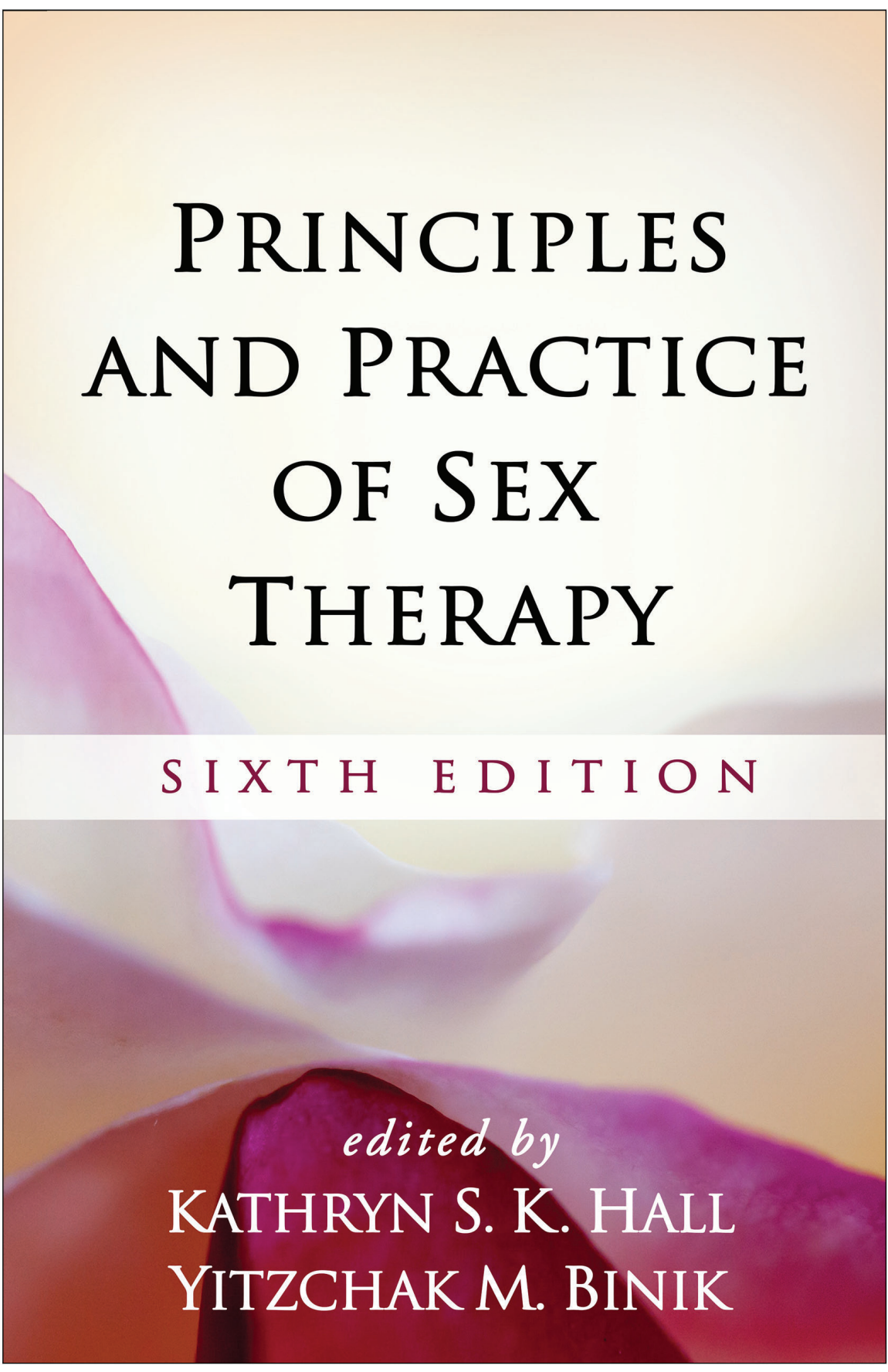
# Principles and Practice of Sex Therapy

SIXTH EDITION



*edited by*

Kathryn S. K. Hall

Yitzchak M. Binik

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# PRINCIPLES AND PRACTICE OF SEX THERAPY

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YITZCHAK M. BINIK

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In memory of Sandra R. Leiblum (1943–2010),
editor of the first four editions of
*Principles and Practice of Sex Therapy*

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# Contents

# Introduction

YITZCHAK M. BINIK
KATHRYN S. K. HALL

When The Guilford Press approached us to edit a new edition of *Principles and Practice of Sex Therapy* (PPST) only 6 years after the publication of the fifth edition, our first reaction was "no way." We did not think there was enough new material, and we did not want to rehash old stuff even if the book would sell. The first five editions of PPST had had an average publication gap of 9 years between them and, in our view, this seemed to be about the right interval given the rate of progress in the field of sex therapy. Despite our protestations, Jim Nageotte, Guilford's wonderful Senior Editor, kindly told us to take a deep breath, consider carefully what was new, and sleep on it.

We put the previous editions of PPST under our pillows for a few nights and thought about Guilford's proposal. After a few sleepless nights, we realized that our reaction "it's too soon for another edition" was too hasty. We remembered that there had been several topics we had wanted to include in PPST 5 but could not, either because there were no available authors or there was not sufficient space. We also realized that the publication of DSM-5, and the impending publication of recently approved ICD-11, had stimulated much theoretical controversy and a surprising amount of new empirical work on diagnosis and assessment. There were also quite a few new clinical trials and many recent studies on prevalence and etiology. Sex therapy and research were spreading across the globe and across therapeutic disciplines. Overall, we were embarrassed that we had not registered the progress.

We somewhat sheepishly called Jim back and said that not only were we prepared to do a new edition but that we needed more space. He kindly declined our request for a longer book, reminding us about the economics of book publishing and sales, but enthusiastically encouraged us to proceed with new ideas and chapters. We scaled down our plans for a longer book, but the current volume has seven totally new chapters (female sexual arousal, sexual aversion, out-of-control sexual behavior, BDSM, cancer, spinal cord injury, and pregnancy, postpartum and parenthood); the chapter on gender dysphoria has been divided into two, one about adults and the other about children and adolescents, in order to provide adequate coverage of an expanding and controversial field. There was so much new material that even in the traditional chapters on sexual dysfunction, we have had to spend much of our editing time helping authors keep to Guilford's page limits.

Not only are there new topics, but there are also plenty of new, first authors in this edition. These new authors include both seasoned and rising scholars, clinicians, and researchers, and are too numerous to name. But a quick perusal of the table of contents reveals a veritable Who's Who of the sex therapy field. These first-time contributors enhance our previous all-star lineup and bring new expertise to PPST. While we believe it is important to revitalize each edition with "new blood," we also believe it is important to maintain our tradition of excellence. As a result, there are a significant number of returning contributors. There has also been a significant shift in the proportion of women first authors in PPST, which has risen from 30% in the first edition to almost 60% in the current volume. We believe this shift accurately reflects the changing gender demographics of our field.

This edition also reflects the growing international expertise and knowledge in our field. All the primary authors in the first edition of PPST were based in the United States; most of the primary authors of this edition live elsewhere. It has become apparent in the last 25 years that much of the innovation in sex therapy is occurring in Canada and Western Europe. This shift is likely the result of sociopolitical changes that have discouraged the continuation of sex research and clinics in the United States and have encouraged it elsewhere. Overall, this globalization of sex therapy seems to us a positive trend, and it is likely that future editions of PPST will include contributors from Eastern Europe, South America, Asia, and Africa.

The central guiding philosophy for all editions of PPST has been the unified presentation of research and clinical practice. This clinical science approach is continued in the current edition and reflects the orientation of both editors, though Kathryn spends most of her time doing clinical work, while Yitzchak is primarily a researcher. Whether our authors are primarily researchers or clinicians, we have insisted that they critically review and synthesize the available research and theory; we also have insisted that they provide practical advice about assessment and diagnosis, including an evaluation of the first years of the new DSM-5 criteria, as well as a discussion of the recently approved ICD-11 classification. We also asked returning authors to update their previous

research reviews and provide new clinical vignettes and cases that appropriately illustrated challenges and changes in intervention strategies in their field.

It was not always easy for us to find individuals willing to write a chapter integrating research and clinical practice, since the academic and clinical worlds seem to be diverging rather than coming together. In some instances, authors asked if they could include a coauthor clinician or researcher because they did not feel sufficiently competent in both domains. We were happy to agree to this, because it ensures that chapters present an integrated and balanced view of research and clinical work. We directed authors to write their chapters with a mental health audience in mind, though we believe the book will be appropriate for any health professional wishing to learn about sex therapy and any researcher looking for clinical relevance.

## Organization of PPST 6

Chapters in Part I, *Sex Therapy for Sexual Dysfunction,* include critical reviews of the research and clinical innovation related to the "traditional" sexual dysfunctions listed in the DSM. In this edition, there are chapters covering the seven sexual dysfunctions now listed in DSM-5 (excluding the nonspecific diagnoses of substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction) and the three dysfunctions (female sexual arousal disorder, sexual aversion disorder, and vaginismus) that were included in DSM-IV but have now been deleted. The ten chapters in this section cover the core material in the field.

Most of the topics in these chapters have been covered in every edition of PPST. Reviewing the parallel chapters in each edition chronologically provides an interesting overview of the evolution of thinking about each sexual dysfunction in the last 40 years. For some problems such as anorgasmia in women, there has been continuing progress, but the basic treatment of directed masturbation was already well established by the time of publication of the first edition of PPST in 1980. For other problems such as dyspareunia, there are few similarities in theory, assessment, or treatment between the approaches outlined in the first and sixth editions. The current edition also reflects the continuing and important contribution of sexual medicine to the understanding and treatment of sexual dysfunction; as a result, information relevant to medical assessments and treatments is always included. There is no longer much opposition among sex therapists to the use of medical treatments and, in fact, many believe that for dysfunctions such as erectile dysfunction and premature ejaculation, combined psychological and medical treatment is superior to either alone.

The first two chapters deal with one of the most controversial issues in the field of sexual dysfunction, the relationship between problems of desire and arousal in women. Since the field is split, we have embraced the controversy rather than taking sides and include chapters with opposing views on the nature and relationship of women's desire and arousal. Chapter 1, by

Brotto and Velten, make the argument for not only grouping problems of desire and arousal into one dysfunction, but also for embracing a new understanding of female sexual responding. Called female sexual interest arousal disorder, it represents a departure from the tradition of equating female and male sexual responses and corresponding dysfunctions. The next chapter, by Meston, Stanton, and Althof, takes the opposite view that problems of desire and arousal are distinct and separable; in fact, they elaborate two distinct subtypes (cognitive and genital) of female sexual arousal disorder. In Chapter 3, Nobre, Carvalho, and Mark point out that the controversy that has characterized the discourse on women has unfortunately been largely absent in the discussion of male desire and arousal. They argue convincingly that the presumed differences between male and female desire may be overstated, and that recent research is beginning to point out many parallels. Despite these parallels, there is little, if any, suggestion that problems of male sexual arousal (erectile dysfunction [ED]) should be collapsed with those of male desire. The vast and still growing literature on ED (Chapter 4) is reviewed by Kalogeropoulos and Larouche, updating the reader on recent developments from both psychosocial and medical points of view.

The next three chapters in Part I address problems related to orgasm, including anorgasmia in women and premature and delayed ejaculation in men. There are well-established cognitive-behavioral treatments for these problems and a long history of interest among sex therapists. In fact, it can be argued that the early successes of sex therapy in treating lifelong anorgasmia in women and premature ejaculation in men helped to establish the field. Despite these early successes, the authors of these chapters point out that there is still much to be learned about etiology and treatment. Mintz and Guitelman, in Chapter 5, review the growing psychological, medical, and pelvic floor therapeutic literatures on orgasm problems in women. They confirm that directed masturbation remains the single most effective technique to help women achieve orgasm but warn therapists about overstandardizing their treatments for fear of ignoring crucial individual differences that may ultimately determine the most effective and caring treatment. They also address the continuing "orgasm gap" and how to remedy the fact that women still have fewer orgasms compared to men in partnered heterosexual sex. In Chapter 6, on premature ejaculation, Althof dispels overly simplistic and enthusiastic sex therapy and sexual medicine treatment recommendations for premature ejaculation. He carefully reviews the outcome literatures for both and discusses the pros and cons of combined psychological and medical treatment. Despite the significant progress made in treating premature ejaculation, he concludes that modest gains in sexual satisfaction are often the outcome. In Chapter 7, Perelman comprehensively reviews the existing clinical and research literatures on delayed ejaculation in the context of his "Sexual Tipping Point" model. His analysis and recommendations based on extensive clinical experience are particularly useful, because most sex therapists have limited experience with this relatively infrequent but highly distressing problem.

The last three chapters in Part I review the literatures on genital pain, lifelong vaginismus, and sexual aversion. DSM-5 collapsed what used to be known as the two sexual pain disorders (dyspareunia and vaginismus) into one disorder known as genito-pelvic pain penetration disorder. The primary reason for combining these disorders was the overlap in symptomatology and the diagnostic difficulties in differentiating them. Despite this diagnostic change, there have been several recent randomized controlled trials (RCTs) employing different treatment protocols for DSM-IV-TR dyspareunia and vaginismus, and demonstrating high treatment efficacy. As a result, we have included two separate chapters, one (Chapter 8) focusing on genital pain syndromes (dyspareunia) and another (Chapter 9) on lifelong vaginismus. Bergeron, Rosen, Pukall, and Corsini-Munt present an innovative and highly developed interpersonal model of genital pain; they also point out that this problem affects a significant number of men. Using a fear and avoidance conceptualization, ter Kuile and Reissing rationalize the development of an *in vivo* exposure therapy that has stunningly effective results. In Chapter 10, Borg, Both, ter Kuile, and de Jong present strong arguments to support the reinstatement of sexual aversion disorder into DSM-5 and ICD-11. They convincingly argue that the sex therapy establishment has ignored the available data suggesting that disgust is an important underlying emotional factor affecting sexual functioning. Their chapter is the first one ever on this topic in any edition of PPST.

Part II, *Therapeutic Challenges for Sex Therapy,* includes 11 chapters divided into three sections: A, *Sexual Limits and Boundaries,* B, *Lifespan and Transitions,* and C, *Medical Issues.* Most of the problems discussed in Part II present "therapeutic challenges" to sex therapists, since they are usually not amenable to treatment using traditional sex therapy techniques. Nonetheless, sex therapists are often called upon to treat or consult about these problems, because other therapists are typically not comfortable talking about sex and are particularly uncomfortable discussing non-normative sexual behavior about which they may make judgmental and damaging assumptions or interpretations.

The title *Sexual Limits and Boundaries* is an apt one for the four chapters included in this first section of Part II. In Chapter 11, Hall and Graham introduce a "cultural developmental pathway" model to help guide our understanding of the diversity of sexual behavior resulting from cultural influences. Although most Western sex therapists will not have had the opportunity to treat clients in the developing world, it is becoming much more likely with increasing emigration that they will treat such individuals or their children in their home countries. Without an understanding of how their culture affects the sexuality of immigrants and their children, sex therapists may misunderstand these individual's sexual dynamics and behavior.

Even within a specific culture, it is sometimes difficult to understand and treat certain types of non-normative sexual behavior. "Out-of-control sexual behavior," often called hypersexuality or sexual addiction, is a prime example

of a set of behaviors that stretches the limits of most therapists' understanding. This is illustrated in Chapter 12 by Braun-Harvey and Vigorito, who review several very different models (e.g., addiction, impulse control, moral incongruence, psychosexual) of out-of-control sexual behavior. While there continues to be controversy on how to conceptualize this behavior, Braun-Harvey and Vigorito's multimodal intervention is a useful and nonjudgmental treatment model.

In Chapter 13, Ortmann suggests that the high prevalence of consensual BDSM in the general population challenges the traditional conceptualizations of BDSM as a paraphilia motivated by underlying psychological difficulties. Several vignettes and case histories illustrate Ortmann's nontraditional therapeutic approach that focuses on clients' pleasure rather than a presumption of underlying psychological difficulties. Doing therapy with people in BDSM or Kink communities will require clinicians to rethink their conceptualizations of "power dynamics," "negotiated consent," "objectification," and "role playing."

Perhaps the most prevalent sexual boundary violation that an individual is likely to experience is infidelity. In Chapter 14, Josephs points out that although three-quarters of Americans think that infidelity is always wrong, it is the leading cause of divorce and a common reason for referral to therapy. How to help couples repair their relationships after infidelity is not at all clear given the lack of systematic therapy outcome studies. This makes sense, as infidelity is neither a sexual dysfunction nor a discrete sexual behavior with a unitary cause or consequence. Josephs reviews available literature regarding the theories and therapy for infidelity. Ultimately, he focuses on the need to attend to personality dynamics when devising appropriate treatment interventions.

Traditional classifications and treatments for sexual problems have implicitly assumed the existence of a stable couple dyad between ages 25 and 55. This assumption has changed. There is now a growing literature on aging and sexuality, and substantial research on early sexual experiences and their effects on later sexual expression. The five chapters in the *Lifespan and Transitions* section relate to the challenges sex therapists face in trying help individuals and couples deal with sexual changes that occur with age or life transitions.

Virtually every sex therapist has heard the report that "my problem started at about the time our children were born." Navigating this transition to parenthood, or its failure in the case of infertility, presents formidable challenges to many couples. In Chapter 15, Rosen and Byers offer important guidelines and advice on how therapists can help couples to navigate the minefields that are hidden in these transitions. They recommend using a biopsychosocial assessment model to uncover potential causes for sexual dissatisfaction during life transitions, then target problem areas to relieve distress. They also discuss the potential efficacy of psychoeducational prevention programs for new parents or couples struggling with infertility, which would benefit from the inclusion of more information about sexuality.

Another inevitable sexual transition is related to aging. As we mature, all aspects of life, including our sex lives, change. In Chapter 16, Watter reviews data demonstrating that many individuals and couples wish to continue expressing their sexuality as they age. Based on an existential orientation to therapy, he argues that sex is often experienced as an essential life force, serving as an important corrective to death anxiety. Understanding this meaning for continued sexual functioning helps the therapist to support the client's wish to remain vital and alive. Sometimes this entails directing appropriate psychosocial and medical interventions, but at other times, understanding, support, and validation of the quest for a dynamic connection is what is needed.

The high prevalence of trauma, abuse, and neglect in childhood is generally acknowledged as an important societal problem. In Chapter 17, MacIntosh, Vaillancourt-Morel, and Bergeron point out that the effects of childhood maltreatment on adult sexuality can be summarized by a dual pathway model. Sometimes childhood trauma leads to sexual inhibition; other times it leads to sexual disinhibition. Predicting accurately which outcome will occur is very difficult, but both patterns of behavior present significant personal and dyadic challenges to sufferers. The authors present a developmental couple therapy model to guide clinicians in the difficult work of treating survivors of abuse, neglect, and maltreatment. Throughout this chapter, we are reminded that all forms of childhood abuse (not just sexual abuse) can affect the ability to enjoy sexuality in adulthood. While this topic could easily have been included in other sections of this book, it is the positive message that sexuality need not be permanently damaged by traumatic events that has resulted in this chapter's placement in the section on transitions.

There are probably few life transitions as dramatic as changing gender. Growing public awareness of transgendered individuals has fueled the scientific controversy concerning whether gender dysphoria should be classified as a mental illness. DSM-5 and ICD-11 have reached different conclusions on this issue. Although there is little controversy concerning hormonal treatment and gender-affirming surgery as the primary treatments for adults, the clinical management of gender dysphoria in children has become a major political and scientific issue. As a result, we are including two chapters on gender dysphoria in this edition, one about children and the other about adults.

In Chapter 18, Zucker, acknowledges the great differences in current clinical opinion on how to manage gender dysphoria in young children. In general, he espouses working with the family using a supportive and therapeutic "wait and see" approach toward the determination of gender choice. His rationale is based on many studies suggesting that it is impossible to predict ultimate gender choice in these children and the difficulties some parents have in accepting gender transition. On the other hand, based on longitudinal data, Zucker suggests that gender transition and biomedical treatment in adolescence is appropriate for psychologically healthy adolescents with familial support. Holmberg, Arver, and Dhejne, in Chapter 19, provide important insights

into the evolving sexuality of transgender individuals. Gender-affirming treatment can bring with it complex sexual problems and pleasures. Supporting healthy sexual functioning and improving the sexual experiences of transgender individuals requires a multifaceted approach, but the endeavor is critical to an enhanced quality of life.

*Medical Issues* is the title of the last section in Part II. Sex therapists are now consulting, carrying out research, and developing intervention programs to address sexual functioning in the context of medical problems, including, among others, diabetes, cancer, multiple sclerosis, and heart and renal disease. Adequate coverage of this field would probably now require an entire book on its own. Unfortunately, there is no overarching theory or approach to dealing with sexuality in chronically ill persons. Thus, rather than trying to cover the topic of sexuality and chronic illness in one chapter, as was done in previous editions, we chose two conditions, spinal injury and cancer, for in-depth reviews. Neither of these topics has been systematically reviewed in previous editions. We also included persistent genital arousal disorder in this section, though it is not yet clear whether it should be conceptualized as a pain disorder, a medical condition, or something yet to be determined.

Bober and Falk, in Chapter 20, point out that cancer patients are reluctant to ask about sexuality, because their physicians rarely bring the topic up. When it is brought up, the recommended interventions are usually biomedical and fail to take into account psychosocial and interpersonal factors. The net result is often poor compliance or treatment failure. With an adequate biopsychosocial assessment, clinicians can provide useful information and promote communication between partners, helping partners to set reasonable sexual goals and attain a satisfying sexual quality of life.

Rehabilitating their sexual function is a very high priority for patients with spinal cord injury. Courtois and Gérard point out in Chapter 21 that there are, in fact, many sexual possibilities for quadriplegic and tetraplegic patients, who often lack services outside of specialized centers. The authors provide basic physiological information concerning the likely attainable limits of sexual function for these patients, which depend on the location and level of the lesion. Once these limits are determined, most of the intervention strategies for sexual rehabilitation fit nicely into a cognitive-behavioral treatment (CBT) framework familiar to most sex therapists.

Pukall and Goldmeier describe a multidisciplinary approach to the understanding and treatment of persistent genital arousal disorder in Chapter 22. This poorly understood problem is characterized by high levels of distressing and often painful genital arousal in the absence of sexual desire for both women and men. According to the authors, controlling the distress and pain are crucial for effective treatment, and they review the small treatment literature using interventions based on mindfulness, cognitive-behavioral therapy, pelvic floor physical therapy, and medication. These interventions attempt to control distress and pain while reintegrating pleasurable sexuality into sufferers' sex lives without creating unwanted arousal. This is still a major challenge.

In our concluding chapter, we are joined by Marta Meana in stepping back and taking a critical look at the field of sex therapy. We provocatively ask, "Where is sex therapy going?" as we note ongoing changes and developments in our field. While sex therapy still struggles with its place in the larger field of psychotherapy, sex therapy and sexual medicine appear to have found a comfortable partnership. Nonetheless, this collaboration may herald a growing interdisciplinarity that we hope will provide better care. In particular, the differences between the recently approved ICD-11 and the DSM-5 have raised important diagnostic and construct validity issues with which the field will have to grapple in the future.

## A Word about Language

For many writers about sex, the use of pronouns has become a significant sociopolitical issue, and for practitioners it has become a clinical concern. In our clinical work, we use pronouns with which our clients feel comfortable. But in this book, we left this usage question to the judgment of each contributing author. As it turned out, all authors adopted a traditional pronoun usage. In the case of the BDSM chapter and the gender dysphoria chapters, this usage reflects the wishes of the clients discussed.

## Conclusion

We are optimistic that our field is up to the challenges it faces as it grows globally to address an obvious need. Editing a volume aspiring to encompass the knowledge and clinical skills that are required for sex therapy raises, a significant challenge, given how much the field is constantly developing. For this edition of the book, there were quite a few topics (e.g., sex therapy for the consensually nonmonogamous, for sexual offenders, and for those suffering from major psychiatric illness, as well as for those with cognitive limitations) that we were not able to include because of space limitations. In addition, a chapter on ethical issues relating to sex therapy is long overdue. We hope a future edition can tackle these important topics.

In 2020, PPST will celebrate its 40th anniversary. There are few, if any, sexology texts that have lasted this long. To a large extent, this longevity is a testament to the vision and hard work of the late Sandra (Sandy) R. Leiblum, who edited the first four editions, joined by her colleagues Lawrence A. Pervin (for the first edition) and Raymond C. Rosen (for the second and third editions). It also reflects the support and interest of The Guilford Press. We have worked hard to preserve Sandy's standards and make this volume an important resource for sex therapists.

# PART I

# Sex Therapy for Sexual Dysfunction

# CHAPTER 1

# Sexual Interest/Arousal Disorder in Women

LORI A. BROTTO
JULIA VELTEN

This first chapter addresses one of the most perplexing issues confronting sex therapy today: the nature of female sexual desire. Existing somewhere in the intersection of motivation, mood, physiology, and relational factors, desire is often thought of as the necessary fuel for positive sexual experiences. There is an ongoing debate, reflected in the different diagnostic categories of DSM-5 and ICD-11, as to whether desire and arousal are separate constructs, or whether, as Brotto and Velten argue, they are intertwined in the early phase of female sexual responding. In DSM-5, the new diagnostic category of female sexual interest/arousal disorder, the topic of this chapter, offers "an expanded conceptualization of what constitutes a sexual desire disorder" in women. The criteria for this new diagnostic category include disruptions in motivation, cognitions, behaviors, mood (pleasure), and genital sensations. Brotto and Velten review the growing research and clinical literature, and offer suggestions for stepwise treatment based on the symptom presentation, including medications, couple therapy, and individual and group approaches. They note, "Nonpharmacological treatments such as sensate focus, CBT, and mindfulness skills show an impressive (and growing) body of science to support their use."

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A lack of interest in sexual activity that creates personal distress and strains relationship satisfaction is the most common reason women seek sex therapy. Described frequently by patients as "I've lost my libido," or "It takes a long time for me to get sexually excited," or "I would be content if we never had sex again!," the presence of little or no desire for sex has received widespread attention from clinicians, researchers, and the lay public because of its complexity and seeming resistance to treatment. A new disorder, female sexual interest/arousal disorder (SIAD), has been included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) to replace hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD) from DSM-IV-TR (American Psychiatric Association, 2000) due to long-standing dissatisfaction with the terms HSDD and FSAD. In particular, criticisms have included the following: (1) HSDD and FSAD rely on Masters and Johnson's (1966) linear sexual response cycle, which may not fit the experiences of all women; (2) the frequency and intensity of desire for sex is only one aspect of how women describe their experience of sexual desire (or lack thereof); (3) reliance on sexual fantasies as an indicator of sexual desire is problematic, because many women with satisfactory levels of desire report not having sexual fantasies; (4) "persistent and recurrent" are ambiguously interpreted in DSM-IV-TR criteria; and (5) use of the term "hypoactive" in HSDD is misleading, as it implies an underlying biological etiology to low sexual desire (Brotto, 2010; Graham, 2010) that is usually impossible to conclude in the clinical scenario. Rather than a merging of the former HSDD and FSAD, SIAD was proposed as an expanded conceptualization of what constitutes a sexual desire disorder (Brotto, 2010). The following vignette illustrates a typical case of female SIAD.

> Janie is a 35-year-old high school principal living with her fiancé, Jin. Over the first year of their relationship, their sex life was fun, experimental, and very rewarding to both of them. They enjoyed role play and incorporated vibrators into their sexual repertoire often. They both felt that the quality of their sex life was among the best that either had

ever experienced. But about a year into the relationship, things changed. Janie's level of desire begn to wane, as it had done in each of her previous long-term relationships. It was a familiar pattern for Janie: As she became more attached to Jin, sex became more routine, less experimental, and less exciting. Her mind started to wander during sex, and she sometimes felt as if her body was just going through the motions, while her head was elsewhere. She no longer fantasized the way she had formerly. Her feelings of arousal began to fade, and she felt less motivation to have sex with Jin. She even stopped initiating sex and sometimes would avoid undressing in front of him so as to avoid his getting aroused, then wanting sex. Although sex still happened, the frequency waned from three times a week to once every 2 months. As a result, the sex they were having became less satisfying. She certainly did not crave it in the way she had when they first met. And when they did have sex, she experienced minimal arousal and pleasure, and found the encounter much less rewarding.

In attempting to identify some possible triggers for this change in Janie's sexual desire, she and her therapist pointed to anxiety. She had experienced anxiety throughout her lifetime and was a self-described perfectionist, who strove to excel in everything. Janie's anxiety was centered on fear of failure leading to catastrophic outcomes. She was hyperattuned to signs of disapproval and ridicule in other people.

As sex with Jin became less novel and less exciting, Janie's anxiety rose. And with that, sex also became stressful and anxiety provoking for her. She became increasingly self-conscious about her body. Suddenly, Janie found herself as a spectator of the encounter rather than an active and engaged participant. And as she slipped into watching more than participating, her body's sexual response was further blunted, and she desired sex even less. At the advice of her family doctor, Janie scheduled an appointment with a sex therapist.

In applying SIAD criteria to Janie's situation, it is clear that she meets the threshold for several of them. The criteria for SIAD are polythetic and require that a woman experience a minimum of three symptoms for at least 6 months. Criterion 1 is a lack of interest in sexual activity, and Janie showed reduced sexual desire and motivation for sex. Criterion 2, reduced or absent erotic thoughts or fantasies, was also met, in that Janie no longer fantasized like she did in the past. Criterion 3 focuses on behavior and reflects a reduced level of initiating sex and/or responding to a partner's sexual advances. Janie evidenced this by no longer initiating sex and by avoidance of being naked in front of her partner so as to prevent his overtures. Criterion 4 is reduced pleasure during sexual activity, and Criterion 6 is reduced genital and nongenital sensations (i.e., arousal); Janie experienced all these symptoms. And finally, Criterion 5 refers to a lack of responsive sexual desire (or desire that emerges after one becomes sexually aroused). Although it is not immediately evident from Janie's case whether she experienced responsive desire, the fact that sex

was no longer rewarding suggests that the encounters may not have elicited sexual desire. The introduction of polythetic criteria means that two women with different symptom expressions may both meet criteria for SIAD (Brotto, Graham, Paterson, Yule, & Zucker, 2015).

In contrast to Janie's situation, which is chronic and persistent in the majority of her sexual encounters, a diagnosis of SIAD would not be applied to a woman who lacks sexual desire only at the outset of a sexual encounter but then becomes aroused and sexually motivated during an encounter (Carvalheira, Brotto, & Leal, 2010). The latter group may present for treatment on the basis of a dissatisfied partner who mourns her loss of innate sexual desire or because a woman herself believes that desire *should* be felt often.

## Epidemiology

### How Common Is Low or Absent Sexual Desire in Women?

Given that SIAD has been in existence only since 2013, epidemiological studies on its prevalence have yet to be published, except for one online Flemish study that evaluated both spontaneous and responsive sexual desire (Hendrickx, Gijs, & Enzlin, 2014)—discussed later; however, there have been many recent, large, representative studies focusing on the symptom of low or absent sexual desire. The third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) assessed 6,777 women (who had a sexual partner in the last year) and found that 34.2% of women across ages endorsed low desire (Mitchell et al., 2013). Across the age cohorts, the highest prevalence was among women in the 55- to 64-year-old category, and age was negatively associated with sexual desire. Between 15 and 35% of women across the age categories reported having a discrepant level of sexual interest compared to their partners (Mitchell et al., 2013). In a study of Canadian middle-aged women, the rates of low desire were similar (Quinn-Nilas, Milhausen, McKay, & Holzapfel, 2018), and those with medical health conditions and poor overall health were more likely to report low desire in both studies. Low sexual desire is common among women affected by serious or life-threatening illnesses (e.g., cancer, cardiovascular diseases). This is true for acute illnesses and chronic conditions (e.g., thyroid disease, multiple sclerosis, arthritis; McCabe et al., 2016). Women who have experienced childhood sexual abuse experience lower levels of sexual desire compared to nonabused women (Loeb et al., 2002; Stephenson, Hughan, & Meston, 2012).

Having been pregnant in the past year or having young children in the home also predicted low desire for women only. Lacking enjoyment in sex (adjusted odds ratio 8.95) and feeling no excitement or arousal during sex (adjusted odds ratio 9.16) were strongly associated with low desire. Multinational studies find higher rates of low sexual interest in Middle East and Southeast Asian countries (McCool et al., 2016).

The study by Hendrickx et al. (2014) compared the prevalence of

difficulties with both spontaneous sexual desire and responsive desire. A total of 19% of the 17,534 participants endorsed a lack of spontaneous sexual desire, whereas 14% endorsed a lack of responsive sexual desire. Among the partnered women, 9.1% endorsed having symptoms of both. Furthermore, there were high rates of comorbidity between sexual desire symptoms and sexual arousal symptoms, which the authors interpreted as support for the SIAD diagnosis.

Although low desire becomes more prevalent with age, rates of distress associated with low desire do not necessarily follow the same pattern (Rosen et al., 2009), with evidence that low desire may be more distressing for younger as compared with older, menopausal women. Since not all women with low desire are distressed by it, it is clinically important to identify which women with low desire are, in fact, experiencing distress. Predictors of distress include decreased sexual pleasure, the negative effects of a sexual symptom on sexual frequency (Stephenson & Meston, 2015), and less dyadic communication (Hendrickx, Gijs, Janssen, & Enzlin, 2016). It is important to also consider whether distress is personal or interpersonal. A notable change from DSM-IV-TR to DSM-5 was that the distress criterion moved from causing "marked distress or interpersonal difficulty" (American Psychiatric Association, 2000) to causing "clinically significant distress in the individual" (American Psychiatric Association, 2013). Most women with low desire (over 50%) experience perceived partner distress, with only one-fourth of women having personal distress (Hendrickx et al., 2016).

### Loss of Arousal in the Context of Low Sexual Desire

Women with SIAD may also experience a reduction in or absence of genital and/or nongenital sensations during sexual activity; however, the prevalence of this symptom is unknown, because past studies assessing arousal concerns have tended to focus on lack of lubrication, which ranges in prevalence from 2.6 to 31.2% (Graham, 2010). When a composite measure of arousal that included feeling aroused during sex, having pleasant tingling in genitals, and enjoying genitals being touched was assessed, the prevalence over the past month was 12.2%. Clinically, women often report difficulties with both sexual interest and capacity for sexual arousal. In NATSAL-3, women with loss of sexual desire were nine times more likely to also have lost excitement or arousal (Graham, Boynton, & Gould, 2017).

### Our Declining Sexual Behavior Rates

Using data from the General Social Survey, a nationally representative sample of Americans older than 18, collected between 1972 and 2014, Twenge, Sherman, and Wells (2017) examined the item pertaining to frequency of sex in the last 12 months. They found that Americans, on average, had sex about seven times per year less often in the early 2010s compared to the early 1990s,

with a sharp decline in annual sex frequency after the year 2000 (Twenge et al., 2017). The role of declining sexual desire in these lower rates of sexual activity is unknown.

### What Do We Know about Couples Who Experience Desire in a Long-Term Relationship?

People who continue to feel passion even in a long-term relationship (Frederick, Lever, Gillespie, & Garcia, 2017) were more likely to have consistent orgasms and to receive oral sex. They were also more likely to engage in a variety of sexual acts, and to incorporate more communication strategies than those who were sexually dissatisfied. Those with enduring passion were more likely to use mood-setting techniques, such as lighting a candle, playing music in the background, or engaging in sexy talk (Frederick et al., 2017). They were also more likely to use the advice of sex books. Each of these may be useful strategies to promote desire in long-term relationships in the clinical setting.

## Etiology and Models

The incentive motivation model of sexual response describes how biological, psychological, and contextual factors interact to elicit sexual interest and arousal (see Laan & Both, 2008, for a review). It posits that sexual desire results from an interplay between a sexual response system and effective stimuli that activate this system (Toates, 2009). Early views (Kaplan, 1977, 1979; Lief, 1977) likened sexual desire to other drive states, such as hunger and thirst, which were based on the premise that these appetitive reactions originate from within an individual. In clinical practice, however, patients are less likely to agree with this drive-like description of sexual desire and more likely to report a feeling of personal distress caused by a lack of sexual responsivity to intimate touch or the lack of the desire for sex that was cultivated during intense eye contact with an attractive partner. In comparison with former linear models of sexual response, the incentive motivation model fits the experiences of women with and without sexual concerns, because it emphasizes the important role of adequate sexual stimuli (i.e., internal or external cues that are perceived as sexually arousing) that trigger motivation and response. Some of the various biological and psychological factors that can influence the responsiveness of the sexual system are considered below.

Basson (2002a, 2002b), took the empirical findings from incentive motivation theory and applied them clinically to formulate a circular model of sexual response that has gained widespread interest. The model notes that women begin sexual encounters for any variety of sexual or nonsexual reasons. Awareness of any innate feelings of desire may be absent and are not prerequisite for entering a sexual situation. During a sexual encounter, if a woman experiences some sexual arousal and excitement, this then triggers "responsive sexual desire"—a desire for the sexual activity to continue for

now more sexual reasons, in addition to whatever initial incentives were present. If the outcome is emotionally and/or physically rewarding, she might have more motivation to initiate or respond to cues in the future. Women with and without sexual difficulties often relate to this experience of "responsive desire" more than any initial awareness of sexual desire (Carvalheira et al., 2010; Goldhammer & McCabe, 2011). Even among women who reported high levels of sexual arousal, the majority (85%) reported that they at least occasionally began a sexual encounter with no desire (Carvalheira et al., 2010). A series of recent studies has shown that many women, especially those reporting high sexual distress and/or low levels of sexual functioning, endorse the circular model of sexual response (e.g., Ferenidou, Kirana, Fokas, Hatzichristou, & Athanasiadis, 2016).

### Hormonal Factors

The responsivity of women's sexual system may be affected by hormones. Steroid hormones activate mechanisms of sexual excitation by directing the synthesis of enzymes and receptors for several neurochemical systems (Kruger, Hartmann, & Schedlowski, 2005; Pfaus, 2009). The most abundant and potent hormone before menopause is 17ß-estradiol (known as "estradiol" [E2]). Adequate levels of estradiol are important for maintaining vaginal lubrication and avoiding dyspareunia (Guthrie, Dennerstein, Taffe, Lehert, & Burger, 2004; Sarrel, 1990).

Androgen levels peak when women are in their 20s and drop gradually with age, so that women in their 40s have approximately half the level of circulating total testosterone as women in their 20s. Despite long-held popular beliefs, both population-based and clinical studies have shown minimal or no correlation between testosterone levels and sexual desire in women (Davis, Davison, Donath, & Bell, 2005; Santoro et al., 2005), and one systematic review of 10 studies concluded that the evidence does not support measuring serum testosterone when women are presenting for treatment of low sexual desire (Reed, Nemer, & Carr, 2016).

Progesterone receptors are found in many of the same brain areas as estrogen receptors, including the hypothalamus and the limbic system. Data on their effects on human sexual behavior are, however, still scarce. A study of naturally cycling women suggested that saliva progesterone levels might predict decreases in sexual desire found in the luteal phase of the cycle (Roney & Simmons, 2013). There is no consistent finding on the use of exogenous progesterone and its effects on sexual desire (Worsley, Santoro, Miller, Parish, & Davis, 2016; Wren, Champion, Willetts, Manga, & Eden, 2003).

### Relational Aspects

The link between sexual function and relationship well-being has been repeatedly shown. Sexual problems might be both the cause and the result of unsatisfactory relationships. A woman's feelings for her partner are a major

determinant of her sexual desire, above and beyond any hormonal contributors (Dennerstein, Dudley, & Burger, 2001; Guthrie et al., 2004), and this is not surprising given evidence that sex strengthens the relationship bond, and promotes feelings of closeness and couple satisfaction (Debrot, Meuwly, Muise, Impett, & Schoebi, 2017). In a longitudinal study of 66 couples who completed daily diaries, women's sexual desire was predicted by relationship quality (Dewitte & Mayer, 2018). Additionally, relationship satisfaction on one day led to more sexual activity for women the following day. Formalization of the relationship can also influence sexual desire. In married women, the institutionalization of the relationship, overfamiliarity, and desexualization of roles can dampen sexual desire (Sims & Meana, 2010). There is evidence that relationship duration impacts women's desire negatively far more than it impacts men's desire (Mark, Leistner, & Garcia, 2016). Clinically, a therapist must therefore balance concerns about a woman's complaints of loss of motivation for once highly passionate and erotic sex in the context of her now decade(s) long relationship. Some of the specific ways of cultivating sexual desire in a long-term relationship include accepting that sexual desire ebbs and flows; having realistic expectations about sexual desire; feeling attracted to one's partner; challenging monotony; making the relationship a priority despite external conflicts; building positive anticipation for sex; maintaining one's own identity and autonomy; having a solid self-esteem and confidence (and seeing oneself as a sexual being); and having low levels of stress and fatigue (Mark & Lasslo, 2018).

Specific partner-related attributes can also affect sexual desire, in either a positive or a negative direction, including the negative effects of having a partner with a high sexual interest who asks for (or even demands) sex with minimal efforts to elicit her sexual response; a partner with poor sexual technique or particularly rigid sexual beliefs about sexual technique; a partner with sexual needs that the woman believes she cannot satisfy; and a partner to whom the woman is not attracted (Witting et al., 2008). Partner factors that influence the range and intensity of stimuli used and the woman's response to those cues become an important focus in the clinical scenario. Communication has been identified as a major contributor to a woman's level of sexual desire, as well as consequence of sexual problems, and should always be addressed in the clinical setting.

## Sociocultural Influences

Sexuality has always been subject to the influence of social constructs. Negative messages about masturbation in girls and the view of women as passive recipients of men's sexual desires and actions may encourage a passive attitude to sexual activity and inhibit sexual desire (Boul, Hallam-Jones, & Wylie, 2009). Inadequate sex education, failure to meet cultural norms concerning sexual attractiveness or sexual response, fatigue due to family and work obligations, or conflict between the sexual norms of culture of origin and those of

the dominant culture may be at the heart of many sexual problems, including low desire (Tiefer, Hall, & Tavris, 2002) and therefore deserve attention clinically. Among one of the many potential sociocultural influences on women's sexual desire is ethnicity. Cross-cultural studies find markedly disparate rates of low desire depending on a woman's ethnic background (Cain et al., 2003; Laumann et al., 2005), and certain variables, such as sex guilt and religiosity, mediate the association between a woman's culture and her level of sexual desire (Woo, Brotto, & Gorzalka, 2011; Woo, Morshedian, Brotto, & Gorzalka, 2012). In the absence of qualitative data on how women from various ethnocultural groups experience sexual motivation, however, one must be cautious in assuming that a lack of motivation for sex means the same thing to women across cultures (Brotto, Atallah, et al., 2016).

## Assessment and Diagnostic Issues

The assessment of women with sexual interest and arousal problems is based on three main elements: a structured interview, a physical examination, and, to a smaller extent, a laboratory investigation.

### Structured Interview

A thorough biopsychosocial assessment should comprise a complete medical history (including hormonal status and mood), a demographic overview (along with sociocultural and family-of-origin issues that may have affected views on sexuality), and a developmental history (including past sexual experiences—wanted and unwanted). As in previous editions of this textbook, we continue to rely on the assessment/treatment algorithm illustrated in Figure 1.1. In evaluating the criteria for SIAD, the clinician must start by finding out how the woman understands and experiences sexual desire; what language she uses; and how and where in her body she experiences it. From there, the clinician can inquire about both frequency and intensity of sexual interest, fantasies/erotic thoughts, pleasure during sex, and physical sensations, both genital and nongenital. Some women may be more concerned with changes in frequency (how often they do, or do not, experience sexual interest/arousal), whereas other women may recognize changes in the intensity of their response. The range of sexual stimuli that might elicit a woman's sexual interest and arousal should also be explored, along with her current and past responses to such stimuli. An effort to be as sensation-inclusive as possible (i.e., what types of touch, tastes, sounds, sights, smells elicit excitement for her) is important. The clinician should also assess typical patterns of initiation between the couple given that a woman's lack of initiating sexual activity may not necessarily point to a problem (Velten & Margraf, 2017).

If the woman is currently in a relationship, assessment of nonsexual aspects of the relationship, level of commitment, partner's perspective on

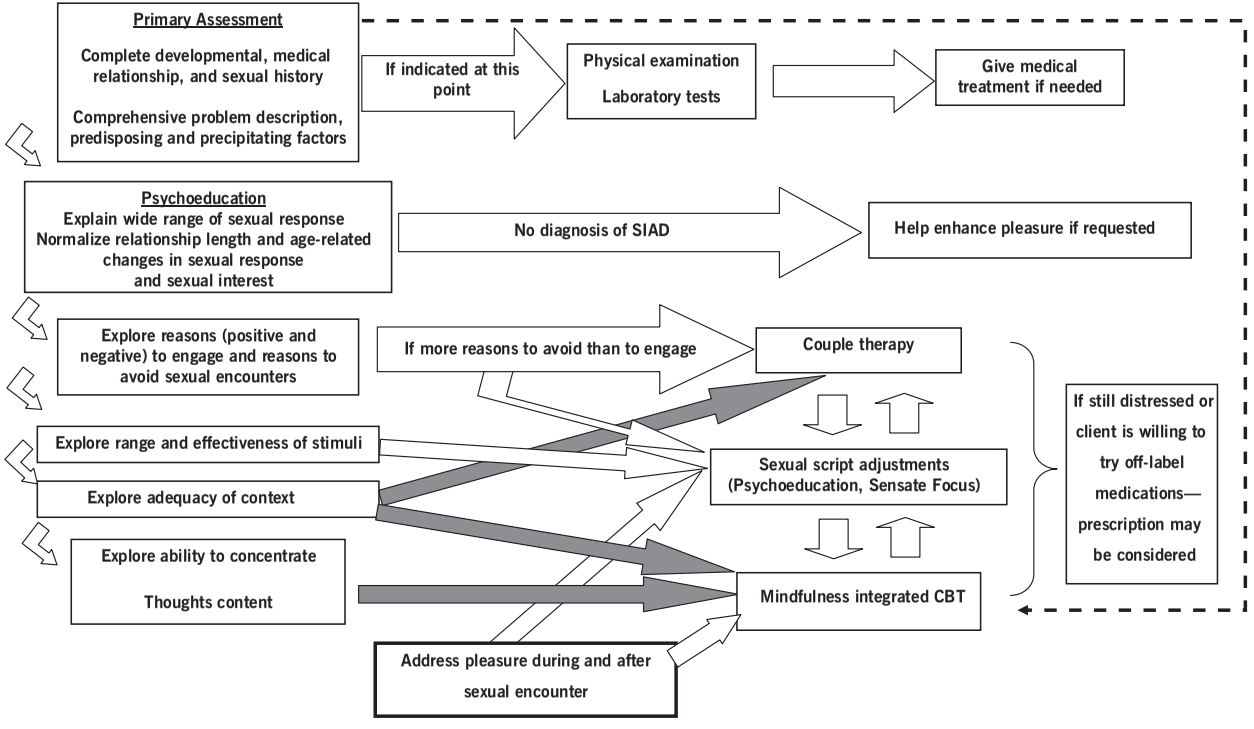


**FIGURE 1.1.** Assessment and treatment algorithm. After initial assessment, if medical problems are found, further medical examination and treatment are warranted. If psychological or couple issues are first detected, the client may benefit from treatment focusing on cognitive processing, mindfulness skills, and behavioral changes. In some cases, couple therapy is needed. Psychoeducation is imperative to overcome unfavorable beliefs and to define and adjust expectations. If there are few or no motivations to be sexual, sexual stimuli are not satisfactory, or thought content is distracting or disturbing, mindfulness-integrated CBT is recommended. Address sexual scripts and develop alternatives as needed. Address pleasure. Off-label medications are indicated only if previous steps were unsuccessful, after the client received full explanation on the limitations and possible risks of medical treatment.

symptoms, and partner's sexual function should be assessed. An interview with the partner (together and alone) can be invaluable. Specific to evaluating the diagnostic criteria for SIAD, the clinician should assess the woman's motivations (or lack of motivation) for sexual activity, as well as disincentives to engage sexually. The range of stimuli and current and past response to such stimuli, her ability to stay focused and experience responsive desire, and the sexual outcome—whether the sexual experience is emotionally and/or physically satisfying or pleasurable—should also be assessed. Even if a woman describes only a few effective cues that elicit her sexual desire/arousal, it is still crucial to evaluate her partner's sexual technique and other partner-related factors that may be explaining her symptoms (Laan & Both, 2011).

There are a large number of self-report and clinician-administered scales and interviews that assess sexual desire in women (for a review, see Brotto, Bitzer, Laan, Leiblum, & Luria, 2010). Although these can be useful for screening sexual symptoms in a busy medical setting, they are of unknown reliability in making a diagnosis of SIAD. The 17-item NATSAL-SF (Short Form) addresses some of the current gaps in the measurement of sexual functioning, as it not only assesses the most relevant symptoms of sexual dysfunctions but also includes questions on personal distress and sexual relationships (Mitchell, Ploubidis, Datta, & Wellings, 2012). We recommend that clinicians consider using this measure, since it allows clinicians not only to evaluate the presence or absence of sexual difficulties but also to assess whether relationship factors (e.g., sexual difficulties of a partner) play an important role (Mitchell et al., 2012).

### Physical Examination, Laboratory Investigations, and Specialized Examinations

At present, there are no strong data to support the use of physical examinations, laboratory investigations, or specialized examinations in the assessment of low desire in women. In the case in which a mental health professional is providing care, a referral to a primary care physician, nurse practitioner, or specialist may be warranted when pain is a contributor to low desire. Vulvovaginal hypotrophy or atrophy is common after menopause, in breastfeeding women, in women treated with low-estrogen or progesterone-only contraceptives, and in hypothalamic or pituitary disease. Ruling out these contributors to low desire/arousal is essential given that chronic vulvo-vaginal pain can contribute to chronic low sexual desire.

Laboratory evaluation is seldom of use in the identification of female sexual desire and arousal problems. That said, pain with sex can directly contribute to loss of sexual desire, and as such, a woman's hormonal status should be considered in the woman with SIAD, both at the time of assessment and as treatment unfolds. Given that loss of estrogen can contribute to sexual pain in the case of vulvo-vaginal atrophy, estrogen deficiency is best detected by

history and a physical examination. Androgen serum levels do not correlate with sexual desire and are currently not recommended (Reed et al., 2016). Assessment of genital sexual response with vaginal photoplethysmography, thermography, laser doppler imaging, or clitoral photoplethysmography are commonly used in the research and not the clinical setting (Chivers & Brotto, 2017; Chivers, Seto, Lalumière, Laan, & Grimbos, 2010), yet there is increasing evidence that examining concordance between genital and self-reported measures of sexual arousal may be relevant to improvements in sexual desire with treatment (Brotto, Chivers, Millman, & Albert, 2016).

A number of specialized tests, which are available to evaluate vascular and neurological parameters of women's sexual function, are usually available only in research settings. Their use in identifying women with SIAD is currently unknown, and they are not used clinically.

## Approaches to Treatment

Figure 1.1 outlines our treatment algorithm, which is based on the principles of incentive motivation (i.e., that sexual desire/arousal emerge in response to effective cues, and that each individual has a predisposition to sexual responsiveness that is influenced by both biology and psychology). This model emphasizes the importance of incentives for sex, stimuli, and context. Each of these aspects is addressed in treatment, identification of "breaks" in a woman's cycle is used to guide treatment, and this approach has been found effective in women with SIAD (Jabs & Brotto, 2018). For example, treatment of Jane, who states that her only motivation for sex is to avoid her husband's outbursts of anger and that she derives no personal benefit from sex, may include couple therapy focused on nonsexual dynamics, possibly including couple communication and emotional regulation skills for Jane's husband. On the other hand, some women may report having a variety of positive reasons to engage in sex but deriving little to no pleasure from sexual touch may limit foreplay to just a few brief moments prior to intercourse. Such patients and their partners may benefit from couple exercises in sensate focus and exploration of stimuli through skills in sexual technique. This may include psychoeducation on the nature of the sexual response, including the role of age, relationship duration, and sexual myths.

### Nonpharmacological Treatments for SIAD

The literature on nonpharmacological treatments for low desire/arousal has significantly increased in recent years; however, at present, there is insufficient evidence for a single "evidence-based" treatment. There is considerable interest in evaluating psychological treatments, in particular, cognitive-behavioral therapy (CBT) and mindfulness-based interventions (MBIs). At present, we can conclude that there is good evidence for these methods in improving women's

low desire and arousal, but additional research is needed that includes comparison groups that account for nonspecific therapeutic factors, such as time spent with an empathic therapist and the opportunity to discuss sexual matters (Brotto et al., 2017).

### *Cognitive-Behavioral Therapy*

Cognitive distraction during sexual activity negatively affects women's sexual esteem, sexual satisfaction, and sexual response. Such cognitive interference, which distracts the person from focusing on the erotic encounter, can also activate the autonomic nervous system, triggering negative affect that is not synonymous with sexual arousal or pleasure. Behavioral avoidance is a natural consequence, which further exacerbates the anxiety about performance (Barlow, 1986). Compared to women without sexual difficulties, those with sexual dysfunction hold stronger negative beliefs about the influence of age and body image on sexuality, and this makes them more vulnerable to activation of negative self-schemas (specifically those of incompetence) when confronted with a negative sexual situation (Nobre & Pinto-Gouveia, 2006). These self-critical schemas then trigger negative automatic thoughts, which prevent the woman from focusing on sexual stimuli and elicit negative affect, which further impairs sexual response. These findings provide a strong justification for the use of CBT skills such as challenging problematic thoughts and shifting attention allocation through performance-based exercises (see Brotto, Chivers, et al., 2016, for a review).

Eight weeks of individual CBT (including sensate focus, directed masturbation, and the coital alignment technique) significantly increases sexual desire and leads to lasting improvements 6 months later (Hurlbert, 1993). CBT administered in group format over 12 weeks to women with HSDD significantly reduces HSDD severity, with sustained gains even a year after treatment (Trudel et al., 2001). The finding that CBT for low desire, administered with minimal intervention and using a self-help manual, led to only marginal improvements (van Lankveld, Everaerd, & Grotjohann, 2001) suggests that this approach may be inadequate to address the complexity of loss of sexual interest within a relationship.

A meta-analysis by Frühauf, Gerger, Schmidt, Munder, and Barth (2013) identified 20 studies that included a wait-list control group, and another eight head-to-head comparisons. Most of the studies focusing on low desire used cognitive-behavioral approaches (a combination of behavioral skill training to improve communication between partners, increase sexual skills and reduce sexual and performance anxiety; anxiety reduction, and cognitive challenging). The meta-analysis found an overall large effect size ($d = 0.91$) for the primary endpoint of low desire, and a moderate effect size ($d = 0.51$) for sexual satisfaction. A summary of this literature also found that inclusion of the male partner in CBT treatment for women's low desire yielded better outcomes (Günzler & Berner, 2012).

### *Mindfulness-Based Interventions*

Clinically, women with SIAD may describe their symptoms as "a disconnect between my mind and my body" and may declare an absence of pleasure despite the genital arousal response remaining robust. MBIs, which aim to cultivate active awareness of the body in an accepting, nonjudgmental, and compassionate manner, might be ideally suited to help with the complaints of low sexual desire (Brotto & Heiman, 2007). Early studies of mindfulness found that three sessions could significantly improve sexual desire, sex-related distress, and perceptions of genital tingling (Brotto et al., 2008). More recently, this research has moved toward an eight-session format, similar to those used in mindfulness-based cognitive therapy for depression. In an uncontrolled trial of this approach for women with SIAD, there were significant improvements in sexual desire, reduced sexual distress, and increased overall sexual function, regardless of women's expectations about the treatment at the start of the program (Paterson, Handy, & Brotto, 2017). Stephenson (2017) reviewed the mechanisms by which mindfulness likely impacts sexual function in women and concluded that increasing attention to the body in a nonevaluative way (i.e., in a neutral and not a negative away) is likely a key mechanism. Other mechanisms by which mindfulness may improve sexual desire in women is by addressing negative sexual schemas, negative expectations about the outcome of sex, and targeting avoidance by teaching women how to remain in the present moment. A meta-analysis of all studies on mindfulness for sexuality in women concluded it to be an efficacious intervention (Stephenson & Kerth, 2017). Brotto's 2018 book *Better Sex through Mindfulness* provides a complete review of the literature on mindfulness and women's sexual desire.

### *Sensate Focus*

Masters and Johnson developed sensate focus as an antidote to spectatoring. They reasoned that sensate focus, with its focus on systematic touching between partners, with the goal of reducing anxiety and without the goal of triggering sexual arousal, could treat a range of sexual difficulties. Early studies of the Masters and Johnson approach showed remarkable outcomes, with high remission rates 5 years later (Masters & Johnson, 1970). In a more recent example of sensate focus instruction, Weiner and Avery-Clark (2014) reminded clinicians that the instructions to partners were to touch for the purposes of noticing sensations—not becoming aroused. Moreover, like the instructions given in mindfulness, partners are encouraged to redirect their minds back to the sensations when they got distracted. Although there are no data on the efficacy of sensate focus specifically for low sexual desire, evidence that 84% of sex therapists use sensate focus with clients suggests its effectiveness.

## Pharmacological Treatments for SIAD

The search for a pharmacological means to cure women's low desire has been fierce. The main paths under investigation include hormonal treatment, dopaminergic agonists, melanocortin-stimulating hormones, alpha-adrenergic antagonists, nitric oxide delivery systems, and prostaglandins. Because most of these agents have been tested in women meeting criteria for HSDD or FSAD, their efficacy in treating SIAD is largely unknown. A recent meta-analysis of 42 different treatment modalities and 26 different classes of medications for women's sexual dysfunction provides a current update as to the status of pharmacological treatments in desire (Weinberger, Houman, Caron, & Anger, 2019). Among the estrogens, given the direct causal relationship between low estrogen levels and atrophy, estrogen therapy, unless contraindicated, is the current standard of care for treating this condition (Tan, Bradshaw, & Carr, 2012). A recent review of systemic estrogen therapy concluded that restoring estrogen to periovulatory levels can increase desire (Cappelletti & Wallen, 2016) given that painful sex can reduce desire. However, guidelines from the International Society for Sexual Medicine recommend that data do not support the use of systemic estrogen for any postmenopausal sexual dysfunction, and note that vaginal estrogen to improve dryness and genital pain may indirectly increase sexual motivation (Santoro, Worsley, Miller, Parish, & Davis, 2016). For women with a history of hormone-dependent cancer, management is decided in consultation, with the oncologist balancing quality-of-life concerns and risk of recurrence.

The controversy surrounding the use of testosterone for the treatment of low sexual desire has a long history and continues to be hotly debated today. Although, as reviewed earlier, there is no consistent relationship between women's self-reports of desire and their measured levels of testosterone, a review of studies in naturally and surgically menopausal estrogen-replete women concluded that most studies do show a statistically significant improvement in sexual desire compared to placebo (Achilli et al., 2017). Despite its lack of U.S. Food and Drug Administration (FDA) approval, some expert consensus panels continue to recommend its use (Goldstein et al., 2017). The Endocrine Society reappraised its previous recommendations, and in 2014 indicated that a 3–6 month trial of testosterone for postmenopausal women with HSDD could be considered (Wierman et al., 2014).

Available in 90 countries (but not in North America), tibolone is a 19-nortestosterone derivative and a selective tissue estrogenic activity regulator (STEAR) that is metabolized into metabolites with estrogenic, progestogenic, and androgenic properties. A 2013 Cochrane Review concluded that the current evidence does not suggest an important effect of tibolone or of SERMs (selective estrogen receptor modulators), alone or combined with estrogens, on sexual function in women (Nastri et al., 2013).

Dehydroepiandrosterone and its sulfate ester, DHEA-S, are the most

abundant steroid hormones in women. In addition to being a prohormone for the intracellular production of testosterone and estrogen, DHEA has multiple direct actions throughout the brain and body. Vaginal DHEA, which is now approved by the FDA, has been found to improve vaginal lubrication and comfort with sexual intercourse, produce easier and more intense orgasms, and increased desire (Labrie et al., 2016). In women with reduced genital sensitivity (one of the six SIAD criteria) associated with oral contraceptive use, daily administration of 50 mg DHEA significantly improved symptoms (van Lunsen et al., 2018). It is likely that the beneficial effects of DHEA-S on desire are directly mediated by its effects on genital sensitivity.

### Centrally Acting Investigational Medications for Low Desire/Arousal

Since the previous edition of this book, there has been a major advance in the field with the FDA approval of flibanserin (i.e., Addyi) in the United States in 2015, and by Health Canada in 2018, for the treatment of low desire in premenopausal women, after two previous failed attempts at approval in 2009 and 2013. A large part of the success was attributed to a forceful campaign led by Sprout Pharmaceuticals called "Even the Score." The campaign used feminist rhetoric and demanded that gender inequities in the approval of medications to treat sexual dysfunction need to stop. They repeated that men have 26 available medications, whereas women have zero, which ultimately swayed the FDA board's decision.

There have been three systematic reviews or meta-analyses of flibanserin. Focusing on published data only, Gao, Yang, Yu, and Cui (2015) analyzed four double-blind RCTs and found that the standardized mean difference between flibanserin and placebo was only 0.59 for sexually satisfying events per month. The standardized mean difference between the flibanserin and the placebo group was 0.32 units on the Female Sexual Function Index (FSFI) Desire subscale. Women given flibanserin were 1.54 times as likely to experience an adverse event as women in the control condition. A second systematic review included three unpublished clinical trials of flibanserin, and found a less impressive outcome, with an increase of 0.49 sexually satisfying events per month, compared to placebo (Jaspers et al., 2016). Moreover, twice as many women in the flibanserin group discontinued participation due to adverse events, compared to placebo, with high odds ratios for dizziness (4.0), somnolence (3.97), nausea (2.35), and fatigue (1.64). A third meta-analysis has been published (Hassan Saadat et al., 2017), based on six published and four unpublished studies on a total of 8,345 women. This analysis concluded that although flibanserin was associated with significant increases in sexual desire, the magnitude of this increase did not differ from placebo (Saadat et al., 2017).

What can we conclude from these large systematic reviews of flibanserin? Well, if prescribing patterns are any indication of its popularity, flibanserin is

not likely to make significant shifts in our management of women with SIAD. Although it was statistically more effective than placebo for improving the number of sexually satisfying events, the absolute count was rather modest. Perhaps more importantly, its contraindication with alcohol (due to the finding that it potentiates the risk for dizziness, hypotension, and syncope) for the entire duration of its use may be contributing to the lack of uptake (Fugh-Berman, 2016).

## Peripherally Acting Investigational Medications for Low Desire/Arousal

Pharmacological agents that target genital congestion may not be clinically relevant given that most women who present for treatment because of sexual interest or arousal concerns have normal genital congestion when measured in the laboratory. If difficulties with genital sexual sensations predominate the clinical picture and/or if the genital arousal response is related to spinal cord injury or diabetes, sildenafil may be considered. Combining centrally acting with peripherally acting agents has been proposed as a means to address the complex etiology of low desire in women (Bloemers et al., 2013; Poels et al., 2013) and though promising, to date, none of these medications has received FDA approval.

Bremelanotide (Vyleesi), a melanocortin agonist, crossed the finish line second in June 2019 as a treatment for low desire in premenopausal women. It has received considerable attention given its unique mode of delivery and different side effect profile from flibanserin. Early research with bremelanotide focused on an intranasal route of administration, but research over the past several years has focused on subcutaneous delivery. In an RCT of 1.25 mg and 1.75 mg bremelanotide given to premenopausal women with HSDD who were in a stable relationship and currently sexually active, treatment resulted in an increase of 0.7 sexually satisfying events per month, whereas the increase was only 0.2 for the placebo group (Clayton et al., 2016). The most common adverse events were nausea (up to 24%), flushing (up to 17%), and headache (up to 14%) in the bremelanotide arm compared to the placebo arm (where up to 3% experienced these adverse events). None of the women had reactions due to the injections. A meta-analysis comparing flibanserin to bremelanotide found that the Cohen's *d* effect size for flibanserin was 0.4 (compared to placebo) and for bremelanotide was approximately 0.3 (compared to placebo (Pyke & Clayton, 2018). By comparison, their analysis of psychological studies that included a wait-list control group revealed a median effect size of 0.72 over wait list (range: 0.11–1.79).

The placebo response represents a true therapeutic effect and we would do well to understand its underlying mechanisms (Bradford & Meston, 2009). Weinberger et al. (2018) carried out a meta-analysis of randomized trials to quantify how much of the pharmacological treatment response was due to the placebo effect. They concluded that the placebo effect accounts for two-thirds

of the treatment effect in the 4,000 women who participated. Psychological treatments, too, are impacted by the placebo response, since even studies that include a no-treatment or support therapy control group in psychological RCTs show benefits. Brotto et al. (2017) conclude that it is very challenging within psychological treatment outcome studies to have a true control group that does not administer any therapeutic elements.

### What Can We Conclude Based on Treatments for Low Desire?

Taken together, the literature reviewed suggests there is much work to be done in terms of evaluating treatments for women with SIAD. The algorithm in Figure 1.1 indicates that if medically indicated, pharmaceutical treatment may be useful, though the clinician must bear in mind that most of them remain off-label. Nonpharmacological treatments such as sensate focus, CBT, and mindfulness skills show an impressive (and growing) body of science to support their use. We advocate a stepwise treatment plan that includes psychoeducation and clarification of myths early on, followed by more concentrated couple and/or individual therapy at subsequent stages. If lack of motivation/incentives for sex, difficulties with effective stimuli, or a problematic context are contributing to the SIAD symptoms, we advocate strongly for involvement of the partner in therapy.

## Case Discussion: Mindfulness-Based Cognitive Therapy in the Treatment of SIAD

Tae was a 56-year-old, full-time mining company vice president in a common-law relationship with Jonathan, a bank manager. They had no children together, but Tae had two adult children from a previous marriage. They presented for treatment after struggling with discrepant desire in their relationship for the past 10 years of their 12-year relationship. Tae reported a low interest in sex in this relationship, but not with her previous husband, nor with partners prior to that. At the time of her assessment, she did not initiate sexual activity with Jonathan but occasionally "gave in" to his requests for sexual activity, as she noticed he was kinder and easier to get along with after sex. In recent years, Jonathan initiated sex less often, and they both found this distressing. Tae did report fantasizing as a way of deliberately triggering sexual arousal while she had sex with Jonathan, and they were both accepting of this. When asked about triggers for her sexual desire, Tae said that in the past, she experienced a noticeable increase in her desire for sex at ovulation, but since becoming postmenopausal 3 years earlier, she no longer had any peaks of spontaneous desire. She reported feeling aroused when they watched movies with erotic scenes, though she did not watch erotica or pornography. Sex was occasionally painful since perimenopause, and she stated that her gynecologist had

confirmed signs of vulvo-vaginal atrophy. Tae's use of a vaginal lubricant, as well as moisturizer, provided sufficient relief, and she was not using any hormonal oral medications. Tae had difficulty identifying any nongenital signs of arousal during sex, and it was, as a result, only minimally pleasurable.

The combination of low interest in sex, lack of initiation of sex, difficulties with genital and nongenital sensations, and lack of pleasure during sex, which elicited significant personal distress, and which has lasted for more than 6 months, meant that Tae met diagnostic criteria for SIAD. The clinician also evaluated Tae's mood and history of psychological functioning. Tae struggled with a lifelong history of anxiety—particularly revolving around a fear of negative evaluation. These symptoms intensified during postmenopause, which coincided with her promotion to vice president at work. She took increasing amounts of work home with her in the evenings, and her sleep was disrupted due to waking up and thinking about her deadlines. Tae also found that hot flashes and sleep disruption increased her levels of irritability, and she occasionally had anger outbursts toward Jonathan over issues that, in her words, would have "barely raised an eyebrow" in the past. Her family doctor had put Tae on trazodone (an antidepressant commonly prescribed for sleep disturbance) to help with her poor sleep and she experienced some benefit.

Using Figure 1.1 as a guide, the clinician carried out a complete history of Tae's low desire concern and determined that this was generalized, as well as acquired. The clinician did not refer Tae for assessment of vulvo-vaginal symptoms given that she regularly sees her gynecologist, who carried out a physical examination, and that Tae was benefiting from a lubricant and moisturizer. There were two possible issues from Tae's past that may have contributed to her current concerns. First, she was sexually assaulted as a teen, and for a period of 2 years was in treatment for posttraumatic stress disorder, which was largely in remission except for ongoing struggles with irritability. Second, Tae reported that her first husband had erectile dysfunction, and that for the last 5 years of their marriage, sex was fast (i.e., less than 2 minutes) to capitalize on the duration of his erection. As a result, Tae ceased engaging in sexually arousing activities prior to intercourse.

The entire first treatment session was spent providing psychoeducation and describing the circular model of sexual response, as well as principles of incentive motivation theory. The therapist guided Tae to think about her reasons for sex, and Tae stated that sex nurtured emotional intimacy with Jonathan, ensured that he was in a good mood, and provided her with feelings of self-confidence. The therapist provided Tae with a list of reasons for sex and encouraged her to read them over and identify any reasons that she might consider "trying on" in a future encounter. In addition, they explored triggers for Tae's sexual response, and the clinician shared a list of stimuli that were tactile, visual, and auditory, as well as olfactory. Tae found it very useful to think about stimuli across a range of sensory capacities, and not just touch. Early sessions focused on exploring possible positive incentives to engage in

sex and having Tae experiment with various stimuli as a way of cultivating sexual response.

Tae then participated in a mindfulness group for women with low sexual desire. The group was of 8 weeks' duration and led by a different clinician with expertise in mindfulness meditation skills, as well as sex therapy. The first four sessions focused on formal mindfulness practice consisting of 30 minutes per day of a guided meditation. Tae practiced the body scan daily for the first 2 weeks of the program and became increasingly adept at noticing sensations in her body, including physical sensations associated with anxiety or irritability. She was able to "ride out" uncomfortable physical sensations, and as a result stated that her sleep improved. Over the next 2 weeks, she learned mindfulness of the breath, of sounds, and of thoughts. The latter allowed Tae to manage symptoms of irritability, and she labeled these as "mental events" as opposed to her typical pattern of ruminating over the things that irritated her. She found that her ability to manage the large team at the mining company improved markedly.

In the next four sessions, Tae learned to progressively incorporate her mindfulness skills into sexual scenarios, starting with body scans while she touched herself. She started with non-goal-oriented self-touching with her eyes closed, in which she focused intently on the various feelings that arose. This was also an opportunity to observe judgmental thoughts she had of herself as a result of perimenopausal body changes. She could observe these negative thoughts "from a distance"—as by-products of mental activity rather than definitive facts that needed to rule her life. From there she moved to mindfulness goal-oriented touching and she could follow the moment-by-moment mounting tension of arousal that culminated in orgasm. Importantly, Tae reported enjoying these exercises.

Sensate focus was then prescribed, and described through the language of mindfulness (Weiner & Avery-Clark, 2014), with no particular goal in mind other than becoming aware of sensations, and providing feedback to Jonathan about the touch sensations (and vice versa) during the touching. Both found sensate focus to be very arousing, and it exposed them to physical sensations elicited by the other person's touch that they had never noticed before.

Sensate focus was eventually replaced with a deliberate folding in of mindfulness skills during sexual activity—not just during intercourse, but starting with the earliest indication that a sexual encounter might ensue, and through to the hours after the encounter ended. Tae used visual mindfulness to observe Jonathan and his body, without judgment. She also closed her eyes to focus on the range of unfolding physical sensations—genital and nongenital—that arose with stimulation. She even shifted attention to sounds and smells and described a "sexual awakening" that she had not expected at this stage of her life.

Jonathan responded positively to Tae's increased pleasure during sex, and he began to initiate sex more often, which Tae accepted willingly. She deliberately thought of various reasons why she wanted to proceed with sex, even

when she was not "in the mood" when Jonathan invited her. By the end of the 8 weeks, Tae felt that she had gained considerable awareness of her various reasons for sex, and the range of triggers that could elicit sexual response for her, and she was comfortable asking for what she wanted to feel pleasure. Tae also kept up her daily practice of guided meditations, with a focus mostly on body scans and mindfulness of thoughts practices. Though there was ongoing work to do, Tae and Jonathan were in a markedly different place after 3 months of individual work coupled with the 8 weeks of mindfulness group, and they were both highly motivated to continue. In fact, they both signed up for monthly meditation drop-ins at their local meditation center.

## Conclusions

Low sexual desire continues to be the most common sexual concern expressed by women; it is distressing, and impacts various facets of individual and interpersonal functioning. Though SIAD as a diagnostic entity was only approved relatively recently, in 2013, data concerning its prevalence and studies recruiting women with SIAD are starting to emerge, and there is evidence that most women previously diagnosed with HSDD would still meet criteria for SIAD. When assessing women with low desire, there is evidence for the usefulness of including criteria focused on lack of arousal sensations, as well as lack of pleasure during sexual activity. Since difficulties with arousal commonly co-occur with low or loss of sexual motivation, it is important that sexual desire and sexual arousal both be assessed in the clinical context. Existing models that emphasize the responsive nature of sexual desire, the importance of sexual stimuli, the role of memory and attention in eliciting sexual response, and that highlight the role of motivations for sexual activity are extremely useful and should be incorporated into both assessment and treatment of low desire. We advocate for a comprehensive biopsychosocial assessment that is attentive to the woman's own understanding and definition of sexual desire and motivation, is sensitive to her own sociocultural context, and does not solely rely on the use of self-report questionnaires.

There is good evidence for the efficacy of both CBT and MBIs for improving women's sexual desire and associated aspects of quality of life, and sensate focus remains a long-standing staple in the treatment of low desire. Although flibanserin and bremelanotide are the only medications approved by the FDA for the treatment of low desire, the magnitude of their improvement is small, and the side-effect profile is high. There is considerable promise for other investigational medications that may have better outcome data, but no others have yet been approved.

The field of sex therapy must move toward identifying particular patient characteristics that would improve the efficacy of particular treatments over others, so that clinicians can make better informed decisions about what works best for whom. Moreover, we know virtually nothing about the efficacy of

combined psychological and pharmacological approaches. Given the dramatic improvement in the scientific literature on women's sexual desire over the past decade, we expect the next decade to see even more marked advances that will allow our field to make a meaningful contribution to the sex lives of women facing low sexual desire.

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CHAPTER 2

# Female Sexual Arousal Disorder

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Whether female sexual arousal disorder (FSAD) is a stand-alone problem is one of the most controversial topics in the field in the field of sexual dysfunction. The exclusion of this diagnosis from DSM-5 but its inclusion in ICD-11 attests to this controversy. Whereas Brotto and Velten (Chapter 1) make a cogent argument for the blending of arousal and desire problems into an expanded DSM-5 diagnostic category of female sexual interest/arousal disorder (FSIAD), in Chapter 2, Meston, Stanton, and Althof not only argue for the existence of FSAD as a distinct diagnosis but they also suggest there are two distinct subtypes, female genital arousal disorder (FGAD) and female cognitive arousal disorder (FCAD). We have included both arguments in this volume, so that readers may make their own informed decisions. The authors of this chapter review the extensive theoretical and empirical literatures concerning sexual arousal in women, provide detailed descriptive and clinical information regarding their proposed subtypes of arousal, and offer guidelines on how to differentiate them from disorders of sexual desire in women. The authors conclude that "refining the subcategories of FSAD—that is, explicitly distinguishing between FGAD and FCAD and developing clinical assessment measures and interventions around these diagnoses—will provide meaningful options for clinicians who identify, evaluate, and treat women with female sexual arousal disorder."

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Consider a premenopausal woman who is approached by her partner to engage in sexual activity. She was disappointed when her partner did not want to have sex yesterday, so she feels particularly motivated to do so today. When they commence foreplay, she notices that she is not feeling the physiological genital sensations that she typically feels during sexual activity (e.g., warmth, pulsing, tingling), and her vagina also fails to become lubricated. She is not "turned on," and she begins to think about the work that she needs to get done rather than focusing on relevant sexual cues. Even after sufficient stimulation, she is not mentally aroused, and her lack of lubrication makes penetration unpleasant and somewhat painful. In the past few months, she has experienced repeated episodes of not being able to become genitally or cognitively aroused. She feels really distressed by these symptoms, and she is concerned that sex may never be as pleasurable as it once was. Should these symptoms continue, she may be diagnosed with both female genital arousal disorder (FGAD) and female cognitive arousal disorder (FCAD), the two distinct subtypes of female sexual arousal disorder (FSAD).

In this chapter we argue that FSAD is a stand-alone condition that includes a genital subtype and a cognitive subtype. The genital subtype (FGAD) describes deficits in genital blood flow, genital sensations and lubrication, whereas the cognitive subtype (FCAD) is characterized by a lack of mental arousal (commonly referred to as subjective sexual arousal or cognitive sexual arousal) during sexual activity (Parish et al., 2019). If the arousal concern is exclusively genital, then a diagnosis of FGAD is appropriate; if the arousal concern is exclusively cognitive, then a diagnosis of FCAD is appropriate. Women may report decreases in both components of arousal, in which case both diagnoses are applicable.

## Defining the Diagnosis and Assessing Relevant Symptoms: What Does Sexual Arousal Dysfunction Look Like in Women?

The most recent version of the DSM, DSM-5, published in 2013, merged hypoactive sexual desire disorder (HSDD) and FSAD into a new diagnostic category called female sexual interest/arousal disorder (FSIAD), which is characterized by six symptoms (three are needed to establish the diagnosis; American Psychiatric Association, 2013). The criterion set includes some symptoms of hypoactive sexual desire (e.g., lack of/lowered concern with sex, lack of/lowered cognitions and fantasies about sex) and some subjective and physiological aspects of female sexual arousal (e.g., lack of/lowered sexual arousal/enjoyment during sex, reduced physical sensation; American Psychiatric Association, 2013).

The rationale for this change was based on studies demonstrating that (1) women fail to differentiate between desire and arousal (Brotto, Heiman, & Tolman, 2009; Graham, Sanders, Milhausen, & McBride, 2004), (2) deficits in subjective arousal rarely occur independently of decreased sexual desire, and (3) there is considerable significant symptom overlap in women with HSDD and FSAD.

The 11th edition of the *International Classification of Diseases* (ICD-11) will include a new chapter on conditions related to sexual health (Reed et al., 2016). The proposed guidelines for this chapter include separate diagnostic categories for HSDD (which is gender-neutral) and FSAD (which can only be applied to women). According to ICD-11 proposed diagnostic criteria:

> Female sexual arousal dysfunction is characterized by absence or marked reduction in response to sexual stimulation in women, as manifested by any of the following: 1) Absence or marked reduction in genital response, including vulvovaginal lubrication, engorgement of the genitalia, and sensitivity of the genitalia; 2) Absence or marked reduction in non-genital responses such as hardening of the nipples, flushing of the skin, increased heart rate, increased blood pressure, and increased respiration rate; 3) Absence or marked reduction in feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation. The absence or marked reduction in response to sexual stimulation occurs despite the desire for sexual activity and adequate sexual stimulation, has occurred episodically or persistently over a period at least several months, and is associated with clinically significant distress. (World Health Organization, 2018).

Other organizations and scholarly societies may choose to publish their own recommendations for diagnostic criteria. Several sexual health organizations have done so, including the International Society for the Study of Women's Sexual Health (ISSWSH; Parish et al., 2016, 2019), the International Consultation on Sexual Medicine (ICSM; McCabe et al., 2016), and the American Foundation of Urologic Diseases (AFUD; Basson et al., 2000).

As diagnostic systems change to reflect the findings of current research, there have been discussions and disagreement about the nature of sexual arousal in women among these societies. There is agreement that sexual arousal and sexual desire are separate constructs and are therefore diagnostically distinct, as reflected in ICD-11 but not DSM-5. A consensus panel convened by ISSWSH at first suggested that cognitive arousal is an aspect of sexual desire (Parish et al., 2016), implying that a cognitive subtype of FSAD was not needed. However, a later consensus panel agreed with the ICSM and the AFUD recommendations that FSAD include a cognitive subtype, FCAD (Basson et al., 2000; McCabe et al., 2016). The ISSWSH Consensus Committee made a clear statement to the effect that sexual desire and sexual arousal are separate constructs, as are genital and cognitive arousal, though deficits in any of these areas can occur contemporaneously (Parish et al., 2019). Cognitive sexual arousal was described as a mental state *during* sexual activity, as in a particular level of mental excitement that is maintained throughout intercourse or self-stimulation.

Evidence in support of the notion that cognitive arousal[1] is distinct from sexual desire comes from the original validation study of the Female Sexual Function Index (FSFI; Rosen et al., 2000), which indicates a shared variance between the domains of Desire and Arousal (the domain that most closely assesses cognitive arousal) of 58%. This modest percentage not only suggests relatedness between constructs, which is not surprising given that desire problems can lead to arousal problems, and vice versa, but also demonstrates a clear distinction between desire and arousal. Similar evidence comes from an online study of 933 women, in which correlations between individual items from the FSFI that most clearly reflect desire and cognitive arousal were also shown to be in the low-to-moderate range for both sexually functional and dysfunctional women (Althof et al., 2017). A third line of evidence indicates that levels of cognitive arousal to erotic films did not differ between sexually functional women and women with low desire. If desire and cognitive arousal were one and the same, we would expect to see significantly lower levels of cognitive arousal among women with low desire compared to women with no desire concerns (Althof et al., 2017).

Laboratory studies have documented low levels of agreement or concordance between measures of genital arousal and measures of cognitive arousal (Chivers, Seto, Lalumière, Laan, & Grimbos, 2010). These data have been used to suggest that women are unable to detect their genital cues or are disconnected from their genitals and to argue against including cognitive arousal in the classification or definitions of FSAD. However, recent research demonstrates that women are quite capable of detecting their genital responses.

[1]The term "subjective arousal," which has been used relatively consistently in the literature over the past several decades, was replaced with "cognitive arousal" for increased clarity and simplicity. "Subjective" implies that a woman's mental experience of arousal is unreliable or based on opinion rather than fact.

When women with and without FSAD were asked to continuously report on the level of arousal in their genitals, significant relationships emerged between their perceived genital arousal and their actual genital arousal (Handy & Meston, 2016, 2018). Therefore, it is unlikely that low correlations between cognitive and genital arousal are due to an inability to detect genital cues. Rather, they may be due to individual variability in the degree of importance that is attributed to genital cues within the context of the overall arousal experience (Meston & Stanton, 2018). For some women, the experience of sexual arousal is closely associated with their genital response (Rellini, McCall, Randall, & Meston, 2005). For other women, sexual arousal is likely determined by their level of cognitive engagement during sexual activity, which may be affected by relationship factors, contextual factors, body image, and previous sexual experiences.

This following two vignettes illustrate cases of FCAD and FGAD, respectively, in women who report strong sexual desire.

> Carol, a 37-year-old woman, has been married to Robert, age 50, for 6 years. Carol's presenting complaint is that she does not feel "turned on" by Robert. She wants Robert to be more sexually aggressive—pulling her hair, engaging in "rough sex," prolonged kissing, and slow but intense lovemaking. When they were initially dating, Robert was more forceful; he would push her against the wall, kiss her passionately, and he was eager to make love to her. This all stopped after marriage. Carol confided that she enjoys reading erotica and watching pornography in which women are dominated, bound, and demeaned. There was no significant deficit in Carol's ability to become lubricated with sexual stimulation or to experience genital sensations.
>
> Carol loves Robert and feels guilty about her perception of him as "too soft." She knows that many other women would prefer Robert, but she needs someone more dominant to feel engaged during sexual activity. As Robert became less forceful, she focused on one of her fantasies while having sex; but over time, this strategy resulted in her feeling disconnected from Robert and guilty over her specific needs. Presently, she cannot find a way to become aroused and engaged in sex with Robert.
>
> This is a challenging case, because Carol and Robert have different sexual scripts. A few different directions for intervention were discussed with the couple: (1) Seek compromise by suggesting that Robert act out Carol's fantasy, and that Carol act out Robert's fantasies as well; (2) attempt to change or broaden their sexual scripts by investigating mutually arousing sexual stimuli; (3) attempt to decrease Carol's shame regarding her fantasy life by acknowledging the lack of sexual chemistry between them; and (4) explore the possibility of an open marriage. After presenting these options to the couple, Carol and Robert both agreed to engage with each other's fantasies through role play and to attempt to identify mutually arousing sexual activities with the help of

the therapist. They decided to keep the open marriage option on the table for later consideration should the interventions fail to increase Carol's arousal.

Shelly is a 48-year-old, widowed female. Two years ago, her husband of 20 years died suddenly of a massive heart attack. Shelly was devastated by his unexpected death and sought help from a local grief support group. With the urging of her support group, Shelly felt ready to date. She dated several men, usually once or twice, not meeting anyone special.

Eighteen months after she began dating, Shelly met Eric and really liked him. As their relationship deepened, they became sexual. At the age of 35, Shelly had undergone a total hysterectomy and began hormone replacement therapy. This allowed her to continue having a frequent and satisfying sexual life with her husband. However, during intercourse with Eric, she experienced vaginal dryness and had almost no genital sensations. She acknowledged having strong sexual desire and felt mentally turned on by Eric, yet her body was not responding. She consulted her gynecologist, thinking something was physically wrong. The gynecologist ruled out genitourinary syndrome of menopause and suggested she speak to a therapist.

As the therapist and Shelly reviewed her sexual relationship with Eric, she disclosed her conflict—she wanted to move on in her life, and she found Eric to be quite attractive, yet she felt as if she were having an affair. She knew this was irrational but could not get past her feelings.

Although a woman's initial complaint may be, "I don't feel turned on," it is up to the clinician to assess both the cognitive aspects ("Are you turned on mentally?") and genital sensations (Are you experiencing warmth, tingling, or throbbing?"). The therapist recommended that Shelly engage in mindfulness exercises to increase her awareness and perception of her genital sensations. To increase attention to her sensory perceptions, the therapist also encouraged Shelly to start practicing sensate focus to build intimacy with Eric.

## Measuring Sexual Arousal in Women

Assessment tools that gauge both genital and cognitive subtypes of arousal help clinicians select interventions that best treat the presenting symptoms and researchers determine which participants to include in treatment outcome studies. Assessment of sexual arousal concerns may include clinical interviews, self-report measures, and laboratory procedures. Clinical interviews should include a comprehensive sexual history that assesses all domains of female sexual function (e.g., desire, cognitive arousal, genital arousal, orgasm, satisfaction, pain), as well as general mental health concerns, partner variables (e.g., quality of the relationship, partner sexual function, partner sexual skills), and

sexually relevant cultural factors. Questions that inquire about genital arousal specifically should probe the presence–absence of specific genital sensations and lubrication, whereas questions related to cognitive arousal should assess the degree to which lack of mental engagement during sex interferes with satisfying sexual function. These questions should also help determine the degree of distress experienced by the individual, the context of the problem (e.g., does the patient experience decreased genital or cognitive arousal in all situations or in specific situations?), and the duration of the problem (e.g., lifelong or acquired). The clinician may also ask about factors that are known to impact cognitive arousal, including distraction from sexual cues, negative self-talk, and partner/relationship concerns.

Self-report measures, which have practical benefits, may also be used to assess for arousal dysfunction and to differentiate genital arousal concerns from cognitive arousal concerns. No existing psychometric instruments exclusively assess cognitive sexual arousal in women. Similarly, no questionnaires have been empirically validated to distinguish cognitive arousal from genital arousal. However, there are subscales of existing validated measures that independently assess both the mental experience of arousal and the genital sensations associated with arousal. For example, the FSFI (Rosen et al., 2000) has an Arousal subscale, which includes items that pertain to cognitive arousal (e.g., "Over the past 4 weeks, how would you rate your level of sexual arousal ('turn on') during sexual activity or intercourse?"), and a Lubrication subscale, which includes items that assess the amount of vaginal lubricant produced during sexual activity, a key aspect of genital sexual arousal. Other self-report measures, including the Sexual Function Questionnaire (SFQ; Quirk et al., 2002) and the Changes in Sexual Function Questionnaire (Clayton, McGarvey, & Clavet, 1997), also inquire about aspects of cognitive and genital sexual arousal.

In a laboratory setting, genital sexual arousal is most often assessed using a vaginal photoplethysmograph, which contains a light source that illuminates the capillary bed of the vaginal wall and a phototransistor that detects the amount of back-scattered light (Sintchak & Geer, 1975) to provide an indirect index of vasocongestion. Other laboratory-based assessment tools that measure genital arousal include thermography, which documents physiological changes by detecting and photographing infrared patterns (Kukkonen, Binik, Amsel, & Carrier, 2007), and pulsed-wave doppler ultrasonography, which uses ultrasound technology to produce an image of blood vessels and surrounding organs in real time (Goldstein & Berman, 1998).

Laboratory measurement of cognitive sexual arousal can be either discrete, such as the Film Scale (Heiman & Rowland, 1983) which includes several items that tap into the construct of cognitive arousal (e.g., feeling "turned on," mental excitement), or continuous. Continuous measurements allow women to report on their level of cognitive arousal in real time *during* exposure to a sexual stimulus. Participants move either a computer mouse or a lever (e.g., Rellini et al., 2005), to indicate their level of cognitive arousal over

a period of time. These laboratory tools are clinically useful in that they can track treatment-related changes in arousal over time.

## Epidemiology

Prevalence estimates for genital arousal and lubrication problems as defined in DSM-IV-TR range from 8 to 23% of women, although higher rates (21–28%) have been noted when assessing sexually active women (for a review, see Lewis et al., 2010; McCool et al., 2016). When assessment includes accompanying distress, prevalence rates are lower (3.3% of U.S. women ages 18–44; Shifren, Monz, Russo, Segreti, & Johannes, 2008). Given the similarity in diagnostic criteria between the DSM-IV-TR diagnosis of FSAD and the criteria for FGAD as proposed by Parish et al. (2016, 2019), it is likely that prevalence rates are comparable for FSAD and FGAD. To date, there are no prevalence statistics available for FCAD.

In terms of risk factors, women who report good overall health are less likely to have any type of sexual dysfunction. Hypertension and hypertensive drugs are associated with decreased lubrication, as well as orgasm and desire concerns, and stress urinary incontinence is negatively associated with all aspects of women's sexual dysfunction, including arousal (Lewis et al., 2010). Anxiety, depression, and antidepressant medications, particularly selective serotonin reuptake inhibitors (SSRIs), are also associated with sexual arousal problems (Barlow, 1986; Keltner, McAfee, & Taylor, 2001; Kennedy & Rizvi, 2009).

## Etiology of Genital and Cognitive Sexual Arousal

### Genital Sexual Arousal

Genital sexual arousal in women results from the processing of physical and nonphysical emotional stimuli, which leads to increased activity in the central and peripheral nervous systems (Parish et al., 2016). This in turn leads to a number of genital changes. Vaginal lubrication is the first sign of genital arousal in women (Masters & Johnson, 1966). Basal vaginal fluid, produced from a variety of glands and epithelia (Levin, 2003), does not fully lubricate the vagina, but it generates enough moisture to prevent adhesions. As arousal intensifies, vasocongestion and capillary pressure force more fluid into the tissues, which increases the volume of fluid on the surface of the vaginal epithelium. After about 20 seconds of sexual stimulation, the onset of vaginal lubrication is followed by an increase in vaginal vasocongestion to the internal and external genitalia (Azadzoi & Siroky, 2010). Heightened sympathetic nervous system activity leads to increased vascular blood flow to the vulva, vagina, and clitoris, leading to engorgement, increased temperature, and lubricating sensations (Giuliano, Rampin, & Allard, 2002). This process leads to

increased vaginal length, relaxation of the pelvic floor, and increased conduction in the pudendal and genito-femoral nerves (Schultz, van Andel, Sabelis, & Mooyaart, 1999).

Hormones play an important role in genital arousal. Androgens, including dehydroepiandrosterone (DHEA), facilitate increased vaginal lubrication via aromatization to estrogens (Bancroft, 2002), which protect the integrity of the vaginal tissue (Yoon et al., 2001). Indeed, when circulating estrogen decreases after menopause, vaginal lubrication also decreases; reductions in local estrogen levels postmenopause result in the shrinking of the vaginal epithelium and the atrophy of smooth muscle in the vaginal wall (Park et al., 2001). Phenomena that disrupt any of these systems—medical disorders that result in decreased estrogens and androgens, primary central and peripheral nervous system disorders, vascular disorders, and genital infections—can impact genital arousal and ultimately result in dysfunction.

### Cognitive Sexual Arousal

Cognitive sexual arousal requires women's attention to and positive appraisal of erotic cues. It is influenced by a number of variables, including relationship and partner factors (e.g., partner's sexual function), beliefs and attitudes toward sexuality, a history of sexual abuse and/or negative sexual experiences, as well as mood, anxiety, and perceived stress. Women who are satisfied with their relationships and report high levels of emotional intimacy are less likely to experience arousal problems (Jiann, Su, Yu, Wu, & Huang, 2009; Pascoal, Narciso, & Pereira, 2013). Communication about sexual preferences and responsiveness to sexual requests may decrease the likelihood of arousal concerns and other sexual problems (MacNeil & Byers, 1997, 2009).

Cognitive arousal may be compromised by beliefs and attitudes such as internalized guilt and shame related to certain sexual activities or to sexual expressions in general (Nobre & Pinto-Gouveia, 2008), or by negative views about the sexual self (Middleton, Kuffel, & Heiman, 2008). Many, but not all, women with a history of childhood sexual abuse avoid sexual interactions and are therefore less receptive to and cognitively engaged in sexual activity with a partner (Rellini, 2008). Women who have had negative sexual experiences may develop negative sexual self-schemas that increase distraction and thereby decrease cognitive arousal during sexual activity.

Negative affect, depressed mood, and anxiety all impact cognitive arousal. Decreased sexual arousal is common among women diagnosed with major depressive disorder (Kennedy, Dickens, Eisfeld, & Bagby, 1999), possibly because they are likely to engage in negative self-talk, which has been associated with decreased arousal in both men and women (Nobre & Pinto-Gouveia, 2008). Women diagnosed with an anxiety disorder are more likely to have sexual arousal concerns (Kalmbach, Ciesla, Janata, & Kingsberg, 2012; van den Hout & Barlow, 2000), and acute stress has been associated with decreased cognitive arousal (ter Kuile, Vigeveno, & Laan, 2007). Performance

anxiety (Wiegel, Scepkowski, & Barlow, 2005), thoughts about one's physical appearance (Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012), or perceptions that a partner disapproves of one's body during sex (Pascoal et al., 2013) can shift attention from sexual cues to nonsexual cues, thus decreasing cognitive arousal.

