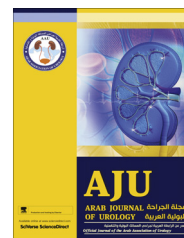




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REVIEW

# Psychological and interpersonal dimensions of sexual function and dysfunction



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## KEYWORDS

Sex therapy;  
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Plissit model;  
Satisfaction

## ABBREVIATIONS

HSDD, hypoactive sexual-desire disorder;  
ED, erectile dysfunction;  
PE, premature ejaculation;  
(I)CBT, (Internet-delivered) cognitive behavioural therapy

**Abstract Introduction:** Sex therapy techniques comprise behavioural and cognitive as well as psychodynamic and educational interventions, like reading ('bibliotherapy'), videotapes and illustrations of anatomical models. Contemporary approaches focus on desire, pleasure and satisfaction.

**Discussion:** It is important to assess medical and biological factors involved in the genesis of sexual dysfunctions. Sex therapy techniques were developed by Masters and Johnson, and their premise was to eliminate 'performance anxiety' by emphasizing the undemanding nature of the sexual relation. New methods were introduced, like Internet-administered techniques, and 'mindfulness therapy', and they proved to be effective.

**Conclusions:** Psychological treatments have some relieving effects on sexual dysfunction, but for studies of the outcomes it is difficult to meet the requirements of evidence-based medicine.

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## Introduction

It is obvious to most sexual therapists that psychological and interpersonal factors are important in both the causes and maintenance of sexual problems. In this article I review the most significant psychological treatments for sexual dysfunction, i.e., sex therapy. I will also include a review of the efficacy of these interventions.

## Sex therapy

Sex therapy is a specialised form of psychotherapy that draws upon an array of technical interventions known to effectively treat male and female sexual dysfunctions. Sex therapy can be conducted in an individual, couple or group format, depending upon the initial problem and the motivation of both partners.

Traditional approaches to sex therapy concentrate on intercourse and orgasm, a method that reinforces the unhelpful perspective of sexual-goal orientations that might underlie the sexual problem [1]. Tepper [2] theorised that these approaches do nothing more than to reinforce the misguided value that is best to have sexuality in the 'normal' way.

More contemporary approaches focus on desire, pleasure and satisfaction, to bring attention to the best sexual experience outside of how it is done. Contemporary understanding purports that the undoing of sexual dysfunction through sex therapy involves much more than the returning of malfunctioning genitalia to working order.

Sexual therapy techniques comprise behavioural and cognitive interventions, as well as psychodynamic systems, relationship and educational interventions like reading, bibliotherapy, videotapes and illustrations of anatomical models.

Before deciding on the type of sex therapy, it is important to examine the patient's or couple's sexual history, current sexual practices, relationship quality and history, past sexual trauma, and to assess all of the relevant medical and biological factors that might be contributing to the development or maintenance of the current problem.

## Psychological treatment of sexual dysfunctions

This form of therapy originated from the ground breaking contribution of Masters and Johnson [3]. Their basic treatment elements included an emphasis on 'sensate focus exercises' and the elimination of performance anxiety.

To eliminate performance anxiety, Masters and Johnson emphasised the undemanding nature of the sensual exchange. Later modifications of their treatment format were introduced. Couples did well when seen weekly and by one therapist.

One method that the present author uses is termed PLISSIT [4], and it can be used for males and females with sexual dysfunctions. It shows that not all sexual dysfunctions need intensive therapy. It is possible to tailor therapy to the needs of the patients. Below is a description of this method.

## The PLISSIT model of sex therapy

Many years ago, the American psychologist Jack Annon developed a simple model illustrating that most people

with sexual problems do not need an intensive course of therapy [4]. He used the acronym PLISSIT for the four basic forms of sexual therapy:

'P' stands for Permission, as many sexual problems are caused by anxiety, guilt feelings or inhibitions. It follows that a therapist who, using his or her professional authority, simply 'gives permission' to do what the patient is already doing, can alleviate much unnecessary suffering (e.g., guilt feelings and anxiety because of masturbation).

The next step of the therapeutic intervention is called 'LI' or 'Limited Information'. Often it is enough to give the patients the correct anatomical and physiological information to restore their sexual functioning. It is not uncommon that a patient has erroneous notions about the functioning of their body and thus fall victim to unrealistic expectations (e.g., a 'real man' can sustain intravaginal intercourse for half an hour before ejaculation). In this step, bibliotherapy, i.e., giving books on sexuality to the patient to read, has produced successful outcomes.

The next step is 'SS', 'Specific Suggestions' and requires practical hints of exercises tailored to each case. Many of the exercises of mutual pleasuring recommended by Masters and Johnson belong to this category. These exercises include 'sensate focus', and 'stop and start'.

