sex experience and not fear it.

Tell me what your usual sexual experience is like? How long do you usually last during sexual relations?

C: I think it's only about a minute or so. Sometimes even less.

T: What have you done to try to control it?

C: I've tried thinking of other things like work or sports, but that doesn't work.

P: Also, he won't let me touch him. We hardly have any foreplay because he's afraid he'll ejaculate. I just lay there. I don't know what to do anymore. It's awful. I sometimes cry afterwards.

T: How long do you think sex should last?

C: I don't know, but certainly longer than I can now. I know that guys may exaggerate and say they can last for 30 min or more, but my friend says he lasts 15 min. I believe him.

T: Well, your friend may be telling the truth, but actually most men last about 2–8 min. The most important point is that you and your partner enjoy what you are doing. By focusing everything on how long you last, you have made sex tense and unpleasant. It is important for both of you to work toward enjoying sex and not worry about performing. The first thing you must do is forget about how long you last, and enjoy what you are doing. Many couples who experience quick ejaculation will approach sex with different strategies to work around this behavior. For example, some couples will bring the female partner to orgasm before or after intercourse by hand stimulation or oral sex. Also, it is important to not get angry or frustrated when you ejaculate. Rather, enjoy the experience. After you ejaculate, continue with intercourse. Many men can maintain their erection for a minute or two after ejaculation, and this can help couples enjoy sex more. Why do you think you ejaculate quickly?

C: I don't know. I just thought that I had weak nerves or something. I tried to tell her I couldn't control it, but she didn't believe me.

P: Well, I just think you are out for yourself. You're always out with your buddies, you don't talk about our problems, and it just seems like you have no time for me.

T: It sounds like some other issues might be affecting how you feel about each other.

Clinical Comment

The exchange with this couple is typical. It illustrates the usual combination of misunderstandings, maladaptive approaches, and general relationship problems. Premature ejaculation complaints rarely come from couples who get along well and have an otherwise satisfactory sexual relationship. Unless the problem is extreme, most couples who do get along well can work around premature ejaculation.

Atypical or Problematic Responses

Treatment of premature ejaculation is more difficult in the single male who is not working with a cooperative, trusting partner. Working with a

partner provides a greater opportunity for a common understanding and a common set of sexual goals. A single male without a steady partner has to deal with unpredictable partner responses. Also, because the single male must be more concerned about sexually transmitted diseases and unwanted pregnancy, he cannot afford mistakes with condom misuse. Consequently, he would be advised to withdraw immediately after ejaculation so that his condom will not slip off. Thus, attention is focused on ejaculation. The emphasis in treating a single male with premature ejaculation is to focus on partner selection and general sexual skills. The man should be encouraged to select a partner who is nonjudgmental, easy to talk to, and sexually flexible. A man who selects a judgmental and rigid person is likely to encounter much more pressure and disappointment. With the "right" partner, the man should be able to focus on more general pleasure and sexually please his partner in a variety of ways.

Finally, consideration should be given to the use of a pharmacological approach as an adjunct to therapy. There is considerable supportive evidence that selective serotonin reuptake inhibitors (SSRIs) may be beneficial for slowing ejaculation (Rowland, Perelman, & Brehm, 2008). Although this is a side effect of SSRIs, it is helpful in many cases. I consider using this approach in cases when ejaculation occurs consistently prior to or immediately upon penetration. The use of SSRIs to slow the ejaculation process may take some experimentation with various dosage levels of different medications before the most helpful solution is found. The most common medications used are Anafranil®, Paxil®, Prozac®, and Zoloft®. These medications may be used as needed or taken daily.

Homework



- ✎ Have the couple read Chapter 7 of the workbook and answer the chapter review questions.
- ✎ Instruct each partner to think of the time when he or she experienced his or her most intense orgasm. Clients should compare this to a time when they had a very mild orgasm and complete the Factors Affecting Sexual Experiences worksheet in the workbook.

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Chapter 7 *Problems With Pain and Discomfort During Sexual Relations*

(Corresponds to chapter 8 of the workbook)

There are no materials needed

Outline

- Review any homework assigned in the previous session
- Discuss problems with pain and discomfort during sexual relations
- Assign homework

Overview

A medical etiology should always be considered whenever pain or discomfort is present during penetration. In cases where the pain is present with one partner but not with other partners, a medical explanation is less likely. Partner-specific pain suggests partner-specific problems, and not medical problems. If there is any doubt whatsoever, a medical consultation is necessary.

Principles Underlying Treatment

Dyspareunia is defined as a "recurrent or persistent genital pain associated with sexual intercourse in either a male or a female" (*DSM-IV-TR*, p. 513). This disturbance causes marked distress or interpersonal difficulty. Vaginismus is specific to females who experience involuntary

perennial muscle spasms associated with attempts at any vaginal insertion (e.g., penis, finger, or tampon).

Therapy for dyspareunia or vaginismus must help the client feel normal and must reassure the client that therapy will not force him or her to participate in sex against his or her will. Therapy will not include any unexpected surprises and will be within the control of the client. The client must be reassured that the therapeutic process is without pressure and that the therapist is trustworthy. Also, it must be made clear that the purpose is desensitization of anxiety and is not meant to create arousal.

Main Concept Conveyed to Client

The main concept to convey to clients is that any behavior can be broken down into smaller, more gradual components. Clients are used to conceptualizing intercourse as all or none. The therapist can help structure a gradual approach to penetration. For example, the approach to penetration can begin with the client privately practicing touching her labia. Steps toward realization of penetration may include brief, partial penetration using one finger, then insertion of two fingers for longer periods of time.

Problems With Pain and Discomfort During Sexual Relations

Both men and women can experience pain during sexual relations and especially during penetration. Men though rarely complain of pain or discomfort during intercourse. If a man has constant pain in the penis or testicles during or after sex, he should consult a doctor, as such pain is often a medical problem. However, women may experience pain during sexual relations due to purely psychological problems as well as medical problems.

Therapist Note

■ *Since pain during sex can be caused by a variety of medical conditions in both men and women, it is essential that clients always consult a medical doctor if sexual pain is experienced.* ■

Common Medical Causes for Men

The experience of pain during sexual relations is less common for men. When pain is experienced by men during sex, the most common causes are epididymitis (an inflammation of the epididymis (sperm duct); chronic prostatitis (inflammation of the prostate); or a varicocele (abnormal dilation of the veins of the spermatic cord). These medical conditions are most effectively treated by a urologist.

Other Medical Causes for Men

In addition to experiencing sexual pain when one of the previously discussed medical conditions is present, some men experience pain during sexual relations or during masturbation because of a medical condition called Peyronie's disease. Peyronie's disease usually occurs in middle aged or elderly men and involves a severe bending of the penis when it is erect. The bending is caused by the growth of plaque on the side of the penis. This condition can occur following an injury to the penis or it may occur for no known reason. Men may also experience pain during sex because of an inflammation of the prostate called *prostatitis*. Pain during sex for men can be experienced in the penis or in the testicles.

Common Medical Causes for Women

For women, pain during sex may be caused by the anatomy of the vaginal opening. The opening may be too small to allow comfortable penetration. Pain may also be present because of inflammation of the vulva (vulvitis) or inflammation of both the vulva and the vagina (vulvovaginitis). The most common cause of pain for women during sexual relations that has a medical basis is vaginal atrophy. Vaginal atrophy occurs most commonly in older women following menopause and is usually associated with a decrease in vaginal lubrication. In addition to vaginal atrophy, women may experience endometriosis. This is often a painful condition caused by tissue from the lining of the uterus to grow outside of the uterus. These conditions are most effectively treated by a gynecologist.

Common Nonmedical Causes for Women

Both men and women can have pain during or after sex for no medical reason although this type of pain is most common in women. This kind of pain is called *dyspareunia*. There are several causes for pain during or after sex, including fear of sex, low desire for sex, lack of arousal, or past sexual trauma.

A person who links sex with pain often avoids sex, which can add to the problem. Couples often think of sex in an all-or-nothing way, avoiding sex entirely or trying to have complete intercourse every time. The solution to the problem is a gradual approach to sex over a period of time. Dyspareunia is best treated with the help of a professional therapist who is an expert in treating sexual problems. With this approach, penetration is increased little by little over time. Chapter 10 has more detailed solutions for dealing with pain during sex.

Therapist Note

■ *A good rule to remember is that behaviors can be broken down into simpler steps. Solving a problem one little step at a time makes the problem less overwhelming. This approach is very helpful for solving sex problems linked to stress or anxiety.* ■

Useful Information for Women Who Cannot Tolerate Any Penetration

For some women, penetration during sex is not possible at all because the muscles in the vagina tighten up. For many of these women, this happens even in situations that have nothing to do with sex. For instance, it can happen when the woman tries to insert a tampon. Some women are unable to insert even their little finger into their vagina without tightening their muscles. This condition is called *vaginismus*. Some women who have it have never been able to bear any penetration at all. For other women, it occurs only after they have had intercourse that was painful.

Psychological Effects of Vaginismus and Dyspareunia

Most men and women do not know much about vaginismus and dyspareunia. The effects of these conditions can frustrate and embarrass a woman and her partner. The problem is made even worse by the blame and anger that often go along with them. A woman and her partner sometimes think the solution is just a matter of trying harder; however, this is not true. Most women very much want to be able to have sex, but their bodies will not let them. The psychological causes of vaginismus may be the same as those for dyspareunia. The ways for dealing with them are the same and are outlined in more detail in Chapter 10.

Case Vignette

T: Have you always experienced pain during sexual intercourse, or have there been times in the past when sex has been comfortable for you?

C: I never had sex with anyone before marriage, and my husband and I both agreed to hold off on sex until we got married.

T: What was sex like for you when you first attempted sex after you were married?

C: Our honeymoon was awful. I felt like my husband was attacking me and I started crying. I kept feeling like he was going to hurt me if he penetrated me. We tried more than once but it never worked out. He became very angry and the whole honeymoon was spoiled. The hardest part was that after our honeymoon, people would ask us how it was and everyone assumed we had great sex. It really hurt to lie to people.

T: Why did you feel that sex was going to hurt?

C: I don't know. I just remember hearing that sex could hurt. My mother never talked to me at all about sex, but she warned me not to get pregnant. I know my family would have disowned me if I got pregnant before marriage.

T: Were you ever comfortable with inserting your finger or a tampon in your vagina?