## Theoretical Models of Female Sexual Arousal

Basson's (2000) cyclical model of the female sexual response directly addresses both genital and cognitive components of arousal. Responding to concerns that genital responses and other traditional indicators of sexual desire, such as fantasy and motivation to masturbate, overshadow other important facilitators of sexual arousal in women (e.g., emotional closeness, acceptance, intimacy, affection), Basson described the complex associations between genital and cognitive arousal. She recognized that mental excitement and genital changes may not occur simultaneously and concluded that nonsexual rewards may be equally, if not more, motivating than the biological drive toward arousal and orgasm.

Barlow (1986) suggested that lack of attention to and/or distraction from sexual stimuli during sexual activity are largely responsible for the maintenance of sexual problems. Women may disengage from sexual stimuli because they are having negative thoughts about their level of physical attractiveness or their performance, which leads to decreases in cognitive arousal. These thoughts may drive avoidance of sexual situations, potentially building negative associations around genital sensations and other components of the sexual experience.

According to the Toates (2009) incentive motivation model, a woman's sexual responsiveness is influenced by biological and psychological factors. In the context of the model, sexual behavior provides positive feedback by enhancing motivation, and orgasm strengthens the power of future incentives by inducing satiety. As this occurs, information processing takes place, and automatic genital reactions must be appraised as sexual in order to positively influence future sexual motivation. As such, a woman's conscious application of a sexual meaning to her genital response may trigger cognitive arousal and subsequent sexual desire.

## Approaches to Treatment

### Medical Treatments

Treatment depends on the nature of the presenting concern, and care must be taken to determine whether that concern is exclusively genital, exclusively cognitive, or a combination of the two. Medical or pharmacological treatments include both hormonal and nonhormonal approaches. Hormonal approaches

may be most appropriate for genital concerns. In the United States, testosterone is often prescribed "off-label" in the form of patches or pills (Kingsberg et al., 2017; Kingsberg & Knudson, 2011), as testosterone has not yet been approved by the U.S. Food and Drug Administration (FDA) to treat low arousal in women. Estrogen therapy may be effective if the arousal problem stems from vulvo-vaginal atrophy (Tan, Bradshaw, & Carr, 2012). Tibolone is a synthetic steroid with tissue-specific estrogenic, progestagenic, and androgenic properties (Nappi et al., 2006). Though it has not been approved in the United States, tibolone has been used to treat postmenopausal women with vaginal dryness. In one study, women receiving tibolone reported increases in lubrication, sexual desire, and overall sexual function (Nijland et al., 2008). Although no hormonal treatments have been approved to treat sexual arousal dysfunction in women, these options are promising. A hormonal option was approved by the FDA in 2016 to treat vulvo-vaginal atrophy, which may negatively affect sexual arousal, particularly among postmenopausal women. Prasterone is a DHEA compound that is applied intravaginally; after 12 weeks of treatment in postmenopausal women, vaginal tissue integrity significantly improved with prasterone compared to placebo (Labrie et al., 2009a, 2009b), as did arousal (Labrie et al., 2009a) and sexual pain (Labrie et al., 2011).

Some centrally acting medications have been tested in women with desire and arousal problems, but studies have not explicitly differentiated genital arousal from cognitive arousal. Bupropion (Wellbutrin), a norepinephrine–dopamine reuptake inhibitor, led to increases in sexual desire and arousal among women with HSDD (Segraves, Clayton, Croft, Wolf, & Warnock, 2004). Buspirone (BuSpar), a serotonin 5-$HT_{1A}$ partial agonist, significantly improved sexual function in women with SSRI-induced sexual side effects (Landen, Eriksson, Agren, & Fahlen, 1999). Several combination drugs are currently in development for the treatment of low arousal and decreased desire in women. Lybrido, which combines sublingual testosterone and a phosphodiesterase type 5 inhibitor (PDE5I; Van Rooij et al., 2014), was developed for women with a low sensitivity to sexual cues, and has been shown to increase sexual satisfaction relative to placebo (Poels et al., 2013; Van Der Made et al., 2009). Lybridos, which combines sublingual testosterone with buspirone to decrease sexual inhibition (Van Rooij et al., 2014) has been shown to increase sexual satisfaction among women with low arousal and other sexual problems.

Flibanserin, a 5-$HT_{1A}$ agonist, 5-$HT_{2A}$ antagonist, and a weak partial agonist on dopamine D4 receptors, is the only drug currently approved by the FDA to treat acquired HSDD in premenopausal women. Although it was developed to treat HSDD, it has implications for arousal dysfunction. In animal models, the drug increases levels of dopamine and norepinephrine while decreasing serotonin (Popova & Amstislavskaya, 2002; Stahl, Sommer, & Allers, 2011); dopamine is thought to promote sexual desire and arousal, whereas serotonin has been shown to inhibit them (Pfaus, 2009; Stahl et al., 2011). A systematic review and meta-analysis of treatment outcomes for

flibanserin revealed that, on average, treatment results in one-half of an additional sexually satisfying event per month and a small increase in sexual desire (Jaspers et al., 2016), though it is difficult to parse apart sexually satisfying events into specific effects on arousal, desire, frequency of sexual activity, and overall sexual function.

Several other drugs that target sexual arousal and/or desire in women are currently in development or being tested in clinical trials. One such drug is bremalanotide, a melanocortin-4 receptor agonist that has the potential to modulate brain pathways involved in the sexual response (Wikberg et al., 2000) by stimulating dopamine release in the medial preoptic area, a brain region implicated in sexual behavior (Pfaus, Giuliano, & Gelez, 2007; Pfaus, Shadiack, Van Soest, Tse, & Molinoff, 2005). Among premenopausal women, bremelanotide led to an increase in the number of sexually satisfying events per month, improvements in overall sexual function, and a decrease in sexuality-related distress (Clayton et al., 2016).

## Psychological Treatments

Cognitive-behavioral approaches may be particularly helpful with respect to cognitive arousal. Challenging cognitive distortions (e.g., unrealistic expectations of sexual performance) and maladaptive thoughts (e.g., body image concerns) in the context of sex therapy may help to undermine the beliefs that maintain arousal problems. Cognitive restructuring may help women to identify their automatic negative thoughts and test the accuracy of those thoughts through specific behavioral experiments. For example, a woman who believes that her breasts are too small and therefore unattractive to her partner might attempt to cover her chest with a blanket during sexual intercourse. She may be distracted by the thought of needing to cover herself or by the concern that certain positions will be particularly unflattering. A therapist might help her identify evidence for and against her belief and/or direct her to test the accuracy of the belief. A behavioral experiment may involve having sex in a specific position that highlights the size of her breasts or having sex without covering her breasts, then requesting feedback from her partner. The feedback could set the stage for a new, more adaptive thought that accurately describes the partner's feelings about her breasts. Although no treatment studies have specifically tested cognitive-behavioral therapy (CBT) for women with only arousal-specific concerns, CBT was most likely to be effective for arousal and orgasm difficulties in a study that included women with a range of sexual problems (McCabe, 2001).

"Sensate focus" is a psychosocial, couple-based intervention in which partners take turns engaging in sensual touch. The "giving partner" touches the "getting partner" over the course of several sessions, progressing from nonsexual touching without full body contact to kissing to sexual touching of the genital areas and the breasts, and finally to penetrative intercourse, if clinically appropriate (Masters & Johnson, 1970; Weiner & Avery-Clark, 2014).

Sensate focus is effective for treating women with a variety of sexual concerns, including low arousal (Seal & Meston, 2018). Improvements in arousal due to sensate focus may be the result of increased attention to erotic cues and sensations, increased comfort with one's partner, or decreased anxiety during sexual activity.

"Mindfulness" is a clinical technique that increases nonjudgmental body awareness by focusing attention on the present moment. In the context of sexuality and sexual function, mindfulness involves the awareness and acceptance of sexual sensations as they occur (Brotto & Goldmeier, 2015). When practicing mindfulness during sexual activity, women are encouraged to focus on the process of the sexual experience rather than the outcome (e.g., achieving orgasm) and to refrain from reacting to potentially distracting thoughts. Mindfulness-based interventions have led to significant increases in desire and perceived lubrication (Brotto & Basson, 2014; Paterson, Handy, & Brotto, 2017), but they do not seem to increase blood flow to the genitals (Brotto, Seal, & Rellini, 2012; Brotto, Basson, & Luria, 2008). The cognitive arousal findings are mixed; studies have reported both trending increases and significant decreases (Brotto et al., 2008, 2012; Brotto & Basson, 2014).

Therapists who treat sexual arousal concerns may also guide women in discovering and acknowledging their own sexual scripts or arousal patterns. Sexual script theory suggests that sexuality is learned from cultural messages that define what "sex" actually encompasses, how to recognize sexual situations, and how to act during a sexual encounter (for a review, see Frith & Kitzinger, 2001). Discussing fantasies in therapy, reading erotic passages for homework, and watching pornography that is consistent with a woman's individual sexual script may augment psychotherapy and facilitate increases in arousal.

### Other Approaches

"Low heart rate variability" (HRV), defined as the degree of variation in the lengths of time between successive heart beats, has been associated with poor sexual arousal in women (Stanton, Lorenz, Pulverman, & Meston, 2015). Brief, single-session interventions that increase HRV through autogenic training in the laboratory have led to acute increases in both genital and cognitive arousal among women with and without arousal concerns (Stanton, Hixon, Nichols, & Meston, 2018; Stanton & Meston, 2016). A recent study that compared 1 month of at-home HRV biofeedback delivered via mobile app to a wait-list control showed significant increases in genital arousal, perceived genital sensations, and cognitive arousal among women assigned to HRV biofeedback (Stanton, Boyd, Fogarty, & Meston, 2019).

Adjuncts to therapy may include mindfulness meditation, self-help books and erotica, as well as behavioral exercises such as sensate focus. Reading erotic literature may help women identify their arousal patterns. Finally, sensate focus may help couples communicate sensually and decrease performance

anxiety. Taken together, these techniques, suggested at the appropriate time, with the appropriate patient, may prove very helpful.

Given that treatment for low arousal may include some combination of biological, pharmacologic, and psychosocial approaches, a multi-disciplinary approach is most likely to benefit the patient. Such an approach may be particularly helpful for women who have both cognitive and genital arousal concerns. Although no data exists for combining pharmacological and psychotherapeutic approaches for FSAD, combination therapy has been shown to be effective in treating arousal problems in men (Perelman, 2006; Steggall, Fowler, & Pryce, 2008).

## Case Discussion

Bettina, age 42, and Jamal, age 45, an African American couple, were married two years ago. They sought treatment because both partners had sexual problems. Bettina experienced both genital and cognitive arousal difficulties, and Jamal struggled with episodic erectile dysfunction (ED) and premature ejaculation (PE). The partners were disheartened, because they had followed their religious beliefs and abstained from intercourse, believing that after marriage they would easily transition into a pleasurable sexual life. Six months prior to beginning couple therapy, Bettina had undergone surgery for endometriosis, which had caused pain during intercourse. Although intercourse was no longer painful, Bettina's arousal difficulties could have been a conditioned response to the pain. This thought, however sensible, would prove to be wrong.

Traditionally, partners are seen together for the first meeting, followed by individual sessions for both partners. The couple meeting focuses on the presenting problem from a biopsychosocial perspective. The individual meetings are to obtain a family, sexual, and medical history. In her individual session, Bettina disclosed several relevant issues. She tearfully described having been the victim of an older neighbor's unwanted repeated sexual advances. The abuse began when she was 12 years old and lasted until she was 15 years old. Although Bettina had told her mother about the abuse, she did little to protect Bettina. As Bettina grew older, she wondered why her mother had not been more protective and also why the neighbor had chosen her to abuse (i.e., "Was I putting out sexual signals? Were my clothes too suggestive?"). During sex with her husband, Bettina episodically experienced flashbacks to the abuse episodes. Over the past 3 years, Bettina had gained 30 pounds. She was very unhappy with how she looked and with her need to purchase clothes three sizes larger than before. She wondered whether Jamal was still attracted to her. Bettina had her sexual debut in high school but derived little pleasure or satisfaction from these limited encounters. During college, she "found" religion and vowed not to be sexual again until she married.

Jamal grew up the middle child in a large religious family. He attended parochial schools, excelled academically, but did not date in high school. He incorporated a negative (i.e., "You're sinful, evil"), unsafe view of sexuality.

He dated infrequently in college, instead choosing to focus on his studies. After college, his religious beliefs compelled him to remain a virgin until he married Bettina. Noncoital activities with Bettina were infrequent due to a combination of the couple's religious guilt and her lack of arousal. After the marriage, when attempting intercourse, Jamal episodically lost his erection and consistently ejaculated within 30 seconds.

In the first conjoint therapy session following the assessment, the biopsychosocial factors that contributed to their sexual difficulties were reviewed. Both partners had sexual difficulties—but for different reasons. Biologically, Bettina's pain from the endometriosis may have been one factor in decreasing her arousal, both genital and cognitive. However, the major precipitating issue was likely psychological and rooted in her unresolved feelings concerning her childhood sexual victimization. Having flashbacks supported this hypothesis and distracted her from whatever arousal she experienced. Additionally, Bettina's negative body image concerns further contributed to her lack of arousal. She experienced herself as "dirty," "used," and "unattractive." In spite of her arousal difficulties, Bettina had strong sexual desire, as she felt motivated to seek out sexual activity with Jamal and was able to achieve orgasm with foreplay. Jamal's ED and PE were likely due to a combination of psychological factors, including his sexual inexperience, the negative messages he received from his religious upbringing concerning sexuality, his failure to monitor his level of excitement, and his desperate desire to please Bettina. He was very distracted while attempting lovemaking, worrying about his erection, ejaculation, and Bettina's arousal. Interpersonally, they appeared to be a loving couple whose relationship dynamics did not contribute to the sexual problems. Because the couple preferred to be seen together, treatment commenced in a conjoint format rather than referral of Bettina to a separate therapist to deal with her history of abuse.

Bettina clearly recalled the episodes of abuse and was able to tearfully talk about them. In one of the early conjoint sessions, she suddenly realized that Jamal's skin tone resembled the abusive neighbor's, something she had never put together before. She wondered if this might be a factor in the flashbacks and her sexual arousal difficulty. Therapy also addressed her body image concerns. We considered whether the weight gain was a tactic to ward off being sexual and/or to punish herself for having been abused. Bettina was asked to read two books on sexual abuse. She found them to be a mixture of upsetting and reassuring, as she realized that she was not alone with her suffering. For several months, therapy helped her to process her feelings.

Simultaneously, therapy focused on Jamal's negative view of sexuality. He blamed himself for Bettina's lack of arousal. He was given suggestions for staying more focused on his arousal and asked to begin stop–start exercises (see Althof, Chapter 6, this volume, on premature ejaculation).

After 3 months, the therapy began to address Bettina and Jamal's struggles with arousal. Each partner was asked about his or her sexual scripts and what fantasies he or she found arousing. Bettina mentioned that she found the Bible's *Song of Songs* ("Let him kiss me with the kisses of his mouth—for

your love is more delightful than wine . . . ") particularly arousing (Song of Solomon 1:2; Biblica, 2015). She was asked to reread the passages and see if she could become aroused. She reported feeling more "turned on" after reading it and also started to read erotic romance novels. In work with less religious couples, homework might have also included reading erotica or viewing pornography. Bettina felt that Jamal was not attracted to her because of her weight gain. It was helpful for her to repeatedly hear that he was very turned on by her but felt bad because he had his own problems with being sexual.

The next step was to assist Bettina in mentally separating Jamal from her abusive neighbor. Bettina needed to feel safe, in control, and allow herself to become aroused. Bettina thought that if she looked into Jamal's eyes during lovemaking, it would keep her safely connected to him and block out flashbacks of the neighbor. During lovemaking, Bettina was able to feel more genitally and cognitively aroused. Mindfulness strategies were introduced. She used these techniques to focus on pleasurable sensations, which led to less distraction during sexual activity and was therefore greater cognitive engagement. Jamal still experienced occasional ED; his PE had significantly improved as he conscientiously practiced the stop–start technique. After a year, they were satisfied with their sexual life and treatment was terminated.

This vignette demonstrates several themes that interfere with this couple's engaging in pleasurable sex. First, it demonstrates how one partner's sexual problems impact the sexual response of the other, or something that we have called "It takes two to tango." Both Bettina and Jamal had arousal difficulties; however, each partner interpreted them in a personally negative and maladaptive manner. Bettina felt that Jamal's loss of erection was due to his not being turned on to her. Jamal felt that her lack of arousal was due to his rapid ejaculation and difficulties with maintaining an erection. Therapy focused on the meanings that each partner created regarding the other's dysfunction and worked on diminishing the impact of these cognitive distortions.

This case also highlights the significant impact of sexual abuse, a mother's failure to protect her daughter, and self-blame on developing positive sexual schemas. It also addresses how, for some couples, surmounting the negative messages of religion can create sexual problems. Last, the vignette describes Bettina's struggle with body image—both wanting to appear attractive and fear that being attractive was a cause of her abuse. Therapy sought to address all these concerns and provide the partners with more positive meanings of being sexual with one another. They did well in treatment, and as one partner started to get better, the other did as well.

## Conclusions

Sexual arousal is a complex, psychosomatic process that involves both physiological changes and cognitive–affective interactions (Parish et al., 2019). As such, it is critical to approach a patient with multiple tools to assess the

different components of arousal. When the specific arousal problem has been identified and discussed, clinicians can choose a treatment approach or a combination of treatments that best address the presenting concern.

Research on women's sexual arousal has historically focused on either pharmacotherapy or psychosocial interventions. Combined pharmacological and psychological research may be particularly appropriate in the context of women's sexual arousal. Unlike the drugs that were developed to treat ED, which led to robust responses, flibanserin and other drugs currently being tested show modest effects on sexual arousal in women. Adding a psychological component to a medication would target improvements in FCAD and likely enhance efficacy.

As the conceptualization of female sexual arousal has evolved, researchers and clinicians may consider adapting their approaches to address both genital and cognitive arousal in intervention development and treatment. Future research should always differentiate between the two components of arousal. Refining the subcategories of FSAD—that is, explicitly distinguishing between FGAD and FCAD, and developing clinical assessment measures and interventions around these diagnoses—will provide meaningful options for clinicians who identify, evaluate, and treat women with FSAD.

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## CHAPTER 3

# Low Sexual Desire in Men

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In Chapter 3, Nobre and colleagues challenge "the stereotypical idea that low sexual desire, or limited motivation for sex, is *a woman's thing*." While there has been an extraordinary amount of research about and clinical interest in female sexual desire, until recently, this interest has not been extended to men. Regarding male sexuality, the focus has been primarily on performance, with the result that there is a ratio of 30 studies concerning erectile dysfunction to every one study of low desire. In reviewing the available psychological and biological research on male desire, the authors conclude that the emphasis on gender differences may be overstated. They present a sophisticated model of male sexual desire, emphasizing the role of cognitions, emotions, and dyadic factors in explaining predisposing, precipitant, and maintaining psychological factors that affect desire. Based on this model, treatment suggestions are offered, with the caveat that there is a need for randomized controlled therapy outcome studies.

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"Sexual desire" is often defined as an internal state driving individuals toward sexual behavior. Sexual desire depends on the intersection between biological aspects that set up the basis for the emergence of desire, psychological factors shaping individuals' predisposition to *feel* desire or behave accordingly, and social dimensions that regulate how sexual desire is expressed and appraised (Levine, 2003). Sexual desire is regarded by most as a motivational state and traditionally is seen as primordial in the sexual response trajectory (Kaplan, 1979). Some theorists, however, consider it secondary to states of sexual arousal, serving distinct intimacy and contextual purposes (Basson, 2000). Another more recent view suggests that desire is the cognitive component of arousal—the conscious appraisal of arousing states—so that sexual desire may indeed follow sexual arousal (Both, Everaerd, & Laan, 2007); this view is supported by data showing great overlap between measures of desire and arousal (Prause, Janssen, & Hetrick, 2008). All of these approaches conceptualize desire as a multifaceted construct, encompassing not only the erotic motivational component but also motivational aspects relating to nurturance or power (Chadwick, Burke, Goldey, Bell, & van Anders, 2017).

Sexual desire has been the focus of a considerable amount of research. However, this topic is addressed far more often in women than in men (Carvalheira, Træen, & Štulhofer, 2014). Even among studies on male sexuality, there is one study on low desire for every 30 on erectile dysfunction (Meana & Steiner, 2014). In part, this reflects the great emphasis on sexual performance issues for men rather than the motivational aspects of sexual response (Janssen, 2011). Although the prevalence of erectile problems may be far higher than that of low desire in men, the relative lack of research and clinical interest may also mirror the stereotypical idea that low sexual desire, or limited motivation for sex, is *a woman's thing.* Recent studies, however, suggest that the stereotype

may not be accurate and that there are increasing numbers of men reporting significant distress associated with low sexual desire.

## Diagnosis

Disorders of sexual desire have been formalized in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) and in the *International Classification of Diseases* (ICD-11; World Health Organization, 2019). DSM-5 mirrors the overlapping view of desire/interest in sex, subjective sexual arousal (i.e., perception of excitement/pleasure), and genital sensations (cf. Brotto, 2010a; Graham, 2010). Yet this vision is controversial and has been exclusively applied to women (Reed et al., 2016). Accordingly, DSM-5 presents distinct criteria/nosology depending on gender. While sexual desire difficulties in women may fall under the heading female sexual interest/arousal disorder, sexual desire difficulties in men may fall under the label male hypoactive sexual desire disorder (MHSDD).

MHSDD manifests through persistent and recurrent deficient (or lack of) thoughts, fantasies, or desire for sex. These symptoms must exist for at least 6 months and cause significant distress. When judging the quality and quantity of the symptoms, the clinician must be aware of mitigating background factors (e.g., age, life context). Despite the different classifications, there is some evidence that men, just like women, merge the concepts of desire and "mental" arousal (Brotto, 2010b). Further studies of the symptomatology of low desire in men are required before a strong conclusion can be reached about whether there is a gender difference (Sarin, Amsel, & Binik, 2013). Also, it is worth noting that some have argued that there is not sufficient evidence, justifying the separation of the genders in DSM-5, regarding the desire/arousal controversy (Balon & Clayton, 2014; see also Brotto & Velten, Chapter 1, this volume).

Hypoactive sexual desire dysfunction, in men and women, is included in the new chapter dedicated to conditions related to sexual health and is defined as the "absence or marked reduction in desire or motivation to engage in sexual activity" (World Health Organization, 2018). Thus, ICD-11 does not merge diagnoses related to desire and arousal and includes gender invariant criteria for sexual desire and sexual arousal dysfunction in men and women.

## Comorbidity of Low Desire with Other Male Sexual Dysfunction

Despite the efforts to define the nosology of sexual desire difficulties in men, the symptomatic presentation may be more complex, as men with low sexual desire often report erectile difficulties (Carvalheira et al., 2014; Fugl-Meyer

& Fugl-Meyer, 1999). In a clinical study conducted in men, low sexual desire was found to be the sole diagnosis in only 5% of the men investigated; it was comorbid with erectile dysfunction, premature ejaculation, and delayed ejaculation, in 38, 28, and 50% of cases, respectively (Corona et al., 2013). Accordingly, it is difficult to determine whether low sexual desire may be a cause or a consequence of other sexual dysfunction. Hypoactive sexual desire in men is believed to be involved in erectile dysfunction (Corona et al., 2004) or delayed ejaculation (Corona et al., 2013), and they may share similar pathogenic pathways (Corona, Isidori, Aversa, Burnett, & Maggi, 2016). Indeed, a study comparing the adequacy of different symptom factor structures indicated that while sexual desire emerged as an independent entity in sexually healthy men, male sexual function was better explained by a model merging sexual desire, erectile function, and orgasmic function in men with sexual dysfunction (Carvalho & Nobre, 2011a).

> Phil and Darren initially presented in couple therapy with complaints of lack of physical intimacy in their relationship. After four sessions, Darren disclosed that the real problem was that Phil had trouble maintaining an erection during sexual activity, and this built up an avoidance pattern in which Darren just avoided all forms of intimacy, including sex. After working through a mutual understanding about the need for intimacy in general, Phil began to express that he preferred that his intimacy needs be met by nonsexual acts. He admitted that his lack of interest in sex was a source of shame for him that exacerbated his erectile problems when sex did occur.

## Epidemiology of Low Sexual Desire in Men

The overall prevalence of low sexual desire or interest has been estimated as 3–28% of men (Fugl-Meyer & Fugl-Meyer, 1999; Laumann et al., 2005; Quinta-Gomes & Nobre, 2014). The few studies on low sexual desire in young men (ages 18–29 years) suggest prevalence rates between 6 and 19% (Laumann, Paik, & Rosen, 1999; Najman, Dunne, Boyle, Cook, & Purdie, 2003; Træen & Stigum, 2010), while the prevalence rates increase with age (e.g., 27% in 60- to 67-year-old men; Træen & Stigum, 2010). Similarly, while only 1% of young men never think or fantasize about sex, this prevalence rises to 20% in older groups (Corona et al., 2013). Even so, Najman et al. (2003) reported higher prevalence in young men (i.e., 19% in 18- to 29-year-old men vs. 16% in 50- to 59-year-old men), which suggests that reduced sexual desire may be felt as more problematic in younger men.

As for the prevalence of low solitary (i.e., desire to engage in sexual behavior with one's self) versus dyadic sexual desire (i.e., desire to engage in sexual behavior with a partner), Martin et al. (2012) have reported that 68% of men presented low solitary sexual desire, while 14% of men reported low

dyadic sexual desire. Incidence data from a 5 year period (Martin et al., 2014) showed a higher rate (18%) of low solitary sexual desire than low dyadic desire (8%).

Recent research suggest that low desire is very common among gay men, with reported prevalence rates between 19 and 57% (Hirshfield et al., 2010; Peixoto & Nobre, 2015). Moreover, Peixoto and Nobre found that low sexual desire was significantly more commonly reported by gay men (19%) as compared to heterosexual men (9%).

Data regarding gender differences in sexual desire are also scarce given that most studies on this topic are conducted with women. Still, one consistent difference is that low sexual desire problems are considerably more prevalent in women (Laumann et al., 1999, 2005; Nobre, Pinto-Gouveia, & Gomes, 2006; Simons & Carey, 2001; Ventegodt, 1998). These findings are consistent with Regan and Atkins's research (2006) suggesting that, on average, functional men present a higher intensity and frequency of sexual desire (four times more) than women.

Also, interesting to note are intergeneration patterns (i.e., cohort effects) showing increasing sexual desire from the 1990s to the 2000s but decreasing reports from 2005 to 2016 (Beutel et al., 2018; Lindau & Gavrilova, 2010). Such findings need to be carefully followed up to determine whether they reflect societal changes, different criteria for defining desire, or other contextual factors.

## Biopsychosocial Factors Affecting Low Sexual Desire in Men

Recently, there has been an increase in the number of studies taking a biopsychosocial approach to the study of male sexual desire. This strategy of research possibly reflects a paradigmatic shift from an exclusive focus on organic factors to a broader understanding including psychosocial influences. Accordingly, in this section, we summarize studies that framed male sexual desire within a biopsychosocial perspective, with a particular emphasis on the psychological nature of low sexual desire. It is important that most of these studies do not differentiate between manifestations of desire that are spontaneous versus responsive, or between those that are generalized versus situational; this deficiency makes the interpretation of data difficult (Connaughton, McCabe, & Karantzas, 2016).

In a cross-cultural study including heterosexual men from Portugal, Croatia, and Norway, researchers evaluated the psychosocial correlates of a distressing lack of sexual desire, as well as reasons underlying a lack of sexual interest (Carvalheira et al., 2014). Determinants of distressing low sexual desire included low confidence in achieving erection, reduced attraction toward one's partner, living in a long-term relationship, sexual boredom, and professional stress. Interestingly, the prevalence of low sexual desire was

highest in men between ages 30 and 39 years. One possible explanation is that stressful life events that are common at this age (e.g., career investment, family/parenthood) may result in the lowered sexual desire rates (Carvalheira et al., 2014). Similarly, while Corona and colleagues (2013) found that reduced male sexual desire not explained by organic factors was associated with higher postschool qualifications and disturbed domestic context, Martin et al. (2012) reported that men's qualifications were associated with lower dyadic sexual desire but increased solitary sexual desire. Also, the desire to have a baby (Nimbi, Tripodi, Rossi, & Simonelli, 2018a) and actually having young children (< 4 years old; Durette, Marrs, & Gray, 2011) was associated with reduced sexual desire and low sexual enjoyment. Accordingly, it seems that in this specific stage of life, men's lifestyle characterized by demanding career achievements and family related challenges, may present as a vulnerability factor for reduced sexual desire.

Further studies on male sexual desire have taken a more theoretically grounded approach. Instead of focusing on a series of predictors, these studies have framed male sexual desire within a cognitive-behavioral approach (see below). In this way, the contribution of biopsychosocial factors can be tested, while clinically relevant variables (i.e., those that represent clinical targets) may emerge. In one of these studies, the authors assessed the predictive role of medical (past/current history of medical conditions), relationship (dyadic adjustment), psychopathology, and cognitive–emotional dimensions (sexual beliefs, sexual thoughts and emotions during sexual activity) in predicting men's sexual desire (Carvalho & Nobre, 2010b). Specific cognitive and emotional variables emerged as key predictors, pointing to the benefit of framing male sexual desire within a psychological perspective. While restricted/conservative attitudes toward sex, lack of erotic thoughts, concerns about erection during sexual activity, and emotions of sadness and shame (as a result of these thoughts) were significant predictors of lower sexual desire, dyadic adjustment, medical history, and age were nonsignificant predictors. Such findings, particularly those relating to the role of negative/distractive thoughts during sexual activity, suggest the potential role of attention mechanisms in male sexual desire. While attentional focus has been mostly related to erection difficulties (e.g., Barlow, 1986; Jong, 2009), it may be that attention focus toward detrimental cognitions may have a role in motivational issues. Likewise, when the interrelated role of these factors was weighted, restricted sexual beliefs (e.g., "It is not appropriate to have sexual fantasies during sexual intercourse") and negative automatic thoughts (e.g., "My penis is not responding") predicted male sexual desire, above and beyond the medical, relationship, or psychopathology symptoms (Carvalho & Nobre, 2011). This key study strongly supports the involvement of psychosocial dimensions in the vulnerability and/or maintenance of low sexual desire in men.

More recently, Nimbi and colleagues (2018a) examined new dimensions, such as quality of life, sexism, alexithymia, and sexual functioning, in addition to those tested by Carvalho and Nobre (2010b, 2011). Again,

dysfunctional sexual beliefs, negative automatic sexual thoughts, emotional response associated with these thoughts, and overall sexual functioning explained the highest amounts of variance in men's sexual desire. Likewise, Nimbi, Tripodi, Rossi, and Simonelli (2018b) combined these dimensions into a model testing partial and full mediation effects between variables. They showed that erection concerns and lack of erotic thoughts during sexual intercourse had direct negative effects on men's sexual desire, and that this relationship was further mediated by emotional states. Hence, the combination of cognitive states and the associated emotional reactions is likely to influence men's sexual desire.

## Theory and Models of Low Sexual Desire in Men

As we mentioned earlier, the existing studies on male sexual desire focus on cognitive and emotional predictors, as well as dyadic processes. Based on these two lines of research, we present below a brief review of cognitive–emotional and dyadic models of low sexual desire in men.

### Cognitive–Emotional Models

David Barlow was the pioneer in studying cognitive–emotional factors of sexual problems. Barlow and his group developed a systematic research program (mostly based on experimental studies conducted in the laboratory) to investigate the role of cognitive and affective dimensions in explaining sexual dysfunction, particularly in men (Bach, Brown, & Barlow, 1999; Barlow, Sakheim, & Beck, 1983; Mitchell, DiBartolo, Brown, & Barlow, 1998; Weisberg, Brown, Wincze, & Barlow, 2001). Based on the main findings, Barlow developed a model (1986) that emphasized the interaction between autonomic arousal (sympathetic activation) and cognitive interference processes in determining sexual dysfunction. The model posited that while sexually healthy individuals focus their attention on erotic stimuli during sexual activity, men and women with sexual problems focus their attention on nonrelevant stimuli (negative consequences of not performing). This focus becomes progressively more efficient as autonomic arousal increases (due to worries about performance), inhibiting sexual arousal. The original model has been updated with the inclusion of more complex cognitive processes (Sbrocco & Barlow, 1996; Wiegel, Scepkowski, & Barlow, 2007).

Following Barlow's legacy, Nobre and colleagues have conducted a series of research studies and developed conceptual models of sexual dysfunction including desire problems for men (Carvalho & Nobre, 2010b, 2011; Nobre, 2009, 2010; Soares & Nobre, 2013). The model (see Figure 3.1) postulates three different levels of factors: (1) predisposing factors (e.g., personality factors, such as neuroticism and dysfunctional sexual beliefs), (2) processing factors (e.g., cognitive schemas activated in response to negative sexual events),

and (3) maintaining factors (e.g., negative cognitions and emotion during sexual activity).

### *Predisposing Factors*

Regarding personality factors, findings indicate that neurotic traits are reported significantly more often by men with sexual dysfunction, in comparison to sexually healthy controls (Quinta-Gomes & Nobre, 2011). Moreover, extraversion has also been found to be associated with higher levels of sexual functioning overall, and sexual desire in men and women (Costa et al., 1992; Quinta-Gomes & Nobre, 2011). These findings suggest that neurotic and introversion traits may constitute general predisposing/vulnerability factors for the development of sexual problems, including low desire. Regarding sexual beliefs, studies have shown that men with sexual dysfunction report significantly higher scores on the Zilbergeld's (1999) list of sexual myths (Baker & de Silva, 1988). Also, Nobre and Pinto-Gouveia (2006) found that men with sexual dysfunction are more likely to report beliefs related to excessive sexual performance demands and inaccurate beliefs about women's sexual response and satisfaction. Moreover, studies indicate that restrictive and conservative sexual attitudes are significant negative predictors of men's sexual desire (Carvalho & Nobre, 2010b, 2011; Nimbi et al., 2018a). The model postulates that these demanding and unrealistic sexual beliefs as well as the conservative beliefs may work as specific predisposing factors, making men more vulnerable to develop sexual difficulties, and particularly low desire.

### *Cognitive Processing Factors*

Nobre and Pinto-Gouveia (2009) found that when exposed to negative sexual events, men with sexual dysfunction activated significantly more negative self-schemas as compared to individuals without sexual problems. More specifically, men with sexual dysfunction tend to interpret negative events as a sign of failure and personal incompetence. The same pattern of negative schemas was found to be a significant predictor of men's sexual desire in the Nimbi et al. (2018a) study. Nobre's model proposes that men with dysfunctional sexual beliefs (as described earlier) would be more vulnerable than other individuals to activation of negative self-schemas whenever an unsuccessful sexual event occurs. The negative events would act as a precipitant for the activation of negative self-schemas (mainly self-incompetence schemas), with sexual beliefs and trait factors such as neuroticism and introversion playing a moderator role.

### *Maintaining Factors*

Regarding the role of cognitions, studies have shown that negative sexual cognitions are associated with increased levels of sexual difficulties (Nelson

& Purdon, 2011; Purdon & Holdaway, 2006; Purdon & Watson, 2011). In particular, studies have indicated that men with sexual dysfunction report significantly more automatic thoughts related to erection concerns and failure anticipation, and significantly fewer erotic thoughts compared to men without dysfunction (Nobre & Pinto-Gouveia, 2008). The same pattern of thoughts was identified as the best predictor of men's sexual desire (Carvalho & Nobre, 2010b, 2011; Nimbi et al., 2018a). Nobre's model hypothesizes that these negative automatic thoughts during sexual activity are the result of the previous activation of negative self-schemas described earlier, and that they play an important role as maintaining factors for sexual dysfunction.

Regarding the role of emotion, research suggests that depressed mood (lack of positive affect, sadness, disillusion) is strongly associated with lowered sexual response and desire. Findings show that during sexual activity, men with sexual dysfunction reported significantly more sadness, disillusionment, and fear, and significantly less pleasure and satisfaction, as compared to sexually healthy men (Nobre & Pinto-Gouveia, 2006). A similar pattern of emotions (sadness, and shame) emerged as a significant negative predictor of male sexual desire (Carvalho & Nobre, 2010b). Moreover, results from experimental studies conducted in the laboratory (Mitchell et al., 1998; Nobre et al., 2004) further support this association, suggesting that depressed mood has a negative impact on sexual arousal and desire. The model hypothesizes that depressed mood during sexual activity is strongly linked with the negative self-schemas activated by individuals with sexual dysfunction, impairing sexual response and playing an important role as a maintaining factor of sexual dysfunction and particularly low sexual desire.

## Dyadic Models

Sexual desire difficulties are the most frequent complaint in couple therapy (Davies, Katz, & Jackson, 1999; Mark & Lasslo, 2018). Some authors posit that sexual desire problems should be regarded as a product of the dyad rather than a product of the individual (Levine, 2002; Mark & Lasslo, 2018; Tiefer, 2001), supporting a systemic vision instead of a disease-centered approach. Given the important role of interpersonal factors, researchers have examined discrepancies in sexual desire as a way to investigate systemic influences on sexual desire. When one member of the couple has lower or higher sexual desire than his or her partner, this negatively impacts sexual and relationship satisfaction (Mark, 2012, 2015; Mark & Murray, 2012; Sutherland, Rehman, Fallis, & Goodnight, 2015). It is not low desire per se that is problematic, because when both members of the couple have low desire, this concordance may actually positively contribute to their relationship satisfaction. However, when a sexual desire discrepancy exists and it is the male partner with lower desire, this can be particularly disruptive to a relationship. Adherence to rigid sexual scripts (i.e., that men should always be ready for sex) has been linked with low sexual desire (Sanchez, Crocker, & Boike, 2005) and the impact of

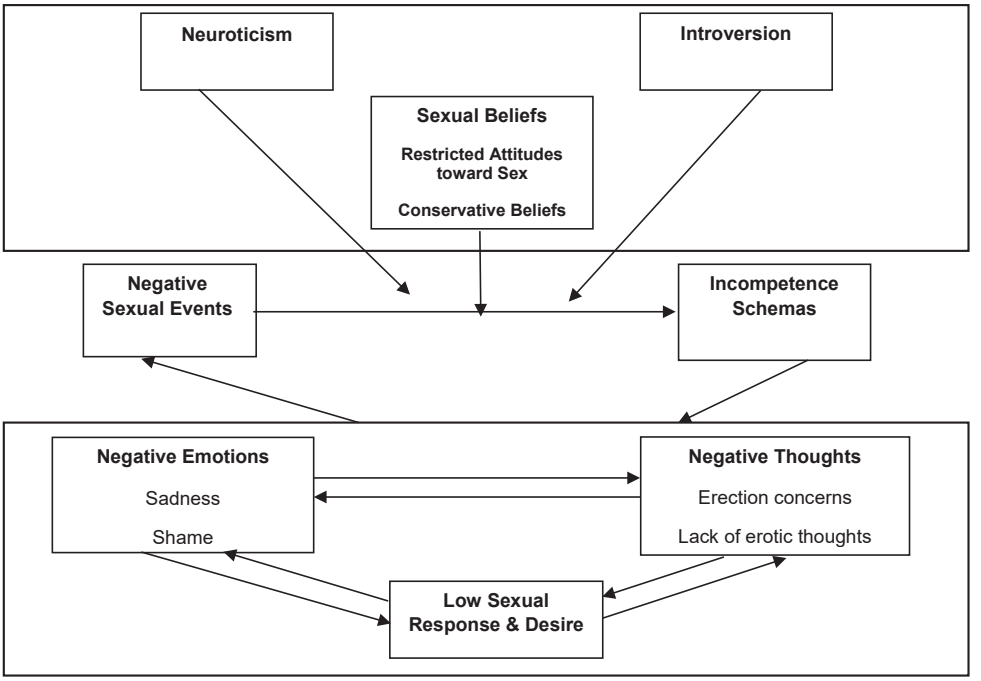


**FIGURE 3.1.** Schematic structure of Nobre's cognitive–emotional model for low sexual desire in men.

sexual desire discrepancy can be heightened when men deviate from these traditional masculinity norms (Murray, 2018). Additionally, sexual desire for a partner positively predicts sexual satisfaction in men, whereas solitary sexual desire negatively predicts sexual satisfaction (Peixoto, 2019), further supporting a dyadic approach to sexual desire problems. Careful consideration through clinical judgment is used to determine whether low sexual desire is an expected adaptation to one's environment (e.g., a dissatisfying relationship, masculinity expectations, life stress) or whether it is deficiency in sexual desire independent of contextual issues.

> Mark and Monica came to therapy at Monica's initiative. She felt angry that she was always the one to initiate and sex and hurt that Mark appeared to prefer masturbation to having sex with her. The call to the therapist was prompted by Monica walking in on Mark masturbating after he had refused her sexual advance. In an individual session, Mark admitted that he felt desire for other women but not for Monica. He felt that masturbating was preferable to cheating on Monica, as he wanted to stay married. In therapy, Mark was able to identify and become more assertive about the things that made him unhappy in the marriage. Monica was able

to recognize that she could not expect a sexually assertive mate while demanding a passive partner in other aspects of the relationship. As they rebalanced their roles and worked on communication and conflict resolution, Mark's desire for sex with Monica returned.

## Assessment of Low Sexual Desire in Men

Regarding medical factors, possible causes may include low levels of testosterone (T) or high levels of prolactin (PRL) (Balon & Segraves, 2005; Conaglen & Conaglen, 2009; Maurice, 2007), which are seen in some medical conditions (hypogonadism, hypothyroidism, and hyperprolactinemia; Corona et al., 2013, 2016). Moreover, aging is strongly related to decreasing testosterone levels (Buvat, Maggi, Guay, & Torres, 2013) which, together with other psychosocial factors, may help explaining the higher levels of low desire in older men. If patients do present with any of these clinical conditions, both physical examination and endocrinological assessment (measurement of serum total testosterone, PRL, and thyroid function) should be conducted to better understand the role of biomedical factors in explaining the low desire. In addition to these clinical conditions, medications such as antidepressants, antipsychotics, or antiepileptics may also induce low sexual desire.

Since low sexual desire is commonly comorbid with other psychological and emotional disorders (particularly depression) as well as other sexual dysfunctions (e.g., erectile dysfunction), a differential diagnosis should be carefully made to assess whether the low desire may be better explained by another psychological disturbance or sexual dysfunction. This should include questions about depression symptoms and whether they preceded the onset of low sexual desire. In such cases, the clinicians should consider treating the depression first. Also, if erectile difficulties or other sexual dysfunctions are present, a careful assessment of the temporal relationship between the low desire and the other sexual complaints should be made before deciding on the main focus of the intervention.

In order to diagnose MHSDD, the clinician should not only assess the level of desire for sexual activity but also the lack/absence of sexual thoughts and fantasies, since both are required to assign a clinical diagnosis (DSM-5). These symptoms should be persistent (i.e., more than 6 months according to DSM-5 criteria) and cause significant clinical distress to the individual. Also, the frequency of sexual activity (e.g., masturbation or partnered) should not be used as the sole marker of sexual desire, since many men with low desire engage in sexual activity to please their partner or for other reasons. Also, the absence of sexual activity per se does not imply lack of sexual desire, because some men may have difficulty in finding a sexual partner for a number of reasons. Moreover, the discrepancy between partners' levels of sexual desire should be assessed, since having lower desire for sexual activity than one's partner is not sufficient to assign a clinical diagnosis.

A thorough clinical interview should include detailed information on a number of biomedical and psychosocial factors: (1) partner factors (e.g., partner's sexual problems; partner's health status); (2) relationship factors (e.g., communication; couples' discrepancies in desire for sexual activity); (3) individual vulnerability factors (e.g., personality; sexual beliefs, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement); (4) cultural or religious factors (e.g., religious beliefs and attitudes toward sexuality); and (5) medical factors relevant to prognosis, course, or treatment (American Psychiatric Association, 2013).

A number of self-report measures may also be used to assess sexual desire and associated features in conjunction with the clinical interview.

- *Sexual desire*. The Sexual Desire Inventory (SDI; Spector, Carey, & Steinberg, 1996) may be used to assess dyadic and solitary sexual desire and also to identify the existence of sexual discrepancy in the couple. Additionally, the Sexual Arousal and Desire Inventory (SADI; Toledano & Pfaus, 2006) may be used to assess the relationship between subjective sexual arousal and sexual desire, which is often common in both women and men.

- *Sexual functioning*. The International Index of Erectile Function (IIEF; Rosen et al., 1997) might be helpful to assess levels of sexual functioning and presence of comorbid sexual difficulties (e.g., erectile dysfunction, orgasmic disorders).

- *Sexual distress*. The Sexual Distress Scale for men (SDS; Santos-Iglesias et al., 2018) can be used to assess the level of distress caused by the low sexual desire, which is an important criterion for clinical diagnosis.

## Treatments for Low Sexual Desire in Men

### Biomedical Treatments

A number of possible biomedical interventions may help in the treatment of low sexual desire in men. If hormonal disturbances (e.g., hypogonadism) are detected, then the use of testosterone replacement therapy (TRT) may be helpful, though the effectiveness of TRT is only observable when testosterone levels are clearly below the normal threshold (Corona et al., 2013, 2016). Also, treatments to restore thyroid function in the case of hypothyroidism or to solve the primary causes of hyperprolactinemia or PRL-lowering medications may be useful to increase sexual desire (Corona et al., 2013).

Moreover, if the patient is taking medication that has a detrimental effect on sexual desire, this should be addressed, and alternative medications should be chosen whenever possible. This is often the case for many antidepressants that are commonly taken by men with low sexual desire given the relatively high comorbidity with depression. For these men, their current medication

can be replaced by another antidepressant (e.g., agomelatine, mirtazapine, bupropion, tianeptine, trazodone, vortioxetine, buspirone) with fewer desire-reducing side effects.

In addition to these interventions to address medical conditions and to reduce the detrimental effects of some drugs (antidepressants), there is so far no approved pharmacological treatment for low sexual desire in men. However, recent systematic reviews and meta-analyses have emphasized the possible benefits of TRT in increasing sexual desire and also erectile function, particularly in men with more severe hypogonadism (Corona et al., 2017; Snyder et al., 2018).

## Psychological Treatments

Cognitive-behavioral therapy (CBT) is the most common psychological treatment for sexual dysfunctions, and there is substantial evidence of its efficacy when compared to wait-list conditions or other forms of therapy (see Brotto et al., 2016, for a review). Additionally, mindfulness-based approaches have been recently used, with results showing preliminary evidence of its effectiveness, particularly in women (Bossio, Basson, Driscoll, Correia, & Brotto, 2018; Brotto et al., 2012; Brotto & Basson, 2014; Brotto, Basson, & Luria, 2008; Brotto & Heiman, 2007). However, in contrast to female sexual desire problems, there is very limited empirical information and no randomized controlled trials (RCTs) concerning the effectiveness of psychological interventions for men with low sexual desire (Berner & Günzler, 2012; Brotto et al., 2016; Frühauf, Gerger, Schmidt, Munder, & Barth, 2013).

The only published RCT that included men with low sexual desire comprised couples with mixed sexual dysfunctions (men with hypoactive sexual desire, erectile dysfunction, or premature ejaculation, as well as women with hypoactive sexual desire disorder (HSDD), orgasmic disorder, vaginismus, or dyspareunia; van Lankveld, Everaerd, & Grotjohann, 2001). In this study, the majority of the male sample reported low sexual desire as their main sexual dysfunction. The 204 couples were randomized to a cognitive-behavioral bibliotherapy (including psychoeducation, sensate focus exercises, and rational emotive analyses), or a wait-list control group. Findings indicated that significantly more men in the treatment group reported improvements on sexual functioning at posttreatment and follow-up compared to the wait-list control group. Moreover, men in the CBT bibliotherapy reported fewer complaints regarding infrequency of sexual interaction and lower levels of distress at posttreatment. Interestingly, the largest treatment effect was related to an increase in the frequency of sexual interactions in men with primary low desire complaints and those with erectile dysfunction and premature ejaculation. As the authors concluded, this finding shows a global effect of CBT on the frequency of sexual activity regardless of the sexual problem (van Lankveld et al., 2001), suggesting that CBT approaches include components that address common psychological factors of male sexual dysfunctions.

In summary, little is known about the efficacy of psychological interventions for men with low sexual desire. We think that future research should consolidate the existing evidence on psychological and interpersonal factors and systematically develop rigorous RCTs examining standard CBT interventions as well as mindfulness treatments for low sexual desire in men.

## Case Discussion

### Case 1

Jayson, a 43-year-old cisgender, heterosexual man, presented in therapy with a self-described inability to engage in meaningful romantic relationships due to little interest in sex. He blamed the end of several recent relationships ranging in length from 1 month to 3 years on his low sexual desire, and he believes this has always been an issue for him, dating back as early as he can remember.

Given that his low desire was lifelong, the therapist sent Jayson for an endocrinological evaluation, but T and PRL levels were within the normal range. During the initial evaluation, Jayson was introduced to the concept of asexuality as a sexual orientation. Although this was fruitful in further assessing Jayson's attitudes toward his sexual identity and preferences, an asexual identity did not resonate with him.

The theoretical framework for treatment was CBT targeting predisposing, processing, and maintaining factors within the context of a narrative therapy process (Monk, Winslade, Crocket, & Epston, 1997). In narrative therapy, the patient is encouraged to see himself as separate from his problems; in this case, Jayson was encouraged to see himself as a person who was having difficulties with sex rather than defining himself as a sexually dysfunctional man.

Predisposing factors: Jayson, the oldest of two boys, was raised in a traditional family in which his father worked and his mother took care of the household and the children. Jayson never saw his father participate in housework (e.g., he never cleared the dishes or prepared a meal and was always "waited on" when he came home from work). Jayson's father expected Jayson to participate in and excel at sports, despite the fact that Jayson was not athletically gifted. Jayson felt bullied by his father to participate in team sports, in which he ultimately felt inadequate and humiliated. In his teen years, Jayson recounted his father "teasing" him about dating and using crude sports analogies relating to sex (e.g., getting on base, scoring). Through a narrative therapeutic approach, Jayson came to understand his story of how it was that he came to feel that he was "less than a man." He also came to see that his avoidance of those sources of shame (sports and dating) were how he avoided the "less than" feeling.

Processing factors and maintaining factors: Once Jayson recognized that he was trying to live up to unrealistic expectations of masculinity in his sexual relationships, he was able to more fully describe his sexual experiences. Jayson recounted that when he was in a relationship and did not feel like having sex,

the thought "I'm not a real man" would arise, echoing the societal narrative, endorsed by his father, that *real men* take any opportunity to have sex. This thought would then prompt Jayson to either find a good reason for not wanting sex ("I'm not really attracted to her") or avoid the situation (the person or intimate moments) and future potential situations for sex. This meant that he would often end a relationship, or his partner would end the relationship for lack of intimacy and involvement on his part. This recognition changed the narrative of his story from one of inadequacy ("I cannot maintain a relationship") to one of understanding the complexity contributing to his breakups ("I am avoiding relationships"). Jayson was also able to recognize that the idea that he was *not a real man* was present even during sex. Jayson was anxious about his masculinity and sexual ability, and he was vigilant during sex for signs of incompetence and impending humiliation. This spectatoring increased the likelihood of erectile difficulties, which increased his anxiety and sense of failure, and ultimately led to a decrease in a desire to engage in sex. Once Jayson gained this insight, he was challenged to adjust his expectations. He recognized that, as with all emotions and appetites, there would be variability: He did not always have to want to have sex, just as he did not always have to want to have dessert. A combination of sexual skills training, homework exercises, and cognitive restructuring helped Jayson interrupt the negative feedback cycle that was contributing to his low sexual desire. Jayson had the opportunity to practice focusing on erotic thoughts and sensual feedback during masturbation (homework exercises) and casual sex encounters that occurred throughout the course of individual therapy. While his success with casual and solo sex increased his confidence, it did not address his concerns with longer-term romantic relationships, which he admitted had higher stakes (especially in the case of a relationship that he wished to maintain). After 12 sessions of individual therapy spaced over 6 months, Jayson met and began seriously dating a woman he met at a friend's party. Although the therapist saw this development as providing an opportunity for Jayson to work on his issues in the context of a committed relationship, Jayson decided to end therapy. It is therefore not known whether Jayson was able to translate his treatment gains into sustained desire in the context of a relationship in which he was highly invested.

### Case 2

John is a 32-year-old white, cisgender man in a long-term marriage to Sarah, a 31-year-old white, cisgender woman. The two met in college 10 years ago and were very attracted to each other; they described the first 6 months of their relationship as being full of sexual excitement with equally high desire for sexual activity.

John and Sarah presented in couple therapy with a significant sexual desire discrepancy, in which Sarah complains that she no longer wants to initiate sex because she feels that it is one-sided, and she is sick of feeling sexually

rejected by John. The current frequency of sexual activity for the couple is once every few months, but the desired frequency for Sarah is a couple of times a week and the desired frequency for John is around once a month. To compensate, Sarah has been masturbating to orgasm about twice a month but feels resentful about this because she would prefer to have sex with her husband. The partners have been discussing the possibility of having children, and Sarah is particularly worried that the transition to parenthood will only further damage their sexual frequency and satisfaction. Sarah is hesitant to move ahead with starting a family until they sort through their sexual problems. John and Sarah report that they love each other and are committed to their marriage, but both admitted that their sexual difficulties were taking a toll on them.

During his individual evaluation session, John said that he could recall masturbating at times in his life, but he reports this as infrequent. He does not currently masturbate, nor does he report experiencing sexual fantasies. Over the past 4 years, sex just does not cross his mind. This decrease in his sexual interest in Sarah from their early days of courtship to the present does cause John significant distress, in large part because he is afraid to lose Sarah.

In the beginning stages of therapy, John and Sarah discussed their adherence to the gendered script of men as the initiators of sex. Sarah was warned as a teenager that "boys only want one thing" while John was encouraged to "go for it" (meaning sex) when he was dating a girl.

One of the first therapeutic tasks was to remove the stigma of blame and to reframe their experience such that Sarah could feel empathy rather than resentment. It was incredibly beneficial for Sarah to hear John talk in depth about the guilt and shame he felt for not living up to the accepted script for male sexuality. Sarah erroneously assumed that John's lack of interest in sex equated to a lack of interest in *her,* which was the source of her resentment. John reassured Sarah that he was still very attracted to her and wanted to want to have sex with her, just not as often as she wanted to have sex with him. Sarah communicated her relief to hear him express this attraction to her and asked that he do this more often.

Sarah and John remembered a time when sexual desire was concordant between them, so it was beneficial to normalize the idea that sexual desire ebbs and flows over time (Herbenick, Mullinax, & Mark, 2014), while acknowledging the impact this experience has on both individuals. Sarah had spent years feeling neglected and rejected in a way that ran counter to all of the messages she had internalized about married sex (i.e., that women are the ones who lose interest in sex, and men are always begging for it). John was able to listen to Sarah's experience without being overwhelmed by his own guilt for disappointing her. Allowing them to experience one another's vulnerability was a crucial step prior to engaging in interventions that directly targeted their sexual interactions.

The main behavioral intervention was sensate focus, which provided an opportunity for the couple to have intimate physical interactions with specific

rules governing their touch, so that neither of them was individually implicated if something went wrong. It provided physical intimacy—something that Sarah was so desperately missing. Sexual desire was not required for initiating or participating in the exercises, so John did not have to feel that he was disappointing Sarah from the outset. The couple slowly but successfully moved through the stages of sensate focus; this took approximately 3 months. In sessions, discussions of what transpired during the sensate focus exercises was combined with psychoeducation regarding different types of sexual desire (spontaneous and responsive) and the application of the circular model of sexual response (Basson, 2000) in which sexual response can be provoked before, during, or after sexual activity. John and Sarah began to recognize that John's sexual desire was more than a simple on-off switch. Rather, they recognized that his desire was a complex interplay of thoughts, emotions, and physiology. John recognized that his wish not to hurt Sarah by rejecting her led him to avoid the very types of interactions that might otherwise have evoked his own sexual desire. As Sarah worked through her feelings of rejection to understand that John might not want sex as often or whenever she did, John was encouraged to stay present in the relationship and approach or respond to Sarah with intimate gestures of love and affection, which did not need to lead to sex. As Sarah's feelings of rejection diminished, she was open to working on ways to approach John for sex. Their intimacy, both physical and emotional, increased, as did their satisfaction with each other and with their relationship. The psychoeducation that occurred in the therapy sessions was supplemented with reading material on sexuality. Concurrent with these interventions, John and Sarah reported an increase in the frequency and quality of their sexual interactions and lower distress from moments of sexual rejection or inactivity.

John and Sarah continued with couple therapy for 32 sessions. Although John's low sexual desire and the desire discrepancy that resulted were the impetus for seeking therapy, they found that as they confronted their sexual issues, their sexual satisfaction improved, and creating more opportunities for taking emotional risks led to even more intimacy. In this context, John and Sarah were able to make the decision to become parents. At the end of therapy, John and Sarah's frequency of sex was around once a week, and John reported consistently experiencing responsive desire generated by physical and emotional sexual overtures made by Sarah. Sarah reported feeling desired, as she could tell that John enjoyed being sexual with her when they did engage in sex. Sarah was also happy with this outcome. A follow-up card from the couple a few years later revealed that about a year after therapy ended, Sarah gave birth to a healthy baby girl named Hannah. They are currently planning to have a second child.

## Case Discussion Summary

In both of these cases, the biopsychosocial perspective was beneficial for positive treatment outcomes. In the case of Jayson, it is unknown whether or not

the treatment progress he made in individual therapy was sustained throughout his new relationship. Ideally, Jayson and his partner would seek couple therapy if his desire disappeared in his new relationship given the interpersonal nature of his concerns. Integrating a dyadic approach to the biopsychosocial perspective appears to be the most evidence-based and clinically relevant treatment for low sexual desire in men. In the case of John and Sarah, a couple-based approach that did not directly target raising the level of John's sexual desire but rather focused on the relational aspects of sexual desire was effective in improving overall sexual satisfaction for both partners.

## Conclusions

There is a false assumption that low sexual desire is a women's problem. Although the majority of the studies consistently indicate higher prevalence rates of low desire in women compared to men, recent studies suggest that an increasing number of men complain of low or absent desire. While there is some dispute as to whether there is a fundamental gender difference in sexual desire and sexual desire disorders, the few studies using a biopsychosocial perspective to examine gender differences have found that the similarities outnumber the differences (Carvalho & Nobre, 2010a, 2010b, 2011). Particularly, cognitive factors, such as sexual beliefs (sexual conservatism, restricted sexual attitudes), and cognitions during sexual activity (lack of erotic thoughts, negative thoughts), were found to be the best predictors of sexual desire in both men and women, above and beyond the role of biomedical factors.

In the same line, the existing theoretical models of low desire in men are scarce. In this chapter, we have reviewed Barlow's and Nobre's cognitive models of sexual dysfunction, which emphasize the role of cognitions and emotions in explaining predisposing, precipitant, and maintaining psychological factors of sexual desire and have received some promising supporting evidence. Moreover, we also have summarized the important role played by dyadic factors in explaining low desire in individuals and couples, particularly the discrepancy between levels of desire experienced by the partners.

When it comes to treatment, it is interesting to note that contrary to the situation for low sexual desire in women, no drug has been approved for the treatment of low sexual desire in men. Moreover, despite the evidence of the benefits of psychotherapy, and particularly CBT approaches for men and particularly women with sexual dysfunctions, very little is known about the efficacy of psychological interventions for men with low sexual desire. This fact is congruent with the shortage of research on the psychological processes involved in men's low sexual desire and is more evident when compared with the amount of research on women's sexual desire problems. Given the increased percentage of men complaining of low sexual desire, it is of utmost importance to develop RCTs to consolidate the existing evidence and better

understand the mechanisms of change in the psychological treatment of low sexual desire in men.

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CHAPTER 4

# An Integrative Biopsychosocial Approach to the Conceptualization and Treatment of Erectile Disorder

DENNIS KALOGEROPOULOS
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Chapter 4 reviews the voluminous and still growing medical and psychosocial literatures on erectile disorder (ED), concluding that while significant progress has been made in understanding the biological determinants of erectile dysfunction, these advances have not been paralleled in the psychosocial domain. In fact, the default treatment for ED now appears to be the prescription of a phosphodiesterase type 5 inhibitor (PDE5I) by family physicians, despite the reported high dropout rate in the use of these medications. The authors argue for an integrative and multifaceted approach to conceptualizing and treating ED and note, "Despite the paucity of research pointing to the effectiveness of psychosexual interventions when used alone, the combined treatment studies show that adding a sex therapy component to medical treatments has a synergistic effect." Kalogeropoulos and Larouche outline and illustrate their approach, which combines sex therapy with elements of cognitive-behavioral therapy in concert with medical interventions. This approach, they cogently argue, will improve treatment outcomes for the men suffering ED.

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Erectile disorder (ED), a common sexual dysfunction affecting men of all ages, causes significant personal distress for individuals and their partners. Because ED is associated with numerous physiological, psychological, interpersonal, and sociocultural factors, effective treatments necessitate the use of integrative, biopsychosocial paradigms (Perelman & Pastuszak, 2016). While many clinicians and researchers advocate such frameworks, their use is not common in clinical practice. Over the last 20 years, since the arrival of sildenafil, primary care physicians are the practitioners most frequently consulted by men with ED, and medical treatment is the main intervention. The use of biopsychosocial frameworks has become a theoretical rather than a practical and/or clinical reality, as it is easier to prescribe a "pill" for ED than to engage in more thorough assessment and treatment. Under the prevailing paradigm, it is quite possible the psychosocial factors of some men with ED are not being assessed and treated appropriately. It is time to take stock of where we are, and to develop *and* adhere to a *truly* multifaceted, integrative approach to the assessment, conceptualization, *and* treatment of ED.

## Definition and Classification of ED

According to DSM-5 (American Psychiatric Association, 2013), the diagnosis of ED requires the typical occurrence of significant problems in either getting or keeping an erection or a noticeable decrease in penile turgidity/stiffness. Additionally, the symptoms must have persisted for at least 6 months and occurred in 75% of all occasions. ED can be further classified as lifelong rather than acquired and as situational rather than generalized. DSM accurately recognizes that ED causes the individual significant personal distress and requires a degree of severity rating that can be categorized as mild, moderate, or severe (American Psychiatric Association, 2013). The diagnosis also necessitates ruling out that ED is not due exclusively to other pathologies such as medical, sexual, and/or psychiatric conditions.

The World Health Organization (2019) recently approved the 11th revision of the *International Classification of Diseases* (ICD-11). It defines ED as the inability or a marked reduction in attaining or sustaining an erection of sufficient rigidity or duration for sexual activity. The definition requires that the difficulty occur despite the presence of desire for sexual activity and adequate sexual stimulation. ED can occur episodically or persistently, over a period of at least several months, and is associated with clinically significant distress. ICD-11 identifies categories of ED based on the lifelong rather than acquired and generalized rather than situational dimensions, as well as a *male erectile dysfunction-unspecified* category. It outlines descriptors for each of the categories that include factors associated with medical conditions (e.g., injury, effects of surgery or radiation), chemical factors (e.g., use of medication or psychoactive substances), and psychological/behavioral factors (e.g., mental disorders, lack of knowledge/experience, and relationship factors) (World Health Organization, 2018). These descriptive categories appear to accurately reflect the most common etiological factors associated with ED and thus appear to have good face and content validity. They also have significant diagnostic and treatment implications, as decisions need be made about what problem to target first clinically and/or what additional medical or psychosocial interventions need to be used. The advantage of the ICD-11 classification over that in DSM-5 is that ED can be diagnosed even if there is a concurrent or underlying medical, psychological, or relational problem. It is our hope that future research utilizing these diagnostic systems will shed light on their clinical utility.

## Prevalence and Epidemiology

ED appears to be a highly prevalent problem affecting men of all ages (Lewis et al., 2004). Population based studies conducted in Australia (Richters, Grulich, de Visser, Smith, & Rissel, 2003) and the United Kingdom (Mitchell et al., 2013) report prevalence rates of 9.5 and 12.9%, respectively, while Selvin, Burnett, and Platz (2007) report an overall prevalence rate of 18% in a U.S. sample. The prevalence of ED increases with age (Lewis et al., 2004). Rates appear to be lower than 10% in men under age 40 (Selvin et al., 2007), about 20–40% of men in their 60s, and 50–75% of men older than 70 (Lewis et al., 2010).

## An Integrative Biopsychosocial Conceptualization of ED

There are several distinct advantages to integrative, multifaceted models. They do justice to the etiological complexity of ED; circumvent old organic–psychogenic dualities; facilitate the more appropriate assessment, diagnosis,

and treatment of ED; stimulate the use of combined treatment approaches; promote collaborative work between medical and mental health professionals; and help bridge the scientist–practitioner gap.

## Physiological Contributing Factors

Numerous etiological factors have consistently been associated with ED. Erectile problems can be caused by vascular, neurological, endocrine, urological, and iatrogenic factors mediated through endothelial and smooth muscle cell dysfunction. Medical conditions, medication/drug use, and lifestyle factors also play an important role (Colson, Cuzin, Faix, Grellet, & Huyghes, 2018). These risk factors exert their critical effect directly or indirectly, and the relationship between the comorbidities can be quite complex.

Vascular factors are at the root of the most common etiological risks for ED (Jackson et al., 2010). ED is no longer being viewed simply as a consequence of vascular disease but is now recognized as an early indicator and independent risk marker of cardiovascular disease (CVD) and has been found to predict future diagnoses and precede cardiovascular (CV) events, such as stroke and myocardial infarction, by up to 5 years (Hippisley-Cox, Coupland, & Brindle, 2017). Its predictive value is particularly impressive in men between ages 40 and 49 years. Inman and colleagues (2009) suggest a 50-fold relative risk with incident ED in younger men. A recent review and meta-analysis (Osundu et al., 2018) found a consistent association between ED and measures of subclinical CVD and atherosclerosis, even in patients without a diagnosis of vascular disease, independent of diabetes.

Neurological conditions such as Parkinson's disease, multiple sclerosis, epilepsy, and stroke are also frequently associated with ED (Lomarbardi et al., 2015). Men with spinal cord injuries also have varying degrees of erectile difficulties depending on the location and extent of the lesion (Courtois & Gérard, Chapter 21, this volume). ED is a common complication of diabetes and can affect up to 85% of patients (Phé & Rouprêt, 2012). Diabetes can impact erectile function via vasculopathy, neuropathy, and hypogonadism. Diabetic men tend to develop more severe ED, 10 to 15 years earlier, than men without diabetes (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994).

Androgens play a key role in maintaining erectile function. Testosterone is involved in the nitric oxide pathway, affects cavernosal nerve function, and works at the level of smooth muscle and endothelial cells. It also regulates the timing of erection as a function of sexual desire (Corona & Maggi, 2010). However, many men with low testosterone do not have ED, suggesting that androgens are beneficial, but not essential, for erection (Bolona et al., 2007). Low testosterone levels have also been associated with failure to respond to PDE5Is, and testosterone replacement therapy (TRT) has been shown to improve the response (Corona et al., 2016). The multicenter Testosterone Trial study provides evidence that TRT has a positive impact on overall sexual function in men over 65 years of age (Snyder et al., 2016). Not only can low

levels of testosterone contribute to ED, but an excess of other hormones such as prolactin and thyroid hormones may also play an important role (Soran & Wu, 2005).

Prostate cancer is the second most commonly occurring cancer in men (World Cancer Research Fund, 2018). Treatment for prostate cancer results in various degrees of ED. Research has shown that 25–75% of men experience postoperative ED (Sanda et al., 2008). Studies on radical prostatectomy indicate that spontaneous recovery of erectile function occurs 12–24 months after surgery, but relatively few men recover baseline function, particularly those over the age of 60 (Nelson, Scardino, Eastham, & Mulhall, 2013). In contrast, when radiation is used, the onset of ED is delayed, occurs 24–36 months after treatment, and worsens over time (Gaither et al., 2017). Penile rehabilitation strategies involving the use of PDE5Is have, to date, provided unclear benefits (Segal, Bivalacqua, & Burnett, 2013). Other urological conditions, such as lower urinary tract disorders, also appear to be associated with ED (Colson et al., 2018).

The use of a variety of medications such as antihypertensives, nonsteroidal anti-inflammatory drugs, diuretics, and antacids has been associated with ED (Razdan et al., 2018). One recent study (Mazzilli et al., 2018) also found that 9–42% of patients taking psychotropic medication reported ED. The use of selective serotonin reuptake inhibitors (SSRIs) is associated with several sexual side effects such as genital anesthesia, loss of desire, delayed orgasm, and ED that, in some cases, persist after discontinuation of the medication (Bala, Nguyen, & Hellstrom, 2018).

Lifestyle factors such as cigarette and alcohol use have long been associated with ED. Smoking is a well-known CV risk factor and an independent risk factor for ED (Kovac, Labbate, Ramasamy, Tang, & Lipshultz, 2015). ED affects 59–72% of alcoholic men (Arackal & Benegal, 2007). In small quantities, alcohol use can improve erections and increase desire due to its anxiolytic effects. However, chronic alcoholism may cause hypogonadism and neuropathy, thereby interfering with erectile function (Grover, Mattoo, Pendharkar, & Kandappan, 2014). Despite the ever-increasing worldwide use of medical and recreational marijuana, there is wide consensus that its effects on men's sexual health has not been adequately studied. Both beneficial and detrimental effects on erectile function have been found. In low doses, it can raise plasma testosterone, but chronic use can decrease testosterone levels and cause endothelial damage and therefore interfere with erections (Shamloul & Bella, 2011).

## Psychological Contributing Factors

### *Cognitive Factors*

Cognitive factors appear to play a central role in predisposing, triggering, and maintaining erectile problems. In their seminal work on sexuality, Masters and Johnson (1970, p. 10) concluded that "one of the most common

distractions affecting sexual functioning is fear of performance." They coined the term "spectatoring" to refer to the cognitive aspects of anxiety during sexual activity. Spectatoring and concomitant distraction have a negative impact on sexual response, as they interfere with the processing of erotic cues that facilitate arousal and promote healthy erectile functioning.

Studies on attributional style have suggested that men with ED tend to give more internal and stable attributions to negative sexual events compared to sexually healthy men (Scepkowski et al., 2004) and that they report significantly more negative automatic thoughts around both erections and intercourse (Nobre & Pinto-Gouveia, 2006). Nobre and Pinto-Gouveia also found that men with sexual dysfunction, when exposed to negative sexual events, activate significantly more negative schemas than do males with healthy sexual functioning. These researchers point out that sexually dysfunctional males tend to interpret unsuccessful events as a sign of personal failure and/or incompetence.

### *Affective Factors*

In addition to cognitive distraction, patients report experiencing significant anxiety during sexual activity and often focus on the physical symptoms of anxiety. Our clinical experience suggests that anxiety may play a varied and complex etiological role and could have disruptive effects on erectile responsivity, act as a signal of underlying sexual threat, or motivate active avoidance of sex.

Depression is often associated with ED (American Psychiatric Association, 2013; McCabe & Althof, 2013). Some studies suggest that depressed men are twice as likely to have ED as those in the general population (Araujo, Durante, Feldman, Goldstein, & McKinlay, 1998). A longitudinal study conducted by Chou et al. (2015) followed 2,527 patients with ED over 5 years and found that the risk of depression was significantly higher in men with ED, with a markedly higher risk in the first year after onset. Depressed mood can negatively impact sexual functioning by lowering libido, triggering negative self-schemas and automatic thoughts, as well as contributing to feelings of hopelessness and helplessness. These factors can be responsible for both triggering and maintaining symptoms of ED over time.

McCabe and Althof (2013) conducted a systematic review of 40 published studies examining the psychosocial outcomes associated with ED before and after drug treatment. In addition to reporting poor sexual relationships and sexual satisfaction, patients also reported diminished confidence, low self-esteem, and symptoms of depression before treatment. Huri, Sanusi, Razack, and Mark (2016) conducted a cross-sectional prospective study on a Malaysian sample of 93 males presenting with ED, ranging in age from 31 to 81 years. In addition to depression, they found that ED was strongly associated with feelings of guilt, self-blame, failure, and anger, as well as concern about disappointing one's partner during sexual intercourse. While the available

literature does not shed much light on the causal link between ED and affective variables, it does point to significant emotional distress in men presenting with ED. These findings highlight the importance of addressing psychological factors when assessing and treating ED (McCabe & Althof, 2013; Huri et al., 2016).

### Behavioral and Socioenvironmental Factors

Our clinical observations suggest that men with ED often develop a pattern of avoiding sexual activity and, sometimes, all forms of intimacy with their partners. While behavioral avoidance may provide temporary relief from anxiety, it maintains ED over time by creating a maladaptive cycle that deprives the individual of opportunities to engage in new sexual experiences that could facilitate healthy sexual functioning.

Misinformation and lack of sexual skills may also play a role in contributing to ED (Zilbergeld, 1992). Rosen, Miner, and Wincze (2014) explain that men who are misinformed about sexuality and lack necessary skills may approach sex with a narrow, awkward behavioral repertoire and be more prone to experience erectile difficulties when their unrealistic expectations are not met.

ED may sometimes be associated with a history of negative sexual messages generated by family, culture, and/or religion (Rosen et al., 2014). Culture and religion may also dictate practices that affect sexuality. Important elements of the couple environment include time to relax and connect, privacy, and comfort (Rosen et al., 2014). Attempting sexual activity in environments, or at times, that are not conducive to sexual intimacy could further compromise arousal and erectile functioning.

### Relationship Factors

It is a widely held belief that relationship difficulties contribute to and/or exacerbate erectile problems (Cameron & Tomlin, 2007; McCabe & Matic, 2008). Clinical evidence supports this view, as many couples presenting with sexual dysfunction report relationship difficulties as well. Even though the importance of relationship factors has been acknowledged in clinical literature over the past five decades, very few studies have examined the specific role these factors play in the etiology and/or maintenance of erectile difficulties, nor have they examined the relationship between couple conflict and treatment outcomes for ED (Rosen et al., 2014). The cause–effect relationship between couple difficulties and ED remains unclear.

Empirical evidence suggests that when partners are dissatisfied with their sexual relationship or are experiencing a difficulty such as ED, they tend to be less satisfied with their overall relationship (e.g., McCarthy & McCarthy, 2013). Sexual satisfaction appears to be influenced by the effectiveness with which partners talk about sex (Montesi, Fauber, Gordon, & Heimburg, 2011).

Invariably, this can contribute to, or exacerbate, erectile difficulties and highlights the need for assessing relationship difficulties and relationship satisfaction in couples presenting with ED.

## The Relationship between ED and Premature Ejaculation

There appears to be a strong association between ED and premature ejaculation (PE), as about one-third of men presenting with ED have concomitant PE (McMahon, Lee, Park, & Adaikan, 2012). A recent comprehensive meta-analysis and systematic review revealed that the risk of ED (in participants with PE) was higher in older men, those with lower levels of education, and those not in a stable relationship (Corona et al., 2015). Furthermore, men who had both ED and PE more often reported anxiety and depression, as well as a lower prevalence of associated organic comorbidities, and these associations were confirmed even after adjustment for age. Corona and associates conclude that the co-occurrence of ED and PE may thus have more of a psychosocial etiological component.

## Case Discussion

Philippe (62 years old) and Catherine (57 years old) had been in a relationship for 5 years and had cohabitated for the last 4 years. Both were divorced and had adult children from their marriages. They worked full time in professional occupations, were self-employed, held university degrees, and were financially comfortable. Philippe presented with ED subsequent to a radical prostatectomy that had taken place 4 years earlier. He was cancer free and had no signs of recurrence. Since then, he has been unable to attain an erection in all sexual situations. The couple was referred to therapy by Philippe's urologist, who worked collaboratively with the treating psychologist. The urologist had prescribed sildenafil (100 mg) in the past with limited success and was considering suggesting intracavernosal injection therapy (ICT) to the couple.

Philippe had no prior history of erectile or ejaculatory difficulties and did not masturbate when in a relationship. In the previous year, the couple had ceased all attempts at sexual intercourse and avoided all nonpenetrative sexual activities. Catherine was discouraged by the lack of erection and became uninterested in sex. Philippe developed significant performance anxiety, and Catherine was frustrated and felt helpless. She was also very critical of Philippe's lovemaking abilities. Both reported being fit and in good physical health. Catherine complained that although they were good friends and enjoyed participating in several physical activities together, she did not feel desired and was ambivalent about her attraction to Philippe.

Philippe was anxious and felt that Catherine avoided him by working long hours. In fact, the partners rarely spent more than a couple of hours together on weekends.

The initial assessment focused on their relationship and individual histories. They both agreed that their relationship was a result of Philippe's determination to win Catherine over, but they differed significantly in their recollections of their sex life prior to Philippe's diagnosis of prostate cancer. Philippe seemed to idealize their relationship and recalled a rich and satisfying sex life with no sexual difficulties, whereas Catherine felt that it was stilted, boring, and predictable despite being functional (i.e., no problems with desire, arousal, or orgasm).

Philippe was diagnosed with prostate cancer 1 year into their relationship and a radical prostatectomy was deemed the treatment of choice. Despite understanding that the ED was a likely consequence of nerve damage caused by the surgery, Catherine could not accept a medical treatment such as sildenafil or ICT. She believed that sexuality should be spontaneous and reflect a couple's mutual attraction to one another.

An overview of their individual life histories revealed a long-standing sense of masculine inadequacy in Philippe, who was raised by a critical, dismissive mother and an absent father in a household with four older sisters. His first sexual and romantic relationship, at the age of 18, ended when he discovered that his girlfriend had had an abortion without consulting with him. He reported a persistent insecurity in his lovemaking abilities and placed a great deal of pressure on himself to be an ideal sexual partner, despite never having received any negative feedback. He married in his late 20s and described his ex-wife as having a very difficult personality and being emotionally dysregulated; their sexual life was greatly limited by the chaotic nature of the relationship. After struggling with infertility, he and his wife adopted, but they later divorced when their daughter was a preteen. The marriage lasted 20 years.

Catherine described a neglectful home environment and having to become autonomous from an early age. Her family was quite poor, and her parents were busy working and taking care of her younger, developmentally delayed sister. She became sexually active at the age of 13 and had multiple boyfriends until she married in her early 20s and had two children. She described her ex-husband as hardworking and emotionally unavailable but reported a very passionate and satisfying sex life with him. The marriage ended after 25 years, when she discovered that he had cheated on her repeatedly. She suspected that she experienced a depressive episode during and after her divorce but had never sought treatment. She described having many lovers but no committed relationship until Philippe.

Throughout the assessment, Catherine was critical of Philippe and blamed him for making poor choices and being passive and noncommunicative in the past. She was unable to see how her criticism could contribute to Philippe's ED and the sexual dynamic given its organic etiology, and she

had little hope that psychotherapy could be helpful. Philippe willingly took on the role of the identified patient despite having good insight and excellent communication skills.

A case conceptualization was presented that involved a combination of physiological etiological factors (possible nerve damage caused by the radical prostatectomy) and individual and couple psychological contributing and maintaining factors. Catherine's ambivalence and critical stance were highlighted as a potential trigger to Philippe's performance anxiety, relationship insecurity, and masculine incompetency schemas. Their active avoidance of affection and nonsexual intimacy was emphasized as a maintaining factor, and the need to develop a flexible sexual repertoire was also suggested. Both agreed they needed to spend more quality time together and improve communication about sexuality. A combined medical and psychological treatment plan emphasizing simultaneous work on individual vulnerability factors, the relationship, and the sexual problem was proposed.

## Integrative Biopsychosocial Assessment of ED

### Medical Evaluation

The first step in evaluating ED is always a detailed medical and sexual history of men and, when available, their partners. Taking a comprehensive medical history may reveal one of the many common disorders associated with ED in addition to potentially reversible causes, such as medication use, hormonal abnormalities, tobacco, alcohol, and drug abuse. Primary care physicians and/or urologists should conduct a focused physical examination to examine genital anatomy for any related abnormalities (e.g., Peyronie's disease, testicular atrophy), signs of prostatic disease, hypogonadism, and neurological and cardiovascular status (Bella, Lee, Carrier, Bénard, & Brock, 2015). Laboratory testing is usually tailored to the man's complaints and risk factors. Testing for low levels of testosterone is appropriate when diabetes is present, for men who also experience hypoactive desire, and for those who do not respond to PDE5Is (Bella et al., 2015).

Specialized diagnostic testing such as the nocturnal penile tumescence and rigidity (NPTR) test, the intracavernous injection (ICI) test, neurophysiological testing, and the duplex ultrasound (DUS) of the penis are now performed infrequently and may not be readily available or accessible (Bella et al., 2015). More detailed evaluation may be indicated when the man is young, has experienced pelvic trauma or lifelong ED, has a family history of CVD, or has not responded to prior treatment (Burnett et al., 2018). NPTR testing is used to assess the quantity and quality of nighttime erections by placing strain gauges on the penis during sleep and has been used historically to differentiate organic from psychogenic etiology. ICI testing is used to assess the vascular function of the penis by injecting an erectogenic agent into the penis. DUS is considered the gold standard for vascular evaluations and may

be combined with ICI to provide information on arterial and veno-occulusive function (Sikka, Hellstrom, Brock, & Morales, 2013).

### Psychosexual Assessment

A thorough and comprehensive psychosexual assessment should include objective measures in addition to detailed clinical interviews with the male and his partner. The International Index of Erectile Functioning (IIEF; Rosen et al., 1997) and the quick and efficient five-item Sexual Health Inventory for Men (SHIM; Cappelleri & Rosen, 2005) can be used to screen for and evaluate ED severity.

Clinical interviews should assess the specific sexual contexts in which the ED occurs, whether it is a lifelong difficulty or an acquired one, and its frequency of occurrence. Factors that improve and/or worsen the problem should also be identified, including key associated cognitions, feelings, and behaviors. It is important to examine the evolution of the ED across time, as well as both partners' sexual histories. One should inquire about their early sexual education, the nature of their early sexual experiences, and whether they experienced any sexual trauma.

It is also important to understand how ED affects the couple in different areas of life. The quality of and satisfaction with their current relationship needs to be examined, as well as their past relationship history. Current life stressors and the presence of possible comorbid conditions must also be identified. Finally, one should ask about clients' objectives in seeking therapy. Are they realistic?

## Integrative Biopsychosocial Treatment of ED

### Physiological Interventions

First-generation PDE5Is such as sildenafil, vardenafil, and tadalafil revolutionized the management of ED and have become the first-line treatment modality for ED as recommended by major urology associations (e.g., Burnett et al., 2018). Currently, three PDE5Is are widely available: sildenafil, vardenafil, and tadalafil. The new second-generation PDE5I avanafil has recently become available in the United States and others, such as udenafil and mirodenafil, are now in clinical use in Asia and Russia (Ventimiglia, Capogross, Montorsi, & Salonia, 2016).

Sildenafil, tadalafil, and vardenafil are currently the most widely used PDE5Is. Both sildenafil and vardenafil work within 60 minutes, have an 8-hour duration of clinical efficacy, and have a delayed onset of action when consumed with fatty foods. In contrast, tadalafil has a 2-hour time of onset, a 36-hour duration, and no interaction with food. Second-generation PDE5Is have comparable safety profiles but may have additional benefits. For example, avanafil has an onset of 15 minutes, whereas mirodenafil is short

acting (2.5-hour half-life) and udenafil is long acting (11- to 13-hour half-life) (Huang & Lie, 2013).

Several studies have shown that PDE5Is are effective in more than 80% of patients (Burnett et al., 2018). Both men and women preferred once-daily tadalafil, and psychological outcomes such as self-esteem, confidence, and satisfaction with the sexual relationship were higher when compared to sildenafil. Men who took tadalafil felt less time pressure, a reduced sense of urgency, and did less planning. The different pharmacokinetic profile of this drug may give patients more freedom around their sexual encounters (Gong et al., 2017).

Nonetheless, the reported dropout rate from first-generation PDE5I treatment is very high, ranging from 30 to 80% (Corona, Rastrelli, Burri, Serra, et al., 2016). This relatively recent review and meta-analysis that assessed the incidence of PDE5I dropout and its associated factors revealed that almost 50% of men taking PDE5Is discontinued use after 1 year. This rate was higher in younger men and in those with more comorbidities. Other reasons for discontinuation included couple problems, cost, lack of efficacy, side effects, and recovery from ED. Despite mimicking natural erections, their ease of administration, and their safe and effective profiles, numerous challenges remain with the use of PDE5Is.

Corona, Rastrelli, Burri, Jannini, and Maggi (2016) reviewed placebo-controlled randomized clinical trials and conducted a meta-analysis on the effects of avanafil, a new second-generation PDE5I. Although comparative studies are still lacking, they found that avanafil had comparable efficacy but a lower incidence of side effects as compared to first-generation PDE5Is. They believe that the pharmacological profile of avanafil, specifically its high selectivity for PDE5, could address several of the problems documented with first-generation PDE5Is. It appears to act rapidly, is the only PDE5I that can be taken as needed only 15–30 minutes prior to sexual activity (in contrast to 45 minutes or more), and it is not influenced by alcohol or food consumption. It is also the least expensive of the PDE5Is. More studies are needed to determine patient preference profiles for the various drugs available.

For men in whom PDE5I use is contraindicated or for those not wishing to use these medications, other approaches to the management of ED are available such as vacuum constriction devices (VCDs), transurethral suppositories (MUSE), and ICT. Penile implants, although invasive and irreversible, are an option for treatment-resistant ED or for men who are dissatisfied with available treatment options. Other surgical procedures such as arterial revascularization and venous surgery are usually reserved for young men subsequent to pelvic trauma or in the presence of clearly defined and visualized venous leakage (Hellstrom et al., 2010).

Medical treatments remain at the forefront of the future of ED therapy and have been recently reviewed (e.g., Le & Burnett, 2016; Campbell, Milenkovic, Albersen, & Bivalacqua, 2018; Ismail & El-Sakka, 2016). Low-intensity extracorporeal shock wave therapy (LIST) aims to modify the underlying pathological

process that causes ED and may include regenerative elements such as revascularization and improved endothelial function. LIST has been found to be effective even in patients with severe ED who do not respond to PDE5I (Kitrey et al., 2016). However, the effect is better in the short term and more durable in the long term in patients with milder ED and fewer risk factors (Kitrey et al., 2016).

Other therapies that have the potential to restore normal tissue function include stem cell therapy and gene therapy. Preliminary results of Phase I clinical trials on the use of stem cells appear promising for improving erectile function, but much information regarding mechanism of action, ideal cell formation, and dosage is still lacking (Matz, Terlecki, Zhang, Jackson, & Atala, 2018). Similarly, gene therapy hopes to improve erectile function by delivering genes that produce proteins that repair dysfunctional biochemical pathways in the penile tissue. Although preclinical studies show promise, clinical success has yet to be achieved (Gur, Abdel-Mageed, Sikka, Bartolome, & Hellstrom, 2018). In one recent study, Coombs, Reece, and Dangerfield (2018) reported on the potential of a novel nerve grafting technique to restore erectile function following radical prostatectomy and found recovery of erectile function in 82% of men. Overall, these new treatments for ED appear promising, but they are still considered investigational and, in some cases, experimental.

### Lifestyle Interventions

The role of lifestyle interventions in the treatment of ED is increasingly being recognized. In a recent systematic review and meta-analysis, Silva, Sousa, Azevedo, and Martins (2017) found that physical activity and exercise interventions reduced ED symptoms, especially when combined with any specific pharmacotherapy. Smoking cessation has been shown to decrease ED and cardiovascular risk by 36% (Harte & Meston, 2013). The potential advantages of lifestyle modification may be more pronounced in men with greater psychosocial contributors than in those with more serious medical conditions such as CVD or diabetes (Wing et al., 2010). While lifestyle alterations benefit ED symptoms, they may be most beneficial for primary prevention.

Regardless of the type of medical treatment used by a man and his partner, it is important that they understand the mechanism of action of the proposed treatment, have a positive attitude toward treatment, and have realistic expectations. Patients need to be educated about underlying conditions that may be causing the ED and appreciate the opportunity to change certain negative lifestyle behaviors. Couples need time to incorporate the treatment into their sexual scripts, and strategies should be attempted at least eight times before switching to another treatment option (Kirby et al., 2014). The role of psychoeducation should not be underestimated. Many men may not appreciate the impact depression, anxiety, stress, and relationship conflicts have on erectile function. In addition, men need to be informed about the normal changes in erectile function (e.g., increased refractory period) associated with

aging. Referral of men with ED to a mental health professional is now recommended by the Canadian, American, and European urological associations to clarify psychosocial contributors, eliminate performance anxiety, provide psychoeducation, modify sexual scripts, promote treatment adherence, and integrate treatments into their sexual relationships (e.g., Burnett et al., 2018). Unfortunately, this multidisciplinary approach is not always available, cost-effective, or easy to elaborate, and communication between the health professionals involved can be limited.

## Sex Therapy/Cognitive-Behavioral Therapy Approaches

Key elements of sex therapy/cognitive-behavioral therapy (CBT) interventions used to treat ED include psychoeducation about healthy erectile functioning; reduction of performance anxiety; promotion of mindfulness during sex; an increase in couple communication about the effectiveness of sexual techniques, ensuring the use of appropriate sexual stimulation; and promotion of a more flexible sexual repertoire. These goals are achieved through verbal discussion and explanation, bibliotherapy, as well as the use of relevant instructional films/videos. Changes in actual behavior are achieved through the prescriptive parts of sex therapy, which include masturbation training and sensate focus exercises.

Our clinical experience suggests that there are several advantages to assigning regular masturbation exercises to men with ED. Masturbation can facilitate a greater awareness of one's sexual response; individuals can experiment with different types of self-touching and become more aware of the types of stimulation that facilitate/block arousal. Men can learn to appreciate that erectile tumescence varies during sexual activity and, perhaps, become less worried about the rigidity of their penis, thereby reinforcing erectile confidence and feelings of control. Positive visualization techniques can also be used. As self-stimulation exercises occur in a low-stress context, there is a greater likelihood of pairing relaxation with sexual arousal.

Sensate focus exercises are used extensively in the treatment of ED in the context of couple therapy. Initially developed by Masters and Johnson (1970), these exercises involve a series of gradual steps of specific sexual behaviors in which couples engage to rebuild their sexual repertoires. Weiner and Avery-Clark (2017) released an excellent illustrated manual detailing sensate focus. Several elements embedded in sensate focus help men with ED reduce anxiety, interrupt cognitive distraction, and facilitate a focus on appropriate erotic and sexual cues. These include *in vivo* exposure, built-in anxiety reduction techniques, deemphasis of goal-oriented sex, improvement of couple sexual communication and stimulation, and creation of a more flexible sexual repertoire that reduces the pressure to have an erection throughout sexual activity.

Men with ED subscribe to a variety of myths and misconceptions about sexuality and erectile function. Appropriate psychoeducation may help dispel some of these erroneous beliefs (Wincze, 2009). Negative cognitions, myths and misconceptions, and cultural or religious beliefs that are more deeply

entrenched may require more intense cognitive restructuring techniques, as suggested by Nobre (2017).

## Research on Psychological Treatments for ED

There is a surprising and serious lack of empirically validated psychological treatments for ED despite the widely held belief that psychological factors are often associated with this disorder (Nobre, 2017; Rosen et al., 2014). In an early study, Hawton, Catalan, and Fagg (1992) evaluated the effectiveness of sensate focus and graduated sexual stimulation techniques in couples presenting with psychologically based ED. They found that couples with higher ratings of marital satisfaction responded more rapidly and with better outcomes to sex therapy interventions. One literature review on couples presenting with sexual dysfunction (Berner & Gunzler, 2012) found that a CBT treatment intervention successfully improved the sexual functioning of males, particularly those with ED.

Frühauf, Gerger, Schmidt, Munder, and Barth (2013) conducted a systematic review and meta-analysis on the efficacy of psychological treatments such as sex therapy, CBT, psychoeducation, couple therapy, and other psychotherapies. Seven studies included direct comparisons between psychological treatments for ED and wait-list control conditions. Overall, the findings revealed small effect sizes for improvements in the symptom severity and sexual satisfaction of ED participants in the sex therapy and couple therapy conditions. Frühauf and associates found that the studies classified as "other psychotherapies" showed larger effect sizes. The two studies included in this category used CBT-type interventions—including rational emotive therapy (RET; Munjack et al., 1984) and an Internet-based CBT intervention (McCabe, Price, Piterman, & Lording, 2008). Munjack and associates (1984) compared 12 biweekly sessions of RET to a wait-list control and found that participants with ED reported significantly more sexual intercourse attempts, reduced sexual anxiety, and a greater number of successful intercourse attempts. McCabe and colleagues (2008) compared the effectiveness of an Internet-based CBT intervention to a wait-list control and found that men in the treatment group reported significantly greater improvements in erectile functioning and sexual relationship satisfaction.

Over the past decade, several researchers have investigated the effectiveness of Internet-based treatments for sexual dysfunctions, including ED (e.g., Andersson et al., 2011). Most of these employed traditional sex therapy and/or CBT interventions in short-term, structured therapy formats. These studies are limited by inconsistent use of control groups, failure to include sexual partners, short and/or absent posttreatment follow-up, and high attrition rates. In their review, Connaughton and McCabe (2017) concluded that although Internet-based sex therapy is a relatively new field, studies do provide support for the effectiveness of treating sexual dysfunctions (including ED) utilizing online interventions, and these programs appear to replicate the findings of face-to-face therapy.

## Combined Treatment

A combined integrated and collaborative approach to ED therapy, irrespective of the medical therapy, probably represents the future of ED treatment (Perelman & Pastuszak, 2016). Schmidt, Munder, Gerger, Frühauf, and Barth (2014) evaluated the comparative efficacy of psychological interventions, sildenafil, and their combination in the treatment of ED. The psychological interventions included in their meta-analysis were counseling, cognitive-behavioral sex therapy, and psychoeducation, offered individually, in a couple, in a group, or on the Internet. Overall, the combined treatments had a superior effect on ED symptoms and on sexual satisfaction. No differences were found between psychotherapy and PDE5Is with respect to impact on ED symptoms. The superiority of the combined treatment was independent of the intensiveness of the psychological intervention.

A randomized controlled study compared the efficacy of vardenafil alone and vardenafil combined with couple cognitive-behavioral sex therapy, and found that the combined approach led to a better maintenance of positive erectile results (Boddi et al., 2015). Some argue that pharmacological treatment provides rapid symptom relief (Schmidt et al., 2014), whereas psychotherapy allows for the processing of emotional reactions, such as performance anxiety and avoidance, that can interfere with the ability to obtain and/or maintain erections.

### *Case Discussion: Integrative Treatment*

Therapy with Philippe and Catherine consisted of regular sessions over a 1-year period. Early interventions focused on shifting their communication style away from criticism toward empathy and appreciation, setting time aside for the couple to engage in pleasant activities, and gradually breaking the pattern of avoidance around expression of affection. Flexible sensate focus exercises were recommended to reintroduce sensual touch and to experiment with broadening their sexual repertoire. Initial sessions focused on decreasing Philippe's performance anxiety during sensate focus and a fear of disappointing Catherine. He was encouraged to engage in self-stimulation exercises and was instructed in mindfulness and breathing techniques in session.

