Sex Therapy Basics

For Advanced Practice Nurses, Physician Assistants, and Health Care Professionals

Melissa A. Farmer, PhD
Department of Physiology
Northwestern University
Chicago, IL

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What is sex therapy?

- Talk therapy (no hands-on interactions)
- Sexual education and normalizing variations
- Problem-solving approach to identify factors that diminish desire/arousal/satisfaction
- Promoting pleasurable sexual experiences
- Concomitant treatment of psychiatric issues
Core Elements of Sex Therapy

- Therapeutic Relationship .......... enhances patient’s confidence
- Psychosexual Education ............. providing accurate and normalizing information
- Relaxation Training/Mindfulness ... connect with body/mind as they become aroused
- Guided sexual imagery/fantasy ...... to guide sexual thoughts into behaviors
- Sexual communication .................. to ensure partners’ needs are taken seriously
- Cognitive restructuring .................. to identify and establish realistic goals
- Directed masturbation (via bibliotherapy, expanding sexual repertoire)
Selecting the Optimal Approach

- **Psychosexual Education:** everyone
- **Relaxation Training:** anxious, stressed, low sexual self-awareness
- **Guided sexual imagery/fantasy** (via bibliotherapy): limited self-awareness
- **Sexual communication:** individuals who like rules and need objective yardstick when things get emotional
- **Cognitive restructuring:** logical individuals
- **Directed masturbation** (via bibliotherapy): highly motivated, low self-awareness
Preparations


3. In your setting, what paperwork is necessary? documented Informed consent? HIPPAA? Can you access their medical records?

4. Do you want to collect data for research? does this require approval by an ethics board?

5. What educational materials are needed, given your patient/client base? Different translations?

7. Creating an optimal environment for disclosure
   Highly recommended: sex-positive material to “break the ice”

8. Officially, you are providing sexual education, not sex therapy.
   If you are interested in future ASSECT certification, keep track of hours.
Creating an Environment for Disclosure

1. Privacy

2. **Patient has control** over the interaction (especially with abuse history)

3. Warm interpersonal **rapport**

4. Ideally, assessment takes place in a secluded space, no ambient noise, dim lights, carpeted, away from the “outside world”

5. Adopt a patient’s **sexual vocabulary**

6. **Break the ice** with sex-positive material ([www.sexsmartfilms.com](http://www.sexsmartfilms.com))
Therapeutic Relationship

One of the most important factors that determine a patient’s improvement.

Common ingredients of therapeutic change, classically described by Jerome Frank:

a) Patient’s expectation s/he will be helped
b) Therapeutic relationship
c) Therapeutic rituals provide meaning for symptoms
d) Active collaboration between Therapist/Patient as they execute the ritual

Recent meta-analysis: common factors explain 45% of variability in treatment outcomes (Laska, Gurman & Wampold, 2014)
Psychosexual Education

Encompasses:

1. Anatomy (diagrams, models)
2. Physiology of sexual response
3. Medications that can interfere with sexual function
4. Examination of unrealistic expectations of self & sexual encounters – Normalize!
5. Address myths of sexuality
Human Sexual Response

Masters and Johnson Model
(Masters & Johnson, 1966)

Circular Model
(Whipple, 2002)

Non-linear Model
(Basson, 2001)

Excitement
Plateau
Orgasm

+ Objective
+ Face Valid

- Reductionist
- Heteronormative

Emotion, Intimacy
Context

+ Emotional Intimacy
+ Spontaneous Sexual Drive
+ Sexual Arousal
+ Emotional and Physical Satisfaction
+ Seeking Out and Being Receptive to

Emotion, Intimacy
Difficult to Test

Context
Not based on physiological data

Model Depictions from Association of Reproductive Health Professionals
Targets for Interventions

PAIN

RELATIONSHIP DISTRESS
• Couple conflict
• Perceived rejection
• Lack of intimacy

SENSORY FACTORS

MALADAPTIVE COGNITIONS
• Attention to pain
• Catastrophization
• Emotional coping
• Self-blame

SEXUAL IMPAIRMENT
• Reduced desire
• Lack of physiological arousal
• Decreased sexual enjoyment
• Partner develops associated sexual impairment

EMOTIONAL RESPONSES
• Anxiety / Depression
• Anger
• Guilt
• Fear of pain
• Sense of loss

