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Topics in Human Sexuality: Sexual Disorders and Sex Therapy

Introduction

Sexual disorders, such as erectile disorder in men, and orgasmic disorder in women, cause much psychological stress, both to the person with the disorder and to his or her partner. These disorders are also a primary reason that couples seek counseling. Although these disorders have been around for quite some time, psychological understanding of sexual disorders is relatively new. As with much of psychology, clinicians used Freud's theories to explain sexual behavior. Sexual disorders were seen as pathological in nature and there was little distinction between difficulties in function and sexual "perversions."

This changed in the 1970s with the publication of Masters and Johnson's *Human Sexual Inadequacy*. Unlike prior explanations of sexuality, which were based on theory, Masters and Johnson studied the psychology and physiology of sexual behavior in a laboratory. They also recorded physiological data from the sex organs during sexual excitation, and framed their findings using language that described sex as a healthy and natural activity that was also source of pleasure and intimacy. Their work is pivotal to our understanding of sexuality and sexual disorders. Many of our cognitive behavioral treatments and techniques extend from this body of work.

This training material will define the term "sexual disorder," and will discuss various kinds of sexual disorders. It will examine the physical and psychological causes of sexual disorders and will discuss therapies for sexual disorders.

Educational Objectives

1. Define the term "sexual disorder"
2. List the characteristics of male erectile disorder
3. Define Premature/Early Ejaculation, including proposed DSM V changes and use of the squeeze technique
4. Describe Male Orgasmic Disorder, and list causes and treatment
5. Describe Female Orgasmic Disorder, and list causes
6. Define Female Sexual Arousal Disorder, state common causes of the disorder, and describe treatment alternatives
7. List symptoms and causes of dyspareunia
8. List symptoms and causes of vaginismus
9. Discuss sexual desire disorders
10. Discuss commonly used approaches to sex therapy

Defining Sexual Disorders

A sexual disorder (or sexual dysfunction) is a problem with sexual response that causes a person psychological distress. Sexual dysfunction generally refers to a difficulty experienced during any stage of a normal sexual activity as described below.

These stages of normal sexual activity are:

- Desire: Desire to participate in sexual activity, including fantasies about sexual activity
- Excitement phase (initial arousal): Combines the psychological sense of sexual pleasure as well as physiological changes, in men, erections, and in women, vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitals
- Orgasm: Peak of sexual activity.
- Resolution phase (after orgasm): Sense of muscular relaxation and well-being. Males have a refractory period during which further erection and orgasm is not possible. Women are capable of additional stimulation and multiple orgasm.

Sexual disorder, then, involves difficulties with desire, arousal and orgasm, and in women also include sexual pain disorders (dyspareunia, vaginismus). In looking at these examples, it follows that there is a continuum; many people experience problems like this from time to time, and part of the difficulty is in determining when a problem is considered a disorder. Some factors to consider in making a judgment as to whether a disorder is problematic is the age and experience level of the person, the frequency and chronicity of symptoms, and effect on overall functioning. Another important factor in assessing sexual disorders is the determination of whether such a disorder is purely physical or whether there are psychological factors. There may also be a combination of the two.

Male Erectile Disorder

Case Vignette
Laura and John had been in couples counseling for a number of sessions when they began to open up about recent sexual activities. The couple had been married for 9 years, and had a satisfactory sexual relationship to this point. Recently, however, John and begun to experience difficulty sustaining an erection. Laura felt devastated, and as if she was unattractive.

One of the most psychologically distressing male disorders is erectile disorder. Erectile disorder is the persistent or recurrent inability to attain, or to maintain

until completion of the sexual activity, an adequate erection. Most men experience transient episodes of erectile disorder that are temporary and usually associated with fatigue, anger, depression or stressful emotions.

Basically, an erection occurs when blood fills the penis. Erections begin with a sexual signal or stimulus such as a partner's touch, erotic visuals, sexual sounds, certain smells, fantasies or other stimuli. During arousal, the blood vessels of the penis dilate, and muscles around the penis relax, allowing for an increase in blood flow and resultant penile erection. Erectile disorder can occur at any stage during this process.