C: Oh, never! I don't even look at myself down there. I know that some women do that, but I feel I would hurt myself if I inserted anything. I believe I am built differently than other women, and inserting something might hurt.

T: Has a doctor ever examined you and told you that you were built differently?

C: No. I haven't been to a doctor for a few years, and the last time I went to a doctor I wouldn't let him examine me down there.

T: How would you feel about going to a doctor now?

C: I would be very nervous, but I know it is necessary.

Clinical Comment

It is very important for women like this client to have a thorough medical examination. A current medical examination can reassure her that she is physically normal, or provide specific information regarding a physical cause for pain associated with penetration. In this client's case, there are also nonmedical reasons for her pain. She is very uncomfortable with her body in general, and she is uncomfortable about sex. It is extremely important to deal with cognitive issues associated with pain or even the anticipation of pain. Dealing with cognitive issues will help facilitate a behavioral approach to a more satisfying sexual experience, possibly through a gradual insertion approach to intercourse.

In many cases, sexual problems are linked specifically to problems with body image. In this case, the client's poor body image was related to negative messages about sex from her mother and also related to a severe case of acne she had as a teenager. Acne and weight problems in teen years may result in insecurity about one's appearance. This may extend even into adulthood, long after the teenage acne or weight problems have disappeared. In such cases, you can work with the client to identify positive body traits and challenge automatic negative thinking about body image. Practicing looking at oneself in the mirror may also help desensitize the client to poor body image.

Body image problems may also be more severe signs of psychopathology in the form of body dysmorphic disorder. In such cases, long-term psychotherapy may be necessary for any progress to occur.

Women who experience pain or discomfort during sex may also avoid going to medical doctors. The fear of a medical examination of one's genitals may be greater than the fear of a medical disease. In such cases, it is helpful to identify a physician or nurse practitioner who is sensitive to this problem and who can help the woman desensitize herself to the fear, using a gradual, repeated approach to medical examination.

Atypical or Problematic Responses

For the treatment of most sexual problems, a cooperative and understanding partner greatly facilitates progress. In the treatment of vaginismus or dyspareunia, the partner's support and cooperation are especially important.

In some cases, a partner can interfere with progress. We have had some cases in which the male partner had strong beliefs that intercourse was the only acceptable sexual practice. Consequently, a gradual approach to intercourse or sexual interactions without intercourse was not acceptable. Because of very restricted beliefs by a male partner, there is more pressure on the female and less chance for desensitization to occur. Trust and control are very important to the female experiencing dyspareunia or vaginismus. When the male's sexual beliefs supersede the female partner's wishes, the female's sense of control and trust is undermined, making successful treatment extremely difficult.

In a situation where a couple's beliefs are in conflict and may interfere with treatment, the therapist should explore every possibility of compromise with the couple. The differences in beliefs should be addressed as objectively as possible, so that neither partner feels blamed or at fault for their beliefs. By openly discussing the issue in an objective fashion, the partners are presented with the limitations or obstacles they are facing. Some couples will accept a change in their beliefs as a "temporary" change to solve a problem. If this is not an option, the therapist may

choose to work with the female partner alone, encouraging her to practice self-insertion in the privacy of her home, if this is acceptable to her. The client should first establish a hierarchy of 15–20 steps, with the first step being something achievable such as touching the outside of the vagina for a few seconds. The final step should be full insertion of two fingers for 2 min. Progress from one step to the next should be guided by the client's comfort level. When a woman can comfortably complete a step with little or no pain for a period of 2 min, then progress to the next step can be taken.

Homework



- ✎ Have the couple read Chapter 8 of the workbook and answer the chapter review questions.
- ✎ For the female client who is experiencing pain associated with penetration, ask her to set aside about 15 min a day when she is most relaxed to practice self-insertion. Many women find just before bed time most conducive to practice that is private and relaxed. Instruct the female client to practice self-insertion about 5 days a week to ensure consistency and steady progress.

Chapter 8 *Importance of the Sexual Partner*

(Corresponds to chapter 9 of the workbook)

Materials Needed

- Possible Partner-Related Factors That May Interfere With Sexual Relations worksheet
- Positive Communication Skills worksheet

Outline

- Review any homework assigned in the previous session
- Discuss the importance of the sexual partner
- Assign homework

Overview

When a couple like each other and the partners are attracted to each other, most sexual problems can be worked out. Because a good partner relationship is so crucial to successful sex therapy, a therapist must focus on the relationship when treating sexual problems. Even with single individuals, it is important to focus on partner relations, so that a single person will be able to select a compatible partner when the time comes.

Principle Underlying Treatment

The principle to consider in couples treatment is that the severity of a couple's nonsexual problems will determine the initial focus of therapy.

If partners have a positive attitude toward each other and are able to communicate effectively, sexual problems can be addressed immediately in therapy. If, on the other hand, there is considerable anger or distrust between partners, or if the communication is problematic, these nonsexual issues must be addressed before sexual issues can be addressed. In such cases, it is important to explain clearly to a couple that progress in overcoming sexual difficulties can best be assured if nonsexual issues are addressed first. In our experience, most couples readily understand and agree, even if they assumed the sexual issues would be the only focus.

Main Concept Conveyed to Client

The main concept to convey to clients is that blaming oneself or one's partner for a sexual problem is unproductive, and usually interferes with progress. Overcoming sexual problems is best achieved when a client and his or her partner work together.

Importance of the Sexual Partner

Treatment for almost all sex problems must start with working on good partner relations. A couple must view and approach a sex problem as a shared one if they are to overcome it. The couple must put aside blame for the problem in order to reach a solution. This couples approach to a sex problem is important whether or not the couple is married and whether or not they are a same-sex couple or a heterosexual couple.

Chapters 5 and 6 pointed out the many important factors that can help or interfere with a couple's sex life. This chapter focuses on the things in a partnership that lead to a satisfying sex life. It is true that sometimes two people dislike each other and do not get along but still have a great sex life together. This may be true in spite of major problems in the relationship. It is also true that a couple can love each other deeply and get along very well and still have an awful sex life. Ideally, the person one loves is the person one has great sex with, but this does not always happen.

Factors for Short-Term Relationships

Couples who have been together only a short time may find that there are two factors that are the most important ones for sex: the chance for sex and the physical attraction ("chemistry") they have for each other. For a new couple, the newness itself can cover up basic differences between them. However, even a new partnership can have sex problems. Partners might feel a lot of pressure from the relationship. Also, a new partner might remind the person of something negative, such as someone whom he or she does not like. It is easy for such an interfering thought to shut off the desire for sex and result in a sex problem.

In addition, if a man or woman has experienced a sexual problem in a previous relationship, this problem may be present with a new sexual partner. Worry about sexual performance and insecurity can cause a continuation of the same problem. For example, a man who has experienced ED may worry that this same problem will occur with a new partner. Consequently, a man will focus on the outcome of his performance with a new partner rather than the enjoyment of the moment and ED will likely occur again. In a similar way, a woman may worry so much about whether or not she will achieve orgasm that she does not.

Factors for Long-Term Relationships

There are many interpersonal factors that can affect the sex life of a couple who are in a long-term relationship. These include the following:

- One partner wants to control. The other partner is silent but resentful.
- Both partners wish to control. They often clash over even minor issues and have difficulty compromising and solving problems.
- Partners do not have skills for communicating and make negative assumptions about each other.

- The partners drift apart because they have no common interests and values.
- A partner may not be able to resolve anger about past events, substance abuse, or conflicts.

Many other interpersonal factors may lead to sexual problems; however, these five factors are the ones that are the most common. These factors lead to anger, lack of respect, and distance between the two partners. When such factors exist, couples tend to avoid sex and go longer and longer without having sex.

Some couples get along very well but still may have sexual problems. The man may have a problem with erections, or the woman may have one with having an orgasm. In these types of relationships, the problems come from a person's attitudes toward sex or from not feeling secure. For the most part, they do not come from interpersonal conflict.

Feelings Toward the Partner

Partners might have been angry toward each other for a very long time. They may have no interests in common. Their long-term goals may be very different. They may not be able to talk to each other or do not care about the other's feelings. Yet, when asked what keeps them in the relationship, they say because "I love him/her."

There are many possible meanings behind such statements about love. Some people just mean that they put up with the partner and that it is a "familiar" relationship. Others mean that even with many bad parts of their partnership, they have some good feelings toward their partners. They feel sexually attracted to or feel sorry for their partner. Others may mean that there are family or financial reasons to stay together. They label these "obligations" as love.

Therapist Note

■ *It may be helpful for clients to explain their true feelings for their partners in terms of other emotions, rather than using the word "love." The Possible Partner-Related Factors That May Interfere With Sexual Relations worksheet in the workbook can assist in this exercise.* ■

In addition to couple conflicts and negative feelings towards the partner, certain approaches to sex and attitudes toward sex can interfere with sexual enjoyment. Not being very interested in sex, placing too much importance on sex, and an approach that is narrow-minded or rigid can all cause sexual problems, especially for couples in long-term partnerships.

Lack of Enthusiasm for Sex

Often one partner in a couple has little or no enthusiasm for sex. The other partner may say, "My partner tells me to hurry up and get it over with," or "My partner just lies there and hardly moves." These are common complaints. A partner's lack of enthusiasm for sex will surely affect a person being able to perform, because a partner's sexual excitement is a big part of one's own excitement.

I have often encountered patients who say that their partner was more enthusiastic about sex at the beginning of the relationship but lacked enthusiasm after a while. The reason for this is that after the newness has worn off, a person's more natural or baseline attitude toward sex takes over. Thus, a person who normally has little interest in sex may still respond with enthusiasm during sex in a new relationship but then return to their usual low amount of interest over time. On the other hand, a person who normally has a strong interest in sex will explore ways to keep sexual interest over time.

Attaching Too Much Importance to Sex

Sex is an important part of many people's lives, but some place too much importance on sex. They view any sex problem almost as seriously as they would view a fatal illness. For some people, a sex problem means they are no longer masculine or feminine. Others view any sex problem as a sure sign that the relationship is over. Most of the time, depression or extreme tension goes along with such views. People with these negative views almost never enjoy sex in a relaxed way. They focus

too much on how they perform and not enough on having fun, being creative, and feeling satisfaction.

People who attach too much importance to sex may be insecure and equate sex with love, self-esteem, and personal attractiveness. In such cases, a person may focus on frequency and keep track of sex. Usually the results of this type of pressure have the opposite effect. The more a person is available for sex and pressures his or her partner for sex, the more the partner moves away from sex. Remember, sex is much more interesting when it is unpredictable and not always obtainable.