Only the last step, 'IT' or 'Intensive Therapy', requires a long-term intervention addressing the complex underlying causes. This therapy addresses issues of intrapsychic conflicts and couple issues.

## The psychological treatment of male sexual dysfunction

### *Disorders of sexual desire*

There are no reports solely on the psychological treatment of men presenting with hypoactive sexual-desire disorder (HSDD). Using the PLISSIT model described above, it might be necessary to offer intensive therapy in these cases, especially if there are issues related to masculinity, gender and sexual orientation.

### *Erectile dysfunction (ED)*

The cause of ED is multifactorial, i.e., it has both psychological and biological components. From a psychological perspective ED could also be caused or worsened by intrusive negative thoughts, increased self-focus and feeling tense. ED has been associated with depression, anxiety, low self-esteem, decrease in quality of life [5], relationship dysfunction [6], social and work relationships, as well as loss of affection and sexual alienation [7].

### *The psychotherapy of ED*

Men with lifelong acquired ED typically have significant gains, both initially and in the long term, after being

treated with sex therapy, although men with acquired ED generally have a better outcome than those with life-long problems. In a review of the studies of treatment for ED, Mohr and Bentler [8] wrote: *'The component part of this treatment typically includes behavioural, cognitive, systemic and interpersonal communication interventions. It appears that approximately two-thirds of men suffering from [ED] will be satisfied with their improvement at follow-up from 6 months to 6 years.'* These studies used either a couple or a group form of therapy.

There are various interventions using sex therapy for ED, e.g., systematic desensitisation, sensate focus, interpersonal therapy, behavioural assignments, sex education, communication and sexual skills training, and masturbation exercises.

All forms of intervention were equally effective in producing a sustained change. Wylie [9] used a combined package of modified sex therapy and behavioural systems as 'couple therapy', and 87% of men had an improvement in their sexual symptoms with six sessions of treatment.

Internet-administered treatments normally consist of a package of comprehensive self-help material and exercises used weekly [10]. Administration of psychological treatments via the Internet is believed to be cost-effective [11]. Another benefit of this treatment approach is that patients, who experience shame because of their problem, might have the opportunity to work with their problem in their home environment [12].

Studies showed that Internet-delivered cognitive behavioural therapy (ICBT) for ED was better than a waiting-list control group [13]. In a more recent study [10] using ICBT, the treatment group had significantly greater improvements in erectile performance than the control group. This study provides support for the use of ICBT format for ED.

All studies with a long-term follow-up noted a tendency for men to relapse. To prevent relapse, MacCarthy and MacCarthy [1] suggested that therapists should schedule periodic 'booster maintenance' sessions after terminating the original therapy.

### **Psychotherapy for premature ejaculation (PE)**

Therapy approaches using strategies such as 'stop-start' or the 'squeeze' technique have been used to treat PE. Most studies that included a long-term follow-up have documented reduced rates of PE after therapy. However, Hawton et al. [14] reported that only 64% of men were successful in overcoming PE. This limited success of psychotherapy for PE reinforces the popular belief that the cause of PE is organic [15]. Psychotherapy would still be indicated for more complex situations that involve relationship and communication difficulties.

Although there are psychological issues in most patients with PE, as a cause or as a consequence, research on the effect of psychological approaches to PE has generally not been controlled or randomised, and lacks a long-term follow-up.

In a recent article [16], the authors wrote: 'Overall there is weak and inconsistent evidence regarding the effectiveness of psychological interventions for therapy of premature ejaculation. The early success (97.8%) of Masters and Johnson could not be replicated.' Most of the studies reported had a small sample. Randomised trials with larger samples are required to confirm or refute the current available evidence for psychological interventions in treating PE.

Sex therapy that places a focus on genital function in men might significantly impair future sexual functioning, by overlooking the pressured beliefs, myths and misconceptions that might maintain the dysfunction.

Performance-focused physicians could be missing the underlying fear and distress about interpersonal sexuality that is implied in treatment approaches for ED, so a focus on distress components (in addition to performance components) might give better treatment outcomes.

### **Female sexual functioning**

Research show that female sexual functioning can be impaired by cognitive distractions of both a sexual and nonsexual nature. Concerns about physical appearance have a negative influence on sexual function in women. Changes in the appearance of the body have been linked to changes in the sexual response, e.g. female patients who have undergone surgery that alter their body showed decreased sexual arousal and interest after surgery.

### **The psychological treatment of female sexual dysfunction**

Female sexual complaints range from a lack of, or diminished, sexual desire or interest, to pain during both genital and nongenital sexual activities. They also report sexual dissatisfaction that does not involve actual physical impairment.

#### *The treatment of sexual desire disorders*

There is little agreement about what constitutes 'normal desire' in women of various ages. Consequently, there is little agreement as to what constitutes a sexual desire disorder. A generalised and chronic lack of desire is more resistant to interventions and suggests that there are different causes.