Although empathic to his anxiety and acting as a supportive coach during the exercises at home, Catherine maintained a critical stance and expressed frequent discouragement and scepticism. She struggled with recognizing the amount of pressure she placed on him, vehemently rejected a "good enough" model of sex, and showed considerable cognitive inflexibility. For her, Philippe's lack of erection meant that she was unattractive and activated her fear of aging.

In contrast, Philippe was able to see his ED as a consequence of removal of his prostate, not one of diminished masculinity. He became more confident and assertive, and his anxiety decreased. On the therapist's recommendation, and to eliminate any medication-related anxiety, his urologist prescribed the

use of daily tadalafil. This, combined with regular self-stimulation and sensate focus, made it possible for Philippe to gradually obtain and maintain an erection sufficiently rigid for intercourse.

Despite experiencing pleasure and orgasm with a greater nonpenetrative sexual repertoire and with subsequent restoration of intercourse, Catherine complained about lack of spontaneity in their lovemaking and frequently refused Philippe's initiatives, complaining about work stress. Philippe was delighted with their progress but dismayed by Catherine's reaction and lack of enthusiasm. Catherine chose to unexpectedly end therapy, citing professional constraints on her time.

Six months later, Philippe informed the therapist that the couple had come to the mutual decision to end their relationship and that he was content with the gains made in therapy. This case highlights an integrative approach to conceptualizing ED and a combined medical and psychological treatment, delivered in a couple context. Philippe experienced long-standing insecurities about his lovemaking abilities that were exacerbated by the sequelae of prostatectomy and led to erectile difficulties. Therapy increased his sexual confidence and decreased his performance anxiety, thereby enabling the PDE5Is to be effective in treating the ED. However, removal of the sexual problem allowed for crucial, unrelated individual and couple issues to emerge, which eventually led to the partners to end their relationship.

## Conclusions

The empirical and clinical literature of the past 20 years strongly points to the etiological complexity of ED that invariably necessitates the use of multifaceted biopsychsocial frameworks for the conceptualization, assessment, and treatment of ED. Regardless of the etiology of the problem, all men who experience erectile problems may benefit from combined treatment interventions that include sex therapy. Although combined, integrated, and collaborative approaches to ED are recommended, the empirical and clinical reality remains very much medicalized. Despite the paucity of research pointing to the effectiveness of psychosexual interventions when used alone, the combined treatment studies show that adding sex therapy components to medical treatments has a synergistic effect. There is thus a strong need for more extensive and rigorous research examining the contribution of psychosocial factors in the etiology of ED and the effectiveness of psychotherapeutic treatments.

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## CHAPTER 5

# Orgasm Problems in Women

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In Chapter 5, Mintz and Guitelman focus attention on "the orgasm gap, which is the consistent empirical finding that during heterosexual sex, men have substantially more orgasms than women do." The authors' careful review of the literature on female orgasm and female orgasm disorder reveals "that the problem lies in our cultural mores around heterosexual sex, rather than on women's orgasms being more complicated than men's." Effective treatment for women who experience difficulty with orgasm continues to center on cognitive-behavioral approaches incorporating traditional sex therapy techniques, such as directed masturbation and sensate focus. While psychological treatments remain the most empirically validated, other and adjunctive options are reviewed, ranging from unsupported treatments, such as botanical creams and nutritional supplements, to medications, mechanical devices, and pelvic floor therapy. Mintz and Guitelman outline a comprehensive assessment protocol and illustrate how to individualize treatment planning for women with difficulties experiencing orgasm in partnered and in solo sex.

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"How to make a woman orgasm" is one of the top 10 questions that people put into the Internet search engine, Google (Yenisay, 2017). However, concern with female orgasm long precedes the advent of the World Wide Web in 1991. Writing about 40 years ago, one author observed that the female orgasm inspires enormous interest, debate, popular press literature, and scientific writing "solely because it is so often absent" (Symons, 1979, p. 79). This chapter details the prevalence, causes, and treatment of such absent, as well as markedly diminished and delayed, female orgasms. Before delving into this topic, it is important to discuss terms that seem straightforward at first glance but are far from simple: "female/woman" and "orgasm."

Despite an increased awareness that not all individuals identify with the sex they were assigned at birth, almost all of the epidemiological and treatment literature on orgasm issues has focused on cisgender women. We thus do not know, for example, if a person with a vulva who identifies as a man would respond to treatment for an orgasm problem the same way a person with a vulva who identifies as a woman would, although Mintz's clinical experience indicates that aspects of treatment pertaining to one's genitals (e.g., being directed to masturbate) transfer easily, whereas aspects of treatment pertaining to social and cognitive factors need to be adapted. Nevertheless, in the absence of sufficient literature on orgasm problems in intersex, gender diverse, and transgender individuals, we focus in this chapter on orgasm problems in cisgender women.

Before discussing orgasm problems, it is essential to answer the question of what an orgasm is. As stated by Komisaruk, Whipple, Nasserzadeh, and Beyer-Flores (2010), "As simple as this question sounds, and as obvious as the answer may seem to most of us, defining 'orgasm' can prove to be difficult" (p. 2). Defining female orgasm is particularly difficult, and in fact, some women themselves report uncertainty about whether they have ever experienced orgasm (Graham, 2014), such as Mandy, who presented to therapy stating, "My friends say I'd know if I had an orgasm, but I just don't know if I have or not." Contributing to Mandy's confusion is that, compared to male orgasm, which is generally accompanied by ejaculation, there is no tangible evidence that a female orgasm has occurred. Nevertheless, in a now classic study, researchers Vance and Wagner (1976) found that expert judges could not distinguish between women's and men's descriptions of orgasms. Both described a buildup of tension, followed by a very pleasurable release of this tension, with many also describing a state of altered consciousness. These personal descriptions parallel the observations made in another now classic article by Mah and Binik (2001), who stated that while there is no universally accepted definition of orgasm, most definitions include both subjective

experiences (e.g., pleasure, altered mind-state) and physiological changes. They also noted that the subjective experiences and the physiological changes vary both between and within individuals. Despite this variability, a basic understanding of female genitalia and the physiology of orgasm is essential to treating women experiencing orgasm difficulties.

As aptly pointed out by Buehler (2017), practitioners treating women with orgasm concerns should have, and be able to explain to clients, a basic drawing of the external female genitalia (i.e., mons pubis, inner lips, outer lips, clitoral glans, clitoral hood, vaginal opening, urethral opening). Buehler (2017), Kerner (2004), and Mintz (2017) provide such drawings. It is also important for practitioners to know that the clitoris includes external (i.e., glans and hood) and internal (i.e., clitoral shaft, clitoral legs, clitoral bulbs) parts. A rudimentary understanding of the physiology of orgasm is also important to treatment.

To understand the bodily processes associated with orgasm, one must know that the internal and external clitoris, as well as other parts of the female genital anatomy (e.g., the inner lips), contain erectile tissue. This tissue is similar to that found in the male penis. Erectile tissue has special capillaries that, during sexual excitement, let the blood flow in but not out. The blood going into but not out of erectile tissue creates tension that builds up to a very high point. Orgasm occurs when powerful, rhythmic muscle contractions release that tension, forcing the accumulated blood out and preventing additional blood from coming in. The muscles that contract are called pelvic floor muscles. Bodily changes during orgasm are not limited to rhythmic genital contractions, however. Other changes include contractions of muscles in other parts of the body (e.g., fingers and toes curling), increased breathing and heart rate, and various forms of myotonia, including facial grimaces. Additionally, during orgasm, pleasure-promoting neurochemicals are released, and the brain also generates chemicals involved in attachment, such as oxytocin and prolactin (Sayin, 2012). Importantly, recent brain research indicates that leading up to orgasm, parts of the brain associated with conscious thought turn off, resulting in brain waves that resemble a meditative-like state (Prause, 2017). Whereas prior research seemed to indicate that these brain areas turn off during orgasm (Komisaruk & Whipple, 2005), this recent research using more sophisticated methodology seems to indicate that these parts of the brain turn off before orgasm and may turn on again during orgasm, thereby pulling one out of this trance-like state. This research points to the idea that it is not orgasm that triggers deactivation in the brain, but that deactivation in the brain is necessary to trigger orgasm. Regarding the stimulation that triggers orgasm, some women orgasm from nongenital stimulation (e.g., of the nipples), and there have been reports of women who can reach orgasm from fantasy alone (Komisaruk & Whipple, 2012). Yet the most common type of stimulation that triggers orgasm is genital.

There is a long history, starting with Freud and continuing to this day (e.g., Brody, 2010), of a categorization of female orgasm based on the point of

genital stimulation (i.e., clitoral vs. vaginal orgasms) and the labeling of those achieved by vaginal penetration as superior. According to recommendations reflecting the consensus view of experts in sexual medicine (i.e., standard operating procedures [SOPs] for female orgasm disorder [FOD][1]), this view is "outdated" (Laan, Rellini, & Barnes, 2013, p. 76). It is now agreed that even orgasms that occur from stimulation of the vaginal canal involve the internal clitoris. Even more importantly, experts agree that not reaching orgasm via penetration does not qualify as a sexual disorder. Indeed, both the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) and the SOPs for FOD (Laan et al., 2013) are adamant in their statements that failure to experience orgasm during sexual intercourse in the absence of additional clitoral stimulation is normative rather than being a disorder. Nevertheless, due to cultural factors that we detail subsequently, many women present to sex therapists with distress concerning lack of coital orgasms.

While this chapter details orgasm concerns that may not meet benchmarks for a sexual dysfunction, it is important to be aware of such diagnostic criteria. DSM-5 (American Psychiatric Association, 2013) defines FOD according to three dimensions; frequency, timing, and intensity. For a woman to receive a DSM diagnosis of FOD, orgasm must be delayed, attenuated, rare, or never experienced. Furthermore, a diagnosis is not given for transient fluctuations in sexual response, so difficulty experiencing orgasm must occur in the majority of sexual situations over a significant period of time period (6 months). DSM-5 includes four specifiers to more fully clarify the diagnosis of FOD. Duration is one such factor, as it is important to know whether a woman has at one time been orgasmic and now is not. These subtypes are often referred to in the literature as primary and secondary anorgasmia, respectively. Second, the scope of the orgasmic dysfunction must also be identified, so that it is clear whether and under what conditions there is the ability to experience orgasm (including partnered or solo sexual activity and type of stimulation). Of note, for many women, orgasm comes easily in masturbation but not during partner sex (Brewer & Hendrie, 2011; Hite, 1976). A third specifier is if the woman has never experienced an orgasm under any situation. Fourth, it must be specified whether the woman experiences mild, moderate, or severe distress concerning her orgasm issues. As noted earlier, orgasm concerns caused by inadequate sexual stimulation do not qualify for a diagnosis of FOD.

The recently approved 11th edition of the *International Classification of Diseases* (ICD-11; World Health Organization, 2019) contains more general

[1]We draw from the SOPs for FOD, as well as four other sources citing or summarizing research on female orgasm problems (Bueher, 2017; Carpenter, Williams, & Worly, 2017; Ishak, Bokarius, Jeffrey, Davis, & Bakhta, 2010; Mintz, 2017), in this chapter. When we reach conclusions based on multiple studies and/or a study conducted prior to 2009, we do not cite these studies and instead cite the secondary source. However, if additional research within the last 10 years supports a conclusion that is not cited in the summary source, we cite it. Finally, we only cite older studies if they are considered seminal (e.g., Hite, 1976).

criteria. Specifically, the ICD-11 states that to be classified as having a sexual dysfunction, the problem must occur frequently (although it can be absent occasionally), have been present for at least several months, and be associated with clinically significant distress. Orgasm dysfunctions are described as difficulties related to the subjective experience of orgasm. ICD-11 also contains codes to specify etiological causes and includes other sexual disorders, medical conditions, psychological and behavioral factors, substances or medications, lack of knowledge or experience, relationship factors, and cultural factors. Due to the less stringent time criteria and the more inclusive etiological criteria (e.g., lack of knowledge, which is often associated with insufficient sexual stimulation), more women would meet the diagnostic criteria for ICD-11-defined orgasm dysfunction than for DSM-5-defined FOD. It is not known how many women meet DSM-5 or ICD-11 criteria for FOD or orgasm dysfunction, respectively, as no prevalence studies using these criteria have yet been conducted.

## Prevalence of Orgasm Concerns

Although orgasm problems are the second most common sexual complaint among women (Ishak et al., 2010; Laan et al., 2013), estimates of just how many women are struggling with this issue varies greatly depending on how the questions are asked and who is being surveyed. In one study (Elsamra et al., 2010) of almost 600 women presenting to a urology clinic, 54–87% of women (depending on age) scored in the dysfunctional range on the orgasm domain of a widely used measure of sexual functioning (Female Sexual Function Index; Rosen, Brown, Heiman, & Leib, 2000). When reviewing studies conducted with women in the general population, the percentages are lower, ranging from about 3 to 34% (Graham, 2010). However, the overwhelming majority of the reviewed studies did not use the full DSM criteria for the disorder. In reviewing five studies that utilized the full criteria from DSM IV-TR (American Psychiatric Association, 2000), Carpenter et al. (2017) reported that about 3–10% of women in the United States and Europe suffer from FOD.

A consistent epidemiological finding is that only about half of women who are unable to orgasm are distressed about this (Graham, 2014; Laan et al., 2013). Nevertheless, some women who are not distressed about lacking orgasm still present to treatment due to their partner's upset regarding their missing orgasm, such as Carrie, who stated that she was satisfied with the emotional and physical closeness of sex with her partner, Jim, but that he was hurt by her missing orgasm, interpreting the fact that she did not orgasm during intercourse as a reflection on his masculinity and as a barometer of their relationship health. The fact that Carrie had never under any circumstance, including masturbation, had an orgasm did not convince Jim that the problem was not a reflection on him or the relationship. Like Carrie, 10% of the female population reports never experiencing an orgasm under any circumstance (American Psychiatric Association, 2013).

## Etiology of Problems with Orgasm

Problems with orgasm can stem from and be maintained by medical and medicine-related factors, as well as individual vulnerability factors (e.g., a woman's history, psychological makeup, and current stressors). Relational concerns can also contribute to orgasm concerns. Orgasm concerns also occur within a cultural context, and cultural factors play a role in etiology. Orgasm issues are often comorbid with other disorders. Finally, there is some evidence that orgasm functioning has a genetic component. We review in the following section all such etiological factors; unless noted as being based on clinical writings or wisdom alone, all statements regarding etiology are based on medical, epidemiological, and qualitative and/or quantitative research, sometimes alone and sometimes also bolstered by clinical writings. Also, while many of the subsequently mentioned etiological factors overlap and influence once another (e.g., depression may be related to relationship discord), the etiological factors will nevertheless be presented as distinct.

Regarding genetics, based on their thorough review of the empirical literature, including a twin study and a study on gene receptors, Ishak et al. (2010) concluded that there seems to be a heritability factor involved in a woman's difficulty reaching orgasm. A later study (Burri, Greven, Laupin, Spector, & Rahman, 2012), conducted with over 1,400 twins employing a statistical modeling procedure, in which both genetic influences and nonshared environmental effects can be disentangled, found that orgasm functioning was moderately heritable and that nonshared environmental factors accounted for more of the variance in orgasm functioning than genetic influences. Specifically, this study reported that 28 and 72% of the variance in orgasm functioning was accounted for by genetic factors (i.e., heritability) and nonshared environmental factors, respectively. Such findings led the study authors to conclude that both biological and individual factors, including those we will subsequently detail (e.g., physical health, depression, relationship satisfaction, cultural expectations) contribute to orgasm and other sexual concerns among women.

Poor physical health has consistently been associated with orgasm problems (Graham, 2014). Many medical conditions have known associations with orgasm problems, although it is often unclear whether it is the conditions, their treatments, or their psychological effects that affect orgasmic function (Laan et al., 2013). A nonexhaustive list of conditions mentioned in the clinical and epidemiological literature as being associated with orgasm issues includes chronic pain, multiple sclerosis, arthritis, fibromyalgia, thyroid problems, spinal cord injuries, kidney disease, vulvar diseases, and pelvic conditions (e.g., pelvic nerve damage, pelvic prolapse disease). Due to their effect on the blood flow that is so key to orgasm, atherosclerosis and its related risk factors (e.g., smoking, diabetes, hypertension, and peripheral vascular disease) are also associated with orgasm issues.

While both age and menopausal status are inconsistently associated with orgasm problems (Carpenter et al., 2017; Graham, 2014), decreased levels of

estrogen, progesterone, and testosterone as women age have been implicated in orgasm and related issues. For example, low estrogen levels can cause a weakening of the pelvic muscles and a reduction in vaginal lubrication (Ishak et al., 2010).

A number of medications also contribute to orgasm problems. Mood stabilizers, cardiovascular medications, chemo-therapeutic agents, and hypertension drugs all have possible negative effects on orgasm functioning (Clayton & Balon, 2009). Rates of orgasmic dysfunction among patients taking antipsychotics range from 5 to 25% or higher (Serretti & Chiesa, 2011). Selective serotonin reuptake inhibitors (SSRIs) commonly prescribed for depression have been found to delay or inhibit orgasm in over one-third of women who take them (Ishak et al., 2010; Lorenz, Rullo, & Faubion, 2016).

While antidepressant medications can contribute to orgasm problems, so can depression itself given that depression is characterized by markedly diminished interest or pleasure in all, or almost all, activities (American Psychiatric Association, 2013; Buehler, 2017). In one study, over 50% of women who met criteria for FOD also met the criteria for depression (Laan et al., 2013). There is also an overlap between anxiety disorders and orgasm problems, with over 27% of women with FOD also suffering from anxiety (Laan et al., 2013). Clinical wisdom indicates that thought patterns associated with anxiety and depression, including rumination and difficulty redirecting one's focus to the present moment, might help explain these relationships (Laan et al., 2013), particularly in light of the research we cited earlier regarding the importance of brain deactivation to orgasm.

Women's cognitive distraction due to life stressors and self-observation and evaluation during sex (often referred to as "spectatoring") have been related to orgasm issues (American Psychiatric Association, 2013, Buehler, 2017, Carpenter et al., 2017, Ishak et al., 2010; Laan et al., 2013). Much of this spectatoring concerns performance anxiety and negative body image, including negative genital self-image, thereby explaining why negative body-image is a risk factor for orgasm issues. Illustrating spectatoring is Jill, a 28-year-old client in a loving, committed relationship, who reports orgasming easily during masturbation but when receiving oral sex, consistently worries that she is taking too long and about the smell and appearance of her genitals. This self-monitoring results in her inability to orgasm during partner sex.

Another individual vulnerability factor that can contribute to orgasm problems is a history of sexual trauma. However, not all women who have survived sexual trauma have orgasm concerns (Laan et al., 2013). According to clinical writings, those who experienced physical sensations of sexual arousal or even orgasm during the abuse, a common occurrence due to our nervous system not being under conscious control, might be especially prone to orgasm issues (Buehler, 2017). Also of relevance, clinical writings suggest that some survivors report overusing alcohol prior to sexual activity to numb out memories and associations of sexual activity with the abuse (Buehler, 2017). While a small amount of alcohol can enhance orgasmic response, large amount can diminish it, as can street drugs (Buehler, 2017; Ishak et al., 2010). Certainly,

alcohol- and drug-related issues with orgasm are not limited to survivors of sexual trauma and can interfere with any woman's orgasmic response.

Finally, in terms of individual vulnerability factors, both personality types/style and cognitive–affective modes of responding have been linked to orgasm concerns. In their review of the empirical literature, Ishak et al. (2010) reported evidence that emotional intelligence is associated with higher orgasm frequency, whereas introversion, emotional instability, and not being open to new experiences are associated with orgasmic infrequency. Perhaps related, in the clinical literature, fear of losing control has been implicated in orgasm concerns, as has heightened negative reactions to lack of orgasm (e.g., seeing it as a reflection of competence; Laan et al., 2013). This latter finding may be related to the clinical observation that setting orgasm up as a goal to achieve makes orgasm less likely (Mintz, 2017). Finally, the clinical literature implicates sex-negative attitudes (e.g., feeling guilt and shame about sex) in orgasm concerns (Laan et al., 2013). Such sex-negative attitudes generally stem from religious, familial, and cultural messages about sex.

Shedding light on the cultural issues that contribute to orgasm issues is what researchers call the "orgasm gap," which is the consistent empirical finding that during heterosexual sex, men have substantially more orgasms than women do (Armstrong, England, & Fogarty, 2012). Demonstrating that the problem lies in our cultural mores around heterosexual sex rather than on women's orgasms being more complicated than men's is the fact that women have more orgasms when they have sex with other women than with men (Garcia, Lloyd, Wallen, & Fisher, 2014), and that the vast majority of women who masturbate reach orgasm when doing so. In her classic study, Hite (1976) reported that all but 5% of the women in her sample who masturbated reached orgasm this way and a recent study, conducted with a convenience sample of over 3,500 Portuguese women, revealed that all but 7.6% of women who masturbated reported that they were able to reach orgasm this way (Carvalheira & Leal, 2013).

The reason that women orgasm more frequently when with other women and when alone is a more central focus on external (i.e., vulva and clitoris) stimulation (Carvalheira & Leal, 2013; Hite, 1976). Conversely, when with men, the primary focus becomes penetration (Mintz, 2017). Heterosexual sexual encounters generally follow what researchers refer to as our current cultural script for sex, which proceeds as follows: foreplay (just to get the woman ready for intercourse), intercourse, and male ejaculation (which marks the conclusion of the activity). In this cultural script, the man is responsible for the woman's orgasm, giving her one by lasting long and thrusting hard (Muehlenhard & Shippee, 2010). In short, despite experts no longer considering orgasms from penetration the ideal, many women and men still believe that the way men most reliably reach orgasm (i.e., penetration) should also be the way that women reach orgasm. Clinicians note that this false belief contributes to many women and their partners presenting to therapist's offices with concerns about not orgasming during intercourse (Beuhler, 2017; Mintz, 2017).

A number of related partner and relationship issues have been associated with orgasm issues, including a partner's lack of interest or skill in sexual acts involving clitoral stimulation and a couple's strict adherence to the previously described current cultural script for sex. Additionally, the clinical literature mentions that anger, resentment, and trust issues can contribute to orgasm issues (Buehler, 2017). Communication issues, including both the couple's and the male partner's discomfort discussing sex has been linked to problems with orgasms. One specific communication problem related to orgasm issues includes both the woman's and her partner's discomfort discussing preferences regarding clitoral stimulation (Ishak et al., 2010). Finally, a partner's premature ejaculation and erectile dysfunction also contribute to women's orgasm concerns (Laan et al., 2013); clinical observation indicates that this may be especially true for couples who adhere strictly to our current cultural script for sex, assuming that the partner's penile functioning is essential to the woman's pleasure.

Finally, other sexual issues are often comorbid with orgasm issues, including problems with arousal, lubrication, desire, and sexual pain, including pain with vaginal penetration, which can occur due to a multitude of causes, including insufficient stimulation prior to penetration and vaginal dryness and atrophy associated with menopause (Buehler, 2017; Ishak et al., 2010). As stated by Laan et al. (2013, p. 75), "Because of this high level of comorbidity . . . most women will present with a complex combination of problems, requiring a comprehensive assessment."

## Assessment of Women Presenting with Orgasm Issues

Comprehensive assessment of women presenting with orgasm concerns should focus on the aforementioned risk and etiological factors (Laan et al., 2013). Accordingly, DSM-5 (American Psychiatric Association, 2013) directs that along with assessing whether the orgasm concern is lifelong or situational, the following five factors should be assessed: (1) partner factors; (2) relationship factors; (3) individual vulnerability, psychiatric comorbidity, or stressors; (4) cultural/religious factors; and (5) relevant medical factors. Along similar lines, the SOPs for FOD (Laan et al., 2013) state that the following should be assessed: (1) psychosocial factors (e.g., religiosity, feeling guilty about sex, sexual inexperience, and negative attitudes toward sex); (2) cognitive and affective factors (e.g., anxiety, depression, attentional focus on sexual cues, body image, negative thinking styles); (3) relationship factors (e.g., difficulties with general and sexual communication, feelings of anger, and conflict resolution skills); (4) history of childhood and adult sexual abuse (and other forms of mistreatment as a child); (5) relevant medical history; and (6) current medications (e.g., especially those associated with orgasm issues). For a thorough assessment of medical- and medication-related causes of orgasm

problems, the client should be referred to a knowledgeable physician (Buehler, 2017; Carpenter et al., 2017); Carpenter and colleagues provide details on precisely what should be done in a thorough gynecological exam to rule out physiological and anatomical etiologies.

As noted earlier, both the distress that is being caused by the problem and whether insufficient or inadequate sexual stimulation is responsible for the orgasm problem also must be assessed (Laan et al., 2013). In terms of assessing the latter, we find it quite useful to ask the client to describe a typical sexual encounter with her partner, and to ask relevant follow-up questions as needed to assess the type of stimulation she is receiving. It is also essential to ask the client whether she masturbates, what she does when she masturbates, and whether she experiences orgasm in this way.

Assessment should be iterative given that clients often only share critical details once they are comfortable with the therapist (Carpenter et al., 2017). Assessment should also be tailored to the client's concern and conducted in a culturally sensitive manner (Carpenter et al., 2017; Laan et al., 2013). Of course, even though the etiological factors are presented in this chapter (as well as in DSM-5 and the SOP for FODs) as distinct, the assessing clinician should also assess for cause-and-effect relations among them (e.g., is depression caused by marital discord?). Finally, to track progress in treatment, as well as a starting point for a discussion in therapy, standardized assessment instruments can be used. The Female Orgasm Scale (McIntyre-Smith & Fisher, 2010) and the FSFI (Rosen et al., 2000) are especially useful.

## Treatment of Orgasm Issues

Treatment of orgasm concerns should coincide with assessment of what is causing, contributing to, or maintaining the problem. However, prior to detailing available treatments and evidence supporting them, it is informative to frame these treatments within Annon's seminal (1976) PLISSIT (permission, limited information, specific suggestions, intensive therapy) model and to discuss treatment modality.

The PLISSIT model is a stepwise model for treating sexual concerns, in which providing permission, limited information and specific suggestions are the first-line approach, followed by intensive therapy if the problem is not resolved. However, recent recommendations note that intensive therapy can be provided in concert with the first three steps (Mintz, Sanchez, & Heatherly, 2017). Still, according to the original model, the majority of sexual problems can be solved without intensive therapy (Annon, 1976). The SOPs for FOD (Laan et al., 2013) point out the utility of this approach in treating orgasm concerns, particularly in "uncomplicated cases" (p. 78), such as those caused by lack of knowledge or insufficient stimulation during partner sex.

Cases of insufficient stimulation during partner sex raise the question of partner involvement in treating women with orgasm concerns. While there are

limited data on the efficacy of couple versus individual therapy, the current recommendation is that if the woman is able to orgasm during self-stimulation but not partner sex (i.e., secondary anorgasmia), the partner should be involved in treatment (Laan et al., 2013). Additionally, a woman with primary anorgasmia may learn to orgasm during masturbation, then face difficulties transferring this to partner sex; thus, involving partners in these cases may also be warranted (Laan et al., 2013). However, in cases where the couple has excellent communication or when there is not a consistent partner, such transfer skills can be accomplished by providing interventions (e.g., psychoeducation, communication skills training) to the woman herself. Finally, in terms of modality, orgasm concerns have also been treated in group therapy with good success, with most such interventions containing a significant amount of psychoeducational material (e.g., Robinson, Munns, Weber-Main, Lowe, & Raymond, 2010).

## Psychoeducational Interventions

Clients struggling with orgasm concerns often benefit from a range of information, including but not limited to that pertaining to sexual anatomy, sexual response, the fact that the vast majority of women pleasure themselves solely with external genital stimulation (Carvalheira & Leal, 2013; Hite, 1976), and the wide range of variability in the appearance of women's genitals (Carpenter et al., 2017). The latter is especially useful for women struggling with genital self-image; indeed, given that woman's level of satisfaction with her genitals is associated with better sexual function (Ålgars et al., 2011; Herbenik et al., 2011), exposing women to realistic images of genitalia could lead to an improvement in orgasm rates.

Providing education on women's genital anatomy is particularly important, going over the simple line diagram mentioned earlier, making sure to point out the sexually responsive inner lips and external portion of the clitoris. Clients presenting with concerns about not orgasming during intercourse should be provided with statistics on this topic. Briefly, in a recent study, Shirazi, Renfro, Lloyd, and Wallen (2017) found that 51–60% of women reported being able to orgasm during intercourse in which the woman or her partner simultaneously stimulates her external clitoris, whereas only 21–31% report that they can orgasm during intercourse without concurrent clitoral stimulation. Mintz (2017) reports that when asking a question devoid of the word *intercourse* and instead asking approximately 500 college women about their "most reliable route to orgasm," only 4% say intercourse alone. The remainder say their most reliable route involves direct clitoral stimulation alone (34%) or clitoral stimulation coupled with penetration (43%). Such statistics can be quite normalizing for women, helping them let go of the notion that orgasms via penetration are normative or ideal. For many clients, it is also helpful to explain that trying to have an orgasm during intercourse may simply not be within one's biological makeup, sharing research that women

who can orgasm from the stimulation of a thrusting penis have less distance between their clitoral glans and vaginal opening than those who do not orgasm this way (Wallen & Lloyd, 2011). Nevertheless, providing psychoeducational information on the clitoris often improves orgasm rates during masturbation but not during sex with a partner (Carpenter et al., 2017; Ishak et al., 2010). This leads to the conclusion that while psychoeducation is an important foundation to treating orgasm concerns, it is generally not sufficient (Carpenter et al., 2017).

## Psychological Interventions

Across decades of research, cognitive-behavioral therapy (CBT) techniques have proven most effective, with directed masturbation (DM) the most empirically supported CBT technique (Laan et al., 2013). DM involves graduated exposure to genital stimulation, occurring over several weeks via at-home exercises. Specifically, after being provided with psychoeducation on genital anatomy, exposure can begin by simply having the client look at her genitals with a mirror, then proceed to increasingly intense solo tactile stimulation using lubricants, hands, and vibrators. For the client who is fearful of losing control, evidence suggests that role-playing orgasm can be a potentially useful early step (Laan et al., 2013). We also find that providing realistic, nonpornographic models of other women masturbating (e.g., those found on *omgyes.com*) can also be a useful early step in DM.

In DM, after the woman becomes orgasmic by herself, she then transfers this to partner sex. Most of the protocols for DM, including the original popular published book version by Heiman and LoPicollo (1987), assume that the woman has one significant male partner, and that treatment will involve him through exercises in which she shows him what to do, verbally directs him, and/or lets his hand rest on hers as she pleasures herself. These partner exercises are typically first done without intercourse, then with intercourse later added in, including incorporating clitoral stimulation during intercourse (Buehler, 2017).

Several randomized clinical trials have shown DM to be effective; after reviewing such trials conducted within the context of individual and group therapy, with and without partner involvement, Laan et al. (2013, p. 78), stated, "The success rates for DM training . . . in women with primary anorgasmia are generally high: 60–90% of the women become orgasmic with masturbation and 33–85% will become orgasmic with partnered sexual activity."

Because DM typically assumes the presence of a steady partner, a word about helping clients without such a partner transfer their masturbatory orgasms to partner sex is warranted. Mintz (2017) advocates increasing comfort and skill in communicating about clitoral stimulation to partners, as well as helping women adopt attitudes that counteract common societal scripts that result in them feeling less entitled to orgasm than men, both in general

and in casual sexual encounters in specific. Such attitudes, which have been found to be related to orgasm function, are sexual autonomy (Laan et al., 2013) and entitlement to pleasure from a partner (Mintz, 2017).

Another cognitive-behavioral technique that has been used to help women orgasm during partner sex is sensate focus (SF). Again, this technique requires a committed partner. Originally developed by Masters and Johnson and subsequently modified by others (e.g., Buehler, 2017), SF involves non-goal-oriented, graduated couple exercises proceeding from nonsexual to sexual touching. Via a focus on pleasurable sensations rather than orgasmic goal attainment, SF can help couples establish or reestablish sexual intimacy and decrease performance anxiety and distractions during sexual encounters (Buehler, 2017, Laan et al., 2013). Of note, SF alone has not been found to result in sustained changes over time in orgasm function, yet DM plus SF has been found to be more effective than DM alone (Laan et al., 2013).

Also noted to be potentially effective in treating orgasm concerns is mindfulness (Buehler, 2017; Carpenter et al., 2017; Laan et al., 2013). Mindfulness helps direct a woman's attention to in-the-moment experiences, including sexual experiences, and also assists her in nonjudgmentally letting go of distracting thoughts (e.g., body monitoring, performance anxiety). As stated by Carpenter et al. (2017, p. 63), "Mindfulness methods seem a natural fit given the negative impact of cognitive interference and spectatoring on orgasm." We also believe mindfulness is both a natural fit and potentially effective in treating orgasm issues given the aforementioned recent brain research finding that prior to orgasm, parts of the brain associated with conscious thought turn off, resulting in brain waves resembling a meditative-like state (Prause, 2017). In one small clinical trial, yoga improved orgasmic functioning, especially for women 45 years old and beyond (Dhikav et al., 2010). This is likely because, like mindfulness, yoga helps one learn an in-the-moment focus (Laan et al., 2013). At this point, however, no studies have specifically examined the effectiveness of mindfulness on women presenting with orgasm issues. Nevertheless, clinical trials show that mindfulness improves orgasm function in women with cancer (Carpenter et al., 2017; Laan et al., 2013).

In terms of psychological interventions, the current best evidence indicates that combination therapies are the treatment of choice (Laan et al., 2013). Such combination therapies generally should couple DM with other interventions. These other interventions may include but are not limited to sex education, SF, mindfulness, anxiety reduction strategies, communication skills training, and CBT and other approaches targeting negative body-image and sex-negative attitudes such as guilt and shame (Beuhler, 2017; Carpenter et al., 2017; Laan et al., 2013).

### Adjuncts to In-Person Psychological Interventions

In addition to using combination therapy during in-person treatment, several adjunctive interventions have empirical support.

### *Bibliotherapy*

Bibliotherapy, or the reading of self-help materials, has been noted to occupy an established position in treating sexual dysfunctions (van Lankveld, 2009). This position is based on an older meta-analysis (van Lankveld, 1998) that found a large effect for bibliotherapy for sexual dysfunction. The majority of studies in this meta-analysis focused on orgasm problems among women, with many using Heiman and LoPicollo's protocol and associated book, *Becoming Orgasmic* (1987), which originally introduced DM to the lay public. A more recent study (Guitelman, Mahar, Mintz, & Dodd, 2019) reported that female university students who read the book *Becoming Cliterate* (Mintz, 2017) improved on orgasm frequency and orgasm satisfaction, as well as other indices of sexual functioning (e.g., attitudes toward women's genitals, sexual pain, sexual assertiveness). There is no evidence to suggest that these results would have been better if provided alongside minimal therapist support (Van Lankveld, 1998), yet we surmise that incorporating bibliotherapy into traditionally delivered in-person therapy could enhance the effectiveness of both.

### *Interventions Targeting the Pelvic Floor*

Given the role of pelvic floor muscles in orgasm, strengthening these muscles with Kegel exercises (via take-home instructions or referral to a pelvic floor physical therapist) is often recommended in the treatment literature, although clinical trials do not demonstrate their effectiveness in treating orgasm problems (Carpenter et al., 2017; Ishak et al., 2010). Still, given evidence that such exercises play a role in enhancing arousal (Lowenstein, Gruenweld, Gartman, & Vardi, 2010) and can also increase sexual comfort and draw a woman's attention to genital feelings, they can serve as a beneficial adjunct to treating orgasm issues (Buehler, 2017; Carpenter et al., 2010). In addition, in one small trial, electrical stimulation of nerves that control the pelvic floor muscles resulted in orgasm in a very small sample of women with treatment-resistant secondary anorgasmia, with no effect on treating resistant primary anorgasmia (Carpenter et al., 2017). More study of pelvic floor physical and rehabilitation therapy (including pelvic floor exercises and electrical stimulation) is warranted.

### *Mechanical Devices*

As noted earlier, vibrators are often included in protocols for DM and, indeed, research shows that women who use vibrators have easier and more frequent orgasms, both alone and with partners (Herbenick et al., 2010). Nevertheless, as stated by Beuhler (2017), "Men (and in the case of lesbian relationships, sometimes women) find their partner's use of a vibrator threatening. This requires education on the part of the therapist" (p. 77). While vibrators are readily available for purchase, the Eros Therapy device is a U.S. Food and

Drug Administration (FDA)-approved clitoral vacuum that increases blood flow and engorgement, and is available only with a prescription. It has been shown to improve orgasmic function in healthy controls, women with unspecified sexual problems, and women who have had radiation for cervical cancer (Carpenter et al., 2017; Ishak et al., 2010).

### Pharmacological Interventions

There is currently no FDA-approved pharmacological intervention for women struggling with orgasm issues. A meta-analysis of hormone therapy for peri- and postmenopausal women found little evidence of improvement in orgasmic function (Nastri, Lara, Ferriani, Rosa-E-Silva, & Martins, 2013). However, other studies of postmenopausal women reveal that testosterone patches and gels have proved effective, as has tibolone, a synthetic hormone therapy available only in Europe, leading to the conclusion that for postmenopausal women, hormone therapy might sometimes be warranted (Ishak et al., 2010; Laan et al., 2013). Additional study of hormone therapy in both pre- and postmenopausal women presenting with orgasm issues is needed (Ishak et al., 2010; Laan et al., 2013).

Due to a few studies finding phosphodiesterase type 5 inhibitors (PDE5Is) to improve orgasmic function among some women (Carpenter et al., 2017; Ishak et al., 2013; Laan et al., 2013), additional research on this is also warranted. Another promising avenue for research is the effectiveness of simply prescribing a placebo medication given that in a recent study, Weinberger et al. (2018) found that almost 68% of the treatment effects of medications prescribed for sexual dysfunction are accounted for by placebo. Finally, bupropion, a nonserotonergic antidepressant, has inconsistent evidence for its effects in treating orgasm issues in nondepressed women (Ishak et al., 2010).

The issue of orgasm problems among depressed women being treated with SSRIs deserves special attention. In a thorough review written for treating physicians, Lorenz et al. (2016) stated that the best clinical evidence supports starting treatment with an antidepressant that has a better adverse sexual effect profile, such as bupropion or mirtazapine. For patients already on an SSRI experiencing sexual side effects, some recommend adding bupropion alongside the SSRI, although this strategy has yielded inconsistent results (Ishak et al., 2010). Switching to a medication with fewer sexual side effects is another option, although there are no clinical trials of this strategy, and it is one that clearly entails risk and trade-off if the current SSRI is alleviating depressive symptoms (Lorenz et al., 2016). Similar concerns have been raised with respect to discontinuing the medication and lowering the dose (Laan et al., 2013; Lorenz et al., 2016). One small randomized, placebo-controlled trial found that augmenting the SSRI with the PDE5I sildenafil was effective (Ishak et al., 2010). Another small randomized, placebo-controlled trial found that augmenting with macca root (i.e., the root of the macca plant, which grows in the Andes mountains in central Peru) was effective (Dording et al.,

2015). Still, it is generally agreed that the first-line option for SSRI-induced orgasm dysfunction is to wait for the sexual symptoms to remit over time, something that occurs in a significant number of patients (Laan et al., 2013; Lorenz et al., 2016). Lorenz et al. also suggest vibrator stimulation, exercising prior to sexual activity, and for those receiving long-term antidepressant therapy in which nothing but the SSRI alleviates the depression, helping the woman accept her sexual functioning by lowering her expectations, focusing on the positive emotional rather than physical aspects of her relationship, and by focusing on the benefits of the medication. These physician–authors also discuss the need for assessing whether the sexual dysfunction is due to the depression or to the medication, and referring the patient to psychotherapy. Indeed, while prescribing physicians may refer depressed patients or patients with medication-related sexual problems to therapists, therapists must also recognize the importance of interdisciplinary collaboration with a knowledgeable physician (Carpenter et al., 2017).

### Unsupported Treatments

Despite the fact that many presenting clients have tried or currently are taking nutritional supplements, there is not enough evidence supporting their effectiveness to recommend them (Laan et al., 2013). One small study showed that the topical botanical Zestra increased orgasm rate, albeit in women with low sexual desire rather than in those with orgasm concerns. However, about 15% experienced burning, so this remedy should be accompanied by a warning to check with one's doctor regarding possible allergies (Buehler, 2017). We have had many clients inquire about high-priced shots in which their own blood platelets are injected into their vaginas (the "O-shot"), a procedure that seems to have been studied among only 11 women (Runels, Melnick, Debourtbon, & Roy, 2014). It is not supported by the medical community, yet it has received much popular press attention. Similarly, we have had clients inquire about vaginal rejuvenation devices marketed for orgasm concerns, something the FDA (2018) has taken a strong stance against, warning of hazards.

## Case Discussion

### Case 1

Janet, a 56-year old woman, presented for treatment with concerns about her lack of orgasm. She reported that she had been married from ages 28 to 35, during which time she had two children, both now adults and no longer living with her. Janet reported that her marriage ended due to her husband's issues with drinking and not contributing to the family well-being, including financially and with respect to both household chores and child rearing. Janet reported that ending the marriage was a decision she felt proud of having had

the strength to make. She also reported that after the breakup of her marriage, her sole focus had been on supporting and raising her children. She reported being proud of the young adults they had become and having close relationships with them. She also reported significant social support, being close with a group of single mothers and maintaining close relationships with her siblings. While raising her children, Janet worked as a secretary, and after her children left home, she enrolled in the local community college to obtain an advanced degree. It was at the community college that Janet met Frank, a 58-year-old man in a somewhat similar situation. Specifically, Frank was a widower who had raised two children after the tragic and premature death of his wife when his now-adult children were toddlers. Janet reported that she had fallen "madly in love with Frank," and that he felt the same. She reported that everything about their relationship was "perfect," except for the sex. Janet reported that she never had an orgasm during sex with Frank, something she found distressing but about which she had not told Frank, faking orgasms instead.

When asked about her past orgasm history, Janet reported that the only other man with whom she had intercourse was her husband, and that it also did not result in orgasm. When asked, Janet indicated that she occasionally masturbated, although she felt ashamed of this behavior, having been raised in a religious household. Although no longer religious, Janet reported that some of the messages she was raised with had stayed with her. When asked how she masturbated, Janet reported that she did so with her hands and occasionally a vibrator a friend had given her years ago. Janet reported focusing exclusively on her external clitoris when masturbating, and reaching orgasm easily. Finally, when asked about a typical sexual encounter with Frank, Janet indicated that they kissed a bit, groped one another a bit, and then proceeded to intercourse. When asked, Janet admitted to having some pain with penetration, which generally diminished as the intercourse proceeded. She reported that she had never revealed this pain to Frank.

The therapist thus spent some time educating Janet about female genital anatomy and response, normalizing her inability to orgasm during intercourse and helping her to understand that she was not getting the sexual stimulation she needed to orgasm. The therapist pointed out the disconnect between how Janet was orgasming by herself (i.e., external clitoral stimulation) and how she was expecting to orgasm with Frank (i.e., penetration only). She was given material to read to normalize this experience; specifically, the therapist provided Janet a copy of Hite's (1976) book, which contains firsthand accounts of women pleasuring themselves externally and women dissatisfied with intercourse that proceeds with little to no clitoral stimulation.

Because of Janet's age and her pain with penetrative sex, although the therapist suspected the latter was at least partially due to insufficient sexual stimulation, the therapist referred her to a local gynecologist specializing in sexual medicine. The gynecological exam revealed that Janet was suffering from mild vaginal atrophy, attributable to menopause. The physician

prescribed vaginally inserted estrogen. Relatedly, the therapist recommended using a silicone-based lubricant during penetrative sex.

The therapist also intervened with Janet's guilt and shame regarding masturbation, encouraging her to continue this practice, indeed applauding her in this regard. She was also given the suggestion to engage in more frequent masturbation. Due to her already successful masturbation practice, graduated DM exercises were not warranted, although psychoeducation and cognitive strategies to alleviate the guilt were.

Most central to treatment, however, were strategies employed to assist Janet in transferring her masturbatory orgasms to partner sex with Frank. Janet was extremely hesitant to communicate her need for clitoral stimulation to Frank and even more hesitant to invite Frank to therapy with her, reporting that she had not told him she was in therapy and stating that needing therapy in such a new relationship seemed like "the kiss of death." She feared that Frank would end the relationship and with tears in her eyes stated that she would rather not orgasm than to lose "the first good man I've been with." After several sessions focused on weighing the pros and cons of talking to Frank, Janet mustered the courage to talk to him about her previously faked orgasms, her work in therapy, her masturbatory practice, and her desire to incorporate clitoral stimulation into their sexual routine. To her great relief, Frank was supportive, stating that he wanted to do whatever Janet needed to orgasm. To her even greater surprise, Frank asked to attend a therapy session to see what he could do to assist Janet to orgasm. Janet indicated that she would feel most comfortable if Frank and the therapist met alone before she joined them, because she thought it would be "less embarrassing" that way.

The therapist respected Janet's wishes and saw Frank for two sessions, spaced 3 weeks apart, to give Frank time to complete some reading material between sessions. Specifically, during the first session, after taking a sexual history that revealed no concerns, Frank was provided with psychoeducation on female sexual functioning and provided Kerner's (2004) *She Comes First* and the chapter written for men in Mintz's (2017) *Becoming Cliterate*. Frank returned having read the material and reported being surprised by it, stating that the only women with whom he had had sex with were his first wife, who seemed to orgasm during intercourse, and a few prostitutes he somewhat sheepishly admitted to frequenting when raising his children.

Frank and Janet were then seen together for several sessions in which they were coached and encouraged in communicating about their sex life and how to incorporate clitoral stimulation into their sexual routine. They tried several strategies, including Janet stimulating her own clitoris during intercourse and a turn-taking model, in which Frank would bring Janet to orgasm using his hands, her vibrator, and oral sex, then proceed to intercourse. The strategy of stimulating her clitoris during intercourse did not work well for Janet, as she stated that she found it difficult to focus on her clitoral sensations this way. When employing the turn-taking strategy in which Frank stimulated Janet prior to intercourse, she initially reported feeling distracted by her worry that

Frank was actually enjoying this, which he reported he was. Janet was thus instructed on mindfulness, practicing this first in her daily life, then applying it to receiving clitoral stimulation from Frank. This was effective, and therapy concluded with Janet becoming orgasmic when Frank provided her with clitoral stimulation.

### Case 2

Ellen, a 31-year-old woman in a loving and committed marriage with Ben, age 33, presented to therapy with the concern of having never had an orgasm. When asked about her sexual history and current masturbatory practices, Ellen stated that she sometimes masturbates but never reaches orgasm, because she "stops when the feelings get too intense." She also revealed a number of previous casual sexual relationships with men before Ben, most of them significantly older than herself. She reported that none of these relationships had been focused or concerned with her pleasure but that "Ben is different," stating that not only are they in love, but that he is also just as interested in her pleasure as his own. When asked to describe a typical sexual encounter with Ben, Ellen indicated that he tries to touch her and give her oral sex before intercourse, but that she usually turns him down or stops this after just a few minutes. When questioned about her prior history, including assessing for a history of abuse, Ellen denied any significant events in this regard, saying that she had been engaging in casual sex for a long time, never having had a healthy, mature relationship before meeting Ben.

Psychoeducation and DM were then undertaken, although Ellen reported knowing everything the therapist discussed in terms of female sexual anatomy and response, stating, "I took a human sexuality class in college that covered all that stuff." As a first step to DM, Ellen was instructed to look at her genitals in a mirror, identifying the parts in the line drawing provided to her. Ellen came back the next session, saying she had tried to do the homework but found the sight of her genitals "disgusting and nauseating." After discussion, the therapist and Ellen decided that instead she would first look at realistic pictures of other women's genitals, and she was sent home with instructions to explore the online site, Gynodiversity. She came back saying that while she found the images "disturbing" at first, she got used to them but could "never find them pretty." She also agreed she was ready to look at her own vulva again, which she subsequently did without revulsion. She then watched some videos of women masturbating on *www.omgyes.com,* and reported that she felt aroused by them, something the therapist had normalized might occur prior to providing the homework, explaining that women are visually aroused and that this arousal can occur regardless of sexual orientation (i.e., heterosexual women can be aroused by lesbian and heterosexual sex scenes). DM then proceeded with Ellen engaging in increasingly intense self-stimulation. While Ellen reported that this stimulation felt good, when she got to a certain point she "freaked out and stopped." At this point, the therapist reassessed

for sexual abuse in Ellen's history, and Ellen told the therapist "something I've never told anyone before." Specifically, she revealed that when she was 12 years old, her 19-year-old cousin had manually stimulated her, then forced her to give him oral sex, during which he held her head forcefully down. He told her to keep this a secret, and she did, holding deep shame about this incident. A great source of her shame, she admitted when the therapist directly asked, was feeling aroused by his stimulation, even though she "knew it was wrong." She also reported that the forced oral sex "made her gag and feel nauseous," a feeling that both the therapist and Ellen noticed as echoing her feelings when initially looking at her genitals.

DM was halted while the therapist and Ellen worked through what the therapist explained to Ellen was indeed sexual abuse given that she was too young to actually consent. The therapist also normalized Ellen's arousal, using the metaphor of being tickled, explaining that someone who is being tickled often tells the other person to stop, even when laughing—not because the person actually secretly wants the tickling to continue, but because, like sexual arousal, laughing is a nonvoluntary response of the nervous system. Ellen sobbed with relief. Also, due to her excellent relationship with Ben, without the therapist even suggesting it, she told him about the session, at which point he offered to do anything possible to help with her recovery. She told him that she would like to stop having sexual relations for a while, so she could work through her abuse in therapy. Ben was understanding and supportive.

For quite a while, therapy focused solely on Ellen working through the abuse, including letting go of guilt, shame, and self-blame, as well as separating what had occurred with her cousin (i.e., abuse) from what she wanted to do with Ben (i.e., consensual, loving sex). When Ellen reported being ready to resume work on her sexuality, she first read, as suggested by the therapist, Wendy Maltz's (2012) book written for survivors of sexual abuse, *The Sexual Healing Journey*. She also shared parts of this book with Ben.

The therapy with DM then resumed, this time paying special attention to when Ellen would be triggered by her own feelings of arousal and developing strategies to calm herself and redefine the pleasure as something she wanted for herself. During the DM portion of treatment, the therapist also suggested incorporating a vibrator. Ellen refused, saying she thought they were a little too "out there" for her tastes. Eventually Ellen had an orgasm during self-stimulation by manually stimulating her clitoris.

The therapist then suggested that Ben join the therapy, and that the couple engage in SF exercises. Ben was eager and willing. SF initially proceeded with few difficulties, and both reported enjoying the exercises immensely. However, when reaching the point in the exercises in which Ben sexually stimulated Ellen's genitals, she was unable to proceed. Such stimulation was simply too triggering for Ellen. After some discussion, the therapist again suggested that Ellen try a vibrator on her own, pointing out that the vibrator would not only give her excellent stimulation but that if she enjoyed it, it could be

incorporated into partner sex and might be less triggering. Ellen expressed concern that she would get addicted to the vibrator, and Ben expressed worry that it would replace him, but psychoeducation alleviated these concerns and Ellen agreed to try masturbating with a vibrator. To her delight, she found that the vibrator provided her very pleasurable and intense orgasms. Ben and Ellen then incorporated the vibrator into their partner sex routine, using it before and during intercourse. Ellen reached orgasm this way, but her orgasms were inconsistent. At the close of therapy, Ellen was orgasmic during partner sex using the vibrator only about 20% of the time that she and Ben had sexual relations. Nevertheless, both she and Ben reported that this outcome was satisfactory to them, and therapy was terminated with an invitation to return at any point if they wanted to focus on increased orgasmic consistency or any other issues.

## Conclusions

Both of these cases represent our approach to treating orgasm concerns—that is, using knowledge of etiology and efficacious research to guide treatment that is individually tailored to the client's history and current situation. The first case represents an uncomplicated case of secondary anorgasmia due to insufficient stimulation in a woman with excellent mental health and strong social support. The second case represents a more complex case of primary anorgasmia involving a history of sexual abuse. Both incorporated ongoing assessment and used combination therapy incorporating, depending on the case, DM, SF, psychoeducation, communication skills training, mindfulness, intensive therapy, bibliotherapy, and referral to a knowledgeable physician. Both clients had supportive partners, making the treatment significantly less challenging than that conducted with unsupportive partners or within more troubled relationships. Likewise, neither had a religious prohibition against masturbation, something that must be respected but makes treatment more challenging given the central role of DM. In neither case was a focus placed on the woman becoming orgasmic during intercourse; indeed, despite the SOPs for FOD (Laan et al., 2013) recommending the Coital Alignment Technique as effective for women wanting to orgasm during intercourse, we find that a more effective strategy is ensuring that the woman gets the more direct type of clitoral stimulation during partner sex that she gets when alone. We often explain to clients, "You can't touch your clit[oris] one way during solo sex and then ignore this during partnered sex. The most crucial action needed to orgasm with a partner is to get the same type of stimulation you use when pleasuring yourself" (Mintz, 2017, p. 127). While neither woman in the aforementioned cases had styles of self-stimulation (e.g., using running water, rubbing on pillows) that are more difficult to transfer to partner sex, we find in our work that almost any style can be transferred with communication and creativity.

In closing, while there is a great deal of excellent research to guide work with women presenting with orgasm concerns, there is individual variability among clients, rendering individualized treatment essential. Indeed, just as the subjective experience of orgasm varies both between and within individuals (Mah & Binik, 2001), the treatment for orgasm concerns must be varied, based on an individual woman's presenting problem, life history, and evolving experiences inside and outside of therapy. Such richness is difficult to capture in randomized clinical trials. Of course, such trials should continue, especially in currently understudied areas, such as the effectiveness of pelvic floor physical therapy, pharmaceutical interventions, mindfulness interventions, and incorporation of bibliotherapy into treatment. However, the field would also benefit from the publications of both detailed case reports and qualitative studies to capture the nuanced joys and challenges of helping women to experience orgasm.

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CHAPTER 6

# Treatment of Premature Ejaculation

## *Psychotherapy, Pharmacotherapy, and Combined Therapy*

STANLEY E. ALTHOF

In Chapter 6, Althof reviews the various diagnostic classifications of premature ejaculation (PE) and notes that a diagnosis of PE typically involves three key constructs: a short ejaculatory latency, the perception of a lack of control over the timing of ejaculation, and significant distress. He critically reviews the various theories of etiology (biological, psychological, and relational), as well as the literature addressing treatment outcome. The conclusion he reaches is that extending ejaculatory latency is only one part of an effective treatment. He observes: "It is not enough to simply offer a drug or behavioral intervention to help delay ejaculation or increase control. The impacts of this dysfunction are deep, chronic and painful for the man and his partner." With an in-depth case presentation, Althof illustrates a multidimensional treatment approach to helping couples affected by PE, combining pharmacotherapy, individual psychotherapy, and couple therapy. However, he ends the chapter with a cautionary note that modest gains in sexual satisfaction are often the outcome.

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The landscape has dramatically changed for patients seeking treatment for premature ejaculation (PE). Prior to the mid-1990s, psychotherapy or behavioral interventions were considered to be the treatment of choice for this distressing sexual dysfunction. By 1995, clinicians began successfully experimenting with the off-label administration of selective serotonin reuptake inhibitors (SSRIs) to delay ejaculatory latency (Waldinger, Zwinderman, Schweitzer, & Olivier, 2004). In 2009, dapoxetine (Priligy), a novel, short-acting SSRI, received medical approval in over 60 countries but not the United States (Pryor et al., 2006). Additionally, there are over-the-counter desensitizing sprays available in the United States and approved in Europe.

Given the efficacy and relative safety of some pharmacological treatments, clinicians and the public may perceive psychotherapy/behavior therapy for rapid ejaculation as an obsolete and antiquated intervention. In my view, psychotherapy and a combination of medical treatment and psychotherapy remain more relevant than ever. These days, delaying men's ejaculatory latency is relatively straightforward; however, restoring men's sexual confidence and reversing the impact on the relationship is more complicated (Althof, 2005).

Psychotherapy remains useful either in its traditional form as the sole intervention for men or couples with rapid ejaculation or, in an updated rendering, as an integral aspect of a combined medical and psychological intervention (Althof, 2003, 2005; Althof & McMahon, 2016; Althof et al., 2014; Perelman, 2003, 2006).

## What's in a Name?: Defining PE

Only since 2008 has there been an evidenced-based definition of lifelong PE that contains specific operational criteria. Previously, several definitions of PE existed, crafted by various professional organizations and/or individuals (American Psychiatric Association, 2000; Masters & Johnson, 1970; Waldinger, Hengeveld, & Zwinderman, 1998; World Health Organization, 1994). The major criticisms of these extant definitions include their failure to be evidence based, lack of specific operational criteria, excessive vagueness, and reliance on the subjective judgment of the diagnostician. Nonetheless, three common constructs underlie most definitions of PE: (1) a short ejaculatory latency; (2) a lack of perceived self-efficacy or control about the timing of ejaculation; and (3) distress related to the ejaculatory dysfunction.

In 2008, the International Society for Sexual Medicine (ISSM) drafted an evidence-based definition that incorporated the three aforementioned

common constructs (McMahon et al., 2008). This definition, with minor additions, was incorporated into the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013).

DSM-5 defines PE as a "persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it." This ejaculatory pattern must occur contrary to the wishes of the individual, must have lasted for 6 months or more, must greatly distress the individual, must not be better explained by a medical condition or its treatment, and must not be the result of other stressors in the individual's life.

DSM-5 also instructs the clinician to specify whether the PE is lifelong or acquired, generalized or situational, and to rate its degree of severity based on intravaginal ejaculatory latency time (IELT). Men with lifelong PE have always struggled with the dysfunction, whereas *acquired* refers to an individual who previously had the ability to control ejaculation but later developed the dysfunction.

A serious limitation of the DSM-5 definition is that it only applies to intravaginal sexual activity. It does not define PE in the context of other sexual behaviors or men having sex with men.

The World Health Organization (2019) published the 11th revision of the *International Classification of Diseases and Related Health Problems* (ICD-11) and proposed that the dysfunction be known as early ejaculation rather than premature ejaculation. "Male early ejaculation" will replace the term "premature ejaculation" and is described as follows:

> Male early ejaculation is characterized by ejaculation that occurs prior to or within a very short duration of the initiation of vaginal penetration or other relevant sexual stimulation, with no or little perceived control over ejaculation. The pattern of early ejaculation has occurred episodically or persistently over a period at least several months and is associated with clinically[1] significant distress. (WHO, 2018).

In my opinion it is disappointing that ICD-11 chose to ignore research demonstrating the efficacy of objective IELT measurements. With this change, men with 5-minute IELT who are distressed by their condition can be diagnosed with PE. Additionally, this revisionist definition is vague, subjective, and will vary among clinicians. It is decidedly unhelpful for research clinicians.

The ICD-11 early ejaculation definition includes the lifelong–acquired and generalized–situational distinctions of DSM-5. However, the ICD also includes a third subtype, listed as a residual category, but which Waldinger and Schweitzer (2019) propose should be used to diagnose men with what Waldinger (2008) describes as subjective PE, which is detailed below.

[1]ICD-11 has yet to ratify the PE criterion.

### Acquired PE

The ISSM Guideline document of 2010 concluded that there was insufficient evidence to promulgate a definition for acquired PE (Althof et al., 2010). However, in 2013, the Committee reconvened and offered a unified definition of lifelong and acquired PE (Serefoglu et al., 2014). The acquired portion of the definition characterizes it as "a clinically significant and bothersome reduction in latency time, often to about 3 minutes or less. There is an inability to delay ejaculation on all or nearly all vaginal penetrations and negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy" (p. 1426). The choice of 3 minutes or less is based on expert opinion (cf. Waldinger & Schweitzer, 2019). I consider it a provisional criterion awaiting further validation.

Acquired PE calls on the clinician to explore the forces that generated the new symptom, which may reflect recent psychosocial stressors or be a consequence of an illness (prostatitis, hyperthyroidism). Many men with acquired rapid ejaculation also suffer from erectile dysfunction (ED). Generally, men first develop ED and recognize that they are unable to maintain erections during lovemaking. They adaptively hurry lovemaking so as not to lose their erection and, in the process, condition themselves to ejaculate rapidly.

> Carlos, a 42-year-old, single Hispanic male, sought consultation because he had developed PE after a humiliating sexual encounter with a new partner. Although he was "not really into her," he decided to have sex anyway. During lovemaking, he lost his erection, which precipitated hostile demeaning outbursts from his female partner. He was really shaken by it.
>
> He stopped dating for several months, then tried again with a new partner. Unlike the prior partner, he liked this woman and was attracted to her. However, at their first attempt at lovemaking, he ejaculated in less than 15 seconds but did not lose his erection. They made love twice more during the night, and on each subsequent encounter he ejaculated rapidly. He felt he had lost his sexual confidence due to the humiliating experience with the earlier partner.
>
> Carlos explained that he always felt self-conscious with women, because he had lost all his hair at 18 years of age and had been chubby as a child. He felt like he had to overcompensate and demonstrate his machismo to women. Having PE made him feel unattractive, weak, and undesirable as a sexual partner. The scolding from the prior sexual partner resulted in his failure to attend to his level of arousal, because he was focused only on pleasing the partner.

## Subtypes of PE

"Anteportal ejaculation," the term for men who ejaculate prior to vaginal penetration, is considered the most severe form of PE. It is estimated that

5% of men with lifelong PE suffer from anteportal PE (Waldinger, Rietschel, Nothen, Hengeveld, & Olivier, 1998).

Based on his extensive clinical work, Waldinger (2008) proposed two additional PE subtypes for men who are distressed about their ejaculatory function but do not fulfill the DSM-5 criterion. These two subtypes are termed "variable PE" and "subjective PE." Variable PE is characterized by early ejaculations that occur irregularly and inconsistently, with a subjective sense of diminished control. This subtype is not considered a sexual dysfunction or psychopathology but rather a normal variation in sexual performance.

Subjective PE is characterized by (1) subjective perception of consistent or inconsistent rapid ejaculation during intercourse; (2) preoccupation with an *imagined* early ejaculation or lack of control of ejaculation; (3) actual IELT in the normal range or even of longer duration (i.e., an ejaculation that occurs after 5 minutes); (4) diminished or lacking ability to control ejaculation; and (5) preoccupation that is not better accounted for by another mental disorder (Waldinger, 2008).

## Prevalence

Early articles on PE characterized it as the most common male sexual dysfunction affecting between 20 and 30% of all men. These studies were based on survey self-report rather than diagnosis by a trained clinician (Jannini & Lenzi, 2005; Laumann, Paik, & Rosen, 1999; Laumann et al., 2005; Rosen, Porst, & Montorsi, 2004). Men reporting dissatisfaction with ejaculatory latency or control, or those men characterizing themselves as *premature* would clearly yield a higher prevalence rate than those diagnosed by a clinician utilizing the DSM-5 criterion.

Seregoflu reported the prevalence of lifelong, acquired, variable, and subjective PE, in the general male population in Turkey, utilizing a methodology of random proportional sampling by postal code (Serefoglu, Cimen, Atmaca, & Balbay, 2010; Serefoglu et al., 2011). His research design was replicated by Zhang et al. (2013) and Gao et al. (2013) in a Chinese population. In these studies, a relatively high proportion of men (20.0% in Turkey and 25.8% in China) acknowledged a concern with ejaculating too quickly. In Turkey and China, respectively, the prevalence was 2.3 and 3% for lifelong PE; 3.9 and 4.8% for acquired PE; 8.5 and 11% for variable PE and; 5 and 7% for subjective PE.

## Etiology

### Biological Theories

For years, the prevailing opinion was that rapid ejaculation is a psychological or learned condition. However, a series of biological investigations has begun to unravel the physiological underpinnings of the ejaculatory process, leading

theorists to speculate about organic contributions to this disorder. At this juncture, unlike ED, in which a coherent story of smooth muscle relaxation–contraction mediated by nitric oxide has been elucidated, the biology of PE remains incomplete and yet to be determined.

The most promising biological etiologies include (1) the role of serotonin or oxytocin receptors, (2) an individual's genetic predisposition, (3) hyperthyroidism, (4) prostatitis, and (5) increased penile sensitivity or nerve conduction abnormalities. However, none of these mechanisms accounts for more than a small percentage of men with PE.

## Psychological Theories

There are multiple psychological explanations as to why men develop PE. Unfortunately, none of the theories evolved from evidence-based research; rather, they are the products of thoughtful synthesis by clinicians from several schools of thought. Although untested, the theories are thought provoking and have been helpful to clinicians over the years.

There are several psychoanalytic theories as to the etiology of PE. They focus on men's unconscious hostile feelings toward women, excessive unresolved issues, or that PE is a psychosomatic disorder (Abraham, 1927; Schapiro, 1943).

Psychodynamic theorists consider anxiety to be the primary etiological agent in precipitating the symptom of rapid ejaculation. However, anxiety is not a singular concept; it is employed to characterize at least five different mental phenomena. Anxiety may refer to (1) a phobic response, such as being fearful (i.e., afraid of the dark, wet, unseen vagina); (2) an affect, the end result of conflict resolution in which two contradictory urges are at play (i.e., the man is angry at his partner but feels guilty about directly expressing his hostility); or (3) anticipatory anxiety, commonly referred to as "performance anxiety," in which preoccupation with sexual failures and poor performance leads to deteriorating sexual function and avoidance of future sexual interactions; (4) state anxiety; and (5) trait anxiety.

Conceptualizing PE in more of a behavioral-learning perspective, Masters and Johnson (1970) emphasized the concept of "early learned experience." By reviewing the case histories of men with PE, Masters and Johnson noted that many men described first sexual experiences characterized by haste and nervousness, for example, making love in the backseat of an automobile or an encounter with a prostitute. Masters and Johnson speculated that, based on their initial experiences, the men became conditioned to ejaculate rapidly. This learning perspective may also apply to men with ED who rush lovemaking and condition themselves to ejaculate quickly.

Kaplan (1974, 1989) considered "lack of sexual sensory awareness" to be the immediate, here-and-now cause of rapid ejaculation. She believed that men fail to develop sufficient feedback regarding their level of sexual arousal. Such men experience themselves as going from low levels of arousal to ejaculation

without any awareness. This lack of sensory awareness hypothesis is the foundation of teaching men stop–start exercises.

Performance anxiety per se does not generally cause the initial episode of rapid ejaculation; however, it is pernicious in maintaining the dysfunction. By the time patients present for psychological intervention, the initial precipitating event often is obscured because of the intensity of the man's performance anxiety. A further complication of performance anxiety is that it distracts the man from focusing on his level of arousal, rendering him helpless to exert voluntary control over sexual arousal and ejaculation. In fact, men believe that focusing on their level of arousal will cause them to ejaculate even more rapidly.

## Psychological Impacts of PE on the Man, the Partner, and the Relationship

Mental health clinicians need to appreciate the significant psychological and relational impacts that PE has on the man, his partner, and their relationship (Burri, Buchmeier, & Porst, 2018; Burri, Giuliano, McMahon, & Porst, 2014; Byers & Grenier, 2003; Hartmann, Schedlowski, & Kruger, 2005; Limoncin et al., 2013; McCabe, 1997; Symonds, Roblin, Hart, & Althof, 2003). It is not enough to simply offer a drug or behavioral intervention to help delay ejaculation or increase control. The impacts of this dysfunction are deep, chronic, and painful for the man and his partner.

In my practice, I have seen men who abuse alcohol and medications, who are severely depressed/suicidal, or who are seeking unproved surgical intervention because the PE has been a major factor in the breakup of their relationships. These examples represent the extremes; nonetheless, the majority of men, their partners, and the relationship significantly suffer from psychological/relational fallout of PE.

Hartmann and colleagues (2005) characterize men with PE as preoccupied with thoughts about controlling their orgasm and anxious anticipation of possible failure. Additionally, men with PE fear embarrassment and being unable to maintain their erection. In contrast, the authors found that functional men focused on sexual arousal and sexual satisfaction.

Single men, or those men not in a relationship, avoid establishing new relationships for fear that their PE will, once again, be the basis of irreparable problems (Symonds et al., 2003). Men in relationships report distress at not satisfying their partners, with some worrying that their partners will be unfaithful to them because of their PE.

Additionally, when comparing men with PE to sexually functional men on emotional, social, sexual, recreational, and intellectual aspects of intimacy, men with PE scored lower on all these aspects of intimacy (McCabe, 1997). Men with PE rated their overall quality of life lower than that of men without PE and reported higher levels of personal distress and relationship difficulty in

contrast to men without PE. In summary, there is often a significant psychological burden for men with PE.

When PE is present, there is often a significant disconnect between the two partners. Women are angry/frustrated with their partners, because they do not feel that their concerns have been genuinely "heard." Men likewise believe that their partners do not understand the degree of frustration and humiliation they routinely experience. This disconnect is the basis for considerable relationship tension.

In 2003, Byers and Grenier described lower partner sexual satisfaction in heterosexual couples in which the man had PE. Additionally, four recent studies have contrasted female partners of men with PE to control women whose partners do not have PE. Using the newly designed scale, the Female Sexual Distress Scale—Revised (FSDS-R; Derogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008), Limoncin and colleagues (2013) found that women with partners with PE were more likely than controls to experience 7 to 10 times greater distress. Canat et al. (2018), utilizing the Female Sexual Function Index (FSFI; Rosen et al., 2000) reported that the total FSFI score and all FSFI domains were lower for the women whose partners suffered from PE compared to control women whose partners did not. Additionally, categorizing the two groups of women as functional or dysfunctional by the FSFI cutoff scores, the author found that 100% of women whose partners had PE were categorized as dysfunctional versus 48% of the control group women. Similar findings had earlier been reported by Hobbs, Symonds, Abraham, May, and Morris (2008), who noted that 77.7% of partners with PE had at least one sexual dysfunction, compared to 42.7% of partners without PE. These results were independently confirmed by Kaya, Gunes, Gokce, and Kalkan (2015), who posited that PE decreases women's pleasure and enjoyment associated with orgasm and indirectly affects the woman's self-esteem and involvement in sexual intercourse.

Burri et al. (2014, 2018), studying women in four countries (Mexico, Italy, South Korea, and Switzerland) reported that female partners of men with PE had a seven to nine times greater possibility of having sexual distress compared to partners of men without PE. In descending order of importance, women whose partners had PE were distressed because of (1) the male's lack of attention and focus on performance (47.6%), (2) the short time between penetration and ejaculation (39.9%), and (3) the lack of ejaculatory control (24.1%). Almost one-fourth of women reported that the man's ejaculatory problem had previously led to relationship breakups. Women who considered duration of intercourse to be important were more likely to report relationship breakups.

Men with PE are preoccupied with their sexual function, resulting in excessive self-absorption and self-focus; they are detached from their female partners and their pleasure/satisfaction. Partners are not just distressed because of the quality of the man's sexual performance; they are also upset because the condition and the man's associated distress often lead to a rapid and unwanted interruption of intimacy.

PE represents a significant burden for men, their partners, and the relationship. In treating men/couples with PE, these psychological impacts need to be addressed, in addition to teaching the man sexual skills.

## Evaluation

### Assessment: What to Ask

Each therapist needs to develop a style and method of assessing PE. What follows is my method.

If the man with PE is in a relationship, I generally ask to see the couple together and thereafter the man and woman alone. When I see partners together, the evaluation focuses on assessment of the quality of the relationship and the ability of partners to communicate about difficult and intimate subjects, and I can inquire about their sexual scripts. Assessment of the female partner on her own allows her to share her views on her partner's dysfunction without fear of causing him embarrassment or fear of his anger or retaliation once the session is over. Assessing for sexual dysfunction (especially genital pain) or other factors that might contribute to her wanting to hurry the pace of her partner's ejaculation is crucial. However, partners are not always initially willing to be part of the process, or the man with PE may not want to invite his partner to therapy. In those situations, I see the man alone. I begin by asking a patient when the PE began and whether there was ever a time when he had control over ejaculation. I chart the course of the problem and ask specifically about average IELT, degree of voluntary control, distress, and sexual satisfaction. I want to know why he, or they, chooses to seek treatment at this point in time and what prevented him, or them, from seeking consultation previously. I also ask about previous treatment(s) or what he, or they, have previously done to attempt to resolve the symptom.

I move on to take a sexual history to identify whether there are any coexisting sexual dysfunctions and to learn whether the patient has PE with all partners or only specific partners. Then I ask the patient to recount in detail a recent sexual encounter. This helps to clarify the degree of performance anxiety, the narrowness or broadness of his sexual repertoire, his cognitions and affect, what happens after he ejaculates, and the responses of the partner to his dysfunction. I attempt to ascertain whether he attends to or has an awareness of his level of sexual arousal. I inquire as to the strategies he has employed to delay ejaculation and whether they were successful. I also ask if he was previously in psychotherapy and what that experience was like for him. From a medical standpoint, I ask about health issues, inquiring about prostatitis and hyperthyroidism, specifically in acquired PE.

The next portion of the assessment focuses on his interpersonal relationship and the impact of PE on the couple's sexual and nonsexual intimacy. I broach questions about the partner, such as the following: What is the impact

of PE on their relationship and her sexual function? Or does she have a sexual dysfunction that may lead the man to ejaculate quickly. Remember, it takes two to tango. Does she engage in strategies to help delay his rapid ejaculation, or does she seem to encourage his ejaculating rapidly? Is she willing to participate in treatment? These questions allow the therapist to form preliminary judgments regarding the partner's willingness to help with treatment versus her potential to sabotage it.

Last, I try to ascertain the patient's interpersonal style, psychological comorbidities, and limitations or strengths regarding treatment. All these data should help me to develop preliminary hypotheses as to the predisposing, precipitating, maintaining, and contextual factors, and what resistances might interfere with treatment.

## The First Decisions: Individual or Couple Treatment, Pharmacotherapy, or Combined Psychological–Pharmacological Therapy?

The evaluation concludes with the therapist offering the patient his or her understanding of the issues and treatment recommendations. The clinician ideally should engage in shared decision making with the patient or couple to agree on the most appropriate approach or treatment method by providing the patient with the necessary evidence-based information, clarifying the patient's needs and preferences, and together selecting among the available treatment options (Hatzichristou et al., 2016).

There are several distinct possibilities: individual therapy for one or both partners, conjoint or couple treatment, pharmacotherapy alone, or combined pharmacological and psychological treatment. The ISSM Guideline (Althof et al., 2014) suggests that patients with lifelong PE be offered, in descending order, pharmacotherapy, behavioral intervention/psychotherapy, and combination pharmacotherapy and psychotherapy. The reason for the emphasis on pharmacological interventions is based on the notion that there are significant biological underpinnings to lifelong PE.

For men with acquired PE, the guidelines suggest, in descending order, that men be offered behavioral intervention/psychotherapy, pharmacotherapy and combination pharmacotherapy, and psychotherapy/behavioral treatment. Because acquired PE occurs after a period of normal function, the focus of therapy is to explore the potential precipitating event(s), which may be both medical and psychological/relational, as well as address the concomitant performance anxiety.

Natural PE and subjective PE are not considered sexual dysfunctions per se, although we recognize the distress that men experience from these conditions. The Guidelines recommend that men with natural or subjective PE be treated by reassurance, education, and psychotherapy/behavioral intervention. Waldinger (2018) suggests that in more extreme cases, these men also

be considered for a topical ointment. He considers it unethical to offer these men SSRIs, because these are powerful drugs with the potential for adverse events.

It is puzzling to me that combining pharmacological and psychological treatment for PE has not established itself as a mainstream intervention (Althof, 2003, 2006; Perelman, 2003, 2006). Combination therapy mirrors the contemporary treatment for anxiety or depression with medication plus therapy. Research strongly supports the superior efficacy of combination therapy for PE over either drug therapy alone or psychotherapy alone (Cormio et al., 2015).

I believe the resistance to combination therapy is rooted in the difficulty with changing established practice patterns by both medical and psychological practitioners. Generally, mental health clinicians offer psychological interventions, and medical practitioners offer pharmacological treatment. Patients benefit most from combination therapy, and professional's resistance to adopting it is unjustified. What follows is a discussion of psychotherapy alone, pharmacological treatment alone, and combined therapy.

## What to Offer and When

Psychotherapy alone is best reserved for men and couples for whom the precipitating and maintaining factors are clearly psychological and the psychosocial obstacles are too great to surmount with pharmacotherapy alone.

Individual psychotherapy is the default choice for single men not in relationships. In addition to treating the sexual dysfunction, therapy must address the frequently seen reluctance of these men to enter into new relationships for fear of humiliating themselves and disappointing the woman. Psychotherapy can only go so far without the presence of a partner. For these men, treatment is sometimes divided into two phases: treatment when there is no partner, and later resumption of treatment when they establish a new relationship.

Combined therapy offers the best of both worlds (Althof, 2003, 2005, 2006; Perelman, 2003, 2006). Pharmacotherapy "kick starts" the treatment by providing relatively rapid changes in IELT, resulting in the man gaining or regaining sexual confidence. Psychotherapy helps the man or couple maximize gains from pharmacotherapy. It seeks to help men and couples overcome the psychosocial obstacles that interfere with making effective use of the pharmacological intervention. The man can be taught to attend to sensations rather than fear his own arousal. He can learn to pace his arousal and expand his sexual repertoire without fear that it will lead to rapid ejaculation. He can be coached to broaden his sexual repertoire while overcoming his fear of getting too excited. In time, he can be slowly weaned from pharmacotherapy and implement what he has learned in psychotherapy. Not all men are able to give up the pharmacological intervention; some, however, are pleased that "on their own" they have triumphed over adversity.

## Psychotherapy Alone

Psychotherapy for rapid ejaculation is an integration of psychodynamic, systems, behavioral, and cognitive approaches within a short-term psychotherapy model (Althof, 2005, 2016; Kaplan, 1974, 1989; Masters & Johnson, 1970). The guiding principles of treatment are to learn to control ejaculation, to understand and change dysfunctional patterns of lovemaking, and to understand the meaning of the symptom and the context in which it occurs. Psychotherapy and behavioral interventions improve ejaculatory control by helping men and couples to (1) learn techniques to control and/or delay ejaculation, (2) gain confidence in their sexual performance, (3) lessen performance anxiety, (4) modify rigid sexual repertoires, (5) surmount barriers to intimacy, (6) resolve interpersonal issues that precipitate and maintain the dysfunction, (7) come to terms with feelings or thoughts that interfere with sexual function, and (8) increase communication.

Alternatively, behavior therapists understand the dysfunction as a conditioned response or a maladaptive response to interpersonal or environmental occurrences. They provide exercises known as stop–start or the squeeze technique as homework to help the man comfortably attend to his sensations and learn to pace his arousal (Semans, 1956). I find a modified stop–start method (detailed later in this chapter) much more effective than the squeeze technique, because it does not require withdrawal from the vagina, and squeezing too hard can be painful for the man. Behavioral interventions may also include sensate focus exercises aimed at diminishing the man's performance anxiety and allowing the man and his partner to gain an appreciation for exciting exchanges of touch (Weiner & Avery-Clark, 2017).

Men fear focusing on their sexual excitement, believing it will cause them to ejaculate even more quickly. They attempt to diminish or limit their sexual excitement by resorting to wearing multiple condoms, applying desensitization ointment to the penis, repeatedly masturbating prior to intercourse, not allowing partners to stimulate them, or distracting themselves by, for example, performing complex mathematical computations while making love. These tactics, however creative, curtail the pleasures of lovemaking, distance the man from the partner, and are generally unsuccessful. These men typically describe themselves as having two points on their subjective excitement scale—no excitement and the point of ejaculatory inevitability. They fail to focus on their arousal and are unable to perceive or linger in midrange sexual excitement. In treatment, men are instructed to focus on their sexual arousal. By utilizing graduated behavioral exercises, they are taught to identify and become familiar with intermediate levels of sexual excitement. Successively, beginning with masturbation and moving progressively through foreplay and intercourse, they master the ability to linger in this range, thereby delaying ejaculation. A more detailed description of the stop–start technique is given in the clinical vignette.

In addition to teaching the men sexual skills and resolving the interpersonal

and intrapsychic issues related to rapid ejaculation, it is also helpful to address the cognitive distortions that help maintain the dysfunction. Rosen, Leiblum, and Spector (1994), in discussing erectile dysfunction, list forms of cognitive distortion that may interfere with sexual function. These forms of distortion are just as applicable to rapid ejaculation and include (1) all-or-nothing thinking ("I am a complete failure because I come quickly"); (2) mind reading ("I don't need to ask; I know how she felt about last night"); (3) fortune-telling ("I am sure things will go badly tonight"); and (4) catastrophizing ("If I fail tonight, my girlfriend will dump me").

Psychoeducational interventions also aim to rework the behavioral repertoire of the man or couple, referred to as their "sexual script." Self-help books may prove helpful to men either by themselves or as a supplement to treatment. Men with rapid ejaculation limit foreplay because they fear becoming too excited. By modifying rigid and narrow scripts, therapists may help couples establish a more satisfying sexual life.

### *Psychotherapy Outcome Studies*

Evidence-based research has become the "gold standard" for judging the efficacy of psychological or medical interventions. Studies at the highest level require the use of stopwatch-assessed IELT, validated questionnaires (e.g., the Premature Ejaculation Profile, the Inventory of Premature Ejaculation, and the Premature Ejaculation Diagnostic Tool; Symonds et al., 2007), and moderate to large sample sizes with designs being randomized, placebo-controlled, double-blinded, and with 6-month to 1-year follow-up data. Sex therapy treatment outcome studies can be characterized as uncontrolled, unblinded trials; few meet the requirements for high-level, evidence-based studies. The literature consists of reports on small to moderate size cohorts of participants who received different forms of psychological interventions with limited or no follow-up. In most studies, active treatment was not compared with placebo, control, or wait-list groups, and few outcome studies examine the impact of treatment on the partner. With few exceptions, the quality of the PE treatment outcome studies is inadequate. While it is almost impossible to compete with multimillion dollar funded pharmacological studies, professional societies should consider putting together communities of psychotherapists with a manualized treatment utilizing validated questionnaires with an adequate duration of follow-up.

Additionally, two high-level PE studies report contradictory results. In a Cochrane Review, Melnick et al. (2011, p. 11) concluded that "there is weak and inconsistent evidence regarding the effectiveness of psychological interventions for the treatment of premature ejaculation." One limitation of this review was that very few articles meet the rigorous search criterion; the authors' conclusion is based on a small number of studies. Cooper et al. (2015, p. 187) performed a systematic review and found that there is "limited evidence that physical behavioral techniques for PE improve IELT and other

outcomes over waitlist and that behavioral therapies combined with drug treatments give better outcomes than drug treatments alone."

Masters and Johnson (1970) reported on 186 men who were seen in their quasi-residential model utilizing multiple treatment modalities, including the squeeze technique, sensate focus, and individual and conjoint therapy, as well as sexual skills and communication training. They reported "failure rates" of 2.2 and 2.7% immediately posttherapy and at 5-year follow-up, respectively. Never before, or since, has any clinical center been able to replicate the initial or posttreatment efficacy rates reported by Masters and Johnson.

De Carufel and Trudel (2006) demonstrated an eightfold increase in IELT among men treated with behavioral techniques compared with a wait-list control condition. The participants maintained their gains at the 3-month follow-up and reported increased sexual satisfaction, in addition to the gains in IELT. This is one of the few high-quality PE treatment outcome studies.

The concept of relapse prevention has begun to be incorporated into sex therapy. McCarthy (1993), in discussing relapse prevention, suggests that therapists schedule periodic "booster" or "maintenance" sessions following termination. Patients remark that knowing that they will be seen again in 6 months keeps them on target, because they know they will have to "report" on their progress. The follow-up sessions can also be used to work out any "glitches" that have interfered with their progress.

## Pharmacotherapy and Medical Options

The several pharmacological and medical options for treating PE include SSRIs, clomipramine, phosphodiesterase type 5 inhibitors (PDESi), tramadol, sildosin, topical prilocaine/lidocaine sprays, hyaluronic acid, acupuncture, circumcision, dorsal neurectomy, and electrical nerve stimulation (Asimakopoulos, Miano, Finazzi, Vespasiani, & Spera, 2012; Dinsmore et al., 2007; Gruenwald et al., 2017; Littara, Palmieri, Rottigni, & Iannitti, 2013; Moon, 2016; Salem et al., 2008; Sato et al., 2012; Waldinger, 2018; Yang, Wang, Bai, & Han, 2018). I review results for treating PE with SSRIs, clomipramine, PDE5Is, and prilocaine/lidocaine sprays. Studies on the other options are not sufficiently robust to recommend their use. Presently, in the United States, there are no U.S. Food and Drug Administration (FDA)-approved medications to treat PE, although Promescent, a lidocaine spray, can be purchased over the counter.

Dapoxetine (Prilogy) has received approval for the treatment of PE in over 60 countries, but not in the United States. It is a rapid-acting and short half-life SSRI with a pharmacokinetic profile suggesting a role as an on-demand treatment for PE (Buvat, Tesfaye, Rothman, Rivas, & Giuliano, 2009; McMahon et al., 2009 ; Pryor et al., 2006). No drug–drug interactions associated with dapoxetine, including phosphodiesterase inhibitor drugs, have been reported. In clinical trials, dapoxetine 30 mg or 60 mg taken 1–2 hours before intercourse is more effective than placebo from the first dose,

resulting in a 2.5–3.0-fold increase in IELT, increased ejaculatory control, decreased distress, and increased satisfaction (McMahon et al., 2009, 2011). Dapoxetine was comparably effective in men with both lifelong and acquired PE. Treatment-related side effects were uncommon and dose-dependent, and included nausea, diarrhea, headache, and dizziness. There was no indication of an increased risk of suicidal ideation or suicide attempts and little indication of withdrawal symptoms with abrupt dapoxetine cessation (Levine, 2006). Although the drug appears relatively effective and safe, it appears that men discontinue this medication at alarmingly high rates. This may be due to its cost, side effects, and limited efficacy (Mondaini et al., 2013).

Off-label treatment with the SSRIs paroxetine (Paxil), sertraline (Zoloft), and fluoxetine (Prozac) and the tricyclic antidepressant clomipramine (Anafranil) has been successfully employed to treat rapid ejaculation (Althof et al., 2014). It is believed that all have similar mechanisms of action. The dose range for each drug is as follows: paroxetine, 20–40 mg; clomipramine, 12.5–50 mg; sertraline, 50–200 mg; and fluoxetine, 20–40 mg. Ejaculation delay is observed within the first week and tends to improve over several weeks. Side effects from these medications are dose-related and include fatigue, yawning, nausea, gastrointestinal upset, and excessive sweating. There is some controversy over whether these medications cause impulsive behaviors and increased suicidal ideation. Like all antidepressants, these drugs may trigger a manic episode. Given the seriousness of these side effects, patients on pharmacotherapy for rapid ejaculation should be closely monitored. Although infrequent, some men report diminished libido and erectile dysfunction after starting on these medications. Side effects are seen in the first week but generally diminish over the course of 2–3 weeks. Finally, these drugs should not be abruptly discontinued. Doing so may lead to an unpleasant and dangerous "withdrawal syndrome" (Waldinger, 2018).

Greater success has been achieved with daily dosing than with "as-needed" schedules. However, men prefer "as-needed" schedules for several reasons, including cost and convenience, and because sexual activity for most men is not a daily event.

The use of topical local anesthetics such as lidocaine and/or prilocaine as a cream, gel, or spray is well established and is moderately effective in delaying ejaculation. PSD502 (Fortacin) has been approved in Europe and is a prilocaine spray with a skin absorbing agent. Trial results indicated that the treated group reported a 6.3-fold increase in IELT and associated improvements in self-administered questionnaire measures of control and sexual satisfaction (Carson & Wyllie, 2010; Dinsmore et al., 2007). Because of the unique formulation of the compound, there were minimal reports of hypoesthesia (numbing of the penis) and numbing of the partner. Other topical anesthetics are associated with significant penile hypoesthesia and possible transvaginal absorption, resulting in vaginal numbness and resultant female anorgasmia unless a condom is used. There are reports that PDE5Is can also be of benefit to men with rapid ejaculation (Asimakopoulos et al., 2012).

### Combined Psychological–Pharmacological Therapy

The psychological aspects of a combined psychological–pharmacological treatment are different from those of psychotherapy alone. Such interventions are more directive, advice oriented, educational, and technique focused. They target the psychosocial obstacles created after the onset of the dysfunction, such as avoidance of foreplay, restrictive sexual patterns that are resented by partners, and unwillingness to discuss the problem, which itself creates a barrier. The goals of combined therapy include (1) augmenting the positive effects of the medical intervention by providing the man/couple behavioral skills; (2) identifying and working through the resistance to medical intervention that leads to premature discontinuation, (3) reducing or eliminating performance anxiety, (4) helping the patient to gain sexual confidence, and (5) helping patients to modify maladaptive sexual scripts.

Combined treatment may be especially helpful when the treatment effects of pharmacotherapy are modest. Due to perceived stigma of psychological treatment, combined treatment may be more acceptable to certain ethnic groups (i.e., Muslim men) than a psychological intervention alone. Steggal wrote about the intense resistance he encountered in trying to provide psychological/behavioral interventions to Muslim men with PE residing in London (Steggall, Fowler, & Pryce, 2008).

## Case Discussion: Combined Therapy for PE

Sophie and Bruce, a married couple in their 40s with two young children, sought treatment because she was experiencing distressingly low sexual desire. I first saw the couple together, then Bruce and Sophie separately, to obtain their family and sexual history. Sophie attributed her low sexual desire to Bruce's lifelong premature ejaculation. She was depressed and having second thoughts about remaining in the marriage. Prior to meeting Bruce, she had strong sexual interest and no problems with arousal or orgasm. Bruce consistently ejaculated in 30 seconds or less. He was so distressed with his PE that he had undergone a circumcision at age 40, thinking that it would decrease his penile sensations.

After reviewing all the possible treatment options, the couple opted to see me for conjoint treatment, while Bruce would see my physician colleague to obtain a prescription for an SSRI. He was started on paroxetine (Paxil) 20 mg, with the plan to increase it as necessary. He had some mild gastrointestinal side effects for the first 2 weeks; they diminished thereafter.

In terms of behavioral exercises, we began with an updated version of stop–start, in which I asked Bruce to imagine sexual arousal on a 0- to 10-point scale, where 9 is a point of ejaculatory inevitability. I sought to teach him to linger in the midrange of excitement, somewhere between 5 and 7. I asked him to go home and masturbate, imagining his arousal on the scale of

0–10. When he reached 6, he was to stop and allow his arousal to dissipate to a 3 or 4. Then he was to start masturbating again and stop at 6. After stopping and starting four times, he could ejaculate. He was to practice these exercises at least four times per week.

After 2 weeks of mastering the self-pleasuring aspects of stop–start, we moved on to having Sophie masturbate him to midranges of arousal. She was told to manually or orally stimulate him until he asked her to stop. Bruce's task was to concentrate on his level of arousal and ask Sophie to stop when he reached a 6. Then, as he had previously, he was to allow his excitement to diminish before Sophie resumed pleasuring him. They were to repeat this stop–start several times before Bruce could achieve orgasm. Sophie was a supportive and committed partner, and understood the purpose of the exercise. After Bruce completed the stop–start exercise, should she wish, Sophie could ask Bruce to pleasure her in any noncoital fashion. She did so on several occasions.

Having been on paroxetine for a month, Bruce's time to ejaculation by himself and with Sophie was significantly increasing. Additionally, he was beginning to feel a sense of ejaculatory control.

Following Bruce's mastery of his excitement with manual or oral stimulation, I suggested that the couple move on to having 2 minutes of intercourse without thrusting. I urged Bruce not to apologize should he ejaculate, but rather to hold Sophie and continue being emotionally intimate with her. She greatly appreciated this suggestion. Bruce did surprisingly well; he ejaculated only once out of six attempts and remembered not to apologize. The couple moved on to have intercourse with thrusting, and again Bruce was instructed to stop the exciting movements when he reached 6 on the arousal scale of 0–10. He was to follow the same pattern of stopping, allowing his arousal to diminish, then resume thrusting until he reached 6. Bruce and Sophie were asked to do this several times before Bruce ejaculated. Bruce's IELT had improved to approximately 4 minutes. He became less focused on his ejaculatory issues and began to broaden his sexual repertoire to include providing Sophie with more pleasure.

I saw this couple for over a year. Between the conjoint therapy, behavioral exercises, and paroxetine, Bruce's IELT was greater than 5 minutes. At about the 3-month mark, Sophie reported that her depression was lifting as she was feeling hopeful about the marriage and their sexual life.

## Conclusions

Psychotherapy, pharmacotherapy, or combining both often helps men and couples to improve their ejaculatory latency and diminish distress, and allows men and couples to have a better sexual and interpersonal life. We have come to better understand the negative impacts that PE has on the man and couple, and treatment is often helpful in diminishing these powerful negative forces.

Although there are cases in which we are unable to helpfully intervene, in general, the majority of men and couples achieve modest gains sexually, psychologically, and relationally.

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CHAPTER 7

# Delayed Ejaculation

MICHAEL A. PERELMAN

Of the two endpoints on the spectrum of male ejaculatory disorders, premature and delayed ejaculation (DE), DE is much less common, and much less commonly understood. Perelman observes that the "psychological and interpersonal impact of DE is often not appreciated by clinicians, who sometimes misperceive and fail to diagnose this condition." In Chapter 7, Perelman explains the physiology of male orgasm and ejaculation, then, using his own sexual tipping point model, describes and reviews assessment and treatment approaches specific to DE. Accurate diagnosis and effective intervention often rely on both understanding a man's idiosyncratic masturbation patterns and exploring differences between arousing sexual fantasies and the perhaps not so arousing reality of partnered sex. Treatment entails the transfer and translation of effective solo sexual stimulation to partnered sexual activities. Perelman is optimistic that "individually nuanced sex therapy" is the best treatment option for men suffering from DE.

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Delayed ejaculation (DE) is a less common and an often misunderstood male sexual dysfunction. Although this chapter focuses on DE, there is a full spectrum of "male ejaculation/orgasm dysfunctions," ranging from premature ejaculation (PE) through various diminished ejaculatory disorders (DEDs). These other DEDs encompass dimensions of reduced ejaculatory volume, force, subjective sensation, direction, as well as the very rare postorgasmic illness syndrome[1] (Perelman, 2018a; Perelman, McMahon, & Barada, 2004; Waldinger, 2016). Historically, there has been considerable confusion about DE nosology, labeling it "retarded ejaculation," "inhibited ejaculation," "inadequate ejaculation," "idiopathic ejaculation," "anejaculation,"[2] "anorgasmia," "male orgasmic disorder," and so forth. Some of these terms were determined to be pejorative and/or inaccurate among members of the sexual medicine and sex therapy communities. There is current consensus to use "delayed ejaculation" to describe the disorder in which men find it difficult or impossible to ejaculate and/or experience orgasm (Segraves, 2010; Abdel-Hamid & Ali, 2018).