Rigid or Narrow-Minded Approach to Sex

Couples who are not very creative or willing to try new things will, in time, lose interest in sex and may even develop sexual problems. For many couples, sex includes little or no foreplay. They focus all interest on intercourse. Some couples have never touched each other's genitals. Some have never tried new positions for intercourse. These couples are limiting the pleasure they could have from sex and are at risk for sexual problems and physical isolation. On the other hand, couples who have enjoyed many ways of giving each other sexual pleasure are better prepared to deal with a problem with intercourse, if one occurs. Giving and receiving pleasure in a number of ways keeps these couples feeling physically intimate and close to each other.

It is especially important for couples to have the attitude of "whatever happens in sex is OK." This, of course, is in the context of consenting sex and not coercive sex. A couple's accepting attitude values each sexual experience with their partner. When there is no blame or evaluation, couples will more likely enjoy their sexual relationship much more over time. On the other hand, couples who have the attitude that "once you start sex you have to finish it" or "the only true sex is sexual intercourse" are more likely to develop problems and sexual dysfunction and have less sex.

Couples who are less rigid and more open about sex will usually flirt more, joke about sex more, show more affection, touch more often, and have sexual experiences that end in a variety of ways. The "ending" may or may not include orgasm and may or may not include intercourse.

Open Communication About Sex

The first and most important step is for the person to discuss the sex problem with his or her partner. This is true for a problem that is caused by interpersonal factors or for problems that stem from attitudes and behaviors about sex. It has been shown that talking really does help. Couples can get rid of a lot tension and can sometimes even correct a sexual problem just by talking about it.

However, couples often do not talk about a problem with the relationship or their sex life. If they do talk, the discussion is often awkward and misunderstandings are much more likely. Poor communication can make discussing problems about the relationship ineffectual. If couples use discussions to blame one another, they will be useless—or worse—harmful to the relationship.

Developing Better Communication

Most couples who have a hard time communicating try to do so at the wrong times (e.g., one person is leaving for work or has just walked in the door). Distractions and interruptions can ruin the chance of the discussion being a good one. On the other hand, couples with good communication skills set aside time for talking. They also make sure there will not be any distractions (e.g., unplug telephones, turn off the television, and make sure the children are occupied) and that they have plenty of time. The Positive Communication Skills worksheet in the workbook lists other good communication skills for being a sender and a receiver.

Clients Currently Without a Sexual Partner

Many single people who do not have a steady partner and who fear failure in sex come for therapy. They may not socialize because they do not wish to set themselves up for failure or embarrassment. Most of the time, avoidance makes them have even more fear, which in turn, leads to more avoidance.

This program strongly recommends that single clients go about socializing and becoming intimate one step at a time. Many of them may need a lot of support and encouragement to start going out again. Often, they continue not to socialize because of false beliefs. Some men, for instance, think that if a woman shows an interest in having sex, then they must attempt sex. So, rather than fail, they avoid. Some women may think that all men are interested in them only for sex and that they will always be pressured for sex. Tell these clients that it is perfectly okay to state to a potential partner that they are not ready for sex. Also, they should not keep going out with someone if they feel pressured and the person is not sensitive to their needs. They should look for someone who attracts them, who shares common interests, and has a flexible and accepting view of sex.

Case Vignette

T: How are things going with you since the last time we met? It has been about 2 weeks.

C: Well, I thought everything was going okay. I suggested that we go to the movies, and at first she agreed, but then she got angry. We had a big fight and ended up not going. I still don't understand what the fight was about.

P: I agreed to go to the movies because it sounded like a good idea. But the more I thought about it, the more I got angry, because I have been asking for years to go out more and you never wanted to go *(getting angry in tone)*. Now, we are in therapy and suddenly it seems like a good idea to you. You always ignore my wants and my feelings, and you do just what suits you. You never do anything for me.

T: (To client) Did you ask your wife the reason for her change in mind and the reason for her anger?

C: Yes. I said, "Why did you change your mind?" She said that I should know. I'm afraid to ask her much more because she starts crying or gets very angry. I feel that either way, I lose.

T: So what strategy do you use to solve problems between two of you?

C: Basically, I just try to avoid conflict as much as possible. I find that if I say nothing at all, the problem will go away.

T: (To partner) What are your thoughts when your husband is silent and doesn't respond to you?

P: I assume he doesn't care about me at all. He just ignores me and doesn't care what happens.

Clinical Comment

This brief exchange illustrates that this couple have considerable negative feelings toward each other and that basic communication skills are lacking. They do not solve problems, and consequently allows past problems and negative feelings to build. Terms like "always" and "never" are used freely, and thereby undermine positive efforts that are made. Also, the couple operate on second guessing each other, because silences and vague responses are common. This leads to misunderstandings and anger.

It would be extremely difficult, and probably a waste of therapy time to attempt direct treatment of sexual problems before addressing the couple's faulty communication and lack of problem-solving skills. The pathway of treatment for this couple would best be structured to address the general communication and relationship problems first, and then the sexual problems (see Figure 2.1). Although this couple originally presented for therapy because of lack of sexual desire, the initial assessment and treatment planning would identify the relationship as the first focus of treatment.

It should be noted, however, that some couples are unable to admit to or acknowledge their relationship problems, and may be very convincing to a therapist by avowing to the solidarity of their relationship. It is common that only after therapy is in progress, and the couple is challenged to deal with specific issues, that deep-seated problems emerge.

Atypical or Problematic Responses

A problematic response that many therapists may encounter is when one partner of a couple discloses that he or she is having a secret affair. In such situations, therapists must be careful not to impose their own morality. An evaluation of the affair, and the impact (if any) on the couple in therapy, must be made as objectively as possible. A determination of whether the person having the affair should disclose or end the affair must be made strictly from the couple's perspective.

Disclosure of an affair can be very destructive or very constructive depending on the strengths and weaknesses of each partner. In most cases, carrying on an affair is counterproductive to the therapeutic process. If the therapist judges the affair to be interfering or counterproductive to therapy, the person having the affair must be confidentially advised of this. It is then up to the therapist to help the client sort through his or her priorities and, in some cases, help the person end the affair. If the person chooses to continue the affair, the therapist is left with the difficult situation of sexual therapy that is not viable. Each therapist may have his or her own style of resolving this situation, but the important point is not to break confidentiality. If therapy is discontinued, do not leave the unsuspecting partner feeling that he or she is at fault for the discontinuation of therapy. At this point, it is possible to suggest an alternative referral, for one or both partners, to individual therapy.

Homework



- ✎ Have the couple read Chapter 9 of the workbook and answer the chapter review questions.
- ✎ Ask each partner to complete the Possible Partner-Related Factors That May Interfere With Sexual Relations worksheet in the workbook.
- ✎ Ask each partner to complete the Positive Communication Skills worksheet in the workbook.
- ✎ Instruct the couple to set aside specific time to discuss their answers.

Chapter 9 *Working With a Partner to Master Sexual Problems*

(Corresponds to chapter 10 of the workbook)

There are no materials needed

Outline

- Review any homework assigned in the previous session
- Discuss working with a partner to master sexual problems
- Assign homework

Overview

Chapter 8 of this guide emphasized the importance of a partner in treating sexual problems. Partners can be helpful or interfering, depending on their attitudes and skills. With single individuals, the *selection* of the "right" sexual partner is important. This chapter emphasizes several key ingredients to consider, once a client is working with a helpful partner.

Principle Underlying Treatment

There is one principle underlying treatment in this chapter. Even when couples have good communication and feel positive toward each other, improved sexual functioning is reached only when a couple establishes common sexual goals and has a shared responsibility for reaching those goals.

Main Concept Conveyed to Client

The main concept to convey to clients is that sex is most rewarding when favorable conditions exist for *both* partners. It is usual for one partner to be more desirous of sex than the other partner. When disparities in desire exist, couples should determine what is most comfortable for both. For example, one partner may say to his or her partner's sexual advance, "I don't feel like having intercourse, let's just snuggle." Such statements are intended to reach a comfortable level of intimacy without rejection.

Working With a Partner

By now, couples should have a good understanding of the nature of their sexual problem and its causes. This chapter reviews the crucial elements for solving a sexual problem when the client is working with a partner.

Setting Aside Quality Time

To agree on goals and to reach those goals, partners must spend priority time with each other. Once a couple has committed to this, they have taken the most important step toward making their sex life better.

Setting aside quality time does not mean setting aside time just for sex. Rather, it means making time in which partners can "connect" a high priority. This connection may include sex, or it may involve just talking or showing affection. Remember, when couples experience sexual problems, there is usually avoidance, and opportunities for sex are filled with other activities or obligations. Setting aside time for intimacy and connecting may begin by devoting an hour or so a week to discuss issues raised in the workbook.

Some couples work best when time for intimacy is very structured, that is, identifying a very specific time and date for intimacy. For example, "we will set aside every Friday at 8pm to 9pm." Other couples work best with unstructured time, that is, agreeing to get together for

intimacy during the week but not specifying the exact date and time. Unstructured time will seem more natural but there is more of a risk of avoidance especially if a couple has some difficulty with communication. Couples will need to decide which strategy would work best for them.

Identifying Conditions That Help Make Sex Satisfying

Men and women often overlook the fact that expectation alone does not guarantee that sex will occur or will be enjoyable; special conditions are required. This does not mean that couples have to make complex plans, but they do need to be aware of what works best for both partners. Awareness can help couples avoid negative conditions and take advantage of favorable ones. The following conditions need to be considered: sleep patterns; work and family obligations; privacy; and relaxed time.

Having the Right Attitude

The most important factor in solving a sexual problem is for the couple to see it as a shared problem. Partners need to work together on common goals and to agree on causes and solutions. Blaming does not help and is often based on misunderstanding. It is obviously very hard for couples not to point fingers when the blame has existed for a long time. To get rid of blame, couples must be open to new information and a new way of looking at their problem. Despite how the sexual problem started, couples must work on solving it with an open mind and through cooperation.

Single clients may be avoiding relationships because of their sexual problems. They must find a partner who will help them to develop a healthy sexuality. They should look for someone who is sensitive to their problems and who has an open attitude toward sex. Clients should find someone else if the potential partner pressures them, is rigid about sex, or becomes angry.