BEHAVIORAL RESPONSES
• Reduced sexual activity
• Avoiding partner
• Pelvic floor muscle contraction
• Defensive withdrawal behaviors
Will reduce desire/arousal
- tired, stressed
- feel pressure to have sex
- fear of pain and discomfort
- sex not a priority

Will increase desire/arousal
- expecting little or tolerable pain
- relaxation, having time
- feeling in control of your body
- not feeling defensive when touched

Open to sexual activity

Averts sexual situations

Physically painful outcome (emotionally negative)

Emotional Intimacy

Sexual Neutrality

INCREASES

DECREASES

Desire/Arousal

HIGH

LOW

PAIN

Pleasure

Open to sexual activity

Pain

INCREASES

DECREASES

Emotional Intimacy

Sexual Neutrality

+
Dispelling Sexual Myths

**Male Sexuality**

1. A hard penis and its performance define the quality of sex.
2. Real men don’t have sexual problems.
3. Real men perform during sex.
4. Real men don’t talk about feelings or emotions.
5. Focusing more intensely on one’s erection is the best way to get an erection.
Dispelling Sexual Myths

Female Sexuality

1. Sex is only for women under 40 (!)
2. All women have multiple orgasms.
3. It’s a man’s job to initiate sex.
4. Women shouldn’t sweat or lose control during sex.
5. All women can squirt (ejaculate).
6. Pregnancy and delivery reduces women’s responsiveness.
7. If a woman cannot have an orgasm quickly and easily, there is something wrong with her.
Dispelling Sexual Myths

Myths of Male & Female Sexuality

1. “Sex” means penile-vaginal intercourse.
2. Sex is only good if both partners have thunderous orgasms.
3. We are finally liberated and comfortable with sex.
4. Any sexual contact should lead to sex.
5. You should know what your partner wants without having to ask.
6. Fantasizing about someone else means s/he is not happy with what a relationship.
What IS normal, anyway?

Men are more likely to orgasm with vaginal intercourse; women are more likely to orgasm following a variety of sexual activities, including oral sex or vaginal intercourse.

At their most recent sexual encounter…

85% of men reported their partner reached orgasm, 64% of women reported achieving orgasm.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Masturbated Alone</td>
<td>62%</td>
<td>40%</td>
<td>75%</td>
<td>45%</td>
<td>81%</td>
<td>60%</td>
<td>83%</td>
<td>64%</td>
<td>84%</td>
<td>72%</td>
</tr>
<tr>
<td>Masturbated with Partner</td>
<td>5%</td>
<td>8%</td>
<td>16%</td>
<td>19%</td>
<td>42%</td>
<td>36%</td>
<td>44%</td>
<td>35%</td>
<td>49%</td>
<td>45%</td>
</tr>
<tr>
<td>Received Oral from Women</td>
<td>12%</td>
<td>1%</td>
<td>31%</td>
<td>5%</td>
<td>54%</td>
<td>4%</td>
<td>63%</td>
<td>9%</td>
<td>77%</td>
<td>3%</td>
</tr>
<tr>
<td>Received Oral from Men</td>
<td>1%</td>
<td>10%</td>
<td>3%</td>
<td>34%</td>
<td>6%</td>
<td>58%</td>
<td>5%</td>
<td>70%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Gave Oral to Women</td>
<td>8%</td>
<td>2%</td>
<td>18%</td>
<td>7%</td>
<td>51%</td>
<td>2%</td>
<td>55%</td>
<td>9%</td>
<td>74%</td>
<td>3%</td>
</tr>
<tr>
<td>Gave Oral to Men</td>
<td>1%</td>
<td>12%</td>
<td>2%</td>
<td>22%</td>
<td>4%</td>
<td>59%</td>
<td>7%</td>
<td>74%</td>
<td>5%</td>
<td>59%</td>
</tr>
<tr>
<td>Vaginal Intercourse</td>
<td>9%</td>
<td>11%</td>
<td>30%</td>
<td>30%</td>
<td>53%</td>
<td>62%</td>
<td>63%</td>
<td>80%</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>Received Penis in Anus</td>
<td>1%</td>
<td>4%</td>
<td>1%</td>
<td>5%</td>
<td>4%</td>
<td>18%</td>
<td>5%</td>
<td>23%</td>
<td>4%</td>
<td>21%</td>
</tr>
<tr>
<td>Inserted Penis into Anus</td>
<td>3%</td>
<td>6%</td>
<td>6%</td>
<td>11%</td>
<td>27%</td>
<td>24%</td>
<td>21%</td>
<td>11%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>
## IT DEPENDS ON WHAT TURNS YOU ON

