EFPT Psychotherapy Guidebook

Sex Therapy

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Brief historic overview

From the beginning of the twentieth century until the late 1960s, sexual dysfunctions were predominately managed within a psychoanalytic framework, as were most psychological problems. Sexual problems were viewed as originating from unresolved conflicts dating back to childhood and as such, symptoms were not addressed directly, and psychotherapy was long-term.

In 1970, Masters and Johnson pioneered the development of a brief treatment method for dealing with sexual dysfunctions which led to the growth of a new area of study and practice that has come to be known as sex therapy. This 'new' therapy was brief, problem focused and directive, and predominately used a behavioural perspective. The couple had to reside within the clinic for a period of 2 or 3 weeks, and this involved isolation from their daily routine, intensive focus on the therapy and a connotation of a holiday. It focused on helping individuals understand how changing their behaviour would lead to changes in how they were feeling. The individual's sexual behaviours which elicit anxiety reactions were replaced by others, prescribed by the therapist, in the form of directive sexual exercises, that resulted in pleasurable sexual experiences.

Later on, Helen Kaplan introduced her version of sex therapy in 1974-1979, which was an eclectic combination of psychodynamic, systemic and behavioural approaches, including pharmacotherapy when needed.

In 1986, the work of Barlow marked a turning point in the conceptualization of sexual dysfunctions. Barlow proposed a model according to which an individual's distracting cognitions interact with negative emotions, such as anxiety, to produce sexual dysfunctions.¹ This marked the beginning of cognitive behavioural therapy for sexual dysfunctions which focuses on helping patients challenge their unrealistic thoughts about sexuality, and at the same time initiating behavioural change that would lead to more sexual satisfaction.

Also, during the 1980s, systemic psychotherapy shifted the focus of sex therapy from the individual to the relationship concluding that a system, such as a couple, is more than the sum of its parts. Relationships have properties that people bring to them, therefore therapy should focus on interpersonal dynamics and patterns of interaction with others in order to effectively treat sexual dysfunctions.

In 1998, after the introduction of phosphodiesterase type 5 (PDE-5) inhibitors and their robust efficacy and safety, some thought that sex therapy, at least for men with erectile dysfunction, would cease to exist. It is known today, however, even in men with erectile dysfunction, that medical and psychological interventions complement each other for a more efficient and long-term treatment of

sexual dysfunctions and sex therapy remains a critical component to the success of the medical intervention.²

Description

Sex therapy is a specialized form of psychotherapy that draws upon an array of technical interventions known to effectively treat male and female sexual dysfunctions.² Today's psychosexual therapy comprises cognitive-behavioural interventions, systems/couple interventions and psychodynamic interventions. These are often combined with medical therapy, thus providing care through a biopsychosocial perspective. The goal of treatment is the restoration of lasting and satisfying sexual function.

Components of an Integrative, Biopsychosocial, Multidimensional Model of Sexual Dysfunction

Biological factors: physiologic dimensions of sexual function: vascular, neurologic, hormonal, and lifestyle

Psychological dimensions: Cognitions: assumptions, beliefs, perceptions, expectancies; Behaviors: actions; Emotions: feelings, for example, confidence; resentments

Relationship dimensions: Identity: relationship cognitions, for example, couple expectations such as autonomy, commitment. Cooperation: Interactions, for example, mutual conflict resolution. Emotional intimacy: relationship feelings, empathy.

Psychosexual skills: cognitive, behavioural, emotional, and interpersonal aspects of love making

Behavioural aspects of sex therapy

Rationale of behavioural interventions

The assumption behind behavioural interventions is that a behaviour that evokes positive emotions and rewards is likely to be repeated, and a behavior that generates negative emotions is likely to be inhibited. In this way, when sexual arousal is associated with negative feelings, it results in the learned inhibition of the sexual response.

Description of behavioral interventions

Behavioural aspects of sex therapy mainly involve two broad types of interventions. One is the prescription of structured behavioural assignments which the patient does alone or with the partner in between sessions. The other, through behavioral experiments, aims to help the patient or couple

identify, analyze and experimentally modify behaviour having a negative influence on sexual encounters.

Cognitive aspects of sex therapy

Rationale of cognitive interventions

The cognitive aspects of sex therapy deal with automatic thoughts which are believed to arise from more enduring cognitive phenomena, such as beliefs. Some of these beliefs are core beliefs, in a sense that they are global, rigid and generalized (e.g. 'I am inadequate'), while other beliefs are more like 'assumptions or rules' (e.g. 'I must always be able to satisfy a woman, or else I'm a failure'). Research work has identified several dysfunctional automatic thoughts and beliefs associated with sexually dysfunctional individuals, as well as thoughts and beliefs related to negative emotions during sexual activity and problematic sexual function. Thoughts, emotions and sexual response work in a synchronous fashion and influence each other, maintaining the sexual dysfunction.