This program guides clients through the following steps:

1. Learn about sexual problems in general and begin to assess your problems (Chapters 1–4 of the workbook).
2. Learn the important information about your sexual problem (Chapters 5–8 of the workbook).
3. Master your problem by working with your partner. Then prevent slipping back by forming plans to deal with slips and to get back on track (Chapters 9–13 of the workbook).

It is important for couples to complete each step before going on to the next. It is necessary to be thorough in these steps in order to solve sexual problems and to prevent slipping or developing new ones.

Case Vignette

T: It has been about two weeks since we last met, and I want to review how you have been doing. We were focusing on two related areas. One area was your general stress level, and the other was your ability to focus on pleasure during sex. What has been your experience over the past 2 weeks?

C: I feel much more relaxed, and it seems that everything is working well right now. I think I've changed my attitude quite a bit. I now don't worry about everything, and I know there are lots of things I can't control.

T: (To partner) How do you feel things are going?

P: He definitely seems more relaxed. He can't tell when he is stressed out, but I can. I can read him like a book, and tell when he is nervous. He has trouble expressing his emotions. And when he is nervous, I become nervous.

C: Yeah, she does know me better than I know myself.

T: What has been your experience with sex during the past 2 weeks?

C: Everything worked well. I really got into it and we ended up having intercourse, although we didn't plan to. Again, my wife was very helpful. She told me it didn't matter if we had intercourse, and she really made me feel better.

P: He puts a lot of pressure on himself. I've always told him not to try so hard. Talking about it in therapy helped a lot.

T: Sex works best when you think about enjoying what you're doing rather than performing. Were you able to get lost in your thoughts during sex and just enjoy?

C: Because I wasn't even planning to have sex, I wasn't worried. Everything just seemed to work.

T: Were you actually able to have penetration and intercourse?

C: Yes.

T: I think this experience demonstrates to you how important your mental attitude is. Sex is like sleep. It is something you can't force, but you have to create the right conditions. Sleep works best when you feel sleepy and you're not worried about getting to sleep. If you try to force sleep when you aren't sleepy, or if you put pressure on yourself to go to sleep, it is usually interfered with. Sex is the same. It works best when you feel like having sex (when you are aroused), and when you just let it happen and don't try to force it.

C: That makes a lot of sense. I know I have been trying too hard.

T: (To partner) Because you are able to tell when your husband is stressed, you can help by letting him know and by suggesting at those times that it might be better just to hold each other.

P: I can do that. I think he will listen to me now.

Clinical Comment

This case vignette is a typical exchange. It illustrates a couple who communicates effectively and works well together. We have found that the analogy to sleep helps clients understand the negative impact on performance anxiety and trying too hard during sex.

One common problem often encountered in sex therapy is limited quality time for sex. This occurs in married couples when they are both busy professionals or work different shifts. Also, this occurs in an individual without a steady partner when sexual opportunities are more random and unpredictable. When limited opportunities for sex exist, the tendency is to take advantage of an opportunity for sex even if one partner doesn't feel like it.

Such situations have to be thoroughly discussed with single individuals or couples to help reduce negative sexual experiences. A common statement by a client in such situations might be, "I know if we didn't try to have sex this weekend, it would be 3 weeks before we would have another opportunity. I tried having sex, although I didn't really want to."

Couples with such time constraints must be told that it is better to have a limited intimate experience that is pleasant, than to have a more full-scale sexual experience (usually meaning intercourse with orgasm) that is unrewarding. It is important for the therapist to help a couple communicate about their sexual feelings and accept, without negative repercussions, a more limited yet mutually pleasant and agreeable sexual encounter. Thus, a couple might forgo attempts at sexual intercourse in favor of holding, kissing, and caressing. Absolutely fantastic sex may only occur for a couple when they are able to get away together for a vacation.

Homework



- ✎ Have the couple read Chapter 10 of the workbook and answer the chapter review questions.
- ✎ Instruct the couple to review with each other the sexual goals that have been reached and discuss plans for reaching any goals that remain.

Chapter 10 *Mastering the Sexual Problem*

(Corresponds to chapter 11 of the workbook)

Materials Needed

- Common Causes or Sources of Sex Problems worksheet

Outline

- Review any homework assigned in the previous session
- Identify the causes or sources of the sexual problem
- Discuss solutions for personal sources
- Discuss solutions for interpersonal sources
- Discuss solutions for medical sources
- Treat specific sexual problem
- Assign homework

Overview

Chapter 11 of the workbook helps clients put together all of the information they have learned thus far to effectively deal with their sexual problem. At this point in the program, clients should have achieved an adequate sexual knowledge base and should have established favorable conditions in their relationship.

Clients should also have achieved an understanding of the factors contributing to their sexual problem. This chapter helps clients further

pinpoint the sources of their problem and find possible solutions for overcoming it.

Principle Underlying Treatment

The main principle underlying treatment is that even with similar symptoms and presentation of problems, each case is unique and treatment strategies may be very different from client to client. The Common Causes or Sources of Sex Problems worksheet in the workbook allows the therapist to help the client address the unique issues that have led to his or her sexual problems. Therapists should avoid jumping to conclusions just because a client's symptoms are similar to those of a previous client.

Main Concept Conveyed to Client

The main concept to convey to clients is that full treatment of sexual problems progresses in stages and that within each stage, progress may move erratically. Couples may experience rapid progress on some issues and slow progress on others. Comprehensive treatment takes time, rarely goes smoothly, and often takes repetition and practice to achieve lasting changes. Summarize for the client what has been achieved so far, and what to expect in the next step.

Identifying the Causes or Sources of the Sexual Problem

Couples or individuals begin Chapter 11 of the workbook by completing the Common Causes or Sources of Sex Problems worksheet (a copy for your reference is provided on page 92). This worksheet helps pinpoint the various possible sources of a person's sexual problem: personal, interpersonal, and medical. Each item on the worksheet corresponds to a "source" presented in the chapter. Clients may find general information pertaining to each item they have checked "yes" and a suggested treatment strategy. The general information and specific suggestions for

each source item will help clients understand how the source has contributed to their sexual problem and how they can begin to overcome the problem. By addressing all items marked "yes," the therapist guides the client through a comprehensive treatment program.

In addition to addressing the personal sources of a sexual problem, there is often a need to address the specific nature of the sexual problem itself. For example, a woman may have complained of low sexual arousal. When she reviews the worksheet, she may check off items 1 and 4 under "Personal Sources," item 3 under "Interpersonal Sources," and item 2 under "Medical Sources." The general information and specific suggestions should be addressed for each of these items. After addressing each item, she should turn to the specific guidelines in Chapter 11 of the workbook for treating low sexual arousal. Under this section, she will be guided through sensate focus. The combination of addressing all items checked "yes" as sources of sexual problems, and responding to the treatment suggestions, will complete her treatment program.

Common Causes or Sources of Sexual Problems

Personal Sources:

1. When you were a child or teenager, did messages about sex or your body make you upset or uneasy? ___Yes ___No
2. As a child or teenager, did you receive incorrect information about sex? ___Yes ___No
3. As a child or teenager, were you a victim of sexual abuse or did you know of family and friends who were victims? ___Yes ___No
4. As an adult, have you ever had an experience with sex that made you feel upset or ashamed? ___Yes ___No
5. Do you have general anger toward or fear of the opposite sex? ___Yes ___No
6. Do you now have a personal problem that is not related to sex? This might be low self-esteem, worry, depression, trauma, or fear. ___Yes ___No
7. When you have an opportunity for sex, is it in a private, comfortable place? ___Yes ___No
8. Do you feel confused about your sexual direction? ___Yes ___No

Interpersonal Sources:

1. Is your sex partner tense or uneasy about sex or does he or she seem uninterested? ___Yes ___No
2. Does your partner have his or her own sexual problems? ___Yes ___No
3. Is it hard for you to talk with your sex partner? ___Yes ___No
4. Do you feel tension or anger toward your sex partner? ___Yes ___No
5. Do you lack physical attraction toward your partner? ___Yes ___No
6. Do you have a strong physical attraction toward someone other than your partner___Yes ___No

Medical Sources:

1. Are you now using or abusing alcohol or other drugs? ___Yes ___No
2. Are you taking a drug to treat a mental problem, high blood pressure, ulcers, or seizures? ___Yes ___No
3. Do you have diabetes, heart disease, nerve disease, or spinal cord injury? ___Yes ___No
4. Do you have a health condition that causes you pain, fatigue, or nausea or that makes you feel self-conscious or embarrassed? ___Yes ___No
5. If you are male, do you *not* have erections at any time? That is, when you are with a partner, when you masturbate, or when you wake up in the morning? ___Yes ___No

The treatment guidelines for specific problem areas are outlined for therapists, whether or not your clients are using the *Enhancing Sexuality* workbook. Comprehensive treatment, of course, depends on your assessment. Assessment should identify all the relevant factors contributing to your client's sexual problem. The most common treatment approach for each problem area will follow. In any problem area, there may be additional appropriate treatment strategies depending on the nuances of your client's problem.

Solutions for Personal Sources

Negative or False Information About Sex

Most of the sources of personal sexual problems come from the family conditions in which the person grew up. Parents may give positive or negative messages about sex through their behavior. If parents argue a great deal, rarely hug or kiss, or are not around to comfort and guide, they may give their child a negative message about sexual intimacy. With this kind of family environment, the person has learned to be uneasy with showing affection and being close.

Some parents give only explicit warnings about sex, sowing the seeds of a very negative attitude toward sex. If necessary warnings and cautions about sex are not balanced by positive statements about sex, a child is left with only the negative ideas. Warnings and threats of punishment for getting pregnant out of wedlock, learning that sex is dirty or sinful, and hearing statements about pain or trauma related to sex can give a person a negative view of sexuality.

Sexual abuse is another source of sexual problems. Either direct or indirect abuse can give a person negative ideas about sex. This is very true if the person has not been able to talk with a caring adult about his or her trauma. Such a discussion could have helped place the experience in a healing light.

Also, many men and women grow up with false information and ideas about sex that can lead to sexual problems. For instance, a person might think that sex should always be exciting and amazing and when it is not

that, the person may begin to think that something is wrong with him or her. The person who thinks that he or she is at fault might then take a lot of worry into the next sexual encounter. Doing so causes a problem because he or she focuses on performance, not on pleasure.

Specific Suggestions

One way to solve personal sexual problems is to start with a solid base of correct information. The first four chapters of the workbook and the Common Sexual Myths handout at its end provide that basis.