<table>
<thead>
<tr>
<th>Activity</th>
<th>WANT IT (love it or like it)</th>
<th>SEXUAL EXPLORATION GAP</th>
<th>DID IT (past 2 months - year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wearing sexy lingerie or underwear for a partner</td>
<td>0%</td>
<td>38%</td>
<td>22%</td>
</tr>
<tr>
<td>Reading sexually explicit magazines</td>
<td>46%</td>
<td>32%</td>
<td>14%</td>
</tr>
<tr>
<td>Engaging in role play</td>
<td>37%</td>
<td>30%</td>
<td>7%</td>
</tr>
<tr>
<td>Tying up or being tied up by a partner</td>
<td>29%</td>
<td>25%</td>
<td>4%</td>
</tr>
<tr>
<td>Going to a strip club</td>
<td>29%</td>
<td>24%</td>
<td>5%</td>
</tr>
<tr>
<td>Using a vibrator or dildo</td>
<td>46%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Having sex in public</td>
<td>27%</td>
<td>22%</td>
<td>5%</td>
</tr>
<tr>
<td>Having a threesome</td>
<td>23%</td>
<td>21%</td>
<td>2%</td>
</tr>
<tr>
<td>Taking and sharing sexy photos with a partner</td>
<td>32%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>Participating in group sex</td>
<td>17%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>Playful whipping as part of sex</td>
<td>20%</td>
<td>14%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Relaxation Training / Mindfulness

• Learning to refocus attention (e.g., nonjudgmentally notice areas of tension) and enhance awareness of internal/external sensations.

• **Includes:** progressive muscle relaxation, diaphragmatic breathing, autogenic training, guided visualization, or simply experiencing the moment.

• **Pro-tip:** this is optimal strategy for reducing awareness of pain or discomfort; can be used WITH self-stimulation to enhance distraction from pain.
Guided Sexual Imagery / Fantasy

• Discuss and normalize variety in sexual fantasy
  - A taste of “normal” variety in women: My Secret Garden (Nancy Friday)
  - BDSM (The Story of O; Sleeping Beauty Trilogy)
  - write their own erotic stories

• Encourage exploration of fantasies with self- or partner-stimulation
Sexual Communication

• We are not conditioned to communicate about sexuality (requires practice!)
  - feelings for one’s partner
  - how sentiments, feelings, and needs are expressed
  - words, gestures, physical affection, eye contact
  - what discrepancies are there between partners?

• Histories of abuse or emotional/sexual issues that reduce trust

• Creating a ritual or pattern in communication that works for the couple
All fantasies are normal.
Directed Masturbation

- **Establish comfort with looking at and touching oneself**
  - Mirror exercises: view genitals and entire body (notice reactions)
  - Self-stimulation exploration
  - Feeling sexy: what is necessary and sufficient?
  - Identification of “blocks,” or deterrents, of desire/arousal/orgasm
  - Practice!

- **Body image issues, religiocultural background, and negative sexual attitudes** may be challenges
Cognitive Restructuring

- Identify problematic thoughts/beliefs about sexuality and sexual encounters
- Normalize negative feelings (anxiety, fear, distress, disappointment)
- Challenge and ultimately **change the content** of problematic thoughts
  1. Provide education
  2. Stick to the facts (rather than emotional reasoning)
  3. Identify cues that increase chances of misinterpretation
  4. Decatastrophize (What if the worst case scenario actually happened?)
  5. Keep diary of thoughts, feelings, outcomes
Problematic Thoughts

- All-Or-Nothing (experiences are only good or only bad): “It hurts every time.”
- Mind Reading (belief that one understands how others perceive her/him): “You didn’t want me to approach you in the kitchen, so I didn’t.”
- Catastrophizing (expectation of increasingly worse outcomes): “I’ll never have an orgasm. Ever.”
- Shoulds/musts (“Musterbating”): “I must not fantasize about my priest, that’s twisted.”
- Filtering (focus on negatives, ignore positives): “I am waiting for the pain, which will happen because my muscles are already tight and I’m sweating…”
- Maximization/Minimization (exaggerating/reducing): “I held my erection last time, what a fluke.”
- Emotional Reasoning (what I feel is the reality): “I already ejaculated early with her, so she’ll just expect me to fail every time now.”
Excitatory/Inhibitory Factors