	Automatic Thought Dimensions					
Female	Sexual abuse thoughts	Failure disengagement thoughts	Partner's lack of affection	Sexual passivity and control	Lack of erotic thoughts	Low self body-image thoughts
Male	Failure anticipation thoughts	Erection concern thoughts	Age and body related thoughts	Negative thoughts toward sex	Lack of erotic thoughts	

Table 1. Automatic thoughts and beliefs associated with sexual dysfunction.³

Description of cognitive interventions

Cognitive interventions comprise techniques for bringing more awareness of our thoughts and modifying them when they are not useful. This approach does not involve distorting reality in a positive direction or attempting to believe the unbelievable. Alternately, it uses reason and evidence to replace distorted thought patterns with more accurate, believable and functional ones.⁴

Systemic aspects of sex therapy

Rationale of systemic interventions

Systemic or relational interventions focus on the dynamic interplay between the individuals involved in a sexual relationship. Each partner brings to the sexual interaction a set of experiences embedded in family therapy as well as the larger social system, which influence the meanings each individual

attributes to the behaviour of the other partner(s). In addition, the sexual relationship occurs in the context of the general relationship. Therefore, non-sexual relationship problems may influence sexual functioning. Sexual problems can be simultaneously the cause or the consequence of unsatisfactory relationships.⁵ Lack of communication, low relationship satisfaction, hostility, anger and low levels of affection are only some of the factors that have been found to be associated with sexual dysfunctions.⁶

Description of systemic/couples therapy for sexual dysfunctions

Couples therapy is often integrated in sex therapy and focuses on issues related to the relationship.⁷ However, when a couple has salient relationship problems, these should be the focus before treating the sexual problem. There is a lack of consensus regarding the choice of conceptual framework or intervention strategies for overcoming relationship conflicts in couples with sexual problems. These issues have been approached through various psychotherapeutic perspectives (mainly, systemic, cognitive behavioral or psychodynamic perspectives), and this essential aspect of treatment is often based upon an eclectic array of techniques and interventions.

Psychodynamic aspects of sex therapy

Rationale of psychodynamic interventions

In psychodynamic theory, sexual dysfunction is viewed as a symptom that represents a pathological process in personality development, with deep-rooted conflicts of unconscious fear or fantasies playing a key role.⁸ Several of these unconscious fears have been described: incest, castration, loss of control, sperm loss and others. It's believed they are the result of an incomplete or distorted psychosexual development.

Description of psychodynamic approaches for sexual dysfunctions

The emphasis is not on symptom removal, but on working through conflicts which are believed to have resulted in the symptom. The symbolic content and functional utility of the symptom are, therefore, explored. Other features include examining and reclaiming memories of early childhood experience in relationships, interpreting and working through resistance to change in therapy and attending to the transference and countertransference aspects of the therapeutic relationship. Being a more long-term and expensive therapy compared to other alternatives (e.g. cognitive and systemic methods), it is less used nowadays.

Main Indications

- Desire disorders —lack of sexual desire or interest in sex;
- Arousal disorders —inability to become physically aroused or excited;

- Orgasm disorders —delay or absence of orgasm (climax);
- Pain disorders — pain during intercourse.

Efficacy

Firstly, the literature suggests better long-term outcomes when relationship issues are treated and resolved. A combination of biological and psychological therapy has the potential of significantly advancing the manner in which men, women and couples receive treatment for sexual dysfunctions. Unfortunately, there are few well-designed studies, regarding sex therapy as a whole and the predominant levels of evidence tend to fall between systematic reviews of cohort studies (level 2) to expert opinion without explicit critical appraisal (level 5). There is a great need for large-scale, randomized, controlled studies employing validated outcome measures and long-term follow-up to be conducted. Nonetheless, the current outcome studies do support the importance of psychosexual interventions and new methods continue to be developed.^{9,10} Hopefully, progress will continue in both the clinical and research domain in order for the field of sexual medicine to provide patient-centered care.

Comment from an expert and a famous psychotherapist

“Sex therapy is not a “cookbook” exercise of interventions for each specific disorder. Instead it represents a unique alchemy of patient, couple, and therapist, influenced by “chance events,” client motivation, contextual components, and favorable timing. In short, it’s important to be lucky as well as good”

Sandra R. Leiblum, in “ Principles and Practice of Sex Therapy, 4th Edition (2007)”

“Sex Therapy must be integrative and consider patients’ individual, relational, and cultural specificities when expressing suffering. We should offer a multidisciplinary care, consisting of specialized professionals working together to better understand and answer the patient’s requests. It is not only fundamental the establishment of a relationship of trust through an attitude of acceptance, empathy and respect, but also motivation to change from the patient .”