Negative Sexual Experiences as a Child or a Teen

A person who grows up in surroundings that are sexually negative often is uneasy or anxious about his or her body and about sex. It is best to deal with such feelings as fears. The best way to face a fear is to break it down into small, manageable steps and then work through them one step at a time. The longer a person avoids a fear, the harder it is to overcome.

Single people may avoid sex by not even dating. A married person may avoid sex in many different ways, for example, by staying up later than the spouse, by working long hours, or by starting an argument at the wrong time. A partner might also turn off the television or switch channels when something sexy comes on. Whatever way the person uses to avoid sex, it does not solve the sexual problem but is destructive in the long run. To add to this problem, partners sometimes do not communicate well and the partnership becomes very stressed and unhappy.

Specific Suggestions

Clients must recognize their avoidance and begin to approach sex very slowly. If the client is married or has a steady partner, then he or she has

to open up. To create conditions that allow a step-by-step approach to sex and closeness, partners must agree to the following conditions:

- Practice sex and being intimate on a regular basis. At the least, this practice should occur twice a week for about 2 hr each time. Most of the time, practicing more often will lead to success more quickly.
- Set aside the time and place for practice so that you have privacy and are not pressured or rushed in any way. Turn off telephones and make sure nothing else will intrude.
- Agree with your partner that the goal is comfort, *not* wild sex. The goal is *not* orgasm, erection, or intercourse.
- Start with behaviors with which you are comfortable, such as hugging or back rubs. Try to include more intimate behaviors each time you practice.
- You may include any behaviors that you and your partner agree on. Also agree that you may stop with anything that causes "too much anxiety." You are the judge of what is "too much anxiety," but try to push yourself each time and do not give up early.

If partners agree to these five things, they should notice changes within a couple of weeks. They should keep practicing until they are at ease with all the sexual behaviors that both partners want in their relations.

If clients are single and have fears of sex, it is important for them to socialize in situations where they can meet potential partners. They should try to only date people whom they are comfortable with and who seem at ease with their own sexuality.

If clients are uncomfortable with seeing or touching their own bodies, they should work on reducing their fear. Again, clients should break down the fear into small, manageable steps and practice, practice, practice. For instance, they can gradually increase the amount of time spent looking at their bodies. Or a little at a time, they can expose or touch the part or parts of their bodies that disturb them the most. They should make sure their practice sessions are frequent and private. Some people have found that looking at erotic pictures or movies helps reduce fear;

however, clients should be sure to choose material that does not offend them, but that they find acceptable and not upsetting.

Depression, Anxiety, and Other Mental Health Problems

If the sexual problem is a result of other personal problems, those problems must be treated first. Clients should review their past and ask themselves if they had sexual problems when they were not feeling depressed, insecure, or worried in any way. If they had no sexual problems during better times in the past, then their problem may not be sexual.

Specific Suggestions

The client will need to pinpoint the source of the personal problem that is affecting him or her. You might have to agree to refocus the client's therapy or to refer the client for other help. It is not likely that a person can make progress to solve a sexual problem while having other personal problems.

Not Enough Time or Never the Right Time for Sex

Some people think they have a sexual problem when, in fact, their problem is either not making quality time for sex or trying to have sex at the "wrong" time. The wrong time is a combination of two things: (1) conditions that interfere with sex and (2) the environment is not favorable for sex. A couple might be busy with two jobs, have work hours that conflict, or be busy with children or parents. Such couples often try to have sex when they have the opportunity but not the desire. Most of the time, the result is less than satisfying.

Specific Suggestions

Clients first need to ask themselves, "What are our priorities?" Clients may have obligations to work, to children, or to parents, but they also have an obligation to their partnership. Often couples put everything

else first and do not set aside time for each other. So, sex happens "catch-as-catch-can," not as the natural result of close, intimate time spent together.

Couples should sit down and make plans together. The plans might simply be taking a walk together or having a quiet talk together. They should make plans for short time together every week and for longer times together that may involve a full day, weekend, or vacation. When couples make plans, time together becomes a priority and everything else becomes less important, unless there is a crisis.

A second part of this solution is for partners to make an agreement that sex can mean a whole range of activities. It does not always have to mean intercourse or result in orgasm. If a partner does not have the desire for sex, he or she should be able to suggest a more limited kind of sex without fear or anger from the other partner.

Same-Sex Attraction

Individuals who are attracted to members of both genders often find this confusing. If a client is wondering about his or her sexual direction, he or she must find out how strong his or her attractions are. A person who has sex with someone not out of attraction, but because that is what is expected or accepted will likely have problems. This is especially true in a long-term partnership.

Specific Suggestions

Sexual direction (also called sexual orientation) does not change. Clients must accept their sexual direction and seek partners who meet their strongest desires.

Heterosexual couples in which one partner is attracted to those of the same gender does not always lead to sexual problems if the partner also has desire for his or her opposite-gender partner. This also applies to same-gender couples in which one partner has desires for those of the opposite gender. In either type of relationship, the issue is the same—faithfulness and trust. The couple must discuss the issue, understand

how each is vulnerable, and assure each other of faithfulness. Often, such a talk can clear up any misunderstandings that can lead to anger and withdrawal.

Solutions for Interpersonal Sources

A Partner Brings a Sexual Problem Into the Relationship

People commonly blame themselves for a sexual problem even when their partner brought the sexual problem into the relationship. In a long-term partnership, finding the original source of the problem can sometimes be difficult. If the person can recall other relationships that were enjoyable and free of stress, then his or her partner might have brought the problem into the relationship. If the person gets along well with his or her partner and enjoys sex, then the sexual problem is most likely the partner's problem.

Specific Suggestions

If one partner brought the problem, it is crucial to think of the problem as a couple's problem. Blaming one partner will only be destructive.

The client should discuss the facts with his or her partner and reassure the partner of his or her love and attraction. If the talk goes smoothly, the couple should be able to agree to work together on the problem. The client can encourage his or her partner to pinpoint the source of his or her problem and then follow the solutions outlined in this program. The client should support and help his or her partner with all the necessary steps so that both of them benefit.

When Communication Is a Problem

When partners do not communicate well, sexual problems can occur because one or both partners become angry or do not understand what is going on with the other. Not talking can also keep a sexual problem going even when the problem was caused by something else, because a couple may avoid looking for solutions. Talking about sex is hard,

even for couples who communicate well. It is a common issue for most couples who are trying to solve a sexual problem.

Specific Suggestions

If couples have a communication problem, they should review the section about communicating in Chapter 9 of the workbook. They should pay very close attention to their sender and receiver skills.

Couples should agree on regular times to meet to practice good communication. Couples should make sure they will not be bothered (e.g., by telephone calls or children). Scheduling meetings at least two or three times a week will increase the chances of improving communication skills. Each meeting should be from 1/2 hr to 1-hr long. In the first meeting, couples should talk about the sender and receiver skills that each partner needs to develop. Each partner should pinpoint skills that he or she needs to improve for himself or herself; partners should not judge each other's communication problems.

The next step is to talk about affection and sexual intimacy. A good rule is to let one's partner know what he or she is doing that one likes. Couples should discuss the types of affection and sexual behaviors they want as part of the partnership.

Clients should keep in mind that there are no right or wrong sexual behaviors. There are only likes and dislikes. One partner may not like a certain behavior or an approach to sex. The other partner may greatly desire it. Being a good lover does not mean knowing some great secret to wonderful sex, but paying attention to one's partner's words and actions to learn what he or she does and does not like.

Anger at the Partner

Anger and tension related to one's partner will surely get in the way of sexual closeness. For most people, it is impossible to feel like having sex with their partners if they are angry with them. The important question is whether or not the person's anger is so great or has lasted so long that he or she cannot put it aside. For some couples in treatment, the anger is so great that progress is not likely.

Specific Suggestions

The first step is for the client to ask him or herself whether he or she can put aside feelings of anger and tension long enough to work on increasing sexual intimacy. Clients can either work past their feelings or they can end the relationship. If they believe that their anger or tension can be treated, then they can go to the second step.

The second step is to try to resolve anger through talking and trying to agree on things. Most couples will find that two things can help solve the problem: following the communication steps in Chapter 9 of the workbook and focusing on the causes of anger. Once anger is resolved, couples can proceed to work on other sources of their sexual problem.

Not Attracted to One's Sexual Partner

This problem occurs when a person's partner just does not make the person feel sexually aroused. This can be very frustrating and can happen even when a person has very strong positive feelings for a partner and sees many good things in him or her. For some couples, it has always been this way. Perhaps the partner reminds the person, for example, of his or her mother, whom he or she cannot think of in a sexual way. For other couples, it develops over years of partnership. A person may have sexual desires but just does not find his or her partner arousing. The partner may, in fact, be a very attractive person. On the other hand, the partner might have become less attractive because of weight gain or other changes that come with time.

Specific Suggestions

Perhaps the partner reminds the person of someone (e.g., a relative) whom he or she cannot think of in a sexual way. Perhaps, the person views his or her partner as so virtuous or good that it is hard to think of him or her in a sexual way.

To solve this problem, a couple may need to try to spend time in more erotic and romantic settings. Getting away to a hotel or resort for a romantic weekend once in a while can help. A couple might try setting

aside time to date each other on a weekly basis. For this, one partner chooses the type of date one time, and the other partner chooses the next time.

Another possible way to solve the problem is the use of erotic materials, such as movies or clothes. Couples must do this with care and caution to make sure that the material does not offend either partner. Wearing something sexy or acting in a sexy or romantic way may help partners see one another in a new light, but can work only if both partners agree to try it and if neither partner is insecure or defensive about it. Attempts at change should be repeated a number of times and not given up after only one.

Desire in a long-term relationship can be lost in a number of ways.

Always being available for sex and never saying no: Being available all of the time almost always takes away desire for both partners. It is very normal and natural not to always be interested in sex. The person who is willing to have sex all of the time is likely having sex at less than desirable times. Also, with such a partner, the mystery, novelty, and risk of sex are taken away. These are very important for keeping desire alive. The person who is always available is, in effect, saying, "Your appearance or sexual skills do not matter; I'll do it anyway."

Letting your appearance go by not taking care of yourself: If a person does not try to keep himself or herself attractive, he or she is saying, "I don't have to work on this relationship anymore; you'll always be there anyway." On the other hand, keeping oneself attractive says, "I want to look my best for you because you are special."