There are varying patterns of erectile disorder. Men with erectile disorder may report the inability to experience any erection from the beginning of a sexual experience, while others experience an erection that is not maintained at penetration. Other men may lose the erection during sexual intercourse, and others can only experience erection upon awakening or during self-masturbation. There are a number of causes of erectile dysfunction including drugs and alcohol, age, fatigue, certain medications, medical problems (diabetes, cardiovascular disorders) and psychological factors (stress, anxiety).

Men with erectile dysfunction should be evaluated medically to determine any physiological factors in erection problems. Sometimes erectile problems can be addressed through lifestyle changes, or the use of Kegel exercises strengthen the pelvic floor, which can lead to stronger erections and enhanced ejaculatory control or through medications such as Viagra, Cialis or Levitra.

Premature Ejaculation

Premature ejaculation is defined as persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Premature ejaculation is also known as *rapid ejaculation*, *rapid climax*, *premature climax*, or *early ejaculation.* When assessing for the presence of premature ejaculation the clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity. Thus, both psychological and biological factors can play a role in premature ejaculation.

Premature ejaculation is a common sexual complaint. Estimates vary, but as many as 1 out of 3 men may be affected by this problem at some time. There are a number of subtypes of this disorder, including lifelong/acquired type, and generalized/situational type.

Although we know that premature ejaculation is relatively common, one of the difficulties in establishing accurate prevalence statistics is the absence of an agreed

upon definition of what timeframes constitute premature ejaculation (Beutel, 2006). The DSM V Workgroup has looked at these issues, and proposed the following criteria for Early Ejaculation (previously called Premature Ejaculation):

A. The symptom must have been present for at least 6 months and be experienced on all or almost all (approximately 75%) occasions of sexual activity: Persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute of beginning of sexual activity and before the person wishes it.
B. The problem causes clinically significant distress or impairment.
C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due to the effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Another interesting change proposed for the DSM V is the attempt to specify the possible causes of the disorder. Although physiological factors are represented here (e.g., medical conditions) the majority of potential causal factors are psychological. These specifiers include:

1) With concomitant problems in sexual interest/sexual arousal
2) Partner factors (partner's sexual problems, partner's health status)
3) Relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity)
4) Individual vulnerability factors (e.g., poor body image, history of abuse experience) or psychiatric comorbidity (e.g., depression or anxiety)
5) Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity)
6) With medical factors relevant to prognosis, course, or treatment

There are a number of potential treatment options for Premature Ejaculation. These include Cognitive Behavioral Therapy, Medications (antidepressants and topical anesthetic creams). The most common treatment, however, is known as The Squeeze Technique (Mayo Clinic, n.d.):

1. The couple begins sexual activity as usual, including stimulation of the penis, until the male with early ejaculation feels the urge to ejaculate.
2. Partner squeezes the end of his penis, at the point where the head joins the shaft, and maintain the squeeze for several seconds, until the urge to ejaculate passes.
3. After the squeeze is released, the couple is instructed to wait for about 30 seconds, then go back to foreplay.
4. Repeat the squeeze process.

By repeating this process as necessary, the male can generally engage in sexual intercourse without ejaculating prematurely. After a few practice sessions, the problem generally remits.

Male Orgasmic Disorder (Retarded Ejaculation)

Male orgasmic disorder involves persistent or recurrent inability to achieve orgasm despite lengthy sexual contact or while participating in sexual intercourse. The affected man may regularly experience delays in orgasm, or may be unable to experience orgasm altogether. As with Early Ejaculation, Male Orgasmic Disorder may be lifelong/acquired or generalized/situational.

Male orgasmic disorder is found in all races and ethnic groups. The lifelong type of the disorder generally occurs around puberty. In the acquired type of male orgasmic disorder, the person will have had the previous experience of normal sexual function. In these cases, a situational factor generally precipitates the disorder (causes will be discussed below). Male orgasmic disorder is relatively rare, with prevalence studies of male orgasmic disorder placed at about 0 - 3% of the population (Simons & Carey, 2001).