Personal “recipe” for enhancing desire and arousal

1. Generating lists of conditions or factors which positively & negatively affect arousal, such as:
   - Context (energy level, appropriateness, etc)
   - Positive mood (for oneself and one’s partner)
   - What kinds of emotional and sexual stimulation are needed?
   - Relative strength of “inhibitory” factors
   - Faulty beliefs (to challenge with cognitive restructuring, sexual communication)
   - Resilience: coming back after a mood-killer
   - Penetration-based sexual script: Sex doesn’t need to end with a lost erection

2. Work to create conditions that optimize excitatory factors

3. Review what worked/didn’t work; revise and try again!
Bibliotherapy

• Useful when therapist contact is limited or absent therapist contact (e.g., self-help manuals, brief skills training, education):
  - *Sex for one: The Joy of Self-Loving* (Betty Dodson)
  - *Coping with erectile dysfunction* (Metz & McCarthy)
  - *For yourself: The fulfillment of Female Sexuality* (Lonnie Barbach)
  - *Becoming orgasmic: A sexual growth program for women* (LoPiccolo & Heiman)
  - *When sex seems impossible* (Peter Pacik)
  - *Seven Principles for Making Marriage Work* (Gottman)
  - *Mating in Captivity* (Esther Perel)
  - *She Comes First* (Kerner)

• Meta-analyses suggest bibliotherapy rivals pharmacotherapy (e.g., yohimbine) in effectiveness for treating anorgasmia
LGBT Populations

While about 7% of adult women and 8% of men identify as gay, lesbian, bisexual or transgender, the proportion of individuals in the U.S. who have had same-gender sexual interactions at some point in their lives is higher.

**Factors influencing impaired sexuality may include:**

- Psychological issues accompanying choice to “pass” as straight
- Body dysmorphia
- Gender identity issues: care in using personal pronouns (he/she/they)
- Identity & “coming out” conflict
- Variants in sexual expression
- Non-monogamy
- High frequency of desire discrepancy/inhibited sexual desire in lesbians & sexual script issues
Sexuality and Disability

• Body image issues (especially women)

• Sparse information about sexuality in disabled persons
  - Betty Dodson’s Sex & Disability blog posts: http://dodsonandross.com
  - David Sternberg Photography

• Surrogates are controversial, some individuals feel this is their only option

• Do not assume you know the capabilities of another’s body
  - Center for Sexual Health and Rehabilitation
    Ergonomic Sex: http://www.sexualrehab.com/
Notes of Caution

Especially in the context of sex therapy, your patient is **exquisitely vulnerable**.
It is your obligation as a professional and human being to do no harm.

1. Psychology defenses are there for a reason; do not remove a defense if you cannot re-establish it within the hour.

2. Your goal is to help your patient attain her goals. Your personal biases and judgment are irrelevant and should not enter the room.

3. Transference/countertransference are real and can be used to enhance therapeutic progress.

4. Sexual attraction may occur between women and men, men and men, women and women—the only time it needs to be explicitly addressed is if it interferes with the therapy. This is not simply sexual tension—it may include active fantasizing.

5. Maintain contact info of a clinical psychologist or psychiatrist on hand; if a patient expresses suicidal ideation, it is your responsibility to ensure their safety.
Thank you for your attention!

melissa-farmer@northwestern.edu

@Farmer_MindBody
Assessing Genito-Pelvic Pain

**Pain Description**
- Intensity (out of 10)?
- Pain location? Quality?
- Other accompanying symptoms?
- Age of onset/pain duration? Gradual or sudden onset?
- Pain pattern (cyclic, constant, provoked, spontaneous)?

**Potential Causes of Pain**
- Provoked or idiopathic? Pain triggers?
- Aggravating/relieving factors?
- Past surgery or trauma to area?
- For women, use of hormonal birth control, parity?

**Consequences of pain**
- Interference with daily life, relationship(s), sexual health?
- Behavioral response to pain?
- Medication use?

**Psychosocial aspects of pain?**
- Sexually active? Sexual dysfunction secondary to pain?
- Anxiety/catastrophizing/depression about pain?
- Current or past sexual abuse?