Being too close and too familiar: Some couples boast that they do everything together. There are few interests, activities, or friends that they do not share. This kind of relationship sounds good on the surface, but it is not good in a long-term relationship. The best long-term partnerships have a good core of interests, activities, and friends that are shared. They also have some interests, activities, and friends that are not shared. Things that are not shared, in fact, add to the relationship and help to decrease too much familiarity. Being too familiar can take away sexual desire, for example, walking around naked in front of one's partner and not keeping bathroom behaviors private. Keeping mystery in the partnership adds to and keeps up desire.

Having Attractions to Other People Besides One's Partner

Physical attractions to other people are a normal and natural part of life. It is not realistic to expect that they will stop once a person is in a relationship. Physical attraction to a person other than one's partner does not have to cause a problem. It causes a problem only if the person becomes distracted with the attraction or if he or she acts on it. Being attracted to someone else will not of itself interfere with the partnership. It can, though, when the person already has doubts about the relationship.

Specific Suggestions

If the person has not acted on the attraction, but finds it hard to stay faithful to his or her partner, he or she should seek help right away. Sharing one's secrets with a therapist or a trusted friend can help one to put the attraction into perspective. The person must find out if his or her "other attraction" is a sign of not being happy with oneself or with his or her partner.

It is much easier to deal with an attraction to someone else when the person has not yet acted on it. Once the person has acted on it, he or she has exposed himself or herself to a number of risks. These risks include disease, pregnancy, the break up of the relationship, and hurting loved ones. They can even include revenge from the person's partner or the other person's partner.

Solutions for Medical Sources

Alcohol or Drug Abuse

The use of alcohol or other drugs to excess can have a negative effect on sex in both men and women. Alcohol or other drugs can affect being able to have sex while the person is intoxicated or "high." In some cases, the damage can be permanent even after the person stops drinking or taking drugs. The treatment of the sexual problem can never work as long as the person is still abusing alcohol or other drugs.

Specific Suggestions

If the client is not sure if alcohol or other drugs are affecting his or her sex life, he or she can test it by stopping drinking or by taking other drugs for one month and seeing how his or her sex life is affected. Clients should not judge sexual success or failure on the basis of just one encounter, but look at his or her total record for a month. If a month does not give a full picture, then the client can try sex without alcohol or other drugs for 2 or 3 months. If the person cannot stop substance abuse for at least a month, then most likely he or she does have a problem.

Use of Prescribed Medications

If a person thinks that his or her sexual problem began after starting taking a certain medication, then it is worthwhile for the person to talk to his or her doctor. Clients should never change or stop taking a prescribed drug without first talking to his or her doctor. In most cases, a doctor may be able to change the medicine without the change affecting the person's health.

Specific Suggestions

The client and his or her doctor may agree either to stop or to change the medication. If so, the person should ask the doctor how long the old medication stays in his or her system, and how long until the new one takes effect. The person cannot expect any change until the old medication is out of his or her system. No conclusions should be made until the person has had sex several times over a period of at least 1 month after the medication has taken effect.

If the person continues to have sexual problems, the medication may not be the cause. At this point, the person should talk to his or her doctor again or conclude that the sexual problem may be a result of other factors.

There are many medical conditions, such as spinal cord injury, when not being able to have sex occurs right away. If this is the case, it is clear that the medical condition has caused the problem. With certain chronic diseases, however, not being able to have sex comes on slowly over a long period of time. These include cardiovascular disease, such as stroke and heart attack, metabolic syndrome (Esposito & Giugliano, 2005), and diabetes. They also include diseases that affect the nerves, such as multiple sclerosis. Men may notice that their erections are less firm or that orgasms are less intense. Women may notice a decrease in vaginal wetness and a decrease in the number of orgasms.

Specific Suggestions

If a person has a chronic disease, it is quite likely having an effect on his or her sex life. In most cases, however, medical and psychological assistance can help the person find a sex life that he or she can enjoy (Alterowitz & Alterowitz, 2004; Wincze & Carey, 2001). In many cases, controlling the disease can bring back one's ability to have sex. It is crucial that the person follow his or her doctor's advice to keep his or her illness under control as much as possible.

The next step is to make sure that conditions for sex are favorable for the most part. Also both partners need to be able to accept a sex life that does not exactly match what they enjoyed in the past. The best approach is for couples to accept the changes in sexual functioning and take the attitude "whatever happens, happens." Each encounter should be enjoyed for what it is and not compared to past ones.

Some people may choose to use a medical method to help improve their sexual functioning. For men and women, this may include a number of options that range from changing habits to a healthier life style, taking prescribed drugs, to having surgery. The good and bad points of each option should be discussed with a doctor or therapist who has knowledge of them.

Acute Medical Condition

Some acute medical conditions such as prostatitis (inflammation or infection of the prostate gland) can have an immediate adverse effect on sexual functioning. Sexual functioning usually returns once the disease is treated. It is important to understand that acute medical conditions, like chronic medical conditions, can have either a direct or an indirect effect on sex. Some medical factors such as cardiovascular disease may directly affect blood flow to the genitals and cause sexual dysfunction, while other diseases such as the common cold affect sex only because they make sex less appealing or less comfortable.

Specific Suggestions

If a medical condition is having an effect on a person's sex life, he or she should find out about the condition. For many of these conditions, there is reading material that can help a person adjust to having or understanding the impact of the disease. The latest readings will discuss sex and give some advice and tips (Alterowitz & Alterowitz, 2004). Local self-help groups for people with particular chronic conditions are also a great source of information. Talking to people with similar problems can help a person find ways to make sex better.

The first step to improving sex is to wait until the chronic medical condition is stable and not likely to get worse, or until the acute medical condition has been treated. During this time, couples may still show physical affection toward each other. This is a way to be intimate and does not have to lead to sex. Affection can keep partners from being isolated and also creates the conditions for sex at a later time, when both partners are ready.

Determining Whether an Erection Problem Is Caused by Medical factors or Psychological or Nonmedical Factors

Psychological factors such as anxiety, depression, or excessive worry can contribute to sexual dysfunction in men and women. A comprehensive medical assessment can help rule out the presence of medical conditions.

With medical conditions eliminated as an explanation of sexual dysfunction, attention can focus on the presence of nonmedical conditions such as psychiatric diagnosis, marital conflict, poor self-esteem, lack of privacy, and stress in one's environment. The term "nonmedical" is preferred to the term "psychological" since many patients confuse the term "psychological" to mean "mental illness."

In cases of erectile dysfunction, nighttime erections are a valuable source of information to determine the presence or absence of medical factors. Men normally have erections at night while they are sleeping and these are referred to as *nocturnal penile tumescence* (NPT). It is normal for men to have such erections throughout their lives. Most of the time, a man has from one to six erections while he is sleeping. A man is aware of the erection only if he happens to wake when it is occurring. Most of the time, the erection cycle occurs while a man is dreaming, but the dream does not have to be sexual. Most men think that a full bladder causes nighttime erections, but a full bladder has nothing to do with causing the erection. They are caused by a release of chemicals in the brain that occurs during dreaming. If a man has nighttime erections, then the cause of the erection problem is likely not a medical one. Nighttime erections are most accurately evaluated by the use of a RigiScan. A RigiScan is a medical device attached to the penis that records erections while a man sleeps.

Also, if a man has good erections when viewing sexy material or masturbating, his sexual problem is not a medical one.

Specific Suggestions

In cases in which the nonmedical factors meet the criteria for a psychiatric diagnosis such as major depressive disorder or obsessive-compulsive disorder, or in cases in which the nonmedical factors are related to relationship issues, the therapist must use his or her clinical judgment to determine which problem to focus on first. Psychiatric disorders or relationship stress can be so intrusive and disruptive that focusing on treating sexual problems can be unproductive. If the therapist does not focus on the sexual problem first then, it should be explained to the patient why the sexual issue is being temporarily put aside.

At this point, the person should have addressed personal, interpersonal, and medical factors contributing to his or her sexual problem. The following treatments will work only if the person has done all of the prior groundwork for mastering sexual problems. Some problems may respond to more than one of the strategies discussed next.

Erection and Orgasmic Problems

The therapeutic strategy of sensate focus is most commonly used for erection problems in men and orgasmic problems in women (Masters & Johnson, 1966). The therapist's role is to help clients understand why this is a worthwhile approach to overcoming sexual problems. Some clients will say that they tried this approach, but it did not work. In most cases, however, the client assumes that sexual intercourse will proceed if everything is functioning. The therapist must point out that sensate focus is a focus on sensations, not function. The reason that previous attempts might not have worked may have been because the client allowed function to be the ultimate goal, even if this was not originally intended. Sensate focus works best when a couple agrees to a prescribed scenario and sticks to it.

Explain to the client that sex works best when an individual is only thinking about sensations, and not the performance. It is a focus on process not outcome. Describe sensate focus as a strategy to help get a person back to focusing on sensation. It is a means to an end, and not the end itself or an indicator of how sex "will be" for a couple.

Talk in detail to the couple about using the sensate focus strategy. The discussion should include the following: at what point in a continuum of behaviors the couple should start the practice; how often and where a couple should practice; how long each session should last (give a range of time from 15 to 30 min); what the goals of the sessions are; and how each session should be initiated, as well as who is responsible for initiating. Explain to clients that the goal of sensate focus is not sexual arousal, although many find the process arousing, but to enjoy the sensations without having to worry about function. In addition, the

sensate focus procedure usually helps couples communicate their sexual needs, because they are encouraged to give positive feedback to each other about what felt good.

The sensate focus strategy begins by explaining to the client or couple that sexual problems are often maintained by focusing too much on performance. What is needed is a focus on sensations or pleasure. The focus on sensations is necessary to break the negative cycle of focusing on performance. To break this cycle, the couple must set aside specific relaxed times when pleasure can be explored without any expectations for performance. Key ingredients for successful sensate focus by a couple usually include an agreed prohibition on intercourse, no matter what degree of arousal occurs; a conceptualization of sex as a menu of behaviors to choose from, not as something that must be "completed" with intercourse; and sex play, erotic massage, and affection as positive sexual exchanges, and not as "teasing" or "misleading" in a negative, hurtful sense. The couple should provide you with descriptions of their practice. You should offer suggestions on how to work through specific problems and explain what the next steps are for the couple. Such suggestions might include how to break down specific behaviors into simpler steps, and when to include intercourse in the sensate focus sessions.

It is helpful to ask couples how they work best. Do they work best just knowing the concept and applying it as needed or, do they work best with very structured and planned sessions? Some couples have very strong opinions about the use of structure when implementing a strategy. It is not unusual to start with one strategy and then switch to another strategy if the first strategy didn't work. This should be discussed a priori with each couple.