Men with DE usually have no difficulty attaining or maintaining erections, can often ejaculate with masturbation, and frequently present for treatment with a partner-related complaint. Men with DE usually report less coital activity, sexual dissatisfaction, lower subjective arousal, anxiety about their sexual performance, and suffer more general health issues than do sexually functional men. They often report feeling "less of a man," and have higher levels of relationship distress (Abdel-Hamid & Saleh, 2011; Perelman & Rowland, 2006). Some partners initially enjoy the extended intercourse duration. However, they may eventually experience pain, injury, and/or distress, and question their own desirability: "Does he really find me attractive?" Although initially blaming themselves, partners sometimes become angry at the perceived rejection. Finally, men with DE may fake orgasm to avoid negative partner reaction(s).

DE has been considered a clinical rarity since the beginning of sex therapy, with low prevalence rates reported in the literature (rarely exceeding 3%) (Laumann, Paik, & Rosen, 1999; Perelman & Rowland, 2006). However, DE rates will likely rise secondary to demographics, particularly ejaculatory decline secondary to age-related diseases (e.g., prostatic hypertrophy) and the medications used to treat them (Perelman, 2003a; Georgiadis et al., 2007). Despite rates remaining low relative to other male sexual dysfunctions, millions of men worldwide suffer from DE.

[1]Those suffering the postorgasmic illness syndrome (POIS) become ill with flu-like symptoms after ejaculation, whether immediately or within 24 hours, regardless of the type of stimulation triggering the ejaculation.

[2]Anejaculation is the complete absence of ejaculation. Medical approaches, typically employed for infertile men, include the collection of nocturnal emissions, penile vibratory stimulation, probe electroejaculation, sperm retrieval by aspiration from either the vas deferens or the epididymis, and testicular sperm extraction.

The psychological and interpersonal impact of DE is often not appreciated by clinicians, who sometimes misperceive and fail to diagnose this condition. There are no U.S. Food and Drug Administration (FDA)-approved treatments for DE; physicians often report finding it difficult to treat, and when attempting to do so, generally report poor results (Perelman & Rowland, 2006). Yet, four decades of clinical research and practice by myself and others suggest that many of these men can gain the necessary skills to overcome their suffering from this disorder (Perelman, 2016a; Blair, 2017). To be sure, not all therapists have found this to be the case, as suggested by a reader's response to the blog: "Why Delayed Ejaculation Is More Common Than Folks Realize."

> "I (55) have suffered from the inability to ejaculate with a partner all my life. . . . Most if not all my partners would freak out and start asking questions like 'don't you find me attractive?' or 'don't I turn you on?' To say this has caused sexual unhappiness is an understatement. . . . When having 'one off' sex with a stranger or paid sex I didn't suffer with the inability to ejaculate . . . only when having sex for the 2nd or 3rd time with the same woman that the sexual dysfunctions would crop up. . . . Married in my late 30s, sexual functioning with my wife was very bad and it caused a lot of friction. . . . We spent a few years going from Sex Therapist to Sex Therapist. . . . Finally, my wife told me we were wasting out [*sic*] money and that we just have to learn to live with the situation. . . . the marriage has been sexless now for 15 years. I never had any problem when masturbating . . . my only way to get sexual release. I wouldn't wish this terrible sexual dysfunction on my worst enemy." Signed, Al Q.[3]

Both implicit and explicit information contained in Al's "response" could lead to treatment strategies that would improve the situation for Al and his wife. My purpose in this chapter is to offer therapists reading this chapter enough understanding of DE's assessment and treatment to enable them to provide successful assistance when confronted with a similar patient themselves.

## The Physiology of Ejaculation and Orgasm

Ejaculation is a reflex that can be anticipated through recognition of premonitory sensations that often include but are not limited to increased heart rate, breathing, muscle tension, and pleasure. Ejaculation itself is a process that involves emission, bladder neck closure, and expulsion of fluid (often erroneously presumed to be the only indication of ejaculation). During emission, seminal fluid is delivered to the posterior urethra. Sympathetic innervation controls the emission, as well as contraction of the bladder neck to prevent retrograde ejaculation. During expulsion, the bulbocavernosus muscle and

[3]Posted to the *Psychology Today* "Sexual Tipping Point" blog, February 27, 2019 (*www.psychologytoday.com/us/blog/sexual-tipping-point/201812/why-delayed-ejaculation-is-more-common-folks-realize*).

pelvic floor muscles contract to expel semen in an antegrade fashion through the urethra. In general, this reflex is mediated by both sympathetic and somatic neural inputs, as well as sensory inputs. Many neurotransmitters such as dopamine, norepinephrine, and especially serotonin are known to have roles in ejaculatory physiology. Genetically predetermined ejaculatory thresholds have a prodigious impact on ejaculatory ease and latency time, and are distributed in a manner similar to a number of other human characteristics (Abdel-Hamid & Ali, 2018; Perelman, 2009; Waldinger, 2011). The timing of a particular ejaculation is the result of a multitude of medical, psychosocial, behavioral, and cultural factors that influence the biologically predetermined range (Perelman & Rowland, 2006).

As noted earlier, male orgasmic disorder and anorgasmia are distinct but related conditions to DE, as ejaculation and orgasm usually occur simultaneously, despite being separate physiological phenomena. Orgasm is usually coincident with ejaculation, but is a central sensory event that has significant subjective variation, most often characterized as very pleasurable sensations followed by feelings of well-being and lessened tension. While I focus in this chapter on DE, both arousal and ejaculation have other subjective components independent of orgasm, and some patients do need to increase awareness of their sensations during preejaculatory stimulation (arousal), ejaculation itself, and orgasm. There are numerous parallels between male and female orgasmic disorders, with controversy over varying emphases when discussing their respective subjective and physiological processes.[4] There are some men who report orgasm (sometimes "multiple") without ejaculation. Many of these individuals are typically pleased with that capability, cultivated (often rehearsed during masturbation) using an "edging" process.[5] Both men who attempt "edging" and/or those men who misunderstand "stop–start" PE treatment methods may seek professional help when they fail to properly distinguish between premonitory sensations and emission. Their attempts to "stop" and interrupt stimulation are "too late." Both situations result in a "partially retarded ejaculation," in which fluid dribbles from the urethral tip and orgasmic sensations are diminished (Perelman, 2017).

To summarize, men who describe themselves as suffering from DE may also experience diminished orgasmic sensations or report a complete lack of orgasm. The workup for all these conditions is quite similar in terms of the initial diagnostic procedures, and treatment is primarily a consequence of the data gained from history taking. I intermittently discuss male orgasmic disorders in the context of the subjective elements associated with ejaculation, but for simplicity's sake, I focus in this chapter on the etiology, diagnosis, and

[4]For some men who suffer from male orgasmic disorder and/or DE the "mindfulness" techniques can be integrated with this chapter's treatment recommendations, but describing the variability and specifics of such integration is beyond this chapter's scope.

[5]Stimulation that brings one to the "edge" of an orgasm with interruptions to that stimulation (often several) before finally achieving orgasm; meant to intensify orgasm, volume of ejaculate, and force of ejaculation.

treatment of DE, as this is the complaint of the preponderance of men seeking assistance for DEDs.

## Definition and Diagnosis

The third International Consultation on Sexual Medicine (ICSM) defined DE as an intravaginal ejaculatory latency time (IELT) threshold beyond 20–25 minutes of sexual activity, accompanied by negative personal consequences such as bother or distress (Althof & McMahon, 2016; McCabe, Althof, Assalian, Chevret-Measson, Leiblum, et al., 2010). The 20–25 minutes IELT criterion was chosen because it represented greater than two standard deviations above the mean found in the "worldwide" normative studies. That research, with heterosexual males in stable relationships (the only large studies available to date), found an approximate 5–6 minutes median IELT (Patrick et al., 2005; Waldinger, McIntosh, & Schweitzer, 2009). Those IELT population studies had helped form the basis for the earlier ISSM ejaculation disorder definitions (McCabe et al., 2016; Serefoglu et al., 2014; Waldinger et al., 2005, 2009).

Perelman (2016b), disagreeing with those groups' conclusions, observed how overemphasizing limited quantitative evidence led to artificial narrowing of diagnostic classifications. Since male ejaculatory latency data display a very large range, too restricted a focus on a temporal criterion may limit access to care. Current quantitative evidence only documented a global average heterosexual IELT; many men have sexual experiences that are not limited to heterosexual penile/vaginal thrusting (e.g., noncoital heterosexual and homosexual sexual acts), which should also be incorporated into DE definitions.

Perelman (2016b) emphasized the substantial evidence that satisfactory sexual experiences and the distress related to both PE and DE are probably mediated more by perceived control over an ejaculation (including manual, oral, coital, and anal stimulation regardless of the partner's gender) than by its latency time (Gagnon, Rosen, McMahon, Niederberger, Broderick, et al., 2007; Perelman, 2016a, 2016b). For those requiring a quantitative metric for global research and regulatory requirements, Perelman suggested an approximate, bilateral one standard deviation from the male majority's average IELT be used as one of three criteria in defining either PE or DE, thus providing consistent criteria for these two most commonly treated ejaculatory disorders (Jern, Gunst, Sandqvist, Sandnabba, & Santtila, 2011; Perelman, 2016a, 2016b).[6] DE can be diagnosed when a patient reports either an inability to achieve ejaculation or a prolonged ejaculatory latency (IELT greater than 10 minutes) *as long*

[6]This suggestion served as a compromise to those researchers who believed, correctly or otherwise, that a quantitative temporal metric was necessary for global studies, clinical trials, and government regulatory agencies. Such a compromise avoids negating or minimizing what clinical research and practice teaches about the more important factors of control and distress.

*as the patient also* indicates a perceived "lack of control" and "distress." For instance, a man who ejaculates in 15 minutes, who is not distressed, would not be diagnosed with DE. However, a man who is unable to ejaculate during coitus within 10 minutes, who desires to do so (consistent with the majority of other men, i.e., ~65%), and subjectively experiences "no choice" (control) and is distressed, could be diagnosed as suffering from DE.

The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; 2013) does not have a quantitative latency metric, and the condition is labeled "delayed ejaculation" instead of the previous DSM manual's "male orgasmic disorder." Despite the diagnostic label, the DSM-5 definition also includes those cases in which male ejaculation is not only delayed but also does not occur at all or occurs only infrequently. As is true with all the DSM diagnoses of sexual dysfunction, the problem must be distressing to the individual and be fairly stable, manifesting during the majority of occasions over a significant duration of time (at least 6 months). The DSM diagnostic criteria encourage the exploration of the context in which DE manifests, including sociocultural, relational and medical factors (American Psychiatric Association, 2013).

The World Health Organization's (2019) recently approved *International Classification of Diseases* (ICD-11) also does not require an IELT temporal criterion as part of its definition of DE. ICD-11 defines DE as an inability to achieve ejaculation or an excessive or increased latency of ejaculation, despite adequate sexual stimulation and the desire to ejaculate. The pattern of delayed ejaculation needs to have occurred episodically or persistently over a period at least several months and be associated with clinically significant distress (World Health Organization, 2019). Whereas DSM labels them "Specifiers" and ICD-11 offers temporal, situational, and etiological "Qualifiers," both manuals allow for further subcategorization based on assessed etiology (i.e., medical, psychosocial, drug sequela, relationship, cultural, and other unspecified factors).

In conclusion, although debate continues over how much emphasis should be placed on both quantitative and qualitative evidence, most sex therapists and a growing number of urologists support the view that the personal impact of the disorder on a man and his partner, in terms of control and distress rather than time, should be considered the more important parameters when diagnosing both PE and DE (Patrick, Rowland, & Rothman, 2007; Perelman, 2016b; Perelman & Rowland, 2006; Althof & McMahon, 2016; Waldinger et al., 2009). Sex therapists will also recognize that men who seek treatment, even when their latency complaint does not meet the previously discussed standards to be formally diagnosed with DE, are still deserving of compassionate and empathic care.

## Etiology

### Psychological Factors

Early psychoanalytic explanations saw DE as an outgrowth of psychic conflicts suggesting malingering, unconscious, and unexpressed anger, whereas

other theories suggested that men with DE are "unwilling" to receive pleasure. Some dynamic theorists attributed DE to fear of semen loss, of the female genitalia, or of hurting the partner through ejaculation. Other factors historically discussed as contributing to DE include anxiety, depression, lack of confidence, and poor body image (Perelman & Rowland, 2006). Alternatively, Apfelbaum (1989) considered DE to be a desire disorder specific to partnered sex, believing that these men prefer sex with themselves rather than partnered sex. From a cognitive-behavioral perspective, pejorative and distracting cognitions (negative "self-talk") interfere with the positive subjective pairing of thoughts and entrancement with pleasurable genital stimulation sensation, thus resulting in insufficient excitement for climax even when an erection is maintained. All of the these dynamics may play a contributory etiological role (Perelman, 2014) and examples of how these factors contribute to DE are incorporated into the case study presented later in this chapter.

### Social/Cultural Factors

Masters and Johnson (1970) suggested that some men's DE is associated with orthodoxy of religious belief. Sociocultural and/or religious beliefs may limit the sexual experience necessary for learning to ejaculate (e.g., masturbatory prohibitions) and may result in DE (Perelman, 2014).

### Masturbation

Perelman (1994) recognized the very important role that both insufficient stimulation and masturbation played in the etiology of DE. An update of an earlier review of over 300 charts from my clients with a DE diagnosis (45 years of practice) continued revealing three masturbatory factors associated with DE (Perelman, 2005).[7] Sometimes the unsettling disparity between a man's sex with his partner and his sexual fantasies (whether or not unconventional) used during masturbation resulted in DE secondary to insufficient arousal (Perelman, 2003b, 2014, 2016a, 2018a). That disparity took many forms, such as body type, sexual orientation, the specific sex activity performed, and partner attractiveness (Perelman, 2003b; Perelman & Rowland, 2006). The second most common association was high-frequency masturbation, which, of course, is a relative metric. A masturbatory frequency that impedes ejaculatory capacity via male refractory mechanisms will vary between men as a function of both innate biological capacity and age. To date, there are no definitive evidence-based data to help guide the clinician's judgment beyond expert opinion and the clinician's own experience.

DE is correlated with high-frequency masturbation, a factor particularly relevant when aging men erroneously presume they can engage in partnered

[7]Some clients in the last 20 years, despite using oral erectile medications that produced adequate erections for coitus, were still unable to ejaculate, as they remained insufficiently erotically aroused (Perelman, 2014).

sex successfully while simultaneously maintaining the masturbatory frequency they did when younger. However, the most common behavioral factor causing DE was an "idiosyncratic masturbatory style," an expression I coined in 1994 and defined as a sexual stimulation technique not easily duplicated by the partner's hand, mouth, or vagina (Perelman, 1994). Such men engage in patterns of self-stimulation notable for one or more of the following idiosyncrasies: speed, pressure, duration, body posture/position, and specificity of focus on a particular "spot" in order to produce orgasm/ejaculation (Perelman, 2016b; Perelman & Rowland, 2006). Learning theory readily explains how such patterns may have conditioned these men and subsequently raised the probability that alternative forms of stimulation would be inadequate to produce an ejaculatory response (Bandura, 1969). In fact, it is surprising that despite a chief complaint of DE and clinical manifestations of penile irritation and erythema, men's masturbation patterns remain unexplored by so many clinicians (Abdel-Hamid & Saleh, 2011; Perelman, 2018a). It is important to note that, almost universally, these men fail to communicate their stimulation preferences to their partners (or to professionals) because of shame or embarrassment (Perelman, 1994, 2005, 2016a, 2017). Sex therapists should be certain to avoid the error of not inquiring about masturbation habits.

### Interpersonal Issues

Numerous other communication/relational conflicts that can result in DE are discussed more fully in the section on assessment. However, two particularly noteworthy partner issues deserve specific mention: fertility and anger/resentment. Clinicians from various theoretical persuasions have correctly noted pregnancy concerns among men with DE, and have also observed how treatment seeking is often tied to a female partner's wish to conceive (Perelman & Rowland, 2006). Distress is often greatest when conception "fails," yet fear of pregnancy leads some men to avoid dating or to avoid sex altogether (Perelman, 2018a).

Fertility related or not, patient–partner anger is an important factor that can be both a direct cause and a maintainer of sexual dysfunction. Anger acts as a powerful anti-aphrodisiac. While some men avoid sexual contact entirely when angry, others attempt to perform, only to find themselves insufficiently aroused and unable to function. Besides perceiving rejection, some partners suspect men with DE of infidelity. These trust issues evoke pejorative consequences for both partners. Misguided accusations and questions regarding the man's sexual orientation can also be especially pernicious. Such tensions often lead to avoidance of partnered sex entirely as feelings of disconnection increase (Perelman, 2016a).

### Biomedical Factors

A number of somatic conditions other than those causing infertility can account for DE, as any procedure or disease that disrupts sympathetic or

somatic innervation to the genital region has the potential to interfere with ejaculation and orgasm. Neurological and endocrine disorders, including spinal cord injury, stroke, multiple sclerosis, pelvic-region surgery (including but not limited to prostatectomy), severe diabetes, alcoholic neuropathies, and hormonal abnormalities, can all cause DE (Sullivan, Stember, Deveci, Akin-Olugbade, & Mulhall, 2013; Abdel-Hamid & Ali, 2018). Consequences of aging (whether organic and/or psychosocial) are significant risk factors for many sexual disorders, and DE is no exception (Lindau et al., 2010). Medications (tamsulosin, alfuzosin, silodosin, etc.) for benign prostatic hypertrophy and medication, even in low doses, for baldness inhibit alpha-adrenergic innervation of the ejaculatory system and are thus associated with DE (Vale, 1999; Witt & Grantmyre, 1993; Sadowski, Butcher, & Brannigan, 2016). Finally, both depression and the pharmaceuticals often used to treat it (presumably serotonin-mediated) can lead to DE (Segraves, 2010; Nurnberg et al., 2008). Comprehensive tables listing all such agents and many antihypertensive, anti-adrenergic agents, and antipsychotic drugs that can cause ejaculatory delay are readily available online (Sadowski et al., 2016).

## The Sexual Tipping Point Model

Biopsychosocial models are often described as "the gold standard" because of their recognition of the "complex interplay of biological, psychological, interpersonal, and sociocultural factors . . . which are . . . the foundation for clinical theories and paradigms including the sexual tipping point, the dual-control model, and systemic sex therapy" (Rullo, Faubion, Hartzell, Goldstein, Cohen, et al., 2018). There are a number of popular biopsychosocial models used to comprehend sexual function and dysfunction (Bancroft, Graham, Janssen, & Sanders, 2009; Basson, 2005; Giraldi, Kristensen, & Sand, 2015). Kaplan, 1995; Levin, 2017; Perelman, 2009; Pfaus, 2009). My preferred model to explain the etiology of any sexual dysfunction, including DE, is the Sexual Tipping Point (STP) model, which also provides a pathway for diagnosis, treatment, and follow-up (Perelman, 2009, 2016c). The STP is defined as the interaction of constitutional sexual capacity with the various biomedical, sexual, relational and cultural factors that determine a sexual response. Evidence supporting the STP model as a clinical and teaching heuristic is currently limited to expert opinion. The STP model is neither binary nor categorical; instead, it illustrates the full spectrum of all the exciting–inhibiting mental and physical factors intrinsic to sexual response and its disorders (Perelman, 2018a, 2018b). As such, it is best described as a "variable switch" model, reflecting our increasing knowledge about the human body (Perelman, 2018a, 2018b). The factors can be described as "sliders" (*mapedfund.org*) or as "dimmer switches," as illustrated in Figure 7.1. Two pans, labelled "Excitation" and "Inhibition" each hold two pairs of interconnected containers. The "Mental" containers include, but are not limited to, factors related to cognition, emotion, social/interpersonal factors, and culture. The "Physical"

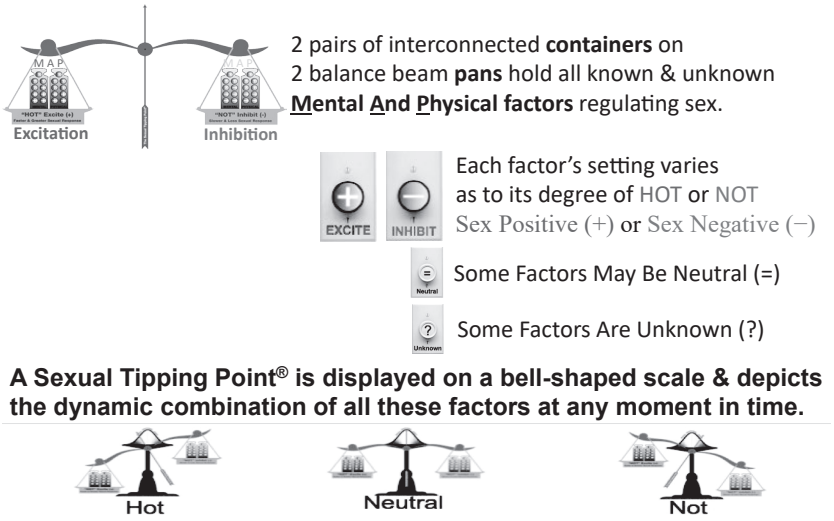


**FIGURE 7.1.** Key to the symbols used in the STP model. Circles inside the Mental And Physical containers represent dimmer switches, whose varying intensity and polarity contribute to the STP. Used with the permission of the MAP Education and Research Foundation (*mapedfund.org*). Copyright © 2018.

containers include, but are not limited to, factors related to anatomy, genetics, endocrinology, drug(s), disease, surgery, and the environment. These Mental And Physical containers symbolically then, hold all of the exciting (+) and inhibiting (–) factors that influence male ejaculatory response.[8] Each of these factors (dimmer switches) is variably charged, and has varying intensity as to the degree it contributes to a man's manifest sexual response at any moment in time. Some of these factors may also be neutral (=), while others have not yet been discovered (?). The STP reflects the net sum of all Mental And Physical factors displayed on a balance scale. Even when manifest DE symptoms appear to be the same, it is hypothesized that a range of conflicting forces dynamically maintain it. These key factors become the treatment targets.

## Evaluation and Functional Assessment

Neither pathophysiology nor psychogenic etiology should be assumed without both medical investigation and a focused psychosexual history (our most important therapeutic tool). Evaluation of a man with DE should uncover

[8]The capitalization of "And" is meant to reflect the fact that the line between mental and physical is porous, since thoughts become translated into biochemical electrical components.

underlying potential physical, psychological, and any learned causes of the disorder. For me, evaluation is primarily a functional assessment, and the preferred methodology is a focused sexual history taking or a "sex status exam" (Perelman, 2003b). Such a focused interview process helps rule out the probability of anatomical, hormonal, neurological abnormalities and pharmaceutical causes by identifying a time line that juxtaposes circumstances in which ejaculation was/is successful with those where it was/is not. A comprehensive sexual history, along with an understanding of the current level of sexual functioning (the sex status), can differentiate DE from other sexual problems by reviewing the conditions under which the man can ejaculate. The problem's developmental course should be noted, including variables that improve or worsen performance (particularly those related to psychosexual arousal). If orgasmic attainment was possible previously, life events and circumstances temporally related to ejaculatory changes should be reviewed. Events in question may include pharmaceuticals, illness, or a variety of psychological stressors.

Questions that are especially relevant for the evaluation of DE include (1) "What is the frequency of your masturbation?"; (2) "How do you masturbate?"; (3) "In what way does the stimulation you provide yourself differ from your partner's stimulation style, in terms of speed, pressure, and so forth?"; and (4) "Have you communicated your preference to your partner(s), and if so, what was the response?" It is also important to assess the patient's subjective experience during solo and partnered sexual activity, including the degree to which he is focused on arousing thoughts and pleasurable sensations versus anti-erotic intrusive thoughts (e.g., "It's taking too long!"). Follow-up questions may be asked to give greater specificity to the putative role of masturbation in the disorder and to clarify other, relevant etiological factors. Perceived partner attractiveness, the use of fantasy during sex, anxiety surrounding coitus, and masturbatory patterns all require meticulous exploration. Important causes of DE might be identified by juxtaposing the patient's cognitions, sense of pleasure, and the sexual stimulation he experiences during masturbation (including fantasy, watching/reading pornography) with a partnered experience. Some patients might balk at these personal questions, but once they are assured that research has shown that such information is critical to successful outcome, refusal to answer is rare.

As a recent sexual experience is explored in depth, the patient is likely to indicate the relevance of partner issues. Look for implicit or explicit expressions of either anger or hurt feelings, which are often antithetical to good sex and can result in DE. Relationship issues can cause/exacerbate DE and must be ruled out and/or explored. Such factors include, but are not limited to, power struggles, intimacy blocks, poor communication, and inadequate conflict resolution skills. Successful treatment benefits from a supportive available partner; however, sex therapists should be sensitive to patient preference regarding partner participation, as patient and partner cooperation is more critical to successful treatment than partner attendance at office visits

(Perelman, 2018a). Sexual and relationship inventories in general, and even those specific to ejaculation, such as the Male Sexual Health Questionnaire (Rosen et al., 2004), improve research methodology but in my experience provide only limited diagnostic enhancement.

In addition to the aforementioned inquiries, the sexual history should include questions regarding previous treatment approaches, including the use of herbal therapies and home remedies, and if there was any benefit. Referral for medical evaluation, usually by a urologist, is especially important in those cases in which the DE is generalized (occurring across all situations, including masturbation) whether primary (lifelong) or secondary (acquired). Typically, a urologist would conduct laboratory studies including a genitourinary examination that may identify physical anomalies, as well as contributory neurological and endocrinological factors (Corona et al., 2010; Corona, Jannini, Vignozzi, Rastrelli, & Maggi, 2012). While abnormally low androgen levels are frequently referenced in medical literature as a typical cause of DE, recent scientific evidence indicates that for men who are able to ejaculate with masturbation, routine androgen evaluation is not necessary (Morgentaler et al., 2017). The exam and medical history also help to rule out organic causes of DE related to trauma sequela, whether from an accident, surgical complications, or other iatrogenic causes.

It must be emphasized that dichotomizing etiology and diagnosis into classifications such as psychogenic and biological are too categorical. Genetic predispositions affect the typical speed and ease of ejaculation for any particular organism; however, many of these components are influenced by past experiences and present context. By the end of the evaluation session(s), it should be possible to offer the patient a formulation that highlights the immediate cause(s) of his problem, and a treatment plan that instills hope may thus be formulated (see Figure 7.2).

## Treatment

A variety of techniques have been used alone or in various combinations to treat DE. Those historically used by mental health professionals have included, but are not limited to, sex education, psychodynamic exploration of underlying conflicts, and/or couple therapy, cognitive-behavioral therapy, mindfulness, and of course, a variety of sex therapies. The goals of therapy for DE are evoking higher levels of psychosexual arousal and pleasure within a mutually satisfying experience. Current sex therapy approaches usually emphasize integrating a behavioral masturbatory retraining within a nuanced sex therapy (Apfelbaum, 1989; Masters & Johnson, 1970; Perelman, 2003b; Perelman & Rowland, 2006; Sank, 1998).

It is useful to help men with primary DE learn to identify their sexual arousal preferences through self-exploration and stimulation. Masturbation training for men is similar to models described for women with anorgasmia,

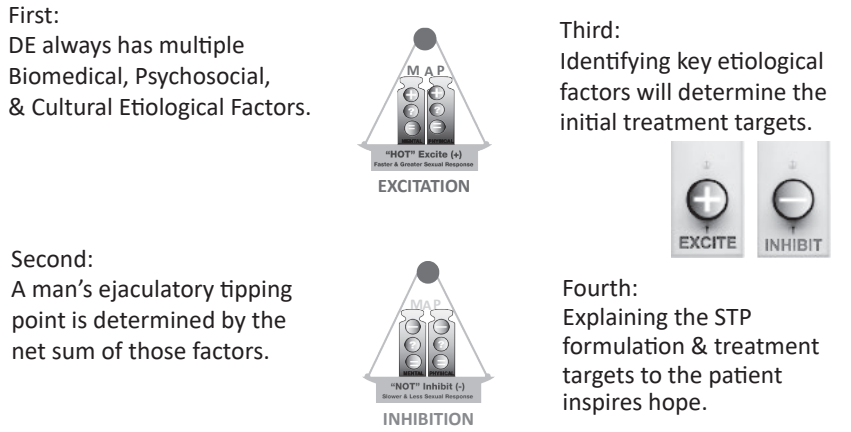


**FIGURE 7.2.** Use of the STP model in treatment formulation. Used with the permission of the MAP Education and Research Foundation (*mapedfund.org*). Copyright © 2018.

but the use of vibrators, often recommended by urologists, is rarely needed (Nelson, Ahmed, Valenzuela, Parker, & Mulhall, 2007; Perelman, 2016a). Masturbation exercises progressing from neutral to pleasurable sensations (without ejaculation initially) can remove the "demand" aspects of performance (Apfelbaum, 1989). Fantasizing can help block thoughts that might otherwise interfere with arousal. In general, a clinician should validate (not encourage) an autosexual orientation when encountering it in a man, as this helps remove the stigma that DE is a form of withholding from a partner. General anxiety reduction techniques may also be helpful in treating some men with DE. Finally, couple therapy, when appropriate, often involves encouraging the man and his partner to share their sexual preferences, so that the needs of both are met.

Therapy for secondary DE shares similarities with treatment for primary DE. However, patients with secondary DE are rapidly counseled to suspend masturbatory activity *temporarily* and limit orgasmic release to their desired goal activity (usually coital orgasm). Reducing or discontinuing masturbation (typically requiring ~14–60 days) often evokes patient resistance. Temporarily refraining from ejaculating alone usually causes a man's need/desire for release to increase, as his threshold for ejaculation decreases, thus making it easier to ejaculate during partnered sex. Recently, during the first conjoint session, a 60-year-old man in a 6-month relationship with a 55-year-old woman he cared for deeply realized how unaware he was of her emotional pain over his lack of coital ejaculation. In sex therapy, he spontaneously acknowledged his hidden masturbation pattern, which was immediately upsetting to her, but was mollified by his equally immediate willingness to temporarily stop

it completely on my suggestion. Stopping was difficult for him, but he also risked sharing what kind of foreplay (oral stimulation) he wanted from his partner for the first time, and she surprised him with her eagerness to provide it. They postponed the subsequent session, as they wanted more time for themselves to process and put into effect what they had learned. They canceled the following session again, but both called separately to thank me for their now revitalized sex life, which, within 3 weeks, included twice weekly coitus, with orgasm for them both. A 6-month follow-up call to each of them indicated that they were now living together happily, having coitus with mutual orgasm weekly, and his masturbation occurred only on business trips, making sure to leave at least a 72-hour abstinence period for their next mutual sexual encounter. Curtailing solo masturbation is most typically not sufficient to solve the problem on its own, but the probability for success during partnered sex is increased greatly.

The clinician must provide support to ensure compliance for a solo masturbation hiatus and can emphasize that the need for such restraint is only temporary and not a permanent injunction against masturbation. Sometimes the amount of time away from solo masturbation must be negotiated and a compromise reached, although it is worth noting that an unwillingness to at least consider doing so is diagnostic of poor motivation and a negative prognostic signal. When a patient refuses to stop solo self-stimulation, I typically negotiate a masturbation frequency reduction, with a minimum commitment of no ejaculation within 72 hours (expert opinion) of the next partnered experience. A man who insists on continuing to masturbate alone may continue to progress as long as his normal routine is disrupted, and he is encouraged to alter style (e.g., "switch hands"). Instead of his familiar pattern, he is instructed to try and approximate the stimulation likely to be experienced from his partner (Perelman, 2016a; Perelman & Rowland, 2006). The goal is to limit his orgasmic outlet from his easiest current ejaculatory capacity (usually a specific style) and "shape" it progressively to approximate the desired partnered experience. This is typically followed by his learning to ejaculate from manual, then oral, and finally coital stimulation from his partner, as each provides differing sensations, although that will vary based on the couple's sexual script and perception as to what is erotic.

Besides suspending noncoital orgasmic release, initially at least, the patient should use fantasy and bodily movements during coitus that approximate the thoughts and sensations experienced in masturbation. Single men should use condoms during masturbation to rehearse "safe sex." Sexual fantasies may be realigned, so that thoughts experienced during masturbation better match those occurring during coitus.

In addition to this, considerable reassurance is required for men and their partners who suffer from DE secondary to aging. As men age, there is an expected lengthening of ejaculatory latency, lengthening of their refractory period, and inconsistency of both ejaculatory and orgasmic attainment. Accepting this knowledge is critical in helping men avoid the antisexual

thoughts that will inhibit ejaculation/orgasm from taking place if more is expected from an aging body than is reasonable.

### Medical Treatments

There are no drugs proven to treat DE, as there is no evidence beyond reported anecdotal success in decreasing ejaculatory latency, and there are no pharmaceuticals approved for DE by the FDA. However, for a detailed description of drugs (and the rationale for choosing them) that many physicians prescribe for DE, despite the low level of evidence supporting such treatments, the interested reader should seek out selected references (e.g., Abdel-Hamid & Ali, 2018; Butcher, Welliver, Sadowski, Botchway, & Köhler, 2015; Butcher & Branigan, 2016; Butcher & Serefoglu, 2017). Additionally, testosterone (T) was also considered as a first-line treatment, but unless T levels are meaningfully below normal levels, this has not proved to be helpful (Abdel-Hamid, Elsaied, & Mostafa, 2016; Morgentaler et al., 2017). Researchers have also explored other "antidotes" such as yohimbine; however, this research was typically confined to animal experiments (Carro-Juáreza & Rodríguez-Manzo, 2003). To date, research has failed to identify a drug that will decrease orgasmic latency for patients whose compliance is challenged when experiencing antidepressant-induced DE, although some experts still believe that Wellbutrin holds promise for some (Clayton et al., 2004; Blair, 2017; Perelman, 2018a).

## Case Discussion

Jack, 59, sought treatment, complaining of progressively more severe DE of a few years' duration, as well as more recent ED. His urologist (whom he first consulted) hoped that prescribing sildenafil would help both Jack's DE and ED, but as is so often the case, a sole pharmaceutical approach was insufficient. Initially, sildenafil did help restore Jack's erections, but understandably, it did not improve Jack's DE, as his ED was secondary to his DE rather than the reverse. Ironically, sildenafil had indirectly even made Jack's DE worse, as will become evident below. In his initial phone call to me, Jack reported, "The Viagra is not working at all."

During the first sexual status interview, Jack indicated (referencing penile vaginal intercourse), "Even if I get inside, I can't cum. . . . I love my wife [Jill, 58], and she still looks great!" Further inquiry indicated Jack was distracted during sexual activity, with negative thoughts (e.g., "Oh, sh*t, this will not work again"). As such, his arousal level never reached an STP sufficient for him to ejaculate, even when his sildenafil-assisted erections allowed for coitus, let alone once he actually began losing his erections. Initially, he and his wife became upset when coitus lasted more than 20 minutes with no ejaculation at all many times. He importantly reported that he was avoiding partnered sex,

and masturbated secretly, which unfortunately was making coital DE more probable. While very distressed about his DE and his erections, Jack was eager to restore "what was a great sexual relationship" between himself and Jill, his wife of 20 years, with whom "I have a wonderful marriage." The sex status had revealed a lack of any direct foreplay for Jack beyond kissing and cuddling, as he only concentrated on Jill. He quipped, "I never needed it before." Again, he was unable to keep any erotic thoughts in mind when attempting coitus, even with a sildenafil-assisted erection.

Jack was confused about why he was not able to ejaculate during coitus: "My wife is unhappy and questions if I still am attracted to her. It's just not like it was." I explained about the normal need for more direct sexy stimulation (friction) and thoughts (fantasy) as one ages, using the illustration in Figure 7.1. At the end of the evaluation, I suggested that he masturbate while taking his prescribed sildenafil, and that he experiment with erotica. He was to take his time and make it fun, and not a test. Jack's confidence was boosted as we spoke. He seemed hopeful and optimistic. Jack said Jill was eager to have sex with him, and she reportedly wanted to participate in the sex therapy. We scheduled a follow-up couple appointment, with an option for Jill to have some individual time if desired.

Jack began the second session, reporting, "Good news and bad. . . . Masturbating with the Viagra worked well! But a few days later we tried having sex. . . . I got an erection using Viagra but still couldn't come!" I asked them to describe their last sexual experience in detail, which is a great question for initiating follow-up discussions. Jill interrupted Jack as he began to speak and asked if she could speak with me alone. Jack left the room temporarily.

Jill expressed desire to be with Jack, mentioning how pleasing the foreplay was, but grimaced when discussing their coital failures. She cried, "I want sex because it used to be so good. When it goes on for so long now, it starts to hurt, and I lose interest. . . . We are so confused." She indicated that her own orgasms, usually experienced during oral sex foreplay, were now more muted since menopause, and that initially, "menopause hit me like a ton of bricks . . . hot flashes, the whole nine yards." Not surprisingly, she indicated that it now took longer to lubricate and become aroused. When I reassured her of these being normal, age-related changes, she cried and indicated that aging bothered her, and she wanted back what they used to have. "His erection and ejaculation problem is just making the whole thing worse. My gynecologist says it's normal to stop at our age. I tried the lubes she suggested, but he felt less, and it still hurt." Jack rejoined us and self-consciously admitted he was aware that sex was hurting her now. He clearly felt guilty knowing this, but with her encouragement, he would try intercourse anyway. They reported never talking explicitly about her pain, but it was clearly an additional distraction and worry for them both.

The case was formulated using a typology of immediate, midlevel, and remote factors using the STP model. The primary immediate factor contributing to Jack's DE and ED was his lack of adequate stimulation, both mental

("I'm hurting her . . . ") and physical (no foreplay for him). He had never needed much foreplay previously, and mistakenly was not seeking it now when his aging and continued masturbation had diminished his ejaculatory and later his erectile capacity.[9] His positive sexual thoughts were being overwhelmed by his inhibiting cognitions of "failure" and causing his wife pain, negating his arousal and thus also limiting his ejaculatory capacity, even when erect with assistance from sildenafil. I believed that temporary continued use of the sildenafil would provide increased assurance that his erections would remain adequate even if he had some intermittent negative thoughts. His rate of detumescence would be reduced by the pharmaceutical restriction of blood outflow. As his confidence increased, his sexual thoughts (fantasy) would be unchallenged by a diminished prevalence of inhibiting ones. Combined with more effective physical stimulation (friction), both sustained erection and ejaculation would be more probable.

Importantly, both partners were clinging to their previous sexual script in which his erections and subsequently their sex together was automatic and spontaneous. Reeducation regarding that script and other age-related themes were initiated from the beginning and continued throughout treatment. Jack and Jill agreed to a "no intercourse" rule until further notice, which reduced performance pressure on them both. Their initial attempt to pursue their old script of coitus almost as soon as an erection appeared required correction. Jack was to masturbate again (with Jill's knowledge) in order to increase awareness of his own likes–dislikes, so that he could eventually communicate them to Jill, who was eager to learn more about what pleased him. She was previously unaware of his masturbation and had alternated between thinking she was no longer attractive to Jack and worrying that something was wrong with Jack physically. Jack was told he would be weaned from sildenafil during treatment, as it would probably not be necessary long term, but to initially continue with his doctor's prescription to help facilitate erectile maintenance. During that ensuing 3-week period, in response to my suggestion for further medical evaluation, Jill's gynecologist prescribed dilators and an estrogen-based cream, which Jill used diligently. She very quickly found that her pain with penetration diminished and began experiencing orgasms while doing so.

The sex therapy continued, and by the fifth session, Jack reported being able to orgasm from Jill's manual stimulation. The previous week, he had masturbated himself in her presence. A few days later, she had learned to use a similar technique to bring him to erection and ejaculation. During this fifth session, Jack was now told to temporarily desist from masturbating until further notice. She had effectively communicated techniques she wanted him to use when stimulating her during foreplay, which resulted in her experiencing "better orgasms than ever!" They were instructed to repeat that exercise and assured that their expressed desire to incorporate oral stimulation into their

[9]As men age, the latency of their refractory period for both erection and ejaculation increases.

"outercourse" pleasuring was fine. The "no penetration" rule, in combination with limited sexual frequency (no more than once weekly was instructed), increased their biological need/capacity when stimulating each other both manually and orally.

The following week, they reported "no sex at all. . . . Other responsibilities and life got in the way." This often happens during sex therapy. During the course of treatment, other issues did emerge, which were managed directly using a problem-solving cognitive-behavioral approach that I always integrate into the sex therapy. This method simultaneously models how to keep "sex alive" in the face of normal life stressors. Jill was helped with a variety of matters, including her job, management of her "disabled" sister, and issues surrounding her grown children from her previous marriage. Jack was assisted with his stress about various work challenges. All of this was managed within the aforementioned weekly, 45-minute conjoint sessions. As couples begin to improve sexually, it is useful to use session time to help stabilize and ensure continuation of the progress being made by beginning to deal with issues that might potentially trigger a relapse.

At their seventh visit, Jack and Jill sheepishly reported successful "unauthorized intercourse" with mutual orgasms. They were delighted and pleased with their progress, and since the sex was so good, they decided to try again the next day. Not surprisingly, Jill was tender, and while Jack was able to become erect and orgasm, she experienced pain, and in the session she expressed concern for their future. Reassurance, education about how age-related sequela may limit sexual frequency, reminders about "outercourse" options, and guidance on the use of lubricants were all suggested and accepted.

The next weekend, Jill initiated sex when they returned home after dinner. They had successful intercourse with mutual synchronous orgasms. This occurred again the following week. Enhancement techniques (e.g., teaching clitoral stimulation by self or partner with guidance as to positions) were discussed during the next few sessions. As their sex life improved, so did their mood and confidence. Jack was asked to wean himself from the sildenafil with his urologist's concurrence over the next 3 weeks. Treatment concluded after three more sessions spaced over 8 weeks (during which time Jack weaned himself successfully from sildenafil) with a follow-up session scheduled for 6 months later.

I always try to schedule a follow-up session, as it seems to help keep the lessons learned more predominant in patients' minds. If there is a relapse and patients have not returned earlier for reasons of shame/embarrassment, it allows them to show up "disgrace" free. In this case, the news was good, and the couple reported an average of three successful intercourse experiences per month, with occasional manual or oral sex to orgasm occurring for variety's sake. They enthusiastically reported that their general stress levels about sex were lessened, and that it was "no longer a big deal at all. . . . We no longer need to 'line up our ducks' so everything was just so, like you taught us in sex therapy. . . . Instead it is kind of like it was in the good old days. . . . yet

somehow a bit different . . . less intense and automatic but in a nice relaxed way."

## Treatment Outcome

I offer the case of Jack and Jill not to suggest that DE can always be treated so successfully, but rather to emphasize the importance of obtaining specific sexual experience data throughout evaluation and subsequent sessions, because of their profound ability to direct the course of treatment and influence outcome. Successful treatment depends on the patient's willingness to follow therapeutic recommendations, which are influenced by the extent of organicity, relational issues, and potentially deeper patient–partner psychodynamics. Naturally, more complex cases require more time for treatment.

### Additional Obstacles to Therapeutic Success

Despite being the patient–partner's initial goal, coital ejaculations, once obtained, may be surprisingly disappointing, less pleasurable, and less intense than masturbatory ejaculations for some men. Sometimes these men need clinician support to express their preference for noncoital ejaculations, especially when their coital ejaculations are less satisfactory and only obtained by painstaking effort (Perelman, 2017). An additional common pitfall for the sex therapist to remain alert for is when treatment is experienced as being mechanistic and/or insensitive to the partner's needs and goals. Understandably, a female partner responds negatively to the impression that man is essentially masturbating with her body as opposed to engaging in connected lovemaking. Indeed, some men are emotionally disconnected from their partners. The clinician must empathically help the partner become comfortable with the idea of temporarily postponing the desired intimacy level during sexual activity, while simultaneously encouraging the importance of making intimate connections outside of sex to help mitigate the partner's sense of rejection. Once the patient is functional, the clinician can encourage a man–couple toward greater overall intimacy, presuming that is what they desire. Sometimes both partners may be disconnected from each other but are otherwise in a stable relationship they deeply value. In such cases, it is important that the therapist support patients' goals, and not push the man (couple) toward the clinician's own preordained concept of a relationship.

As mentioned in the section on etiology, fecundity issues can meaningfully complicate treatment. Women (and sometimes men) often resist any suggestions that may cause a delay to their plan to conceive. For some couples, fertility issues can be bypassed by using artificial insemination with the husband's sperm supplied by masturbation, as treatment for DE often requires that coitus be postponed. As a rule of thumb, a clinician who suspects that the patient's DE is related to conception fears should note any disparity between

sex when contraception is used and "no contraception" sex. If the DE only occurs during "unprotected" sex, the clinician can assume that impregnation reluctance is a primary variable. Fertility issues typically require individual and often conjoint work with the man and his partner. Resolution of the conflict can be challenging.

Often the most difficult cases are men suffering sexual sequelae subsequent to seriously debilitating diseases such as prostate cancer, whether treated surgically, medically, or with radiation. Here the previously deprecated vibratory devices become more necessary, as greater intensity of stimulation is required secondary to the damage caused by the disease and/or its treatments (Nelson et al., 2007; Tajkarimi & Burnett, 2011). Sex therapists may find themselves extremely challenged when rehabilitating a response that is severely anatomically limited. As described in the fifth edition of this text, a patient treated for postprostatectomy changes was helped to face his own limitations: "It used to feel like a jet engine. . . . It became a "paperclip" after surgery. You've got me back to a prop plane and that is what I need to live with." Certainly, the greater the anatomical damage, the more psychotherapy facilitates adjustment to the loss rather than restoration of function (Perelman, 2014).

## Conclusions

In summary, high-frequency idiosyncratic masturbation, sometimes combined with fantasy–partner disparity, can predispose men to experience problems with arousal and ejaculation. These factors occur disproportionately in many patients who will be seen by sex therapists, but a clinician's approach to DE must always be an individualized one, based on a focused history. Clearly, a good "sex status" will help identify a variety of key factors (the previously discussed masturbation-related ones and others) that result in diminished arousal, leading to an inability to ejaculate. The sex therapist must identify and prioritize these targets. An individually nuanced sex therapy that is derived from an appreciation of all potential factors determining the multidimensional etiology of the patient's DE, as well as multidisciplinary cooperation within an integrated treatment, is the optimal approach. The STP model can provide a useful framework for helping the patient (and partner) understand DE etiology, diagnosis, and treatment. The sex therapist can explain simply how the mental and physical erotic stimulation a man is receiving is insufficient for him to ejaculate in the manner he prefers, and how this can be changed to achieve the desired result. Successful treatment will depend on the patient's willingness to follow therapeutic recommendations, which, of course, will be influenced by the extent of organicity, his psychodynamics, and relational issues.

For now, many sex therapists do report good success rates (as high as 75%) when treating DE (Masters & Johnson, 1970; Perelman, 2017; Perelman

& Rowland, 2006). However, their results should be viewed as exploratory, albeit encouraging. Althof and Leiblum (2016) note the difficulty in evaluating sex therapy treatment outcomes, because the published studies use small samples, uncontrolled, nonrandomized methodologies, and lack validated outcome measure. Disparity between the results of different professionals may well reflect clinically different treatment populations. Only well-designed multicenter clinical trials will establish a more definitive answer. Nevertheless, at present, sex therapy remains the best option for men suffering from DE.

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## CHAPTER 8

# Genital Pain in Women and Men

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Current prevalence estimates for genital pain suggest that this complaint may be one of the most common problems bringing clients into sex therapists' offices. While pain during intercourse has traditionally been considered a woman's problem, Bergeron, Rosen, Pukall and Corsini-Munt point out in Chapter 8 that it affects a significant number of men as well. The consequences of this problem, whether for women or men, extend beyond sexual intercourse and can affect all aspects of sexual expression, including desire, arousal and orgasm. Sufferers also report significant interpersonal distress that typically impacts their relationships and couple satisfaction. The authors review the biological, psychological and social causes of genital pain and present a multidisciplinary model for care. They also present a new Interpersonal Emotion Regulation Model that emphasizes the interactional aspects of the pain experience and "highlights how interpersonal factors may function to inhibit or promote more adaptive emotional processes, with subsequent implications for the couple." This model is integrated into a manualized cognitive-behavioral treatment protocol, which has demonstrated effectiveness in a randomized controlled trial.

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**Caroline F. Pukall, PhD,** is Professor in the Department of Psychology at Queen's University in Kingston, Ontario, Canada, and Director of the Sex Therapy Service at the Queen's Psychology Clinic. Dr. Pukall's research focuses on genito-pelvic pain, sexual difficulties, and diverse relationships. She applies a multimethod approach to her research, tackling complex clinical issues (e.g., vulvodynia, persistent genital arousal disorder) with sophisticated research designs that consist of multiple methodologies (e.g., brain imaging, psychophysics), relating the findings of these methods to self-report measures. Dr. Pukall is Associate Editor for *Sexual Medicine Reviews* and is on the editorial board of several journals, including the *Archives of Sexual Behavior*.

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"Will I ever enjoy sex?"; "Is there something physically, psychologically, and sexually wrong with me?"; "Do I still love my partner?"; "Is the pain all in my head?"; "Am I still a woman?"; "Can my relationship survive this?" Most women and men who suffer from genito-pelvic pain ask themselves questions such as these as they struggle to understand and cope with this distressing problem, which negatively affects their sexuality and romantic relationships. Nearly all health professionals have seen a woman or a couple that suffers from genito-pelvic pain, whether they know it or not. Estimates of the prevalence of genital pain range from 10 to 28% in reproductive-age women in the general population (Pukall et al., 2016a). Furthermore, 20% of sexually active adolescent girls reported vulvo-vaginal pain of more than 6 months' duration (Landry & Bergeron, 2011).

Genito-pelvic pain, often causing dyspareunia (painful intercourse), can result from not only underlying physical pathologies such as endometriosis, interstitial cystitis, lichen sclerosus, and other genital infections (e.g., candidiasis, herpes, bacterial vaginosis) but also from events such as childbirth and menopause.

Genito-pelvic pain can also fall under the general term *vulvodynia*—which is a vulvar pain of at least 3 months' duration, without clear identifiable cause and potential associated factors (Bornstein et al., 2016). The *2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia* further provides the following pain descriptors: localized (i.e., a portion of the vulva) or generalized (i.e., the entire vulva), provoked or spontaneous, primary or secondary onset, and temporal pattern (e.g., intermittent). It is unclear whether these descriptors characterize distinct etiological pathways and/or are predictive of women's pain trajectories. The most common subtype of vulvodynia is localized provoked vestibulodynia (PVD), a burning pain elicited via pressure to the vulvar vestibule or attempted vaginal penetration in sexual and nonsexual contexts. Some women report suffering from pain located deeper in the vaginal canal, which often manifests as deep dyspareunia. Unfortunately, little research has been conducted with this population in order to accurately describe the condition. The information presented in this chapter, however, is likely still pertinent for women experiencing deeper vaginal/pelvic pain.

Despite strong arguments in favor of a pain conceptualization (Binik, 2010), DSM-5 (American Psychiatric Association, 2013) has retained dyspareunia in the chapter on sexual dysfunction. However, dyspareunia and vaginismus have been collapsed into a single diagnostic entity called *genito-pelvic pain/penetration disorder,* due to considerable overlap between the two conditions. The diagnostic criteria for this disorder include difficulty with at least one of the following: (1) experiencing vaginal penetration; (2) pain with vaginal penetration; (3) fear of vaginal penetration or of pain during vaginal penetration; and (4) pelvic floor muscle dysfunction. The change emphasizes the multidimensional aspects of genito-pelvic pain. In contrast, ICD-11 (World Health Organization, 2019) classification still utilizes the term *Sexual Pain Disorders* in the category of *Conditions Related to Sexual Health,* distinguishing these disorders from the sexual dysfunctions. Unfortunately, they do not include vulvodynia in this category; rather, vulvodynia is classified as one of the *diseases of the genitourinary system,* in the category of *pain related to the vulva, vagina, or pelvic floor.* There are three problems with this classification: (1) It perpetuates the dichotomy between organic and psychogenic genito-pelvic pain; (2) it is not based on scientific evidence that would support a distinction between so-called "sexual pain" and "pain related to the vulva, vagina or pelvic floor"; and (3) it removes sexuality from the experience of genito-pelvic pain. On a practical level, ICD-11 classification may make it more difficult for a woman with vulvodynia to obtain reimbursement for sex therapy, and as such, may inadvertently contribute to a reduction in the quality of patient care.

## Assessment

Harlow et al. (2014) found that only 60% of women who reported chronic genital pain seek treatment, and about half of those women never receive a

diagnosis. This finding highlights the importance of routinely inquiring about genital pain. Direct questions are often necessary, as women may not volunteer information about this problem for fear of stigmatization (Nguyen, Turner, Rydell, Maclehose, & Harlow, 2013).

> Sarah and Nina consulted a sex and couple therapy clinic complaining about Sarah's pain during sex. They had seen a physician for the pain, but the prescribed local anesthetic made Sarah's pain worse. Her partner of 3 years, Nina, harbored anger toward the physician and mistrust toward the therapist during their first session. Both women complained about how much the pain was taking a toll on their sex life.

Assessment and diagnosis of genito-pelvic pain should include organic, cognitive, affective, behavioral, and interpersonal factors that may be involved in the onset and persistence of this pain. Creating an open, validating, and nonjudgmental context for the assessment is essential. When a woman is in a committed relationship, her partner should be encouraged to attend and participate in the assessment.

The psychosocial assessment should begin with a detailed evaluation of the pain, including (1) properties of the pain, such as onset, temporal pattern, pain duration, location (superficial or deep), quality, and severity; (2) factors that may ameliorate or exacerbate the pain; (3) interference of the pain and other comorbid issues (e.g., other sexual problems, other pain problems, relationship and/or psychological distress); (4) personal explanations for the pain; and (5) previous treatment attempts and outcomes. It is important to ask about genital pain during nonsexual activities (e.g., urination, tampon use, physical exercise), which will demonstrate an understanding of whether and how the pain influences other aspects of women's lives. Next, a sexual history should include both partnered and unpartnered activities; prior sexual experiences, including any unwanted sexual experiences; and the impact of the pain on sexual desire, arousal, orgasmic capacity, and frequency of sexual activity/intercourse, as well as sexual satisfaction. If the client is in a relationship, then the presence of sexual difficulties in the partner should be evaluated. Any history of interpersonal trauma, in childhood or at present (i.e., intimate partner violence) must be assessed, as it has important implications for treatment.

The final component is an assessment of the cognitive, affective, behavioral, and interpersonal dimensions of the pain in both the woman and her partner, if she is in a relationship. Several important cognitive distortions may play a role in genital pain and in treatment outcomes, including catastrophizing, hypervigilance, and pain self-efficacy (i.e., the belief in one's ability to control the pain). Affective reactions, such as fear of pain and heightened anxiety or depression, are also common. These responses likely contribute to the extensive avoidance, which can go beyond vaginal intercourse to include the avoidance of other sexual activities and expressions of physical affection seen

in many women and couples. It is useful to assess couples' goals or reasons for having sex, because they have differential consequences: Are the partners pursuing a positive relationship outcome ("I want to have sex to feel close to you") or trying to avoid a negative outcome ("Let's just do it to avoid a fight tonight")? Finally, how the pain affects relationship dynamics, as well as how relationship factors may affect the pain and sexual impairment, need to be carefully assessed. These factors may include partners' responses to the pain that are solicitous ("Are you OK? Any pain?"), negative ("It doesn't hurt—it's all in your head!") or facilitative ("Let's try a sexual activity that is not painful for you"), as well as the degree of emotional self-disclosure about the pain and subsequent validating and invalidating partner reactions. As the following vignette illustrates, sometimes the difficulty involves misinterpreted communication.

> Gillian, a young woman in her 20s, had been experiencing genito-pelvic pain for the last 2 years. In therapy, she and her partner explored the different ways in which they communicate about the pain. Gillian revealed that when Tom said, during sex, "I miss having intercourse with you," it made her feel inadequate and anxious, and reduced her arousal. Tom was in fact trying to express how much he enjoyed his intimacy with her. The therapist helped Gillian and Tom to share more about, and better understand, their respective experiences of their sexual interactions. They were both able to show more empathic responding toward one another's views of their sexuality, which strengthened their intimacy and subsequently reduced the tension around their discussions about pain.

Standardized self-report questionnaires (e.g., Female Sexual Function Index [Rosen et al., 2000]; McGill Pain Questionnaire [Melzack, 1975]; Vulvar Pain Assessment Questionnaire [Dargie, Holden, & Pukall, 2016]) may complement, but should never replace, a thorough psychosocial assessment. These measures may be useful for making comparisons with clinical norms or to assist in tracking treatment progression.

A physician or gynecologist who is knowledgeable about genital pain should take a medical history and conduct an interactive, educational gynecological examination (i.e., one that includes education about anatomy, rationales for all procedures as they happen, and ideally, a hand-held mirror; (Huber, Pukall, Boyer, Reissing, & Chamberlain, 2009). The examination should include a cotton-swab test, which consists of palpating different areas of the vulva and asking the woman to rate the intensity of the pain (e.g., on a scale from 0–10), as well as vaginal and cervical cultures to exclude infection-related pain, and serum hormonal testing for abnormalities (Goldstein et al., 2016). If possible, careful palpation of the uterus and adnexae using a small speculum and/or a transvaginal sonographic assessment may be performed for deep genito-pelvic pain (van Lankveld et al., 2010).

## Etiology of Genito-Pelvic Pain

Historically, genito-pelvic pain has been considered to be a consequence of either physical factors or psychological and sexual difficulties, despite research and theorizing that suggests these two perspectives can and should be combined. We have proposed an integrated model taking into account the interdependency of biopsychosocial factors in genito-pelvic pain and its associated impairments (Bergeron, Rosen, & Morin, 2011).

### Biomedical Factors

A number of biomedical risk factors have been found to be more common in women with genito-pelvic pain than in controls, including early puberty and pain with first tampon use, inflammation, early use of oral contraceptives, vulvar pain receptor proliferation (i.e., increase in the number of receptors) and sensitization (i.e., touch may become perceived as pain), and lower touch and pain thresholds (Pukall et al., 2016a). A study using a mouse model of PVD showed that recurrent yeast infections can cause persistent vulvar pain by replicating important features of human PVD, such as allodynia (Farmer et al., 2011). These findings suggest that both peripheral (i.e., at the vulva) and central (i.e., in the brain) mechanisms play an etiological role in genito-pelvic pain.

Controlled studies investigating pelvic floor muscle (PFM) dysfunction and using noninvasive, validated measurement (e.g., four-dimensional [4D] ultrasound) indicate that abnormalities of the PFMs while at rest, including hypertonicity, poor muscle control, hypersensitivity, and altered contractility, may close the vaginal hiatus and thus interfere with penetration (Morin, Bergeron, Khalifé, Mayrand, & Binik, 2014; Morin, Binik, et al., 2017). Women may also exhibit a defensive reaction of the PFMs during attempted vaginal penetration (e.g., guarding or muscle contraction). A vicious cycle involving the pain and further muscle dysfunction makes it difficult to identify cause and effect, and is complicated by the involvement of psychosocial factors.

### Childhood Maltreatment

Large-scale studies among community samples indicated that adult women and adolescent girls with genito-pelvic pain were more likely to report sexual abuse and severe physical abuse than controls (Harlow & Stewart, 2005; Khandker, Brady, Stewart, & Harlow, 2014; Landry & Bergeron, 2011). In addition, women with genito-pelvic pain who experienced child sexual abuse reported significantly lower levels of sexual function and psychological adjustment than those reporting no sexual abuse (Leclerc, Bergeron, Binik, & Khalifé, 2010). Similar results were found in a dyadic study focusing on different

forms of child maltreatment (Corsini-Munt, Bergeron, Rosen, Beaulieu, & Steben, 2017). Victimization may complicate women's and partners' adjustment to the sexual, psychological, and relationship repercussions of genito-pelvic pain by leading to impaired emotion regulation (Rosen & Bergeron, 2019).

### Cognitive, Affective, and Behavioral Factors

Several studies indicate that anxiety is a precursor, a consequence, and a maintenance factor in the experience of genito-pelvic pain (Khandker et al., 2014; Paquet et al., 2018). Cognitive factors that predict greater pain intensity, sexual impairment, or both, include pain catastrophizing, hypervigilance to pain, lower pain self-efficacy, negative attributions about the pain, perceived injustice, negative cognitions about penetration, and contingent self-worth, whereas avoidance of pain and sexual activity is the core behavioral factor that may maintain genito-pelvic pain (Bergeron, Corsini-Munt, Aerts, Rancourt, & Rosen, 2015). Psychological factors linked to less pain and better adjustment include pain acceptance and self-compassion (Boerner & Rosen, 2015; Santerre-Baillargeon et al., 2018)—both of which can be targeted in a third-generation cognitive-behavioral therapy such as mindfulness.

### Interpersonal Factors

We have recently proposed the *Interpersonal Emotion Regulation Model* of women's sexual dysfunction for conceptualizing the contribution of interpersonal factors to genito-pelvic pain (Rosen & Bergeron, 2019). The model suggests that interpersonal factors acting at the distal level (i.e., traits or predisposing aspects of the relationship) and the proximal level (i.e., what occurs before, during, and immediately following painful sexual activities) modulate couples' emotion regulation concerning the pain and associated sexual difficulties, and in turn, women's experience of pain and couples' sexual and psychological adjustment. Emotion regulation is hypothesized to act as a central pathway given the high negative affect (e.g., shame, anxiety) and threat value of genito-pelvic pain.

This model is based on robust evidence pointing toward the important role of interpersonal factors in genito-pelvic pain, with many findings stemming from dyadic daily diary studies, which allow for the examination of couples' sexual activity as it unfolds in their natural environment. Distal factors include intimacy, romantic attachment, ambivalence over emotional expression and sexual communication, and partners' pain catastrophizing, attributions, and self-efficacy. The most studied proximal factors are partner responses to pain, which can be solicitous (e.g., expressions of attention and sympathy), negative (e.g., expressions of hostility, frustration), and facilitative (e.g., affection and encouragement of adaptive coping), with the two former associated with more negative woman and partner outcomes and the latter,

positive outcomes. Other proximal factors include mood and sexual motivation, specifically, sexual goals, sexual communal strength, and unmitigated sexual communion (Rosen & Bergeron, 2019), all of which can be targeted in sex and couple therapy. Relative to other conceptualizations of chronic pain and sexual dysfunction, the interpersonal emotion regulation model places a greater emphasis on the relational aspects of the pain experience and its co-regulation by both partners, as well as proposing that partners are dynamic players in the interactions that impact their sexual and psychological well-being, and are impacted by their respective vulnerabilities. In summary, the model highlights how interpersonal factors may function to inhibit or promote more adaptive emotional processes, with subsequent implications for the couple.

## Male Genito-Pelvic Pain

In contrast to the large literature devoted to genito-pelvic pain in women, there is relatively little coverage of male genito-pelvic pain. What does exist suggests that males can suffer from various conditions affecting their genital and pelvic organs, leading to localized or generalized pain during nonsexual and/or sexual activities, such as erection and ejaculation. Recent data suggest that the prevalence of male genito-pelvic pain ranges from 2.2 to 9.7% worldwide (Condorelli, Russo, Calogero, Morgia, & La Vignera, 2017).

Although several research groups have made great strides in the domain of male genito-pelvic pain in recent years, the diagnosis of male genito-pelvic pain has been excluded from DSM-5 (American Psychiatric Association, 2013) because of insufficient data. Therefore, one needs to look elsewhere for an empirically based definition of male genito-pelvic pain. The most recent term, *urological chronic pelvic pain syndrome* (UCPPS), describes a variety of urogenital pain symptoms due to different conditions such as chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS; recurrent idiopathic pelvic pain), interstitial cystitis/bladder pain syndrome (IC/BPS), and other issues (Landis et al., 2014).

The Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP; Landis et al., 2014) network has put forth a multisite, longitudinal protocol to extensively phenotype patients with UCPPS into subgroups. Within a controlled study design, this protocol consists of biweekly online measurement of self-reported symptoms, in-clinic phenotyping of symptoms (urological and nonurological), measurement of psychosocial factors, and additional investigations, such as neuroimaging and quantitative sensory testing. The aim of this network is to explore underlying pathological mechanisms that can guide treatment of clinically relevant subgroups. Approaches such as this one have been suggested in the past and have proven clinically useful: Shoskes, Nickel, Rackley, and Pontari (2009) proposed that each patient with UCCPS has different etiological mechanisms, disease characteristics, symptom

constellations, and progression pathways that should be described in a clinical phenotyping classification system called UPOINT. It details the domains that need to be evaluated by the physician: urinary, psychosocial, organ-specific, infection, neurological/systemic, and tenderness. Comprehensively evaluating each domain can lead to the recommendation of specific therapies and help tailor sex therapy to specific patient needs. For example, if tenderness of skeletal muscles is predominant, pelvic and/or general physical therapy exercises would be recommended. Higher scores in the UPOINT system have been associated with higher symptom scores and longer symptom duration, and using the system to guide treatment has resulted in significant symptom reduction (Shoskes & Nickel, 2013).

The UPOINTS system represents recent efforts to incorporate sexual dysfunction in the UPOINT system, yet it has yielded mixed results. For example, there have been some improved correlations with quality of life in one study (Davis, Binik, Amsel, & Carrier, 2013a) but not in another (Samplaski, Li, & Shoskes, 2011). However, sexual concerns should be assessed thoroughly in order to provide a patient with a comprehensive treatment plan. Particularly, since one clinical phenotyping study that assessed multiple variables (e.g., pain descriptors, psychosocial and sexual measures, urinary and prostate measures) in a sample of males with UCCPS revealed seven subgroups (e.g., long-term genito-pelvic pain, testicular pain). One of these subgroups was characterized by "ejaculatory pain and sexual dysfunction" (Davis, Binik, Amsel, & Carrier, 2013b).

Interestingly, patterns of sensitivity, pelvic floor muscle function, and neural activation and structure in males with UCCPS closely mirror findings in women with PVD (Davis, Morin, Binik, Khalifé, & Carrier, 2011). This information may lead to a new understanding of the factors involved in the development and maintenance of male genito-pelvic pain and may provide support for a novel reconceptualization of UCCPS similar to what has happened in the domain of female genito-pelvic pain in DSM-5 (American Psychiatric Association, 2013).

Another condition that males can experience is anodyspareunia, recurrent or persistent anal pain experienced by the receptive partner during anal intercourse. Prevalence rates range from 12 to 14% in men who have sex with men (Damon & Rosser, 2005), with mild pain reported in about 33% of one study sample, 17% mild to moderate, 4% moderate, and 2% severe (Vansintejan, Vandevoorde, & Devroey, 2013). A lack of, or inadequate, stimulation before penetration was the strongest predictor of anal pain (Vansintejan et al., 2013).

## Approaches to Treatment

Treatment interventions for genito-pelvic pain are multiple and target different hypothesized etiological mechanisms. They tend to be delivered in a linear

fashion, beginning with purportedly less invasive, safer options, followed by more risk-laden modalities such as surgery, depending on the subtype of genito-pelvic pain and patient preference. This approach is based on clinical observations and, when possible, empirical evidence.

## Medical Options

Because women with genito-pelvic pain often consult their family physicians in their initial help-seeking attempts, they often receive a medical intervention, which includes topical applications and oral medications, the most common of which are topical lidocaine and tricyclic antidepressants. However, conclusions from the *Fourth International Consultation on Sexual Medicine* (Pukall et al., 2016b) indicate that these are not recommended due to lack of evidence supporting their efficacy; rather, the best treatment options are psychological interventions, pelvic floor physical therapy, and vestibulectomy (for provoked vestibulodynia).

Vestibulectomy, a minor day surgery involving the excision of about 2 mm of the lower part of the vulvar vestibule, has been the most studied treatment for PVD. Recent publications continue to support the positive outcome of this surgical excision, with success rates of 65–70% or higher (Landry, Bergeron, Dupuis, & Desrochers, 2008). Because research concerning vestibulectomy has many methodological limitations, some clinicians warn that it should be recommended only after failure of more conservative options. Others claim that this cautionary statement is not justified by data. A clinical trial was conducted to compare vestibulectomy, group cognitive-behavioral sex therapy/pain management (CBT), and electromyography (EMG) biofeedback (Bergeron, Binik, Khalifé, et al., 2001; Bergeron, Khalifé, Glazer, & Binik, 2008). Although all three treatments yielded significant improvements at posttreatment, and at 6-month follow-up on pain during intercourse, vestibulectomy resulted in approximately twice the pain reduction as the two other treatments. At the 2.5-year follow-up, vestibulectomy remained superior to the other conditions in its impact on pain during the cotton-swab test but was equal to group CBT for pain during intercourse. Overall, these results suggest that vestibulectomy is a safe and efficacious treatment for PVD, although, at long-term follow-up, no better than CBT. Hence, within a multimodal treatment approach, nonsurgical interventions are recommended first.

## Pelvic Floor Physical Therapy

In their randomized trials, both Bergeron et al. (2008) and Danielsson, Torstensson, Brodda-Jansen, and Bohm-Starke (2006) showed significant pre- to posttreatment changes in pain and sexual function in women assigned to the biofeedback condition, although they did not differ significantly from CBT or topical lidocaine. Some have argued that multimodal pelvic floor physical therapy might be a more optimal modality, as it includes but is not limited to

EMG biofeedback. Physical therapy also involves education about the role of the pelvic floor musculature in the maintenance of genito-pelvic pain, as well as manual and insertion techniques. In their systematic review of the effectiveness of physical therapy for PVD, Morin, Carroll, and Bergeron (2017) concluded that although the literature is plagued with methodological shortcomings such as nonstandardized intervention and use of other ongoing treatment, multimodal physical therapy showed consistent effectiveness across studies, with a significant improvement of pain in 71–80% of women. Furthermore, the overall effectiveness of multimodal physical therapy surpassed that of isolated modalities (e.g., biofeedback alone). Although less commonly included as a main endpoint, sexual function also improved after physical therapy. To this effect, the combination of physical therapy and sex therapy as a first-line intervention in a multidisciplinary approach to treatment is promising.

### Cognitive-Behavioral Sex Therapy/Pain Management

Cognitive-behavioral sex therapy and pain management generally focus on reducing pain, improving sexual function and well-being, and increasing relationship satisfaction by targeting the thoughts, emotions, behaviors, and couple interactions associated with the experience of genito-pelvic pain. They can be delivered in group, couple, or individual therapy formats. The first stage of treatment typically involves psychoeducation about a multidimensional view of pain and its negative impact on sexuality, including the role of psychological factors in the maintenance and exacerbation of the pain and ensuing sexual difficulties. Self-exploration of the genitals in order to localize the pain and the use of a pain diary are generally introduced at this stage. The second stage focuses on reducing maladaptive coping strategies such as catastrophizing, hypervigilance to pain, avoidance, and excessive anxiety, while increasing adaptive strategies such as approach behaviors; self-assertiveness; reconnecting with the partner through nonsexual physical and emotional intimacy; expanding the sexual repertoire to steer the focus away from intercourse and optimize pleasurable sexual experiences; and facilitating experiences of desire, arousal, and sexual intimacy for both partners. Depending on the assessment and unfolding of treatment, issues such as childhood maltreatment, significant mood and/or anxiety disturbances, and significant relationship conflict may need to be addressed if they are thought to be related to the genito-pelvic pain or to interfere with the targeted work on pain and sexuality, and/or if the patient wishes to do so.

Bergeron et al. (2008) investigated the efficacy of a combination of group cognitive-behavioral sex therapy and pain management (CBT) in two different randomized studies of women with PVD. In the first study, described previously in the subsection on medical options, participants who received CBT reported significant reductions in pain at a 6-month follow-up and, at a 2.5-year follow-up, were equivalent to women having undergone a

vestibulectomy with respect to pain experienced during intercourse. In another study (Bergeron, Khalifé, Dupuis, & McDuff, 2016), participants were randomly assigned to either a corticosteroid cream condition or to group CBT for a 13-week treatment period. At posttreatment, women in the CBT condition were significantly more satisfied with their treatment, displayed significantly less pain catastrophizing, and reported significantly better global improvements in pain and sexual function than women assigned to the topical application condition. These findings suggest that CBT may yield a positive impact on more dimensions of PVD than does a topical treatment. In a randomized clinical trial involving a mixed group of 50 women with vulvodynia, Masheb, Kerns, Lozano, Minkin, and Richman (2009) also found that individual CBT resulted in significantly greater reductions in pain and improvements in sexual function than supportive psychotherapy.

Two novel third-generation CBT, acceptance-based approaches were recently developed. The first is a 12-week couple therapy intervention based on research highlighting the role of relationship factors in genito-pelvic pain. An open trial, prospective pilot study yielded significant pre- to posttreatment improvements in pain during sexual intercourse and sexual function for women, and in sexual satisfaction for women and partners, highlighting the potential benefit of a couple-based approach (Corsini-Munt, Bergeron, Rosen, Mayrand, & Delisle, 2014). Another innovative intervention is that of Brotto, Basson, Smith, Driscoll, and Sadownik (2015), who developed a mindfulness-based group CBT program delivered over four 2-hour sessions and consisting of education about PVD and pain, CBT skills to address problematic thoughts, progressive muscle relaxation and mindfulness exercises, as well as sex therapy. Using a quasi-experimental design and a wait-list control comparison group, they found significant improvements between pre- and posttreatment, and from posttreatment to 6-month follow-up in pain catastrophizing and hypervigilance, cotton-swab provoked allodynia, and sexual distress, but not for pain experienced during intercourse (Brotto et al., 2015). CBT is thus an empirically validated, noninvasive therapeutic option offered in different formats that may be a good starting point in the multimodal management of genito-pelvic pain.

### Summary

To conclude this section, although there is still a pressing need for more randomized clinical trials, it is noteworthy that sex therapy/pain management is the most empirically validated intervention to date. Despite the high number of medical options, only vestibulectomy has demonstrated efficacy. Moreover, in line with a biopsychosocial model of genito-pelvic pain, it is unlikely that any single modality will have a positive impact on all aspects of the condition, which underlines the importance of adopting a multidisciplinary, multimodal treatment approach.

## A Multidisciplinary Model of Care for Genito-Pelvic Pain: Promises and Pitfalls

In parallel with accumulating evidence suggesting the involvement of multiple etiological pathways, a multidisciplinary model of care has now been espoused by most experts in the field, as per the recommendations of the *Fourth International Consultation on Sexual Medicine for Women's Sexual Pain Disorders* (Goldstein et al., 2016). Advantages of this model—especially when interventions are applied in a combined rather than sequential fashion—include a speedier treatment process, less resistance to any single modality, more engaged patients and health professionals, increased coherence among the various physicians and therapists involved, and, last but not least, multiple dimensions of dyspareunia being targeted simultaneously. This multidisciplinary model is reflected in an excellent self-help book (Goldstein, Pukall, & Goldstein, 2011) and in the information provided by the National Vulvodynia Association (2018), a patient advocacy group. In particular, sex therapists are well positioned to coordinate treatment efforts and to provide education about pain and sexual function, as well as interactions therein. The broad range of interventions they offer can contribute to reducing pain, psychological distress, and relationship difficulties, in addition to improving sexual function and adhering to other treatment regimens. A key to the success of working in a multidisciplinary fashion lies in challenging patients' assumptions about their pain being entirely physical or psychological. Until they adopt a multifactorial view of their problem, it remains difficult to develop a strong therapeutic alliance and to work collaboratively, irrespective of the type of treatment or health professional. One of the ways to achieve this is to provide education about the interdependency of biomedical, cognitive, affective, behavioral, and relationship factors in the onset and maintenance of dyspareunia.

## Case Discussion: Targeted Couple Intervention for PVD

When possible, it is recommended that women and their partners participate in empirically developed cognitive-behavioral pain management and sex therapy programs, either in a group format, such as the manualized treatment developed by Bergeron, Binik, and Larouche (2001), or a couple format, such as the manualized treatment developed by Corsini-Munt et al. (2014). The advantage of a group format is that it reduces the shame and stigma often felt by women with genito-pelvic pain, and it is cost-effective. The group can also serve as a powerful motivating force for its members. The advantage of a couple therapy format is that interpersonal dimensions that influence the woman's pain experience and both partners' sexual functioning can be targeted directly. When neither group nor couple therapy formats are possible

or appropriate, the essential elements of both treatments can be delivered in individual therapy. A couple therapy case is described and discussed below.

## Nadine and Ben: A Couple Coping with PVD

In their mid-30s, Nadine and Ben, married for 6 years, felt pressure to find a solution to Nadine's genito-pelvic pain given their desire and family pressure to have a child. They were both working as professionals in their respective fields and were used to succeeding in their careers in finance and law. They engaged in friendly banter between themselves and with the therapist. Nadine had suffered from acquired genito-pelvic pain for 2 years; both she and Ben reported that the pain began after repeated vaginal infections, which had since been treated. Nadine's family physician suggested she needed to work on relaxing during sex, and a gynecologist prescribed a topical anesthetic ointment, which she and Ben found offered little relief and was annoying to use. The gynecologist believed that Nadine's pain was consistent with PVD and had prescribed the least invasive treatment option she knew. She was unaware that Nadine was experiencing distress on a personal and relational level, and therefore was not cued to suggest a psychological treatment option. These treatment attempts occurred a year prior to the couple's presentation to therapy, and in frustration, Nadine avoided the topic with her doctor for that whole year. "The pain is my fault for not treating my yeast infection sooner, and now I'm stuck with it and might not be able to get pregnant." Ben believed her lack of initiative to find a solution meant that she was secretly not interested in him sexually anymore. He often verbalized his disappointment when Nadine experienced pain during sex. As he stated, "I just don't understand why she doesn't want to fix this. She doesn't hesitate to tackle other problems. Maybe she's done with sex. Maybe she's not into sex with me anymore."

Nadine and Ben self-referred for couple sex therapy following an Internet search for possible treatment options conducted by Ben. They came to therapy feeling both hope for improvement and scepticism that therapy could help.

### *Overview of Assessment*

During the assessment, the therapist invited each member of the couple to discuss the impact the pain has had on them as individuals, as well as on their relationship and sex life. Sex was frequent and varied prior to the onset of Nadine's genito-pelvic pain. Initially, Nadine and Ben would cope with the pain by replacing vaginal intercourse with anal intercourse, but Nadine began to refuse, because she started to feel constipated, which she found both physically uncomfortable and embarrassing. More recently, when they were sexual with one another, they were still attempting vaginal intercourse each time to see if anything had changed. The pain would often be too much for Nadine after a minute or two, and all sexual activity would end. Nadine would often leave the bedroom and cry by herself in the bathroom. Such experiences left her

feeling inadequate, Ben feeling helpless, and both feeling frustrated. Nadine's pain ranged from 5 to 8 on a scale of 0–10. Ben's frustration was palpable as Nadine described how their sex life had changed. The therapist also devoted time getting to know the couple by asking them to share their story and how they typically handle conflict. This not only helped the therapist develop a clinical understanding of the couple (i.e., coping skills, and conflict and resolution styles), but it also helped Nadine and Ben feel as though the therapist cared about them as a couple. Given their apprehension about the usefulness of therapy, developing rapport was integral to facilitating their engagement and motivation in the therapeutic process and use of homework exercises. Finally, the therapist used the assessment phase of therapy to identify preliminary goals with both members of the couple, individual and shared. At the same time, she shared statistics with the couple about treatment outcomes and stressed that improvement was different for everyone. By tempering the couple's expectations, Nadine and Ben were able to set more realistic goals. Nadine said, "It would be great if the pain could just go away, but what I want more than anything is for sex to stop being so stressful. I would like to enjoy sex again. I want to be able to make Ben happy again." Ben expressed a similar goal: "Of course, I wish she didn't have pain. I just want to be able to have sex with my wife again."

### *Overview of Treatment*

The treatment was structured across twelve 75-minute sessions and followed a manualized cognitive-behavioral couple therapy. The treatment focused on acceptance-based, third-generation CBT practices, and both members of the couple attended all sessions. Topics focused on psychoeducation, approach and avoidance goals for sex, multidimensional understanding of pain, communication skills, impact of pain on sexuality for both partners, relaxation and mindfulness, facilitation of sexual desire and arousal, assertiveness, cognitive defusion, pain attributions, and partner responses to pain. An important element of the couple therapy experience was encouraging the partners to work as a team, so that they could cope with the pain and its impact together rather than further burdening the woman to address the pain and its consequences on her own. As Nadine put it, "I'm so relieved Ben is here with me. I wouldn't be able to explain everything to him, and I feel like he's starting to understand that I'm not exaggerating about the pain."

One of the first interventions delivered to the couple was psychoeducation about the multidimensional nature of pain (i.e., prevalence rates and known biopsychosocial factors that influence pain). Psychoeducation allowed for the expression and exploration of their reactions to the new information. It was particularly helpful for Ben to hear and see scientific information about genito-pelvic pain, its prevalence, its consequences, and the role of interpersonal factors. "I never thought Nadine was making it up, but I don't think I really *got* that it was so common. Seeing that all these doctors and professors

are working on it means it's a real problem. I also didn't realize that the way I'm acting can play into it." Nadine found it helpful to apply the multidimensional perspective to her own pain by keeping pain journals, an exercise assigned by the therapist in which the client documents pain duration; intensity; pain-related thoughts, feelings, and behaviors; and sexual function and coping efforts in response to both sexual and nonsexual stimuli. "I was sceptical about keeping a pain journal at first—I thought it would be too much focus on the pain. But avoiding it this past year hasn't helped either." Nadine found that if her husband was acting "flirtatiously" toward her during the day, she anxiously anticipated sex, and her pain was more intense than when her husband "surprised" her by initiating sex at bedtime.

In the second session, the therapist asked Nadine and Ben to identify their reasons for having and *not* having sex, and had them write each reason on a small piece of paper. This exercise draws from research about approach and avoidance goals (Rosen et al., 2018). She explained that this exercise is about helping them identify the reasons that were closest to their own values, since acting in accordance with one's values can lead to feeling more fulfilled. The therapist asked the couple to sort their reasons from highest to lowest priority, then they each shared them with the therapist and one another. The therapist explained that approach goals (e.g., having sex for pleasure) are associated with better outcomes compared to avoidance goals (e.g., having sex to avoid a fight). While many of Ben's reasons for wanting to have sex related to wanting to connect, be close, and experience and give pleasure, Nadine was tearful as she compared them to her reasons, which were more avoidance-oriented: "because of the pain" or "despite the pain." She was emotionally moved to learn that Ben prioritized closeness with her but also frustrated that pain colored her experience of sex. The therapist explored their feelings about these reasons for having sex, helping each find meaning in his or her own and any potential connection with the partner's reasons. Given Nadine's tendency to act on avoidance goals, the therapist continued to facilitate the development and use of approach goals throughout treatment. Nevertheless, focusing on the pleasurable aspects of sex remained a challenge for Nadine until the end of therapy.

Anxiety is almost ubiquitous for women experiencing PVD, and sometimes for their partners as well. The therapist facilitated a discussion of the couple's experience with anxiety related to pain and sex. She presented relaxation strategies to them, such as diaphragmatic breathing, mindfulness body scans, and tantric breathing exercises that they could practice together. Nadine said, "I'm finding the daily breathing exercises helpful, and it was weird at first to try the tantric breathing, but now it's become a little ritual we use before fooling around."

Around the sixth session, the therapist explored the topic of partner responses to pain (i.e., solicitous, negative, and facilitative responses) in depth with the couple. She invited them to share their perspectives on Ben's responses to Nadine's pain, before, during, and after a pain experience. She presented

the relevant research on partner responses in a way that did not place blame on any potentially problematic partner responses, but motivated the couple to appreciate the opportunity for behavior changes. Ben was particularly struck by this information. "Since learning that my responses to Nadine's pain can have such a strong impact, I have been very conscious of how I react when she has pain. Sure, I still feel helpless and frustrated sometimes, but now I know of ways to respond that are more helpful." For some couples, this discussion is illuminating and reassuring, whereas for others, it can open wounds relating to not feeling understood, unmet sexual needs, and sexual frustration. The risk for conflict is therefore heightened, and the therapist is encouraged to be proactive in facilitating communication and emotionally focused disclosure. It was during this session that Nadine became very tearful and expressed her anger and sadness about not being able to tolerate vaginal penetration and therefore not being able to start a family yet. Through tears she said, "I'm just happy that Ben understands now, because his disappointment was always like another dagger. I hate what this has done to us, but I'm glad we're starting to figure out ways to help. I'm so appreciative that he's here with me." The therapist encouraged Nadine to turn to Ben and share the same feelings with him directly, rather than through the therapist.

Other communication work with the couple focused on skills that included expressing sexual and relationship needs (e.g., "I need to feel that you desire me, I need to be touched by you") and building intimacy through the effective use of self-disclosure and empathic responding. Facilitating emotional disclosure between the partners and encouraging empathic responding helped Ben and Nadine to communicate more effectively regarding their needs. This improved communication also allowed for better problem solving. These skills were practiced in the session with the therapist, with some coaching and feedback provided as needed.

Building on the tantric breathing exercises, the therapist also gave *sensate focus exercises* as homework to aid in identifying the partners' sexual needs and reducing anxiety and pressure. Nadine and Ben were initially enthusiastic when hearing about sensate focus and reacted similarly when discussing sexual activity other than vaginal intercourse. However, after several sessions, they were still attempting vaginal intercourse every time they were sexual or trying out a sensate focus exercise, and they were frequently frustrated because Nadine was still experiencing a fair amount of pain. The therapist gently presented the partners with the paradox of their enthusiasm and behavior. Avoidance and resistance can manifest differently in each case. In this instance, the partners seemed eager to try an exercise but kept circumventing the purpose of the exercise by relying on old patterns. They responded well to the therapist's gentle confrontation—they disclosed their continued belief that the pain might just go away. The therapist was sensitive and firm in reminding the couple of their reality facing this pain problem: "Yes, you are a couple with pain. But you have this rich opportunity to recreate your sex life as you work on the pain." They were proud to report in the next session that they

had been sexual without attempting intercourse. Ben said, "I don't think I've seen Nadine that comfortable in her own skin in a long time. She was so sexy." And Nadine reported that knowing sex was "off the table" liberated her from worry. "I didn't realize how tense it was making me. I can see the sensate focus exercise being good for us—less focus on the pain and more on making each other feel good."

Another intervention that the couple was given to bring home involved graduated vaginal dilatation exercises using Nadine's own fingers and Ben's fingers, with the pace and angle of insertion guided by Nadine. Ben was able to practice more facilitative responding throughout this exercise. On two of the insertions, Nadine experienced pain, and they stopped. On one, she experienced no pain, and on a fourth attempt, she experienced pain but did some cognitive defusion, a technique she learned in an early session. "I'm noticing that I'm having the thought that this is impossible. It's only a thought, and thinking it does not make it true. It's OK, Ben loves me." She also incorporated some deep breathing, and they tried again with success. This same strategy was employed in graduated steps until, toward the end of therapy, Nadine and Ben attempted intercourse with discomfort but no pain. Both felt more sexually satisfied than when they had started therapy.

By the end of treatment, Nadine and Ben reported a handful of pain-free sexual experiences that included some vaginal penetration. While Nadine's pain had decreased significantly, she was still nervous to have vaginal intercourse for longer than a couple minutes. She still felt an immense pressure to get pregnant, but she and Ben were feeling more optimistic that they could work towards that goal, now that they had new ways of coping with the pain. Ben was relieved that they had come to therapy. "I feel like my understanding of Nadine's pain has been completely reconfigured. I feel like having done this couple therapy, it's part of our journey, and I know we can face this together. I don't feel so upset or useless when she has pain now. I try to suggest other things like tantric breathing or a massage. . . . I feel like we're connecting more now."

The therapist validated the progress Nadine and Ben had made, and together, they identified future challenges and how Nadine and Ben might face them.

## Conclusions

Not all couples fare as well as Nadine and Ben. Some present with more extreme avoidance and require targeted motivational work, whereas others are willing to try all of the strategies suggested by the therapist. Some couples discontinue therapy because they do not believe it is helping. Some couples present with a higher degree of conflict, and others arrive at therapy contemplating separation. The therapist may have to prioritize these issues prior to focusing on pain and sex. For women and couples who have been coping with

genito-pelvic pain for many years, therapy addressing pain and sex can be experienced as threatening, because it asks them to confront something that has been physically and emotionally painful for so long. The therapist working with couples with genito-pelvic pain must exercise sensitivity, patience, and flexibility to adapt to the unique presentation of each couple.

Just as not all cases present the same way, treatment gains look different for each couple. Some couples see improvements across all domains (i.e., pain, sex, psychological and interpersonal), whereas others may still experience pain but start to feel less anxiety and more sexual desire following treatment. It can be a hard reality to face for couples when treatment gains are nonexistent or not as the couple expected. This is where the therapist can play an important role in providing space for the partners to share their disappointment, highlight gains they may be overlooking (e.g., Are they communicating more effectively? Are they catastrophizing less? Are they feeling more united as a couple?). Treatment gains that are seemingly unrelated to pain intensity and sexual function can be easy for couples to overlook, but they are extremely important to the groundwork necessary for them to eventually implement effective pain coping strategies. Moreover, the therapist can also serve as an expert and reliable resource to help direct couples to other treatment modalities (e.g., physical ther'apy).

Our clinical experience suggests that genito-pelvic pain may not always be treated successfully by a single health professional. Unfortunately, there is very little research evaluating a multimodal approach to the treatment of genito-pelvic pain, although the outcome appears very positive (Brotto, Yong, Smith, & Sadownik, 2015; Spoelstra, Dijkstra, van Driel, & Weijmar Schultz, 2011). These promising findings point toward the need for more empirical work aimed at validating an integrated approach to care for this prevalent women's sexual health issue.

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# CHAPTER 9

# Lifelong Inability to Experience Intercourse (Vaginismus)

MONIEK M. TER KUILE
ELKE D. REISSING

Only a few sex therapy interventions meet the highest efficacy standards for psychotherapy outcome research. One such intervention, the therapist-aided prolonged *in vivo* exposure treatment developed by ter Kuile and colleagues, and discussed in Chapter 9, is likely to allow most women who have been suffering from lifelong vaginismus to be able to experience vaginal penetration. In addition to the persuasive empirical validation of this treatment, the authors present a strong theoretical foundation based on a fear avoidance model. Essentially, vaginismus is reconceptualized as a specific phobia and treated accordingly. One challenge for sex therapists is that the *in vivo* exposure intervention is ideally carried out in a clinic or hospital environment. While there is little doubt that overcoming lifelong vaginismus is a major advance, the authors point out that many women who have successfully benefited from this treatment still do not experience significant pleasure during vaginal penetration. This provides a new frontier of research and a therapeutic challenge for future clinicians and therapists.

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Julie, age 28, was referred by her general practitioner with the complaint that sexual intercourse has never been possible during her 5 years of marriage to Peter. When they attempt intercourse, Julie experiences pain and fear of penetration. Julie has never been able to insert a tampon and indicates that she feels like she is "hitting a wall" when she tries. Peter thinks that Julie may also tighten her pelvic floor muscles during attempts at vaginal penetration. Both are very motivated to overcome this problem, because they want to conceive children "in the natural way."

## Description and Diagnosis of the Problem

Julie meets criteria for the DSM-5 (American Psychiatric Association, 2013) diagnosis of genito-pelvic pain/penetration disorder (GPPPD) and for the proposed diagnosis of sexual pain/penetration disorder (SPPD), in the 11th edition of the International Classification of Diseases (ICD-11; World Health Organization, 2019). In both nosologies, the previous diagnostic criterion of vaginal spasm has been replaced by similar lists of diagnostic criteria including pelvic muscle tension, pain, and/or fear and anxiety.

The SPPD and GPPPD diagnostic systems, however, are not identical (Navarro-Cremades, Simonelli, & Montejo, 2017; Reed et al., 2016). In DSM-5, GPPPD includes vaginismus, dyspareunia, and vulvodynia when not completely attributable to other medical conditions. DSM-5 criteria are based on the available empirical literature pointing toward an overlap of dyspareunia and vaginismus, perhaps best summarized as a continuum of severity with regard to interference with vaginal penetration (Binik, 2010). In ICD-11, lifelong vaginismus is classified separately as SPPD and does not include dyspareunia or vulvodynia. Dyspareunia is classified as a medical complaint under conditions related to sexual health in the ICD-11 chapter outlining diseases characterized by pathological changes to the genitourinary system (World Health Organization, 2018). More research is necessary to determine whether ICD-11's categorical classification of lifelong vaginismus is more appropriate than the DSM-5 continuum that includes lifelong and acquired vaginismus and dyspareunia (Binik, 2014; Reissing et al., 2014).

In this chapter, we focus on women, like Julie, who have *never* been able to experience vaginal penetration. For brevity, we, for the most part, refer to

*lifelong vaginismus* as *vaginismus*. For information about women who are able to have vaginal intercourse but experience pain to the point that they are unwilling to continue trying, Bergeron, Rosen, Pukall, and Corsini-Munt's discussion on genital pain (Chapter 8, this volume) may be more appropriate. However, if, in addition to pain, intense fear and strong avoidance of penetration characterize the woman's experience, our approach may be appropriate.

## Prevalence

The literature on epidemiological studies of vaginismus is very limited and uninformative. Lifelong vaginismus has not been investigated specifically, and the definitions used reflect different nosologies. The best available prevalence estimates range between 0.4 and 6.2% (Christensen et al., 2011; Kadri, Mchichini, & Mchakra, 2002; Oberg & Fugl-Meyer, 2005). Prevalence rates reported in clinical settings in non-Western conservative societies range from 58 to 68% (e.g., Amidu et al., 2010; Dogan, 2009; Oniz, Keskinoglu, & Bezircioglu, 2007; Ozdemir, Simsek, Ozkardes, Incesu, & Karakoc, 2008), and tend to be much higher than those (14–25%) in Western settings (e.g., Catalan, Hawton, & Day, 1990; Nobre, Pinto-Gouveia, & Gomes, 2006).

## Etiology

There is a paucity of new research on the etiology of lifelong vaginismus. Reviews of the literature highlight methodological limitations resulting in few definite, evidence-based conclusions (Reissing, Binik, & Khalifé, 1999; Lahaie, Boyer, Amsel, Khalifé, & Binik, 2010). We review the promising areas of research under the headings of somatic and psychological factors.

### Somatic Factors

Somatic causes for vaginismus are found very infrequently (> 5%) and may include hymeneal or vaginal abnormalities (Reissing, Binik, Khalifé, Cohen, & Amsel, 2004; van Lankveld et al., 2006; ter Kuile, Melles, de Groot, Tuijnman-Raasveld, & van Lankveld, 2013). Many (40–100%) women diagnosed with vaginismus also experience vulvar pain on touch (see Lahaie et al., 2010), which is typically diagnosed as provoked vestibulodynia (PVD). From a clinical perspective, we note that some women react with generalized reports of pain when *touched* in the vulvo-vaginal area. With decreased fear and pelvic floor reactivity, women with vaginismus tend to report significantly reduced pain. This clinical impression needs to be confirmed by systematic research.

