Introduction to Sex Therapy

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Agenda

- What is sex therapy and why is it important?
- Development and current situation
- Common presenting issues
- Conclusion
- Useful resources

What is sex therapy and why is it important?

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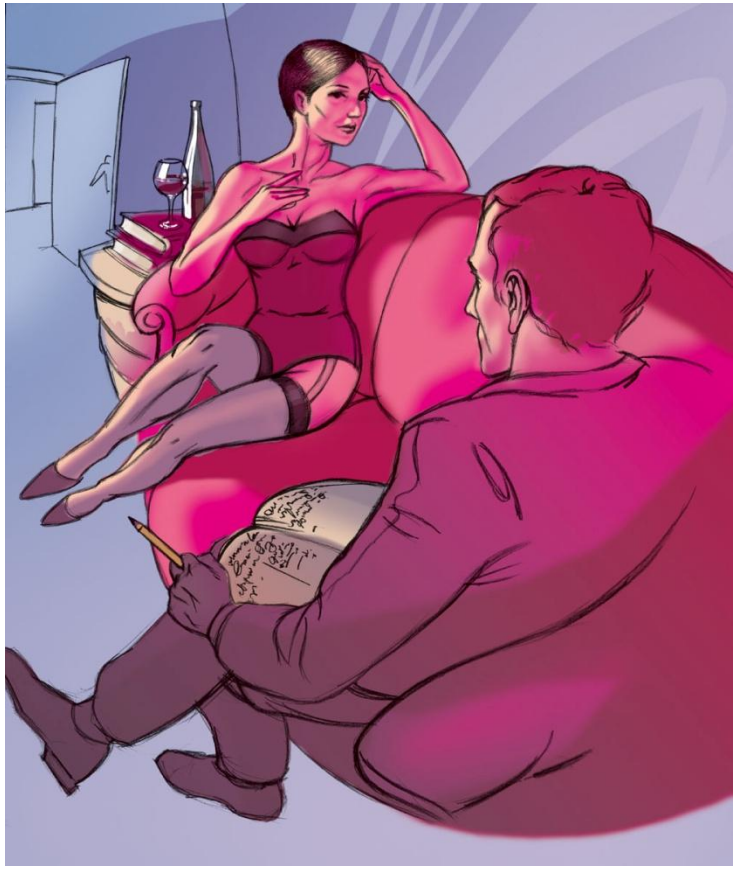
What sex therapy isn't!



What is sex therapy?

A traditional definition:

> "a strategy for the treatment of sexual dysfunction when there is no medical etiology or as a complement to medical treatment."

Source: http://en.wikipedia.org/wiki/Sex_therapy

Common sexual dysfunctions

Hers	His	His and Hers
Painful sex	Premature ejaculation (PE)	Low desire
Vaginismus	Erectile dysfunction (ED)	Low confidence
		Aftermath of sexual abuse/assault
		Relationship issues
		“Sex addiction”
		“Kinky stuff”

Taking sex therapy further

- Questioning the medical/dysfunction model
- Addressing wider anxieties about sex/sexuality
- Encouraging sexual expression and experience of pleasure
- Recognising the value of alternative sexualities
- Incorporating sex education
- Exploring the role of physical therapies

What is sex therapy?

A revised definition:

"a means to help individuals address sexual anxieties and difficulties, promote greater sexual awareness and confidence , and encourage the expression of our unique sexualities".

Why is sex therapy important?

- Anxiety about sex is a common experience
- Our sex lives are a barometer for other aspects of our lives, particularly relationships
- Sex is key to who we are and who we can be
- Sex is always present in therapy but not always addressed and often taken for granted
- Failure to address sexual issues or refer when necessary may fail the client

What any therapist can do

- Be aware of their own sexuality
  - Know their own potential and limits
- Enable clients to talk openly about sex
  - What role does sex/sexuality play in their lives?
  - Does their presenting issue impact their sex life?
  - What happens in their intimate relationships?
- Be aware of changes in sexual culture
- Question media representations

Development and current situation of sex therapy

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Sexual guidance is not new

"Because a man and woman depend upon one another in sex, it requires a method."

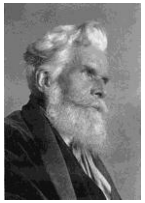
"Pleasures are a means of sustaining the body, just like food. But people must be aware of the flaws in pleasures, flaws that are like diseases. For people do not stop preparing the cooking pots because they think, 'There are beggars', nor do they stop planting barley because they think, 'There are deer'."