Male Orgasm

To better define male orgasmic disorder, it is important to review male orgasm. Orgasm in the male includes emission followed by ejaculation. *Emission* refers to a sensation of approaching ejaculation produced by contractions of the prostate gland, seminal vesicles, and urethra. This is accompanied by muscular tension, perineal contractions, and pelvic thrusting. Following orgasm, there is a period of resolution characterized by feelings of well-being and muscular relaxation.

Causes of Male Orgasmic Disorder

The cause of male orgasmic disorders may be organic or psychological.

Organic causes:

- Use of antidepressant medications, especially SSRIs
- Substance abuse
- Thyroid disorders (both hyperthyroidism and hypothyroidism)
- Pituitary conditions (such as Cushing's syndrome)
- Hypogonadism, in which the testes do not produce enough testosterone.
- Diseases that affect the nervous system, such as strokes, multiple sclerosis, diabetic neuropathy and spinal cord injuries
- Surgery affecting the prostate and other pelvic organs

Psychological causes:

- Depression
- Feelings of guilt, anger, fear, low self-esteem, and anxiety
- Fear of getting partner pregnant or of contracting a sexually transmitted disease
- Severe stress
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma
- Having been raised in atmosphere of strict sexual taboos

Treatment

The most common cases of male orgasmic disorder are related to use of SSRIs. The course of action here is to try another medication or to try another medication as an antidote to the SSRI.

For male orgasmic disorder that is unrelated to SSRIs, standard treatment for inhibited orgasm involves eliminating performance anxiety and ensuring adequate levels of physical stimulation. Similar to the squeeze technique, the couple is instructed to caress the penis manually or orally until erection is attained, but told to cease stimulation when arousal approaches the point of orgasm. This reduces performance anxiety and allows the man to enjoy the sexual pleasure provided by touching. The eventual goal is to allow the man to reach orgasm.

Female Orgasmic Disorder

Female Orgasmic Disorder is the persistent or recurrent inability of a woman to have an orgasm after adequate sexual arousal and sexual stimulation. Inability to have an orgasm, discontent with the quality of orgasms, and the ability to have orgasms only with one type of stimulation are common sexual complaints among women. Some studies have found that about half of all women experience some orgasmic difficulties, but not of all these difficulties are considered Female Orgasmic Disorder. About 50% of women experience orgasm through direct clitoral stimulation but not during intercourse, thus not meeting the criteria for a diagnosis of Female Orgasmic Disorder. About 10% of women never experience an orgasm, regardless of the situation or stimulation.

Female Sexual Response and Orgasm

In order to better understand Female Orgasmic Disorder, it is helpful to review the physiological process of female orgasm. When a woman is sexually excited, the blood vessels in the pelvic area expand, allowing more blood to flow to the genitals. This is followed by a surge of fluid into the vagina, which provides lubrication before and during intercourse. These events are called the "lubrication-swelling response."

Body tension and blood flow to the pelvic area continue to build as a woman receives more sexual stimulation; this occurs either by direct pressure on the clitoris or as pressure on the walls of the vagina and cervix. This tension builds as blood flow increases. When tension is released, pleasurable rhythmic contractions of the uterus and vagina occur; this release is called an "orgasm." The contractions carry blood away from the genital area and back into general circulation.

It is normal for orgasms to vary in intensity, length, and number of contractions from woman to woman, as well as in a single individual from experience to experience. Unlike men, woman can have multiple orgasms in a short period of time. Mature women, who may be more sexually experienced than younger women, may find it easier to have orgasms than adolescents or the sexually inexperienced.
In orgasmic disorder, sexual arousal and lubrication occur. Body tension builds, but the woman is unable or has extreme difficulty reaching climax and releasing the tension. This inability can lead to frustration and unfulfilling sexual experiences for both partners.

The most effective form of therapy for female orgasmic disorder is a program of directed masturbation, which is used to maximize familiarity with pleasurable sensations. Use of erotic materials (videos, books) or vibrators. Many therapists also encourage erotic or nonerotic fantasy.

Kegel exercises (contraction of the pelvic floor) may also be used to strengthen vaginal muscles that have been stretched through childbirth. Kegel exercises also help to increased muscle tone, improve orgasmic intensity, correct of orgasmic urine leakage, provide distraction during intercourse and improve awareness of sexual response.