Resulting from the lack of supporting evidence, DSM-5 and ICD-11 have abandoned vaginal spasm as the key diagnostic criterion for vaginismus. However, pelvic muscle tension or tightening associated with attempts of

vaginal penetration are included in the diagnostic criteria for both GPPPD and SPPD (American Psychiatric Association, 2013; World Health Organization, 2018). In practice, sufferers and their partners often report the perception that tight vaginal muscles contribute to their difficulties with vaginal penetration, tampon use, and gynecological examinations. Indeed, there is some evidence of differences in muscle tone and tension between women with vaginismus and those with dyspareunia and control participants (e.g., Lahaie et al., 2015; Reissing et al., 2004). Increased electromyographic (EMG) activity at rest and with introital touch was reported in controlled studies using needle electrodes to measure EMG activity in the pelvic muscles (Frasson et al., 2009; Gammoudi, Affes, Mellouli, Radhouane, & Dogui, 2016; Shafik & El-Sibai, 2002). However, research utilizing surface EMG measures was inconsistent in revealing significant differences in women with vaginismus compared to women with dyspareunia (e.g., Engman, Lindehammar, & Wijma, 2004). In one study using surface EMG, women showed increased muscle activity when exposed to sexually threatening films (van der Velde, Laan, & Everaerd, 2001). The researchers suggested that increased pelvic muscle tension and pelvic contractions may be a general protective mechanism in response to potential threat for all women. This generalized pelvic floor defense reaction in response to *potential* vaginal penetration may result from different behavioral coping styles (avoidance) and/or different cognitive processing styles regarding vaginal penetration (Klaassen & ter Kuile, 2009).

## Psychological Factors

A number of psychological and partner factors (e.g., childhood sexual abuse, relationship adjustment, partner sexual dysfunction, negative sexual attitudes, lack of sexual education) have often been discussed as potential causes of vaginismus; there is, however, no consistent empirical support for these (Lahaie et al., 2010; Reissing et al., 1999). Non-Western clinical researchers and clinicians highlight that a woman's need to guard her virginity, lack of sexual information and inexperience, under-or over familiarity with the partner, family pressures regarding consummation of marriage, and importance of fertility, may play a significant role in the reported high prevalence of vaginismus in traditional and religiously conservative societies (e.g., Lema, 2014; Muammar et al., 2015; Ramzy, 2018; Yasan & Gürgen, 2009; Zgueb, Ouali, Achour, Jomli, & Nacef, 2019).

In Western clinical practice and in survey studies, women with vaginismus reported a range of causal beliefs for vaginismus, including beliefs of genital incompatibility; fears of pain, injury, or loss of control; fear of intimacy; and disgust concerning sexual organs, sounds, and secretions (e.g., Borg, Peters, Weijmar Schultz, & de Jong, 2012; Klaassen & ter Kuile, 2009; Lahaie et al., 2015; Reissing, 2012; van Overveld et al., 2013). The most common of these causal beliefs is the *fear* of experiencing pain with vaginal penetration. In fact, over a century ago, Walthard (1909) suggested that

vaginismus is a phobic reaction to an excessive fear of pain. More recently, Reissing et al. (2004) demonstrated that women with vaginismus, undergoing gynecological and physical therapy examinations, displayed significantly more defensive and avoidant behaviors than matched controls of women with dyspareunia/PVD and no pain. These findings were supported by Lahaie et al. (2015), who found that fear, measured via self-report, physiological, and behavioral indicators, was significantly higher in women suffering from vaginismus compared to women with dyspareunia/PVD and no pain. Furthermore, Klaassen and ter Kuile (2009) found that women with vaginismus report more negative appraisals of vaginal penetration (e.g., catastrophizing pain) than women with dyspareunia and controls. These findings suggest that women with vaginismus are more fearful of vaginal penetration and are more likely to use avoidant coping strategies in response to their specific fears regarding vaginal penetration (Lahaie et al., 2015; Reissing et al., 2004). On the basis of these findings concerning fear, we developed the fear-avoidance model of vaginismus (FAM-V), which has motivated much of our work (see Figure 9.1).

In addition to fear, disgust has been suggested as a relevant emotional factor in the etiology and maintenance of vaginismus. From an evolutionary point of view, disgust is hypothesized to be a defensive reaction serving to protect the body from contamination with pathogens. In women suffering from vaginismus, such reactions may be triggered in anticipation of penetration (de Jong, van Overveld, Weijmar Schultz, Peters, & Buwalda, 2009). Indeed, women with vaginismus report more disgust associated with sexual activity in general (van Overveld et al., 2013; Cherner & Reissing, 2013b), and when watching sexually explicit film excerpts (Cherner & Reissing, 2013a). When exposed to sexual stimuli eliciting disgust, women with vaginismus reacted

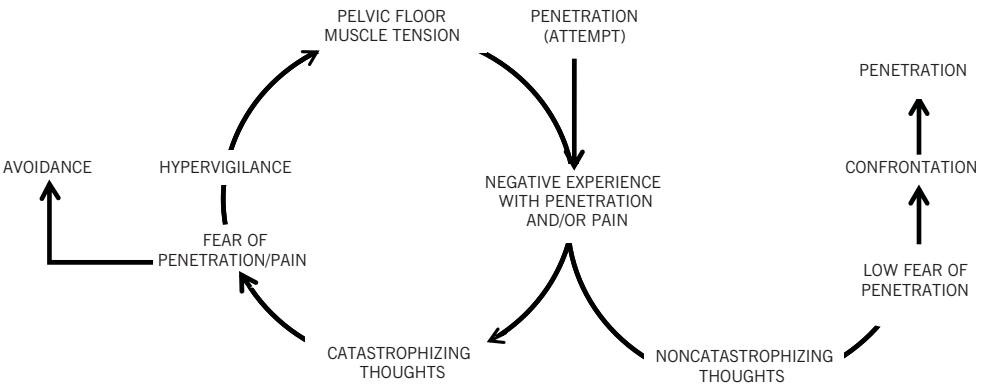


**FIGURE 9.1.** The fear-avoidance model of vaginismus (FAM-V; Reissing, 2009; ter Kuile, Both, & van Lankveld, 2010; based on Vlaeyen & Linton, 2000).

with increased levator ani muscle activity, a unique physiological expression of disgust (Borg, de Jong, & Weijmar Schultz, 2010). It is not clear whether disgust is specific for women with high levels of penetration fear or whether disgust is independent of specific fears (see Borg, Both, ter Kuile, & de Jong, Chapter 10, this volume).

In an attempt to further understand the etiology of vaginismus, separate studies exposed women suffering from vaginismus and control participants to pictures or film excerpts related to erotic vaginal penetration and other sexual activities (e.g., oral sex). The dependent variables in these studies were responses on laboratory reaction time tests (Melles et al., 2014; Melles, Dewitte, ter Kuile, Peters, & de Jong, 2016), genital sexual arousal measured by thermography (Cherner & Reissing, 2013a), and brain responses measured via functional magnetic resonance imaging (Borg et al., 2014). Each of these responses is assumed to reflect a relatively automatic response to sexual stimuli not strongly affected by cognitive appraisal. Overall, the results from these studies showed no differences between women with vaginismus and controls, which suggests that relatively reflexive responses to sexual stimuli in women suffering from vaginismus are intact, but that those subject to cognitive appraisal and processing are negatively affected. What differentiates women suffering from vaginismus is an avoidance-based, maladaptive coping strategy that exacerbates negative appraisals of vaginal penetration resulting in fear and further negative appraisal. This conceptualization is consistent with our FAM-V (see Figure 9.1) and suggests that challenging fear and avoidance, and thereby confronting and disconfirming negative appraisals, is essential in resolving vaginismus.

## The Fear–Avoidance Model of Vaginismus

In response to the existing etiological literature on lifelong vaginismus, the circular FAM-V has been proposed (Reissing, 2009; ter Kuile, Both, & van Lankveld, 2010). Based on the fear avoidance model for chronic pain (Vlaeyen & Linton, 2000), the basic tenet of the model is that negative beliefs and expectations regarding vaginal penetration (termed "catastrophic" thinking) give rise to specific vaginal penetration-related fears (pain, injury, etc.). To cope with fear, a woman with vaginismus avoids attempts at penetration and experiences temporary relief. However, she also experiences negative reinforcement of her fears after successful avoidance. When the woman attempts intercourse again, she is likely to be hypervigilant to stimuli that are related to her specific "catastrophic" thinking (e.g., genital incompatibility, loss of control). Hypervigilance likely results in exaggerated attention to physical sensations and increased anxiety in turn facilitating the experience of pain during attempted vaginal penetration. These attempts result in, or exacerbate, defensive pelvic muscle contractions. Increased muscle tone, along with lack of sexual arousal and lubrication, result in further pain. The inability to

"achieve" penetration in turn contributes to negative experiences, confirming negative expectations, thereby further exacerbating and perpetuating the vicious cycle of vaginismus.

Vaginismus, as conceptualized by the FAM-V, may be similar to a specific phobia. As with the treatment of phobias, exposure to the feared object or situation is essential in overcoming the fear. The goals for treatment in vaginismus are to reduce catastrophizing thoughts and beliefs, to promote a decrease in avoidance, and to increase positive experiences with vaginal penetration via direct confrontation with and disconfirmation of penetration-related fears. The FAM-V is a heuristic model derived from the best available empirical evidence. The model explains the cycle of avoidance in women with vaginismus and forms the theoretical rationale underlying our approach to the assessment and treatment of vaginismus.

## Assessment and Diagnostic Issues

### Physical Evaluation

Consultation with a gynecologist is advisable to rule out hymeneal and vaginal pathology. This may not always be possible because of fear and avoidance of such examinations. Ideally, therapists should seek collegial alliances with gynecologists who are willing to carry out an educational pelvic examination (EPE; Huber, Pukall, Boyer, Reissing, & Chamberlain, 2009), to prevent distress. During an EPE, the gynecologist transfers a sense of control to the patient and engages in dialogue aimed at explaining the steps of the examination and having the patient be an active participant (e.g., following the examination with a handheld mirror; Domar, 1986). The examination typically includes inspection of the external genitalia, including the introitus, vulvar vestibule, and proximal part of the vagina. This usually provides sufficient information about the existence of coitus-obstructing somatic factors. Digital palpation and speculum insertion should generally be avoided, since they usually cause unnecessary distress. Women are also instructed to tense and relax their pelvic floor muscles, which prepares them for exposure sessions during which these instructions will be repeated. Women who are unable to successfully follow these instructions may need additional training in advance of treatment. In our experience, almost all women, if adequately prepared, can complete such an examination. For many, a successful EPE is reassuring, eliminates fears about physical pathology, and represents an important first treatment step.

> Julie's physical examination was limited to a visual inspection of her external genitalia, and no pathology was noted. She was quite anxious in anticipation of this examination but was put at ease by the clear explanation of the process of the EPE. She could contract and release her pelvic floor muscle tension on instruction.

## Psychological Evaluation

Psychological concerns need to be assessed prior to treatment. Although there is no evidence from the research literature that women with vaginismus demonstrate reduced psychological adjustment (e.g., Lahaie et al., 2010; van Lankveld et al., 2010), problems such as untreated trauma, affective disorders, significant couple conflict, or a partner's sexual problem can interfere with treatment in general and exposure therapy in particular. A brief, structured interview and the use of standard self-report questionnaires can be very useful in determining when exposure should be postponed to address primary psychological or relational concerns.

> No mental health concerns were noted during Julie's interview, and she reported no sexual abuse.

Specific to exposure treatment, a number of particular domains should be assessed before the start of exposure sessions, including treatment motivation, catastrophizing cognitions, avoidance/hypervigilance, pelvic muscle reactivity, and vasovagal syncope (dizziness and fainting).

### *Treatment Motivation*

Treatment motivation is a particularly important issue to consider when assessing couples. Overcoming vaginismus can be exceedingly challenging, because, as explained by the FAM-V, avoidance of intercourse is reinforced by a temporary relief of symptoms. Potential collusion to maintain the status quo is common and needs to be countered with a significant commitment to therapy. It can be very helpful to use the FAM-V to explain, normalize, and anticipate discomfort with treatment as the partners confront their prior avoidance and examine previous treatment failures (if relevant). Anticipation and expectation of difficult moments in treatment help couples work through them when they inevitably occur.

A common motivation to seek treatment is the desire to conceive a child. It is important to determine whether this represents the primary motivation for treatment, and if this is the case, information about artificial insemination at home or referral to a fertility clinic may be useful. If conception by insemination is successful, women suffering from vaginismus are sometimes concerned about childbirth. There is a limited body of research on obstetric outcomes in women with vaginismus, but there is some evidence to suggest that women with vaginismus request and receive cesarean section more frequently than others (Goldsmith, Levy, & Sheiner, 2009; Moller, Josefsson, Bladh, Lilliecreutz, & Sydsjo, 2015; Nieminen, Stephansson, & Ryding, 2009; Peleg, Curelaru, Geva, Warsof, & Shachar, 2018). In women with vaginismus, the presence and degree of fear of childbirth and whether treatment may reduce cesarean section requests remains to be investigated (Moller et

al., 2015). Our clinical experience is that obstetricians and midwives familiar with vaginismus can sufficiently reduce the fear of these women during the birthing process and mitigate the perceived need for cesarean section.

> Julie and Peter both reported a strong desire to conceive but wished to do so through intercourse. Nonetheless, it was not easy for Julie to pursue treatment. Like most other women with vaginismus, Julie had never been able to have an internal pelvic exam and had avoided using tampons. For as long as she could remember, Julie reported having had a vague sense that intercourse was not possible for her, because she believed that there was a physical obstruction (in her vagina) and that her vagina was too small for penetration. Her family physician attempted to address the supposed physical obstruction by referring her to a pelvic floor physical therapist. Exceedingly high levels of fear, however, interfered with this treatment, and Julie did not follow up on vaginal insertion exercises for fear of injuring her vagina. Peter was not prepared to insist that Julia practice the exercises, as he too was uncertain about potential physical factors interfering with penetration. In addition, he had felt a tightening of Julia's vaginal muscles on their few attempts at penetration and was very concerned about hurting or injuring her. A previous consultation with another sex therapist assisted the couple in connecting sexually with nonpenetrative sexual activities but did not increase their motivation for vaginal insertion exercises.

### Catastrophizing Cognitions and Penetration-Related Fears

The psychological assessment focuses substantively on the explanation and personalization of the FAM-V, outlining specifically how the woman's catastrophizing cognitions result in specific, penetration-related fears. Common penetration-related fears are that penetration is impossible because of a small vagina or pathology resulting in excessive pain with vaginal penetration. While some fears and beliefs can be readily identified and discussed, the Vaginal Penetration Cognition Questionnaire (VPCQ; Klaassen & ter Kuile, 2009) can be helpful in assessing further vaginal penetration cognitions.

> Julie initially indicated that she desired nothing more than being able to experience intercourse, but her inability to insert a tampon led her to believe that her vagina could not possibly accommodate a penis; this further reinforced her fear that intercourse would be impossible or very painful.

### Avoidance and Hypervigilance

The avoidance of vaginal penetration eliminates the possibility of confronting and disconfirming catastrophic cognitions about vaginal penetration. The occasional attempt at intercourse made by a woman suffering from vaginismus

typically results in significant fear and hypervigilance to possible pain sensations; this confirms and reinforces the existing catastrophic cognitions concerning penetration. This vicious cycle of avoidance and hypervigilance is very difficult to break, especially when a concerned partner is understandably reluctant to persist in attempts at intercourse.

> Julie's husband colluded with her in avoiding intercourse. He shared her fears about physical pathology resulting from vaginal penetration and did not wish to cause her severe distress. They did not avoid sexual intimacy, but they explicitly agreed that vaginal penetration would not be attempted.

### Marked Tensing or Tightening of the Pelvic Floor Muscles

Pelvic muscle reactivity is an important component in the assessment of vaginismus, as illustrated in the FAM-V. Such reactivity may make attempts at penetration painful and often impossible. It is not clear whether women with vaginismus are able to provide reliable information concerning the presence or severity of their pelvic floor muscle tone and/or reactivity. Gynecologists, physiotherapists, or partners may be able to observe reactive pelvic muscles. Therapists can question their patients about micturition and/or defecation problems, which can be indicative of more chronic and severe tonicity (e.g., urinary frequency, urgency, incomplete emptying, constipation, pain during or after bowel movements). Some women may benefit from a formal assessment by a pelvic floor physical therapist. Therapists may be able to help their patients increase proprioception and accuracy of self-assessment of the pelvic floor by instructing them on how to practice contraction–release exercises. One treatment report using the exposure paradigm but emphasizing pelvic muscle release and desensitization suggested that, for some women, a referral for pelvic floor physical therapy could be beneficial (Perez, Brown, & Binik, 2016).

> Peter had observed muscle tensing with attempted vaginal penetration, and Julie indeed displayed an elevated degree of pelvic reactivity during the EPE, but she reported no micturition or defecation problems. She had had some contact with a pelvic floor physiotherapist in the past and was instructed to remember pelvic relaxation exercises that she might find helpful during exposure exercises.

### Vasovagal Syncope

Most women with vaginismus respond with increased autonomic arousal upon exposure to the feared penetration stimulus; in addition, our clinical experience suggests that approximately 5–10% respond with vasovagal syncope (Barlow, 2002, p. 415). This consists of a diphasic response in which heart rate and blood pressure increase briefly, then suddenly drop, with the

effect that the individual becomes dizzy and possibly faints. In our clinical experience, patients who respond to attempted penetration with vasovagal syncope typically have a history of fainting upon exposure to other feared stimuli such as blood, injections, or fear of injury. Briefly verifying such experiences is useful in the development of the treatment plan.

> Julie recalled experiencing fainting spells when exposed to blood and injections. She was very afraid that she would faint during the gynecological examination and indeed, she reported heightened feelings of dizziness.

## Approaches to Treatment

### Medically and Physiologically Focused Treatments

Although medical etiologies are rarely identified (e.g., Lahaie et al., 2010), different medical treatments have been used to address vaginismus. These include surgical interventions to remove the hymen or to enlarge the introitus, injections of botulinum toxin (Pacik & Geletta, 2017), application of topical anesthetic creams, and the use of anxiolytic medication. Positive outcome reports, however, are limited to case studies and clinical reports (Maseroli et al., 2018). Women with vaginismus may be referred for pelvic floor physiotherapy as a stand-alone treatment or as part of a multidisciplinary approach to treatment (Perez et al., 2016; Reissing, Armstrong, & Allen, 2013). In a recent controlled Iranian study, researchers compared botulinum toxin injections and 12 sessions physiotherapy with a strong educational component (Yaraghi et al., 2019). They concluded that physiotherapy was superior to injections in improving sexual function and successful intercourse, with 93% of patients reporting intercourse compared to 66% with botulinum injections.

### Psychological Treatments

There is a long history of uncontrolled treatment reports concerning vaginismus (Maseroli et al., 2018; Melnick, Hawton, & McGuire, 2012). The majority of the treatments include anxiety-reduction techniques in combination with gradual exposure to vaginal penetration. Other interventions include cognitive restructuring, sex education, and sensate focus couple exercises. In a recent meta-analysis, Maseroli et al. (2018) concluded that psychological treatments, regardless of intervention focus, can be considered effective but cautioned against publication bias and weak methodologies.

The first randomized controlled trial (RCT) for vaginismus investigated 117 women with lifelong vaginismus assigned to cognitive-behavioral therapy (CBT) either in group or bibliotherapy format, or to a wait-list control group (van Lankveld et al., 2006). The duration of treatment and wait-list period was 3 months. Treatment included sexual education, relaxation exercises, gradual exposure to vaginal penetration using dilators or fingers, cognitive

therapy to challenge catastrophizing beliefs (e.g., "My vagina is too small"; "The pain will be unbearable"; or "I am afraid to lose control"), and sensate focus exercises. Eighteen percent of the treated participants had successfully attempted intercourse, compared with none in the wait-list group. This modest treatment outcome was confirmed recently by an RCT of an online treatment protocol for women with acquired and "lifelong inability to experience intercourse" (Zarski, Berking, Fackiner, Rosenau, & Ebert, 2017). The intervention incorporated comparable ingredients as the CBT intervention of van Lankveld et al. (2006): psychoeducation, relaxation, cognitive restructuring, body exposure, sensate focus, and gradual exposure to and preparation for intercourse. While 34% of participants in the active intervention group experienced intercourse at the end of treatment, 21% of the women in the wait-list control group also reported intercourse. Neither of these treatment studies produced improvement in subjective reports of sexual functioning of the women or their partners (van Lankveld et al., 2006; Zarski et al., 2017). Successful treatment outcome for participants in the 2006 RCT (van Lankveld et al., 2006) was partly mediated by a reduction of "fear of coitus" and avoidance behaviors (ter Kuile et al., 2007). Consequently, it was hypothesized that the effectiveness of treatment could be enhanced by focusing more explicitly and systematically on exposure to the stimuli that are feared. In the second half of this chapter, we focus on the development of a therapist-aided exposure treatment.

### *In Vivo Exposure*

Based on the FAM-V and our earlier treatment experiences (ter Kuile et al., 2007), a prolonged, therapist-aided exposure treatment was developed (ter Kuile et al., 2009). Exposure sessions involved a maximum of three 2-hour sessions per week that were carried out in the hospital by the patient who performed vaginal penetration exercises (own fingers, graduated dilators, tampon), facilitated by a female therapist, and followed up with exercises at home. Of the 10 participants, nine reported intercourse following treatment, and, for five participants, intercourse was possible within the first week of treatment. Exposure was successful in decreasing fear, and negative penetration beliefs and treatment gains were maintained at 1-year follow-up. These results were replicated in a multicenter, wait-list RCT including 70 women with lifelong vaginismus (ter Kuile et al., 2013). Following treatment, 89% of the participants were able to experience intercourse and reported decreases in negative penetration beliefs and sexual distress. For most (90%), intercourse was possible within the first 2 weeks of treatment after an average of 2.5 hours of exposure at the hospital. Treatment outcome (coital frequency, symptoms of vaginismus, and coital pain) at 12 weeks was mediated by changes in negative and positive penetration beliefs at 6 weeks, in particular by more pronounced reduction of catastrophic pain penetration beliefs (ter Kuile et al., 2015). As the large reduction of negative penetration beliefs and avoidance behaviors only occurred as a consequence of the exposure treatment, we may conclude

that exposure treatment *disconfirmed* the negative penetration beliefs, which supports the FAM-V.

Success in the ability to experience intercourse does not necessarily result in desire for and pleasure with sexual activity in general or with intercourse in particular (e.g., Cherner & Reissing, 2013a). Nonetheless, in the ter Kuile et al. (2013) study, two-thirds of the women could be characterized as being within the normal range of sexual functioning at the end of treatment. In addition, all couples who were able to experience intercourse at the 3-month follow-up were offered three sessions of sex therapy aimed at increasing overall sexual function and pleasure. More than 40% chose additional sex therapy. Nevertheless, at the 1-year follow-up, there were no indications that the additional sessions of sex therapy affected treatment outcome (e.g., intercourse frequency, sexual distress, or overall sexual functioning as measured with the Female Sexual Function Index).

In summary, therapist-aided exposure therapy for vaginismus is a promising and highly successful approach. This success supports our previously suggested conceptualization of vaginismus as a penetration phobia. Treatment is comparable to treatment of specific phobias, with considerable treatment success using *in vivo* exposure to feared objects and situations (e.g., Barlow, 2002). Therapist-aided exposure results in fewer avoidance behaviors and greater reduction of fear compared to treatment with less therapist involvement. A critical component of exposure is that the duration of the session has to be long enough (2–3 hours) to disconfirm a priori catastrophic expectations and to consolidate such learning (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). Massed, *in vivo* exposure (i.e., over several consecutive days) is more effective for fear reduction than spaced exposure (i.e., one weekly session). Exposure in a variety of locations and situations (e.g., different positions, locations, with and without partner, with and without sexual arousal) to a variety of stimuli (one's own or the partner's fingers, dilators, tampon, penis) can reduce the rate of relapse. Furthermore, evidence from the treatment literature for specific phobias suggests that including the partner can improve outcome (e.g., Barlow, 2002).

### WHO SHOULD OR CAN BE THE THERAPIST FOR *IN VIVO* EXPOSURE?

In most countries, it has been a medical professional such as a physician, nurse, or pelvic floor physiotherapist who can conduct vulvo-vaginal examinations. In this tradition, our therapist-aided exposure was initially carried out by physicians with special training in sexology, even though the therapist never touched the women's genitals. As a result of reformulating vaginismus as a penetration phobia, we began to believe that psychologists who are trained in the basic principles of exposure therapy may be better equipped than medical professionals to execute anxiety-focused interventions. After 2 years of discussion regarding the ethical implications, psychologists were permitted to conduct this type of treatment without the presence of medical

personnel. Today, this practice is standard in The Netherlands and is, in fact, the recommended treatment for lifelong vaginismus (Dutch Society for General Practitioners, 2015). We hope that psychologists in other countries will initiate such discussions and that they, too, will be able to carry out our therapist-aided exposure treatment. One example of successful dissemination/implementation of this exposure treatment for vaginismus is found in the United States. Following a multiyear collaboration with the Dutch team, a university-based medical center in Northern California is implementing this exposure treatment in a research clinic setting in which team members are gathering data on patient safety; patient preferences for treatments; and patient perceptions of the value, utility, and acceptability of exposure therapy. At this point, the Dutch team is still involved, providing supervision and consultation. These efforts were coordinated with local, regional, and national psychological associations for ethical oversight, and are expected to result in this treatment being offered as routine clinical care by psychologists within the next year.

### *IN VIVO* THERAPIST-AIDED OR HOME-BASED EXPOSURE

*In vivo* exposure for vaginismus can be therapist-aided or only home-based exposure. Therapist-aided exposure has a number of advantages over home-based exposure. The initial exposure session takes place in a professional setting with a knowledgeable therapist, increasing the woman's feelings of reassurance. The role of the therapist is to guide the woman (and her partner) through the difficulty of approaching the penetration-related fears, to manage the associated intense fear, and to encourage nonavoidance. The therapist can assist patients to identify and verbalize catastrophic thoughts and to address them directly. In addition, the therapist may help the patient to practice in challenging situations (e.g., how to manage increasing pain sensations, a panic attack, or irrational fears of a finger or tampon remaining "caught" in the vagina).

While exposure at the hospital is preferable, if it is not possible, then home-based treatment is feasible. The FAM-V needs to be carefully explained, and it is important to highlight the essential role of confronting avoidance, managing anticipatory anxiety, and practicing massed exposure. The therapist should empower and facilitate the partner so that he can lend support during the exposure/insertion exercises and prevent avoidance. During home exercises, insertion is carried out by the woman and her partner usually for three to four sessions a week for a minimum of 30 minutes. Prolonged exposure sessions are only carried out under the supervision of a therapist in the hospital. The partner becomes involved in the insertion exercises in a stepwise manner (i.e., from more passive to more active). The last insertion exercise during (home-based and therapist-aided) practice should be "successful"; for example, if the last part of the exercise with three fingers was unsuccessful, then return to practice with two fingers to end "successfully."

Home-based exposure should be closely followed by a therapist to discuss treatment challenges and answer any questions. Our clinical experience is that the home-based exposure is much easier for a couple (and the therapist) and has better results when it is preceded by a therapist-aided exposure session at the hospital. The couple knows what to expect during the home exposure exercises and how to cope with difficult practice situations.

## Case Discussion

It was recommended that Julie and Peter start with therapist-aided exposure treatment, because they were very fearful about possible physical pathology resulting from vaginal penetration. This treatment is emotionally intense, and homework assignments are time-consuming; therefore, we generally recommend that couples take time off from work in the week following the first exposure session. In our experience, practicing relaxation exercises prior to *in vivo* exposure does not contribute to treatment process and outcome; therefore, these were not included in the treatment. During the therapist-aided session, however, relaxation and/or breathing instruction can be suggested by the therapist (for the treatment manual, see ter Kuile et al., 2009, 2013).

Prior to the first exposure session, Julie and Peter attended an information session that covered the following topics: (1) the rationale of exposure treatment for vaginismus (using the FAM-V); (2) information on what to expect during exposure therapy; (3) the nature and frequency of homework exercises; (4) Peter's participation at the hospital and his active involvement in the exercises at home; and (5) the development of a hierarchy of fear- and tension-eliciting vaginal penetration stimuli to use during exposure (tampon; finger[s]; and at home, penis with and without movement).

Julie was still fearful of injuring herself with vaginal insertion and believed that her vagina was too small for intercourse. Although, she felt reassured by the gynecologist that she could go ahead with treatment, her most feared exposure exercise was insertion of the larger size dilator. The goal of the exposure sessions at the hospital was for Julie to insert a dilator or fingers slightly larger than the circumference of the erect penis of her partner.

### The Therapist-Aided Exposure Session

A brief conversation at the beginning of the exposure session indicated that, as expected, both partners were very nervous. We asked both partners the following question: "What are you most worried will happen during the exposure session? On a scale 0–100%, how likely does this seem?" Julie's worst worry at an 80% probability was that she would injure herself and it would be very painful. Peter agreed at a 70% probability.

It had been established in the assessment that Julie was at risk for vasovagal syncope; therefore, she was asked to drink two glasses of water before

the session to prevent loss of blood pressure. She was also instructed to briefly stop the exercises and tense the muscles of her body if she felt dizzy. Care was also taken to arrange the gynecological examination chair or table in a manner that did not interfere with the exercises and prevented falling in the case of fainting. We started with Julie sitting in a chair in a more horizontal position.

The therapist stood beside the chair. Julie, Peter, and the therapist were able to see the vaginal penetration exercises by means of a handheld mirror. Julie began by touching her vulva with her fingers and spreading her labia minora. As expected, she felt increasingly dizzy when touching (and seeing) her vulva and vaginal entrance. The therapist instructed her to use applied tension. Within a couple of minutes, she was able to compensate for the decrease in blood pressure and continue the exercises. She was very relieved that she had mastered this step and subsequently proceeded with the gradual insertion of one finger using lubricant. Julie was inclined to withdraw her hand immediately whenever she had unpleasant feelings or sensations. She was very afraid that these sensations would get increasingly worse and eventually become very painful. Rather than avoiding these feelings, she was encouraged by the therapist to "test her expectation" by holding her finger still and describing sensations and feelings she was experiencing. The unpleasant sensations did not increase; it disappeared within a few seconds. The experience of increasing anxiety, being able to tolerate the feelings, and the subsequent decrease in sensations and anxiety was described by Julie as "surprising" and increased her confidence that she would be able to handle more exposure exercises.

She was encouraged to move her finger gently in and out, which she experienced without much anxiety. As a result, the chair was moved back to the original position, allowing for practice in different positions. One hour after the start of the session, Julie was able to insert two fingers. She was surprised by her progress in disconfirming her penetration-related fear that vaginal penetration was impossible and painful. She experienced some pain when she moved her fingers, but the pain subsided when she focused on a gentle downbearing pressure in her pelvic area. She did not feel a physical obstruction, and her fear of injuring herself was disconfirmed very quickly. Next, she practiced the same steps in squatting, sitting, and standing positions, first with her finger, then with different-size dilators. She experienced a precipitous rise in anxiety and intense desire to terminate the session when inserting the third dilator. She was encouraged to focus on the sensations she felt, to describe her sensations, and to stay still and practice relaxation with slow diaphragmatic breathing. Negative sensations subsided gradually, and Julie felt significant joy and pride at her success in sustaining and reducing heightened anxiety. After 2 hours of practice, she was able to insert three of her fingers (about 10-cm circumference), followed by a 12-cm circumference vaginal dilator, achieving her goal for the exposure session. To conclude, she practiced with a lubricated tampon, which she was able to insert without problems.

During the postexposure conversation, Julie stated that she was extremely relieved and very satisfied with the results she had achieved. She was asked,

"Did what you were most worried about occur?" She answered, "No, not at all." The therapist then asked, "How do you know?" Julie described the experience of unpleasant feelings and sensations disappearing gradually if she did not stop the exercise. She noted that trying to relax her body while also experiencing a good degree of apprehension was the most important step to prove to herself that she was able to overcome vaginismus. Persisting in efforts to insert a finger after initial feeling of dizziness was definite proof to her that there was no vaginal obstruction, and that she could accommodate penetration. Julie was then asked to indicate what she had learned, and she described how the experience of vaginal penetration with very little pain was a direct disconfirmation her fears. When asked the same question, Peter noted that he felt reassured learning that vaginal penetration was possible for Julie without pain and injury, and he felt empowered to assist his wife actively in home exercises.

The couple went home with instructions to repeat the same exercises the same day, using plenty of lubricant. Progressive steps for Peter during homework exercises included (1) inserting his fingers (one, two, or three); (2) touching the entrance to Julie's vagina with his erect penis without penetration; (3) inserting his erect penis without thrusting; and (4) inserting his penis with thrusting.

### Following the Therapist-Aided Exposure *In Vivo* Session

Julie and Peter had an appointment at the outpatient clinic 2 days later, during which they reported that practicing at home had gone well. Peter could easily insert two fingers, but inserting three was more difficult. His penis could be inserted halfway, but he still felt fearful of hurting Julie. The therapist and the couple concluded that no further exposure sessions at the hospital were necessary while daily home exercises continued. During the third appointment, 4 days later, the couple reported that intercourse was possible and painless.

Julie's menstruation had started 1 day after the final appointment, and when she tried to insert a tampon, she experienced heightened anxiety and nearly fainted. Peter stayed calm, reminded Julie to practice the applied tension exercise to manage her dizziness, and suggested that she insert the tampon while lying on her back. She followed these steps for a couple of days, and every day tampon insertion became easier. Managing and overcoming this challenge was an important step for Julie and Peter, and increased their confidence that, working together, they had the necessary tools to handle any future challenges.

During the 6- and 12-week consultations, Julie and Peter reported that sexual intercourse was still possible but not pleasant. Sexual arousal experienced during foreplay decreased as soon as penetration was attempted. Three additional monthly sessions over a period of 3 months were planned, focusing on the maintenance of sexual arousal during penetration. Julie chose to practice alone initially by allowing arousal to build with clitoral stimulation, then by inserting a finger or a small vibrator. During the third consultation,

Julie recounted that she was able to move the vibrator intravaginally and to facilitate orgasm. The couple encountered more difficulty when practicing together. Julie appeared to be hypervigilant to unexpected movement from her husband, which prompted a decrease in arousal. They believed, however, that they could progress further without additional therapist sessions. During a final appointment a year following treatment, Julie and Peter were satisfied with their sex life, stating that sexual intercourse was arousing and pleasant for both if they used the woman-superior position. Other positions still elicited a decline in sexual arousal. Nevertheless, they stated that they were very satisfied with the results achieved and looking forward to eventually conceiving a baby. As a result, treatment was concluded.

## Conclusions

In this chapter, we have summarized research and clinical intervention for women with lifelong vaginismus. We presented the FAM-V, which has motivated our work. This model and our treatment research and experience suggest that lifelong vaginismus may be quite similar to a specific phobia, in this case, a phobia of vaginal penetration. Our data strongly suggest that focusing treatment on the reduction of fear and avoidance behaviors using *in vivo* exposure will result in a significant decrease in negative penetration beliefs and fears, which in turn will result in successful intercourse for nearly all women with lifelong vaginismus. Despite, the success of *in vivo* exposure in allowing women suffering from vaginismus to experience intercourse, this treatment does necessarily not make penetration pleasurable. Future research is needed to investigate which additional treatment interventions may be helpful to improve overall sexual function and pleasure.

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# CHAPTER 10

# Sexual Aversion

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A critical feature of sexual aversion, according to the authors of this chapter, is that "sex is experienced as *inherently* disgusting." While historically classified as a sexual desire disorder, present diagnostic nosology has subsumed sexual aversion into the category of genito-pelvic pain/penetration disorder (DSM-5), or a sexual pain/penetration disorder, or a phobia (ICD-11). However, Borg, Both, ter Kuile, and de Jong make a strong case in Chapter 10 that the decision to eliminate a separate diagnosis of sexual aversion was misguided, observing: "When individuals who are disgusted by sex are nonetheless forced to engage in it, this may give rise to fear and pain, but this does not imply that such individuals can best be categorized as suffering from a phobia or from GPPPD." They point out that because of the universality of the emotion of disgust, there are strong theoretical reasons to believe that this emotion can interfere with sexual function. They support this contention through case histories and empirical studies. They point out that sexual aversion disorder may not only exist as a separate disorder but in fact, may also be a primary underlying issue for many individuals suffering from reduced desire and arousal or vaginismus. Unfortunately, there are no systematic treatment studies for sexual aversion, but clinical experience and theory suggest that prolonged and hierarchical exposure is an important first treatment step.

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Aimee had never touched or even looked at her own genitals, which she considered dirty. Despite being in a long-term and committed sexual relationship, she was disgusted by French kissing, insisted on using condoms for intercourse, and wiped away any remaining ejaculate immediately after being intimate. In time, she began to avoid sex altogether.

## Diagnostic and Clinical Description

The previous clinical vignette reflects typical symptoms of sexual aversion. Aimee is disgusted by saliva and as a result is reluctant to kiss her partner; she also insists that her partner engage in a "safety behavior" (i.e., wearing a condom during intercourse). Similar emotional reactions and safety behaviors are characteristic of what used to be termed "sexual aversion disorder" (SAD), a disorder that is no longer included in the DSM-5 (American Psychiatric Association, 2013). In earlier editions (DSM-III-R and DSM-IV), SAD was listed as one of the two sexual desire disorders. It was defined as "a persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a partner, which causes distress or interpersonal difficulty." It was deleted from DSM-5 because of its overlap with other anxiety disorders and the lack of research supporting its existence as a unique disorder (Brotto, 2010).

Although SAD is included in the current ICD-10 (*International Classification of Mental and Behavioural Disorders*; World Health Organization, 1992), it will not be listed as a separate diagnosis in the ICD-11 (Reed et al.,

2016). Symptoms of sexual aversion could be classified in ICD-11 as a sexual pain/penetration disorder or specific phobia, or in DSM-5 as genito-pelvic pain/penetration disorder (GPPPD), or specific phobia (Reed et al., 2016). In our view, this classification ignores a critical feature of sexual aversion (i.e., sex is experienced as *inherently* disgusting). When individuals who are disgusted by sex are nonetheless forced to engage in it, this may give rise to fear and pain, but this does not imply that such individuals can best be categorized as suffering from a phobia or GPPPD (cf. Borg, de Jong, & Elgersma, 2014; Borg, Bosman, Engelhard, Olatunji, & de Jong, 2016). In fact, available epidemiological evidence suggests that symptoms of sexual aversion are very common and should therefore be reconsidered for inclusion in future classifications.

## Epidemiology

Thus far, three Dutch language studies have been published on the prevalence of sexual aversion. In one Internet study ($N$ = 4,147), 30% of women reported experiencing symptoms of sexual aversion at some point in their lives, but only 4% met DSM-IV criteria for SAD (Bakker & Vanwezenbeek, 2006). A more recent population-based (ages 15–71) questionnaire study ($N$ = 8,000) suggested a comparable prevalence for women (4.5%) but also reported that 2.4% of men experience persistent symptoms of sexual aversion (Kedde, 2012). An unpublished patient file study of all the women ($N$ = 4,533) attending the sexology department of Leiden Hospital Medical Center from 1996 to 2015 suggests that 2.8% of these women received a DSM-IV-TR diagnosis of SAD as their primary problem. Together, these studies suggest that the symptoms of sexual aversion may be quite prevalent, and that the diagnosis of SAD may be as prevalent as that for vaginismus (Kedde, 2012).

Why there has not been any epidemiological research outside of The Netherlands is not clear, but there is no reason to believe that the prevalence of sexual aversion would be very different in other Western countries. We are aware of one unpublished report based on the files of 8,042 women attending the Vivian Hospital for Sexual Health in Jaipur, India, which suggests a 6.2% prevalence of SAD (J. Saatish, personal communication, October 17, 2018). This higher prevalence in India may reflect the notion that sex is more likely to be considered disgusting or bad in India, after women feel that their "family has been completed" and they do not plan to have more children.

## Disgust and Sexual Aversion

In the last decade, there has been an increased interest in the emotion of disgust (de Jong & Borg, 2015) as a relevant factor affecting sexual function

(Borg & de Jong, 2012) and dysfunction (e.g., Borg, de Jong, & Weijmar Schultz, 2010; Borg et al., 2014). *Disgust* is defined as "something revolting, primarily in relation to the sense of taste, as actually perceived or vividly imagined; and secondarily to anything which causes a similar feeling, through the sense of smell, touch, and even of eyesight" (Darwin, 1872/1985, p. 250). By eliciting inhibitory tendencies and defensive reflexes, or by actively motivating avoidance, disgust is thought to protect us from contamination by nonvisible but potent pathogens (Curtis, de Barra, & Aunger, 2011; Oaten, Stevenson, & Case, 2009). Supporting the view that disgust might serve to protect against disease, it has been found that disgust responsivity (see the section on assessment and diagnostic issues) is heightened in people with low immune status (Fessler, Eng, & Navarette, 2005). For instance, disgust propensity (i.e., the likelihood to experience, and to respond with disgust) was found to be relatively high during the first trimester of pregnancy when mother and fetus are most vulnerable to infectious disease (Fessler et al., 2005). Because sexual behaviors imply significant pathogen exposure, sexual stimuli and behaviors seem to be obvious candidates for eliciting disgust. In line with this, it has been shown that sexual by-products (e.g., saliva, sperm) can be strong elicitors of disgust (Stevenson, Case, & Oaten, 2011). Clearly disgust-induced avoidance may help prevent exposure to an infectious disease. However, such avoidance also interferes with the competing goal of procreation. It thus seems that in sexually mature individuals, other sexual stimuli acquire the potency to elicit sexual excitation and approach. These stimuli are those that indicate reproductive fitness (*signaling sexual stimuli*; e.g., breasts, lips, broad shoulders).

Recent research indicates that sexual stimuli and behaviors (e.g., kissing) elicit disgust and avoidance in prepubertal children, in contrast to sexually mature pubertal adolescents (Borg, Hinzmann, Heitman, & de Jong, 2019). Most people seem to "unlearn" this default disgust response, because sexuality serves the even more important evolutionary function of procreation. During adolescence, with its hormonal changes that increase sexual arousability, sexual stimuli begin to evoke sexual excitation and pleasure that compete with and ultimately overcome the disgust that was originally elicited. It is possible that excitement allows the kissing to occur, and if this kissing is rewarding, people may gradually acquire sexual–reward associations with kissing (and other behaviors) that may result in competing kiss/saliva–disgust and kiss–reward associations.

So it seems that there are stimuli involved in sexual behaviors that serve sexual excitement and ultimately procreation (e.g., petting, breasts, lips), whereas other stimuli inherent to intimate behaviors are more likely to elicit disgust (e.g., saliva, vaginal fluid, semen). Nevertheless, as a result of associative learning, even the initially disgusting stimuli might transform to sexually exciting stimuli, which in turn reduce the perceived disgusting properties of sexual behaviors. In addition, disgust itself also declines due to repeated

exposure (Kort et al., 2014). Notably, disgust- and excitement-eliciting stimuli might be concurrently present and ambiguous. Which one will predominate depends on the relative strength of the respective disgust and arousal associations.

## Pathways to Sexual Aversion

Below we outline three specific pathways that may explain why particular sex stimuli or behaviors could become aversive and be avoided.

### First Pathway

Through lack of opportunity or because of exposure to restrictive moral standards, people may have not experienced sufficient sexual reward and may therefore not acquire appetitive–sex associations that can overcome the disgust-eliciting properties of intimate behaviors (see discussion below). In this regard, it is important to emphasize that disgust may not only be elicited by potential contaminants that threaten the integrity of the individual, but may also be the result of social–moral transgressions that may be seen as threats to the integrity of the individuals' social network. This more ideational type of disgust may also be elicited by sexual behaviors that seem to violate important and deeply ingrained social–moral beliefs (Borg, de Jong, & Weijmar Schultz, 2011). Crenshaw (1985), in her seminal article, wrote that patients presenting with primary aversion often were raised in strict religious and moral environments and perhaps had limited exposure to sexual stimuli. Possibly the aversions were developed before the individual experienced partnered sexual activity and before the signaling sexual stimuli could acquire an attractive association (Janata & Kingsberg, 2005).

### Second Pathway

Negative or traumatic experiences such as rape, sexual abuse, or sexual misuse may lead to aversive associations with sex, feelings or thoughts of having been contaminated, and self-repugnance. Such experiences might color the appreciation of sexual stimuli more generally through evaluative conditioning (i.e., a change in the valence of a stimulus that is due to the prior pairings of that stimulus with another stimulus; De Houwer, 2007). This negative valence to sexual stimuli, which are then perceived as "bad" or "disgusting," would motivate avoidance, which in turn precludes corrective and possibly positive experiences relating to sexuality, thereby helping to maintain the persistent negative valence to sexual stimuli. Following a traumatic experience, sexual stimuli may also activate memories of the dreadful event. This may motivate avoidance of intimate behaviors as a means to prevent the triggering of these traumatic memories (de Jong & Borg, 2019).

### Third Pathway

Due to alterations in one's own or one's partner's body, actual or imagined physical contact may elicit aversion and/or self-disgust. Body alterations (e.g., mastectomy, colostomy bag) can lead to feelings that one is no longer deserving of sexual pleasure and not an appropriate sexual partner. Aversion may also be experienced if the appearance of the partner changes significantly, for example due to an illness (de Jong & Borg, 2015).

## Assessment and Diagnostic Issues

### Specificity and Character of Sexual Aversion

Given the paucity of research on sexual aversion, there are no established assessment protocols specific to this problem. We therefore base our proposals on how assessment is carried out for other disgust-related psychopathologies, such as contamination-based obsessive–compulsive disorder, and some specific phobias (e.g., spiders).

Essentially, the clinician needs to find out whether there is an aversion to or avoidance of sex and whether this aversion or avoidance is a cause for personal distress or interpersonal difficulty. The assessment of sexual aversion should identify whether the aversion is the main problem of concern or whether it is comorbid with another psychopathology, such as a specific penetration phobia, low sexual arousal disorder, or posttraumatic stress disorder (PTSD).

An important task for the clinician is to determine whether the aversion is generalized (e.g., sexuality and intimacy in general, including cuddling), or to specific stimuli (e.g., saliva, genitals). It is important to ask about the emotions (disgust, fear, shame) that are elicited by the different provoking stimuli and activities, and whether the patient can differentiate between these emotions.

The clinician also needs to determine whether the aversion is lifelong or acquired. This can provide insight into what has changed and what may be the cause of the aversion. It is also relevant to distinguish between not wanting sex due to low sexual interest/arousal and feelings of disgust. For example, when the presenting reason for seeking help is loss of sexual desire, it is important to clarify whether past sexual contact was pleasurable or, on the contrary, it elicited mostly negative feelings, and whether these feelings are best characterized by experiencing sex as inherently disgusting or as creating fear of concrete future threats (see "Treatment").

### Predicted Catastrophe, Associations, and Avoidance

Another assessment task for the clinician is to understand the expected outcome of particular sexual behaviors and in what way these anticipated outcomes are aversive. For example, one may avoid sex because of the anticipation

of uncontrollable physical contact with specific disgusting stimuli ("Having sex is just dirty"), or because it may elicit "moral disgust" and is felt as doing something wrong (i.e., "Sex is animal-like and bad to indulge in"). In both cases, the clinician should build with the patient a hierarchy of the most aversive and avoided stimuli or behaviors.

Avoidance that is a characteristic expression of aversion can range from complete avoidance of all sexual stimuli (physical sensations, fantasies) to engaging partially in sexual situations, and even dissociation. It is useful to assess what exactly is avoided and why. Partial engagement with certain stimuli could signify safety behavior, in order to prevent feelings of aversion. While such behavior might momentarily decrease the levels of disgust and allow some sexual engagement, it will preclude prolonged direct physical contact and thus hinder "real" exposure and habituation (Frank, Noyon, Höfling, & Heidenreich, 2010; Borg et al., 2011).

## Vulnerability, Maintaining Factors, and Comorbidity

The vulnerability of an individual (e.g., excitability levels, disgust propensity, history of child abuse, negative experiences or traumatic events, moral standards/proneness, and sexual beliefs) for responding to sexual stimuli with disgust should be carefully assessed. Disgust propensity can be measured by a questionnaire that has been used primarily for research but is appropriate for use as part of the assessment. This disgust propensity trait measure is called the Disgust Propensity and Sensitivity Scale (van Overveld, de Jong, Peters, Cavanagh, & Davey, 2006). It is context independent and contains items such as "Disgusting things make my stomach turn." Furthermore, to specifically measure the disgust response to sex-related stimuli, items from the Sexual Disgust Questionnaire (van Overveld et al., 2013) may also be used. This questionnaire contains items such as "To what extent would you be disgusted when you use a towel for your face after it has been used to wipe off sperm from your partner?"

With regard to specific examples to learn about disgust propensity, one can also probe whether the patient has specific cleansing behaviors (e.g., rubbing the skin to remove the hypothetical dirt, or women who never touch their vaginas during washing) that give insights into the relevance of disgust-based concerns. If the clinician asks directly about disgust, he or she might not get the true feelings, because individuals often use different kinds of avoidance strategies to prevent the experience of disgust. Furthermore, feelings of disgust may only become evident when a person is asked what he or she would experience if unable to avoid particular sexual behaviors and/or when he or she would have to give up safety behaviors such as extensive cleaning.

In identifying the maintaining features of the expressed aversion, the clinician needs to identify to what extent various factors in a person's current life situation, such as quality of the relationship, might have contributed to the sexual aversion (e.g., the realization that his or her partner has been having

an affair for many years). There may also be comorbidity of partner sexual problems (e.g., premature ejaculation, sexual arousal disorders, erectile dysfunction), as well as the presence of other psychiatric disorders, such as obsessive–compulsive disorder (OCD) or PTSD, that should also be investigated. Treatment of psychopathologies such as OCD or PTSD should be given priority (e.g., Jung & Steil, 2013).

The assessment of disgust may also be difficult because of the embarrassment possibly experienced by the patient in discussing sensitive issues about his or her partner. A patient may be reluctant, with good reason, to disclose feelings of disgust related to his or her partner's body (e.g., a surgical incision or a prosthetic breast). Therefore, it can be helpful to include some individual sessions in the assessment process.

## Treatment

The treatment literature on sexual aversion consists of case reports (Kaplan & Klein, 1987) that focus on dealing with avoidance by using various interventions (e.g., desensitization, sensate focus, drug treatment). Similar treatment interventions are also mentioned by Janata and Kingsberg (2005), who also emphasize the relevance of cognitive-behavioral therapy to deal with the abhorrence and disgust that characterizes SAD. However, there is no empirical research on the effect of these approaches. The relatively new disgust-based treatment literature (Meunier & Tolin, 2009) provides important suggestions for the treatment of sexual aversion. In general, the aim of these interventions is to reduce the aversion experienced in reaction to sexual stimuli and thus break the avoidance cycle.

Disgust seems to be a "sticky" or perseverant emotion that is more resistant to extinction than other emotions, such as fear. One possible explanation for this stickiness is to the nature of the threat occasioned by disgust. Stimuli that are inherently disgusting do not habituate easily, and this habituation takes longer than that for emotions like fear (de Jong, van Overveld, & Borg, 2013). Exposure tasks should therefore be designed in such a way that they provide prolonged physical contact with the disgust-eliciting cues (e.g., touching vaginal fluid, feeling its texture) or prolonged involvement in disgust-eliciting behavior (e.g., touching the genitals), allowing the automatic disgust responses to subside (Bosman, Borg, & de Jong, 2016). Based on the available literature and theory, the treatment of sexual aversion is based on the following types of interventions.

### Exposure

Based on a disgust hierarchy identified in the assessment, the patient is exposed *in vivo* to the stimuli from least to most disgusting, with the goal of promoting habituation. During treatment sessions, the exposure exercises

are prepared in detail, but almost all the *in vivo* exposure is home-based, with the partner acting as cotherapist. In order to target dysfunctional catastrophic coping concerns, one needs to encourage the client to come into direct contact with his or her aversive stimuli. For example, in case of aversion toward semen, the patient would need to look, smell, touch, and feel the semen, as well as discuss and rate his or her reactions. People may have low self-efficacy expectations (e.g., "I cannot stand touching vaginal fluids") that may fuel avoidance and escape responses. These can be addressed by using exposure exercises that are designed to elicit expectation-violating experiences, by providing the opportunity to learn that, in fact, he or she is well able to withstand prolonged touching of vaginal fluid. Habituation is crucial for persistent change of disgust; thus, it is relevant to continue exposure until emotional reactions are strongly reduced, and to continue with exposure exercises until the target stimuli no longer automatically elicit the strong urge to avoid them. It is important that the patient refrain from even subtle safety behaviors such as distraction during exposure, because such behaviors can interfere with habituation.

### Counterconditioning

Associating the aversive sex stimulus with something pleasant that the person enjoys can build a positive feeling toward sex. Counterconditioning may be applied by combining exposure exercises with pleasant (e.g., candles, wine) or sexually exciting stimuli. This learning may facilitate a pleasant emotional reaction and, over many repetitions, the patient may eventually learn to respond more neutrally or even in a positive manner to the previously considered aversive and avoided stimuli. It is important, however, to attempt counterconditioning only when the positive stimuli are more potent than the negative ones in order to prevent reverse counterconditioning. This may be difficult to assess when the sexual stimuli are highly aversive, but strategies developed from the spider phobia literature may be useful in this regard. In this context, de Jong, Vorage, and van den Hout (2000) first reduced the phobic fear via exposure, and the counterconditioning procedure only started when people were able to handle the spider without excessive fear.

### Emotion Regulation

Conceptual reorientation as an emotion regulation strategy can also be beneficial in challenging the impact of disgust (Rozin & Fallon, 1987). This refers to a cognitive switch or reframing in the conceptualization and understanding of objects previously perceived as aversive. This can be done, for example, by providing information on the anatomy and function of the genitals, the purpose of sperm and vaginal fluid, designed to change attitudes from negative ("ugly wrinkled dark-colored vulva," "disgusting fishy smelly slime") to more positive ones ("intriguing, sophisticated, complex organ," "natural fluid

assisting pleasurable and comfortable penetration") (de Jong et al., 2013). In the same thinking, imagery restructuring (Arntz, 2012) can be used to transform mental images of aversive sexual stimuli (i.e., from a "disgusting piece of wrinkled pink skin" to a "fresh flower bud"). A recent study we conducted suggests that written instructions are useful emotion regulation interventions to increase levels of sexual arousal and decrease levels of disgust (Pawlowska, Faur, Borg, & de Jong, 2019).

## Case Discussion

Aimee, a 30-year-old sales manager, has been unable to have intercourse for the last 3 years because of pain during attempted penetration. In addition, she reports a lack of sexual interest. Aimee has lived with Marc, a 32-year-old a technician, for 12 years and they have no children. Aimee reports that in the first years of their relationship, sex was not problematic, although she could not remember experiencing much pleasure. During this period, she was responsive to Marc's initiation of sex, occasionally experienced sexual arousal and possibly a few orgasms, but she never initiated sex on her own. During intercourse, Aimee and Marc always used a condom, in addition to Aimee's use of oral contraceptives. According to Aimee, this is because she feared becoming pregnant when she did not feel ready for it. After about 3 years, she experienced an increasing decline in sexual interest, and over time vaginal penetration became more painful. Sexual contact was limited to coitus, and when coitus was no longer possible because of pain, sex was no longer part of their relationship.

Both Aimee and Marc were healthy and used no medication, but Aimee reported being sensitive to stress and less relaxed than Marc. Physical examination by the gynecologist did not show any pathology. Self-report questionnaires did not show psychological concerns, and there was no history of sexual or physical abuse for either partner.

Aimee and Marc were very committed to each other and when ready, they planned to have children through intercourse. As a result, they consulted a sex therapist, who diagnosed GPPPD with comorbid sexual interest/arousal problems. The couple agreed to start therapy with sensate focus, pelvic floor relaxation, and individual genital exploration exercises. Soon, it became apparent that Aimee struggled with feelings of aversion during these exercises. For example, looking at her genitals to learn about the effect of contracting and relaxing her pelvic floor was very difficult for her to do. Aimee had never looked at or touched her genitals, which she considered a dirty part of her body that should be kept hidden. These negative thoughts and feelings were discussed, and the rationale for stepwise exposure exercises to help her reduce these feelings was explained. It was agreed that Aimee would first work on this individually.

As a first step, Aimee started to wash her genitals with her bare hands

instead of using a washing glove. In subsequent steps, she managed to look at her genitals with a mirror and to touch them. She recognized that, as a child, she had learned that "that thing" was dirty and that self-touching was wrong. She started reading a book on female sexuality, and through this information, her ideas about her genitals became more positive. She learned to challenge her fixed negative beliefs and to make use of more helpful thoughts. Repeated "observation" of her vulva and touching (prolonged contact, until the disgust weakened) in combination with using more helpful thoughts resulted in a decrease of her negative feelings.

After 3 months of individual sessions, Marc rejoined the therapy, and they continued with nongenital sensate focus exercises. Although it took effort, especially for Aimee to find time for the exercises, and to relax and concentrate during touching, both started to enjoy the exercises. When Marc carefully initiated kissing during touching, Aimee reacted negatively, especially when he tried to kiss her using his tongue. Aimee expressed feelings of disgust for Marc's saliva, mixed with the fear that kissing would make touching more sexual and stimulate expectations of intercourse. By making explicit agreements on the boundaries to be kept during these exercises, and by providing Aimee with a level of control in stepwise intimate kissing (i.e., first without tongue, then with a little tongue for a brief time, and then increasing both the amount of tongue and time), she was able to overcome her tendency to avoid kissing.

When they agreed to also start caressing their genital areas during the sensate focus exercises, touching Marc's penis elicited mixed emotions in Aimee. She was happy to give him pleasure, but she also felt disgust toward his penis, and especially toward sperm. To prevent contact with sperm, she stopped caressing Marc's penis when he became very excited, allowing him to self-stimulate to orgasm. The couple also agreed to avoid contact with ejaculate by covering Marc's belly with toilet paper before he reached orgasm. After orgasm, he would immediately wrap up the paper and go for a shower to prevent any ejaculate from getting on the sheets; if this happened, the sheets were to be changed. They both lamented that this was not a nice ending to being sexually intimate, and they agreed to use an extra sheet over the bed, to use a towel to remove sperm after ejaculation, and to hold each other for some time before they went to the bathroom.

Aimee and Marc also read a sex education book to learn about different kinds of sexual stimulation. This phase of therapy focused on communication. They were encouraged to share with each other what they liked or disliked, and what they did not know yet but would like to try. A familiar pattern was that Aimee reacted with irritation and avoidance when Marc tried something that was outside her comfort zone. New sexual activities, such as Marc caressing Aimee's vulva and clitoris more extensively to find out what was pleasurable and what could be sexually exciting for her, elicited a mix of fear and shame in Aimee. In the past, Marc would immediately stop when he noticed any negative feelings or avoidance. They realized that this pattern

resulted in avoidance of any new sexual stimulation that could bring more sexual pleasure. They circumvented this avoidance by using stepwise vulvar stimulation, during which Aimee tried to attend to what felt pleasurable and communicate it to Marc. Also, they read information on the character and function of vaginal fluid and sperm, which helped Aimee to see these bodily fluids, as more natural and functional.

Aimee then worked on pelvic floor relaxation and stepwise penetration exercises with her fingers and dilators to overcome her fear of penetration pain. This was extended with stepwise penetration exercises with Marc's finger and later with his penis. Initially, Aimee wanted to do this with a condom because of her fear of unplanned pregnancy, but she began to realize that her insistence on using a condom was also because she still felt an aversion to sperm. This was discussed and it was decided that they would start the exercises with a condom and later on practice without one. For Aimee, the pain gradually diminished, and she was ultimately able to have intercourse with a condom, and later without.

When therapy was completed after 18 sessions spanning over one and a half years, Aimee was open to sexual contact and to having intercourse. Aimee still did not want to experiment with oral sex, because she considered it too dirty, even though she realized that it might be pleasurable. However, as Aimee formulated it, sex was still not her greatest "hobby." She felt more desire for Marc and felt that sex could be pleasurable even if this was not always the case. Aimee probably experienced orgasms; however, these were not "intense" or frequent. Both Marc and Aimee were satisfied with the outcome; she was happy with having "a complete marriage" including sex, and Marc was pleased with resuming sex and finding Aimee less avoidant.

This case history is quite typical in our experience with sexual aversion. We believe that the roots of Aimee's aversion lie in her sexually restrictive upbringing. The interventions we describe are not part of a standard protocol for the treatment of sexual aversion, since this does not yet exist. Nonetheless, our therapy does reflect a theory and experience-informed approach.

## Conclusions

Based on our review of the literature and our clinical experience, we believe that SAD should be reintroduced to DSM and ICD classifications. Like most other sexual dysfunctions, SAD can occur by itself or be comorbid with other problems. In line with the information presented in this chapter, the signaling features of SAD are an explicit aversion or strong dislike, expressed as avoidance of sex and sexual stimuli. Alternatively, SAD can be concealed behind the expression of fear or anxiety at the prospect of coming into contact with the aversive, disgust-eliciting stimuli. Prolonged (hierarchical) exposure to the disgust-eliciting stimuli and avoided behaviors is currently the most obvious first step in treating the debilitating effects of sexual aversion.

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# PART II

# Therapeutic Challenges for Sex Therapy

SECTION A

# SEXUAL LIMITS AND BOUNDARIES

## CHAPTER 11

# The Privileging of Pleasure

## *Sex Therapy in Global Cultural Context*

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Chapter 11 considers the disparate sociocultural factors at play in both the genesis and treatment of sexual problems. Taking a global perspective, Hall and Graham note that "cultural norms and values necessarily act to constrain certain sexual behaviors, while promoting others." They also importantly comment on the role of gender, observing that "cultural and societal pressures act more strongly to inhibit the expression, if not the experience, of female sexuality." After reviewing the growing body of literature on sexual problems cross-culturally, the authors offer their cultural–developmental pathway (CDP) model to help understand how culture influences sexual interests, behaviors, and problems. Noting that other therapies have made modifications to account for cultural variations, Hall and Graham outline a culturally sensitive sex therapy model in which sex therapy itself is viewed as a culture and the therapy as a process of acculturation. Adding gender considerations to the equation, the authors of this chapter suggest that in traditional and patriarchal cultures approaching female sexual pleasure from the perspective of its enhancing effect on male pleasure may have the best chance for success and acceptance.

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Cultural diversity presents an opportunity and a challenge for sex therapists. Adhering to the biopsychosocial model, clinicians and researchers inevitably consider the biological, psychological, and sociocultural factors that contribute to the genesis or maintenance of sexual problems, and that must be addressed for treatment to be successful. While a great deal of attention has been paid to the biological and psychological factors that contribute to sexual dysfunction, only recently has the contribution of disparate sociocultural factors been considered. The sex therapy literature offers little, if any, guidance on how to therapeutically address cultural messages that interfere with sexual functioning and sexual pleasure. We have only rudimentary knowledge about how to work with people from divergent sociocultural backgrounds.

To understand how we are still in the beginning stages of cultural competence, it is important to know that sex therapy and research were developed in the West (North America and Western Europe) with research participants and sex therapy patients who were most often from Western cultural backgrounds themselves. The influence of culture has been mostly consigned to understanding the "sex-negative" messages of a restrictive Western societal boogeyman. These messages included the notion that masturbation is an activity in which only sexually frustrated people engage, that (women's) genitals are unclean, that men have stronger sex drives than women, that women want emotional closeness when they want sex, and that monogamy is the ideal. Some of these cultural messages have receded in importance over time, while others persist. In response to these *sex-negative* messages, sex therapy espoused its own cultural views, including the importance of accurate sex education and open and honest communication, the imperative of consent (ideally accompanied by desire), and the focus on sexual pleasure and satisfaction for the sexual participants. In many ways, we in the sex therapy community thought we had largely vanquished the negative cultural taboos. The proliferation of self-help books spoke to the North American value of sexual pleasure: *The Guide*

*to Getting It On: Unzipped* (Joannides, 2017); *Reclaiming Your Sexual Self* (Hall, 2004); *Becoming Cliterate* (Mintz, 2018); *Come as You Are* (Nagoski, 2015); and *She Comes First* (Kerner, 2010) represent just some of the titles on the shelves of virtual and "brick and mortar" bookstores. On the Internet, one can see demonstrations of female sexual pleasure on websites such as OMGYES (*www.omgyes.com*) and photographs of the variety of vulvas on the website Gynodiversity (*http://gynodiversity.com*). And yet, time passes and culture is not static. In what has been called the "Orgasm Gap," and lately has been broadened to be termed the "Everything Gap" (Herbenick, 2019), even in Western society, heterosexual men are having more pleasurable sex than are their female partners.

In this chapter we review the literature regarding culture and sexual dysfunction, and outline a model for how culture impacts the manifestation of sexual difficulties. We also describe a treatment approach in which there is a reciprocal interaction between two cultures: the culture of sex therapy and the cultural context of the patient(s), resulting in changes on both sides of the proverbial couch. We focus on gender in a cultural context and argue that improving the experience of female sexual pleasure will be the key to successful resolution of many sexual complaints in both men and women.[1]

## Culture

"Culture" can be broadly defined as the constructed and shared values of a group that are passed from one generation to the next. Culture is best understood as a dynamic force, as it is constantly being renegotiated and thus changing (Causadias, Vitriol, & Atkin, 2018). Culture functions on several levels, from the macro level of the broader cultural group (often delineated by nationalities or ethnicities) to the micro level of neighborhoods and families. Sexual values and attitudes are transmitted and translated at these various levels; for example, the government may enact laws regarding marriage, legislate the prohibition of certain sexual acts, and define age of consent; media depict who and what is sexually appealing; while schools, churches, and community groups provide moral direction and education. It is often in the immediate or extended family that these messages are synthesized into daily life (Agocha, Asencio, & Decena, 2014).

Traditional cultures, as described in this chapter, are those that embrace sexually conservative (often religious) values. Such cultures restrict access to sex education (except perhaps for abstinence-only or faith-based curricula), emphasize the importance of virginity (more for women, but often also for men), restrict sex to marriage, privilege male sexual pleasure, and value duty

[1]This chapter is limited to a discussion of the experience of cisgendered men and women, as the complexity inherent in the cultural experiences of sexual and gender minorities is beyond its scope.

over individual fulfillment. The status of women in traditional cultures is substantially lower than men's, reducing women's ability to make important life decisions on a daily basis (e.g., when and how to have sex) or for the longer term (exercising the option of working outside the home, making reproductive choices). In traditional cultures, sexual values are significantly different than those upon which sex therapy was based. Consent to marry is often given not by the bride (or groom) but by a parent or representative of the family, often implying that there is no further need to gain consent for sexual activity, as it is a husband's prerogative and a wife's duty. In many traditional cultures, female sexuality is considered dangerous and in need of control. Therefore, it is not socially acceptable for a woman to advocate for her own sexual pleasure, to demonstrate a knowledge of sex, and/or to question her husband (Hall & Graham, 2012).

It is important to understand that one's culture is a core aspect of identity: *It's who I am*. It is not easy for anyone to reject or violate cherished cultural norms, as in many ways this is a repudiation of one's self. The social and familial consequences of cultural transgressions can also be severe and may involve ostracism, exclusion, and isolation. In religious groups, if transgressions are apparent (divorce, cohabitation, homosexual sexuality), one could be denied the right to participate in important religious ceremonies and rites (e.g., Catholic communion, baptisms); in extreme cases, violating religious rules regarding sex may result in excommunication.

*Ethnicity* and *culture* are terms often used synonymously. While *race* refers to physical, genetic, and biological distinctions, culture and ethnicity are socially determined, with ethnicity referring more broadly to individuals who share cultural values *and* a common ancestry, history, geographic region, nation, or language (e.g., Han Chinese, Armenians, Midwesterners in the United States). For the sake of consistency, we use the term *culture* to more specifically denote individuals who share values and related social, familial, and personal practices. We caution that individuals should not be stereotyped by a unidimensional view of their cultural (ethnic) identity, but rather be seen to "embody and experience cultural hybridity and complexity" (Kirmayer & Ryder, 2016, p. 143). This is most apparent in pluralistic societies in which cultural diversity is obvious. However, even in relatively closed communities, such as the Orthodox Jewish community described below, there are multiple cultural influences at play.

> Ruth was raised in an Orthodox Jewish household, in an Orthodox community on the East coast of the United States. She was raised to believe that pleasing her parents was paramount. When it came time to choose a husband, Ruth consented to marriage with a man of whom her parents approved. She was not sexually attracted to him, but she did not understand the importance of attraction in choosing a mate. She had no sex education other than the advice she received from a bride counselor on the eve of her wedding, instructing her on the religious strictures regarding sexual behavior. Sex on the wedding night and for years after was

unpleasant, unwanted, and obligatory but consensual. Ruth became aware from her exposure to mainstream American media, as well as the conversations she overheard between other women in her community, that sex was supposed to be something that she should desire and enjoy. Because she did not, she felt there must be something wrong with her, a thought that upset her greatly. Her husband became concerned about Ruth's increasing anxiety related to sex and was also concerned because his own pleasure was thus diminished. Many years after her marriage, Ruth presented for therapy with the request for help "to enjoy sex more."

Although it might not be readily apparent from this vignette, it is important to clarify that culture and religion are also not synonymous and the importance of religion in cultural identification varies. Different cultural groups interpret and adhere to religious teachings differently. Indeed, even families translate religious beliefs in their own style.

Ruth's husband had been raised in the same cultural and religious community as Ruth, but his immediate family translated the cultural value of marriage and sexuality differently. Ruth learned the value of duty over individual pleasure, whereas her husband saw sexual pleasure as a way to strengthen the marital bond, add harmony to the family, and fulfill the religious duty to procreate. Sex was joked about and hinted at in his family as they celebrated marriages, pregnancies, and births. Sex was never discussed in Ruth's family. Her husband's requests for sexual intimacy and pleasure baffled Ruth and also made her feel inadequate and therefore anxious.

Ruth's story also demonstrates another important dimension of understanding cultural impacts: Cultural values often differ across genders in terms of the restrictions placed on sexual behaviors and the (in)tolerance and consequence of transgressions (Hall, 2019).

Ruth's husband was aware that sex was supposed to be pleasurable, an understanding that may have been conveyed clearly to the males in their cultural group and more obliquely or not at all to the females. This difference may also have resulted from an interaction between Ruth's gender and her family's approach to sexuality, as Orthodox tradition does emphasize the value of female sexual pleasure within marriage. Ruth's early experiences of sexual pleasure during masturbation worried her and left her feeling confused, guilty, and anxious lest her feelings be discovered. Her husband's early experiences of his own sexual interests delighted him and left him in excited anticipation of marriage.

Interpretations of the biopsychosocial model of sexuality not only fail to adequately consider the importance of gender differences but also to fully acknowledge the influence of sociopolitical factors, particularly as regards the

status of women in many parts of the world (Hall, 2019). We discuss this issue later in the chapter.

## Sexual Dysfunction in Cultural Context

The precise nature and prevalence of sexual dysfunction cross-culturally is difficult to assess. Studies use different methods of sampling, assessing, and defining sexual problems, making cross-cultural comparisons problematic. Culture is often delineated by national boundaries in the research literature, but nationhood may or may not reflect unique or distinct cultural groups. Furthermore, many, if not all, of the studies reviewed for this chapter were published in the English language, thus further obscuring a more comprehensive evaluation of cultural variations in sexual difficulties. Nevertheless, despite these methodological shortcomings, cultural disparities in sexual values, beliefs, and practices, as well as differences in the high prevalence of Western-defined sexual dysfunctions are well documented (Atallah et al., 2016; Heineman, Atallah, & Rosenbaum, 2016; McCabe et al., 2016).

### Male Sexual Dysfunction in Global Context

Premature ejaculation (PE) and erectile dysfunction (ED) are prevalent concerns of men worldwide, with midlife estimates ranging from 15 to 40% for ED and 8 to 30% for PE (McCabe et al., 2016). However, while PE and ED are considered the most common male sexual dysfunctions worldwide, a closer examination reveals cultural variations. Concerns related to semen loss are actually more prevalent than Western-defined male sexual dysfunctions in many parts of the world, especially in Southeast Asia. In a community sample of 894 men in rural India, over three times as many men were concerned about a defect in semen (64.4%) as compared to those who were concerned about loss of libido (21%) (Singh et al., 2018). Similar levels of concern regarding semen loss were evident in a clinical sample of 364 men presenting to an outpatient dermatology clinic for sexual concerns. Among the unmarried men, 28% met the criteria for Dhat syndrome, while another 28% were concerned more specifically about experiencing nocturnal emissions. Over two-thirds of the patients (68.7%) reported significant distress regarding their complaints, and many of these patients had been to numerous doctors regarding their sexual problems (Banerjee & Roy, 2018). Dhat syndrome, characterized by *excessive preoccupation* concerning physical ailments and weakness as a result of semen loss, has long been regarded as a culture-bound syndrome. However, its high prevalence in not only Asia but also the Middle East and other countries around the world calls that classification into question (Arafat, 2017).

Distress is a necessary condition for the diagnosis of sexual problems according to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013); however, the

distress associated with specific sexual problems may or may not be similar cross-culturally. PE is one of the most common sexual dysfunctions in many Asian countries. Concerns about shortened pleasure for themselves and/or their partner or shame and anxiety about performance or fertility may be disproportionately and differentially experienced by men in different cultures. For example, men suffering from PE in the West are distressed about their inability to control the timing of their ejaculation and worry about their partner's perception (if not her pleasure), whereas men in the Middle East are primarily distressed because of their foreshortened pleasure (McMahon, Lee, Park, & Adaikan, 2012). Dhat syndrome is distressing to unmarried men most often because of the need to be sexually functional and virile once married (Banerjee & Roy, 2018). Indeed, in traditional societies, there is intense pressure on men to perform sexually on their wedding night with an unfamiliar bride and a waiting audience, despite having little, if any, sex education and previous sexual experience. The term "handkerchief stress" has been coined for this anxiety, as the men are often expected to produce a bloodstained cloth (handkerchief) as proof of their sexual ability, as well as confirmation of the bride's chastity (Hall & Graham, 2012).

## Female Sexual Dysfunction in Global Context

The global prevalence of female sexual dysfunction is quite high, with estimates of the percentage of women endorsing one or more sexual complaints between 2000 and 2014 (excluding distress criteria) continuing to hover around 40% (McCool-Myers, Theurich, Zuelke, Knuettel, & Apfelbacher, 2018). An even higher percentage was evident from results of the third National Survey of Sexual Attitudes and Lifestyles [NATSAL-3]), based on interviews conducted during the years 2010 to 2012, of 15,162 individuals ages 16–74 years living in Britain. Over half (51.2%) of the 6,777 women respondents reported at least one problem with sexual function lasting 3 months or longer in the previous year. This figure reduces to 10.9% of women reporting distress about their sexual functioning (Mitchell et al., 2013).

Low sexual desire is the most frequent complaint that brings women to seek treatment in North America (Brotto & Velten, 2020), indicating that this condition also causes significant distress for a proportion of women (Mitchell et al., 2016). When standardized measures such as the Female Sexual Function Index (FSFI; Rosen et al., 2000) are used, orgasm and arousal/lubrication problems are the most frequently reported sexual dysfunctions of women in India, Iran, Nigeria, and China (Atallah et al., 2016). For example, in a study of 149 women attending an outpatient clinic in India, using a Tamil translation of the FSFI, a high percentage of women reported sexual difficulties: lack of desire (77.2%), arousal problems (91.3%), lubrication difficulties (96.6%), orgasm difficulties (86.6%), low sexual satisfaction (81.2%), and pain (64.4%). On follow-up questioning, many of the women stated that their problems were due to partner illness, lack of privacy, disinterest in

their husbands, relationship problems, and infidelity (Singh, Tharyan, Kekre, Singh, & Gopalakrishnan, 2009). These results highlight the effects of poverty and illness, as well as the cultural devaluing of privacy, relationship quality, and fidelity on sexual behavior.

In an interview study in Nigeria (Fajewonyomi, Orji, & Adeyemo, 2007), a large proportion of women of reproductive age who were attending an outpatient hospital clinic reported problems with sexual functioning. Of the 384 women interviewed, 63% reported at least one sexual dysfunction, with anorgasmia (63.6%) and dyspareunia (22.7%) topping the list. Lack of desire (8.3%) and arousal (5.4%) were less commonly reported. The women in the study attributed their sexual difficulties to an uncaring partner (81.4%), lack of foreplay (33.1%), or competition among wives in a polygamous marriage (33.1%). The authors noted that the culture of male dominance in the local area of Nigeria in which the study was conducted makes it difficult, if not impossible, for the women to complain about sex or to get treatment for sexual difficulties. In a culture in which women cannot advocate for their sexual needs, anorgasmia during sexual activity with an uncaring partner should not be considered a female sexual dysfunction, but rather a realistic response to an unsatisfactory sexual situation.

Studies of help-seeking behavior can provide information about important or distressing sexual problems. Vaginismus, unconsummated marriage, and sexual pain are the most frequently reported female sexual problems in the traditional cultures of the Middle East and Asia. Prevalence rates are high and vary between 43 and 73% of women in Turkey and 8 and 30% of women in Iran when surveying those seeking help for these sexual problems. The high prevalence is often attributed to the premium placed on virginity in traditional cultures (Heineman et al., 2016). It is also worth noting that the high prevalence among treatment seekers is likely due to the fact that vaginismus interferes with fertility and male sexual pleasure, making these female sexual problems worthy of complaint or treatment. Clearly, more research on the prevalence and nature of the sexual issues that are important and distressing to women is needed.

The picture that emerges from a review of the literature on the global experience of sexual problems reveals a high prevalence of male sexual dysfunction related to men's anxieties about pleasure and performance. While women may also have difficulty experiencing sexual pleasure, often this difficulty is influenced by situational and relational factors. When women in traditional cultures seek treatment for sexual concerns, this is often related to problems that interfere with their partners' pleasure or their ability to procreate.

## Female Sexual Pleasure in Cultural Context

Cultural norms and values necessarily act to constrain certain sexual behaviors, while promoting others. However, cultural and societal pressures act

more strongly to inhibit the expression, if not the experience, of female sexuality (Baumeister, 2000). Holding sexually conservative values, especially a belief that women should be passive in sex, can lead to sexual dissatisfaction in women (Abdolmanafi, Nobre, Winter, Tilley, & Jahromi, 2018).

The inhibiting effect of traditional cultures on female sexual pleasure is more pronounced in countries where there is a marked gender inequality, in other words, where the macro levels of culture support and sustain a lower status for women compared to men. Such cultures not only limit women's ability to make reproductive choices, and their opportunity for equal pay and equal opportunities in education and occupation, but also restrict their opportunities for sexual expression. McCool-Myers et al. (2018) conducted a systematic review of 135 studies on the prevalence of female sexual dysfunction across 41 countries, published between 2000 and 2014. In addition to country of origin, they further delineated the studies by type of "sexual regime." The prevalence of all female sexual dysfunction was substantially higher in male-centered regimes when compared to those deemed gender equal: for desire disorders, 36 versus 24.8%; arousal problems, 39.3 versus 11%; lubrication difficulties, 37.2 versus 13.5%; problems experiencing orgasm, 31.6 versus 16.8%; and pain, 35 versus 12.1%. Risk factors for developing sexual problems were identified as poor physical and mental health, relationship dissatisfaction, sexual abuse, and religion. Protective factors were older age at marriage, a positive body image, exercise, sex education, and intimacy in communication, and daily affection.

In sexually conservative cultures, female sexuality is restricted to either marriage or, at a minimum, a committed relationship. Sexually conservative values, when combined with economic indicators of gender inequality, reinforce the necessity for women to limit their sexual experiences to the protection of a heterosexual relationship in order to be sexual without societal condemnation. A comparison of the sexual experiences of Spanish and Mexican women illustrates this point. In Mexico, where there is greater gender inequality, women limit their sexual activities to committed relationships to a greater degree than do Spanish women, despite sharing similar values (Gil-Llario, Giménez, Ballester-Arnal, Cárdenas-López, & Durán-Baca, 2017).

With increased access to different cultures as a result of travel, tourism, immigration, global media, and the Internet, there is bound to be a mixing of sexual standards, values, and practices. Expectations may be raised without any way to implement behavior change. An interview study of sexuality in Malaysian women reporting sexual dissatisfaction revealed that women initially had hopes for marital sex that mirrored the Western values of love, intimacy, and equality. While they had access to Western media that depicted such relationships, without sex education, women lacked the skills to develop such interactions, so in practice the women were more passive and conservative than they had expected or hoped to be. They felt too shy and did not know how to speak to their husbands about their sexual needs. Many of these women reverted to traditional roles and began to treat sex as a duty to be

performed within a marriage and continued to have sex without desire or arousal (Muhamad, Horey, Liamputtong, Low, & Sidi, 2018).

In a large-scale study of 770 marriages in Hong Kong, female sexual initiation and refusal were overwhelming endorsed as acceptable practices by both women and men (95–97%; Zhang & Yip, 2018). However, when asked whether this was an accepted practice in their own marriages, only 28% of couples agreed that female initiation was possible, and only 34% of couples agreed that female refusal was an option. Marital and sexual satisfaction were highest when men accepted the right of their wives to initiate or refuse sex *and* when their wives exercised this option. This study, although recently published, relied on data from 2007, which was gleaned from couples' answers to only four questions, and should therefore be interpreted with caution. However, the point is still valid that cultural acceptance of the right to initiate or refuse sex is different from the culturally sanctioned ability to be assertive about one's sexual needs and pleasure during sex.

Nonconformity to traditional gender roles in other aspects of life may make it easier for women to hold more progressive ideas regarding the importance of their own sexual pleasure. Solo sexual practices may be more amenable to change given that communication with and active participation with a male partner (for heterosexual sex) is not required. In a survey conducted in China in 2000, the vast majority of women (82–96%) ages 20–64 reported never masturbating, compared to a recent sample of 235 Chinese women ages 16–58 years, who reported not only masturbating but also masturbating with a vibrator. Of the 68.5% who used a vibrator, 44.7% reported using their vibrator at least once weekly. The Chinese women who endorsed non-gender-conforming attitudes on questionnaires were more likely to have positive attitudes toward vibrator use, which in turn predicted actual vibrator use (Jing, Lay, Weis, & Furnham, 2018).

"Acculturation," the process by which immigrants adapt from their culture of origin to their new culture, may entail conflicts, both psychologically and relationally expressed, especially when traditional and liberal values clash. In a study asking women to describe their sexual experiences, Chinese Canadian women made reference to the sexually inhibiting effects of their Chinese culture, despite the fact of being born and raised in a relatively (sexually) liberal country. In contrast to their male counterparts (none of whom made explicit reference to culture), the women felt that expression of their sexual desire would lead to social condemnation, embarrassment, and being perceived as "unladylike" (Dang, Chang, & Brotto, 2017, p. 319). While this study involved only a small sample of 20 (10 women and 10 men), it nevertheless provides an intriguing view of the pervasive effects of culture and the significant and long-term impact of the family's cultural value system on women's sexual experiences.

Although cultural pressures may act more strongly to constrain women's sexuality compared with men's, the impact of such beliefs may also diminish the pleasure men would otherwise experience. Even in traditional cultures,

sexual satisfaction for both men and women is enhanced by female sexual pleasure and agency (Hall, 2019). An awareness of this fact may eventually help make treatment of female sexual disorders more acceptable in traditional cultures by reframing the improvement of female sexual pleasure as a way to increase their male partners' enjoyment of sex. While this approach will be objectionable in the West, as it situates the value of female sexual satisfaction predominantly in the context of male pleasure, it may provide an initial pathway for the expression and experience of female pleasure in patriarchal cultures.

## The Cultural–Developmental Pathway

To date, there are few, if any, models describing the process by which culture may influence the manifestation of sexual problems. The biopsychosocial model simply offers the observation that sociocultural factors contribute to sexual problems, with little further explanation to distinguish the unique contribution of these factors as different from psychological factors that may interrupt sexual performance and pleasure. In this chapter, we offer a rudimentary model—the cultural–developmental pathway (CDP) —within the context of a larger biopsychosocial perspective to begin the discussion regarding the influence of culture on sexuality, as well as explore the treatment implications for working with people from diverse cultures.

In the CDP, culture influences sexuality via two main pathways: by shaping the sexual experiences to which we have access, and by shaping our thoughts and feelings about these experiences before, during, and after the sexual activity. If the sexual activity is that which is culturally sanctioned and pleasurable then the likelihood of reexperiencing the sexual activity and engaging in sex-related behaviors (thinking, planning, reading, and learning about sex) is greatly increased. This congruence between culturally acceptable sex and pleasure reinforces a positive connection with sex. On the other hand, pleasurable sexual activities that are not culturally sanctioned can result in shame, confusion, and avoidance.

In essence, the CDP describes a dynamic interaction between the individual and his or her culture. In this model, messages about sex are translated and synthesized through the various levels of culture by the individual, who then shapes their own cultural standard for sexuality, an individual cultural standard (ICS). Usually this means the development of a set of norms and expectations culminating in an aspirational ideal. This process is ongoing, beginning well before puberty and continuing throughout the lifespan, as messages about relationships, body types, affection, sex, and gender roles are omnipresent. In pluralistic societies, some cultural messages may contradict others, while in more homogeneous groups, the messages may be more consistent and coherent, if not rigid. How the individual interprets cultural messages, which messages are given priority, and which messages are discarded

will be a product of biology (gender, sexual orientation, sexual preferences), as well as psychology (personality traits, mood states, attachment). The ICS may be shared by others (and so reinforced) or it may be unique. Sexual experiences (including sexual thoughts, fantasies, and behaviors) are compared to the ICS, with resulting attributions about the experience and oneself as a sexual being. This process is also reciprocal and dynamic, as sexual experiences and the attributions one makes about them may impact and change the ICS. Sexual experiences may be consensual, nonconsensual (e.g., assault or abuse) or accidental (e.g., walking in on someone having sex, seeing sexually explicit images on a computer screen, experiencing nocturnal emission). Sexual responses that result from these sexual experiences will be evaluated according to the ICS with attributions about self, other, and sex resulting from the degree of fit or alignment between the response and the cultural standard. Sexual responses may include pleasure, disgust (moral or visceral), neutral feelings, and/or pain. The interaction between sexual responses and the ICS is also dynamic and reciprocal.

> Returning to the story of Ruth, we find that as a young girl she masturbated as she read romantic novels. She felt ashamed of her behavior and strove to compensate for this moral failing by being more fastidious in her daily habits and personal grooming. Her ICS was that sex and sexual pleasure occurred during marriage and were the result of the husband's efforts and knowledge. Her own sexual interests and energy were not part of this ICS, and the ideal of a passive woman being sexually awakened by a man was only reinforced by the romance novels she read. On her wedding night, Ruth was passive; her husband, who knew nothing about sex himself, was enthusiastic and erect, and quickly proceeded to have vaginal intercourse with her. The pain that Ruth felt that night and every time they had intercourse did not match her ICS. Since she had no knowledge of sex, she assumed that the sex she was having with her husband did match the standard—she was passive and he was enthusiastic and active. Apparently, the sexual activities also matched her husband's ICS. When it became obvious over the course of several years that Ruth was not enjoying sex, both Ruth and her husband assumed that she had a problem.

## Acculturation

"Acculturation" is a process of change, both cultural and psychological, that results from ongoing contact between people of different cultural backgrounds (Berry, 2006). This process occurs often in pluralistic societies such as the United States and Canada, where people from various ethnic and cultural contexts often live, work, and/or socialize together. Travel and tourism, but most obviously immigration, necessitate some form of acculturation.

Acculturation has been found to have a liberalizing effect on the sexual behavior and attitudes of immigrants from traditional cultures when assimilating or integrating into liberal host cultures (Brotto, Chik, Ryder, Gorzalka, & Seal, 2005; Darvishpour, 1999). However, more recent studies have found nuanced effects influenced by gender. In a study of Asian Americans living in the United States, American acculturation was found to be associated with greater acceptance of liberal sexual behaviors (multiple partners, aggregate number of sexual partners, engaging in casual sex, taking the initiative) predominantly for men. Retention of sexually conservative heritage (Asian) values continued to be applied to female sexuality. These results suggest that the effects of acculturation on sexual attitudes are more pronounced in their liberalizing effects for male sexual behavior, and when combined with retention of restrictive attitudes toward women's sexuality, result in a strong adherence to the double standard. Adherence to the double standard was more pronounced in Asian American men compared to Asian Amerian women (Guo, 2019).

Sam and Berry (2010) outlined four acculturation strategies (assimilation, integration, separation, and marginalization) that vary in degree of retention of heritage culture and acceptance of the host (new) culture. *Assimilation* (the wish to relinquish ties to the heritage culture and adopt the culture of the host) and *marginalization* (often enforced alienation from the heritage culture as a result of discrimination or racism, with no effort to adapt to the host culture) involve loss of the heritage culture, which often means losing family ties and support. In a meta-analysis of 79 studies examining acculturation and HIV risk behaviors of migrant populations, acculturation strategies were associated with an increased probability of engaging in risky sexual behaviors (e.g., unprotected sex, early sexual initiation, multiple partners). These effects were observed most strongly for women from traditional cultures who adopted the sexual values of their host culture. This group's sexual behavior likely changes more drastically than men's, with social consequences that further women's alienation from the heritage culture. Latinas who disregard the heritage value of sexual abstinence before marriage may find themselves without family support and guidance as they navigate their sexual relationships and may therefore be more vulnerable to engaging in unprotected sex with the sexual partners on whom they become dependent for social, economic, and relational support (Du & Li, 2015).

Clinicians need to be sensitive to the dual allegiance to heritage and mainstream culture, and to be aware that despite assimilation of some aspects of mainstream culture (clothing, occupation, language), clients may retain heritage values with respect to family and sexuality. The same may be true for first-generation clients who were raised with traditional values of the heritage culture but have greater exposure to mainstream culture.

Cultural sensitivity needs to extend to an awareness and appreciation of various patterns of adherence to the old culture and adoption of the new culture. Acculturation strategies may be used in the therapy office when a patient

from a traditional or sexually conservative culture encounters the more liberal culture of sex therapy. We return briefly to the case of Ruth.

> In therapy, Ruth came to discover her sexual attractions, interests, and ability to experience sexual pleasure. She could do this because the therapy provided a judgment-free zone for her. Ruth lamented the fact that she was not physically attracted to her husband. As Ruth processed the cultural messages that shaped her ideal of sex (her ICS), she realized that she gravitated to cultural messages about male sexual prowess and female passivity in part because of her anxiety that she would not "get it right" if she were more assertive sexually. This was in keeping with her perfectionistic tendencies in all aspects of her life. Ruth was reluctant to view any sexual resources provided by the therapist, as they were not preapproved by her rabbi, yet she did not want to include her rabbi in her therapy. However, Ruth was able to discuss and deconstruct the romantic novels she read. She was also encouraged to process cultural messages that endorsed a more assertive female sexuality. She discussed books, movies, advertisements, and the sexual messages they conveyed. Shy and perfectionistic, Ruth had great difficulty bridging the cultural divide that separated the role of a perfect Orthodox Jewish wife and mother from the identity of a sexually assertive woman. The first step was to understand her own sexual needs, and the next and more difficult task was to share this information with her husband. So, as an intermediate step, she took "instructions" home from sex therapy for her husband to follow. In this way, she was able to have their sexual interactions be more focused on her pleasure and arousal. As both of them experienced better sex as a result of her increased enjoyment, Ruth was able to gradually become more communicative with her husband about her sexual pleasure. She thus aligned her cultural values (to have pleasurable sex with her husband) with her sexual behavior (more assertive, engaging in more sexual activities to arouse her prior to intercourse).

## Assessment and Diagnostic Issues

Compared with earlier DSM versions, there are several modifications in DSM-5 (American Psychiatric Association, 2013) related to its consideration of cultural influences on sexual disorders. Importantly, DSM-5 replaced "culture-bound syndromes" with three different types of culturally related distress: *cultural syndromes* (clusters of symptoms associated with but not bound to or limited to a particular cultural group, such as Dhat syndrome); *causal explanations or attributions* (e.g., a "locked" vagina); and *cultural idioms of distress* (e.g., a nervous breakdown) (Kirmayer & Ryder, 2016).

In ICD-11 (World Health Organization, 2019), sexual dysfunctions have been moved to a chapter on conditions related to sexual health, thus

eliminating the need for the division into organic and nonorganic etiologies. Instead, there are nonexclusive etiological qualifiers, one of which is *associated with cultural factors* (e.g., culturally based inhibitions about the expression of sexual pleasure, the belief that loss of semen can lead to weakness, disease, or death) (Reed et al., 2016, p. 208).

The approach to diagnostics in ICD-11 is to describe the essential features of a disorder, ones that would most likely be seen in all cases, including those across cultures. Symptom counts and specification of duration are avoided unless empirically validated, thus allowing for cultural variations in symptom presentation (Reed et al., 2019).

It is, however, unclear how accurately sex therapists can distinguish cultural factors that might contribute to sexual dysfunction. One reason for this is the previously noted lack of clear data regarding the expression and experience of sexual problems across cultures. Another reason relates to the lack of training regarding cultural issues in diagnosis and, finally, there is evidence of a cultural (mis)attribution bias: "the tendency to see racial/ethnic minorities as members of a group whose traits, beliefs, and behaviors are shaped primarily by culture, and to perceive the White racial/ethnic majority as autonomous and independent actors who are instead largely influenced by psychological processes" (Causadias et al., 2018, p. 243). This misattribution bias perpetuates the belief that Western (White) patterns of sexual behaviors are the standard against which all others are judged. Both DSM-5 and ICD-11 attempt to circumvent such problems by adding a distress criterion to the diagnosis of a sexual dysfunction. Nevertheless, reliance on Western classification systems and assessment tools makes the misattribution bias almost inevitable. Certainly, distinguishing minority stress ("I do not meet the standard") from personal distress requires insight and awareness on the part of the diagnosing clinician.

Assessment instruments such as questionnaires and symptom checklists are typically of limited value for clinical practice. Most of the current assessment measures were developed in the West, for use with Western, English-speaking client populations. Although measures are developed and validated for use with individuals from other cultures, it is difficult to find them, if they do exist. When seeing clients from non-Western cultures, we suggest caution when using assessment measures developed in the West. It is recommended that therapists first check to see that the measure in question has been validated for use with a specific population and carefully look at clients' answers to specific items, including following up with further inquiries to ensure that the meaning of the question was clear. At present, the clinical interview is the best strategy for the detailed assessment of sexual difficulties in diverse patient populations.