Joana Florindo, Clinical Psychologist and Sex therapist from Lisbon, Portugal

Comment from a trainee with some kind of experience

“Sex and intimacy are an intricate part of our lives shaping our relationships. My training as a sex therapist helped me feel more comfortable addressing and understanding sexual dysfunction, being specially rewarding helping people regain control of their sexuality.”

Daniel Esteves-Sousa, Psychiatry Trainee, Hospital de Cascais, Portugal

Books, manual, videos, published online courses or international association:

<https://www.youtube.com/watch?v=7gSCGibPg38>

Yitzchak M. Binik, Kathryn S.K. Hall, Joseph L. Wetchler. Principles and Practice of Sex Therapy. The Guilford Press (2014)

Zoë D. Peterson. The Wiley Handbook of Sex Therapy. Wiley Blackwell (2017)

Barry McCarthy. Sex Made Simple Clinical Strategies for Sexual Issues in Therapy. PESI Publishing & Media (2015)

International Societies:

- European Federation of Sexology - <https://www.europeansexology.com/>
- European Society for Sexual Medicine - <https://www.essm.org/>
- International Society for Sexual Medicine - <https://www.issm.info/>
- World Association for Sexual Health - <https://www.worldsexology.org/>

National Societies:

AUSA - Albanian Urologists and Sexologists Association	Albania
AAPAMH - Austrian Association for Promotion of Sexual Medicine and Sexual Health	Austria
OAG - Österreichische andrologische Gesellschaft	Austria
OEASM - Austrian Academy For Sexual Medicine	Austria
BASM - Bulgarian Association for Sexual Medicine	Bulgary
CSSM - Czech Society for Sexual Medicine	Czech Republic
SSSM - Scandinavian Society for Sexual Medicine	Denmark, Norway, Sweden
FSSM - Finnish Society for Sexual Medicine	Finland

<u>AIUS</u> – Association Interdisciplinaire post Universitaire de Sexologie	France
<u>SFMS</u> – Societ� Francophone de Medecine Sexuelle	France
<u>GSSM</u> – Georgian Society for Sexual Medicine	Georgia
<u>DGSMTW</u> – German Society for Sexual Medicine, Sexual Therapy, and Sexual Science	Germany
<u>GASR-DGfS</u> – Deutsche Gesellschaft f�r Sexualforschung (DGfS)	Germany
<u>HUA</u> – Hellenic Urological Association	Greece
HSA-MAT – Hungarian Society of Andrology	Hungary
<u>HSSM</u> – Hungarian Society For Sexual Medicine	Hungary
Society of Sexual Medicine Ireland – Comhlucht Leigheas Gn�asach Na hEireann	Ireland
ILSSM – Israeli Society For Sexual Medicine	Israel
<u>SIA</u> – Societ� Italiana di Andrologia	Italy
<u>SIAMS</u> – Societ� Italiana di Andrologia e Medicina della Sessualit�	Italy
SMD – Sexual Medicine Society of Lithuania	Lithuania
SASHM – Societatea de Andrologie �i S�n�tate Sexual� din Moldova	Moldova
PSSM – Polish Society for Sexual Medicine	Poland
SPA – Sociedade Portuguesa de Andrologia	Portugal
SPSC – Sociedade Portuguesa de Sexologia Cl�nica	Portugal
<u>AMSR</u> – Asociatia pentru Medicina Sexualitatii din Romania	Romania

<u>ASESA</u> – Asociacion Espanola de Andrologia	Spain
SSMS – Society for Sexual Medicine of Slovenia	Slovenia
<u>SSS</u> – Swiss Society of Sexology	Switzerland
<u>NVVS</u> – Dutch Scientific Society for Sexology	The Netherlands
<u>SUS</u> – Society of Urological Surgery	Turkey
TAD – Turkish Society of Andrology	Turkey
<u>UAASM</u> – Ukranian Association of Andrology and Sexual Medicine	Ukraine
UASA – Ukranian Association of Sexologists and Andrologists	Ukraine
<u>BSSM</u> – British Society for Sexual Medicine	United Kingdom

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- 2 Althof S. What's new in sex therapy. J Sex Med 2010;7(1):5-13.
- 3 Nobre PJ, Pinto-Gouveia J. Cognitions, emotions, and sexual response: analysis of the relationship among automatic thoughts, emotional responses, and sexual arousal. Arch Sex Behav. 2008 Aug;37(4):652-61.
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10 Montorsi F, Adaikan G, Becher E, et al. Summary of the recommendations on sexual dysfunctions in men. *J Sex Med* 2010;7(11):3572-3588.