Female Sexual Arousal Disorder

Case Vignette
Maria and Jose had been married for 12 years. They had recently started to argue about sexual difficulties in the marriage. Since Maria had started the "change," she was no longer was easily aroused sexually. Although the couple would attempt to proceed with intercourse, it was uncomfortable, and Maria was increasingly avoiding sexual intimacy.

Female Sexual Arousal Disorder is a characterized by a persistent or recurrent inability to attain sexual arousal or to maintain arousal until the completion of a sexual activity, or an adequate lubrication-swelling response that otherwise is present during arousal and sexual activity. As the name and characteristics suggest, this disorder is specific to the physiological desire component of sexual activity, not in a loss of interest in sexual activity. Subtypes of this disorder include lifelong/acquired and generalized/situational.

Prevalence statistics for Female Sexual Arousal Disorder vary widely, with some sources reporting a lifetime prevalence of 5-10% of adult females, and some reporting up to 20% of adult females.

Causes of Female Sexual Arousal Disorder may be either physical or psychological. These include:

Physical causes

- Surgical procedures such as a hysterectomy may affect changes in blood flow, which can cause a lack of sensitivity and sexual arousal
- Decrease in estrogen levels associated with menopause may make the vagina dry and thin, even causing it to shrink
- Medications such as oral contraceptives, antihypertensives and antidepressants, benzodiazepenes
- Chronic diseases such as diabetes; vascular disease associated with diabetes
- Surgical trauma or nerve damage to the pubic area

Psychological Causes

- Depression, stress
- Poor body image
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma
- Having been raised in atmosphere of strict sexual taboos

Dyspareunia

Dyspareunia refers to pain experienced during intercourse. It is a general term used to describe all types of sexual pain. Sexual pain may occur upon penetration, during intercourse, and/or following intercourse. It can exist anywhere in the genital area – the clitoris, labia, or vagina, etc. While dyspareunia is generally though to be a female disorder, men can experience pain during intercourse.

Glatt et al., (1990) conducted a prevalence study of dyspareunia in women. They surveyed 428 women. 39.0% of those surveyed had never had dyspareunia; 27.5% had had dyspareunia at some point in their lives which resolved, either spontaneously or with specific treatment. Frequency of intercourse was not different among any of the groups analyzed, although 48.0% of the women reported a decrease in sexual frequency and 33.7% reported an important adverse effect on their relationships as a result of dyspareunia. Most of the women had not discussed their dyspareunia with a doctor and were unaware of the cause of their problem.

There are a number of possible causes of dydpareunia. These include:

Physical causes

- Insufficient lubrication
- Injury, trauma or irritation. Includes injury from pelvic surgery, episiotomy or a congenital abnormality.
- Inflammation, infection or skin disorder
- Reactions to birth control products. Allergic reactions to foams, jellies or latex or an improperly fitted diaphragm or cervical cap.
- Vaginusmus (see below)
- llnesses. Including endometriosis, pelvic inflammatory disease, uterine fibroids, cystitis, irritable bowel syndrome, hemorrhoids and ovarian cysts.
- Infections. An infection of the cervix, uterus or fallopian tubes.

Psychological causes

- Depression, stress
- Unsatisfactory relationship with sexual partner
- Past history of sexual trauma

A personal lubricant can make sex more comfortable. It is also important to treat underlying physical conditions. For postmenopausal women, dyspareunia is often caused by inadequate lubrication resulting from low estrogen levels, and can be treated with a prescription cream or oral medication.

Vaginismus

Vaginismus is a condition where there is involuntary tightness of the vagina during attempted intercourse. The tightness is actually caused by involuntary contractions of the pelvic floor muscles surrounding the vagina. In some cases vaginismus is so severe that the woman cannot have intercourse (Reissing et al., 2003/2004).

Vaginismus is not a common disorder in the general population, but it is common among couples seeking therapy, accounting for 12 to 17 percent of cases (Spector & Carey, 1990).