DSM-5 elaborated on the cultural formulation outlined in previous editions of the manual to produce a Cultural Formulation Interview (CFI; American Psychiatric Association, 2013). The CFI is intended to supplement diagnostic protocols, with the intent to clarify the contribution of cultural factors

to patients' presenting complaints. It emphasizes four domains of assessment: Cultural Definition of the Problem; Cultural Perceptions of the Cause, Context, and Support; Cultural Factors Affecting Self-Coping and Past Help Seeking; and Cultural Factors Affecting Current Help Seeking (American Psychiatric Association, 2013). Examples of the types of questions on the CFI include the following: "People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?"; "Sometimes people have different ways of describing their problem to their family, friend, or others in their community. How would you describe your problem to them?" (American Psychiatric Association, 2013, p. 752). Follow-up questions include asking about why the patient feels the problem is happening to him or her, and inquiring as to which aspect(s) of the problem bothers him or her the most. Research from field studies with the CFI indicates that it takes less than 30 minutes, with time decreasing with frequency of use, and that while clinicians tend to find it a bit cumbersome, patients have appreciated its focus on understanding their views. The CFI has some demonstrated utility in helping clarify diagnoses of psychotic disorders, posttraumatic stress disorder, and other anxiety states (Lewis-Fernandez et al., 2014).

As we have done previously (Hall & Graham, 2014), we advocate for an approach to assessment in which the clinician tries to understand the presentation of symptoms from the client's perspective, recognizing that this perspective is strongly influenced by the culture in which the client was raised and in which he or she currently lives (not always synonymous). At present, we believe that the best way to conduct a culturally sensitive assessment is to carry out a thorough diagnostic interview, incorporating questions from the CFI, and being conscientious about doing a culturally sensitive assessment for all patients regardless of their outward racial, ethnic, and religious presentation. In this way, any misattribution bias may be mitigated. Finally, we encourage all clinicians to be informed about sexuality, sexual values, and sexual practices in other cultures.

## Treatment: From Culturally Competent to Culturally Sensitive Sex Therapy

Cultural competence "denotes the capacity to perform and obtain positive clinical outcomes in cross-cultural encounters" (Lo & Fung, 2003, p. 162). Successful treatment of sexual problems requires tailoring treatment to the unique cultural requirements of the individual or couple. In some cases, traditional psychotherapy or sex therapy approaches can be modified (Ahmed & Bhugra, 2007; So & Cheung, 2005). Culture-specific modifications to the method of treatment may be most successful when the sexual problems are similar to those for which sex therapy was designed—problems of sexual function (e.g., ED, ejaculatory problems, and orgasm difficulties)—and when

the clinician is familiar enough with the culture to make the necessary modifications. For example, So and Cheung (2005) outlined ways in which sex therapy could be modified for Chinese couples, including the admonition that sex therapists be directive and authoritative. However, tailoring therapy in this way requires the therapist to be a chameleon, may modify the therapeutic relationship to the extent that it is no longer therapeutic, and requires that treatment approaches be adapted in ways that may alter the success of therapy (Sue, Zane, Nagayama Hall, & Berger, 2009). It also requires a breadth of cultural knowledge that most clinicians simply do not possess. This approach also promotes overgeneralizing (Sue et al., 2009) or stereotyping, as clearly it is not feasible to understand the diversity and nuances of all cultures. It is simply not workable to have a model of cultural competence that requires that treatments be modified for each culture.

We believe that a culturally sensitive approach to sex therapy is one that recognizes the centrality of culture in shaping sexuality. Moreover, we argue that the importance of the therapist and client sharing meanings is central to the success of therapy and that, with sensitivity, a shared meaning can be developed between therapists and clients of different cultural backgrounds. Therefore, we prefer the term "culturally sensitive sex therapy" (CSST), which stresses a flexible attitude, rather than the term "competent," which emphasizes knowledge and behavior.

Other forms of psychotherapy, most notably cognitive-behavioral therapy (CBT), have adapted treatment protocols more broadly to be applicable for patients from traditional cultures. There is empirical validation of their superior efficacy over nonadapted treatments (Zane, Bernal, & Leong, 2016). In keeping with Hall and Graham's (2014) suggestions for adapting sex therapy, successful cultural adaptations of other therapeutic approaches have three main targets: the facilitation of a strong therapeutic alliance, encouragement of patient disclosure, and the development of a shared understanding between patient and provider regarding the identified problem and the treatment goals (Sue & Sue, 2012).

In many ways we see the process of CSST as akin to the process of acculturation. The regular contact of two cultures, that of the therapist (the culture of sex therapy) and that of the patient, inevitably results in changes in both. Thus, CSST should evolve and adapt with increasing exposure to patients from different cultures. Patients, in terms of their sexuality, should evolve and adapt as they interact with the culture of sex therapy. The degree to which they wish to maintain their heritage culture or adopt the new culture determines the strategy of acculturation (Sam & Berry, 2010). Ideally, we would propose that therapy is best accomplished by the strategy of integration, in which aspects of the heritage culture are maintained while patients participate in an integral way in the new culture. Thus, the heritage culture is blended with the culture of sex therapy, so that sex education, sexual pleasure, communication, and consent are folded into and integrated with identification with the heritage culture. In the case of Ruth, her contact with a respectful

and inquisitive sex therapist allowed her to integrate two previously incompatible roles: the good wife and the sexually assertive woman.

## Case Discussion

Paavan and Sunita came to therapy at Sunita's insistence. Sunita is a 36-year-old, slender, attractive, woman and Paavan is 44 years of age and slightly heavy around the waist. They have been married for 17 years and have two children, both boys, ages 16 years and 13 years. The presenting complaint is Sunita's sexual dissatisfaction: specifically, that sex is infrequent, predictable, not very pleasurable, and not intimate.

Both Sunita and Paavan are present in the first meeting, but whereas Sunita is animated, Paavan is subdued; he smiles and nods throughout the session but rarely adds his own opinion or viewpoint. Initially, Sunita's affect is angry and mildly aggressive. Later in the session she becomes tearful and states that she is hurt by her husband's perceived sexual indifference to her. Sex occurs about once a month at her initiative. She is refused sex more often than it occurs. There is little foreplay and intercourse lasts between 3 and 5 minutes. There is no cuddling afterward, as Paavan leaves to clean himself in the bathroom shortly after he ejaculates. Sunita brings herself to orgasm with her hand while her husband is washing himself. Paavan agrees with this narrative and states that he is "very open" to having sex be more pleasurable for his wife. When asked what they had done to try to resolve this issue on their own, both agreed that apart from arguing about it, they had done nothing. They had previously been to couples therapy, but the therapist did not discuss their sexual issues with them, and they were reluctant to bring them up.

Paavan and Sunita are from a similar area in the south of India and met through a matchmaking service. Both sets of parents agreed to the match, as did Paavan and Sunita. After marriage they moved, with Paavan's parents, to New Jersey, and Paavan enrolled in an MBA program in New York City. The four continue to reside together. Paavan's work history is inconsistent, so about 5 years ago he and Sunita bought franchises for hair and nail salons and began their own business.

### Paavan

Paavan is the only child born to his parents. He was considered a "miracle baby," as he was born 13 years into his parents' marriage and long after they had assumed infertility. He is the only son in his small extended family; he has two female cousins but is estranged from them. Paavan was engaged previously. The bride's family called off the wedding after the bride persisted in her refusal to agree to the match. This was very humiliating to Paavan and his parents, as well as to the matchmaker, who quickly proposed a match with Sunita. The family was pleased with Sunita, as she seemed to be a sweet girl

who was excited about the prospect of marrying Paavan. Paavan acknowledged a history of social shyness and generalized anxiety. He clearly felt the pressure of living up to his father's reputation in India as a professor of mathematics, but he struggled academically. His father tutored him throughout his schooling, including his MBA, but Paavan continued to struggle professionally; he worked at a succession of consulting companies, was laid off several times, and now does accounting for the family business. Paavan takes a low-dose antidepressant, a selective serotonin reuptake inhibitor (SSRI) for his anxiety but otherwise has had no psychological intervention. He found the previous couples therapy to be unhelpful and mildly stressful. He is apprehensive about this therapy and confides his concern that his wife is unstable and depressed. He fears that nothing will make her happy and wonders aloud whether she is depressed, and whether she should be on medication or hospitalized. He is clearly more comfortable talking about the possibility of his wife's problems than discussing his own. Paavan is also concerned about his sons' future successes and is very involved in tutoring them. Paavan explains that he cannot be sexual with his wife more frequently because he is often tired from tutoring well into the night.

### Sunita

Sunita is the third of five children born to her parents. Her mother runs a sari shop in India. Her father was a salesman but lost his job due to alcoholism. He beat his wife and daughters, sparing only his two sons from his violence. Sunita's parents separated shortly after her marriage to Paavan by her mother's choice. Relegated to the streets, Sunita's father died from complications related to his alcoholism. Sunita felt a great deal of guilt, as she was already living in the United States when her father died and did not return for his funeral.

Sunita has difficulty getting along with her in-laws, a fact that her husband uses to support his belief that she is mentally unstable. She feels that her husband will never grow up as long as they are living with his parents. Her mother-in-law continues to do Paavan's laundry and to cook and serve him food despite Sunita's disapproval. Sunita has taken on the task of managing the beauty and nail salons the family owns. Working outside the home has given Sunita increased confidence. Listening to the banter at the salons has also given her a new perspective on her sex life. As she has listened to the stories of the women who work for her, Sunita has become more interested in learning about sex and relationships prompting her to do some Internet searches and to read magazine articles. As her financial and other contributions to the family make her aware of her worth, Sunita has become more sensitive to being treated fairly. She asked to be given a salary as manager so that she might have and manage her own money. Sunita's sense that she is being treated unfairly extends to sex—Paavan is her only sexual partner and he is denying her sexual pleasure: "I want a healthy relationship with my husband,

I want to be treated fairly, to be treated as his equal." Sunita is interested in exploring oral sex, would like to use sex toys with her husband (she recently bought herself a vibrator), and would like to experience intercourse in different positions.

### Cultural Assessment

Paavan and Sunita had very limited sexual experiences prior to marriage, as dictated by their culture. Both felt that they had followed the correct path and had kept themselves pure and chaste for their spouse. Both shared an ICS of a potent, sexually desirous and assertive male and a passive, pure, and attractive female. In their marriage, neither followed the culturally sanctioned role and each blamed the other for this deviation.

Paavan's ICS was very focused on purity. As an adolescent he masturbated only very occasionally, as he wanted to keep himself "healthy" and "pure" for his future wife. Although his father instructed him on the basics of sex prior to his wedding, Paavan was ill prepared for the reality of sex, which was not "pure" in the way of cleanliness he had imagined. In his mind, sex was rather disembodied, while, in reality, pubic hair, sweat, vaginal lubrication, and flesh could not be ignored. Paavan was proud to have fathered two sons, and his interest in sex diminished after the birth of the second child (they had decided to have only two children); it was further reduced by his wife's increasing sexual demands. Paavan thought her sexually assertive behavior was a manifestation of her mental instability.

Sunita also knew the importance of purity, as her chances (and her siblings' chances) for a good marriage necessitated that her chastity be unquestioned. While as an adolescent, she did experience men touching her sexually (on her breasts and buttocks) on crowded streets and public transportation, and saying lewd things to her as she walked by, she was proud that she had guarded her virginity and was excited to be marrying Paavan. Her ICS was also focused on being pure, and she too had an idealized vision of sexual pleasure within marriage. Her vision of purity was not one of cleanliness, but was focused on being pure of heart, being good, and being loving. This vision, gleaned from Bollywood films and movie posters, persisted despite the unhappiness and turmoil in her family. Being "good" would result in a "good" match with a "good" man (unlike her father) and would result in happiness. This message was drummed into Sunita's head by her unhappy mother.

As Sunita became discouraged with her marital and sexual life with Paavan (after all, she had been more than good—she gave birth to two healthy sons, she was now providing income for the family, and she had kept herself looking attractive)—Sunita was overcome with the feeling that she was being treated unfairly. Perhaps this was also fed by the political climate of the United States, in which she now found herself. Therapy took place the year that a record number of women were elected to the U.S. Senate and Congress following the contentious appointment to the Supreme Court of Brett Kavanaugh

(accused of sexually assaulting a young girl when both were in their teens). Gender equity was a source of conversation at the salons and in the media, and Sunita referenced these conversations during therapy.

The treatment plan involved helping Sunita and Paavan integrate some of the cultural messages of sex therapy into the ICS that each held. Incorporating the values of communication, mutual pleasure, and equal assertiveness around sexual desires would challenge their cultural standards. It was hoped that by broadening their sexual experiences, their resulting pleasure would reinforce these cultural shifts.

## Therapy

In therapy, Paavan is obliging and agreeable. The partners agree to try some sensate focus exercises and for Paavan to initiate. The early caressing exercises do take place. But Paavan balks when the instructions for sensate focus include stimulation of his wife's genitals. He does not schedule time for sensate focus and/or he does not show up for agreed-upon times. He is alternately too busy tutoring his sons, too tired, or just *not in the mood*. When Sunita cajoles him finally into doing some touching, it is rote, and he is emotionally distant.

## Cultural Misattribution?

Whereas Sunita saw Paavan as using his power to withhold sex from her, I (Kathryn Hall) viewed him as being too rigidly tied to his ICS, such that the emphasis on purity (disembodied cleanliness) and the belief that the man should initiate were interfering with his own pleasure (and in fact maintaining his mild aversion to Sunita's genitals and reinforcing his avoidance behavior). Thinking that sex education, including some sexual skills training, would be helpful, I gave the couple a book about sexuality, with sexual diagrams and instructions to take home and practice. The next week Paavan was hospitalized with severe anxiety.

In retrospect, it was his anxiety that tied Paavan to his ICS and limited his sexuality. He did not want to fail in yet another way as a man. Working too quickly to institute change made Paavan highly anxious, triggering his underlying anxiety disorder.

After his hospitalization, Paavan at first refused to return to therapy, blaming the therapy for his anxiety. He did ultimately return, with the encouragement and support of his psychiatrist. The CSST model requires careful listening to the patient's perspective, and perhaps Paavan's perspective had been dismissed both by the therapist and by his wife. On his return to therapy, Paavan described his fears regarding change in his sexual relationship: He worried that he could not please Sunita sexually, as he felt that oral sex was a pathway to germs and throat cancer; he believed that if she were capable of enjoying sex but not with him, he would feel a failure and Sunita would leave him. Paavan was assured that he would not be required to do anything sexually to which

he was opposed. Sunita agreed, and said that although she was intrigued by oral sex, she would be happy if they explored other ways that Paavan could pleasure her, instead of leaving this as an afterthought for her to accomplish. The fear that Sunita could not be pleased and that he was not man enough to please her tortured Paavan and was confronted later in therapy.

Sex therapy homework was not prescribed. Instead, the pacing was set by how much Paavan could integrate and tolerate without serious anxiety. Therapy was modeled along the path of cultural integration, so that Paavan and Sunita could encounter the culture of sex therapy at their own pace, allowing them to determine what aspects of their heritage culture (their ICS) and what values and practices from sex therapy they would incorporate into their lives. Therapeutic discussions of sex through a cultural lens was helpful, as they were able to talk about sex as lessons they had learned rather than as manifestations of their self-worth. Rather than just focusing on sex, the therapy was also a forum for Sunita and Paavan to examine those aspects of their culture they wanted to keep with respect to their household, their parenting, and their finances, and which aspects of Western culture they wanted to adopt. Paavan talked about his desire to be a Western businessman, but he felt rejected by first his classmates and later his business colleagues. As Sunita listened to Paavan describe his hopes to fit into a Western world, and his anxiety and sadness for his "failure," she was able to see him outside her cultural framework of a powerful and controlling man. At this point, Paavan was initiating sex more often, and he was engaging in manual stimulation of his wife's breasts and vulva. His aversion to touching Sunita's genitals had subsided greatly as he found himself being aroused by her arousal. Indeed, Sunita was pleased and aroused, but not orgasmic by his touch.

Several months into the therapy, Sunita suggested incorporating her vibrator into their sex life. As Paavan protested that he did not have to do anything he didn't want to do (and he didn't want to use the vibrator), Sunita made several helpful suggestions: They could just have it on the nightstand "in case," she would show him how to use it, and she would use the vibrator when they were together. None of these suggestions helped persuade him, and the more Sunita advocated for the vibrator, the more anxious Paavan became.

In an individual session with Paavan (scheduled at the therapist's request), the fear that Sunita would leave was explored in greater detail. The discussion turned to the one time in his life when a woman did leave him, his previous engagement. Paavan had not previously disclosed that at the time the engagement was called off, he had discovered that his then-fiancée had had sex with another man and preferred this man (now her husband) to him. After the engagement was broken, Paavan's parents had assured him that they were there for him, and that although he could not count on a wife, he could count on them. His parents' continued presence in his life in ways that usurped his wife's place and authority perpetuated this belief that he could only rely on his parents to stay with him. They encouraged his belief that Sunita was unstable whenever she argued with them. An obedient and subservient daughter-in-law

fit their cultural stereotype, and Paavan came to understand that when his anxiety was reinforced by his cultural beliefs (and vice versa), it was difficult for him to calm himself or to make behavioral changes. With this insight, and with the support of his wife and therapist, Paavan was able to change the pattern of his domestic life to include his wife on a more culturally appropriate level. He allowed her to serve him his food and in other respects take care of his personal grooming (shopping for his clothes, doing his laundry). While these might not seem like status elevations to a Western-born woman, Sunita was delighted. Delighting Sunita continued to be a theme for the two, and eventually Sunita experienced orgasm by Paavan's manual stimulation. Both were delighted with and aroused by the experience.

## Sex Therapy as a Process of Acculturation

It should not be left solely to the skills and creativity of individual therapists to modify their practices for culturally diverse patients. This chapter has outlined some challenges presented by cultural diversity and has offered potential adaptations. However, there is a need for more guidance regarding the process of modifying sex therapy for diverse cultures, as well as empirical validation of the efficacy of these approaches. Viewing sex therapy itself as having a culture and envisioning the process of sex therapy with patients from traditional or conservative backgrounds as a process of acculturation is a starting point. Following the recommendations we have made earlier (Hall & Graham, 2012, 2014), listening to the patient and discerning the meaning in any sexual complaint is imperative for culturally sensitive sex therapy. Understanding that cultural beliefs, values, and practices are more difficult to address in therapy because they are reinforced by many layers of culture and are a key part of one's identity will help ensure a sensitive approach to working with patients from traditional and conservative backgrounds. Working in a culturally diverse context will change not only the individual therapists who do the work, but will (we hope) ensure the continued evolution of the practice of sex therapy.

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# CHAPTER 12

# Out-of-Control Sexual Behavior

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"What's in a name?" This famous Shakespearean question could be aptly designated as the theme of Chapter 12. Variously called "sexual addiction," "sexual obsession," "compulsion," or "dysregulation," increasing numbers of (primarily) men are seeking treatment for sexual behavior that appears to be out of control. Noting the lack of clear evidence in favor of one label over another, Braun-Harvey and Vigorito favor the moniker "out-of-control sexual behavior" (OCSB) to reflect the subjective experience of the people who present for help, as well as to avoid stigmatizing diagnostic language based on unsubstantiated theoretical assumptions. The authors of this chapter offer a comprehensive review of the growing and often contentious literature regarding etiology and treatment and ultimately recommend a non-pathology-based paradigm for assessment and intervention. They note, "The central tension for people with OCSB is *being of two minds*—wanting to behave one way while acting in another." In this chapter they detail an assessment approach that allows for the design of "individualized, ethical, and effective treatment strategies." These strategies, as outlined in this chapter, range from pharmacotherapy to group, individual, and relationship therapy approaches. The combination of these treatment approaches is well illustrated in the detailed case example.

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A significant number of individuals who experience distress associated with managing their sexual urges, thoughts, and behaviors are turning to sex therapists for help. Consider the following three cases:

> Lyndon often viewed online sexual imagery of submissive men in BDSM scenes at work and home. Lyndon started therapy after his wife found him masturbating to these images on his smartphone next to her, when he thought she was sleeping. He told his therapist: "I think I'm addicted to porn."
>
> Alberto reported as many as three daily sex partners with men he met with mobile apps. He decided to see a therapist after missing an important work meeting because "a hook-up took too long." "It's like I can't stop myself. I hooked-up even after I lost my job."
>
> Duane and Nikki entered couple therapy to address their tension-filled, 6-year marriage. They were in crisis after Nikki found Duane's secret second cell phone and read his texts with sex workers. "He is a monster, he's really sick. He must be addicted or something."

Sexual dysregulation (i.e., perceived or actual lack of sexual self-control) is a complex clinical issue that involves various underlying mechanisms, biopsychosocial factors, and sexual expressions. It is associated with a range of negative consequences: significant emotional distress and social impairment (Carnes, 1991; Coleman, 1992), sexually transmitted infections (Miner & Coleman, 2013), sexual offending (Kingston & Bradford, 2013), and spousal distress and family dysfunction (Reid, Carpenter, Draper, & Manning, 2010). Individuals who meet threshold measures for a putative sexual dysregulation disorder commonly report multiple behaviors as compulsive. The most common behaviors include masturbation (17–75%), use of visual sexual stimuli (VSS; approximately 50%), and perceived promiscuity, cruising, and multiple relationships (Briken, Habermann, Berner, & Hill, 2007; Raymond, Coleman, & Miner, 2003; Reid, Harper, & Anderson, 2009). Among clinical samples, men[1] make up the majority of treatment-seeking patients, with

[1]Transgender or nonbinary populations are not reflected in the demographics of most sexual dysregulation research.

an expected male-to-female ratio from 2:1 and 5:1 (Grant, 2018; Dickenson, Gleason, Coleman, & Miner, 2018).

Over the past 40 years, researchers and theorists have not identified a singular etiology for sexual dysregulation. This lack of consensus affects research on prevalence rates, development of diagnostic descriptions, and treatment evaluation. It also requires sex therapists to critically evaluate their chosen conceptual framework to ensure effective and ethical care. This chapter organizes the discussion of sexual dysregulation into four conceptual categories before reviewing assessment and treatment: (1) pathology-based models; (2) symptom of a preexisting medical or psychiatric disorder; (3) moral incongruence; and (4) psychosexual problem. These categories reflect the debates among researchers, theorists, and clinicians about the potential etiology, diagnostic criteria, and sociocultural influences that affect sexual control.

## Conceptualizations of Sexual Dysregulation

### Epidemiology

Rendering precise prevalence rates for sexual dysregulation is difficult due to symptom variance across disparate disease conceptualizations, clinical disagreements for measuring this condition, and a shortage of systematic U.S. epidemiological studies for a pathology-based sexual dysregulation disorder (Dickenson et al., 2018; Kraus et al., 2018; Walton, Cantor, Bhullar, & Lykins, 2017). Most prevalence estimates are based on small self-report samples and vary widely depending on how sexual dysregulation is defined and measured (Kraus et al., 2018; Winters, 2010). Large data samples of self-diagnosed sexual behavior disorders may actually reflect normal variance of human sexuality problems (Ley & Grubbs, 2017). Common estimates of an addictive or psychiatric sexual behavior disorder within the general adult U.S. population range from 3 to 6% (Kuzma & Black, 2008). Yet 10.3% of male identified and 7% of female identified participants in an adult U.S. sample ($N$ = 2,325) endorsed distress and/or impairment associated with difficulties controlling sexual feelings, urges, and behavior, as measured by the Compulsive Sexual Behavior Inventory (Dickenson et al., 2018). Among samples of college and university students, one study found that 18% self-reported hypersexuality ($N$ = 73; Reid, Carpenter, & Lloyd, 2009); another study found that 2% meet criteria for compulsive sexual behavior ($N$ = 1,837; Odlaug et al., 2013); and yet another found that 17.4% had sex addiction traits worthy of further evaluation and treatment ($N$ = 240; Seegers, 2003). In an online international sample of adults, approximately 20% of respondents ($N$ = 510) endorsed clinically relevant scores on the Hypersexual Behavior Inventory (HBI; Walton, Cantor, & Lykins, 2017).

### Pathology-Based Models

The central narrative throughout the nomenclature is to establish a sexual dysregulation disorder that describes difficulties controlling repetitive and

problematic sexual urges, thoughts, and behaviors. Four pathology-based conceptualizations proposed to classify disordered sexual regulation from normal sexual variation are sexual addiction (SA), sexual impulsivity, sexual compulsivity, and hypersexual disorder (HD; Winters, Christoff, & Gorzalka, 2010; Walton, Cantor, Bhullar, et al., 2017; Dickenson et al., 2018). These models acknowledge the importance of biopsychosocial factors but differ on etiology and subsequent focus in treatment (Coleman et al., 2018). Currently, a sexual dysregulation disorder is not included in current psychiatric nosology, as both SA and HD were excluded from DSM-5 as a result of insufficient supporting evidence (American Psychiatric Association, 2013; Kafka, 2014). Compulsive sexual behavior disorder (CSBD), however, was included in the recently approved ICD-11 as an impulse control disorder (Reed et al., 2019).

### *Sexual Addiction*

The SA model applies the pathological mechanism of substance addiction to sexual dysregulation etiology and emphasizes the influences of family systems and childhood trauma (Carnes, 1991). SA theorists often apply substance addiction criteria from contemporary DSM editions to substantiate SA as a psychiatric disorder (Goodman, 1992; Wines, 1997). In early SA literature, etiology centered around the ability to produce opiate-like chemicals in the brain during sexual activity as literal evidence of the addictive qualities of sex (Keane, 2018). Endorphins were the initial neurochemicals of concern (Carnes, 1991) but were replaced with dopamine in contemporary SA literature (Toates, 2018). Sharing etiology with substance-based addictions is problematic as "addiction" does not have a standardized definition (Reid, Carpenter, & Fong, 2011; Prause & Williams, in press). Despite this definitional problem, common addiction features include a compulsion to seek the drug, loss of control over consumption, withdrawal, and neurological adaptions over time that promote craving (Koob & Le Moal, 2006; Robinson & Berridge, 2000). What sets SA apart from all the other disease models is the central concept of withdrawal and tolerance (Carnes, Hopkins, & Green, 2014). There has been insufficient scientific evidence to support applying these addictive features to sexual dysregulation (Winters et al., 2010; Prause, Janssen, Georgiadis, Finn, & Pfaus, 2017). More recently, laboratory research using VSS directly tested and falsified[2] the addiction model (Prause, Steele, Staley, Sabatinelli, & Hajcak, 2015, 2016).

### *Compulsive Sexual Behavior Disorder*

Researchers often discuss impulsivity and compulsivity as occurring at opposite ends of a spectrum, with impulsivity driven by the desire to obtain

[2]The falsification approach requires that every core tenet of the model hold, or else the entire model must be rejected (Popper, 1963).

gratification or pleasure and compulsivity as an attempt to alleviate discomfort or anxiety. Both types, however, can share a common struggle to delay or inhibit repetitive behaviors (Reid, Berlin, & Kingston, 2015). Under the compulsive sexual behavior model, people are motivated by the expected relief from the anxiety associated with their obsessive sexual thoughts, urges, and fantasies (Reid, Carpenter, et al., 2009) or to escape stress or the emotional pain from past traumas (Howard, 2007). Over time, these behaviors become habitual and strengthened through the process of negative reinforcement (Miltenberger, 2008). The sexual impulsivity model describes sexual dysregulation as an impulse control disorder, characterized by an inability to control one's sexual urges or to engage in sexual behaviors that might bring unwanted consequences. In this model people act suddenly, without planning or forethought (Barth & Kinder, 1987). The primary motivation behind these impulsive sexual urges is to experience pleasure or gratification (Giugliano, 2009). The sexual impulsivity model features inadequate impulse control or underregulation of sexual desires strengthened through the experience of sexual pleasure (Montaldi, 2003).

Few people presenting with sexual dysregulation meet the criteria of obsessive–compulsive disorder (OCD; Giugliano, 2009; Reid et al., 2015). People who engage in sexual behavior to regulate persistent and unwanted sexual thoughts, urges, and fantasies rarely engage in rigidly followed, rule-based sexual behaviors inherent in the OCD criterion (Walton, Cantor, & Lykins, 2017). Impulsivity is an important factor, but it does not fully explain the wide variety of sexual dysregulation. Approximately 50% of clients seeking treatment for hypersexuality scored significantly higher on general impulsivity measures (Reid et al., 2012; Reid & Kafka, 2014). Reactivity to sexual cues is associated with having more sexual partners (Prause et al., 2015) and desire for partnered sex (Demos, Heatherton, & Kelley, 2012) but may not explain problems with viewing sexual imagery (Voon et al., 2014). Men seeking HD treatment had no significant differences across neuropsychological tests of executive functioning and impulsivity as compared with a community sample (Reid, Garos, Carpenter, & Coleman, 2011). Impulsivity is also a core symptom in other recognized psychiatric disorders such as bipolar disorder, some personality disorders, and established impulse control disorders, which confounds identifying a discrete impulsive sexual disorder (Reid et al., 2015).

CSBD, classified under impulse control disorders in the recently approved ICD-11, moves the focus from anxiety regulation to an inability to control impulses (Grant et al., 2014). Balancing the potential impact of sexual dysregulation on public health with a concern about pathologizing normative sexual behavior, the ICD-11 classification excludes paraphilic disorders, symptoms of another psychiatric disorder, and distress related to sexual moral conflicts. Proponents of these diagnostic guidelines hope they will improve diagnostic consistency and thus inform treatment decisions for people seeking sexual dysregulation treatment (Kraus et al., 2018). Criticism, on the other hand,

centers around the dangers of establishing a disease classification before field trials adequately test the reliability of these specific criteria and the potential to misconstrue the ICD-11 classification as a consensus regarding etiology (Prause, 2017).

## Symptom of a Preexisting Medical or Psychiatric Condition

Sexual dysregulation can be the symptom of a preexisting pathology in the form of a medical or psychiatric condition. Several medical conditions associated with sexual dysregulation include Kleine–Levin syndrome (Afolabi-Brown & Mason, 2018), Klinefelter's syndrome (Fisher et al., 2015), Parkinson's disease (Bronner & Korczyn, 2018), Huntington's disease (Roth, 2019), dementia (Torrisi et al., 2017), traumatic brain injury (Jarial, Purkayastha, Dutta, Mukherjee, & Bhansali, 2018), and stroke and neurosurgical injury (Mondon et al., 2007; Mutarelli, Omuro, & Adoni, 2006).

People with clinically relevant scores on SA, compulsive sexual behavior, and HD measures have high comorbidity rates with psychiatric disorders, including mood disorders, anxiety disorders, substance use disorders, posttraumatic stress disorder (PTSD), attention-deficit/hyperactivity disorder (ADHD), and paraphilic disorders (Kaplan & Krueger, 2010; Reid, Carpenter, Gilliland, & Karim, 2011; Schultz, Hook, Davis, Penberthy, & Reid, 2014; Wéry et al., 2016). For treatment-seeking populations, there is a modestly elevated risk for comorbid personality disorders (e.g., narcissistic personality disorder; Carpenter, Reid, Garos, & Najavits, 2013) and subclinical personality traits such as sexual narcissism (Widman & McNulty, 2010) and alexithymia (Reid, Carpenter, Spackman, & Willes, 2008).

Although *comorbidity* is a misnomer when applied to an issue that is not a disorder, it is generally acknowledged that people seeking treatment for sexual dysregulation frequently meet criteria for a range of psychiatric conditions. In these cases, distress about sexual control is often a symptom of the co-occurring psychiatric condition, which may remit once that condition is treated (Braun-Harvey & Vigorito, 2016). Especially among men, sexual dysregulation can also function as a distraction or coping strategy to deal with the unaddressed issues that induce a negative mood or anxiety (Bancroft, 2009; Wéry et al., 2016). A treatment plan that misidentifies sexual dysregulation as the target condition instead of a symptom of a co-occurring psychiatric disorder will be less effective and risks an iatrogenic injury.

## Moral Incongruence

"There is compelling evidence to suggest that there are very strong associations between moral incongruence regarding pornography use and self-perceived problems associated with pornography use," with religiosity being a substantial predictor of that incongruence (Grubbs, Perry, Wilt, & Reid, 2019, p. 406). As compared with controls, individuals with a perceived sex

or porn addiction report greater levels of personal distress (Grubbs, Exline, Pargament, Volk, & Lindberg, 2017), higher levels of alcohol use (Morelli, Bianchi, Baiocco, Pezzuti, & Chirumbolo, 2017), greater relationship distress and anxiety (Leonhardt, Willoughby, & Young-Petersen, 2018), lower reported levels of sexual satisfaction and well-being (Blais-Lecours, Vaillancourt-Morel, Sabourin, & Godbout, 2016; Vaillancourt-Morel et al., 2017), and increased religious and spiritual difficulties (Grubbs, Exline, Pargament, Hook, & Carlisle, 2015).

Research suggests that one's self perception of sex or porn addiction is not indicative of actual sexual control problems. Clinically relevant scores for individuals with sexual compulsivity were not associated with differences in sexual arousal regulation in a laboratory as compared to control groups (Winters, Christoff, & Gorzalka, 2009). Men seeking HD treatment exhibited no significant differences across neuropsychological tests of executive functioning compared to a community sample (Reid, Garos, Carpenter, & Coleman, 2011). There is evidence to indicate a moderate relationship between VSS use and perceived problems associated with such use. The experience of VSS problems, however, was more associated with moral incongruence and the distress related to that incongruency than with the use of VSS itself (Grubbs et al., 2019). Frequency of use and time spent viewing VSS were unrelated to seeking professional help for "porn addiction" (Gola, Lewczuk, & Skorko, 2016; Kraus, Voons, & Potenza, 2016). Self-identification as a sex addict was predicted more by moral disapproval and religiosity than by the amount of VSS viewed (Grubbs et al., 2015). Furthermore, men who viewed VSS while morally disapproving of it were more likely to experience increases in depression over a 6-year period than others who did not share that incongruence (Perry, 2018). These findings contradict the social and clinical assumptions about the uniquely negative effects on people viewing sexual media (Ley, 2020). Claims of the effects of VSS must also consider the effects of masturbation and orgasm when viewing sexual media (Prause et al., 2015; Steele, Staley, Fong, & Prause, 2013). It remains critical for sex therapists to avoid the "triumph of bias over data" (Prause, 2019, p. 2274) when evaluating the narratives clients report about problems associated with viewing sexual media.

## Psychosexual Problem

Levine's (2010) spectrum of sexual distress organizes sexual difficulties from worries to problems to disorders. Sexual worries are the common, almost universal concerns people have about their sexuality. Disorders, at the other end of the spectrum, are the officially recognized medical and psychiatric diagnoses. Sexual problems are likely a source of distress but are not universal and fall on a spectrum between sexual worries and disorders. Conceptualizing sexual dysregulation as a psychosexual problem allows clinicians to consider the heterogeneous origins and presentations of sexual dysregulation. It

may also overcome the difficulties of interpreting potentially unreliable cutoff scores of pathology-based measures (Walton, Cantor, Bhullar, et al., 2017). Additionally, sexual dysregulation as a psychosexual problem recognizes that individuals can benefit from professional help to manage their distress and improve their overall sexual health without the imprimatur of a disease or psychiatric diagnosis (Cantor et al., 2013). Two models are helpful in conceptualizing sexual dysregulation as a psychosexual problem, both of which situate the problem within a dual process model.

### *The Dual Control Model for Sexual Response*

The dual control model postulates that human sexual response and associated arousal is ultimately determined by the balance between sexual activation or excitation and the suppression or inhibition of sexual arousal (Janssen & Bancroft, 2006). The sociocultural context in which a sexual interaction occurs is an important source of excitatory and inhibitory stimulation and varies depending on the neurobiology of the individual. Sexual inhibition is an adaptive response to reduce the likelihood of sexual response from occurring in disadvantageous or dangerous situations. Last, the propensity for excitation and inhibition varies among people and is usually nonproblematic, but people with a tendency toward high excitation or low inhibition are more likely to engage in high-risk or otherwise problematic sexual behavior (Bancroft, 2008). The neuroscience underlying these individual differences is in the early stages of development (Bancroft, Graham, Janssen, & Sanders, 2009).

### *The Out-of-Control Sexual Behavior Model*

Bancroft and Vukadinovic (2004) first recommended "out-of-control sexual behavior" (OCSB) as a descriptive phrase that does not imply a pathological mechanism or assert a singular overriding definition of sexual dysregulation where one has not been identified. Braun-Harvey and Vigorito (2016) adopted this moniker and further described OCSB as a "sexual health problem in which an individual's consensual sexual urges, thoughts, or behaviors feel out of control" (p. 28)—a definition based on the subjective experience of sexual self-control. Braun-Harvey and Vigorito conceptualize OCSB within a dual process model to understand the various ways people may experience their sexuality as feeling out of control. This model posits human behavior as the joint product of the interaction between two systems of the embodied mind: the affective and deliberative systems (Loewenstein & O'Donoghue, 2007). Each system in this model is a composite of multiple biological and psychological processes. The mechanism that produces behavior combines a rational, goal-oriented process and a reflexive process propelled by emotions, drives, and motivational states. Braun-Harvey and Vigorito (2016) describe the subjective experience of *feeling* out of control as the internal conflict between the affective and deliberative systems resulting in a person's sexual behavior

problems. In other words, the central tension for people with OCSB is *being of two minds*—wanting to behave one way while acting in another. This model recognizes that sexual decision making involves a complex mixture of motivations that are usually aligned but, for people with OCSB, are often competing. The OCSB model examines the diverse configurations of sexual priorities and desires to understand the complexities and contradictions of sexual behavior. The remaining sections of this chapter address sexual dysregulation as a psychosexual problem and use the term "out-of-control sexual behavior" unless referencing a specific model.

## Assessment

A comprehensive assessment is necessary to evaluate the multiple factors that contribute to feeling out of control. Generally, an effective assessment combines valid and reliable measures within a qualitative clinical interview to minimize errant assumptions of sexual pathology (Daspe, Vaillancourt-Morel, Lussier, Sabourin, & Ferron, 2018). Despite the existence of over 30 separate inventories (Womack, Hook, Ramos, Davis, & Penberthy, 2013), no single assessment instrument has sufficient validity to formally recommend it for standard practice (Ley, 2020). As such, therapists are encouraged to develop a process that captures the complex intra- and interpersonal factors and contextual influences that contribute to OCSB. When preparing a client for the assessment, it is important to discuss the conceptualization through which the therapist evaluates sexual problems and educate clients on the objective of their assessment methods. This section organizes the tools of a semistructured interview into three significant assessment areas: (1) sexual urges, thoughts, and behavior; (2) biopsychosocial factors; and (3) values conflict.

### Sexual Urges, Thoughts, and Behavior

People who self-identify as a "sexual addict" are not necessarily engaging in more frequent sex (Kraus et al., 2016), nor do they show significant differences in sexual arousal regulation (Winters et al., 2009). Consequently, it is necessary for therapists to clarify what clients means when they report *feeling* out of control. Such detailed exploration may be unfamiliar and elicit uncomfortable emotions in the client (e.g., shame, fear, disgust) that are important to identify, label, and express. An effective sexual inquiry explores what and when sexual urges, thoughts, and behaviors feel out of control. Available tools include general sexual history instruments (Downey & Friedman, 2009) or targeted exercises such as creating a time line of sexual urges, thoughts, and behaviors that feel out of control (Braun-Harvey & Vigorito, 2016), a client journal, or behavior-monitoring apps.

Measures developed in conjunction with the proposed HD criteria include the HBI (Reid, Garos, & Carpenter, 2011) and the Hypersexual

Disorder Screening Inventory (HDSI; Reid et al., 2012). The HDSI assesses three subfactors (i.e., intense sexual fantasies, urges, and behaviors; distress and impairment; and using sex for coping) and is the most psychometrically sound (Mongomery-Graham, 2017).

The Sexual Addiction Screening Test (SAST; Carnes, 1983) and Sexual Addiction Screening Test—Revised (SAST-R; Nelson & Oehlert, 2008) are nondiagnostic measures that screen for proposed symptoms of addictive sexual behaviors. The SAST-R measures loss of sexual behavior control, sexual preoccupation, affect disturbance and relationship disturbance (Stewart & Fedoroff, 2014) and was developed to address the lack of internal consistency with the SAST for women and gay men (Nelson & Oehlert, 2008). The SAST-R lacks data to evaluate its utility beyond cisgender heterosexual white men (Montgomery-Graham, 2017).

The Sexual Compulsive Scale (SCS; Kalichman et al., 1994) and the 13-item Compulsive Sexual Behavior Inventory (CSBI-13; Coleman, Miner, Ohlerking, & Raymond, 2001) focus on obsessional and compulsive aspects of sexual dysregulation. The 10-item SCS was developed primarily as a research tool and is best used in conjunction with additional screening instruments (Stewart & Fedoroff, 2014). The CSBI-13 is for clinicians to determine whether compulsive sexual behavior is likely to be present and necessitate a more detailed clinical exploration (Miner, Raymond, Coleman, & Romine, 2017).

Most sexual dysregulation disorder measures evaluate how symptoms fit within proposed categorical boundaries and recommended optimal cutoff points (Graham, Walters, Harris, & Knight, 2016). Without diagnostic consensus, researchers tend to use measures consistent with their preferred and often idiosyncratic definitions and conceptualizations (Womack et al., 2013). Some instruments were studied using only specific populations, which limits their generalizability in clinical settings (Hook, Hook, Davis, Worthington, & Penberthy, 2010). Responses to items about types and frequency of sexual acts that are often used to determine pathology reflect and reinforce sociocultural disapproval rather than symptoms of psychiatric disorder (Wéry et al., 2016). The aforementioned surveys are free and easy to administer and score, but whether the data have clinical utility (i.e., actual improvements in clinical decisions or treatment outcomes) remains to be established in the research (Montgomery-Graham, 2017). Furthermore, clinicians may over rely on cut-point diagnostic measures and impose their biases regarding normative sexual behavior without sufficient sexuality training (Dickenson et al., 2018).

We recommend using three non-pathology-based measures in conjunction with an in-depth clinical interview. The Sexual Symptom Assessment Scale (SSAS; Raymond, Lloyd, Miner, & Kim, 2007) is a 12-item self-rating scale that measures the severity of regulating problematic sexual urges, thoughts, behaviors, and consequences over the past 7 days. It helps identify symptom severity in a clinical population and track changes in the client's perception of sexual control without relying on diagnostic cutoff points. The Hypersexual Behavior Consequences Scale (HBCS) is a self-report list of perceived past,

current, or future negative consequences, which can clarify client concerns about their sexual behavior and contextualize their motivation for change (Reid, Garos, & Fong, 2012). The Sexual Inhibition/Sexual Excitation Scales (SIS/SES; Janssen, Vorst, Finn, & Bancroft, 2002) measure individualized levels of sexual excitation (SES) and two inhibition factors: threats due to sexual performance failure (SIS1), and threats due to performance consequences (SIS2). The SIS/SES allows clients to evaluate how OCSB reflects their personal levels of sexual excitation and inhibition.

People concerned about nonconsensual sexual urges, thoughts, or behaviors may seek treatment for OCSB. Given the additional psychopathology present among populations engaging in nonconsensual sex, these individuals should be screened out and precluded from the assessment and treatment guidelines outlined in this chapter.

## Biopsychosocial Factors

A comprehensive, biopsychosocial (BPS) assessment gathers information about intra- and interpersonal factors and contextual influences regarding OCSB. Common areas of inquiry include medical, family-of-origin, adverse experiences, and relationship history, as well as assessing for common co-occurring psychiatric disorders (e.g., mood disorders, anxiety, PTSD, ADHD, personality disorders, and substance use disorders).

The assessment should also gather information regarding romantic, sexual, and familial relationships. Attachment mechanisms may amplify or inhibit sexual feelings; people with different attachment styles may regulate their sexual behavior differently, as they hold different meanings and goals for sexual encounters (Dewitte, 2012). Insecure attachment styles are associated with clinically relevant scores on pathology-based sexual dysregulation measures (Gilliland, Blue Star, Hansen, & Carpenter, 2015). The Experiences in Close Relationships—Relationship Structures Questionnaire (ECR-RS) is a free online instrument that measures the dimensions of attachment-related anxiety and avoidance globally and across multiple relationships (Fraley, Heffernan, Vicary, & Brumbaugh, 2011).

Sexual activity that feels out of control may involve behaviors that disregard romantic relationship agreements (e.g., to be sexually and emotionally monogamous). Motivations for dishonoring sexual agreements are varied and require individualized analysis. The assessment is a space for a curious exploration of the contradiction between making and dishonoring agreements, without privileging particular sexual agreements as healthy or preferred. Distress in response to broken agreements and relationship insecurity may also result in or amplify existing patterns of intimate partner violence and should be screened (Braun-Harvey & Vigorito, 2016).

The Adverse Childhood Experiences (ACE) scale is a health score based on areas of abuse, neglect, and other adverse household experiences (Felitti et al., 1998). ACE scores above 3 (out of 10) are associated with negative adult health outcomes and the likelihood that neurological development was

affected by repeated overstimulation (Repetti, Robles, & Reynolds, 2011). No screening or assessment instrument translates possible underlying neurobiological mechanisms implicated in sexual dysregulation (Reid & Kafka, 2014). Reviewing the ACE survey in a semistructured clinical interview, however, is an effective method to identify historical experiences that may influence a client's sexual health (Braun-Harvey & Vigorito, 2016).

### Values Conflict

Judgments about one's sexual urges, thoughts, and behaviors may be the source of distress rather than actual sexual dysregulation. A detailed and thorough clinical interview can clarify the underlying conflict and reasons for seeking treatment. Clients may present with an internal conflict about their sexuality stemming from moral or religious-based objections. Others may experience disappointment, shame, or fear regarding unwanted but reliably arousing stimuli (e.g., same-sex attractions, paraphilic arousal patterns). OCSB is often a manifestation of unresolved conflicts with clients' sexual and erotic orientations; what clients find sexually or erotically compelling conflicts with their values or self-concepts. The source of conflict may be external if their sexual or erotic interests threaten relationships with romantic partners, peer groups, or religious communities. Clients may attribute their persistent unwanted sexual desires to a compulsion or addiction as a means to express their distress or receive treatment that eradicates these desires. As such, the labels SA, compulsive sexual behavior, or HD may represent clients' strategies to maintain those attachments by avoiding integrating their sexual and erotic desires into their identities and relationships. While the assessment can help clarify their values conflicts, it is important to explain the limits of treatment. Interventions to eradicate consensual sexual and erotic desires is a form of reparative therapy that is ineffective, unethical, and harmful. Instead, treatment can help clients accept their sexual and erotic desires, and determine whether and how they want to express them.

## Treatment

There are few systematic SA, compulsive sexual behavior, and HD outcome studies (Coleman et al., 2018; Grant, 2018) and existing studies often use one term to describe the complexities of sexual dysregulation, which makes it difficult to evaluate outcome research for specific treatment modalities. We review in this section the pharmacological and psychological treatment options available for people concerned about OCSB.

### Pharmacological Treatment

The goals of pharmacotherapy vary from improving self-regulation, increasing distress tolerance, and interrupting repetitive activation associated with

sexual behavior to changing impulse control or compulsions (Coleman et al., 2018). Mood stabilizers, serotonergic antidepressants (clomipramine or selective serotonin reuptake inhibitors [SSRIs]), and opioid receptor inhibitors (naltrexone) may reduce or ameliorate symptoms as measured by pathology-based instruments (Efrati & Gola, 2018). In a recent study, men with HD and co-occurring adult ADHD were found to benefit from combined pharmacotherapy and behavioral therapy (Engel et al., 2019). Anecdotal pharmacological case studies report reductions in unwanted sexual urges and their consequential sexual behaviors that suggest possible dopaminergic modification of mesolimbic functioning (Kraus et al., 2016; Raymond, Grant, & Coleman, 2010). Unfortunately, pharmacological outcome studies mainly comprise homogenous participants (i.e., white cisgender men) and rely on unclear epidemiology of sexual dysregulation (Naficy, Samenow, & Fong, 2013). In the only double-blind pharmacotherapy study (28 men who have sex with men who met the threshold for compulsive sexual behavior), 20 to 60 mg/daily citalopram (Celexa) provided some reduction in use of VSS (Wainberg et al., 2006).

Appropriate use of medication to treat co-occurring psychiatric or medical disorders can mitigate OCSB problems. In the absence of a co-occurring disorder, "off-label" use of psychoactive medications to treat distress related to sexual problems, without consideration of the contextual factors, raises significant ethical concerns (Ley, 2020).

## Psychological Interventions

OCSB psychological treatment focuses on methods for improving self-regulation and attachment patterns, and resolving sexual or erotic conflicts. Most sexual dysregulation models utilize variations of individual, group, and relationship therapy (Kaplan & Krueger, 2010; Rosenberg, Carnes, & O'Connor, 2014; Braun-Harvey & Vigorito, 2016; Coleman et al., 2018; Efrati & Gola, 2018; Grant, 2018). No psychotherapeutic approach has undergone a significant placebo-controlled, double-blind study (Rosenberg et al., 2014). Case studies from the field have significant methodological limitations, insufficient theory to guide clinical work, and no control or alternative treatments, and contemporary methods almost exclusively target cisgender men. "The field is ripe for several well-designed outcome studies examining various treatments" (Hook, Reid, Penberthy, Davis, & Jennings, 2014, p. 304).

### *Individual Therapy*

Common individual therapy methods endorsed in the literature include cognitive-behavioral therapy (CBT; Engel et al., 2019; Garcia et al., 2016; Efrati & Gola, 2018; Grant, 2018; Kaplan & Krueger, 2010), cognitive analytic therapy (CAT; Ryle & Kerr, 2002; Efrati & Gola, 2018), acceptance and commitment therapy (ACT; Grant, 2018), mindfulness training (Coleman et al., 2018), and mentalization-based therapy (Berry & Berry, 2014). Many treatment

approaches include individual therapy in conjunction with a range of adjunct therapies. SA treatment approaches include a highly manualized task-centered model with a series of workbooks (Rosenberg et al., 2014). An integrative BPS and sex-positive model for impulsive/compulsive sexual behavior (ICSB) therapy (Coleman et al., 2018) and the OCSB clinical pathway (Braun-Harvey & Vigorito, 2016) combine intensive individual therapy with a range of adjunct therapies, predominantly group and relationship therapy.

### *Group Therapy*

Group therapy is a prominent modality among most treatment models, though the clinical objectives often differ. Common objectives include improving relationship skills, establishing a system of accountability and support, and normalizing sexual and erotic diversity (Coleman et al., 2018; Katehakis, 2016; Braun-Harvey & Vigorito, 2016). Pathology-based group approaches, however, risk stigmatizing sexual and erotic diversity with interventions that privilege conventional sexual behaviors and reinforce a disease narrative.

The OCSB model that we propose utilizes a combined approach, with group as the primary modality. We recommend group therapy to help clients maintain sexual commitments, improve interpersonal skills, and facilitate sexual and erotic identity development. For example, the group treatment frame (i.e., clearly defined agreements for therapy) is an essential component of the OCSB treatment model, as it generates clinical opportunities to understand and address the client's pattern of breaking personal or relationship commitments (Braun-Harvey & Vigorito, 2016). Therapists deconstruct in-the-moment group events (e.g., when a client does not honor a group commitment) to identify relationship patterns that can be extrapolated to the client's sexual and romantic relationship patterns. Additionally, disclosing sexual details in a group setting can reduce shame and increase acceptance of sexual and erotic desires.

Although not considered group therapy, 12-step fellowship groups are often provided as adjunctive support for OCSB treatment-seeking clients. Based on the Alcoholics Anonymous (AA) dual model of disease and spirituality, 12-step groups consider sexual addiction an advanced-stage chronic disease in which individuals are no longer in control of their lives (Efrati & Gola, 2018). These free groups are intended to lessen shame through a community that values reducing secrecy and stigma associated with SA (Kafka, 2014). SA treatment has universally integrated 12-step sexual recovery groups as adjuncts to their treatment despite lack of published efficacy research (Garcia et al., 2016).

### *Relationship Partner Therapy*

Couple therapy is recommended in all treatment models, but emphases differ depending on the attribution of the distress and relationship consequences of

the client's OCSB. Individual or group therapy may be more relevant when addressing sexual dysregulation as a symptom of a preexisting psychiatric or medical condition, improving self-regulation, or fostering sexual and erotic identity development. Couple therapy may be the primary treatment modality when the client's OCBS is related to a sexual values conflict or difficulties integrating eroticism into a romantic relationship. SA protocols recommend no sexual contact between partners until every secret and lie is disclosed as a proposed precursor to trauma processing and improved self-regulation within the relationship (Katehakis, 2016). Emotionally focused couple therapy (EFT) has been proposed as a tool for repairing attachment injuries related to OCSB (Reid & Woolley, 2006).

## Case Discussion

Drew, a 36-year-old, multiracial (European American and Asian), cisgender, heterosexual-identified man, presented for treatment regarding his perceived "porn addiction." He and his 38-year-old, multiracial (European American and Southeast Asian), cisgender, heterosexual-identified wife, Anna, initially went to couple therapy to address sexual dissatisfaction. In that therapy, Drew disclosed erectile difficulties during partnered sex but not during masturbation. He reported difficulties breaking his pattern of nightly masturbation to VSS after Anna went to sleep. Anna stated her interest in "a marriage without porn" and indicated that to her, porn was tantamount to infidelity. The therapist recommended that Drew get treatment for this sexual issue as a means to resurrect their sexual relationship. The therapist and Anna framed the issue as a "porn addiction," and Drew enrolled in a residential sex addiction treatment program to avoid divorce. Upon completing the program, Drew scheduled an appointment with one of the authors (Braun-Harvey) to enter an OCSB group.

### OCSB Assessment

One of the therapist's first questions to Drew was "What is your vision of sexual health?" It was both an opportunity to gather information about Drew's treatment goals and to introduce the sexual health framework that is the foundation for the treatment. Drew, as are all clients, was introduced to the following sexual health principles geared toward fostering responsible and pleasurable sexual expression: (1) consent; (2) nonexploitation; (3) protection from STI/HIV infection and unintended pregnancy; (4) honesty; (5) shared values; and (6) mutual pleasure[3] (Braun-Harvey & Vigorito, 2016). At the first session, Drew evaluated his behaviors with regard to the sexual health principles and observed that he was not honest with himself and his wife about his

[3]The sexual health principles were adapted from the Pan American Health Organization, World Health Organization, and Association of Sexology (2000).

sexual interests; he recognized a sexual values conflict regarding his use of VSS in his marriage and acknowledged that his sexual relationship with Anna was not mutually pleasurable. These observations established initial questions to explore during the OCSB assessment: What motivations competed against being honest, establishing shared values, and developing a satisfying sexual relationship with his wife?

Drew reported that he was motivated to seek treatment to save his marriage. He left the SA program with the goal of improving marital sexual satisfaction and an aftercare plan that defined monogamy as no extramarital sexual activity at all, including solo sex (i.e., masturbation). The SA program had erroneously concluded that Drew's partnered erectile functioning problems were caused by masturbating to VSS and had directed him to abstain from orgasms or masturbation for 90 days. At the time of the first appointment, Drew said he was "sober" from masturbation since leaving the program, but he expressed ambivalence about maintaining this plan for 90 days. Drew denied nonconsensual sexual behaviors (including nonconsensual VSS), intimate partner violence, and suicidal ideation. Drew thus met the two clinical distinctions for appropriateness for treatment: motivation for change and no participation in coercive or nonconsensual sexual behaviors. Drew did not endorse symptoms of a psychiatric disorder, but he did acknowledge a problematic relationship with cannabis prior to entering his SA program. He agreed to not use while participating in the OCSB assessment and would revisit this agreement before he entered group treatment. The therapist and Drew both agreed to move forward with an OCSB assessment to clarify Drew's clinical picture, devise a written sexual health plan, and establish group and individual treatment goals.

Drew completed a weekly self-report measure (SSAS) which revealed high levels of sexual urges and thoughts related to his "sexual problem" (self-defined as masturbation to VSS) which felt out of control to him periodically. Drew also completed the online SES/SIS. Drew's high SES score, in tandem with moderate scores on both inhibition scales, led the therapist to suggest to Drew that masturbating to VSS might be a strategy he used to regulate his sexual excitability.

On measures of adverse childhood experiences and attachment styles, Drew endorsed four items on the ACE Survey, with themes of neglect, verbal abuse, and parental divorce. Drew's global and spousal attachment styles were dismissive, as measured by the online Experiences in Close Relationships—Relationship Structures Questionnaire (ECR-RS). Follow-up questions in the clinical interview led to the following history: Drew was raised in a nonreligious family by his mother (who immigrated from China at age 15) and his white father (roughly fifth-generation Northern European). Drew described his mother as unprepared for a nurturing role and his father as rigid and narcissistic. They divorced when Drew was 7, after which he stayed with his mother and a succession of her boyfriends. Drew recalled one significant event at age 14, when his mother reacted angrily after walking in on him masturbating. She subsequently arranged for him to live with his father. His father,

"uninterested" in Drew, regularly left him home alone. Drew spent his time reading, playing music, and masturbating in his room.

Drew met Anna in college. They were each other's first romantic and sexual partners. They married after college and had two sons (planned). Drew described the couple's sexual life as "boring and almost nonexistent" after their second son was born. They avoided talking about the changes in their sexual relationship, including Drew's difficulties maintaining an erection firm enough for vaginal intercourse.

The assessment clarified the ways Drew's masturbation pattern remedied various competing motivations. He wanted to stay married and be sexual with his wife. But he felt embarrassed about his unreliable erections and guilty about fantasizing about other women in order to maintain a firm enough erection during partnered sex. Furthermore, his family-of-origin history did not prepare him to communicate directly about uncomfortable feelings or trust that a romantic relationship could survive conflict. A secretive, solo sex life allowed him to stay in his marriage and be sexual without conflict. Once his masturbation pattern was revealed, Drew was faced with finding a new solution to these binds.

The assessment concluded when Drew established a written sexual health plan (SHP) to clarify behavioral boundaries that he felt ready to establish and activities he was ready to pursue to improve his sexual health. To enter the OCSB group, Drew agreed to adhere to their SHP and disclose any boundary crossings during the next group session. This accountability agreement generates clinical opportunities to observe how clients manage commitments, regulate uncomfortable affects, and navigate relationship agreements.

## OCSB Treatment

Drew attended weekly OCSB groups and twice-monthly individual therapy. He shared his commitment to discontinue masturbation and watching VSS to save his marriage. Twice-monthly individual therapy looked at his childhood preoccupation with meeting his parent's expectations, fear of their authority, and threats of rejection. His historical pain of his mother's rejection after discovering him masturbating persisted as a significant emotional wound. In group, Drew regularly avoided discussing details of his erotic interests, as honest disclosure represented a threat to current and historical attachments. As he listened to members describe how they negotiated their erotic lives, he observed how they felt less anxious in their relationships. Some shared playful stories of erotic exploration that the group admired and respected. These conversations encouraged Drew to contemplate being more honest about his erotic desires, which he was eventually able to do.

Drew honestly reported back to the group when he crossed his SHP boundaries. He gradually separated the guilt he felt about not honoring his commitments from the shame he felt about his sexual interests. Over time, Drew revealed previously hidden content he watched: scenes of men having sex with two partners (either cisgender or transgender women), some of which

included men engaging in receptive anal sex. He shared that anal sex and gender fluidity were significant taboos of his cultural Chinese identity. Group members shared their own masculine gender role transgressions and homophobic reactions to otherwise pleasurable sexual acts. Drew expressed fears that his sexual interests would be judged as a symptom of "sex addiction." Instead, the group focused on the conflict between honest discussions about his sexual pleasure and his motivation to avoid rejection.

Drew and Anna resumed couple therapy with a new sex therapist to improve sexual satisfaction and functioning. The couple therapy succeeded in expanding their sexual repertoire by decentralizing the importance of Drew's erections and vaginal intercourse. Drew practiced discussing his turn-ons in group, with the goal of telling his partner. When he finally disclosed his fantasies, Anna was curious and open to finding creative solutions (without opening the relationship to include a third partner). Drew negotiated a return to solo sex as the couple integrated anal pleasure with sex toys and more direct sexual communication. Anna stopped blaming VSS for his erectile problems and disclosed that she could accept his masturbation to VSS as long as they were still having sex. His erectile functioning was more reliable after their sexual interactions changed and his sense of sexual control improved.

For some men in OCSB treatment, disclosure of a pleasurable unconventional or stigmatized erotic interest is a step toward self-acceptance. For others, the disclosure can lead to significant attachment rupture and subsequent relationship crisis. Drew was fortunate that disclosing his sexual desires resolved the values conflict in his marriage and ultimately led him to adopt a sexual identity as "mostly heterosexual."

## Conclusions

Without scientific consensus on a putative sexual dysregulation disorder, it is vital for sex therapists to critically evaluate the conceptual frameworks through which they assess and treat cases related to OCSB to ensure effective and ethical care. People concerned about OCSB can benefit from professional help to improve their overall sexual health without the imprimatur of a disease or psychiatric diagnosis. We recommend conceptualizing OCSB as a psychosexual problem, which frees clinicians to consider the heterogeneous origins and presentations of OCSB and to design individualized, ethical, and effective treatment strategies.

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## CHAPTER 13

# The Pleasure of Power

## *Sex Therapy in the BDSM Community*

DAVID ORTMANN

BDSM is a compound acronym encompassing a variety of power-based sexual interests and behaviors (bondage, discipline, dominance, submission, sadism, and masochism). Historically, individuals who acknowledged such interests would find their sexuality diagnosed as a paraphilia or classified as deviant. Here we take a new perspective: Instead of pathologizing, this chapter focuses on how sex therapists can help individuals and relationships deepen their sexual connection and pleasure by accepting, sharing, and embracing their sexuality rather than hiding, shaming, or eliminating it. Ortmann consistently and cogently makes the point that BDSM and other kink-related activities are not sexual problems, perversions, or dysfunctions. Rather they represent identities, orientations, and preferences. He cites relevant research showing that an increasing number of people have an interest in, or have engaged in, BDSM, thus calling into question its designation as a paraphilia. There is no empirical evidence that people who enjoy power-based sexuality are any different in terms of their mental health from individuals who do not share these sexual interests. Ortmann provides helpful information for understanding power-based sexuality and, combining research with rich clinical examples, he illustrates the important nuances of working with people in the BDSM community to enhance their sexual and relational connections.

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sexual diversity; and alternative relationship paradigms. He is a sought-after consultant and educator. Widely published in fiction and nonfiction, Mr. Ortmann's work appears in popular magazines, academic journals, and anthologies of fiction and nonfiction. His first book (with Richard Sprott, PhD), *Sexual Outsiders: Understanding BDSM Sexualities and Communities,* is regarded as the first sex-affirmative psychological and literary analysis of kink and BDSM. In January 2006, the California State Assembly formally recognized him for his contributions to the city and county of San Francisco. David gives special thanks to Frank Banks, MFT, and Kathryn Hall, PhD.

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"I had to try four therapists before I found Bill," Marianna said to me one afternoon. "I needed some help getting over my anxiety and low self-esteem at work, especially when advocating for myself. The three therapists I had before Bill wanted to focus on how the pleasure I derived from being submissive to my partner was 'wrong.' I was told my pleasure from being tied up was 'unnatural' and that I was the victim of abuse. I was told I was a bad feminist, that I'd likely been abused as a child, and that my sexuality was arrested at age 12."

Marianna's story is not unique. Individuals who enjoy BDSM, Kink, Fetish, and other power-based sexual practices cannot easily access quality, competent mental health services without having their sexuality targeted as the primary problematic focus of therapy. In contrast, my aim in this chapter is to help the reader better understand power-based sexuality to help individuals, alone and in relationships, to improve their sex lives in the context of these rich and complex sexual preferences, identities, and orientations.

The compound acronym BDSM (which stands for "bondage, discipline, dominance, submission, sadism, and masochism") oversimplifies an intricate set of sexual interactions. It is a mistake to assume that because we know the words that make up the acronym, we understand the sexuality behind it. In particular, the terms "sadism" and "masochism" are wrought with clinical, colloquial, and historical value judgments. Sadism derives its moniker from the notorious and prolific author Donatien Alphonse François, Marquis de Sade (today more commonly referred to as, simply, the Marquis de Sade), a French nobleman, revolutionary, and libertine, whose sadistic imagination would not fit the definition of today's consensual BDSM. Sadism is the derivation of pleasure as a result of inflicting physical or emotional pain or watching pain inflicted on another person or persons. Perhaps less well known than the infamous Marquis, Leopold von Sacher-Masoch, was the Austrian literary and philosophical figure after whom the term "masochism" was coined. A talented and extraordinarily prolific writer, Sacher-Masoch had 90 novels to his credit before his death in 1895. He is perhaps best known today for his short 1870 novel *Venus in Furs,* which detailed his own fantasies and fetishes, particularly for Dominant women wearing fur. He was known for both writing

about, and living out, his fantasies with his mistresses and wives. In complementary contrast to sadism, "masochism" refers to the derivation of pleasure from having pain or humiliation inflicted upon oneself. In this chapter, I use these terms to describe *consensual* erotic practices from which great amounts of pleasure, sensation, and catharsis can be derived.

## Terminology

Because BDSM is often misunderstood, it is important to clarify and understand the terms that are used in this chapter and in the BDSM community. As I stated earlier, BDSM is a type of power-based relationship in which power is identified, used, played with, manipulated, or exploited for erotic or sexual pleasure. Important elements of power exchange between the engaged parties include bondage, discipline, dominance, and submission.

*Bondage* involves the act of restraint, often using cuffs, rope, metal, fabric, shackles, or chains. An erotic feeling of immobilization or stimulation from the material and textures of the restraint implements is one of the greatest pleasures resulting from the act of being bound. Bondage can be as simple as a pair of hands tied with a bandana or as intricate as forms of *shibari* Japanese rope bondage, which can take years to craft and master.

*Discipline* is an activity in which a Dominant partner trains a submissive partner in order to produce certain behavior. Discipline incorporates guidelines for behavior and involves various forms of punishment when the prescribed standards of behavior are not met. Many times, discipline can take the form of corporal punishment, or "impact play" to use a term pulled right out of the BDSM communities.

*Dominance* is a state of assuming psychological or physical control over another in a power exchange relationship, a state in which orders may be executed or services performed. Being *Dominant* is not about being domineering, bossy, or arrogant. Some of the best Doms have once been submissives themselves, so they understand the care, protection, nurturing, service, and direction that goes into being a good Dominant. It is similar to good parenting.

*Submission* refers to the state in which an individual willingly and consensually sublimates or bequeaths his or her power to a Dominant partner in a power exchange relationship. In doing so, the *submissive* allows the Dominant to take psychological or physical control. The myth that a submissive has no power is an erroneous and dangerous one. On the contrary, the state of submission may be one of the most powerful states of BDSM consciousness for the very fact that the act of giving over one's power to a trusted Dominant partner is, in and of itself, an act of extreme power and one that should not be taken lightly. Submission should not be confused with passivity or helplessness, *regardless of what it may look like,* especially to an outside and

uniformed observer. Submissives give up their power to trusted Dominant figures and, since you can't give away what you don't have, submissives[1] are, perhaps, the most powerful figures in the BDSM psychodrama.

A *switch* constitutes an identity, as not everyone neatly identifies as exclusively Dominant or submissive. A switch may be submissive to a Dominant partner, while being the Dominant to a submissive of his or her choosing. The array of roles open to those who identify as switch is broad and rich.

*Leather*[2] has both a concrete and abstract definition in BDSM communities. It is the tanned, shiny, and uniquely olfactory cowhide some kinky people fetishize and/or wear. "Leather" is also an umbrella term for all forms of kinky gear and clothing—including leather itself. It is also often used as shorthand to describe gay male BDSM communities (as they have historically, and in some cases continue to, wear leather).

*Fetish* describes a sexual or erotic fixation on an inanimate object that otherwise would hold no general erotic meaning or energy. In the BDSM community, leather, leather clothing, and objects of restraint and other gear may take on their own erotic potential such that their use in BDSM activities is called "fetish play."

Kink[3] is an umbrella term for the less-traveled path of human sexual adventures. The word *kink,* like the word *bent,* indicates a turning away from the mainstream, a twist on what is considered "normal." Under this definition fall behaviors and "scenes," as they are referred to in kink communities, such as impact play (spanking and whipping), bondage, humiliation, role plays, and sex that plays with or exploits a power differential between those involved (often referred to as Dominance and submission).

While it is often used synonymously with BDSM, Kink is also a broader term to describe a community or communities of people who practice diverse and nonmainstream sexual behaviors. The term *kink* is also used by some members of these communities to describe their orientation or identity, as they feel their kinkiness is an inherent part of their sexuality and therefore an important part of their overall identity.

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[1] A convention in the BDSM community of capitalizing Dominance, Dom, Dominant and using the lower case for submission, sub, and submissive is followed in this chapter.

[2] The contemporary Leather and BDSM culture, as we know it, came out of the post-World War II men's motorcycle clubs. Starved for male–male contact and fraternity after the end of World War II, many veterans formed motorcycle clubs and wore leather, as this was the strongest barrier between their flesh and the pavement should there be an accident. To many, this look was erotic, which led to it being fetishized by the film industry in the 1950s. One only need look at films such as Marlon Brando's *The Wild One* (1953) and James Dean and Sal Mineo in *Rebel Without a Cause* (1955) to see how leather and denim (particularly the American brand Levi's) were fetishized as iconically masculine.

[3] Sources are divided on whether or not to capitalize "Kink." When referring to a person's behavior or orientation toward kink, it is usually left in lowercase form. When used as an umbrella term to describe a community or communities, Kink is usually capitalized.

## Pleasure or Pathology?: Paraphilic Disorders in DSM-5 and ICD-11

People who practice what are sometimes known as alternative sexualities have long faced interpersonal, social, and professional discrimination (Giami, 2015). Until the most recent iterations of the major diagnostic taxonomies, engaging in BDSM and fetish play and/or finding these activities highly arousing, was considered a mental disorder. According to DSM-5 (American Psychiatric Association, 2013), "a *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (p. 685). However, a paraphilia on its own no longer warrants a diagnostic label. To be diagnosed with a paraphilic *disorder* according to DSM-5, an individual must have a paraphilia "that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others" (pp. 685–686). DSM-5 lists sexual masochism disorder and sexual sadism disorder as separate diagnostic entities within the overall category of the paraphilic disorders. In addition to having sexual interests of a masochistic or sadistic nature, there are several factors to be considered in diagnosis, and the interested reader is referred to the criteria listed on pages 694–697 in DSM-5 (American Psychiatric Association, 2013). However, some key considerations include distress and interference in the pursuit of social or occupational goals, as well as evidence that an individual has acted in a sadistic sexual manner with a nonconsenting partner.

The recently approved ICD-11 (World Health Organization, 2019) represents a major departure from its predecessor and is more closely aligned with DSM-5 than was ICD-10 (Krueger et al., 2017). There is a significant change in the name of this diagnostic category, which was previously catalogued as disorders of sexual preference. ICD-11 will also adopt the term *paraphilic disorders*. Krueger et al. (2017) note that, like DSM-5 criteria, ICD-11 diagnostic criteria "require a sustained, focused, and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviors and also that the individual must have acted on these thoughts, fantasies, or urges, or be markedly distressed by them" (p. 1542). However, ICD-11 has eliminated the specific diagnoses of sexual masochism and sexual sadism, transvestic and fetishistic disorders from the paraphilic disorders, as these have not been associated with psychological and social maladjustment (Krueger, 2010a, 2010b; Wismeijer & Van Assen, 2013). If these sexual interests cause marked distress they may be diagnosed under the category *Other Paraphilic Disorder Involving Solitary Behavior or Consenting Individuals*. ICD-11 emphasizes the need for significant distress or harm (direct injury or death) to merit a diagnosis of paraphilic disorder. Interference with social or occupational roles is not a diagnostic requirement for a paraphilic disorder in ICD-11 as it is in DSM-5. In ICD-11, the diagnosis of paraphilic disorder focuses primarily on sexual arousal patterns and behaviors that involve

nonconsenting others. The ICD-11 diagnostic category for *Coercive Sexual Sadism Disorder* requires the infliction of physical or psychological suffering on a *nonconsenting* person and specifically excludes consensual sexual sadism and masochism.

Note that in both of these classification systems a paraphilic disorder can be diagnosed, even if the paraphilic sexual interest is not the sole or even the preferential interest or behavior. The diagnostic imperative is distress. Here, it is important to distinguish the distress or shame that is related to an awareness of societal disapproval (often referred to as *minority stress*) and distress inherent in the experience of the sexual interest itself (Reiersøl & Skied, 2006). Moser (2016), who questions the validity of the diagnostic category of paraphilic disorders, notes that it is difficult for a clinician to ascertain the source of the distress. Is it personal distress about their interest, about society's disapproval, or distress about the consequences of that societal disapproval? Likewise, Moser notes that ascribing someone's occupational or social impairment to his or her paraphilia requires clinical judgment in the absence of empirical evidence and validated criteria. So, like Marianna in the case described earlier, many individuals who seek mental health services *and* have a paraphilic interest may find that their paraphilia is the (unwanted) source of clinical attention.

All sexual behaviors, kinky and not, should preclude coercion of any kind. However, I agree with the concern about pathologizing consensual sexual interests. The paraphilia sections of DSM and ICD are best construed as psychiatry's attempt to understand and label what are normal, abnormal, and pathological sexual desires, orientations, and behaviors. But we cannot make rational scientific evaluations of what is sexually normal and not, with our current knowledge base. Our inability to separate the influence of religion, culture, and morality from sexuality renders us simply *not there yet*. Instead of pathologizing, this chapter focuses on how sex therapists can help individuals and relationships[4] deepen their sexual connection and pleasure by accepting, sharing, and embracing their sexuality rather than hiding, shaming, or eliminating it. In essence, this chapter is really about sexual desire and freedom of sexual expression. It is also about pleasure.

## Prevalence

The prevalence of interest and engagement in consensual power-based or kinky sex practices is difficult to judge. Survey data are complicated by low response rates and an overrepresentation of sexually liberal individuals (Joyal & Carpentier, 2017). Nevertheless, many recent surveys show similar results across nations; a large percentage of individuals are interested in and are engaging in BDSM activities.

[4]I use the term "relationship" instead of "couple" throughout this chapter. The word *couple* implies that relationships only involve two people.

In Belgium, the number of men and women in a representative survey endorsing an interest in BDSM and fetish play was 68.8%. While 22% indicated having fantasies but never engaging in any behavior, 46.8% of the respondents had engaged in at least one BDSM-related activity in the past year. There were no gender differences in the prevalence of interest in either dominant or submissive activities. Respondents acknowledged engaging in activities such as movement restriction (use of restraints), hitting, blindfolds, and submissive kneeling, and the vast majority (96%) found them pleasurable (Holvoet et al., 2017).

A broad range of sexual behaviors was the focus of inquiry in a U.S. representative probability survey of 2,021 adults (975 men, 1,046 women) conducted in 2015. Some behaviors often considered unusual were, however, frequently reported by the respondents. Common lifetime "kinky" sexual behaviors included public sex (44.1%), role playing (23.7%), tying/being tied up (21.1%), and spanking (31.9%). Less common were behaviors such as having engaged in threesomes (10% of women, 18% of men) and playful whipping (15%). Uncommon lifetime experiences included group sex, sex parties, and going to BDSM parties (each less than 8%) (Herbenick et al., 2017).

In Canada, a representative sample of 1,040 people living in the province of Quebec completed telephone and online surveys of paraphilic sexual interests and behavior (as defined in DSM-5). Overall, 45.6% of the sample indicated an interest in experiencing at least one paraphilic behavior, while 33.9% had engaged in paraphilic behavior on at least one occasion. Of those surveyed, 7.1% wished to engage in sexual sadism, and 5.5% acknowledged having done so. Sadism was defined as arousal from "making someone suffer, or by dominating or psychologically or physically humiliating another person" (Joyal & Carpentier, 2017, p. 5). Significant gender differences were found for desire and experience of masochism (but not sadism), with more women expressing interest (27.8 vs. 19.2% of men) and reporting experience (23.7 vs. 13.9%). Masochism was defined in this study as arousal "while suffering, being dominated, or being humiliated" (p. 165).

A rather striking finding from this study was the relationship between submissive desires and behavior and a high level of interest in other "paraphilic" behaviors. Joyal and Carpentier (2017) conclude that these results support previous findings (Joyal, Cossette, & Lapierre, 2015) and clinical impressions that individuals, especially women, who have an interest in being sexually dominated have high levels of sexual satisfaction, drive, and activity (Khar, 2008; Brenot, 2012). These results, plus the failure to find a correlation between childhood sexual abuse and sadomasochism, reject popular belief that an interest in BDSM stems from a history of sexual trauma. Instead, the opposite seems to be true: that an interest in BDSM stems from a high level of interest and enjoyment of sex.

Other indications of the widespread appeal of fetishism and BDSM come from the popularity of Fetlife.com (a social networking site for kinky people) and Pornhub, an online streaming service for sexually explicit videos

and other visual erotica. In 2016, Pornhub reported high interest in BDSM-related content on their website, especially from women, as over 80% of the sites visited by women had BDSM content. Lehmiller's (2018) survey of over 4,000 men and women in the United States found that approximately 96% of respondents acknowledged fantasies of BDSM-related activities.

These studies and statistics clearly raise the issue of what constitutes an "unusual" sexual interest. The definition of paraphilia is likely more dependent on current social values and mores than on statistical norms or mental health issues (Giami, 2015). Identifying what is kinky and what is not is highly subjective. As Joyal and Carpentier (2017) note, oral sex was once considered a sign of pathological masochism (cf. Krafft-Ebing, 1886/1965), whereas it is now one of the most popular "normophilic" sexual fantasies (Joyal et al., 2015).

## Etiology

The origins of sexual attraction and interests, broadly speaking, include a variety of etiological theories regarding all forms of consensual sex and are beyond the scope of this chapter. While evolutionary theories abound to explain sexual behaviors such as infidelity and sexual desire discrepancies (Buss & Schmitt, 1993), learning theory is often invoked to understand more esoteric forms of sexual expression and interest (Thyer & Myers, 1998). These post hoc explanations of sexuality must be considered just that, attempts to make sense of an observed, and in this case, unexpected (for mainstream psychology) sexual behavior. Nevertheless, humans like to understand themselves and often seek or offer explanations for important aspects of their identity. Take the story of Christian, who was interviewed specifically for this chapter. Whether his story is about the development of his sexual interests or the first manifestations of them is not as important as the cautionary note about pathologizing developing sexual interests, particularly in children and young people. Christian is a 53-year-old cisgender, heterosexual Italian American male who identifies as a "sexual Dom and happy spanker."

> "I remember the first time I got really aroused by something that later turned out to be a big part of my sexuality. I was about 11 and I had this Superman comic book. On the cover was Lois Lane, tied to the railroad tracks. This wasn't an uncommon image in the land of comic book suspense, but that image of Lois was overwhelmingly erotic to me. I didn't want her to get destroyed by the train—plus, Superman always came to her rescue—but something about her body . . . bound . . . helpless. It stirred something in me. I've always been an artist, and drawing was my passion in those preteen years. I was good at it, too. I remember that image of Lois Lane and how it was reflected in the drawings I did of women with beautiful bodies tied up or bound in some way.

"I mean, it seemed normal to me. I liked women. I liked women's bodies. I liked drawings of women's bodies, and when they were depicted fully dressed, bound, and 'struggling' [I put air quotes around *struggling* because in two-dimensional comics the struggling happens in your mind], because it accentuates certain aspects of her body that a heterosexual 11-year-old boy would generally find exciting. I never thought of it as anything but exciting until the day my father sat me down to discuss the drawings my parents had 'found' in my room.

"My father explained that my attraction to women was normal but my 'obsession' with depicting women who were tied up was 'bad.' It was 'unhealthy.'

" 'Son we may need to get you professional help.

"Professional help? Was I going to see a doctor? Going to be arrested? I was terrified! Do you know, can you even imagine how frightening that was to me at that age? How utterly alone I felt? There was no one else to counter my father's opinion on the subject and, decades before the Internet, I thought I was alone with my sickness. This stayed with me, I mean really stayed with me until I was in my mid-20s.

"As an adult, I finally did open up to my therapist about this shame-filled secret I'd harbored for most of my life. She listened attentively and when I was done, she said, tenderly but with conviction, 'Oh, Chris . . . Is that all?'

"I couldn't comprehend that I was being seen, understood, and accepted by a mental health professional I respected after sharing my secrets and fantasies, especially after carrying them in isolation through most of my life, feeling broken and dirty.

"It was like this huge burden I'd been carrying for half of my life had been lifted in one therapy session. I'll never forget her.

"And, no, I never saw my drawings again."

## Assessment

Helping clients or patients feel comfortable discussing their sexual interests and behaviors, even if, or especially if, they worry about disapproval or condemnation is one of the goals of the first therapy encounters, often considered the assessment phase of therapy. Although questionnaires asking about specific sexual preferences are being developed (Weierstall & Giebel, 2017), and they may be useful for research and in some clinical contexts, in psychotherapy, it is the ongoing conversation between therapist and client or patient that is essential.

It is important to note that people who enjoy kink often also engage in traditional (nonkinky) sex. The term *vanilla* is often used to describe nonkinky people and activities, but I find the word pejorative to those who have more traditional sexual tastes. (However, it can be a delicious ice cream flavor.)

Assessment of sexual functioning should include inquiry into a range of sexual behaviors and take into consideration that functioning may vary across situations. In fact, DSM-5 adds specifiers regarding whether sexual dysfunctions are specific to certain situations or generalized across experiences. One study, albeit with a small sample of 68 people from the BDSM community, compared sexual functioning in BDSM and non-BDSM contexts. Women reported more difficulty maintaining sexual arousal in non-BDSM contexts compared to when they engaged in BDSM-related sexual activities. Men reported being less distressed about sexual functioning when they were engaged in BDSM but otherwise sexual functioning was adequate, if not good, in both contexts (Pascoal, Cardoso, & Henriques, 2015). Meana and Steiner (2014) provocatively raise the issue of whether many instances of hypoactive sexual desire disorder (HSDD) in men is really hidden sexual desire disorder (a new meaning for the acronym HSDD). So one thing to be mindful of when assessing issues of desire and arousal is that one might uncover hidden (at least from others) desires. Some of these desires may be kinky.

During a sexual history, direct inquiry about a variety of sexual experiences is helpful. This not only communicates that you are aware and accepting of sexual diversity, but that you are open to talking about a variety of sexual experiences. It can be daunting but highly therapeutic for someone to "come out" as kinky to his or her therapist, as the story of Christian clearly illustrates.

If a patient or client identifies as kinky, or reveals an interest in BDSM, for example, follow-up questions are necessary. Therapists often feel anxious when they are in sexual territory that is unfamiliar, but a nonjudgmental and inquisitive interest will further the evaluation: "I'm curious what BDSM means to you" may be an appropriate follow-up question. While sex therapists need not know everything about all forms of sexual experience and expression, the high prevalence of kinky sex should motivate us to educate ourselves about the fundamentals. With BDSM, asking how someone identifies is crucial to understanding his or her sexual experience: "Do you identify as a Top, bottom, Dom, sub, Switch?" In all sexual history taking, ensuring that sex is consensual (all aspects of the sexual experience) is vitally important, but especially so when power is explicitly being played with: "I just want to clarify, when you refer to getting beaten—is that consensual or nonconsensual?"

Assessing sexual functioning in the context of BDSM is similar to the assessment of sexual functioning in more traditional sexual contexts. In addition to a sexual history, which includes assessment of the sexual complaint (exploring any differences in the manifestation of the problem in BDSM and non-BDSM situations), one should inquire about relationship issues and past histories of physical, emotional, and sexual maltreatment. While a history of trauma is not an absolute contraindication for sex therapy per se, it needs to be factored into treatment decisions for anyone seeking help. This is where having experience/credentials as both a psychotherapist and a sex therapist is priceless/invaluable. Domestic violence, and high levels of anger in

one or more of the participants, should be screened for in *all* sexual histories and should also be assessed when encountering someone in the Kink community. Clearly, clinical sociopathy and narcissism are contraindicated for most, if not all, erotic play that involves conscious, most often inequitable, power exchanges. However, sometimes the factors that preclude engagement in power-based sexual exchanges are more subtle and may take some time to appear in therapy.

## A Cautionary Tale: Skyler and Tate

Skyler and Tate, in a monogamous relationship for 2 years, presented with the problem of "too little sex and too much arguing." Within the first session they proposed their solution, which was to open their relationship to others and experiment with BDSM. This solution was based on their theory that the presence of other lovers would help increase sexual desire for each other and that BDSM would provide a heathy outlet for their aggression.

As therapy progressed, Skyler and Tate expressed a number of ideas that were therapeutic red flags: (1) Other "lovers" were not described as human beings with desires and feelings, but as objects to be used to make them more interesting to each other; (2) polyamory was mentioned often, but there was a remarkable absence of "love" when talking about other "lovers"; (3) BDSM was not described as a craft or an art or a practice honed over time within a supportive, educational community, but rather as a vehicle for expressing aggression to be practiced in the isolation of their relationship; (4) BDSM, with which they had no previous experience, was conceptualized as a hobby to pick up when bored, like basket weaving or ceramics.

But the reddest flag of all was their lack of expressed affection and love in session and their anger and rage toward others and themselves. By the third session, the signs of one, or both of them, trying to control and manipulate the therapy, each other, and me became more obvious. My fee and gender were suddenly problematic. One of them blamed the inability to concentrate on an "allergic" reaction to my nonexistent cologne. The window in my office was too open and then too closed. After each session, they complained that I was not "greenlighting" them into the worlds of polyamory and BDSM (as if I were the official gatekeeper). They resented and fought my attempts to get them to focus on each other (the source of their collective and individual anger), on what brought them pleasure, and on what brought them together in their relationship in the first place.

I got nowhere. If anything, my basic therapeutic inquiry—a standard part of the initial assessment—just fueled their rage. They wanted results, which they defined as the following: (1) some objects to hit people with (and get hit with); (2) a few other warm bodies in their bed. When I attempted to get them to focus on each other, they would externalize, often hysterically. The "problems" were Dad, Mom, an ex-lover, me, the housekeeper, their neighbor who didn't separate his trash from his recycling, or the President. Incredibly

intelligent, they were passionate about what needed to be changed in society but unwilling to focus on what they needed to change in themselves.

During one session, they casually shared that they regularly threw things at one another—ashtrays, saucepans, books—whatever happened to be nearby. I voiced my concern and immediately tried to explore better ways to deal with anger. This strategy was short-lived. In fact, Skyler and Tate became increasingly angry because therapy continued without integrating polyamory and BDSM play. Both were incensed that I encouraged them to explore their own dynamics before venturing into a land that involved spanking, restraints, and other human beings. I explained, "BDSM is powerful sexuality, and there is too much unmitigated and unexplored rage between you for me to ethically recommend polyamory or power-based sexuality."

"But we came to you because you're supposed to be the guy that tells people that BDSM is OK."

"Well, then, I wish I'd known that sooner, because I am not the go-to guy for a unilateral green light on BDSM play. BDSM is neither 'OK' nor 'not OK.' It's neutral. It takes on a positive or negative cast when it is applied to a positive or negative relationship dynamic. I cannot very well encourage one of you to spank the other at night when you were throwing coffee mugs at each other that afternoon. It would be misguided and unethical."

Skyler and Tate terminated therapy.

## Sex Therapy in the Kink Community: Power, Play, and Pleasure

As the literature reviewed for this chapter attests, an interest in BDSM can no longer be objectively considered an unusual or statistically deviant interest. So, while sexual interest in, and arousal in response to, playing with power dynamics may be part of many people's sexual fantasies and sexual activities, there are some who also extend this interest into a lifestyle. People who practice diverse and nonmainstream sexual behaviors (kink) may form communities, as their kink describes for them not only their sexual preferences but, more importantly, their orientation and/or identity. For example, people may identify (sexually) as Dom or sub, but often these identities are important also in how they conduct their relationships, with protocols, discipline, and power dynamics being apparent. An extreme example of a power exchange relationship that extends beyond sex is the Master–slave dynamic illustrated in the clinical case that follows.

Individuals in the Kink community may experience problems with desire, frequency, and sexual function, much as anyone else does. However, there is little, if any, literature on the prevalence or treatment of sexual dysfunction specific to this population. It is likely that the sex therapy approaches described in this book will be relevant, with some modifications, for the Kink community. Alterations in the practice of sex therapy will necessarily entail

understanding the erotic potential of power, as well as the erotic use of objectification, and of roles and identities, as well as the absolute importance to the Kink community of negotiating consent.

## Power

To explore BDSM, kink, or any of the more esoteric, nontraditional sexual practices that use differentiation, playfulness, and power imbalances to enhance erotic and sexual pleasure without first looking at the concept of power is like going to a bondage party without restraints. For the purpose of this chapter, "power" is defined as a force, an energy, and the ability to do something or act in a particular way that is in line with one's goals and vision, or the ability to have someone else act in a manner that is line with one's goals and vision. While power is present is all sexual exchanges (Ortmann & Sprott, 2013), BDSM communities consciously and consensually employ, manipulate, and exchange power for sexual and erotic gratification and actualization. They employ power consciously to provide or underscore differentiation, distance, and mystery, which ultimately allows for an intensely connected sexual experience.

## Objectification

*Objectification* is the ultimate in distance and differentiation. While the term has negative connotations, objectification is actually quite neutral, and can be extremely erotic and powerful when people agree (consent) to objectify one another. To tease, to strip for, to touch with the intent to arouse but not satiate, to worship—these all rely on a sense of erotic separation. Objectification is a more holistic and relational approach to building arousal compared to the more genitally focused technique often referred to as edging. The International Society for Sexual Medicine (ISSM; 2019) defines "edging" as a technique used to delay orgasm, often used for men with premature ejaculation, as well as a gender-inclusive technique to enhance the experience of orgasm. Objectification, as practiced in the Kink community, involves denying orgasm to one's partner while stimulating him or her from a physical, emotional, powerful, or psychic distance—with the ultimate agreement that satisfaction will occur.

## Identities and Roles

Identities are relatively fixed, whereas roles are mutable and dependent on a specific context or activity. Roles are most often associated with the "play" aspect of BDSM. For example, a Dominant partner may identify as a Dominant in general, not just in the course of a scene. Furthermore, He or She may identify as a Sir (males, females, and people who identify as gender nonbinary can identify as a Sir). In the context of a scene or a BDSM psychodrama, the

same Dominant may take on the role of father, coach, or prison warden, but that role tends to end when the scene ends, whereas the overarching identity of Dominant or Sir is more consistent with the individual's personality construct and process of self-identification and is therefore more stable.

> A leatherboy may identify as a submissive and that *identity* may be one that he carries throughout his leather journey. However, in the course of a corporal punishment scene he may find himself in the *role* of miscreant schoolboy or disciplined football jock, a role that he will relinquish at the end of a scene though his identity as a submissive and leatherboy remains consistently a part of his identity construct. (Ortmann & Sprott, 2013, p. 19)

This is not to say identities cannot and do not change. Identities are subject to change as an individual grows and evolves, but identities do not change with the same frequency as the many roles played within BDSM scenes do.

## Negotiating Consent

In brief, *consent* means saying, "Yes, I agree to engage in certain acts." In the Kink community, those acts are then specified and discussed, hard and soft boundaries are agreed to, and consent is revisited repeatedly during the course of an encounter. In BDSM, consent is for both Dominants and submissives, for Tops and bottoms, and for all genders. Affirmative consent means asking repeatedly, for example, during the course of a long BDSM scene, whether consent is still in play. Anything but the answer "Yes" (unless there is prior agreement on body gestures or other signals as a substitute for "yes" because, for example, one or more participants are bound and gagged), then consent is no longer in play and the encounter stops immediately.

In this #metoo[5] era of increased consent awareness, it is interesting and ironic to note that consent was pioneered by the very people labeled (in the psychological and psychiatric nomenclature) as *deviant* or *perverted*. The gay leathermen practicing BDSM and those in the pansexual Kink and Fetish communities came up with agreements, often written down as detailed contracts, signed by all parties, outlining what behaviors were desired or acceptable, what behaviors were in the gray zone of negotiable, what activities were soft boundaries, and which were hard, non-negotiable, red light boundaries. The Kink community created an entire vocabulary in service to honest, sexual dialogue, with terms such as "Safe, Sane and Consensual" (SSC; Nielsen, 2010), which later developed into "Risk-Aware Consensual Kink" (RACK; Pitagora, 2013).

[5] According to the website *https://metoomvmt.org*, the "me too." movement was founded in 2006 to help survivors of sexual violence, particularly black women and girls, and other young women of color from low-wealth communities, find pathways to healing. It is now an inclusive resource and a dialogue about sexual harassment, sexual abuse and assault, and other forms of nonconsensual sexual behavior.

Members of these diverse and overlapping Kink communities even created the concept of safewords to halt or decelerate a scene if any party involved felt physically or psychologically unsafe or outside his or her comfort zone. Safewords interrupt a scene—because the word, if invoked, would sound so out of place and context that its utterance would rouse players from the erotic rhythm, the subspace, and Domspace that builds during a power-exchange scene. Among the hundreds of safewords I've heard since beginning my work with these communities in 1996, some favorites stand out: "arugula," "library," and "Kermit," to name but three.

Safewords are used because more common terminology for "Stop," or "Slow down" are often invoked within a scene to make it more erotic and powerful. Begging, pleading with phrases such as "Stop!" or "Please don't" or "No" are not acceptable safewords, because these very words are part of what makes a consensual scene even more erotic—the begging, the pleading, and the faux insistence on stopping—and add to the flavor and the fires of consensual nonconsent.

## Arianna and Bryan: Finding Balance and Breaking Rules

Arianna and Bryan are part of the Kink community. Arianna is a slave-identified, bisexual woman in her mid-30s. She is a beautiful, full-figured, proud, Brooklyn-born, Italian American woman with a girlish chuckle and a contagious, genuine laugh. Arianna wears corsets and wide tulle skirts, reminiscent of a ballet dancer's tutu. Her style of dressing shows off her legs and accentuates her curves. She is unabashedly proud of being a "fat girl." Arianna is in charge of the wardrobe department for a prestigious theater and opera company in Manhattan. Although she refuses to travel or tour with the company, she is in her element when helping the costume designers find unique and offbeat items of clothing. Arianna jokes about herself, like her flea market finds, as "what some people consider trash, others consider treasure." Arianna is smart, sexy, and sarcastic.

Arianna is in a relationship with her partner/Master/Owner, Bryan and she was seeking therapy on his order. Arianna was highly motivated to be in therapy, but nevertheless, in the initial sessions, she often reported feeling "out of sorts." This is not uncommon for submissives who have no prior experience of therapy. One of the main defining characteristics of the submissive, and certainly the slave-oriented submissive, is a desire to serve and please. The attention is rarely, if ever, focused on submissives but, rather, on their Master. Despite her eye-catching attire, Arianna was uncomfortable in the spotlight. She was even more uncomfortable having a period of time designated to focus on herself and it sometimes produced anxiety, which we learned to address, just as she learned to address the fact that one can be a slave and also accept attention, care, and service. Since slaves are so focused on serving their Masters (and others whom the Master has ordered them to serve), she had to learn to accept "service" from me, for I was in service to her as her therapist.