The Kamasutra, 3rd Century AD

Modern sex therapy

- Human sexuality becomes an object of professional study in late nineteenth century
- Advances in anatomy and medicine begin to impact our understanding of sex
- Key to development of Freudian psychoanalysis
  - Freud drew on work of now forgotten sexologists
  - Post-Freudian psychoanalysis rapidly becomes sexually conservative and innovation stops
  - Post-Freudian pioneers persecuted or neglected

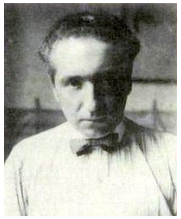
Sex therapy pioneers



Havelock Ellis (1859 -1939). British sexologist who co-authored first medical textbook in English on homosexuality in 1897, and published works on a variety of sexual practices and preferences, including transgender psychology.

Richard von Krafft-Ebing (1840-1902). Austro-German doctor whose *Psychopathia Sexualis,* published in 1886, contains 238 case histories of human sexual behaviour and popularized the terms sadism and masochism.

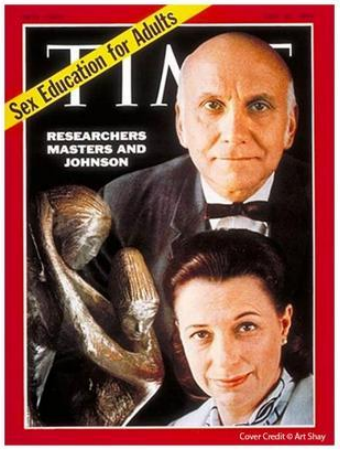
Marie Stopes (1880-1958). British birth control and women's rights pioneer whose *Married Love*, published in 1918, was both a guide to contraception and a practical sex manual.



Wilhelm Reich (1897-1957). Radical Austrian psychoanalyst whose idea of muscular armour, the expression of the personality in the way the body moves, helped shaped body psychotherapy, bioenergetics and Gestalt. His views on sexual freedom were rediscovered by 1960s counter culture.

Late twentieth century pioneers

Alfred Kinsey (1894-1956). US biologist who founded the Kinsey Institute for Research in Sex, Gender and Reproduction. Published Sexual Behaviour in the Human Male (1948) and Sexual Behaviour in the Human Female (1953).



William Masters (1915-2001) and **Virginia Johnson** (1925-2013) pioneered research into the nature of human sexual response and the diagnosis and treatment of sexual disorders and dysfunctions from 1957 until the 1990s.

Helen Singer Kaplan (1929-1995). Sex therapist who founded the first US clinic in for sexual disorders. Combined psychoanalysis with behavioural methods and was a prominent advocate of sex as pleasure in the 1960s.

Masters of Sex

- Work of M&J, etc. was central to the sexual revolution of 1960s and 70s
- Theoretical models and techniques continue to dominate sex therapy today
- Tools still in daily use by therapists include:
  - Couples work
  - M&J model of human sexual response
  - Sensate focus – practical behavioural exercises

Recent social change – negative impact

- HIV and new social conservatism negatively impacted sex therapy in US and UK
  - Little new research
  - Reduced provision of sex education
  - Reduced provision of sex therapy in health care
  - Some approaches, e.g. bodywork, virtually extinct
- Since 1980s society and media becomes more overtly sexualised

Recent social change - positive impact

- Key developments in sex therapy come from margins not mainstream
- Militant feminism played a key role in developing understanding of female sexuality
- Lesbian/gay/bisexual/transgender (LGBT) sexuality and culture becomes mainstream
- Internet offers minority/alternative sexualities means to develop communities

UK sex therapy is in crisis

- NHS provision of sex therapy now minimal
  - Treatment and training centres have closed
  - Residual provision, e.g. transgender and oncology
  - GUM clinics offer limited counselling services
- Drug treatments dominate GP-based therapy
  - Viagra for ED and anti-depressants for PE
- Training courses limited and treatment models outdated

Currently available resources – UK Third Sector

- Some government funding for relationship counselling but not sex therapy *per se*
- Third sector provision focuses on relationships and sexual health/contraception
  - Relate offers sex therapy and trains sex therapists
  - Marriage Care offers no sex therapy
  - Brook offers youth/young adult services
- Sex therapy and disability
  - SHADA and Outsiders

Currently available resources UK private Sector

- Professionally regulated therapy
  - College of Sex and Relationship Therapists (COSRT)
    - 326 accredited members
- BACP, UKCP, BPS practitioners offering sex therapy
- Independent therapists
  - Tantric sex coaches, body workers, surrogates
- Sex workers