Physical Causes

- Medical conditions- including urinary tract infections or urination problems, yeast infections, sexually transmitted disease, endometriosis, genital or pelvic tumors, cysts, cancer, pelvic inflammatory disease
- Pain related to childbirth
- Age-related changes - Menopause and hormonal changes, vaginal dryness/inadequate lubrication

Psychological causes

- Fear - Fear or anticipation of intercourse pain, fear of not being completely physically healed following pelvic trauma, fear of getting pregnant, concern that a pelvic medical problem may reoccur, etc.
- Anxiety or stress
- Partner issues
- Traumatic events

Sometimes there is no identifiable cause (physical or non-physical)

Sexual Desire Disorders

Case Vignette
Mariah and John presented for couples counseling shortly after their son's first birthday. John was angry, stating that Mariah had been rejecting him since the baby's birth. The baby slept in bed with them, and Mariah always had an "excuse" as to why she did not want to be sexually intimate.

Inhibited sexual desire (sexual aversion, sexual apathy or hypoactive sexual desire) is characterized by a low level of sexual interest resulting in a failure to initiate or respond to sexual intimacy. Inhibited sexual desire may be a primary or secondary condition. Inhibited sexual desire may also be specific to the partner, or it may be a general attitude toward any potential partner.

A diagnosis of hypoactive sexual desire disorder refers to a persistent or recurring lack of desire or an absence of sexual fantasies. In hypoactive sexual disorder, sexual performance may be adequate once activity has been initiated. This disorder occurs in approximately 20 percent of the population and is more common in women, though it does affect both men and women.

Sexual aversion disorder refers to a condition in which sexual contact is repulsive. This disorder occurs less frequently than hypoactive sexual desire.

Sexual desire disorders are related to both physical and psychological causes. Many of these causes are similar to other sexual disorders discussed previously and include:

Physical causes

- Physical causes resulting in fatigue, pain, or general feelings of malaise
- Some medications, such as antidepressants
- Hormonal changes
- Insomnia, which can result in fatigue

Psychological causes

- Relationship or communication problems
- Relationships lacking in emotional intimacy
- Lack of affection between partners
- Power struggles
- Lack of one-on-one time for partners to be alone together
- A very restrictive upbringing concerning sex, or negative or traumatic sexual experiences
- Depression or excessive stress
- History of childhood sexual abuse and persons

Therapies for Sexual Disorders

Any therapeutic intervention for sexual disorders begins with an assessment of what underlies the condition. In the case of a psychological cause, therapy is indicated.

Behavior Therapy

The premise of behavior therapy is that sexual problems are the result of prior learning and that they are maintained by ongoing reinforcements and punishments. A key technique is systematic desensitization in which the client is led through exercises to reduce anxiety.

Master's and Johnson (1970) utilize a behavior therapy approach in many of the interventions they developed. A premise of their work is that anxiety is related to goal-oriented sexual performance. Spectatoring involves a person focusing on him or herself from a third person perspective during sexual activity, rather than focusing on one's sensations and/or sexual partner, can increase performance fears and cause deleterious effects on sexual performance.

Sensate focus exercises are aimed at increasing personal and interpersonal awareness of self and the other's needs. Each participant is encouraged to focus on his or her own senses rather that to view orgasm as the sole goal of sex.

Education is another important component of behavior therapy. Topics include information about normal anatomy, sexual function, normal changes of aging, pregnancy and menopause among others.

Cognitive-Behavioral Therapy

Many sex therapists use a combination of the behavioral techniques pioneered by Masters and Johnson (1970) and cognitive-behavioral therapy. Cognitive behavioral therapy is a therapeutic process that attempts to change feelings and actions by

modifying or altering faulty thought patterns or destructive self-verbalizations."(Goldenberg & Goldenberg, 1991) Cognitive restructuring is particularly appropriate in situations in which negative attitudes towards sexuality contribute to sexual dysfunction.

Couples Therapy

The goal of couple's therapy is to address interpersonal issues in the relationship. Common interpersonal conflicts include relationship conflicts; extra-marital affairs; current physical, verbal or sexual abuse; sexual libido; desire or practices different from partner; poor sexual communication. In couples therapy, partners focus on resolving relationship issues, resolving conflicts and enhancing the relationship. Communication is also a key aspect of couples counseling. Communication training helps couples learn how to talk to one another, demonstrate empathy, resolve differences with respect for each other's feelings, express anger in a positive way, and demonstrate affection. Couples are also helped to learn to reserve time for activities together.

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