Arianna, however, perceived me as Dominant, which we eventually got around to addressing, and also I was noticeably a cisgendered male. In working with a submissive female, I had to be mindful of power differentials. Arianna was raised Catholic in a Southern part of the United States. Both of those subcultural factors socialized her to see men as superior to her.

Being a submissive was a part of her identity, not a role adopted for play purposes. The presenting problems she listed seemed to come from her partner, not her: "I need to listen more"; "I need to communicate better"; "I need to control my emotions." So the relationship with Bryan was a part of this individual therapy from the beginning. It was unclear whether Bryan was blaming the relationship problems solely on Arianna. It is sometimes the case that less insightful Dominants do not share in the problems and challenges of the relationship. Sometimes, it all gets blamed on the submissives. "They" need to be changed.

It is important for submissive clients to know that they have agency and autonomy in therapy. So, when asked to clarify her own goals, Arianna at first had some difficulty but eventually stated, "I do want to learn to communicate more, but the whole Dom/sub setup makes it really hard." She went on to describe the ways in which the formality and ritual of the Dom/sub protocol (which she liked most of the time) made "real communication" difficult: "Talking about difficult or challenging things are hardest to talk about when there's no break from the whole 'Yes, Sir. May I speak, Sir' stuff." Protocol, in BDSM relationships, is similar to military protocol, from which some of the hierarchical structure and honorifics are borrowed, and is used to define the behavior and hierarchy between partners. For example, submissives may only be permitted to sit, kneel, or stand in certain areas and must refer to their partner as Mistress, Madam, Mommy, Master, Daddy, or Sir.)

Because I am familiar with the BDSM community, and because a trusting therapeutic relationship had been established, I was eventually able to suggest to Arianna the possibility of a "time-out" from the Dom/sub protocol. A time-out was a way to get Bryan to listen to Arianna not only as a submissive but also as a woman.

"So," I said, "here's the deal: In power-exchange relationships—notice the word *exchange*—power is something you and Bryan exchange all the time. Power moves. It's an energy. A force. Many Master/slave and other formal Dom/sub power relationships have a practice of suspending the D/s dynamic for a period to allow both partners to speak freely with each other. No protocol and no punishments for a sub during this time. In exchange, the sub needs to agree to not see the Dom as less Dominant or less powerful for allowing a time of open communication. Allowing for this time *is* an act of power and trust, so this time is sacred." I continued: "Dom's sometimes feel that overly strict—or 24/7 protocols—dampen communications, too." Arianna had difficulty believing this, but she was willing to consider that it might be true and we then discussed logistics: "Some people do it on a relaxed day of the week—Sundays are common—and it's employed for no less than an

hour—four are optimal—and sometimes it works better to have an entire day in which the dynamic is suspended and the members of the relationship can communicate and come to know each other on a different level. It's also time to talk about difficult things that aren't easily solved within the confines of a 24/7 D/s power dynamic."

Before she could or would process how she felt about the proposed intervention, Arianna was focused on Bryan's potential reaction. However, when Arianna thought about it for a while, she was eager to try it. Arianna was able to suggest the time-out to Bryan as something she and her therapist thought would be a good idea. To her relief, Bryan agreed, and they set aside Sundays from 3:00 P.M. until they went to sleep as the "time-out" period. Bryan's willingness to suspend the protocol indicated an open-mindedness that was a good sign for the relationship.

As the direction of therapy began to focus on relationship issues with Bryan, Arianna disclosed that she had never experienced an orgasm. I was stunned given her previous satisfied descriptions of sex. It turns out that Arianna took great pleasure in Bryan's pleasure. She had no idea whether he knew she was not orgasmic. It turned out that he did not. When asked how she felt about her lack of orgasm Arianna replied, "It's never really mattered to me. My pleasure, I mean."

When asked, Arianna said that she only infrequently masturbated: "I just don't, I guess, put myself—my pleasure—first. It's kind of a submissive thing."

Bingo.

Arianna was intrigued by the idea of sex therapy, and I explained some of the rationale behind the techniques we might be using: "Well, since it's been something that you're not used to focusing on, we'd begin by giving you permission to enjoy your body as a vehicle of pleasure, not just for others, but for yourself."

I suggested to Arianna that she set aside intentional time—"dates with yourself—where the intention is to just explore your body without any goal of orgasm. Just connect with the pleasure. Hands, baby oil, toys, mirrors, it's all good."

"Oh, I could never look in the mirror! Yuck."

Surprise. This sexually adventurous woman, who enjoyed being harnessed, restrained, and flogged, found the idea of looking at her own genitals disgusting.

As a prelude to her homework, I brought a handheld mirror to the next session. First, I took the mirror, held it to my face and commented on my features. No judgment, just observation. Then Arianna did the same. Her at-home exercises were to use the mirror as we did in the session, except at home, she was to look at her genitals. The goal was acceptance and awareness of her genital anatomy. However, the mirror continued to be a part of her self-pleasuring process. Long after the need for the mirror to accept and identify genital anatomy subsided, she continued to use it to observe as she pleasured herself. Arianna was (intentionally or not) using the technique of

objectifying herself in order to intensify her experience of sexual pleasure. I made certain not to conceptualize orgasm as a goal, but rather as part of a process that was inevitable—a process of pleasure in which she was already engaged. The guided masturbation protocol first described by Heiman and LoPiccolo (1996), was individualized for Arianna and served as the basis of her self-pleasuring process.

Therapy is rarely a sequential progression of conquering one goal after another. Life, and other issues, compete for therapeutic attention. One day Arianna came into her session irate: "He's done it this time! He's really done it." Although it took her a while to calm down, eventually Arianna was able to splutter: "He called me 'chattel!' " ("Chattel" is a term referring to property, specifically, property that can be moved. Generally, when used to refer to human property—in this case a consensual slave—it is not a term of high honor.)

The day before our session, Bryan was asking Arianna's opinion about adding another person to their Leather family. Bryan was interested in having another submissive, ideally two (one man and one woman). Even though both he and Arianna were bisexual and polyamorous in orientation, their relationship up to this time had been, in practice, monogamous. Since additional partners were new to their relationship and new to Arianna, it was especially difficult for her to consider another woman in her relationship. A potential male sub would be less threatening. As Arianna expressed this opinion to Bryan, the conversation somehow deteriorated and Bryan ended up saying, "It doesn't really matter. I don't need to ask you about it at all. You're just chattel."

Boom! Bryan had dropped a bomb, and here it was in therapy.

At Arianna's request, I agreed to meet with Bryan. Arianna was pleased and signed a release of information. Bryan came into my office 3 days later. He was right on time. He was an imposing figure, distractingly handsome, dressed in leather with an aura of powerful sexuality. Bryan's firm handshake was a good indication that he wanted to meet with me. Bryan was a "seamster," his preferred term for "male seamstress," as he identified his profession. This very masculine-appearing male eschewed the term "tailor" as too masculine. He worked for the wardrobe department of several theater companies in Manhattan, including the one where Arianna worked, which is where they first met. He was also much in demand in the BDSM and Fetish communities for his sewing skills with leather and other fabrics.

"So," I said, "talk to me. You know I've been seeing Arianna for a while now and she's doing great. She's confronted some really difficult material like a champ."

"Yeah, she's pretty amazing."

"Indeed."

I let the silence be there.

"I fucked up. Didn't I?" This was huge. Bryan led me right to his awareness that something was wrong and that he was a big part of the problem.

"Yeah, you did." I grinned intentionally to show him that I was not judging him. "Guys fuck things up in relationships. We're not perfect. Even Doms."

"Are you a Dom?"

"Yes," I smiled. "Except when I'm not."

Bryan smiled back at my disclosure. The energy in the room was buoyant and relaxed. In that moment we were just two guys who "got" each other.

"Are you strictly Dom?" I asked.

Though this conversation may seem like I am steering him away from the topic at hand, quite the contrary, I am giving him time with the subject, while giving him breaks for us to get to know each other better and to spend some time talking about lighter matters in the interest of building trust and camaraderie.

"Yes," he said. "Now, I mean. I was a sub for a couple of women and for a couple of guys when I was younger. You know, I came up the 'traditional' way. Even though I was clearly a Dom-leaning Alpha male, in order to be a good Dominant, a strong Master, and a powerful leader, you have to experience things from the other end of the whip, you know?"

Bryan was really opening up with me. This topic—whether a Dom can really be a Dom until he or she has experienced being a submissive, even just once, is a controversial subject in our BDSM communities, with the Dominant camps somewhat divided between men who think that the best Doms have been subs at one point or another—and male Doms who believe firmly that, as Doms, they should never and will never sub, and that a Dom who has subbed is not a "real Dom."

"I love Arianna." He took us back to the subject at hand quickly. He was ready.

"Does she know that?"

"Yeah, but I probably don't say it, or show it, enough."

"What's stopping you?"

"Ugh," he exhaled, leaning back, lacing his fingers and cradling his head in them. "This whole 'what it means to be a man' thing. Fuck! I am from Queens [a borough in New York City]. I grew up in the 1980s. Man, it was drilled into me that a 'man' acts in certain ways and not in others. It's what you guys (meaning therapists) call 'toxic masculinity,' and it *is* toxic. The whole posturing like you don't give a shit, playing 'cool' when you're not. It's all bullshit." Bryan went on to talk about the suicide of a young queer college student in New Jersey, outed by his roommate: "That shit broke my heart. That shit shouldn't happen! That's what I mean about toxic masculinity. There are many different ways to be a man. Even though I like being a very "traditional" looking and acting guy, I don't hate on others."

Bryan disclosed that he wanted to marry Arianna, and that he did genuinely want to form a Leather family, but his anxiety was getting the best of him. His family of origin, as with many of Bryan's generation, did not understand his lifestyle and were hostile and rejecting. Sexual outsiders often have to form their own families. And this is what Bryan was trying to do.

Toward the end of the session, Arianna called Bryan and inquired how things were going. At the end of the call, he smiled. "She says she's not coming in next week. She wants us to meet again. I told her we weren't finished with everything. Sometimes I think she's running the show, not me."

"The subs have a lot of power. You can't give away what you don't have, right?"

Arianna continued in individual therapy and was soon enjoying orgasms (first) on her own and (later) with Bryan. It didn't happen overnight, and initially she became frustrated when she felt an orgasm build and then subside. She was used to being successful at sex, and she wanted to categorize this as a "failure." Perhaps I went into therapist Dom mode at this point, forbidding her to criticize herself and telling her to keep doing exactly what she was doing, because "you're enjoying what you're doing—right? You're not used to focusing on your own pleasure, but that's what you need to do. An orgasm is not something you work at, it's an experience you let yourself have. Keep doing what you're doing. Do not stop." She winked and said, "Yes, Sir." It was endearing.

Arianna used her "time-outs" on Sunday evenings to talk to Bryan about how to stimulate her to orgasm. In so doing, she gave him the power to pleasure her. He used this power by incorporating what Arianna had told him she needed into their D/s sexual relationship. Bryan was ecstatic when Arianna had orgasms with him.

Meanwhile, Bryan and I talked about how best to build his Leather family in a way that worked for Arianna and for him. Bryan and I met three times. The sensitive and powerful man that he revealed himself to be in our first meeting was able to recognize the importance of respect and consideration when building his family. He was able to calm his anxiety and proceed with care. I met with Arianna and Bryan once together. We used the same time-out of the D/s protocol in which they engaged on Sunday evenings to allow for an open exchange of ideas, thoughts, and emotions. This time, when Arianna expressed her preference for a male submissive to be brought into the family before a female was introduced, Bryan listened respectfully. Arianna was clear that she wanted to expand the family as well, but she was nervous about changing their relationship. It was now in Bryan's power to sensitively make the changes in their family.

About a month later, Bryan brought a male submissive (Chase) into the family. Arianna told me she loved her "little brother." Arianna and Chase were not sexual together, but they were very affectionate. I recall one vivid description of Arianna and Chase cuddled up under a blanket watching Christmas specials on television while tickling each other. Arianna was happy. Bryan was happy. Chase was happy.

Seven months later, Bryan added a female submissive to their growing Leather family. Arianna was happy and secure in the decision and she and her "little sister" Cristal found their own natural relationship level over time, undisturbed by competition and jealousy.

That spring Arianna and Bryan had a collaring ceremony with their friends and family from the BDSM, Kink, Leather, and Fetish communities in attendance. A "collaring ceremony" is a commitment ceremony whereby a Dominant and submissive pledge their commitment to one another publicly.

Almost a year later, Bryan asked Arianna to marry him. Federal marriage equality had just passed (in the United States) and Bryan, who vowed that he would not marry until other sexual minorities had the same right, now felt free to do so. Nontraditionalists at their cores, the wedding ceremony reflected what the couple had become—a healthy, conscious Master and slave who had successfully navigated both the power exchanges and the need for moments of equality and complete emotional and conversational transparency.

## Conclusions

I was never concerned that Arianna was in an abusive relationship, but my confidence in this was helped by the fact of my being a part of these communities. Working with people in BDSM communities requires becoming familiar with the culture and the philosophy and practice of power exchange. It requires, most of all, suspending judgment and avoiding preconceived ideas of what a good relationship looks like. In power-exchange relationships such as this one, the power moves both ways. It is important to remember that the Dominant only has the power because the submissive has given it. Bryan was concerned that he had "fucked up" not because he had failed to control Arianna, but because he had failed to be caring of her.

It is imperative not to pathologize those in BDSM communities. Research confirms that BDSM is not associated with past abuse or difficulties with "normal" sex (Richters, de Visser, Rissel, Grulich, & Smith, 2008). Neither is a preference for BDSM indicative of a personality disorder. While research fails to distinguish personality variables among BDSM practitioners and nonpractitioners, Dominants and submissives have been found to be similar on measures of empathy, honesty, humility, conscientiousness, openness to experiences, altruism, and agreeableness. While the desire for control is higher for Dominants as opposed to submissives, it does not distinguish BDSM practitioners from others. BDSM is an avenue that people may choose when they wish to express or suppress control rather than engage in something that highly controlling people feel compelled to do (Hébert & Weaver, 2014).

It is refreshing to work with people in relationships in which the power dynamic is consciously negotiated and openly discussed rather than remaining a taboo topic. Arianna and Bryan openly and unapologetically negotiated the power in their relationship. Bryan's identity as Dominant gave him the power to provide and care for Arianna and his Leather family. Arianna's identity as a submissive allowed her to give her power to a trusted person to care for and love her.

Just as the Kink community has pioneered active consent, so may it revolutionize the way people (and therapists) talk about, negotiate, appreciate, and enjoy the power inherent in relationships.

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CHAPTER 14

# Restoring Trust and Sexual Intimacy after Infidelities

LAWRENCE JOSEPHS

Infidelity is not a sexual dysfunction, but it is an issue that frequently brings individuals and couples to sex therapy. In Chapter 14, infidelity is conceptualized as a relational transgression that often results in attachment injury and a wide range of issues, including posttraumatic stress disorder (PTSD)-like symptoms in the betrayed partner, and guilt and shame in the unfaithful one. After the discovery of an affair, partners that choose to stay together often seek help restoring trust and intimacy, including sexual intimacy, within their relationships. Josephs identifies personality variables and cognitive skills deficits that are more highly represented in unfaithful partners and can interfere with emotional and sexual reconciliation and lead to treatment resistance. He suggests treatment strategies utilizing evidence-based treatment techniques that target these personality traits and cognitive issues. Therapists can thus avoid the pitfalls of judgment and moralizing as they help partners to reconnect sexually. An accepting attitude and therapeutic skills are necessary to navigate the charged atmosphere that infidelity can infuse into a relationship and to balance the need to address the betrayal, while focusing on helping couples forge a (renewed) sexual and intimate connection.

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In 2016, 76% of Americans surveyed said that extramarital sex is *always* wrong, down somewhat from 79% in 2000 (Labrecque & Whisman, 2017). Infidelity is a leading cause of divorce (Amato & Previti, 2003) and a common reason for referral to marital therapy (Weeks, Gambescia, & Jenkins, 2003). Infidelity, as distinguished from consensual nonmonogamy, may be defined as consenting to a sexually exclusive relationship, then engaging in extradyadic sex surreptitiously and lying about it if need be. Infidelity is construed as a form of relational transgression that is experienced as a betrayal of trust. While some individuals and couples also label extradyadic emotional relationships and online sexual behavior as infidelity, these behaviors appear to involve different relational dynamics (Martins et al., 2016) and are not discussed in this chapter.

Exposed infidelity is a form of attachment injury (Johnson, Makinen, & Millikin, 2001), as the betrayed partner[1] finds it difficult to trust and feel securely attached to an unfaithful partner. Betrayed partners not uncommonly experience hurt, humiliation, anger, dread of future betrayal to the point of paranoia, obsessive rumination about the betrayal, depression, and injured self-regard. The severity of emotional and sometimes somatic dysregulation precipitated by sexual betrayal suggest posttraumatic stress disorder (PTSD)-like qualities (Baucom, Gordon, Snyder, Atkins, & Christensen, 2006; Warach & Josephs, 2019).

There may be negative emotional sequelae for the unfaithful partner, who may have to contend with shame, guilt, reputational damage, and unforgiving attitudes for the relational transgression when the infidelity is exposed. Prior to exposure, the unfaithful partner may live in dread of being caught in a lie and worrying about relational dissolution if exposure results in divorce. The affair partner may also suffer a serious attachment injury in those situations in which the unfaithful partner was envisioned as a future life partner, but the unfaithful partner reconciles with the betrayed partner and precipitously terminates the affair. The affair partner may also suffer reputational damage if the affair is exposed.

## Prevalence

The most recent, available review of the research literature on prevalence rates suggests that in any given year, 2–4% of spouses engage in infidelity and lifetime prevalence rates are 20–25% of all marriages. Historically,

[1]Terms such as "betrayed" and "unfaithful" are used to describe the participants in infidelity, because this is the language commonly used. Despite the pejorative nature of some of the terminology, a nonjudgmental approach is needed and necessary when working with couples affected by infidelity.

there is a gender gap, with higher rates of infidelity being reported by men (21%) as compared to women (13%) (Labrecque & Whisman, 2017). Citing data from over 13,000 men and women, Labrecque and Whisman found this gender difference to be fairly steady between 2000 and 2016. Other studies suggest that the gender gap is closing, with women reporting infidelity at rates similar to men (Adamopoulou, 2013; Atkins, Baucom, & Jacobson, 2001). Infidelity occurs also in the context of committed relationships outside of marriage (cohabiting, dating) with similar prevalence rates (23.4% of men and 15.5% of women) (Martins et al., 2016). Precise statistics are difficult to ascertain, because a reliance on accurate reporting of a phenomenon that relies on deceit represents a major methodological challenge (Fincham & May, 2017).

Research on prevalence rates of and attitudes toward infidelity can be of limited value to clinicians, as such research may aggregate data from various subcultures between which there might be considerable variability. Research tends to focus on heterosexuals; studying infidelity in sexual minority communities and non-Western cultures may yield different prevalence rates, as well as different attitudes toward monogamy. Unless otherwise specified, this chapter deals primarily with infidelity in the context of heterosexual marriage.

## Individual Personality Differences

Research on overall prevalence rates and attitudes toward infidelity does not further our understanding of who is most likely to be unfaithful. Unfaithful partners, especially men, tend to be relatively higher on the so-called "dark triad" personality traits of narcissism, Machiavellian intelligence, and psychopathy (Jonason, Lyons, Bethell, & Ross, 2013). Anxiously attached females (Allen & Baucom, 2004) and avoidantly attached males (Allen & Baucom, 2004), as well as avoidantly attached individuals in general (Beaulieu-Pelletier, Philippe, Lecours, & Couture, 2011), are most likely to be sexually unfaithful. Narcissism, insecure attachment, and low empathy are associated with more permissive attitudes toward infidelity, and the gender difference in attitudes toward infidelity disappear when researchers control for these personality variables (Shimberg, Josephs, & Grace, 2016).

Research on personality predictors of incidence and attitudes toward infidelity alert clinicians to personality variables that are more likely to be present among unfaithful partners. It is important to keep in mind that the extant research does not suggest a diagnosable personality disorder, only an elevated level of certain personality traits. In addition, the strength of the statistically significant associations between these personality variables and infidelity tends to be on the small to moderate side. That means that many individuals high on these variables will remain faithful, while many individuals low on these variables may have affairs. In addition, some of this research has been

conducted on young, adult undergraduate samples or primarily white, middle-class Americans, potentially limiting its generalizability.

The same personality variables that predict infidelity also tend to predict who is more likely to become an affair partner (i.e., someone willing to have sex with a person in a sexually exclusive relationship) (Jonason, Li, & Buss, 2010). No personality variables have yet to be found that consistently predict who is likely to become a betrayed partner. Those who engage in infidelity are more likely to have been betrayed themselves (Warach, Josephs, & Gorman, 2018).

This line of personality research can be clinically useful to the extent it alerts the clinician to personality variables that might need to be addressed for treatment to be effective. These personality variables are associated with cognitive skills deficits that can contribute to treatment resistance such as self-serving bias (Warach et al., 2018), sexual hypocrisy (Warach, Josephs, & Gorman, 2019), low empathy (Shimberg et al., 2016), low reflective functioning (Allen, 2013), and thinking that tends to be rigid, dogmatic, and dichotomous (Mikulincer, 1997). Cognitive skills such as taking the other's perspective, seeing the shades of grey, seeing one's own role in interpersonal problems, and appreciating the impact of one's own behavior on a partner's mental states may need to be cultivated.

## Motives for Infidelity

There are a variety of motives that can contribute to infidelity and these motives do tend to be associated with the aforementioned personality variables. Unfaithful partners may be looking for (1) sexual novelty and variety outside of an intimate relationship (i.e., casual sex), (2) emotional intimacy that is lacking in the primary relationship, and (3) revenge for a relational transgression in the primary relationship (i.e., retaliatory infidelity [Shaw, Rhoades, Allen, Stanley, & Markman, 2013]).

Allen and Baucom (2004) reported that individuals with a dismissive attachment style reported reasons for being unfaithful consistent with wanting autonomy from the primary relationship. Individuals with fearful and preoccupied attachment styles were more likely to report feelings of neglect or rejection from the primary relationship and a desire for closeness as reasons for being unfaithful. Avoidant attachment style is associated with a tendency to split love and lust, and a preference for more impersonal sexual relationships (Feldman & Caufman, 1999; Hazan, Campa, & Gur-Yaish, 2006). Anxiously attached individuals are more likely to look to sex for reassurance. Anxiously attached women, but not men, are more likely to be unfaithful (Hazan et al., 2006).

Men more frequently are unfaithful looking for casual sex, while women are more frequently unfaithful looking for emotional intimacy (Atkins et al., 2001). That gender difference may be partially a function of men tending to

be more dismissively attached, while women tend to possess more fearful and preoccupied attachment styles (Feeney, 1999). The gender difference in infidelity tends to disappear when just looking at avoidantly attached individuals or securely attached individuals. Anxious attachment style tends to exaggerate gender differences, as anxiously attached men are less inclined to be unfaithful due to their rejection sensitivity, while anxiously attached women are more inclined to be unfaithful looking for emotional intimacy.

Narcissism is associated with unforgiving attitudes toward relational transgressions (Exline, Baumeister, Bushman, Campbell, & Finkel, 2004). For more narcissistic individuals, retaliatory infidelity may be a defensive way of dealing with feelings of hurt and humiliation that hide the underlying narcissistic wound created by relational transgression. Revenge, like anger, can be considered a "hard" or secondary emotion that defensively hides from a romantic partner shame-sensitive "softer" or more primary emotions, such as insecurity or dependency, that seem to expose weakness or vulnerability (Feindler, 2006).

## Developmental, Marital, and Cultural Contributions

Developmental, marital, and cultural factors are implicated in infidelity. In terms of developmental causation, children who suffer parental divorce, parental infidelity, and father absence are less likely to have stable monogamous relationships as adults (Glenn & Kramer, 1987; Hunyady, Josephs, & Jost, 2008; Surbey, 1998). Such individuals are less likely to have parents who role-model good communication and conflict resolution skills. Poor marital communication patterns that undermine the sense of trust appear to be associated with infidelity (Gottman, 2011). And, not surprisingly, more maladaptive communication patterns are associated with insecure attachment styles (Overall, Simpson, & Struthers, 2013).

Coed workplaces facilitate relationships that are more than "just friends" (Glass, 2003), as platonic workplace relationships turn into love affairs. Attitudes toward monogamy are changing in the culture at large as various forms of consensual nonmonogamy, such as open marriage and polyamory, become viable alternatives. Consensual nonmonogamy allows for partner sharing without the element of deceit and betrayal that characterizes infidelity. Such alternative arrangements sometimes require "jealousy work" in order to feel securely attached to a romantic partner one shares with others (Labriola, 2013).

Attitudes toward infidelity have become less judgmental in recent years (Labrecque & Whisman, 2017). To what degree exposed infidelity undermines the entire foundation of trust and connection of a couple may in part be a function of the culturally derived moral judgments through which partners interpret the deeper meaning of extradyadic sex (Perel, 2017).

Exposed infidelity sometimes results in positive outcomes when recovery from infidelity resolves underlying marital conflicts, leads to dissolution of abusive relationships, or results in happier second marriages to affair partners. Hidden infidelity may stabilize chronically dysfunctional marriages/families that might suffer even greater dysfunction were the infidelity exposed (i.e., psychiatric breakdown, homicidal rage, divorce with serious downward mobility, alienation from children). Infidelity has benefits as well as costs, so that only the individuals involved can ultimately judge whether the benefits have been worth the costs.

Moralistic judgments about the character flaws of each of the three members of a love triangle are not uncommon, as unfaithful partners are objectified as "cheaters," affair partners are objectified as "homewreckers," and betrayed partners are objectified as "cuckolds." Infidelity becomes a trigger of self-righteous indignation and moral outrage that defends against exposure of the underlying vulnerability, shame, and guilt that each member of a love triangle might feel. The dread of being unfairly judged makes it challenging for individuals to assume responsibility for the ways in which their interpersonal behavior has been emotionally damaging to another member of the love triangle.

Assuming such responsibility is difficult when so-called "bad" behavior may be an expression of underlying personality issues (i.e., narcissism, insecure attachment). This can be an especially shame-sensitive issue when patients have been previously criticized by romantic partners who angrily demand quick fixes of their apparently insufferable character flaws. The expression of harsh moralistic judgment may reflect a tendency toward dichotomous thinking, seeing the world in black and white (i.e., innocent victim and evil perpetrator), that is most pronounced among individuals with borderline personality disorder who suffer severe emotional dysregulation (Oshio, 2012). Encouraging a nonjudgmental and accepting attitude toward the personality conflicts and associated skills deficits of self and others may attenuate moralistic judgment and facilitate assumption of responsibility for the impact of one's characteristic behavior on a partner's mental states.

## Assessment

The personality issues associated with infidelity have been assessed through a wide variety of self-report measures such as the *Pathological Narcissism Inventory* (Schoenleber, Roche, Wetzel, Pincus, & Roberts, 2015), the *Experiences in Close Relationships Scale* that assesses attachment style (Wei, Russell, Mallinckrodt, & Vogel, 2007), the *Levenson Self-Report Psychopathy Scale* (Levenson, Kiehl, & Fitzpatrick, 1995), and the *Machiavellian Intelligence Scale* (Vleeming, 1984). In addition, attachment style and reflective functioning can be assessed through the *Adult Attachment Interview* (Jessee, Mangelsdorf, Wong, Schoppe-Sullivan, & Brown, 2016). The *Communication*

*Patterns Questionnaire* (Christensen & Sullaway, 1984) can assess the maladaptive communication styles associated with infidelity and insecure attachment style.

Assessment of the sexual problems and frustrations prior to infidelity, during infidelity, and after exposed infidelity is important. Infidelity can be associated with decreased sexual frequency. For couples trying to recover from infidelity, trust needs to be restored, as betrayed partners may suffer flashbacks of the sexual betrayal. Treatment may be sought for the sexual problems that may arise in the relationship with the affair partner. For example, some men might seek sex therapy for help with their erectile dysfunction with an affair partner. Infidelity can be associated with any of the sexual conflicts that humans suffer. For example, some individuals might seek help with conflicts around their sexual orientation, for example, passing for straight in a heterosexual relationship while having affairs with same-sex partners. Infidelity may serve different functions at different stages of development, as young adults might be unfaithful to explore their sexuality, whereas the elderly adult might be unfaithful to cope with an asexual spouse suffering serious medical issues.

The jealousy, hurt, and humiliation associated with infidelity can result in serious anger management problems that need to be assessed. Betrayed partners might violently lash out in anger subsequent to exposure of an affair. Aggrieved affair partners might threaten exposure to end a marriage an unfaithful partner is reluctant to end. Unfaithful partners might use an affair as a way to extricate themselves from an abusive relationship. Part of treating infidelity may be helping patients learn to better cope with the anger management problems of self and others.

## Treatment

Treatment for infidelity is often thought of as couple therapy for recovery from infidelity. Yet not all individuals aspire to recover from infidelity through couple therapy, and many seek individual psychotherapy, looking for other solutions to their conflicted love lives. Unfaithful partners whose infidelity remains undetected may seek treatment for indecision about continuing a secret affair, indecision about whether to leave a marriage for an affair partner, indecision about voluntarily disclosing an affair to the betrayed partner, help with shame and guilt about an undisclosed affair, or indecision about whether to stay with an unforgiving partner subsequent to exposed infidelity. Betrayed partners may seek treatment when they have sneaking suspicions of infidelity yet to be exposed and indecision about whether it is worth trying to recover from an exposed infidelity. Affair partners also present with indecision about whether to continue an affair with married lovers who have yet to leave their partners despite promises to the contrary, as well as for help with their hurt and anger when unfaithful partners abruptly terminate an affair,

hoping to reconcile with their betrayed partners. If there is a common theme when it comes to individuals seeking help for the problems created by infidelity, it is indecision and ruminative worry about what to do going forward.

A variety of approaches to couple therapy have been utilized to help couples recover from infidelity. These therapeutic approaches include marital communication skills training (Gottman, 1999), integrative couple therapy that combines communication skills training with approaches that focus on acceptance and commitment (Christensen & Jacobson, 1998), emotion-focused couple therapy based on attachment theory (Johnson, 2004), and approaches specifically tailored for recovery from infidelity (Baucom, Snyder, & Gordon, 2009). There is not extensive outcome research as to exactly how well such approaches work in helping couples recover from infidelity. Marín, Christensen, and Atkins (2014) found that couples that addressed infidelity in couple therapy did not differ in marital stability and relationship satisfaction from non-infidelity couples even at a 5-year follow-up. However, "secret" infidelity couples that did not reveal infidelity in couple therapy had significantly higher divorce rates compared to the other two groups. A caveat is that these results are based on 19 couples addressing infidelity within a larger study of 134 distressed couples in therapy. Nevertheless, the results make intuitive sense.

Most of the aforementioned therapies are generally short-term treatment approaches that seem to be reasonably effective in helping the relationship survive and restore some sense of trust and attachment security. It is not clear to what extent couple therapy by itself resolves the PTSD-like symptoms that betrayed partners suffer, nor to what extent the personality issues of unfaithful partners are ameliorated through short-term couple therapy. Also unclear is the extent that the effectiveness of the treatment suffers when one or both members of a couple have a serious personality disorder, of which the infidelity is an indirect expression.

At present there is no systematic outcome research on individual psychotherapy for the almost innumerable issues that unfaithful partners, betrayed partners, and affair partners experience. Josephs (2018) has recently suggested treatment strategies for the individual psychotherapy of such patients based on evidence-based treatment techniques for the personality issues that may be associated with infidelity. For example, the techniques of mentalization-based therapy can be helpful when working with patients who suffer low reflective functioning and low empathy (Bateman & Fonagy, 2004). The techniques of transference-focused psychotherapy can be helpful in working with patients whose thinking tends to be rigid, dogmatic, and dichotomous (Yeomans, Clarkin, & Kernberg, 2015). Encouraging a mindful attitude can be helpful in developing patience in relation to the chronic indecision and ruminative worry activated by the problems that infidelity creates (Keng, Smoski, & Robins, 2016), as well as alleviating judgmental attitudes toward the personality issues associated with infidelity.

## Case Discussion: Couple Therapy with a Focus on Mentalization

Roger and Sherry had been married for 10 years and had two young children together when Roger embarked on a serious affair with a work colleague with whom he had grown close. Roger and Sherry rarely had sex, as Sherry was a working mother preoccupied with child care and Roger had a demanding job with long hours and a long commute to work. Though both missed their sexual relationship, they just assumed that a sexless marriage might be inevitable in a long-married, dual-career couple with young children. Sherry did not feel that deprived, as her desire for sex was relatively low when she was worrying about her children, and she was always worrying about her children. In contrast, Roger felt an even greater desire for sex when he was stressed, and he felt continually stressed by the demands of work. In addition, Roger felt sexually rejected and assumed that Sherry did not care about his sexual happiness or sexual frustration. Sherry mistakenly assumed that Roger felt just as she did, disinterested in sex when feeling overwhelmed by the burdensome responsibilities of their family life together.

Roger and Sherry both demonstrated low reflective functioning in relation to their sexual relationship, though they were reasonably empathic and insightful individuals in other respects. It did not occur to Sherry that Roger did not share her ruminative worries about the children and that he misinterpreted her ruminative worrying and disinterest in sex as sexual rejection and cold indifference to his sexual needs. It did not occur to Roger that Sherry was overwhelmed by the burdens of being a working mother and was too stressed and too tired to be interested in sex. He took her apparent disinterest in sex to mean she loved the children more than she loved him. It did not occur to Roger that because he never voiced his sexual frustration, Sherry mistakenly assumed that he had no more interest in sex than she did. It did not occur to Sherry that Roger never asked for sex because he mistakenly assumed that he would be turned down.

Their faulty assumptions about each other's mental states and the actual impact of their own behavior on the other's mental states resulted in communication breakdown. Yet they remained unaware of the communication breakdown, because both mistakenly assumed there was a meeting of the minds based on their erroneous egocentric assumptions about each other's mental states, so nothing needed to be said.

Upon exposure of the affair, Sherry wanted to go for couple therapy to see if their marriage could be saved. Roger agreed more out of guilt than desire for reconciliation. Roger was thinking of separating from Sherry to see if he might be able to have a better relationship with his affair partner, Nancy. Roger discussed how they had grown apart since the children were born, and how he did not feel that they had much of a relationship. Initially, Sherry responded defensively with hurt and anger. Indignantly, Sherry scolded Roger for betraying her trust when she was only doing her best trying to raise their

children while holding down a full-time job. Roger did not defend himself against Sherry's accusation. He just said he was sorry and became emotionally withdrawn. It seemed like the marriage was over.

Roger had a tendency toward an avoidant attachment style. He simply withdrew when he felt rejected and looked for love and acceptance elsewhere. Sherry possessed a tendency toward anxious attachment. When feeling insecure, she became worried, controlling, and irritable, whether with her children or her husband. Sexual betrayal only exacerbated that side of her. They each hid their attachment vulnerabilities behind a defensive façade (i.e., Roger's detachment and Sherry's anxious irritability) without awareness of how their interpersonal defenses against attachment injury impacted the mental state of the other. Thus, they created defensive walls that shut each other out and pushed each other away, without awareness of what they were doing.

During the initial session, I offered my assessment of their difficulties. My assessment integrated ideas from both mentalization-based and emotion-focused therapies. The basic idea in emotion-focused couple therapy is that defenses against attachment injury push partners apart, while exposing underlying attachment vulnerabilities and obtaining an empathic response increases emotional intimacy and attachment security. The therapeutic challenge is to enable partners to let go of their defensive responses, be it the indignant separation protest of the anxiously attached or the emotional withdrawal of the avoidantly attached. In exposing underlying vulnerabilities, partners' capacities for empathy and compassion can be activated, allowing emotional intimacy and trust to be restored. Mentalization-based approaches can augment the process of healing underlying attachment injuries by encouraging partners to transcend their own egocentric assumptions to better assume the other's independent perspective and learn to appreciate the impact of their own interpersonal behavior on a partner's mental states.

In initial sessions, I clarified the nature of the communication breakdown, the ways that the partners appeared to misinterpret each other's mental states, and the impact of their own behavior on each other's mental states. Both Sherry and Roger validated that my analysis was correct and thanked me for the clarification that neither would have thought of on their own. Often, when therapists present patients with insights with which they agree, their immediate response is to ask how to apply the insight. It is not always obvious to patients what to do with a correct insight into a psychological problem. In response to that question, I said that if they hoped to reconcile, they would each need to be responsive to the other's underlying feelings of rejection if they hoped to heal the attachment injury. I noted that further emotional withdrawal or indignant scolding would only exacerbate the underlying injury.

By the next session everything had miraculously turned around. Sherry wrote Roger a letter, confiding that Roger was the love of her life and that she deeply regretted that Roger felt neglected all these years. In retrospect, she realized that Roger was a sensitive person and she had lost sight of that, as she had felt overwhelmed by the responsibilities and worries of motherhood

that absorbed all her attention. She said that she would be lost without Roger and hoped he would give her a second chance. Roger was deeply touched by Sherry's letter. He realized that Sherry understood his vulnerabilities and could love him in a selfless way his affair partner never would. Roger abruptly terminated the relationship with his affair partner and committed to recovering from infidelity.

I noted that Sherry had taken a significant emotional risk for intimacy in letting go of her hurt, humiliation, and anger to expose her hidden vulnerability to Roger once he had more than one foot out of the door. I noted that for the couple to more fully recover from infidelity and restore trust, Roger would also have to take significant risks for emotional intimacy. I noted that Sherry had to trust that Roger would no longer withdraw and look for love outside of the marriage every time he felt neglected or rejected in the marriage. Roger needed to come out of his shell even when he was feeling vulnerable, so Sherry could trust that he was still there for her when she was feeling overburdened by her worries and responsibilities for her children's welfare.

To resume their sexual relationship, both felt they first needed to restore the feeling of emotional intimacy that had been lacking. To that end, they started going out on date nights. Yet Sherry would have periodic flashbacks of infidelity when various reminders of the affair triggered her. For example, one time at a concert, lyrics about infidelity triggered Sherry. When they resumed their sexual relationship, Sherry would be troubled by intrusive thoughts of Roger having sex with Nancy, with whom he still worked. Such traumatic flashbacks would spoil budding moments of sexual intimacy. Roger worried that he might never be forgiven and withdrew. Sherry became irritable when she had misgivings about making herself vulnerable. I coached Roger that being patiently accepting rather than becoming withdrawn in dealing with flashbacks would help Sherry heal and restore her trust in him. I educated Sherry that flashbacks would fade with time as Roger earned her trust by consistently exercising patience and sensitivity when flashbacks were triggered by affair reminders. I encouraged Sherry to practice distress tolerance by mindfully observing her distress and waiting for it to pass rather than express irritability in a way that pushed Roger away.

## Conclusions

Treating couples that have experienced infidelity requires considerable therapeutic flexibility, as infidelity is frequently an aspect of a symptom picture that also includes a variety of personality conflicts and their associated cognitive skills deficits that may have contributed to the infidelity in the first place and may result in treatment resistance. In addition, therapists who treat couples dealing with infidelity must cultivate accepting attitudes toward the painful compromises patients may have to make in their efforts to resolve their relationship issues.

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SECTION B

# LIFESPAN AND TRANSITIONS

CHAPTER 15

# Sexuality in the Transition to Parenthood

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Many life transitions have an important impact on sexual functioning. The transition to parenthood, in particular, potentially impacts the biological, psychological, sociocultural, and interpersonal aspects of an individual's and couple's life. It is no wonder then that sexual functioning can be affected. The transition periods covered in Chapter 15 range from conception and pregnancy through the postpartum period. The "failure" to conceive (infertility), which brings with it a different set of sexual complications, is also briefly discussed. Research in this area is developing with respect to not only the transition to motherhood but also to fatherhood, with many new, expectant and hopeful fathers reporting sexual problems. Noting that changes "to the sexual and romantic relationship during the transition to parenthood will pose more challenges to some couples than others," Rosen and Byers offer a tailored sex therapy framework in the context of a biopsychosocial approach to sexuality to help address the unique needs of couples in transition to parenthood.

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Welcoming a child into the world is typically a time of great joy and excitement, but it is also a period of significant challenge to the intimate and sexual relationships of new parents. Most adults worldwide have children, making the transition to parenthood a highly common experience. We refer to the postpartum as the year following birth, and use the transition to parenthood to refer to both the pregnancy and postpartum periods. Changes to the sexual and romantic relationship during the transition to parenthood poses more challenges to some couples than others. In this chapter, we focus on those for whom it creates sexual difficulties or dysfunction, as in the following case example.

> It has been 8 months since Reneé and Charlie's son was born, and they have attempted sex once, with what they considered to be disastrous results. Reneé feels overwhelmed with caring for their son and that, given the choice, she prefers sleep over sex. On the one occasion that they tried having sex, Reneé was surprised that she had difficulty getting aroused, and she was distracted by thoughts about feeling unattractive due to her remaining "baby weight." Charlie is eager to resume their sex life, because it is important to him and he feels rejected by Reneé's lack of interest. Charlie felt guilty for pressuring Reneé before she was ready, but he was also uncertain and anxious about when and whether they would get their sex life back on track. He experienced some performance anxiety as a

result, which interfered with his erection. The sex ended abruptly, with neither partner feeling satisfied, and they have not tried again since.

Most expectant parents tend to focus on the positive outcomes of becoming a parent, and are confident that their sex lives will return to normal after the baby is born—if they have thought about it all. Unfortunately, as with Reneé and Charlie, the reality is that new parents experience a great number of sexual difficulties, and many feel unprepared to deal with them (Schlagintweit, Bailey, & Rosen, 2016). They also receive very little information about sexuality beyond when it is safe to resume intercourse and the need for contraception, and are reticent to bring up sexual issues with their health care providers (Barrett et al., 2000; Bartellas, Crane, Daley, Bennett, & Hutchens, 2000). Silence on the part of health care providers can serve to reinforce stigma or feelings of guilt/shame (e.g., "I should be focused on my new baby and not worrying about sex"; "Everyone else is able to have a baby and sex without any problems") and creates a missed opportunity to normalize sexual changes and discuss ways to resolve any problems. An open, validating, and nonjudgmental environment for discussing sexual concerns is essential to break down these barriers.

Overall, most people report a decline in sexual functioning and satisfaction over the course of pregnancy and in the early months postpartum, with a gradual improvement over time (Johnson, 2011). Even couples who do not experience major disruptions to their sexuality often report declines in sexual interest and satisfaction in response to the physical and psychological changes associated with this period. Thus, some individuals may meet diagnostic criteria for a sexual dysfunction, and others raise sexual problems that do not constitute a disorder but are nonetheless troubling to them and could ultimately result in a sexual dysfunction. For example, low sexual satisfaction could be a concern and warrants attention even if there is not a diagnosable disorder. In the context of pregnancy, commonly used diagnostic systems (e.g., the *Diagnostic and Statistical Manual of Mental Disorders* [DSM]; American Psychiatric Association, 2013), which typically proscribe sexual problems to be present for at least 6 months for a diagnosis of sexual dysfunction, are clearly inappropriate. Moreover, there is variability in the sexual experiences of expectant and new parents. Indeed, some women report increased sexual desire during the second trimester of pregnancy, and about a third of couples report increased sexual satisfaction postpartum, compared to prepregnancy (Ahlborg, Rudebald, Linnér, & Linton, 2008; Bartellas et al., 2000).

We begin this chapter with a summary of the prevalence of sexual difficulties and dysfunction in the transition to parenthood, followed by a review of biopsychosocial factors that play a role in maintaining or exacerbating sexual problems during this time. Many aspects of the assessment and treatment of sexual difficulties in the transition to parenthood are the same as when these problems are experienced at any other life stage. Our focus is on considerations for assessment and treatment that may be unique or especially

important to the transition to parenthood. We also include a brief discussion of sexual challenges relating to infertility. Finally, two detailed case descriptions illustrate our suggested approach to intervention.

## Prevalence and Description of Sexual Problems in the Transition to Parenthood

We use the term "sexual dysfunction" to refer to sexual problems that meet diagnostic criteria according to the fifth edition (DSM-5) (or fourth edition [DSM-IV] for older studies) of the DSM (American Psychiatric Association, 2013), and the terms "sexual problems" or "sexual difficulties" for those concerns that do not necessarily meet these criteria (e.g., due to study methodology or the nature of the sexual concern, such as sexual dissatisfaction). Prevalence studies have focused almost exclusively on the presence of problems in sexual functioning during the transition to parenthood, ignoring the criteria of distress and persistence. Distress and persistence are important indicators of the clinical significance of these issues and help to identify who might require intervention. Most studies have not adequately captured sexual dysfunction that was present prior to pregnancy and has been exacerbated during the transition to parenthood. Couples may be distressed because they feel unprepared for changes in sexual functioning—such as decreased desire or onset of pain during vaginal penetration—especially if their health care provider did not discuss these possibilities with them (Bartellas et al., 2000). Furthermore, women tend to report greater sexual distress when they believe that their sexual problems have led to lower sexual frequency or satisfaction for themselves or their partner (Stephenson & Meston, 2015), common occurrences in the transition to parenthood. However, similar to other life transitions, some couples are not distressed by changes in their sexual relationship, because they are focused on other priorities (e.g., caring for the baby), are comfortable with a new "normal," or expect their sex life to improve with time.

With these caveats to accurate estimates of prevalence in mind, up to 58% of pregnant women meet clinical cutoffs on standardized measures of sexual problems, including reduced sexual desire, arousal, orgasm, and satisfaction, and increased genito-pelvic pain (Bartellas et al., 2000; Vannier & Rosen, 2017). According to the only study to our knowledge that also examined sexual distress, about one-fourth (of 230 pregnant women) met clinical cutoffs for concurrent sexual problems and sexual distress (Vannier & Rosen, 2017), which is higher than population-based estimates (Shifren, Monz, Russo, Segreti, & Johannes, 2008). In general, the frequency of vaginal intercourse declines in pregnancy (Jawed-Wessel & Sevick, 2017).

In longitudinal studies, sexual functioning problems are higher in the first 3 months postpartum compared to prepregnancy—endorsed by 20–68% of women—and then decline over the next 9 months (5–37%), but not to

prepregnancy levels (Barrett et al., 2000; Sarafinejad, Kolahi, & Hosseini, 2009). In a study of 294 first-time mothers, 14% of sexually active women met cutoffs on standardized measures for problems in sexual functioning and sexual distress at 3 months postpartum, and 18% at 6 months (Vannier, Rossi, Schlagintweit, & Rosen, 2018), with an additional 16% (at 3 months) and 13% (at 6 months) reporting sexual distress in the absence of significant sexual problems. These rates are only slightly higher than population-based estimates (Shifren et al., 2008). Most couples resume vaginal intercourse by 8- to 12-weeks postpartum (Jawed-Wessel & Sevick, 2017).

Much less is known about the sexual experiences of partners during the transition to parenthood, and there are no data on female partners. One prospective study of 312 fathers found a decline in sexual functioning (e.g., low sexual desire, more erectile difficulties) compared to prepregnancy, which persisted across the pregnancy and through the first year postpartum (Condon, Boyce, & Corkindale, 2004). Prevalence of various sexual problems in new fathers has been found to range from 21 to 43% at 3 months postpartum, reducing to 2 to 17% by 12 months (Sarafinejad et al., 2009). Sexual concerns during this period do not always focus on sexual functioning. As depicted in the opening vignette about Reneé and Charlie, the prevalence of distressing sexually related concerns specific to the postpartum period (e.g., changes in body image, impact of child-rearing duties on time for sexual activity, sleep deprivation, and increased discrepancies in sexual desire) are almost ubiquitous: In a study of 259 new parent couples, more than half endorsed at least 16 of 20 sexual concerns, whereas nearly 90% endorsed more than 10 concerns (Schlagintweit et al., 2016). Little is known about the persistence of sexual dysfunction or concerns beyond 12 months; such knowledge is essential given the potentially transient nature of some of the contributing factors. Moreover, considering sexual difficulties to be "dysfunctions" may be inappropriate and indeed stigmatizing given how common these concerns are for new parents, and the array of biopsychosocial factors to which they are adjusting during this period.

## Biopsychosocial Contributing Factors

> Before the arrival of their first child with the assistance of a sperm donor, Lisa and Fatima reported high sexual satisfaction, although they argued at times about Lisa's lack of initiation and lower interest in sex. After the baby arrived, the difference in their sexual interest seemed to grow exponentially.

As this vignette illustrates, some couples have preexisting individual and/or couple sexual problems that worsen during this vulnerable period. Our focus is on factors that lead to, maintain, or exacerbate sexual problems in the transition to parenthood, rather than historical or precipitating

causes. Discussion of causes of specific sexual dysfunctions can be found in other chapters of this book. Researchers have focused almost exclusively on the role of biomedical factors (e.g., mode of delivery) in women's sexual function in the transition to parenthood. Thus, information on the role of psychosocial factors and the sexual experiences of expectant and new fathers, female partners who did not give birth, and adoptive parents remains scarce.

## Biological Factors

Physical factors associated with pregnancy that relate to reduced sexual function include somatic symptoms (e.g., fatigue, nausea, pain, urinary incontinence), increasing abdominal size, and pelvic joint pain (see Johnson, 2011, for review). Pain during vaginal penetration may occur as a result of changes in vaginal physiology to accommodate delivery and reduced lubrication. Increased levels of sex hormones, including estrogen, progesterone, and prolactin, contribute to pregnancy symptoms (e.g., nausea, weight gain, fatigue, breast tenderness), which may interfere with desire and arousal. However, there is limited evidence that sex hormones themselves are linked to reduced sexual functioning in pregnancy (Johnson, 2011).

In terms of the postpartum, breastfeeding results in hormonal changes (e.g., lower levels of androgens, higher levels of prolactin and oxytocin) that may lead to vulvo-vaginal atrophy and reduced sexual function, although some studies have not supported these associations (for reviews, see McBride & Kwee, 2017; Rosen & Pukall, 2016). There is also conflicting evidence for the contribution of parity (number of previous births), mode of delivery, episiotomy, and perineal tears to pain during vaginal penetration. A history of other types of pain (including preexisting painful penetration) and use of forceps or vacuum for delivery appear to heighten risk. Greater vaginal trauma and pain during vaginal penetration are in turn associated with a longer time to resume intercourse postbirth and impaired sexual function compared to prepregnancy.

## Psychological Factors

Psychological contributors to reduced sexual function and satisfaction in the transition to parenthood include anxiety about the consequences of delivery and becoming a parent (e.g., "Will my vulva look different?"); changes in identity and role adjustment (e.g., "Can I view my partner as both a parent and a lover?"); parenting stress; negative cognitions (e.g., "Now that I'm a mother, I'm less of a sexual being"); and concerns about body image. Such factors may also influence sexual behaviors (e.g., choice and comfort with positions; Jawed-Wessel, Herbernick, & Schick, 2016; Leavitt, McDaniel, Maas, & Feinberg, 2017; Vannier, Adare, & Rosen, 2018). Although unwarranted in

low-risk pregnancies, about half of expectant parents report fears that sexual activity could harm the fetus or cause complications (e.g., bleeding, miscarriage, preterm labor), leading them to avoid sexual activity (Beveridge, Vannier, & Rosen, 2017). Moreover, postpartum depression affects 8–20% of new mothers and 10% of new fathers, compromising their health and well-being, including reduced sexual function and well-being (Chivers, Pittini, Grigoriadis, Villegas, & Ross, 2011).

## Social and Interpersonal Factors

Sociocultural factors that may influence sexuality in the transition to parenthood include narratives about women's (ideal) bodies and expectations of motherhood (e.g., "Good parents should prioritize their baby above all"; "Mothers are less sexual"). Such factors also affect whether and how people communicate with their partners and health care providers about any sexual problems (Barrett et al., 2000). Attitudes toward sex during the transition to parenthood are variable across cultures, affecting sexual behaviors in different ways. For example, studies in Pakistan and Nigeria indicate that some pregnant women believe vaginal intercourse can widen the vagina and facilitate labor, whereas a study in Iran noted high fears of intercourse harming the fetus and thus high rates of abstention (Johnson, 2011).

Longitudinal research has shown that new parents experience steeper declines in relationship satisfaction than do nonparents over the same period of time (Keizer & Schenk, 2012). Although the associations are likely bidirectional, reduced sexual function and satisfaction may contribute to this pattern. Changes in the romantic relationship, including perceived roles and responsibilities, less time alone together, and conflict over parenting—all of which may be exacerbated by increased fatigue, low mood, and difficult infant temperament—contribute to couples' reduced sexual and relationship satisfaction postpartum (Doss & Rhoades, 2017; Leavitt et al., 2017).

Relational variables (e.g., partner support vs. conflict) have been found to be more influential relative to women's postpartum sexual desire than nonrelational factors (e.g., fatigue, stress; Hipp, Low, & van Anders, 2012). In a dyadic study, Sagiv-Reiss, Birnbaum, and Safir (2012) found that pregnant women were more motivated for sex by relational concerns (e.g., relationship insecurity) compared to their male partners. Moreover, recent dyadic research has shown that interpersonal factors such as greater empathy for one's partner, being understanding of each other's sexual needs, and smaller discrepancies in sexual interest, are linked to greater sexual and relationship satisfaction for both members of new parent couples (Muise, Rosen, Kim, & Impett, 2017; Rosen, Bailey, & Muise, 2017; Rosen, Mooney, & Muise, 2016). Such findings highlight the potential differential experiences of partners in the transition to parenthood and the importance of considering interpersonal correlates of both parents.

## Assessment

We consider the biopsychosocial model a useful framework for assessment. These factors are often best assessed by a multidisciplinary team. For example, physical therapists can best assess muscle dysfunction including hypertonicity. Physicians can best assess physiological contributions. Pharmacists would be most informed about possible sexual side effects of prescribed medications. When partnered, both parents should be included in the assessment, although it might be useful to see them separately at some point. The clinician should keep in mind that the importance of sex during the transition to parenthood differs across couples, and even between partners. It is essential to create an open and nonjudgmental environment.

Standardized self-report questionnaires of relational and sexual functioning can complement the clinical interview and be useful for comparisons with scale norms. Other chapters in this text provide information about measures to assess sexual dysfunctions. Useful questionnaires specific to the transition to parenthood include the Postpartum Sexual Concerns Questionnaire (Schlagintweit et al., 2016); the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987), which is also validated for use in pregnancy and in fathers; and the Maternal and Partner Sex during Pregnancy scales (Jawed-Wessel, Herbernick, Schick, Fortenberry, et al., 2016).

A comprehensive sexual history of both partners should include current and past sexual activities; prior sexual experiences, including prepregnancy sexual problems, as well as unwanted or unwilling sexual experiences in childhood and adulthood; and, the impact of the transition to parenthood on sexual desire, arousal, orgasm, and frequency of sexual activity, as well as sexual satisfaction for both members of the couple. In doing so, the assessment should explore the biomedical, intraindividual (misinformation/myths/lack of information; negative attitudes; anxiety; cognitive interference; psychological distress; lifestyle), and interpersonal (techniques/communication/sexual script; relationship distress) dimensions of the sexual problems (Lamont et al., 2012). Within these categories, the assessment should attend to any discrepancies in expectations and experiences between partners, as well as the following considerations that are particularly salient to the transition to parenthood.

### Biomedical Assessment

A detailed evaluation of pregnancy, labor, and delivery characteristics should include whether the pregnancy was planned; previous pregnancy outcomes (i.e., miscarriage or termination); and previous deliveries (mode of delivery, presence of trauma). Difficulties achieving a pregnancy and associated consequences should be assessed (see the "Sexuality and Fertility Problems" section). Questions should include whether the woman is breastfeeding and current use of contraception. The presence and experience of genito-pelvic pain requires a detailed evaluation, including a gynecological exam by a qualified

physician or gynecologist, and possibly an evaluation of pelvic floor muscle dysfunction by a physical therapist.

### Psychological Assessment

Given the high prevalence rates, symptoms of depression and anxiety should be carefully assessed in *both* parents. When postpartum depression and/or anxiety is present, the clinician should consider whether the sexual symptoms are in fact secondary to mood problems, and whether treatment for mood should be prioritized. Typically, there can be overlapping contributing factors to reduced mood and sexual functioning (e.g., fatigue, poor communication with partner), and a differential diagnosis may be less important than identifying and modifying these factors. It is important to assess for myths and misinformation/lack of information about sex in the transition to parenthood, including fears of harming the pregnancy, need for contraception, and what is considered to be "normal" with respect to changes in sexual function. Body image concerns, including perceptions that a vaginal delivery negatively impacts the genitals, distracting cognitions during sexual activity, and negative cognitions and attributions about the sexual relationship (e.g., "My partner is no longer attracted to me"; "I guess I'm just not that interested in sex anymore") are common (Cappell & Pukall, 2017; Jawed-Wessel, Herbernick, & Schick, 2016; Vannier, Adare, et al., 2018). As the following vignette illustrates, sometimes the difficulty arises from changes in the context in which the couple engages in sexual activity since having a baby, which introduces new anxieties.

> Leon and Janelle have an 8-month-old baby and presented with significant distress over Leon's recent development of erectile difficulties. Leon revealed that he felt pressure to perform and obtain an erection as soon as they started being intimate, because he felt they were on "borrowed time" between feedings and sleep awakenings. He also felt that Janelle was focused on having sex quickly, so she could sleep a while before waking again to feed the baby. Janelle was empathic to Leon's distress and did not realize she was contributing to a sense of urgency in their sexual activity. They subsequently worked on sensate focus exercises in multiple, but brief, interactions to reestablish a focus on pleasure rather than performance.

### Social and Interpersonal Assessment

Assessing the social context of the family unit provides valuable insight into potential stressors the couple is facing that may contribute to reductions in sexual interest, frequency, and satisfaction. Infant temperament and sleep patterns, financial constraints, division of child care, and availability and quality of external social supports (e.g., both instrumental and emotional) are relevant.

Relationship distress, as well as changes in couples' relationship dynamics in the transition to parenthood, should be assessed. Relationship distress and poor management of couple conflict (e.g., over parenting decisions) typically have a major impact on sexual well-being and functioning. Positive relational factors such as perspective taking, empathic concern for each other, and communication skills should also be assessed. Couples might not have needed to talk openly about their preferred sexual scripts before having a baby. As a result, they may not have the skills to effectively negotiate needed changes to the sexual script (e.g., decreased spontaneity, increased nipple sensitivity, new onset of pain during penetration). Finally, intimate partner violence, which affects 4–8% of pregnant women in the United States (Silverman, Decker, Reed, & Raj, 2006), must be considered. When this violence occurs, it can relate to partner jealousy, insecurity, possessiveness, and the woman's reduced physical and emotional availability during this time.

## Treatment

### Efficacy of Interventions

There is limited evidence of empirically validated psychological treatments specifically targeting sexuality in the transition to parenthood. Those that have been evaluated largely focus on prevention and psychoeducation. Lee and Yen (2007) compared a psychoeducational postpartum sexual health program—that included information on postpartum contraception, sexual physiology, and readiness for sex—to routine care in a sample of 166 Taiwanese women. At eight-weeks post-intervention, those in the sexual health program reported greater sexual health knowledge, more positive attitudes toward postpartum sex, and greater sexual self-efficacy compared to those in the control condition. A multidisciplinary team in Vancouver, Canada, recently developed the Women's Postpartum Sexual Health Program (WPSHP; McBride, Olson, Kwee, Klein, & Smith, 2017), which consists of four sessions (three group sessions; one couple session) that include psychoeducation, an introduction to skills and interventions aimed to enhance sexual and relationship satisfaction, and group support. It is not clear whether the specific targets of intervention in this program are empirically supported to enhance sexuality during the transition to parenthood. Evaluation of the WPSHP is currently under way.

A meta-analytic review of controlled, couple-focused interventions of expectant and new parents—some (but not all) of which included some limited information about sexuality—indicated small effects for couple communication and psychological well-being, and very small effects for couple adjustment (Pinquart & Teubert, 2010). The impact on sexual adjustment was not assessed. Thus, there is a clear need to improve these interventions; it is possible that a greater focus on sexuality may be helpful given the importance of sexuality to couples' physical, mental, and relational well-being (Diamond

& Huebner, 2012). Whether embedded within relationship interventions or through the development of novel, sex-focused interventions, it will be essential to integrate empirically supported targets that are specific to the transition to parenthood and modifiable in treatment (e.g., body image, desire discrepancies, empathy, cognitions).

It also would be valuable to identify potential moderators of treatment effectiveness, so that sexual interventions can be tailored accordingly. For example, there is some evidence that relationship-building interventions are more useful for couples at high risk for maladjustment postpartum (e.g., those with preexisting relationship problems; Jones et al., 2018; Petch & Halford, 2008). Similarly, couples who experienced sexual distress or problems prior to having a baby might benefit more from intervention by buffering against further decline. Moreover, better outcomes for relationship interventions are achieved when they are longer (more than five sessions); include both antenatal and postpartum components; are led by health professionals; are accessible at home; and include skills training (Petch & Halford, 2008; Pinquart & Teubert, 2010). Such findings provide guidance for the development of sexual programs.

## Treatment Approach

When considering treatment, we advocate for a couple-based approach where possible. The risk of targeting only one parent (usually the mother) can lead to a discrepancy in knowledge, expectations, and skills, providing further fuel for couple conflict over the sexual problems. Treatment should be geared toward addressing the sources of the sexual concerns identified during the assessment. Biomedically, sexual problems may be a result of physiological changes, a complicating medical condition, or side effects of medications (Lamont et al., 2012). Consistent with a biopsychosocial approach, even when biological factors are identified as affecting sexual functioning, it is important to also address psychosocial factors that may contribute independently or exacerbate biomedical factors.

Broadly, as in sexual difficulties unrelated to the transition to parenthood, the psychosocial sources maintaining sexual problems during this period include six possible individual factors (myths and misinformation/lack of information, negative sexual attitudes, anxiety, cognitive interference, behavioral and lifestyle factors [e.g., work schedule leaving little quality time for sex, baby sleeping in parents' bedroom], and psychological distress/mental health issues) and two possible interpersonal issues (relationship distress, poor techniques/communication/sexual scripts; Lamont et al., 2012). In most cases, couples' sexual problems are a result of more than one of these sources. In addition, cultural factors may affect the development and maintenance of sexual concerns. Regardless of the nature of the sexual difficulties, myths and misinformation/lack of information are best addressed through psychoeducation; negative attitudes through cognitive restructuring

or cognitive-behavioral therapy (CBT); anxiety through psychoeducation, as well as sensate focus activities, including a focus on relaxation and mindfulness (i.e., sex therapy); cognitive interference through cognitive restructuring/CBT and mindfulness training; behavioral and lifestyle factors through problem solving followed by strategies to promote change (e.g., stimulus control); psychological distress/mental health issues—especially postpartum depression and anxiety—through individual therapy (possibly followed by couple sex therapy); relationship distress through couple therapy, typically followed by specific interventions for the sexual concerns; and poor techniques and communication resulting in failure to engage in a mutually satisfying sexual script through psychoeducation, assertiveness training, communication training, and sensate focus exercises (i.e., sex therapy). It is important not to assume that sexual concerns fall along traditional gender roles; that is, despite the traditional sexual script that values high desire for men but not for women, in their study of new parents, Schlagintweit et al. (2016) found that 50% of couples endorsed the sexual concern whereby the mother had higher sexual desire than the father.

Some couples' concerns during the transition to parenthood are largely due to misinformation/lack of information and unrealistic expectations and thus likely do not require therapy; that is, couples experience many novel changes in their relationship and lifestyle during this period and despite how common these changes are, many are either unaware that these changes occur (e.g., impact of sleep deprivation on sexual desire, reduced sexual frequency) or are unprepared to deal with them (e.g., managing a desire discrepancy). As such, clinicians should keep the PLISSIT model—permission, limited information, specific suggestions, intensive therapy (Annon, 1976)—in mind in addressing the sexual concerns of couples who are in the transition to parenthood and intervene at the lowest effective level (Lamont et al., 2012). According to this model, the sexual concerns of many couples in the transition to parenthood can be effectively addressed by normalizing their experience and providing reassurance (permission). Otherwise, they may also need factual information (limited information) about sexual functioning (e.g., effects of breastfeeding on lubrication and use of lubricants, the typical course of pain following a vaginal delivery). Others may benefit from suggestions (specific suggestions) for change based on evidence-based practice (e.g., from the research literature) and clinical experience with other couples (e.g., creative ways of scheduling sexual intimacy around the schedule of the infant, importance of disengaging affection and sexual intimacy from genitally focused sexual activities). These suggestions should be based on a focused sexual history. They likely involve seeing the couple for a limited number of sessions, between which the partners agree to experiment with the suggestions as a way to either resolve the problem or gather more information that will be useful in refining the suggestion. Finally, some couples require in-depth sex therapy (intensive therapy) based on an in-depth and multifaceted assessment (Lamont et al., 2012). Couples who have sexual dysfunction prior to the transition to parenthood and are

experiencing a high level of couple conflict over the sexual difficulties are particularly likely to need intensive therapy. The presence of postpartum depression or anxiety may also require intensive therapy, concurrently or in advance of treatment focused on the sexual problems.

## Special Considerations

The evidence-based techniques used to treat various sexual dysfunctions are detailed elsewhere in this book. However, they often need to be adapted to address issues specific to the transition to parenthood. For example, couples may have unrealistic expectations (i.e., misinformation) and/or negative attitudes that are specific to this period. They may be dealing with relationship issues specific to changing roles within the couple, differences in parenting styles, and difficulties negotiating division of labor/child care and/or resulting from exhaustion. Furthermore, it may be important to target the reciprocal influences of relationship and sexual well-being given that both tend to decline in the postpartum period (Petch & Halford, 2008). Negative attitudes may be evident in partners viewing themselves or one another as less sexual now that they are a parent. Distracting cognitions may be related to the baby waking up or to new body image concerns.

There may also be more pragmatic concerns that interfere with therapy. For example, the couple may have a baby who is difficult to soothe and/or has medical issues, leaving little energy to engage fully in therapy. Parents may not have access to (trusted) child care and/or it may be difficult for them to schedule relaxed and uninterrupted time to engage in sensate focus or other sex therapy exercises. Such barriers may require engaging in creative problem solving with the couple, providing a more limited intervention than is ideal, with the intention of starting more intense therapy once they have child care and/or the baby is sleeping through the night, or recommending group rather than individual settings in a facility that provides child care.

> Suzanne and Tony presented with significant distress and conflict over Suzanne's lack of interest in sex in the middle of Suzanne's 1-year maternity leave. An assessment indicated that Suzanne's lack of interest in sex predated the pregnancy and birth. Several factors were seen as contributing to the problem, including both partners' lack of emotional intimacy and feelings of being understood. The assessment was conducted over a period of 2 months because of limited access to trusted child care. The couple received feedback on the sources of their sexual difficulties, including the likelihood that therapy might be long term. Discussion of the complication of finding child care while Suzanne was on maternity leave led them to decide to delay therapy until she returned to work and the baby was in day care. The partners were given specific suggestions aimed at preventing their problems from worsening in the meantime.

## Sexuality and Fertility Problems

For some couples, the sexual challenges they face begin with difficulties in becoming pregnant. "Infertility" is defined as the inability to achieve and sustain a pregnancy after 12 months or more of regular and appropriately timed unprotected intercourse or therapeutic donor insemination (Pfeifer et al., 2013). For women over the age of 35, a diagnosis may be warranted after 6 months. International estimates of the prevalence of infertility are 12% (Mascarenhas, Flaxman, Boerma, Vanderpoel, & Stevens, 2012). Fertility problems can take a massive toll on sexual well-being, from triggering or exacerbating mental health problems to initiating sexual dysfunctions (when none existed previously), to shifting the meaning of sex away from pleasure and intimacy and significantly altering a couples' sexual scripts. Sexual dysfunctions such as genito-pelvic pain/penetration disorder and erectile and ejaculatory disorders can interfere with becoming pregnant; however, this circumstance is much less common than sexual problems as a consequence of infertility and its treatment. Sexual problems—whether temporary or persistent—related to infertility occur frequently for both men and women: Estimates range from 10 to 60% of couples (Wischmann, 2010). For many, these difficulties and dissatisfaction persist after fertility treatment has ended, regardless of the success of the intervention (e.g., Schanz et al., 2011). Such findings underscore the pervasive impact of infertility and the role of psychosocial factors in the maintenance of sexual problems even after medical treatment is over.

For women, common sexual complaints include reduced sexual interest and arousal, inability to achieve orgasm, and pain during vaginal penetration; common complaints for men include difficulties with erectile and ejaculatory function, and reduced sexual desire. Factors that may contribute to sexual dysfunctions in the context of infertility include performance anxiety in response to planned and "on demand" sex, extensive and at times painful medical tests, depersonalization of and reduced control over the sexual relationship, repeated pairing of sex with reproductive failure, shifting the meaning of sex away from pleasure and toward reproduction, poor body image, and feelings of sexual inadequacy and guilt (Wischmann, 2010). Couples undergoing fertility treatment may avoid intimacy and affection during nonfertile times. More insecure relationship attachment styles, greater infertility-related distress, and lower sperm quality have been linked to lower sexual function and satisfaction among those seeking infertility treatment (Gremigni et al., 2018; Lotti et al., 2016; Purcell-Lévesque, Brassard, Carranza-Mamane, & Péloquin, 2019). Taken together, the sexual toll of infertility on the couple is extensive and may exacerbate existing relationship problems.

Couples may be reticent to broach sexual concerns with a health care provider for fear that it will interrupt their medical treatment. However, ignoring or minimizing these problems may also serve to worsen psychological and relational distress, which can negatively impact treatment outcomes (Grill & Schattman, 2016). Ultimately, a collaborative and open dialogue between the

couple and health care provider can validate and normalize sexual concerns, and allow for a discussion of when and how such problems may be addressed. Sensitivity to issues of gender and culture is paramount (e.g., threats to masculinity and femininity, comfort discussing sexuality, importance of parenthood), especially since these factors may impact sexual interest and arousal (Daniluk & Frances-Fischer, 2009). In addition, it is important to validate the couple's experiences by acknowledging the common feelings of guilt, shame, and inadequacy in relation to infertility and sexuality, and this will contribute to an enhanced therapeutic bond.

In the fifth edition of this book, Daniluk, Koert, and Breckon (2014) presented an assessment and treatment algorithm to guide decision making around sexual dysfunction in couples with infertility. The first step is to assess the sexual complaint and whether it is impeding fertility treatment. When the sexual dysfunction is not impacting fertility treatment, the couple has more flexibility to decide whether addressing the sexual problem is of high or low priority to them. Some couples might not want to invest the time and energy into resolving the sexual dysfunction while they are focused on becoming pregnant. In such cases, partners can be provided with limited information or specific suggestions, as well as support to help them manage the sexual problem, so that it does not interfere with treatment, such as the use of erotic materials, partner assistance in obtaining a sperm sample, and relaxation strategies during medical examinations (i.e., to reduce pain; Daniluk et al., 2014).

Treatment should be initiated when the sexual dysfunction is impacting successful medical intervention, threatening the couple relationship, and/or if it is highly important to the couple. In consultation with the fertility specialist, the couple must decide whether a hiatus from fertility treatment is feasible. In addition to a comprehensive sexual, psychological, and relationship history, the assessment should evaluate whether the sexual dysfunction is (1) preexisting or secondary to infertility; (2) generalized or situation-specific (e.g., problems more likely to occur when collecting a sperm sample, when the woman is ovulating); and (3) related to medical conditions or medications associated with infertility (e.g., endometriosis, prostatitis, medications such as clomiphene or gonadotropins) (Daniluk et al., 2014).

Typical interventions that target sexual dysfunction can be applied to couples coping with fertility difficulties. There are very few studies that have evaluated the efficacy of interventions specifically targeting sexual difficulties related to infertility. According to a meta-analysis, psychosocial interventions are effective in reducing distress related to infertility and increasing the likelihood of becoming pregnant, but there is mixed evidence for improvements in other areas, including sexual function (Frederiksen, Farver-Vestergaard, Skovgård, Ingerslev, & Zackariae, 2015). In a recent study of 29 couples undergoing fertility treatment, after participating in a six-session group intervention, participants reported reduced psychological distress and improved relationship satisfaction and fertility-related quality of life (Arpin, Brassard, El Amiri, & Péloquin, 2019). They did not, however, report any pre to

postintervention improvements in infertility-related sexual concerns or sexual satisfaction, possibly due to the limited focus on these topics in the intervention. In a randomized controlled trial of 100 couples coping with infertility in Iran, those who received three couple therapy sessions reported higher sexual and relationship satisfaction 3 months later than did a control group that received no intervention (Vizneh, Pakgohar, Babaei, & Ramezanzadeh, 2013). Finally, in a study of 70 women with infertility, those who were assigned to receive two psychoeducational sexual counseling sessions reported higher sexual functioning and satisfaction 4 months later than did a control group that did not receive any intervention (Demir & Aslun, 2018).

Prior studies of interventions focused on infertility and sexuality—although typically not exclusively—are limited by small sample sizes, lack of randomization, and an emphasis on brief psychoeducational interventions that typically are not based on theory. Still, at a minimum, psychoeducation about potential consequences of infertility for couples' sexual relationship during treatment will encourage more realistic expectations and normalize problems if and when they arise. Couples should also be supported (proactively) in strategies for maintaining their intimate connection beyond the focus on reproduction.

## Case Discussion

### Case 1

Robert and Elizabeth (ages 34 and 28, respectively) presented with a complaint of erectile dysfunction. The couple were seen monthly on four occasions. They had tried for the previous year to get pregnant. Initially, there were no sexual difficulties. However, the couple reported that for the past several months, Robert would get a partial erection during foreplay, then lose his erection when attempting penetration. The results of a focused (as opposed to a comprehensive) sex history revealed that the couple had a satisfying sex life without sexual difficulties prior to the decision to try to get pregnant and that there were no other serious relationship issues. The couple described Elizabeth, a nurse, as a generally anxious person and a perfectionist who became "obsessed" with her goals. In the current situation, her "goal" was to have a baby before she was 30 years old, because that was how she had always envisioned her life course, and because most of their friends already had children. She also subscribed to the myth that men are always interested in sex; thus, when she initiated sex and Robert was not interested, she experienced it as a personal rejection. She was closely tracking her ovulation cycle, but her shift work meant that there were days they were not home together when she was ovulating. As a result, she felt highly anxious about getting pregnant and would let Robert know when they "had" to have sex. He experienced this as a great deal of pressure, particularly because, for him, it was important that sex occur at "the right time and place." Four months earlier, due to their busy

work schedules, Elizabeth insisted that they have sex in the 20 minutes available before Robert had to leave for work, and he experienced erectile dysfunction for the first time. This experience was very upsetting to him, and Robert worried about whether the problem would continue. It also was upsetting to Elizabeth, who experienced it as a personal rejection and a threat to her life goal of having a baby before she was 30. She communicated her distress to Robert, which added to the pressure he was experiencing. As a consequence, the next time the couple tried to engage in sexual activity, Robert experienced interfering cognitions about both losing his erection and Elizabeth's reaction should this happen. This set up a downward spiral of sexual functioning for him (even greater performance anxiety, more intense and frequent interfering cognitions, etc.). In terms of the assessment model, the following maintaining sources of the sexual dysfunction were identified: myths and misinformation (Robert and Elizabeth), performance anxiety and cognitive interference (Robert), general anxiety (Elizabeth), and techniques and communication (Elizabeth and Robert).

In terms of the PLISSIT model, given the couple's satisfying sexual history and relationship, the therapist started by intervening at the levels of limited information and specific suggestions; that is, the couple was given information to counter some of their myths (e.g., a penis is not a machine, men are not always interested in sex) and about the impact of performance anxiety and nonerotic thoughts on sexual functioning. The paradoxical effect of Elizabeth's pressure on Robert (i.e., her role in his performance anxiety and that her pressure was taking her further from her goal rather than closer to it) was explained. The importance of "making love" (i.e., quality time together, emotionally connecting, engaging in foreplay) rather than focusing on vaginal intercourse, even when Elizabeth was ovulating, was discussed in the context of both Robert's sexual functioning and the possible long-term consequences of their current pattern of behavior. In an individual (third) session, Elizabeth was introduced to CBT and a self-help book was recommended as a means to reduce her anxiety generally and her anxiety about not getting pregnant specifically. This enabled the couple to implement the suggestions (i.e., Elizabeth worked on changing her cognitions, which then allowed her to change her behavior; the couple stopped having pressured sex) and, after they did so, Robert did not experience erectile dysfunction when they had sex several times. In the final appointment, the couple shared that Elizabeth was pregnant and that she was continuing to work on her negative cognitive distortions. They indicated that they felt that therapy had been very beneficial, and they could manage any future problems that might arise on their own.

### Case 2

Sean and Diana (both age 33 and together for 6 years) sought therapy due to Diana's lack of sexual desire; they had only engaged in sexual activity once in the 7 months since the birth of their daughter (Beth). The couple reported

an uncomplicated pregnancy, labor, and delivery. Diana was breastfeeding and, after some initial adjustment, it was going well. Sean worked for a local telecommunications company, and Diana was at home with their daughter; previously, she had worked as an accountant. The assessment phase consisted of an initial joint appointment, in-depth sexual histories with Sean and Diana separately, and a feedback session.

Diana indicated that since Beth was born, she never thought about sex and would rate her sexual desire as "0." She also experienced very low sexual desire during her pregnancy, and the couple only engaged in sexual activity a few times during that period. Sean indicated that he was reluctant to initiate sex because of Diana's strong negative reaction, although he still did so at times, which Diana experienced as high pressure. Diana reported several behaviors as a means to reduce his sexual initiations: stopping any physical affection, avoiding undressing in front of Sean, and having Beth sleep in their bed. Sean reported that he missed the emotional closeness he experienced from engaging in sexual activity. He indicated that when Diana refused his sexual advances, he felt personally rejected. Diana indicated that she agreed to see a sex therapist because she "wants to want" to engage in sexual activity. The couple reported many common interests and that, with the exception of sexuality, their relationship was excellent, with general agreement on parenting, their future goals, and their values.

The couple indicated that at the beginning of their relationship, they had a positive and frequent sexual relationship that was spontaneous, varied (in terms of activities, time of day, and locations), and pleasurable for both of them. However, they had experienced a gradual decline in sexual frequency due to Diana's lower desire, and this had been a source of stress between them. Diana attributed her low desire to her long history of depression and anxiety. Diana had been diagnosed with and received treatment for postpartum depression by both her family physician (who prescribed a selective serotonin reuptake inhibitor [SSRI]) and an individual therapist; therapy did not include CBT. Diana did not feel that the medication had affected her desire. She reported that due to the medication and her previous therapy, she had learned how to cope with her depression but not her anxiety. Currently, her main source of anxiety was that she was an inadequate mother and that she would inadvertently harm Beth in some way.

Diana reported that she had always found her genitals distasteful and ugly and also worried that they smelled bad, but she did not connect these attitudes to her low desire. She also experienced high anxiety at the thought of engaging in sexual activity with Sean and overwhelming guilt when she refused his initiations, particularly when she could see that Sean was physically aroused. She reported a difficult childhood following her parents' divorce, which resulted in her living full-time with her father and stepmother. She reported experiencing emotional neglect from her father and emotional abuse and neglect from her stepmother. Her experiences of childhood maltreatment appear to have contributed to both her mental health issues and low self-esteem. Diana reported

that she found Sean attractive. However, she indicated that her motivation for sexual activity with Sean (and also with her previous partners) stemmed from a need for emotional closeness and to feel desirable rather than from her own sexual interest. Although she described their early sex life positively, she described a sexual script that included little foreplay and tended to focus on Sean's preferred sexual activities. On the one occasion that they had engaged in sexual activity since Beth's birth, Diana reported experiencing anxiety and interfering cognitions. For example, she worried about the cleanliness of her genitals, whether she and Sean were making "too much" noise and would wake the baby, whether she would orgasm, and whether Sean would notice her "baby fat." As a result, she "just wanted to get it over with" and did not find it pleasurable. She indicated that Sean's sexual initiations were problematic for her, in that she needed more build-up during the day that included intimate interactions (e.g., flirting) rather than an abrupt initiation.

Sean indicated that he hoped that sex therapy would both reduce the discrepancy in their sexual desire and allow them to incorporate the spontaneity and variety that they previously had in their sex life. He frequently did not initiate sex when experiencing desire in order to avoid feelings of rejection and causing Diana to feel guilty about refusing him. He also missed the physical affection they used to engage in; he described himself as a highly affectionate person and felt that their affection made him feel more like they were a team in their new parenting role. However, he did not appear aware of Diana's level of anxiety about engaging in sexual activity or her negative attitudes toward her genitals, seeing the problem as resulting from her low desire. He reported poor ejaculatory control but reported that Diana responded supportively about this, so it was not a problem. He reported that because of his busy work schedule and limited finances for babysitting, most of their leisure time was spent as a family, with little time spent as a couple.

The following maintaining sources of the sexual problem were identified for Diana: myths and misinformation (e.g., if Sean had an erection, she needed to satisfy his desire); negative attitudes about her genitals and sex; and, anxiety, both general and performance anxiety exacerbated by her negative attitudes. Interpersonal factors that contributed to the problem included techniques and communication resulting in failure to engage in a mutually satisfying sexual script (e.g., lack of nonsexual physical affection, no buildup to initiation, little foreplay, Sean's lack of awareness of the discrepancy between Diana's behavior and affect); and lifestyle issues (Sean's schedule, little quality couple time which was necessary for Diana to engage in sexual activity).

Sean and Diana were given feedback about the sources of their sexual problems. After discussion, the couple and therapist agreed that Diana would be seen individually initially, with the goal of helping her develop strategies for dealing with her anxiety generally and with respect to sexuality specifically, as well as to work on challenging and changing her negative sexual attitudes. At the therapist's suggestion, the couple agreed to a temporary no-sex rule (defined as physical behaviors aimed at sexual arousal) to take pressure off

the relationship. This restriction allowed Diana to feel comfortable agreeing to work on rediscovering and increasing expressions of physical affection.

Diana was seen individually for six sessions. She was initially resistant to CBT but ultimately was able to identify cognitive distortions and low tolerance for uncertainty as leading to anxiety, guilt, and low self-esteem, and worked to change them. Of particular importance was challenging her negative cognitions around her motherhood role and potential to inadvertently harm Beth, and need for certainty in these areas. In the fourth individual session, Diana reported that her mood had improved and her general anxiety had reduced significantly. She had started to have positive sexual feelings but "not lust," and was still anxious about engaging in sexual activity with Sean. Diana was challenged to use her CBT skills to counter her negative attitudes/feelings toward her genitals. She also engaged in self-exploration exercises coupled with mindfulness, which further reduced her negative attitudes and emotions toward her genitals, and helped her stay more present with any pleasurable sensations.

The couple then began sex therapy, while the therapist continued to check in with Diana on her success at replacing her distorted cognitions. Therapy first focused on general communication and problem-solving skills aimed at resolving some long-standing issues—exacerbated in the transition to parenthood—around decision making and division of labor in the relationship. The couple then engaged in sensate focus exercises that excluded breasts and genitals as both *in vivo* desensitization and as a means of helping the couple develop a mutually satisfying sexual script that started with sensual touching. A key aspect was a discussion of developing a better script for sexual initiation that took into consideration not only both partners' needs but also limitations related to their parenting schedule. The therapist sought to empower Diana to be able to share and problem-solve around any anxious feelings with Sean rather than either avoiding sexual activity and/or forcing herself to engage in unwanted sexual activities. Initially, Diana was in charge of initiation as a means to interrupt the initiation–refusal pattern that had characterized their recent relationship. After only three couple sessions, Diana found a job in another city that made it impossible for them to continue. She decided that she could engage in and enjoy sexual activity with Sean as a means to feel close to him even if she did not experience desire. The couple decided to end therapy and continue to work on their sexual relationship on their own.

## Conclusions

We have focused in this chapter on sexual problems and dysfunctions experienced by couples assuming a fairly typical presentation and progression from pregnancy to childbirth, with some attention devoted to the case of infertility. The sexual adjustment of couples may be further compromised by additional challenges such as multiple births or health complications experienced by the

infant or mother. Still, because sexual concerns are almost ubiquitous during this period, it is essential to assess the level of distress experienced by each member of the couple before assuming any (intensive) therapy is required. Enhancing awareness of the possibility of novel sexual challenges is likely beneficial simply by normalizing this experience and helping to create more realistic expectations for the sexual relationship during the early phases of new parenthood. A recent knowledge-sharing initiative entitled *#postbabyhankypanky: Keeping the Spark Alive* harnessed the power of social media to disseminate five brief YouTube videos, each based on recent research examining risk and protective factors affecting the sexual relationships of new parents. The goal of this initiative is to normalize postpartum sexual concerns and open the lines of communication between partners, and also between health care providers and new parents. More information and the videos may be accessed at *www.postbabyhankypanky.com*.

Our review of the literature highlights a lack of longitudinal studies on predictors of sexual adjustment in the transition to parenthood, particularly regarding the role of psychological and social/interpersonal factors, making it difficult to draw any causal conclusions. There is a clear need for more rigorous research, particularly dyadic research, aimed at identifying how each parents' thoughts, feelings, and behaviors impact their own and their partners' sexual adjustment. This information would inform the development of novel interventions for couples' sexual problems in the transition to parenthood.

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# CHAPTER 16

# Sexuality and Aging

## *Navigating the Sexual Challenges of Aging Bodies*

DANIEL N. WATTER

> Can you imagine old age? Of course you can't. I didn't. I couldn't. I had no idea what it was like. Not even a false image—no image. And nobody wants anything else. Nobody wants to face any of this before he has to. How is it all going to turn out? Obtuseness is de rigueur.
>
> —PHILIP ROTH, *The Dying Animal*

Sexuality may serve a unique role in the lives of older and aging adults in that it "represents a life force, the antithesis of death that can neutralize the dread associated with the end of one's existence." After reviewing the research literature on sexuality and aging, a literature that challenges the prevailing cultural belief that aging inevitably results in diminished sexual pleasure, Watter suggests in Chapter 16 that Western society's anti-aging bias is rooted in anxiety regarding death. In the tradition of Yalom and other existential therapists, Watter writes that dealing with this death anxiety and the regrets concerning one's life are crucial to any therapeutic process with aging adults. So sex therapy with an exclusive focus on restoring function will not be sufficient for many clients who also need to confront their regrets about life and their terror of death. Watter presents rich case examples that illustrate this existential approach and suggests how sex therapists can increase their therapeutic success by dealing with the existential angst surrounding death.

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Most people say that they are not looking forward to aging. Much like the opening quote from a Philip Roth character (2001), our images of an aging person are often filled with negativity, loss, and fears of irrelevance. Much of Western society is clearly oriented toward a culture of youth, and aging is often treated as a "disease" to be avoided at all costs.

Berliner and Solomon (2018) aver that adults often resist describing themselves as aging because they are aware that being old is a devalued, stigmatized personal identity. However, it is projected that by the year 2035, one person in five in the United States will be 65 or older (Joint Center for Housing Studies of Harvard University, 2016). Bioethicists have recently expressed concern that as American society has aged, many of our policies regarding elderly adults have also become outdated (Berliner & Solomon, 2018). Specifically, they have come to see that a view of aging that focuses almost exclusively on illness is no longer sufficient to meet the ethical and lifestyle challenges of an aging society. This is certainly the case when it comes to understanding the relationship between sexuality and aging. There was a time when the idea of linking sex with aging would have been considered an oxymoron. Historically, Western cultures did not see a society's elders as having sexual needs, wants, desires, and/or interactions. The prevailing narrative of the impact of aging on sexual functioning has been an inevitable process of decline that can only impede one's enjoyment of sex (Agronin, 2014; Bouman & Kleinplatz, 2016). Presently, we understand that this is far from the reality of many aging adults, yet many misunderstandings, misperceptions, and biases persist.

The aim of this chapter is to refute this view by presenting research and clinical information that brings us to a more complete understanding of the role sex plays in the lives of an aging population.

## Research on Sexuality and Aging

Despite the aging of the population, little is known about the sexuality of older people (Lindau et al., 2007). We have few studies, and this results in modest amounts of data. In addition, flaws in our research design taint much of the meager data we do have. Bouman and Kleinplatz (2016) have suggested

that the conflation of aging and disease has had serious detrimental implications for our research strategies. They further argue that much of our research on sexuality and aging has considered the aging population as a single cohort, ignoring the cultural, health-related, religious, and age variance in this heterogeneous group. In addition, the majority of our professional literature on sexuality and aging has concentrated on topics such as sex in residential and nursing home settings, sex and illness/disability, sexuality and dementia, disinhibited sexual behavior, and other topics related to the link between aging and sexual deterioration. Other concerns emphasized by Bouman and Kleinplatz include the inadequate characterization of the sample populations and the drawing of conclusions from small, nonrepresentative and nonrandom samples, and limiting interest to the presence or absence of coital activity.

What we do know is that aging bodies bring changing bodies, and that sexual functioning changes over time for both men and women. Several researchers and clinicians have documented the physical and sexual changes of aging over the years (Agronin, 2014; Laumann & Waite, 2008; Leiblum & Sachs, 2002; Lindau et al., 2007; McCarthy & Metz, 2008). Changes such as decreased frequency of morning erections, decreases in penile sensitivity, the need for more direct penile simulation, slower occurring erections, less rigid erections, reduced ejaculatory urgency/intensity/consistency/volume, longer refractory periods, and more rapid postejaculation/orgasm detumescence are all common occurrences in men as they age. Similarly, for women, vaginas may shorten and narrow, vaginal walls may thin and stiffen, vaginal lubrication may decrease and take longer to occur, and orgasm may become more inconsistent. Both genders likely experience a decrease in frequency, desire, and intensity, and intercourse becomes more difficult as well. Despite these changes, however, Lindau et al. (2007) and Štulhofer, Hinchliff, Jurin, Hald, and Træen (2018) report that the majority of older adults in their samples consider sexuality to be an important part of their lives. This is particularly true for those involved in spousal or other intimate relationships. These findings are echoed by Bouman and Kleinplatz (2016), DeLamater and Koepsel, (2016), Reece et al. (2010), Schick et al. (2010), Herbenick et al. (2010), and Elders (2010). Solway, Clarik, Singer, Kirch, and Malani (2018) found that among those 65–80 years of age, 76% agreed that sex is an important part of a romantic relationship at any age, and 54% of those in a romantic relationship reported that they are currently sexually active. Of note is that in this poll, 73% of those responding indicated they were satisfied with their sex lives (37% *extremely or very satisfied*, 36% *somewhat satisfied*). Women were more likely to be *extremely* or *very satisfied* than men (43 vs. 31%), as were those with a romantic partner as compared with those without one (40 vs. 30%), and those in better health as compared with those in worse health (40 vs. 28%). It is noteworthy that despite the overwhelming data indicating that sexual function changes with age, and that what are typically considered sexual "dysfunctions" are correlated with aging, most adults in these polls report being quite satisfied with their sexual lives.

Of course, we know that much of what limits satisfying sexual activity is related to health, medications, partner availability, and several other mitigating factors. It has been well documented that the causes of sexual difficulties in later life are typically multidetermined (Agronin, 2014; Lindau et al., 2007). However, as Kontula and Haavio-Mannila (2009) reported, although a significant number of older adults report experiencing chronic health conditions, they are rarely cited as barriers to sexual functioning and enjoyment. Given these criticisms, and the data suggesting that almost three-fourths of those surveyed are satisfied with the quality of their sexual lives, it seems advisable that we consider the likelihood that our assumption that changing bodies equate with sexual dissatisfaction may be erroneous.

## Personal Distress and the Fear of Aging

One possible way of reconciling diminished function with increased satisfaction is suggested by the existential therapy literature. Yalom (2008) suggests that many of us cling to the irrational belief that life is a never-ending upward spiral. We often assume that life is supposed to continue to be a productive and constantly improving quest for immortality. As a result, he posits that it is incumbent upon us to do all within our power to thwart (deny) the inevitability of an eventual physical decline. In essence, Yalom proffers the notion that much of our anti-aging fear and bias is rooted in an existential anxiety regarding death. For many, it is not so much the actual process of dying that is feared but rather the irreversibility of the passage of time, the understanding that physical decline and eventual death is in front of us, and the growing awareness that our lives may not have had the meaning or significance we had hoped to realize.

Yalom (2008) and Watter (2012, 2018) have asserted that sex is often experienced as a life force that creates (and maintains) the sense of being alive and vital. Indeed, both Yalom and Watter have separately described multiple cases of patients turning to sex to mollify their terror of death. If we view sexuality as a potent source of vitality and existence, it is no wonder that many men and women suffer great existential angst when their ability to reproduce is compromised. When penises and vaginas no longer function as we have come to expect in our youth, the result is often a crisis in our understanding of what it means to exist, live meaningful lives, and have strong, connected relationships. For many adults, the penis or vagina is the path to living a life of such substance. A fully functional penis or vagina is central to the sense of wholeness, desirability, belonging, and connection. Many of the men I treat with erectile difficulties lament, “I feel like less of a man” or “I feel so broken” or “I feel so weak.” To these men, their problematic erectile functioning wounds them at their core, and their feelings of vulnerability are palpable. This is no less the case for many of the women who are unable to have pain-free intercourse due to the vaginal changes that accompany the aging process.

Consider the following scenario:

> Richard was a 68-year-old married man who had undergone radical prostatectomy 3 years before our meeting. Much to his dismay, he never regained erectile functioning following surgery. He tried oral medications without much success, and found penile injections to be uncomfortable, intrusive, and unsatisfying. As a result of not being able to function sexually as he would like, Richard retreated from all sex and affection with his wife. When queried about this, his response was "Why start something I can't finish?" Clearly, Richard suffered extreme embarrassment and frustration due to his erectile loss, and this created considerable distress for his wife and his marriage. Richard was angry that he wasn't one of the fortunate men who undergo prostate cancer treatment and emerge from surgery with their erectile ability unimpaired. He also admitted feeling dreadfully broken and didn't see how he would ever again be able to view himself as a fully functional man. He further described that even if he were able to regain erections by means of some assistive device, he would be unhappy, because he would know that he was unable to sexually function autonomously. Richard's wife was extremely sympathetic and understanding. She understood the anguish Richard was experiencing, and she tried to offer an alternative view of being sexual. She described her great enjoyment of oral and manual sexual stimulation and tried to frame it as a "journey back in time." She fondly and lovingly recalled the times when they were dating and before they had intercourse. "I don't want to go back to having sex like an adolescent," said Richard. "Yes, but we had such fun back then," she reminded Richard. Richard looked away with contempt, and replied, "Yes, but back then there was the anticipation that we were 'going somewhere.' Now we are going 'nowhere.' " For Richard, the loss of erectile functioning meant substantially more than just not being able to have erections. His changed penis represented to him an existential crisis of being insignificant, a loss of vitality, and the "death" of his youth. A therapy that focused solely on Richard's presenting symptom (erectile dysfunction) would miss the underlying existential anguish that he was suffering. Therapy for Richard, and later with Richard and his wife, consisted of a deep exploration of his fears of death, isolation, and loss of ability to connect with his wife. Once these concerns were adequately addressed, Richard was able to find meaning and connection within the constraints of his physical limitations.