Quick Ejaculation

The strategy most helpful to men experiencing premature ejaculation is a combination of providing accurate and realistic information about men's ejaculation and helping a man and his partner focus on pleasure rather than performance. Most men ejaculate within 2–8 min of penetration. Age and time since last ejaculation will affect speed of ejaculation to some degree. Focus on pleasure during intercourse means

to reinforce that the ejaculation should be enjoyed and not cursed, and that after ejaculation, intercourse may continue momentarily to prolong pleasure, rather than abruptly stopping (as is common) upon ejaculation.

You should also discuss the pros and cons of the use of medication as an adjunct to the behavioral approach. Some individuals have very strong opinions of this, so it should be discussed as an option. It is helpful to present this option as a way to improve pleasure rather than treat a disease.

Difficulty Achieving Orgasm

The most common treatment strategy used for treating orgasmic problems in men and women is to decrease performance anxiety while increasing the amount of physical and erotic stimulation. The most important ingredients in treatment include providing clients with a realistic understanding of the orgasmic experience and the normal individual variations. It is also important to explore options with clients that will provide the maximum erotic stimulation in a conducive environment, possibly using vibratory stimulation, a lubricant, or other erotic material. Therapists are again reminded to be cautious not to focus on performance.

Difficulty with Pain and Penetration

Sexual pain and penetration problems must be referred to a physician to screen out possible medical contributions. Once medical factors have been evaluated and dismissed or treated, psychological treatment can begin. The most useful strategy is to encourage a gradual, step-by-step approach to sexual insertion. Teaching relaxation and breaking sexual approach behaviors into discrete, manageable steps are helpful treatment ingredients. It is important to explore with the client the point in sexual activity where comfort ends and discomfort begins. That is the point at which a client starts practice.

Practice may or may not include a partner, depending on availability of a partner and the comfort level of the client. Practice without a partner often includes looking at and touching one's genitals. For women, practice may include gradual insertion of one's finger. Each step a client will practice should be discussed thoroughly in therapy, and practiced by the client in a private, relaxed setting.

Practice with a partner will usually include outlining for couples the specific steps (e.g., touching outside the vagina with finger, but no insertion) to be practiced during a week and emphasizing that the client can stop a practice trial at any time to reduce anxiety. However, trials should be repeated until a step is accomplished with comfort. An entire hierarchy of sexual approach behaviors should be established at the beginning as a guideline for therapy goals.

It is very important for the therapist to understand how difficult it might be for patients to practice self-exploration and self-penetration. Not only are there often strong emotions such as fear or disgust but patients may have very negative cognitions (self-statements) about the practice itself (e.g., "I feel weird and deviant touching myself.") Such negative self-statements must be identified, discussed, and put into an acceptable perspective before practice begins; otherwise, the practice strategy is likely to fail.

There should also be a discussion about the tendency to avoid practice. Practice should be established on a routine basis at a time when a person is most relaxed and not pressured by other demands. The ideal time for many people may be during a morning shower or at night when preparing for bed. Practice should be consistent and on a daily basis for about 15 min per practice session. The patient should attempt to push himself or herself a little more each practice time. Practice usually occurs in gradual steps.

Low Sex Drive

The expression by a client of a sexual desire problem is often confusing. It is important for you to differentiate lack of sexual desire (horniness) from worry about sex. In true sexual desire disorders, there is an

absence of horniness and sexual fantasies. It is also important to determine if there ever was a time that the client felt desire, or if there are currently conditions under which the client feels desire. Clients with a sexual profile in which they never felt sexual desire are extremely difficult to treat. On the other hand, clients who are able to identify past times or current conditions in which sexual desire has been, or is present, are more easily treated. After ruling out medical conditions or specific medications that can affect desire, therapy usually proceeds with identifying currently inhibiting personal or interpersonal factors.

General worry, anxiety, or depression can affect sexual desire. Treating these conditions often restores sexual desire. In some cases, the suggested use of erotic stimulation (e.g., videos, books, magazines, or movies) may have a positive effect on sexual desire. This topic has to be approached cautiously, as does the topic of vibrators, to ensure that individuals or couples are not offended.

Case Vignette

T: How do each of you feel about working more directly on sexual relations? So far, you have worked on improving communication and structuring your time together. This seems to have improved your readiness to address sexual problems.

C: I think the biggest step has been that we don't blame each other anymore. Neither of us had any sexual experience before marriage, and we just expected that everything would work well once we were married.

P: I was never aware of how my upbringing made me so negative about sex. I thought that once I got married, I would feel differently. When my husband approached me for sex on our wedding night, I thought he was an animal. I couldn't believe his change when I couldn't go through with sex. He became angry, and I wondered if I should have gotten married.

C: I thought that she was angry at me for some reason and was trying to punish me. We never discussed it, and each of us was angry.

T: How do you look at that experience now?

C: I tend to judge people quickly without finding out all of the facts. I simply made some assumptions and operated on these assumptions without checking with my wife.

P: I was intimidated by his anger and I just endured sex, but hated it. Now I can see that it is something to enjoy.

T: The next step in our program is to gradually approach sex in a comfortable way, without pressure. It is very important that sex occurs at times that are agreeable to both of you. If there is any discomfort or stress, it is okay to stop. Each of you has to agree to this, and not respond with anger or disappointment. Remember, think of sex as a pleasurable activity that may include a variety of behaviors. You may pick and choose what you want to do, and you can stop at any time. Many couples have the idea that once they start something, they must finish it. This usually means sexual intercourse. This attitude often leads to total avoidance of sex. A person may feel like hugging and kissing, but not want to have intercourse. By agreeing to the procedure I am proposing, you should feel less pressure and may increase the overall amount of physical contact. You will also guarantee that when sexual intercourse does occur, it is mutually desired.

P: I still feel that I would be disappointing my husband if I asked him to stop.

C: I may be disappointed, but it really is okay. I understand things better now, so I'm not going to be a jerk like before.

Clinical Comment

This is a typical exchange between partners who have spent the initial stages of therapy working on improving communication. If therapy had initially focused on their sexual relationship, without first laying the appropriate foundation, it would have failed. The knowledge

and understanding gained from a discussion of each person's sexual development helped remove blame. Improving communication skills is necessary to diffuse the anger present from early sexual conflicts and ongoing struggles over control issues.

Atypical or Problematic Responses

Sometimes, after initial successful progress, couples will run into roadblocks or experience a setback, and readily return to former destructive patterns. Initial success may have led to a false sense of security or expectations that were too high. We have often seen couples who have worked on problems and shown some success. Then they go away on vacation and experience great sex. A return home to face day-to-day stresses may have subsequently interfered with sex, and the couple feels they have failed and are "back to square one." In such cases, it is important to remind the couple of their previous progress and to assure them that all is not lost. A review of the circumstances related to success and failure will help identify elements that contributed to such a varied experience. This can be used therapeutically to reinforce the need for reviewing important principles. This will also set the stage for understanding relapse prevention.

Homework



- ✎ Have the couple read Chapter 11 of the workbook.
- ✎ Instruct the couple to practice the exercises and techniques outlined in the workbook that are specific to their particular sexual problem.

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Chapter 11 *Continuing Progress and Preventing Relapse*

(Corresponds to chapter 12 of the workbook)

There are no materials needed

Outline

- Review any homework assigned in the previous session
- Discuss how to continue progress and avoid roadblocks
- Assign homework

Overview

Individuals and couples sometimes feel an increase in their stress when they begin to work directly on sexual issues. It is important that clients and therapists recognize and address stalled progress as soon as it occurs.

Principle Underlying Treatment

Therapists can help deal with stalling in therapy more effectively if it is identified as a possibility and discussed at the beginning of therapy. The main principle to keep in mind is that sexual dysfunction is an extremely upsetting experience, and treatment deserves the utmost sensitivity to

each client's pain. It is difficult for most clients to admit they have a sexual problem and come to therapy to discuss and work on overcoming it. Stalling is not unusual, and the therapist must create a trusting environment in which clients feel free to talk about the occurrence of stalling.

Main Concept Conveyed to Client

The main concept conveyed to clients is that stalled progress is not a random event. It is important to clearly identify why progress has stalled and work through that issue. Clients should be cautioned that there may be a desire to avoid therapy if a relapse should occur. Rather than avoid therapy, however, clients must understand why the setback occurred and implement strategies to get back on track. Again, clients should be reminded to focus on overall progress and not a temporary setback.

Continuing Progress and Avoiding Roadblocks

In Chapter 12 of the workbook, guidelines are given to help clients identify avoidance and take corrective steps to allow progress to continue. If either partner is avoiding sexual practice, then the reasons must be pinpointed. The most common reason is a lack of confidence or trust in how one's partner is going to respond. This is especially true if there has been a lot of anger and blaming related to sexual problems in the past. In order to practice, partners have to be reassured that it is okay to make mistakes and they will not be criticized. Avoidance is common in couples who have never discussed sex much and have a lot of anger toward each other.

Steps to Overcoming Avoidance

If there is avoidance, clients can take a number of steps in the following areas: commitment, comfort, expectations, and goals.

Commitment

- Mention to your partner that you are concerned that you have not been able to practice consistently.
- Ask your partner to join you in making a better plan to stick to practice.
- Steer away from blame.
- Make sure that practice is convenient for both of you and that both of you are committed.

Comfort

- Ask your partner if he or she is comfortable with what was planned. It is crucial that you are not trying to practice something that seems overwhelming.
- Start with easier steps; most types of practice can be made simpler. For instance, perhaps you had planned to practice hugging and touching your partner but find these too overwhelming. If so, you can simply talk to each other and hold hands, rather than embracing.

Expectations

- Review with your partner the details of practice: time, place, length of practice, and frequency of practice.
- Be aware that you and your partner might differ in what you expect from practice. This can cause problems. For example, each partner may be waiting for the other to take the first steps and to make specific plans.
- Be sure that after your discussion, you both understand and agree on all of the details.

Goals

- Review your goals. What changes do you expect to achieve and how much time do you expect them to take? If you are working with a partner, are your goals the same?
- Recognize that most of the time, lasting change for most sexual problems takes many months of work. However, changes that help to relieve a problem can occur sooner. Just learning about sexual problems and how to deal with them helps many people. Much of the time, relief comes from talking with a sex partner when it leads to support rather than to blame. Prepare yourself for some relief of your problem after you read about it and set out a treatment plan.