Role for non-specialists

- Clients unable to access or afford specialist sex therapy services
  - Clients with sexual issues more likely to refer/be referred to non-specialists
- Opportunity for non-specialists to assist
  - Other models and techniques are applicable
  - Introductory training is available
  - Need to know when to refer to GP/sex therapist
  - Sex therapists used to working in partnership

Common Presenting Issues

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Common sexual dysfunctions

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Painful sex (dyspareunia)

- Caused by inadequate lubrication/arousal
- Physiological causes include:
  - Womb disorders, e.g. endometriosis
  - Vaginal infections
  - Menopause
- Psychological and situational factors:
  - Anxiety and tension
  - Limited experience and unskilled partners
  - Relationship issues

Vaginismus

- Involuntary contraction of PC muscle and may result from prolonged dyspareunia
- Psychological and situational factors:
  - Abuse and sexual violence
  - Anxiety and tension
  - Lack of body awareness
  - Unskilled partners and relationship issues
  - Unskilled medical examinations
  - Upbringing

Working with dyspareunia/vaginismus

- CBT can manage anxiety and tension
- Mindfulness can address lack of body awareness
- Any relationship tensions should be explored
- Clients and partners may need practical help
  - Sex education to exend foreplay to help lubrication
  - Vaginal trainers for vaginismus
- If in doubt – refer to GP/sex therapist

Premature ejaculation (PE)

- Most common male sexual problem
- Can be primary or situational
- Rapidity of PE varies but it is a problem if it interferes with sexual satisfaction
- Physiological causes unclear but GPs will prescribe for serious cases (SSRIs)
- Psychological causes include:
  - Anxiety and tension – e.g. performance anxiety

Erectile dysfunction (ED)

- Second most common male sexual problem
  - Incidence increases with age
- Can be primary or situational
- Strong evidence of link to cardiovascular disease – always refer to GP
- Psychological causes can cause or worsen
  - Anxiety and tension – e.g. performance anxiety
  - Lack of body awareness

Working with PE/ED

- PE and ED respond well to combinations of talking therapy and drugs
  - CBT can manage anxiety and tension
  - Mindfulness can address body awareness
  - ED drug treatments less successful when the primary cause is psychological
- Relationship tensions should be explored
- Sex therapists can advice on practical exercises
  - “sensate focus”

Sensate Focus Exercise

Example: ED treatment - pleasuring a soft penis

The goal is to get comfortable with touching your soft penis and learn what kind of sensations that produces.

Put some lubricant on one or both of your hands and touch your penis for about fifteen minutes in ways that feel arousing. Try different kinds of touches and strokes. You want to focus on the sensation and feel as sexy as possible, but you don't need an erection. In fact an erection will only get in the way.

If you find your penis is getting hard, just pay attention to the sensation as it does so. But when it's reached what you consider to be about 50-80% of fullness and rigidity, stop touching it. Enjoy looking at it and let it go down.

Spend about ten to fifteen minutes doing the exercise and repeat it two or three times until you feel comfortable touching your non-erect penis and feel that you have improved your ability to focus on the sensations in your penis.

Source: Bernie Zilbergeld, The New Male Sexuality, p.332

General guidance to non-specialists

- Don’t be afraid to explore clients’ sexual issues
  - You don’t need to be a specialist to do this
  - You might get some important insights
- Get comfortable with your own sexuality
  - The more sexual issues are normalised the less problematic they are for client/therapist
  - Know your limits – what you like/don’t like
- Know when to refer and seek advice
  - Sex therapists are generally happy to advise

The future

- Anxiety is a constant in human sexuality
  - Anglo-Saxon societies are currently in the grip of anxiety about sex
- Human sexual culture is always in flux
  - Technology is making change more rapid but debate continues over positive/negative impact
  - Globalisation is beginning to make an impact on “fixed” sexual cultures and sex therapy

Conclusion

“Sexuality is a part of our behaviour. It's part of our world freedom. Sexuality is something that we ourselves create. It is our own creation, and much more than the discovery of a secret side of our desire. We have to understand that with our desires go new forms of relationships, new forms of love, new forms of creation. Sex is not a fatality; it's a possibility for creative life.”

Michel Foucault

The brain is the most powerful human sex organ

Useful resources

- The New Male Sexuality, Bernie Zilbergeld
- Mating in Captivity, Esther Perel
- Sex Aversion, Sex Phobia and Panic Disorders, Helen S. Kaplan
- With the Kisses of His Mouth, Monique Roffey
- Passionate Marriage, David Schnarch