The efficacy of CBT for women with HSDD was reported in two studies. McCabe [17] found that of the 43% of women complaining of HSDD and who had

10 sessions of CBT, 54% had the same complaint after treatment. The programme included interventions designed to enhance communication between the partners, increase sexual skills, and reduce sexual and performance anxiety.

Trudel et al. [18] compared CBT interventions specifically devised to address the desire disorders, with control conditions, and only 26% of the women with HSDD continued to report this problem after this treatment. CBT resulted in a significant improvement over that in the control group in the quality of sexual and marital life, sexual satisfaction, perception of sexual arousal, sexual self-esteem, and there was less depression and anxiety.

### Sexual arousal disorder

There are no published outcome studies focusing on the psychological treatment of female sexual arousal disorders. The emphasis has focused on studying women with physiological or genital arousal complaints, although there is a growing recognition that the largest category of complaints centre on the lack of subjective rather than physical arousal.

### Orgasmic disorders

Clinically it is known that women experience orgasm only 40–80% of the time, regardless of the method of stimulation. The overlap between difficulties of arousal and orgasm in women further complicate the differential diagnosis. Directed masturbation training is most effective for life-long general orgasmic problems [19]. The same authors concluded that after 6–14 sessions with direct masturbation, directed masturbation alone was better than systematic desensitisation, and directed masturbation with a sensate focus was more effective than sensate focus alone. Most treatment programmes for acquired female orgasm problems include a combination of sex education, sexual skills training, couples therapy, masturbation and undemanding touching exercises, as well as intervention to address orgasmic disorders, body image concerns and negative sexual attitudes.

The coital alignment technique was developed specifically to treat female orgasmic disorder [20]. In general, the treatment of coital anorgasmia typically involves directive cognitive-behavioural interventions and sensate focus, with both the woman alone and with her partner. The outcome included a significant improvement in various ratings of sexual and marital satisfaction, but an insignificant increase from 12% to 13% in orgasmic ability with manual stimulation, and a modest increase from 12% to 30% in orgasm during intercourse.

### The treatment of sexual pain disorders: dyspareunia and vaginismus

The treatment of dyspareunia ideally requires a multidisciplinary approach involving a physician, a pelvic massage therapist and a psychotherapist. Treatment focuses on learning techniques to reduce or cope with the pain, as well as dealing with catastrophic thoughts, anticipation of pain and avoidance of all sexual exchange. Biofeedback, vaginal and/or pelvic massage, sensuality exercises and relaxation techniques have all been tried, with varying degrees of success. Education about vulvodynia in general and vulvar vestibulitis in particular has been helpful, as has cognitive restructuring and sex therapy with both partners [21].

#### *Vaginismus*

This is usually treated through a combination of relaxation exercises and *in vivo* graduated self-insertion of dilators of increasing size. (This method may be difficult to implement with Arab women). It is the most common cause of unconsummated marriages in females. Recent investigations have noted somewhat less positive outcomes, although most studies concur in finding behavioural desensitisation to be ultimately successful with motivated women [22].

### The effectiveness of an Internet-based psychological treatment programme for female sexual dysfunction

More recent studies in this area investigated the usefulness of treatments developed from the perspective of CBT, e.g., [23]. That study reported the effectiveness of a short-term CBT programme for female sexual dysfunction which incorporated sensate focus and communications exercises to target maladaptive cognition, increase sexual skills, enhance communication between partners, and decrease sexual anxiety. After completing the CBT programme, 44% of women no longer met the criteria for a diagnosis of female sexual dysfunction.

### Mindfulness

Mindfulness practice, inherited from the Buddhist tradition, is increasingly being used in Western psychology to alleviate a variety of mental and physical conditions, including sexual dysfunctions. Scientific research into mindfulness generally falls into the category of positive psychology.

Brotto et al. [24] found a three-session mindfulness-based psycho-educational intervention led to a significant improvement in the Female Sexual Function Index for women with sexual desire problems.

## Conclusion

Overall, the success of psychological interventions for sexual dysfunction have a variable outcome. Various contextual factors can interfere with the outcome. Treating the contextual and relationship issues that inevitably accompany these problems is crucial, particularly for a long-term improvement. Factors that are associated with a positive treatment outcome include the motivation for success of the partners, relationship satisfaction and compliance with homework assignments. Clearly there are too few well-controlled studies of the outcome of sex therapies, for several reasons, i.e., such studies are difficult to design and conduct, it is difficult to meet the highest levels of evidence-based medicine, and funding is unavailable due to a lack of interest by the pharmaceutical industry. It is also difficult to define a good treatment outcome for both males and females.

## Conflict of interest

None.

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None.

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