Reevaluating Goals and Possible Sources

If clients still cannot make progress, they may need to review their overall goals. Are they realistic for the couple?

Clients may need to review the possible sources of their problem. Have they missed any possible sources? Have they refused to admit certain facts that might be causing the problem? For instance, some couples cannot admit that they are no longer attracted to each other or that they are not in love. They may be confusing other deep feelings for sexual attraction or love. They might feel indebted or obligated. They might really admire or feel very close to their partners. However, these feelings do not necessarily lead to sexual feelings. If a client is not sure about his or her sexual attraction to his or her partner, he or she needs to admit this so it can be worked on directly.

Case Vignette

T: It has been two weeks since we last met. How have things gone for you?

C: Well, we had my mother visit us, and my car battery went dead, and it just seems like we were too busy to do anything.

P: We were awfully busy, and I had to shop and cook because his mother was visiting. It is always very stressful when she visits. She is very critical and everything has to be just right.

T: (To client) How long was your mother's visit?

C: For two days, but it was right on the weekend.

T: Did you discuss practicing the sexual program at some other time?

C: No, we didn't. I think we both got so focused on my mother that we forgot about it.

P: I didn't forget about it, but I felt it was his responsibility to make plans to practice. He always leaves everything up to me. Besides he puts his mother's wishes ahead of mine.

T: (To client) Is there a lot of conflict related to your mother?

P: Shortly after we got married, my husband told me that his mother thought he married beneath himself. He insisted that he loved me, but I always wondered if he really did.

C: I told you I loved you. What more could I say? Just because I do things for my mother doesn't mean I don't love you.

Clinical Comment

This is an example of a situation in which stalling led to a discussion that uncovered a long-standing, unresolved issue. This couple had never thoroughly dealt with the issue of the husband's relationship with his mother or how it affected his wife. Before further progress on the sexual issue (low desire on the part of the partner) could be expected, the couple had to work through their feelings.

It is helpful if, at the end of each therapy session, you ask the client(s) whether any events will be coming up before the next therapy session that will affect practice in any way. Although not all interfering situations can be anticipated, many can be effectively dealt with ahead of time.

Atypical or Problematic Responses

We have dealt with clients who, for one reason or another, have had long periods of time in which their usual sexual partner was not available. Pregnancy and subsequent birth of a child, tours of duty in the service, and long-term business commitments out of the country have all been situations we have encountered that have interrupted ongoing therapy. In such cases, we have outlined progress that has been achieved by the couple, and issues that remain to be dealt with. Whenever possible, we have encouraged reviewing appropriate reading material and, in some cases, worked on individual issues to bridge the gap. Sessions with the available partner alone have sometimes also been helpful to bridge the gap, until a time that the couple could resume therapy together.

Homework



- ✎ Have the couple read Chapter 12 of the workbook and answer the chapter review questions.
- ✎ Instruct each partner to write down his or her goals and the date when he or she thinks those goals can be achieved.
- ✎ Instruct each partner to write down any obstacles to achieving goals.

Chapter 12 *Maintaining Gains and Preventing Relapse*

(Corresponds to chapter 13 of the workbook)

Materials Needed

- Areas of Change and Degrees of Improvement worksheet

Outline

- Review any homework assigned in the previous session
- Discuss relapse prevention
- Assign homework

Overview

At this point, clients have satisfactorily completed the *Enhancing Sexuality* program and therapy is ending. This chapter gives relapse prevention guidelines so couples can maintain therapy gains.

Principles Underlying Treatment

Treatment gains can easily erode without proper planning. Relapse prevention can successfully be achieved by discussing possible future problems and by thoroughly rehearsing effective responses. Reminding clients of all their resources, and reviewing their gains from the beginning of therapy is also helpful.

Main Concept Conveyed to Client

The main concept conveyed to clients is that they have the tools and ability to effectively deal with their sexual problems. Identifying any early warning signs, talking openly with their sexual partner, rereading helpful material, and seeking booster therapy sessions are all within their power.

Relapse Prevention

At this point, clients should have had some positive changes in their sexual problem. Change can be evaluated on a number of levels. To review the areas and the extent of change and progress, have clients look at the Areas of Change and Degrees of Improvement worksheet in the workbook. They should check off the degree of change they believe they have had for each area.

If clients have checked "No Change" for an area, then there are a couple of possible reasons. Perhaps they knew the information before they started this program or perhaps their problem requires more work and time.

If clients checked "Much Improvement" or "Some Improvement" for most areas, then they have made good progress. They can take some specific steps to make sure that they keep making progress and do not slip back.

Identifying Slip-Backs

Clients have gained knowledge about sex and understanding about sexual problems. If they forget some things, a quick review of the first few chapters of the workbook and the Common Sexual Myths handout will remind them of important information.

More likely, progress will slip in terms of sexual behaviors. Areas that might change are:

- how often the client shows affection toward a partner,

- how often the client has sexual contacts with a partner,
- the client's comfort level in approaching sex, and
- the quality of the client's sexual experiences.

Sexual experiences will differ each time; it is the overall picture or pattern of sexual behavior that counts. For each of the four areas of change, clients should set an acceptable range that they can measure. Falling below that range will be a sign of slipping back.

Frequency of Affection

Clients should decide how often affection should occur (e.g., once a day) and the point they should become concerned (e.g., seven straight days without affection). Affection may mean saying a kind word, kissing, hugging, and flirting with one's partner.

Frequency of Sex

Clients should decide how often they would like for sex to occur and the point that they should become concerned. Falling below the set frequency does not mean that clients should become alarmed, but it could be a warning sign.

Comfort Level for Sex

Clients can measure comfort level on a scale from 1 to 10. On the scale, 1 means *very, very uncomfortable*; 5 means *comfortable*; 10 means *very, very comfortable*. For instance, clients might decide that a comfort level for sex at 3 or less than three times in a row calls for a change.

Quality of Sex

Clients can also measure quality of sex, as decided by both partners, on a scale of 1 to 10. Quality should consider emotional and psychological

pleasure and satisfaction as well as physical sensations. As with comfort level, clients can use a similar guideline for deciding when they should become alarmed about the quality of sex.

If clients fall below the expectations that they have set, then it is time to review what might be causing the problem. Most of the time, a major step is just seeing that there is a problem. It can be corrected simply by reviewing the treatment that helped before. When clear expectations that can be measured are set, clients can get back on track before a problem goes on for too long. If clients allow a problem to go on for too long, then they may have a hard time in correcting it. If clients are working with a partner, it is crucial they set their expectations together. Both partners should agree on what is a cause for alarm in each area. They should also keep track of how they are doing by talking. By doing these things, couples can keep from slipping back and can maintain their gains.

Building Structure to Maintain Gains

Relapses occur either slowly or after some major change in a person's life. When a slip occurs slowly over time, most likely a person has become lazy about his or her sex life. A person's sex life needs constant attention for it to stay rewarding and enjoyable. Clients must always be sensitive to their own mental and physical health, as well to the conditions that are best for sex for both partners.

If sex has changed after a major event in the person's life, the person will need to determine what that event has meant to him or her and why it is affecting his or her sex life. Some events, such as having a new baby, will almost always affect one's sex life. Events that bring fatigue, worry, and constant demands on one's time almost always decrease the frequency and quality of sex. When sex has changed because of such an event, it is very important for partners to talk about it. Most likely, couples will have to change their expectations for sex while an event is affecting one or both partners.

Clients should set expectations and a strategy to help them deal with the effects of the event. For instance, in the case of a new baby, couples may

need to change how often they have sex and the kind of sex they have. Adjustments can help to bridge the time when clients are being affected by an event. Remind clients that sex is not an all-or-nothing event; it is a whole range of events.

Case Vignette

T: How do you feel about your sexual relationship at this time?

C: I really feel satisfied with the way everything has gone. In fact, on our ride over here, my husband asked me what we were going to talk about. We both felt that we no longer had problems.

P: I agree. We are both very happy. I can't believe how much we have changed.

T: I'm pleased that you both feel that way and I think we should discuss how to make sure everything stays on track. How would each of you identify if you were slipping back into some of your old patterns?

C: I think the first thing I would notice would be if my husband started withdrawing more, and doing what he used to, like watching TV and not talking to me.

P: I think I would notice if my wife started nagging me more.

T: Certainly, each of you will watch TV and nag at each other in the future, so let's talk about how to more precisely tell if there is a change back to the old ways. Also, we should talk about what to do if you do feel progress has slipped back. (To client) What do you mean by the comment about your husband watching too much TV, and what would you do if you thought that?

C: Before we started therapy, he would watch TV from the time he came home from work until he went to bed. As he said previously, it was his way to unwind from work. Since we have been in therapy, he only watches the news and other programs once in a while. The biggest change is that the TV is not on when we are eating, so we talk a lot more. I think if he started watching TV during dinner, I would

say something. I would remind him that we have a different agreement now.

T: (To partner) How would you respond to that approach?

P: That would be fine, as long as she said it the way she just did. In the past, it sounded like nagging.

Clinical Comment

It is important to help the couple work with meaningful and agreeable criteria. The criteria should be set up as mutual consent between two adults who are working at the same goal. You must be sure that criteria do not come across as blame or faultfinding. We are all subject to slip into old patterns, and it is helpful if each partner reminds the other to stay on track.

Atypical or Problematic Responses

Couples sometimes become so dependent on therapy that there is great insecurity in therapy termination. There is a sense in these couples that all progress will reverse as soon as therapy stops. In such cases, the termination is set up in gradual steps of fading out, with increasing time between sessions. Also, reviewing the progress and resources, and setting up at least one distant therapy session (4–6 months later), is often enough reassurance for couples to terminate with confidence.

Homework



- ✎ Have the couple read Chapter 13 of the workbook and answer the chapter review questions.
- ✎ Instruct each partner to complete the Areas of Change and Degrees of Improvement worksheet in the workbook.

Treating men and women who present with sexual dysfunction problems is usually very rewarding to therapists working with this population. In the majority of cases, clinically significant behavioral changes can be realized using the current therapeutic strategies outlined in this manual. Even in cases that are resistant to behavioral changes, such as those that have been present "life long," accurate information and efforts to increase intimacy rather than specific sexual goals are usually helpful and soothing. Attitudinal changes and a couple's realistic acceptance of their situation, (i.e, their strengths and their weaknesses, their history brought into their relationship, and their living and working environment) may be just as important as actual behavioral changes.

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