Political economist Paul Sagar (2018) notes that fear is not our lone emotion regarding death. He adds that we also may *resent* death, because it is experienced as an assault on our personal agency. He submits that much of our personal distress with regard to aging and death is that it may claim us before we are ready. This loss of agency and decision making may be perceived as a personal affront, a taking away of one's time and vitality before one is

ready to let it go. He insinuates that the desire for immortality is not simply about the desire to live forever, but rather the desire to choose and control when life/sexual functioning will end. Certainly for Richard, the loss of personal agency was palpable.

## Can Sex Actually Get Better as We Age?

Despite the bodily changes that inevitably occur with aging, there are several authors who suggest that sex (and life) may actually improve with age. McCarthy and Metz (2008) describe a certain "sexual wisdom" that comes with maturity and greater knowledge, awareness, and comfort with one's body. Leiblum and Sachs (2002) describe a woman who has become much freer and more open regarding her sexuality at age 75. She reported to them that she is no longer as concerned about what people think of her, and is much more at ease in strongly expressing herself and her opinions. One older female clinician described sex in older age as being different than the sex of youth but no less satisfying. She relates:

> Sex when you're younger is like downhill skiing—you get towed up to the top of this mountain and then, whoosh, you come straight down. But sex when you're older is like cross-county skiing. You get to take your time, see the scenery. It takes time to enjoy yourself, but in highlife, you've got a lot of time. You may be retired, or at least not tied to any schedule, and you can make love whenever you choose. (Leiblum & Sachs, 2002, p. 129)

## Implications for Treatment

In their book on sexuality and the context of culture, Hall and Graham (2013) note that due to the dearth of research on sexual problems in non-Western cultures, we have little knowledge or understanding of what issues may be most important for those of differing cultural backgrounds. While not a different culture per se, our interventions for the aging are plagued by a similar lack of representative research and appreciation for the culture of aging. It seems reasonable then to advance the notion that our emphasis on the restoration of the sexuality of youth implies an inadequate understanding of the "culture" of aging. Much of what we determine to be sexual dysfunction in the aging body is in actuality quite representative of what would be expected as age-appropriate developmental changes in the later stages of the life cycle. As a result, our "treatment" of the sexual problems of elderly adults has largely concentrated on the alleviation of the presenting sexual symptom, and the attempt to restore prior sexual functioning. Medical approaches such as sildenafil citrate (and similar medications), penile injections, vacuum devices, urethral suppositories, penile prostheses, and assorted hormonal regimens

have dominated the recent sex therapy and sexual medicine literature. In addition, Agronin (2014) describes cases in which some of the standard sex therapy techniques have been employed. Sensate focus, sex education related to normal bodily changes associated with aging, suggestions for making accommodations for chronic illness and/or pain conditions, and couple therapy have all been prescribed with varying degrees of success. While these options have undoubtedly been welcomed and appreciated by many, there are others who have found such interventions to be lacking and ultimately unsatisfying.

Among the most sex/aging-positive views of treatment is that of Barry McCarthy and Michael Metz. McCarthy and Metz (2008) and Metz and McCarthy (2007) are strong advocates of the notion that we can be happily sexual well into our 80s and beyond. They have suggested that the most important positive, realistic expectation is that we be accepting of our bodies and their changing functionality rather than fight against the natural aging process. They propose an approach to treatment referred to as the "good-enough sex model" (GESM). In the GESM, the focus is on enjoying pleasurable sex as opposed to some self-defeating performance criterion. Good sex is about acceptance, pleasure, and positive (yet realistic) sexual expectations. In their model, intimacy and satisfaction are the ultimate purpose of sexual behavior, and individuals and couples are encouraged to develop their own sexual styles that reflect the realities of their changing bodies. They believe that their model encourages creativity, flexibility, and growth as aging individuals and couples explore and redefine a model of sexual activity that deemphasizes the importance of rigid penises and well-lubricated vaginas, and instead values pleasure, intimacy, satisfaction, and acceptance.

McCarthy and Metz are not the only authors who suggest that sex in later life can be extremely pleasurable and satisfying. As mentioned earlier, Ménard et al. (2015) have found that, contrary to popular belief, many older adults are quite capable of experiencing highly enjoyable sex. They found that many of the respondents credit personal maturity, receptive openness to experiences, and relationship growth as significant contributors to their sexual enjoyment. Kleinplatz (2010b) has found that aging adults who are present in the moment and experience connection, intimacy, authenticity, risk-taking/exploration, and have good communication and are willing to allow themselves to take risks and be vulnerable can find a sexual connection that is extraordinarily satisfying. Kleinplatz, (2010a), Kleinplatz et al. (2009), DeLamater (2012), and Shaw (2001) call on sex therapists to support patients as they struggle with the challenges of change, growth, and vulnerability rather than merely help them attempt in vain to restore the sexual function of youth.

While many sex therapists would likely endorse the philosophies of sex and aging presented here, most would also voice the frustrating reality that it is often difficult to get our patients to happily accept these suggestions. If we turn back to the case of Richard, we see a man who was unwilling to accept the notion that satisfying sex can be found in the absence of a firm penis and sexual intercourse. True, there are many who willingly accept, adopt, and

appreciate the sexual changes that aging brings. However, these are rarely the individuals and couples seen in sex therapy/sexual medicine offices. We are most likely to be sought out by those who are unable to successfully navigate the inevitable changes and resulting challenges that aging bodies represent.

How, then, does the sex therapist help those who resist accepting their changing bodies find contentment and sexual satisfaction? It is noteworthy that the discussion of how best to manage this resistance seems to be absent from the sex therapy/sexual medicine literature.

The ability to accept or resist the reality of the changing sexual function of aging may lie more within the existential realm than the traditional sex therapy frame. Most sex therapists will likely first gravitate toward those therapeutic strategies already been noted earlier in this chapter. However, in those instances in which therapeutic outcomes are unsatisfactory, it may be the result of two important overlooked factors: the anger, frustration, and inability to grieve the loss of function, as well as the more existential dilemmas that one must confront as one ages.

As mentioned earlier, Sagar (2018) is of the opinion that humans not only fear loss but we actually may also "resent" it; that is, we may experience loss, especially loss that is beyond our control, as a personal "affront" or as an assault on our personal agency. Many of our patients, are palpably angry about aging (or illness, surgery, etc.) robbing them of the sexual functioning they have come to enjoy and expect to maintain. They condemn and rail against the forces that frustrate them but to no avail. If this rage, frustration, and sadness regarding the loss of functioning and youth is left unaddressed, acceptance of a new sexual script will remain elusive.

Much of this distress may also be rooted in the existential angst many find within the aging process. Early existentially oriented psychologists such as Erik Erikson (1963) have noted that if one has not lived well, one will not accept aging well. If, when reflecting on a life, one believes that he or she has not led a meaningful and satisfying life, despair over a life lived regretfully will result. This principle has been echoed over the years by other existential psychotherapists as well (Yalom, 1980; May, 1953).

Until recently, existential approaches to sex therapy have been largely ignored (Barker 2011; Kleinplatz, 2017; Watter, 2018). Yalom (1980, 2008) and Watter (2018) have suggested that much of our sexual distress is rooted in the realm of existential crises. Specifically, aging (and the awareness of an aging body) may precipitate a confrontation with the reality of one's mortality and eventual death. For many, sex represents a life force, the antithesis of death that can neutralize the terror of the end of one's existence. Yalom (2008) has described sex as "death-defeating," and often sex is sought following a collision with mortality. In describing the relationship between sex and death, Yalom (2008) offers the following:

> Sex, the vital life force, often counters thoughts of death. I've encountered many instances of this mechanism: the patient with a severe coronary who

> was so sexually driven that in an ambulance carrying him to the emergency room, he attempted to grope an ambulance attendant; or the widow who felt overcome with sexual feelings while driving to her husband's funeral; or the elderly widower, terrified by death, who became uncharacteristically sexually driven and had so many sexual affairs with women in his retirement community and created such divisiveness that the management demanded he seek psychiatric consultation. (pp. 212–213)

Many who become increasingly aware of, and distressed about, their body's changing sexual functioning may unconsciously perceive these changes as an awareness of their aging and the creep toward death. As a result of this fearful awakening, they experience great difficulty navigating the challenges of aging and sexual function. Therefore, sex therapy for the aging may be most helpful if it focuses on the emotions associated with the distress and regrets of having not lived life well.

Existential psychotherapy in general, and existential sex therapy in particular, posits that those who successfully attain the Eriksonian aspiration of integrity will have an easier time navigating and accepting the vagaries and challenges of developing new sexual scripts that will allow them to find happiness, satisfaction, and pleasure in their sexuality. It is only through the successful resolution of the existential crises of living that one is likely to be welcoming of the prospects of creating a different but nourishing and sustaining sexual life. Given the aforementioned principles of existential thought, the assessment process of existential therapy differs somewhat from what is considered traditional in sex therapy. Psychometric testing, DSM (or ICD) diagnoses, and extensive sex histories are seen as less important than a developmental history that attempts to identify the existential crises the patient may be struggling to navigate. It is through the successful resolution of the existential crises of living that one becomes open to allowing oneself to be vulnerable, and willing to take the risks of allowing the past to be behind us, while discovering the new and different sexual styles ahead of us.

## Case Discussion

Harold, an 82-year-old widowed man, presented for treatment after being referred by his urologist. Harold's primary complaint was that he was noticing decreased penile sensitivity that resulted in a less pleasurable orgasm. In addition, Harold complained that it would sometimes take up to an hour of masturbation to reach climax. At the time of referral, Harold had no partnered sexual activity. His wife of almost 50 years, Jocelyn, had passed away the year before, but they had not had any partnered sexual activity for the last 40 years of their marriage. According to Harold, neither seemed to enjoy partnered sex, and he derived a great deal of pleasure from solitary masturbation. His enjoyment and interest in solitary masturbation had continued until this past year.

At first glance, I found Harold's presentation surprising. It seemed obvious that an 82-year-old man should, indeed, be experiencing reduced penile sensation and a longer time to reach orgasm. I had expected he probably had some difficulty with erections as well, but Harold said that erections were not problematic. I assumed that much of our work would consist of some basic sex education about the normal sexual changes that an aging body experiences, and/or some unresolved grief about the death of Jocelyn, but something told me to hold my tongue and ask him more about his life.

Harold recalled always being an "odd" person. He was never very socially comfortable, and he believed he always struggled to pick up social cues. His childhood was traumatic, and he feared both his mother and father. His parents divorced when he was 11 years old, and he recalls being a "neglected" and lonely child. He did have an older brother, but his brother was quite cruel and abusive. Harold felt like much of his life had been a disappointment. He was Ivy League educated, including a doctoral degree in English Literature. Harold hungered for a university faculty appointment, but positions in English Literature were few and far between. With a poor job market and his inadequate social skills, Harold was unable to obtain the employment he desperately wanted. He settled for a job in a library that allowed him to surround himself with books he loved, but he considered the position far below what he had envisioned for himself. Harold met Jocelyn in graduate school, and they married after 2 years of dating. He reported enjoying married life very much. Although the relationship was minimally sexual, he enjoyed pleasing his wife in nonsexual areas, and she seemed to appreciate him as well. The couple enjoyed reading, visiting museums, and attending chamber music concerts. These are activities Harold had enjoyed doing solo before meeting Jocelyn, and he continued to delight in them even after her death. During Jocelyn's extended illness, Harold took great pleasure in being her caretaker, and he felt as if he had little to occupy his time since Jocelyn's death. Indeed, Harold reported becoming increasingly distressed about the prospect of his own mortality following the death of Jocelyn. The couple had two children, both now grown, and both live several states away from Harold. He reported having a positive relationship with each of the children, but neither required much of Harold. They would not see each other often, but would speak by telephone on a weekly basis.

At our second session, Harold revealed his infatuation with a 15-year-old girl, who was the daughter of a family friend. Harold spoke of her in very romanticized, loving, yet nonsexual terms. He loved sending her poems, music, and books that he imagined would interest her. She would voice appreciation for these gifts, but Harold was frustrated by her seeming lack of enthusiasm for his guidance in life matters. This was not the first time Harold had experienced such frustration. He often found himself enamored by older adolescent/young adult females, and would excitedly try to interest them in his cultural pursuits. Unfortunately for Harold, while most of the girls were polite and gracious, none ever reciprocated his attentiveness.

Harold spent an entire session showing me pictures of his family of origin. His narratives were filled with stories of loneliness, neglect, parental fighting, and a general sense that the world was experienced as an unsafe place. He recalled a life of restraint, fear, tentativeness, loss, and isolation. Harold found his relationship with his mother particularly confusing, as her behavior toward him was very inconsistent. One moment she would be telling him that he was her best friend, and the next she would be humiliating him with insults about his looks and mannerisms. As a result, he both feared his mother and longed for her love, attention, and approval. As he progressed through life, every rebuff reawakened his fears of not being good enough and made him acutely aware of the loneliness and isolation he endured.

Though Harold's stories were painful for him to tell, and for me to listen to, he began to report an improvement in his sexual functioning and enjoyment. Orgasm was becoming easier to achieve, and he was experiencing sex as increasingly more pleasurable. This trend appeared to continue as our sessions progressed. Harold began to reach out to friends and family he had not communicated with for several years. He still enjoyed his solitary time but reported experiencing a newfound enjoyment in social interactions. He joined a hiking group and decided to try online dating. One afternoon, while picking up his dry cleaning, he began a conversation with a 31-year-old woman, Sami, who was working behind the counter at the drycleaners. Harold found Sami to be extremely attractive and friendly, and he began making frequent trips to the drycleaners. One day, Harold decided to ask Sami out for lunch. To his great surprise, she accepted. Harold was very, very excited and began looking forward to seeing Sami socially. Sami was a recently divorced mother of a young girl, who had recently moved to New Jersey from Oregon. She knew few people in the area and was also a bit of a loner. She and Harold began seeing each other frequently, but the relationship remained platonic. Apparently, Sami saw Harold as a mentor and supportive friend. For his part, Harold had more romantic feelings toward Sami, but much as in his marriage, he did not crave partnered sex. Rather, he discovered a feeling of "aliveness" in his relationship with Sami, and he relished her appreciation of his cultural sophistication and her enthusiasm for accompanying him to museums, films, and concerts. Harold reported a significantly enriched sexual enjoyment through masturbation, as well as a generally enhanced overall life satisfaction. Harold's relationship with Sami flourished for approximately 8 months, after which Sami relocated back to the West Coast to be closer to her sister and her sister's family. While disappointed at not being to see Sami regularly, Harold recognized that his relationship with Sami "brought him back to life," and provided him with a renewed sense of "meaning." Harold reported feeling like a "wet blanket" was lifted from covering him, and he found much greater enjoyment in his days. He felt much less lonely, and his fear of his own death substantially diminished. Harold and Sami maintained regular contact via Face Time, and Harold continued to pursue limited social opportunities with verve. Sexually, Harold was also quite content.

This case illustrates that for many aging patients, their loss of sexual functioning can have meaning that goes well beyond the sex per se. For Harold, sex represented life and vitality, and the loss of his sexual functioning was representative of his isolation, loneliness, and mortality.

## Conclusions

Sexuality remains an important part of life throughout the life cycle. The perception that aging represents a "disease" or a "defect" that needs to be resisted must be challenged and contested. Studies have shown that significant proportions of the elderly adult population in Western countries report that sex is important to them, and that they experience a high degree of sexual satisfaction. This chapter has further explored the existential dilemmas and crises the aging process creates for some individuals and couples. The implications for sex therapy and sexual medicine practitioners include the need to look beyond our existing sexual scripts that glorify the sexuality of youth, while demonizing the sexuality of aging.

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CHAPTER 17

# Sex and Couple Therapy with Survivors of Childhood Trauma

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The high prevalence of childhood maltreatment in the histories of sex therapy patients suggests that childhood trauma is a risk factor for the development of sexual difficulties. The authors of Chapter 17 have not limited their analysis to sexual abuse but have also included other forms of childhood adversity (physical and emotional abuse and neglect), noting that "as all childhood traumas involve violations of trust and betrayal, they may all affect the way survivors experience intimate relationships, including in the sexual realm." After reviewing the literature, the authors use a dual-pathway model to understand the sexually inhibiting and disinhibiting effects of early trauma. While this model may explain the effects of childhood trauma, it does not provide specific therapeutic guidelines. MacIntosh, Vaillancourt-Morel, and Bergeron therefore present MacIntosh's Developmental Couple Therapy for Complex Trauma (DCTCT) and illustrate its use with two rich cases. Where there is sexual inhibition, gently removing barriers to sexual reengagement is the therapeutic task, while sexual disinhibition requires the therapist to address secrets and reduce compulsions. Even when sexual inhibition and disinhibition coexist, a not uncommon phenomenon in the view of the authors, DCTCT provides a helpful framework for the important psychotherapeutic groundwork necessary for building an intimate sexual connection.

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Jessica and Jennifer contacted a local couple therapist to work on issues related to what they called "lesbian bed death." Despite the queer-positive therapist's curiosity, openness, and good understanding of LGBTQ issues, they just could not find their way to the bottom of what was inhibiting Jessica and Jennifer in their sexuality. Both Jessica and Jennifer expressed a desire to reengage sexually, but they, and the therapy, were at a stalemate; both partners were feeling frustrated and hurt. It was only in a session, well into the therapy, that Jessica disclosed, offhandedly, that Jennifer sometimes reminded her of her violent father when she yelled at their children. Jessica added that sometimes she was afraid of the possibility of Jennifer's anger exploding into something more, something frightening, something that would draw her back into the traumatic mire of her childhood. This disclosure sucked the air out of the room; from here, holding a trauma-informed practice lens in mind, the therapist was able to find a way in to exploring the invisible line that had been drawn in the sand between Jessica and Jennifer.

For Natalie and Nathan, the role of childhood trauma was at the forefront of their request for services from a sex therapist. Both partners were entirely clear about the role that Nathan's history of sexual abuse might be playing in the sexual difficulties between them. However, many secrets were hidden out of reach, and much of the backstory of Nathan's sequestered sexual life would not emerge in the therapy until their therapist came up against an impenetrable wall of inertia and asked to meet with both partners individually. In that individual session, the therapist

became fully aware of the devastating sexually compulsive double life that Nathan was living, and the shame and fear that immobilized him. The challenges of bringing this couple together in the context of years of trauma-fueled sexual secrets formed the basis of the therapeutic process.

These vignettes illustrate how childhood trauma, including abuse and neglect of all forms, is a devastating force in our society, leading to significant long-term impacts in many areas of functioning and spilling over into couple and family relationships. It was once believed that it was, primarily, childhood sexual abuse that had significant impacts on adult sexuality. We have come to understand, however, that all childhood abuse and neglect constitutes a relational trauma, a violation of the child's trust and integrity in the context of an attachment relationship. In this context, it makes sense that trust, capacity for closeness, and feelings of safety in a romantic relationship might be impacted and, these, in turn, may challenge a survivor's capacity for engaging fully and openly in a sexual relationship with a partner. Interestingly, while many childhood trauma survivors do experience significant challenges in their sexual lives, others demonstrate resiliency and report that they enjoy a full and satisfying sexuality (Fava, Bay-Cheng, Nochajski, Bowker, & Hayes, 2018). Clinicians, then, need to bear in mind that no two stories are the same, and that all survivors experience their traumas differently. The sexual sequelae of childhood trauma need to be understood in the context of this survivor's history, development, and the couple's strengths and challenges.

In this chapter, we outline the consequences of childhood trauma, sexual and nonsexual, on the adult sexual lives of survivors and their partners. Jessica and Jennifer, as well as Natalie and Nathan, come along with us to illustrate how therapists might work with these couples, cognizant of the role and impact of childhood trauma on their sexual struggles.

## Definition and Prevalence of Childhood Trauma

Childhood trauma, or early interpersonal trauma, refers to any act of commission or omission that results in harm, potential for harm, or threat of harm to a child, and includes physical, emotional, or sexual abuse, as well as physical or emotional neglect. These childhood traumas are considered endemic health and social issues. Population-based studies indicate that 35–40% of individuals retrospectively report at least one type of childhood trauma, with multiple chronic victimizations being the norm (Cyr et al., 2013). Indeed, childhood traumas are highly interrelated—rarely occurring independently—with more than 78% of individuals who experienced one childhood trauma also reporting at least one other adverse experience, which has been labeled as polyvictimization, cumulative trauma, or complex trauma (Briere & Scott, 2015).

Prevalence estimates for each type of childhood trauma vary significantly between studies and may be explained in part by methodological issues such

as sampling procedures, the type of instruments, and the definition used. Emotional or psychological abuse, which refers to verbal assaults, such as threatening, insulting, and humiliating behaviors, is reported by 36% of the general population (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2015). Physical abuse, reported by 23%, refers to bodily assaults (e.g., hitting, beating, or shaking) that posed a risk or resulted in injury (Stoltenborgh et al., 2015). Emotional and physical neglect are reported, respectively, by 18 and 16%, and represent a failure of caretakers to provide for a child's basic physical needs, such as food, shelter, and health care, or to meet a child's basic emotional needs, such as love, nurturing, and support (Stoltenborgh et al., 2015). Extreme situations of neglect are easily identified, but most cases are complex, and many neglect survivors do not label their own experiences in this way (Schilling & Christian, 2014). Childhood sexual abuse is by far not only the most studied form of childhood trauma, but it is also the one for which definitions and prevalence estimates show the greatest variation, and the only one suggesting major gender differences in prevalence rates. Average estimates indicate that 18% of women and around 8% of men report childhood sexual abuse (Stoltenborgh et al., 2015).

Although the prevalence rates of childhood trauma are already concerning, they are thought to represent conservative estimates given the challenges associated with disclosure of such trauma. In clinical samples, the rates of reported childhood trauma increase dramatically. Among sex therapy patients, 55% report at least four forms of childhood adversity, with 56% of women and 37% of men reporting childhood sexual abuse (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; Bigras, Godbout, Hébert, & Sabourin, 2017). These higher prevalence rates suggest that childhood trauma may represent an important risk factor for sexual difficulties.

## Research on Childhood Trauma and Sexual Outcomes

Childhood sexual abuse has been the most studied area of childhood trauma in relation to adult sexuality. A recent review indicated that 25–59% of women with a history of childhood sexual abuse report sexual dysfunction, in particular, sexual desire and arousal difficulties. These numbers increase to 84–94% in clinical samples (Pulverman, Kilimnik, & Meston, 2018). However, many of the studies included in Pulverman et al.'s review did not consider other, nonsexual childhood trauma, thus neglecting the high co-occurrence between these negative experiences in childhood. While some studies suggest that childhood sexual abuse has a unique association with sexual outcomes, above and beyond other types of childhood trauma (Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012; Lemieux & Byers, 2008), others indicate that both sexual and nonsexual childhood trauma, such as emotional and physical abuse, are associated with negative sexual outcomes (Corsini-Munt,

Bergeron, Rosen, Beaulieu, & Steben, 2017; Lemieux & Byers, 2008). However, childhood traumas largely co-occur. For instance, inherent to sexual traumas are interpersonal and emotional violations. Hence, it is almost impossible to examine the unique effects of each trauma. The notion of complex trauma refers to multiple or extended traumatic events whereby individual traumas are better understood as one construct resulting in multidimensional complex symptoms (Briere & Scott, 2015). In summary, as all childhood traumas involve violations of trust and betrayal, all may affect the way survivors experience intimate relationships, including those in the sexual realm.

Given the heterogeneity in sexual outcomes of childhood trauma survivors, prevalence rates of sexual difficulties in this population are difficult to estimate. Studies examining associations between childhood trauma and sexual challenges in adulthood report diverse results, with small to moderate, and sometimes nonsignificant, associations. These effect sizes suggest that many men and women who experienced childhood trauma develop a satisfying sexuality at some point in their life (Fava et al., 2018). In some cases, sexual difficulties may emerge over time at critical periods of development, such as marriage or childbirth (Trickett, Noll, & Putnam, 2011; Vaillancourt-Morel et al., 2016c). Partners of individuals reporting childhood trauma may also struggle with sexual issues (Corsini-Munt et al., 2017; Nelson & Wampler, 2000). Thus, clinicians should not assume that the sexual difficulties of an individual with a history of childhood trauma are clearly or only the result of his or her own childhood trauma; the sexual repercussions of childhood trauma are probably multidetermined and may evolve over time. Dose–response effects are also observed in individuals reporting repeated or severe abuse, as well as those exposed to multiple types of childhood trauma, who are at increased risk of developing sexual difficulties in adulthood (Bigras et al., 2017; Norman et al., 2012). These findings support the notion of complex trauma in which each childhood trauma is best conceptualized as part of a dimensional construct that considers the number of traumas experienced and their severity.

While there is no typical constellation of sexual difficulties in childhood trauma survivors, there do appear to be diverse sexual responses, which can be organized into a dual-pathway model. One branch of this model involves inhibition, including sexual avoidance and dysfunction, while the other branch involves sexual disinhibition, such as engaging in sexual activity with numerous sequential or simultaneous sexual partners and risky sexual behaviors, which put the person at risk for sexually transmitted infections (STIs) or unplanned pregnancy. This dual-pathway model has been suggested by clinicians (MacIntosh, 2018), theoretically (Aaron, 2012), and is supported empirically in the case of childhood sexual abuse survivors (Vaillancourt-Morel et al., 2015). Survivors of nonsexual childhood trauma also report sexual outcomes along both pathways (Lemieux & Byers, 2008; Norman et al., 2012). Clinical observations and reviews have asserted that inhibition is the typical

sexual reaction in women survivors, whereas, in men, it is sexual disinhibition (Aaron, 2012). However, empirical evidence has documented both pathways in men and women (Vaillancourt-Morel et al., 2015).

Looking more closely at the sexual inhibition profile, the number and quality of studies are limited, and most have only explored the experiences of female childhood sexual abuse survivors. Yet, in women-only samples, studies indicated that childhood sexual, emotional, and physical abuse were associated with more negative emotions during sexual arousal (e.g., fear, anger, disgust), lower sexual function and satisfaction, and higher levels of sexual withdrawal and sexual problems (Lemieux & Byers, 2008; Schloredt & Heiman, 2003; Seehuus, Clifton, & Rellini, 2015). These findings support the sexual inhibition pathway in women, but some studies suggest that it may also be present in male survivors of childhood trauma. Studies indicate that all five types of men's and women's childhood trauma adversely affect at least one aspect of survivors' adult sexual well-being, including lower sexual function and higher sexual distress (Corsini-Munt et al., 2017; Vaillancourt-Morel, Byers, Péloquin, & Bergeron, in press).

For the sexual disinhibition profile, a meta-analysis revealed that physical abuse (30 studies), emotional abuse (5 studies), and neglect (30 studies) were significantly associated with a 1.57–1.78 increased risk of STIs and risky sexual behavior for men and women (Norman et al., 2012). In a study using documented cases of childhood abuse and neglect followed over 30 years, sexual abuse, physical abuse, and neglect were associated with a 2.84 increased likelihood of any risky sexual behaviors, with the strongest effect being for childhood neglect and the weakest, for sexual abuse (Wilson & Widom, 2011). Other studies indicated that sexual and physical abuse are significantly associated with impulsive sex in both men and women, and that physical and emotional abuse are associated with a higher likelihood of having multiple, new, or casual sexual partners in women (Abdala, Li, Shaboltas, Skochilov, & Krasnoselskikh, 2016; Walsh, Latzman, & Latzman, 2014). These findings support that, in men and women, all childhood traumas may lead to adult sexual behaviors that reflect a disinhibited sexuality.

These disinhibited or inhibited sexual behaviors may also coexist to form a pathway that represents a bifurcation of sexuality, for example, survivors avoiding sexual interactions with an intimate partner, engaging in compulsive sexual behaviors outside of the relationship, such as compulsive masturbation, or seeking out multiple sexual partners in a relationship that has not been defined by both partners as polyamorous. This hypothesis of a bifurcation pathway—or the coexistence of inhibited and disinhibited sexuality—is in line with findings that indicate a 3.13 increased likelihood of infidelity among women survivors of childhood trauma compared with a matched nonabused or neglected control group (Colman & Widom, 2004). The prevalence of extradyadic sexual involvement in survivors of childhood sexual abuse is effectively more than twice the rates among men and women compared with nonabused individuals (Vaillancourt-Morel et al., 2016a).

## Theoretical Models of Childhood Trauma and Sexual Outcomes

There is no single theoretical model that is widely used or well validated empirically to explain the pathways between childhood trauma and difficulties in adult sexuality. The self-trauma model (Briere & Scott, 2014) provides a theoretical conceptualization of the long-term impacts of childhood trauma from a developmental perspective. This model articulates the mechanisms through which childhood trauma, particularly complex trauma, may lead to challenges in adulthood and, for our purposes, to difficulties in sexuality and intimate relationships. With regard to impacts on sexuality, the self-trauma model suggests that survivors may experience disrupted expectations and assumptions about relationships including in relation to the safety and trust that are required for the development of strong and intimate sexual relationships; conditioned emotional responses to reminders of trauma; priming responses of fear and distress to stimuli associated with the trauma, which can include sex, arousal, or vulnerability; sensory reexperiencing of memories of abuse, which can include reliving aspects of early trauma within adult sexual encounters; the suppression of abuse-related memories and material outside of conscious awareness, leading to the potential for repetition and distress in adult interpersonal and sexual relationships when these unconscious rememberings are activated outside of awareness; and difficulties with emotion regulation, orienting survivors away from strong emotions and instead toward dissociation, substance abuse, and externalizing behaviors, which can lead to dissociated reenactments of past traumatic experiences as an effort to, unconsciously, gain control over previously out-of-control traumas and traumatic memories (Briere, 2002). This complex symptomatology refers to how childhood trauma may affect self-capacities, and studies indicate that such alterations in self-capacities partly explain the sexual and relational difficulties of survivors (Bigras, Godbout, & Briere, 2015). Disturbances in self-capacities may also lead to sexual outcomes along both pathways—avoidance, compulsion, or the coexistence of both—as attempts to deal with these potentially overwhelming trauma-related affect, reenactment, and flashbacks. The self-trauma model (Briere & Scott, 2014) takes a developmental perspective that informs interventions for trauma survivors, including Developmental Couple Therapy for Complex Trauma (DCTCT; MacIntosh, 2019), which we explore in more detail in the next sections.

## Assessment

Given how pervasive and damaging the impacts of childhood trauma can be on adult sexuality, it is essential that sex therapists systematically assess trauma experiences with new clients. Not only is this vital to developing a thorough understanding of factors contributing to the etiology of current

sexual difficulties, but by not asking clear questions about childhood trauma, clinicians may inadvertently send messages that reinforce negative abuse-related internalizations (e.g., "I should not talk about my abuse"). Childhood trauma—and its severity—should be assessed using face-to-face interviews, as well as detailed standardized questionnaires, where possible. Assessment methods should include both questions based on objective descriptions and behaviors (e.g., being called names by family members, being touched sexually by an adult) and questions that rely on whether the individual labels this childhood experience as abuse or neglect (e.g., "Have you been physically abused?"; "Have you experienced sexual abuse in your childhood?"). Research has shown that not all survivors, particularly male survivors, define their experiences of neglect and abuse in childhood as traumatic (Vaillancourt-Morel et al., 2016b). A number of measures may be suitable for assessing trauma, including the Childhood Trauma Questionnaire (Bernstein & Fink, 1998), which includes both types of questions and all five forms of childhood trauma.

In couple therapy, therapists may ask about histories of childhood trauma in couple sessions. However, for many survivors, disclosures about childhood trauma may be absent, incomplete, or shameful, and overwhelming emotional states may accompany any efforts to explore the details of trauma. Inquiring about trauma histories in both individual and couple sessions may allow the therapist to draw a more complete picture; many survivors are simply not ready to share their story of trauma with their partner, and individual sessions provide an avenue for preliminary disclosures and discussions about how this vital part of a survivor's history might be brought into the couple sessions. Clinicians also need to titrate the level of emotional arousal in initial sessions to match the emotion regulation capacities of survivors. This may mean going slowly in exploring childhood trauma histories and starting with disclosures of less triggering details and more processed memories, and only going more deeply as emotion regulation capacities develop over the course of therapy, whereby more traumas are processed and partners are better able to support one another as conflict and distress decrease.

After a disclosure of childhood trauma, clinicians may choose to explore whether a survivor primarily identifies with an inhibition and fear pathway or a disinhibition and compulsive pathway, with or without a bifurcation of sexuality in the primary relationship. Some survivors switch from one to the other over time, and clinicians should not assume that a survivor avoiding sexuality with their current partner has always been avoidant, or that they are currently avoidant with all potential sexual partners. For survivors who may be experiencing a bifurcation of sexuality leading to a gradual inhibition of sexual intimacy with a romantic partner and escalating secrets about the sexual double life, assessment must tread carefully to open the door to ongoing conversations but not burst dams that are not yet ready to flow. In particular, it is important that assessment processes not lead to retraumatization, excessive triggering, and emotion dysregulation or premature disclosures leading to betrayal and relationship rupture.

## Approaches to Couple Treatment for Survivors of Childhood Trauma

An impressive body of clinical research, including randomized controlled trials, supports the effectiveness of diverse psychological treatments for posttraumatic stress disorder (PTSD) in adult survivors of childhood trauma. However, these treatments primarily focus on the childhood trauma survivor in isolation from the partner. Very few treatments have specifically addressed the psychological needs of childhood trauma survivors in the context of their couple relationships, and even fewer have specifically outlined approaches to treating sexual difficulties.

Findings of a meta-analysis suggest that psychological interventions are effective, with moderate to high effect sizes for the reduction of symptoms of PTSD, depression, anxiety, and dissociation. Trauma-focused interventions yield larger effect sizes than do non-trauma-focused interventions, as do therapies involving individual sessions compared with those limited solely to group sessions (Ehring et al., 2014). However, these treatments do not focus on sexuality, and studies to date have not examined their effect on survivors' sexual well-being. When examining only treatment approaches for sexual difficulties or documenting effects on sexuality, again, an impressive number of articles and books are available, some that include modules or interventions on sexual outcomes (Briere & Scott, 2014; Zala, 2012). However, very little empirical evidence is available concerning the efficacy of such treatment models, and no studies include couple approaches to the treatment of sexual difficulties in childhood trauma survivors.

One area in which some research has been undertaken beyond individual approaches includes group therapies for childhood sexual abuse survivors. In a sample of 52 female childhood sexual abuse survivors, those in a group intervention based on a feminist approach offered by help centers for sexual assault reported significantly less sexual anxiety at posttreatment compared with survivors in the wait-list condition (Hébert & Bergeron, 2007). In a randomized controlled trial including 166 female childhood sexual abuse survivors, Classen et al. (2011) compared the efficacy of trauma-focused group therapy, present-focused group therapy, and a wait-list condition on various sexual outcomes such as HIV risk, sexual revictimization, risky sex, number of partners, and sexual concerns (i.e., negative affect or thoughts related to sex), as well as PTSD symptomatology. In terms of sexual outcomes, trauma-focused group therapy and present-focused group therapy both showed a significant reduction from pre- to posttreatment in total HIV risk and in sexual revictimization, and present-focused therapy showed a significant reduction in sexual concerns and dysfunctional sex. However, there were no significant differences between treatment conditions, or between each treatment and the wait-list control condition. As for PTSD symptomatology, both groups yielded significantly better improvements than the wait-list condition. The absence of differences between each treatment group and the wait-list condition on

sexuality outcomes may be attributable to the limited focus on sexuality in the two treatments. It is possible that the simple fact of completing sexuality measures may have yielded a statistically significant change in sexual outcomes, albeit with low clinical significance. In a sample of 26 women receiving a mindfulness-based group psychoeducational intervention targeting sexual arousal disorder, women reporting a childhood sexual abuse history had a more marked improvement in sexual distress and sexual arousal compared to women without a childhood sexual abuse history (Brotto, Basson, & Luria, 2008). However, these studies are limited to women having experienced childhood sexual abuse and do not include partners. Thus, to our knowledge, there is no empirically validated treatment for the sexual difficulties of childhood trauma survivors.

When looking specifically at couple approaches for childhood trauma survivors' sexual difficulties, only Maltz (2002, 2012) outlines recommendations for sexual abuse survivors to reconnect sexually with their partners. These guidelines include an understanding of the role of trauma in their current sexual distress; understanding triggers and trauma symptoms in the relationship; and building trust, safety, and strong capacities for communication about needs, desires, and boundaries as couples move toward engaging in structured exercises for sexual reconnection. While highly relevant, these recommendations are not empirically validated.

Writers in the field of Emotionally Focused Therapy for Couples (EFT; Johnson, 2002) have explored the use of EFT with couples dealing with the aftereffects of childhood sexual abuse (Johnson, 2002; MacIntosh & Johnson, 2008). This approach expands the normative approach to EFT to incorporate an understanding of the impacts of trauma on the couple relationship but does not explicitly articulate strategies for addressing sexual difficulties. In research building on the initial work on EFT with trauma survivors, MacIntosh (2013, 2017, 2019) argued that childhood trauma survivors have very particular needs in their relationships and in couple treatment that may not be addressed through EFT. Specifically, survivors have demonstrated high levels of emotion dysregulation and low levels of perspective taking or mentalizing that impair the development and maintenance of strong couple relationships and impede the process and progress of couple therapy (MacIntosh & Johnson, 2008; MacIntosh, 2013, 2018, 2019). Arising from in-depth qualitative research into the process of couple therapy with childhood trauma survivors, MacIntosh developed the DCTCT model that addresses developmental impacts, such as challenges with attachment security, emotion regulation, and mentalization on childhood trauma survivors' capacities to develop and maintain healthy couple relationships, as well as engage fully in and benefit from the couple therapy process. Within this model, MacIntosh (2019) has incorporated specific recommendations for working on sexuality with survivors and their partners. This empirically derived model is presented here as an approach to working with couples' childhood trauma in relation to their sexual difficulties.

## Developmental Couple Therapy for Complex Trauma

DCTCT is a novel treatment model developed by MacIntosh (2019) for couples dealing with the impacts of significant trauma on their sexuality and relationship. The DCTCT model views couple distress through a developmental lens in which building self-capacities such as emotion regulation and mentalizing is at the forefront of the first stages of treatment. Understanding the impact of childhood trauma on survivors' capacities for emotion regulation, mentalizing, and secure attachment provides therapists a framework for working with couples whose high levels of dysregulation and challenges with perspective taking can impede the process and outcomes of couple therapy (MacIntosh, 2013). Sexuality is addressed in the first stage of therapy through psychoeducation and in later stages through direct processing and working through of sexual difficulties (MacIntosh, 2019).

### *Psychoeducation*

Psychoeducation forms an important basis from which to begin work with couples. In the DCTCT model, the first stage focuses on psychoeducation along with conflict deescalation and alliance building. Each psychoeducational module focuses on a specific aspect of how childhood trauma might impact a couple relationship. These include, among others, the impact of trauma on individuals and couples, the impact of shame on couple relationships, challenges with emotion regulation and couple relationships, as well as a specific module on sex and sexuality. Therapists explore the role of childhood trauma in the development of healthy sexuality and the impact of childhood trauma for couple sexual relationships, including the nature of conditioned sexual responses, how to identify and handle triggers, how to communicate about sex, and others. The goal of this psychoeducational process is to shine a light on a vital aspect of the couple relationship that may become hidden due to shame, guilt, or overwhelming emotional distress.

Through this process of psychoeducation, the therapist begins to help the partners identify their avoidance and develop strategies for reducing it; understand triggers and manage dissociation and emotion dysregulation in the context of sex; and develop a strategy for reengaging healthy sexual contact. Through the process of engaging with the psychoeducational material, therapists begin to facilitate previously avoided conversations. As the partners begin to communicate openly about triggers and their origins, they also develop the skills in communicating directly about their sexual needs and preferences. At this stage, therapists also consider imposing a period of conscious sexual abstinence to reduce the pressure and frustration that may be brewing prior to helping the couple learn how to reconnect through gradual shifts from nonsexual to sexual touch (Maltz, 2002).

For therapists, psychoeducation involves beginning to open up hidden layers of shame and secrets. At this stage, it is important to reflect on

assumptions that may be made about what constitutes healthy and "normal" sexuality. Survivors may begin to talk about conditioned arousal or compulsive sexual reenactments that may deviate from therapist's socialization of what constitutes a healthy sexuality. For this process to unfold in a manner that allows for exploration and healthy development, therapists must process their own reactions without imposing values or shame on survivors. For many, conditioned sexual responses to stimuli, such as experiencing sexual arousal in response to violent imagery or pain, or being aroused by fantasies about the gender that is the opposite of the orientation to which they identify, engaging in BDSM or kink as a way to feel mastery over trauma, or even being caught in swirling reenactments may evoke deeply painful feelings of shame and guilt. Attempting to modify or eradicate conditioned sexual arousal is not likely to be successful and is not the role of a therapist. The therapist's role is to open up communication about previously silent aspects of the survivor's sexual life to build dialogue with partners, so that they can understand and find strategies to meet one another's sexual needs in ways that feel good to both partners.

To introduce this topic, therapists provide survivors with a psychoeducational handout that explores the consequences of trauma on adult sexuality. This handout contains information regarding how childhood trauma impacts sexuality in adult survivors and couple relationships, and poses a series of questions to the couple:

> "Have you been able to make a list of triggers and share and discuss these with your partner?"
> "How do you cope with feelings of fear or avoidance in your sexual relationship?"
> "Have you been able to talk together about what turns you on and what you would like more of and less of?" (MacIntosh, 2019).

This process begins the delicate untangling of much that has been unspoken between the couple. For partners who are feeling hurt or confused by their survivor partner's withdrawal or distress in response to their sexual initiation, understanding the specifics of why a particular touch, taste, smell, or sound in a sexual context is triggering can help him or her feel less hurt and develop empathy for the wounded partner, and allow the partners to externalize their sexual distress, becoming allies in healing.

Therapists are recommended to work in both couple and individual sessions to help couples explore aspects of their sexual relationship that they are able to discuss together, and to begin to explore sexual secrets that may need to be disclosed first in an individual session. This may protect the couple from premature disclosures that could lead to deeply painful feelings of betrayal and make the therapy environment feel unsafe. Survivors may experience high levels of shame and avoid disclosures of sexual challenges throughout the early stages of the process and only be able to begin making these disclosures

in judiciously timed individual sessions. Therapists are always walking the tightrope of balancing the work of helping the couple build closeness through disclosure and processing of traumas and secrets, while judging when it is the right time to bring a partner in to discussions about sexual challenges and hidden secrets.

### *Working on Sexuality*

Moving into actively working together on their sexual relationship in a later stage of therapy, couples are encouraged to engage in both dialogue and active strategies to begin to heal their sexual relationship. For some couples, sexuality is front and center in their minds as they seek services for their distress. For Jessica and Jennifer, the cessation of their sexual relationship was their primary reason for approaching a couple therapist, yet they were not aware of the depth of impact of Jessica's childhood trauma. For Natalie and Nathan, awareness of the impacts of trauma on their sexual relationship was clear in their request. Beginning the work of finding ways to explore the couples' current sexuality creates the context for gradually reducing avoidance and dissociation, with the goal of rebuilding intimacy between alienated partners.

A first step in addressing sexual challenges in survivor couples is to begin to navigate sexual triggers that lead to avoidance and inhibition of sexual engagement. In the introductory psychoeducational process, couples are encouraged to articulate and begin to discuss their trauma triggers. In this stage, these conversations deepen, and the therapeutic task is to help the couple develop new strategies for managing and desensitizing these triggers. As partners talk about the triggers and place them in the context of their traumas, it is hoped that feelings of alienation and confusion are replaced with understanding and compassion. Part of the process of unwinding these triggers involves developing strategies to address them. For some survivors, it is easy to develop a strategy to avoid the trigger that is not laden with meaning. For instance, for a survivor who is triggered by the partner coming up from behind to initiate sexual contact, it is not a significant issue to help the partner understand this and simply learn to approach the survivor partner for sexual contact only from the front. However, when one partner is triggered by something that is quite central to the arousal and pleasure of the other partner, this can be more challenging, such as a childhood sexual abuse survivor feeling triggered by nipple stimulation when with a partner who is very aroused by breast play. In this case, developing a strategy for working around the trigger and finding ways for both partners to feel aroused and pleasured becomes more of a challenge. For some survivors, sexual arousal in any form is triggering, so this pervasive squelching of sexuality must be addressed directly.

For triggers that the therapist cannot work around, such as those in response to sexual stimulation and arousal, the therapist needs to help the couple develop the capacity to engage in gradual exposure and desensitization. Some strategies to assist in this process include starting with nonsexual touch

and talking about sexual fears and desires, then slowly moving to reintegrate sexual stimulation using conscious sensate focus exercises, and gradual and scaled exercises to overcome barriers and reduce avoidance (Maltz, 2002, 2012). Taking away the pressure and conflict related to sex by imposing temporary abstinence can allow an opportunity to restart and reengage on fresh ground.

An essential element of the process of working through begins with breaking down sexual secrets and finding ways to reduce any bifurcation of sexuality. Through a combination of individual and couple sessions, the therapist's role is to unpack layers of conditioning, avoidance, compulsions, and secrecy. Individual sessions, while potentially posing a challenge to the ongoing development of a secure therapeutic alliance, provide some protection against potentially premature and damaging disclosures about sexual secrets. Additionally, these individual sessions may allow for safety and greater ease for survivors to disclose potentially shameful, painful secrets, including sexual addictions, compulsions, conditioned sexual responses, and engagement in sexual activities that might constitute a betrayal of the primary relationship. Survivors with sexual secrets often end up living double lives, with sexual compulsions outside of the relationship and avoidant, inhibited sexual engagements within the couple relationship. Partners often feel that something is wrong, that something is hidden out of view, yet when secrets are disclosed, they may feel betrayed, and relationships can fall apart. Disclosures need to be slow and safe for relationships to survive. Individual sessions can also be helpful for partners who need to share their feelings of anger, betrayal, hurt, fear, and even vicarious traumatization.

When facilitating disclosures, a therapist must assist the couple with emotion regulation in situations in which attachment ruptures are always on the horizon. Making decisions about the timing and content of disclosures is paramount to success in resolving bifurcation of sexuality. In many cases, it is enough to share the general theme or overarching flavor of the secrets and not all of the gory details. While it is important to open up the secrets, it is not necessary to devastate a partner with graphic and extensive details about extradyadic sexual exploits. Not all partners are satisfied with an overview, and these partners need gentle guidance and support as secrets are unveiled to a deeper level. Beginning to share the secrets lets the partner in and can start to heal the divide in both the survivor and the couple. The goal of working on sexual issues in couple therapy with childhood trauma survivors is not to engage in a process of attempting to change sexual conditioning that arises from childhood trauma, it is to help couples find ways to talk about, share, and learn to meet each other's sexual needs in ways that are tolerable and pleasurable, and that remove the need to dissociate and divide sexuality in the self and in the couple. Not all couples survive the process of disentangling years of avoidance, withdrawal, secrets, and loneliness. Some couples tear apart with the disclosure of sexual secrets. However, positive outcomes in couple therapy are not limited to those in which the couples stay together.

Sometimes, a positive outcome may be one in which truths are told, frozen states of disconnection and avoidance are broken down, and the couple nevertheless comes apart, but in the coming apart, each partner may also come alive again (MacIntosh & Butters, 2014).

## Case Discussion

Coming back to our couples, Jessica and Jennifer and Natalie and Nathan, we have two examples of the possible divergent outcomes in survivors of childhood trauma.

### Case 1: Jessica and Jennifer

Jessica and Jennifer are in their mid-40s and have been in a close, monogamous relationship for 15 years. They are raising two children (6 and 8 years old) together and report that in all respects other than their sexuality, their relationship is meaningful, intimate, and satisfying. In the first session, they described a typical pattern of intense sexual engagement at the beginning of their relationship, which diminished as the years went on and extinguished after the birth of their second child, a daughter. While Jessica had always been the partner to initiate sex, Jennifer had always eagerly gone along and responded positively to her partner's invitations to sexual intimacy. However, since the birth of their daughter, Jessica has struggled with issues related to genito-pelvic pain, anxiety, and diminished sexual desire. Jennifer, who reported missing their sexual connection, did not seem to know how to pick up the reins and share her desire and interest with Jessica. As the tables turned, the partners were unable to find a new dance of initiation.

After carefully prying open some closed doors, the therapist was able to determine that Jessica was a survivor of childhood physical abuse. Jessica's disclosure that Jennifer reminded her of her father when she was angry at their children opened the door to exploring the impact of Jessica's trauma on their relationship. Initially, Jessica was only able to share that her father had abused her from ages 4–14 and that this abuse had been quite severe. She was not able to share any details of this abuse in early sessions other than to say that it was violent and that she frequently had to hide bruises and injuries from teachers and parents of friends. However, she believed, quite strongly, that her genito-pelvic pain had nothing to do with her abuse, and that it was directly related to the traumatic birthing experience with her daughter. Jennifer had carried their first child and reported that she loved every minute of the pregnancy. Jessica carried their second child and indicated that she became increasingly anxious and fearful, and avoidant of sexual contact over the course of the pregnancy and ever since. Jessica described a traumatic birthing experience that involved intrusive and unplanned medical interventions, a large episiotomy, and feeling completely out of control.

Jennifer was surprised to hear about Jessica's abuse experiences. She reported that she knew that Jessica had had a "rough childhood" and that she had little contact with her family, but Jennifer thought that this was because her parents were not accepting of her sexuality.

As the therapist went through the process of psychoeducation with the couple, Jessica was able to share some limited details of her abuse as they related to her sexual triggers. Jessica was surprised to become aware of the connection between her trauma, the triggers she had not connected with the distress in their sexual relationship, and the gradual reduction of the couple's sexual engagement. While recounting these triggers, a light went on for Jennifer, who had thought that her sexual withdrawal had been related to Jessica's difficult pregnancy and traumatic childbirth, as the two had been unfolding simultaneously. Jessica was able to describe experiences of feeling triggered by Jennifer initiating sex with what she believed to be playful roughhousing that brought back sensory memories, triggered by the bodily and emotional experience of rough physical contact of physical abuse. As the two were able to become more aware of how they had silently grown apart, Jennifer also developed greater empathy for the impacts of Jessica's trauma and learned to better contain and regulate her anger to approach Jessica in less triggering ways. The therapist supported the couple through the process of disclosure, helping Jessica share more about her experiences of violence and betrayal, and helping Jennifer comprehend more fully how her expressions of anger might trigger Jessica and result in avoidance. A delicate therapeutic balance is required to ensure that both partners' needs and desires are validated, and that disclosures are carefully crafted to ensure that responses are measured and result in growth of empathy and closeness rather than anger, shame, and rejection.

Once the psychoeducation process was complete, the therapist facilitated the process of reengagement between Jessica and Jennifer. First, they talked about their fears and desires. Second, they were coached to begin with gentle, slow, nonsexual touch and to gradually integrate sexual touch with clearly articulated boundaries and desires. While Jessica found it difficult to push through her initial avoidance and fear of reengaging with Jennifer, each week she was able to engage a little more with the exercises. Over the course of a number of months, the couple had moved from nonsexual touch to integrating sexual touch and, finally, to having a full-bodied sexual encounter that both reported to be pleasurable. With a few stops and starts, the couple developed a new sexual repertoire, learned to work with and around triggers, and found new ways to initiate sexual contact for which both felt responsible and with which both felt comfortable.

### Case 2: Natalie and Nathan

For Natalie and Nathan, a couple in their late 60s who contacted a local sex therapist to discuss long-standing issues with their sexual relationship,

dealing with sexual compulsions and bifurcation was a major challenge for sex therapy and required long-term commitment. Natalie and Nathan had been together in a heterosexual relationship, which Natalie believed to be monogamous, for 35 years. They indicated that they had always struggled in their sexual relationship. Nathan was very open about his history of childhood sexual trauma and was able to describe the abuse he experienced at the hands of a parish priest, from ages 6 to 12 years. Natalie was aware of this abuse, and both were able to talk openly about this history. However, the therapist sensed that perhaps it was a little too easy for them to talk about it; the trauma story seemed to be almost devoid of emotional life. The couple described a sexual life that had been plagued by disappointment and distress from the very beginning. While they had agreed to wait to have intercourse until after their marriage, their sexual challenges began even before the wedding. Both partners described feelings of awkwardness and insecurity, and Natalie described feeling as though she was never desired, that Nathan was not attracted to her.

Based on the therapist's understanding of the impacts of childhood sexual trauma on survivors, she made the decision to hold individual sessions with each partner at the beginning of treatment. Natalie was open and visibly distressed about what felt like a lifetime of being rejected sexually. She described her many failed efforts to arouse and attract her husband, and her experience of him pulling away from her. When they were sexually intimate, which only occurred every couple of years at this point, Natalie indicated that Nathan had trouble achieving and maintaining an erection, and that they were rarely able to engage in vaginal penetrative intercourse that was satisfying to either of them. At 64, Natalie was reflecting on her life, and she identified this long-term sexual dissatisfaction in her marriage as a major source of grief and loss. Natalie indicated that she used to masturbate frequently but that she had, essentially, given up on her sexuality as raising children, work, life and, eventually, menopause came along, and she feared that her sexual life was over. Natalie appeared to be deeply sad, hurt, and angry.

Nathan was less open in his individual sessions than he was in the initial couple sessions, as though being alone with the therapist was more challenging for him. With some support from the therapist, he was able to talk about his sexual insecurities, his lifelong anxiety about the size of his penis, and the erectile dysfunction that he experienced in his sexual relationship with Natalie. Nathan struggled to describe his feelings about his sexuality, his trauma and his fears, and self-recriminations about his failure to satisfy his wife. When asked about how he felt his trauma impacted his sexuality and the relationship with Natalie, Nathan became mute, he simply was not able to talk. It seemed as though Nathan's primary strategy for regulating emotional distress about his trauma was to suppress and avoid emotional engagement but, in the context of this individual therapy session, efforts to begin to explore his deepest places of disavowed pain led him to simply freeze. As the session wound down to the last 5 minutes and the therapist attempted to help him get grounded and

able to safely leave the session, Nathan began spewing stories about his hidden sexual life, stories of shame and trauma, living in the shadows.

The therapist made the decision to continue with individual sessions to ensure that Nathan's sexual secrets would be told in a safe and contained manner, without the potential for causing unbearable pain to Natalie and irreparable damage to their marriage. In the second individual session, Nathan indicated that early in their marriage, he struggled to fight against his deep urges to seek out young men for sex. Nathan indicated to the therapist that he identified as a heterosexual man and that his urges toward younger men felt dystonic to him; he was clear that this sex was occurring in a wash of dissociation and shame. He described feeling as though he would enter into an altered state in which his thoughts and feelings were hyperfocused on finding a sexual outlet for his overwhelming traumatic memories and feelings. As the years went on, he continued to struggle against these urges but became less and less aware of the conflict internally and more able to dissociate his two lives: the life of his loving but sexless marriage, and the life of his hidden sexual world. As time moved along, Nathan began using the Internet to find men for anonymous sex, and the frequency and intensity of his hidden sexual life increased. Nathan reported that these experiences had to adhere to a strict protocol for him to experience the relief he craved. The man had to be younger, smaller, and willing to not speak at all. Nathan indicated that he would outline these conditions to the men in e-mails and that the more the man expressed arousal by his rigid rules, the better the experience and satisfaction for him. Nathan further described, in a stilted narrative filled with stuttering, stalls, and averted eyes, that this younger, small man, must also be willing to fellate him before they engaged in anal penetration, with Nathan as the top, and the younger, smaller man, the bottom. Nathan indicated that in these encounters, he was able to achieve and maintain a strong erection, and his refractory period between erections continued to be short, even in his 60s, such that these sexual encounters frequently included multiple "rounds." On deeper inquiry, Nathan could, through floods of tears and shame, describe the almost exact replication of his sexually violating childhood traumas in these encounters. He described years of trying to stop his secret sexual compulsions and the pain of living in shame, guilt, and the fear of being found out, year after year. Nathan believed that Natalie had no idea about his secret sexual life, and that she would be devastated if she found out.

The therapist faced the challenge of trying to find a way to help Nathan and Natalie come together again after years of secrecy and segregation of their sexual lives, without blowing their relationship to pieces by encouraging premature disclosures of potentially damaging sexual secrets. In the psychoeducational process, both Natalie and Nathan were quite well versed about the impact of childhood sexual abuse on relationships and sexuality. They had done extensive research over the years, and both were comfortable talking about the inhibition and dysfunction in their sexual relationship. However, bringing the dysfunction in relation to Nathan's secret compulsive sexual life

into this discourse was a real challenge. The therapist introduced the topic by asking about masturbation outside of the couple relationship. Nathan and Natalie were able to talk about their separated sexuality but still stayed pretty clear of Nathan's secret sexual life. After many weeks of moving in and out of discussions about their divided sexuality, the therapist felt that the time was right to introduce the idea of dissociation, reenactment, and bifurcation of sexuality. This determination was made by the therapist's assessment that the partners were able to discuss their sexual feelings, needs, and pain more openly, were demonstrating stronger emotion regulation capacities as they discussed the painful aspects of their sexual relationships, and were able to reflect on the unique and different experience of their partner.

While Natalie was distressed with the turn toward exposing the compulsive side of Nathan's sexuality that had been expressed away from her, she was less distressed than the therapist might have imagined. Natalie indicated that this did not surprise her, that she had always wondered whether Nathan was gay, and whether he had a secret sexual life. The therapist was able to facilitate a discussion on the general theme of Nathan's divided sexual life and to help Nathan turn toward Natalie to build a shared understanding of how their sexual life had grown divided. Natalie was able to listen and seemed to understand the reasons for their separation, and even to discuss some of the details of Nathan's double sexual life. It was only after a few weeks of these discussions that Natalie began to feel the pressure of growing awareness of the years that her husband had been seeking his sexual pleasure outside of their relationship. Nathan reported that Natalie had been crying day and night and that he felt helpless to console her. Natalie agreed that she was distraught but that even if he tried, being close to Nathan only made her feel angrier, betrayed, and alone. Natalie and the therapist met for individual sessions to allow Natalie to fully contact her grief, rage, and deep feelings of loss and betrayal. Nathan was brought back into sessions, and the partners spent many months engaged in healing the divide that had grown between them. This was painful work, but both were committed to healing their rift. Even while Natalie understood, at a cognitive level, the nature of traumatic reenactments, she was still plagued with the fear that Nathan was gay. And, even while Nathan was deeply committed to repairing his relationship with Natalie, he struggled with his compulsive need to seek out sexual encounters with unknown men. However, his increased awareness of the reenacted nature of these encounters allowed him to contain and resist the strong urge.

While these were deeply challenging months of therapy for all concerned, beginning to heal their sexuality together was still in the early days; after many years of isolation and sexual dissatisfaction, it would take more than a few months of therapy to begin to heal the rifts between them. Neither Natalie nor Nathan really understood the other sexually, and in spite of spending many years together, these initial conversations were like starting from the beginning, as though the partners had just met. They found the exercises involving nonsexual touch to be awkward and uncomfortable at first, but

slowly they found ways to touch one another lovingly. The therapist facilitated discussions about what they both might find sexually satisfying and how they might integrate aspects of Nathan's conditioned sexual arousal into their sexual relationship. This was challenging for both partners, as both feared fully delving into Nathan's desires given how these had separated them for so many years. Natalie feared that she would never be able to satisfy Nathan, especially given how conditioned his arousal was to younger, submissive men. However, Natalie was eager to be with Nathan sexually, and to help him break down the wall that divided his sexuality. While Natalie and Nathan could not replicate the hidden, anonymous, and dark nature of Nathan's compulsive reenactment and Natalie would never be a man, they were able to integrate some aspects of Nathan's reenacted sexual scenarios, including Natalie fellating Nathan and taking the role of the submissive bottom. Natalie was not comfortable with anal sex, but she was eager to find ways to arouse and stimulate Nathan. Nathan, on the other hand, was not used to having a sexual partner who could verbalize desires and be a partner with an identity, an attachment, and emotional intimacy. Nathan struggled to find ways to arouse and stimulate Natalie; when he was aware of her desires and interested in meeting them, he would frequently lose his erection. It took many months for Nathan to become comfortable with being sexually intimate with a partner who was not a stranger, to be sexual with someone he loved and to whom he was attached, and to be living his sexual life within his primary relationship.

The therapist worked with Natalie and Nathan for over 2 years, slowly and gently unfurling the secrets and helping them share their deepest longings, fears, and desires for closeness. For many couples dealing with this level of sexual alienation and sexual secrets, relationships do not survive the unfurling of sexual secrets. Natalie and Nathan, who had a long history of loving connection in spite of their sexual dissatisfaction and were deeply committed to healing their relationship, were able to build a new repertoire to meet many of their sexual needs by integrating aspects of Nathan's secret sexual life into their sexuality. Nathan was able to emerge from his dissociative state to be engaged with Natalie, to feel aroused, to engage in stimulating foreplay with her, and to get and maintain an erection, allowing them to engage in vaginal intercourse that was satisfying to both of them.

## Conclusions

The impacts of childhood trauma on adult sexuality can be devastating. While the majority of research in this area initially focused on the sexual outcomes of childhood sexual abuse female survivors, more and more studies are identifying that negative sexual outcomes are not exclusive to childhood sexual abuse; men and women survivors of all forms of childhood trauma experience negative sexual sequelae. A dual-pathway model, including a bifurcation of sexuality that combines both profiles, has been proposed to

understand the ways in which childhood trauma survivors may present with sexual difficulties.

Jessica and Jennifer, a couple dealing with inhibition, and Nathan and Natalie, a couple dealing with disinhibition within a bifurcation profile, provide examples of how these pathways may be expressed in clients presenting for sex and couple therapy. Through these cases, we have illustrated the importance of providing couples with trauma-informed assessment and psychotherapy (DCTCT). Helping them begin to communicate about the impacts of their traumas on their sexuality is a first step in this process. Gradually, the therapist works toward breaking down barriers to sexual reengagement in couples with an inhibition profile, and finding ways to break through secrets and reduce compulsions in couples dealing with a disinhibition in a bifurcation profile. It is only when these preliminary steps have been taken that clinician can begin to help a couple to rebuild a satisfying, safe, and intimate sexual relationship.

This challenging work involves going into deep, dark places where shame, pain and betrayal lurk behind the longing for reconnection and closeness. The role of the therapist is to work slowly, steadily, and honestly to titrate exposure to the emotional tolerance capacity of survivors and to help couples break through barriers and secrets either to find their way back to one another or make the decision to end their relationship. This is not easy work, but it is rich and deeply rewarding when couples divided by trauma and betrayal come together and find sexual satisfaction and closeness.

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CHAPTER 18

# Gender Dysphoria in Children and Adolescents

KENNETH J. ZUCKER

The number of referrals to gender identity clinics for children and adolescents has increased dramatically over the last 15 years, forcing clinicians to confront complex parent inquiries about the rearing and socialization of their children. Professionals have found it difficult to provide advice, since there are often insufficient data to suggest the best course of action. This situation is complicated by various sociopolitical movements for and against accommodating or promoting transgendered identities. In Chapter 18, after comprehensively reviewing the diagnostic, prevalence, and etiological literatures, Zucker carefully summarizes the available therapeutic data for children and adolescents in the following way: "Whereas gender social transition and biomedical treatment for adolescents is probably the most common method to reduce gender dysphoria (GD), it should be recognized that not all clients wish to pursue such treatment and, for them, a supportive psychosocial therapeutic approach can be provided as a first-step alternative." For children, there is no consensus, and a wide range of clinical opinion and practice. Zucker suggests, however, that for most children, a gender social transition be considered only after other alternatives have been fully explored. These developmental issues are of prime importance to sex therapists, as romantic and sexual relationships and a sense of one's sexuality begin in childhood and emerge in adolescence, and will be affected by not only GD but also potentially its treatment.

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In this chapter, I review clinical management and treatment approaches for children and adolescents with a DSM-5 diagnosis of gender dysphoria (GD; American Psychiatric Association, 2013). Although GD is not a sexual dysfunction, emergent romantic and sexual relationships (whether functional or dysfunctional) for adolescents are an important part of the clinical picture and for those who receive biomedical treatment (e.g., hormonal suppression), it should be recognized that this may well affect parameters such as sexual desire; moreover, because adolescents with GD experience such a profound discomfort with their primary and secondary sex characteristics, sexual self-exploration, such as masturbation, and interpersonal sexual relationships may be avoided (Bungener, Steensma, Cohen-Kettenis, & de Vries, 2017; Kaltiala-Heino, Työläjärvi, & Lundberg, 2019). Thus, the practicing sex therapist should be cognizant of this diagnostic class. As there is more and more evidence that an increasing number of people identify along the transgender spectrum, it is likely that more clients with GD or its variants will be seen in the clinical practice of sex therapists who work with adults. It is also quite likely that sex therapists will encounter some couples who have a child or adolescent with GD; thus, they should have some familiarity with clinical management approaches for this pediatric population.

## Clinical Description

For children who present with the DSM-5 diagnostic criteria for GD, the age of onset of symptomatology is almost always during the toddler and preschool years (an exception might be for a child with an intellectual disability). The core elements include a strong wish to be, or a persistent claim that one is, of the other gender. Other common signs may include cross-dressing, cross-gender play and playmate preferences, and sometimes marked dislike of one's sexual anatomy.

### Case 1: Robert

Robert, a 5-year-old boy, was seen for an assessment at the request of his mother. Robert lived with his mother and several older maternal and paternal half-siblings. His parents, who were common-law, lived together but were "psychologically separated." Robert's mother noted that he had always

been "different" from other boys: He preferred to play with girls (although at school, she said, the girls would not play with him), he engaged in "girl play," would always take on female roles in pretend play, liked "beautiful things," and did not enjoy or play with stereotypical boys' toys (e.g., trucks). His mother said that she had always thought his gender-related play was "just play-acting." The reason for referral was that at the age of 3, Robert began to express the wish to be a girl. More recently, Robert had begun to make statements such as "I am a girl" and said to his mother that when he entered high school, she should tell others that he was a girl. These comments led Robert's mother to seek an assessment. Apart from his mother's concerns about his gender identity, it was noted that Robert had a speech impediment (for which he was receiving speech therapy), a variety of sensory sensitivities (e.g., to the texture of clothing), and various signs of separation anxiety (e.g., "He needs to know where I am all the time"), with Robert's mother noting, "We're very attached," and that he slept at night with her, not in his own bedroom. Although he did "ok" at school, his mother noted that Robert would rather stay at home with her. When I met Robert and his mother for the initial assessment interview, Robert was noted to have long hair, was wearing purple nail polish, and had on purple leggings. My subjective impression was that Robert might well be perceived to be a girl based on phenotypic gendered social cues, such as hairstyle and clothing style. Early in the interview, Robert said that he had something to tell me: "I'm wondering if I was born a boy or a girl" and wanted to know what I thought. When I asked Robert what he thought, he said, "I don't know. . . . How can you tell?" As we discussed this, Robert said, "Girls don't have 'dickies' . . . boys do. I have a 'dickie' but I want to be a girl. . . . I might be a girl. . . . Maybe I was born a girl with a 'dickie.' "

For adolescents who present with GD, there are at least three developmental pathways. The first is simply a continuation of GD from early childhood, except that the adolescent may not have been seen clinically prior to puberty. In these youth, sexual orientation is predominantly toward members of their birth sex (in females: gynephilia; in males: androphilia). The second pathway pertains to adolescent males who do not have a childhood history of GD (Zucker et al., 2012a). Expressions of GD manifest in early adolescence, often with a co-occurring transvestic disorder (or traits thereof) and/or autogynephilia (e.g., sexual arousal at the thought of being a female) (Lawrence, 2010). These adolescents, in general, report a gynephilic sexual orientation; however, the attraction to girls "competes" with the autogynephilic feelings. The relative sexual arousal/attraction to girls versus the relative autogynephilic arousal/attraction varies from case to case. For some adolescents, the transvestic fetishism and/or the autogynephilic feelings are ego-dystonic, but for others they are ego-syntonic. The third pathway is one that has only come to clinical attention in recent years, primarily in adolescent females (see Littman, 2018). These adolescents do not appear to have a childhood history of GD; rather, they begin to express feelings of discomfort around gender

during middle school or at some point during adolescence, sometimes rather abruptly. For the females in this subgroup, there is no evidence of transvestic disorder or the parallel to autogynephilia (i.e., autoandrophilia). Although not yet well-studied, their sexual orientation is much more variable than that of the adolescent females who have an early childhood history of GD: Some are gynephilic, others are androphilic, some self-identify as "pansexual," and others are asexual (or perhaps simply "nonsexual").

### Case 2: Jordan

Jordan, a 14-year-old, European American, biological female with an average-range IQ, had just completed eighth grade. She lived with her middle-class parents and an older sibling. At the time of assessment, Jordan had a phenotypic androgynous appearance. In terms of developmental history, her parents stated that there was no evidence for cross-gender identification or GD (e.g., no stated desire to be a boy, a preference for boys as playmates). There was, however, a developmental history of intense interests in specific topics (e.g., dinosaurs) and Jordan, over a period of several years, would run around on the school playground declaring that she was a lizard or a snake. There was also a clear history of behavioral rigidity, with Jordan finding it difficult to transition from one activity to another. Transition times often led to prolonged and intense temper tantrums and, from the parents' point of view, Jordan was extremely difficult to soothe. By late childhood, the parents and Jordan both agreed that she had become a "proud feminist," often advocating for equal rights. Both the parents and Jordan were in agreement that Jordan's discomfort with her female gender began during the eighth grade, when the other girls and the boys started to openly talk about "crushes" and sexuality more generally. "Sex talk" left Jordan feeling that she was being "sexually objectified" (my paraphrasing of her verbalizations), which made her very anxious and suicidal. She began to change her style of dress, wanting to wear loose-fitting sweatshirts to hide her breast development, and asking that her hair be cut. In this context, she declared that she wanted to be a boy and self-identified as "trans." The parents wanted to know if Jordan was "really" trans or if her gender dysphoria might somehow be related to what appeared to be her traumatic reaction to the emergence of sex talk within the peer group. As part of the assessment, I expressed to Jordan my curiosity how a once strongly feminist kid could so quickly want to be a boy, given her dislike of feeling objectified by the boys in her class. She replied, "If you can't beat 'em, join 'em."

## Epidemiology

### Prevalence

As noted elsewhere (Zucker, 2017a), none of the numerous epidemiological studies on the prevalence of mental health diagnoses in children and youth

have examined GD. Accordingly, estimates of prevalence have relied on less sophisticated approaches, including a broader definition of classifying children or youth as possibly having GD.

### Self-Identification as Transgender

In a random sample of sixth- to eighth-grade students from San Francisco (total $N$ = 2,730), Shields et al. (2013) found that 1.3% self-identified as "transgender" in response to the question "What is your gender?", with the other response options being "female" or "male." To my knowledge, this is the only random sample of children who have been asked this question.

In recent years, there have been several representative samples of high school students, in which it has been possible to gauge the percentage of adolescents who self-report a transgender (or some other type of alternative gender) identity. For example, in a sample of high school students from New Zealand (total $N$ = 8,166), Clark et al. (2014) found that 1.2% answered "yes" to the question "Do you think you are a transgender?" Another 2.5% reported that they were not sure about their gender, and 1.7% reported that they did not understand the question. In a sample of ninth- and 11th-grade students from Minnesota (total $N$ = 81,885) (Eisenberg et al., 2017), students were asked, "Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?" For birth-assigned females, 3.6% answered "yes," and the corresponding percentage for birth-assigned males was 1.7%.

### Parent Report

The Child Behavior Checklist (CBCL), a parent-report behavior problem questionnaire, and the Youth Self-Report Form (YSR) are two widely used assessment measures that include items related to cross-gender identification (Achenbach & Edelbrock, 1983, 1986).

On both the CBCL and the YSR, *behaving* like the opposite sex was reported to be more common than *wishing* to be a member of the opposite sex and was more common in girls than in boys. In the nonreferred standardization sample for children ages 4–11 years, only 1.0% of mothers of boys indicated that their sons wished to be a member of the opposite sex "sometimes" and 0% indicated that this was "very true." The comparable percentages among nonreferred girls were 2.5 and 1.0%, respectively. On the YSR, for youth ages 11–18 years, the percentages of nonreferred boys who indicated a desire to be a member of the other gender were 2.5% and < 1%, respectively. For nonreferred girls, the corresponding percentages were 11% and 2%, respectively.

### Sex Differences in Referral Rates

For the clinician, a more practical matter concerns information about sex differences in referral rates to specialized gender identity clinics (Wood et al.,

2013). Among children (12 years of age and younger), the sex ratio historically favored boys. In one Toronto clinic for the years 1975–2011, the sex ratio among referred children was 4.49:1 of boys to girls, which was significantly larger than the 2.02:1 sex ratio of boys to girls from a clinic in Amsterdam. Two more recent studies of children, however, have shown that by late childhood, the sex ratio has become closer to parity (in Amsterdam: Steensma, Cohen-Kettenis, & Zucker, 2018; in London: de Graaf, Carmichael, Steensma, & Zucker, 2018).

Over the past dozen years, there has been a notable shift in the sex ratio of referred adolescents. Prior to the mid-2000s, the sex ratio favored adolescent males over females, at a ratio of about 2:1 (Aitken et al., 2015). Since then, there has been an inversion of the sex ratio to one that now favors adolescent females. In some clinics, the male:female sex ratio is remarkably skewed in favor of females (e.g., Hamburg, Germany: 1:4.29 [Levitan, Barkmann, Richter-Appelt, Schulte-Markwort, & Becker-Hebly, 2019]; Helsinki, Finland: 1:6.83 [Sumia, Lindberg, Työläjärvi, & Kaltiala-Heino, 2017]; for a meta-analytic review, see Zucker & Aitken, 2019). In general, the change in the sex ratio appears to be driven primarily by an increase in the number of referred females, not by a decrease in the number of referred males (see, e.g., de Graaf, Giovanardi, Zitz, & Carmichael, 2018).

## Diagnosis

### DSM-5

Is GD really a mental health diagnosis? This was a fundamental question that the DSM-5 Gender Identity Disorders subworkgroup had to contemplate (Drescher, 2010; Meyer-Bahlburg, 2010; see also the special issue of the *International Journal of Transgenderism,* guest edited by Knudson, De Cuypere, & Bockting, 2010; De Cuypere, Knudson, & Bockting, 2010). Some argued for various kinds of improvements in the conceptualization of what had been called "gender identity disorder" (GID), along with modifications to the diagnostic criteria; others argued that it should be deleted and reconceptualized as some kind of nonpsychiatric medical condition or even as a central nervous system (CNS) limited form of a physical intersex condition (see Meyer-Bahlburg, 2011). However, in the absence of data to support a reclassification as a nonpsychiatric medical condition, others argued that it should remain in the DSM, so that people could access medical treatment through public health care systems or private insurers (Drescher, 2010). A V-code option ("Other Conditions That May Be a Focus of Clinical Attention") was considered untenable, since V-codes are not covered by insurance.

GID was retained in DSM-5 as a mental health diagnosis but renamed "gender dysphoria." In addition to the name change, there were eight other substantive changes from DSM-IV: (1) decoupling of the GD diagnosis from the sexual dysfunctions and paraphilias and placement in a separate chapter;

(2) change in the introductory descriptor to the Point A criterion, including the specification of a 6-month duration criterion; (3) merging of the behavioral criteria from what had been the Point A and Point B criteria in DSM-IV into one set of polythetic criteria; (4) for children, the desire to be of the other gender was now a necessary indicator for the GD diagnosis (in total, six of eight indicators are required for the diagnosis); (5) for adolescents (and adults), the criteria were more detailed than in DSM-IV and, like the criteria for children, polythetic in form (two of six indicators are required for the diagnosis; (6) elimination of the sexual attraction specifier for adolescents (and adults); (7) inclusion of a subtype pertaining to the presence (or absence) of a disorder of sex development; and (8) inclusion of a "posttransition" specifier for adolescents (and adults) (for the rationales, see Zucker et al., 2013).

## ICD-11

On May 25, 2019, the World Health Organization announced that it had formally approved the 11th edition of the *International Classification of Diseases and Related Health Problems* (World Health Organization, 2019). For those unhappy about conceptualizing GD as a mental health diagnosis, the long-awaited revision to the ICD was viewed as an opportunity to consider alternatives (see, e.g., Drescher, Cohen-Kettenis, & Reed, 2016; Drescher, Cohen-Kettenis, & Winter, 2012). Some argued that the diagnosis should be retained in some form, but only for adolescents and adults, since only adolescents and adults require "medical" treatment (e.g., Suess Schwend, Winter, Chiam, Smiley, & Cabral Grinspan, 2018; Winter, 2017; Winter, De Cuypere, Green, Kane, & Knudson, 2016).

The World Health Organization approved the recommendation that ICD-10 diagnoses pertaining to GIDs be removed from the "Mental and Behavioural Disorder" chapter and become part of an entirely new chapter called "Conditions Related to Sexual Health" under the label of "Gender Incongruence," which would appear to at least partly satisfy those who want to emphasize depathologization (see, e.g., Beek et al., 2017), yet at the same time presumably allow continued access to care via private insurance companies or national health care systems.

The proposed criteria for gender incongruence in children are somewhat similar to the criteria for GD in DSM-5, although not written in polythetic format or with a specification of how many indicators are required. In addition, unlike DSM-5, a distress/impairment criterion is not required. Perhaps the most interesting divergence from DSM-5 is the duration and lower bound age criteria: "The [gender] incongruence must have persisted for about 2 years, and cannot be diagnosed before age 5. . . . Although some indications of Gender Incongruence may be present when children are as young as age 2, it is not possible to perform an accurate assessment of Gender Incongruence of Childhood at this age" (Draft Clinical Description and Diagnostic Guidelines,

April 12, 2014). To my knowledge, the rationale and evidence for these two criteria have never been formally provided (for a critique, see Zucker, 2017b, and the section "Approaches to Treatment" below).

## Etiological Models

The causal mechanisms that might account for the development of GD include a range of conceptual models: an emphasis on biological factors, an emphasis on psychosocial factors, or an emphasis on some type of biopsychosocial framework that attempts to integrate both biological and psychosocial factors. For the contemporary clinician who studies this literature, it will become apparent that there is much that we still do not know and that we have to tolerate this ambiguity.

### Biological Factors

Several lines of evidence provide some support for biological mechanisms in the genesis of GD. These include genetic factors, as judged by a higher rate of concordance for GD in identical twins than in nonidentical same-sex twins (Heylens et al., 2012). Candidate gene studies (e.g., genes that code for sex hormone receptors or for enzymes that catalyze the synthesis or metabolism of sex hormones), however, have yielded mixed results in adult males and females with GD, including high rates of "false positives" in control groups and failures to replicate (Lawrence & Zucker, 2014, pp. 612–621; Ngun, Ghahramani, Sánchez, Bocklandt, & Vilain, 2011).

The organizational hypothesis of classical prenatal hormone theory posits that sex differences in behavior (along with morphology) are accounted for in part by sex differences in prenatal exposure to gonadal hormones, particularly androgens—not only in lower animals but also in humans (Wallen, 2009). However, it has long been noted that classic prenatal hormone theory does not easily account for GD, as the vast majority have a normal somatic phenotype. Thus, there is little reason to believe that the prenatal hormonal milieu was grossly atypical. However, it is conceivable that more subtle variations in patterns of prenatal sex hormone secretion play a predisposing role (see, e.g., Berenbaum, 2018). A relevant rhesus monkey animal model demonstrates the dissociation between sex-dimorphic behavioral differentiation and genital differentiation that is related to prenatal hormonal exposure and has the most direct relevance for explaining the marked cross-gender behavior of individuals with GD (Goy, Bercovitch, & McBrair, 1988). Another example potentially related to prenatal hormone exposure is the 2D:4D digit ratio of fingers (the second and fourth digits) that demonstrate normative sex differences (Grimbos, Dawood, Burris, Zucker, & Puts, 2010). Here, it has been hypothesized that the sex difference in 2D:4D digit ratios are related to the sex difference in prenatal exposure to androgen. Whether these differences are

related to GD, however, is not clear (Wallien, Zucker, Steensma, & Cohen-Kettenis, 2008).

A new development in the field has been the use of structural magnetic resonance imaging (MRI) to determine whether or not there are neuroanatomical regions of interest (ROIs) in the brain that are altered in adolescents (and adults) with GD when compared with unaffected males and females, presumably because these ROIs are influenced by some type of prenatal variation in either hormone exposure or cellular receptivity to such exposure (for review, see Guillamon, Junque, & Gómez-Gil, 2016). These studies suggest that some ROIs of individuals with GD are shifted, although not completely, in the direction of the opposite sex. As noted by Guillamon et al., this conclusion is somewhat qualified by sexual orientation differences: The evidence for a shift in ROI in the direction of the "other" sex is stronger for those who are sexually attracted to members of their own natal sex than it is for those who are sexually attracted to the other sex.

## Psychosocial Factors

To merit truly causal status, psychosocial factors should be able to account for the emergence of GD in the first few years of life, when its behavioral expressions are first manifested (at least for those patients who have the early-onset form of GD). Otherwise, psychosocial factors would be better conceptualized as having a perpetuating role.

Parental tolerance or encouragement of the early cross-gender behavior of children with GD has been reported by clinicians of diverse theoretical persuasions and has also marshaled some degree of empirical support (Green, 1987; Zucker & Bradley, 1995). The reasons that parents might tolerate, if not encourage, early gender-variant behaviors appear to be quite diverse, suggesting that the antecedents to this "end state" are multiple in origin. For example, if one listens to the reports by contemporary parents of children who have made an early gender social transition (see below), a common narrative is that the parents are simply "supporting" what they view as their child's essential "nature" (Ehrensaft, 2014). Such parents would argue that the direction of effect is from child to parent, not the other way round, or even some kind of interactive, iterative transactional process. In an earlier generation, parents of children with GD reported being influenced by ideas regarding nonsexist child rearing and were therefore as likely to encourage cross-gender behavior as same-gender behavior. In contemporary times, some parents choose not even to mark their child's gender to others, holding the philosophical perspective that it is up to their child to choose a gender (so-called "theybie" child rearing) (see, e.g., Compton, 2018; see also Travers, 2018). In other parents, the antecedents seem to be rooted in pervasive conflict that revolves around gender issues (Zucker & Bradley, 1995, pp. 213–215).

In the normative development literature, the role of parental reinforcement

efforts in inducing sex-typed behavioral sex differences was studied extensively between the 1970s and the early 1990s. Lytton and Romney (1991) concluded in their meta-analysis that, with one exception, there was "little differential socialization for social behavior or abilities" (p. 267). The exception was in the domain of "encouragement of sex-typed activities and perceptions of sex-stereotyped characteristics" (p. 283), for which the mean effect sizes for mothers, fathers, and parents combined were 0.34, 0.49, and 0.43, respectively. Although Lytton and Romney's overall conclusion minimized the influence of parental socialization on sex-dimorphic behavior, the domain for which clear parental gender socialization effects were found is precisely the domain that encompasses many of the initial behavioral features of GD (see also Zucker & Bradley, 1995, pp. 222–226).

Over the past couple of decades, cognitive-developmental models have come to play a much more central role in the normative development literature regarding gender development (Martin, Ruble, & Szkrybalo, 2002), building on the seminal theoretical work from the 1960s through the 1980s and its emphasis on "self-socialization."

Studies of children with GD have shown that they are more likely than control children to label (or "mislabel") themselves as the other gender and also to show a "developmental lag" in cognitive gender constancy (Zucker et al., 1999). Perhaps this early sex-atypical cognitive labeling (or "mislabeling") of gender contributes to their cross-gender identification, although the reasons why this occurs is unclear. It could, for example, be argued that there is some kind of interactive effect between gender cognitions and the strong interest in cross-gendered behavior (see, e.g., Endendijk, Beltz, McHale, Bryk, & Berenbaum, 2016).

A second aspect of the cognitive-developmental literature pertains to the observation that young children have rather rigid, if not obsessional, interests in engaging in sex-typed behavior: For girls, Halim et al. (2014) dubbed this the "pink frilly dress" phenomenon. Halim et al. argued that this gender rigidity is part of the young child's effort to master gender categories and to securely (affectively) place him- or herself in the "right" category. Parents of such children do not particularly encourage the rigidity, but they also do not discourage it, and there is the assumption that such rigidity will wane over developmental time and there will be a concomitant increase in gender flexibility.

Halim et al.'s (2014) observations jibe rather nicely with empirical data suggesting that many children with GD show very focused and intense cross-gendered interests (VanderLaan et al., 2015). If these early cross-gendered intense interests are reinforced rather than ignored or compensated for by efforts to increase gender-flexible thinking and behavior, then perhaps this contributes to their continuation and an increase in the likelihood that a cross-gender identity will persist.

For adolescents who present with a history of early-onset GD, one could consider the same hypotheses that have been studied with regard to children

with GD. For adolescents with late-onset GD, other explanations are required. For example, if adolescents with late-onset GD did not have a childhood history of marked gender-variant behavior (or GD proper), then, of course, the role of "reinforcement" of such behavior would not apply; that is, there was no such behavior to "reinforce." In the case of male adolescents with a concurrent history of transvestic fetishism and/or autogynephilia, one could argue that the GD emerges in the context of an atypical or paraphilic sexual arousal pattern (Lawrence, 2017). The sexual arousal can be experienced in a pleasurable way and thus is self-reinforcing. In the case of the adolescents described by Littman (2018), various psychosocial mechanisms have been proposed, including the influence of peers who are part of a sexual and gender minority subculture, an intense attraction to social media that values a transgender social identity (something Littman has dubbed as "social contagion") (see also Marchiano, 2017), and the notion that self-identifying as transgender is seen as a coping mechanism in dealing with various mental health issues. At present, however, these ideas are hypotheses that require systematic empirical evaluation. What is required, for example, is a deeper understanding of the mental and psychosocial vulnerabilities that many of these adolescents are experiencing and why adopting a transgender identity provides so many of these youth with a sense of belonging. It is also clear that these youth pose very interesting and important theoretical challenges to the idea that gender identity forms very early in development and remains stable throughout the life course. If these youth truly had a sex-typical gender identity early in development, how do we explain the shift to a different gender identity in early adolescence, if not even later in development?

A multifactorial model of gender development can take into account biological predisposing factors, precipitating factors, and perpetuating (maintenance) factors. Because so much is still not even known about normative gender development (Fausto-Sterling, Garcia Coll, & Lamarre, 2012), clinicians, patients, and their families vary in how much weight (or variance) each of these factors is given. At one extreme, some would argue that biological factors account for the bulk of the variance; at the other extreme, others would argue that psychosocial factors are most influential. As noted by Nieder and Richter-Appelt (2011), the propensity for practicing clinicians (and clients) to utilize dichotomous "either–or" paradigms in conceptualization is a common problem that should be avoided.

## Assessment

As part of a clinical assessment, one has to decide whether a child or adolescent meets DSM-5 criteria for GD. For children, one almost always reviews the criteria with parents. For example, this can be done by having the clinician provide the parents with a copy of DSM criteria and make a judgment as to the presence or absence of each indicator as one reads through them. For

adolescents, one should review the criteria with both the adolescent (in an individual interview) and the parents (on their own).

The practicing clinician can also utilize a variety of quantitative assessment measures that are available in the published literature. For children, a summary of measures can be found elsewhere (Zucker, 2005; Zucker & Wood, 2011), which include parent-report questionnaires, structured play observations, projective testing, and structured interview schedules. I present two examples. The parent-report Gender Identity Questionnaire for Children (GIQC) is a 14-item measure that asks parents to rate the severity of various behavioral criteria for GD on a scale of 1–5—for example, "In playing 'mother/father,' 'house,' or 'school' games, she takes the role of . . . ," with response options ranging from "a girl or woman at all times" to "a boy or man at all times"; "She states the wish to be a boy or a man . . . ," with response options ranging from "every day" to "never." The GIQC shows strong evidence of discriminant validity and sensitivity/specificity, including detection of differences between children who are threshold versus subthreshold for the GD diagnosis (see Johnson et al., 2004; Zucker, 2020a). The Gender Identity Interview for Children (GIIC) is a 12-item structured interview that assesses both cognitive and affective aspects pertaining to gender identity/GD. Each item is rated on a scale of 0–2. For example, one item asks the child, "Are you a boy or a girl?" If the child's response is congruent with his or her birth sex, it would be coded as a 0. If the child says, "I don't know," it would be coded as a 1. If the child's response is incongruent with his or her birth sex, it would be coded as a 2. Another item (Boy Version) asks, "In your mind, do you ever think that you would like to be a girl?" If the child answers "No," it would be coded as a 0. If the child answers "Sometimes," it would be coded as a 1. It the child answers "Yes," it would be coded as a 2. The GIIC shows strong evidence of discriminant validity and sensitivity/specificity, including detection of differences between children who are threshold versus subthreshold for the GD diagnosis (see Zucker, 2020b; Zucker et al., 1993) and has also been validated cross-nationally (see Wallien et al., 2009).

For adolescents, the dimensional measure Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults has excellent sensitivity and specificity, and has been cross-validated (Deogracias et al., 2007; Singh et al., 2010; Zucker, Meyer-Bahlburg, Kessler, & Schober, 2020). Some advantages of this measure are that the items were developed, in part, based on DSM indicators; it is relatively brief (27 items); and it appears well able in identifying caseness.

## Approaches to Treatment

### Children

Current data from the follow-up literature on children with GD indicate the following:

1. The majority of children, when followed up in adolescence or adulthood, no longer have GD and are relatively content with a gender identity that matches their birth sex (for review, see Cantor, 2019; Ristori & Steensma, 2016, Table 1; Zucker, 2018). Across 10 follow-up studies, 47 (14.8%) of 317 children were classified as having a "persistence" of their GD, although the range across the studies was considerable (0–50%). In these studies, the "outlier" sample consisted of the girls in Wallien and Cohen-Kettenis (2008), for which the 50% persistence rate was found. For children whose GD persists, almost all are sexually attracted to members of their natal sex; however, because these youth identify as members of the other gender, their *subjective* sexual identity is heterosexual or "straight."
2. The majority of children with GD, especially boys in whom the GD has desisted, are sexually attracted to members of their natal sex and identify as gay.
3. A minority of children whose GD has desisted are sexually attracted to the opposite sex and identify as heterosexual or "straight." Thus, to date, the most common long-term outcome for children with GD, especially boys, is a homosexual/gay sexual identity, with no continued occurrence of GD.

In the treatment literature on children with GD, three broad approaches appear: (1) psychosocial treatments designed to reduce the GD, in order to increase the likelihood that a long-term gender identity will be more congruent with the natal sex; (2) a neutral or "wait-and-see"/"watchful waiting" approach, in which the clinician suggests that the child be given time to sort out his or her gender identity in one way or another, but without any substantive active interventions; and (3) psychosocial support for an "early" gender social transition—which would reduce the gender dysphoria—because the child is given the opportunity to live in the social role of the "desired" gender (e.g., via a name change, presenting socially via hairstyle and clothing style in the desired gender). These three treatment approaches need to be understood in relation to underlying theoretical, philosophical, and social-value perspectives (for a broad overview of these approaches, see the guest-edited volume by Drescher & Byne, 2012, in the *Journal of Homosexuality*).

The first approach, which Dreger (2009) termed the "therapeutic model," has the longest history. It has taken many forms: behavior therapy, psychodynamic therapy, peer group therapy, family therapy, parent counseling, and interventions in the naturalistic environment carried out by parents, with input from the clinician. From a theoretical perspective, psychosocial treatments have assumed that the child's GD is not yet fixed and is thus amenable to change (Zucker, Wood, Singh, & Bradley, 2012b). From philosophical and social-values perspectives, clinicians probably assume that a child's life would be easier and less complicated if a gender identity that matches his or her birth sex could be achieved. For example, it would reduce the social

ostracism that many of these children experience because of their cross-gender or gender-variant behaviors, and it would avoid the complex medical treatments required to achieve a gender transition (Meyer-Bahlburg, 2002; see also Cohen-Kettenis & Pfäfflin, 2003, p. 120).

Although much less visible in the contemporary treatment literature, some clinicians who have adopted this approach vis-à-vis GD (particularly in the 1960s and early 1970s) have also advocated treatment with the expressed goal of preventing homosexuality (see Zucker, 1990; as an aside, in my entire clinical career, I have never agreed with or endorsed this goal). In this regard, it should be noted that there is little evidence that treatment of children with GD alters their eventual sexual orientation (see Green, 1987); nonetheless, the contemporary clinician should be mindful that parents, even in the contemporary era of so much greater tolerance and acceptance with regard to sexual diversity, vary tremendously in the degree to which they are able to accept and support their child if he or she later develops and expresses a gay or lesbian sexual identity: For some parents, it is not an issue; for other parents, it is an outcome that they eventually are able to embrace; but for yet another group of parents, it is an outcome that causes intense anxiety (for a whole host of reasons—personal, cultural, religious, etc.) (see, e.g., Huebner, Roche, & Rith, 2019). Thus, there is considerable room for psychoeducational discussion with parents about what one might expect from a psychosocial treatment designed to reduce GD, which includes sharing information about what is known about the eventual sexual orientation of children with a diagnosis of GD.

Although there is a reasonably large literature on psychosocial treatments, a perusal of it yields the sobering fact that there is not even one randomized controlled trial for children with GD (American Psychological Association, 2015; Byne et al., 2012). Although there have been some treatment effectiveness studies, which might qualify as Level II standards (e.g., "evidence obtained from well-designed cohort or case–control analytic studies"), much is lacking in these investigations (Zucker, 2008). To put it plainly: There remains a large empirical black hole in the treatment literature for children with GD. As a result, the therapist must rely largely on the "clinical wisdom" that has accumulated in the case report literature and the conceptual underpinnings that inform the various approaches to intervention.

In contrast to the psychosocial treatment approaches designed to reduce GD in children, we have seen in the past 12 years or so the emergence of a therapeutic approach that supports an early gender social transition, which Dreger (2009) termed the "accommodation model," and provides the contemporary clinician (and parents) with a very different conceptual perspective (e.g., Meadow, 2018a; Vanderburgh, 2009; see also the essays in the edited volume by Drescher & Byne, 2012). In this approach, there appears to be an underlying theoretical assumption that the child's gender identity is fixed and unalterable, likely rooted in some type of biological cause. Thus, any attempt to try to change the child's gender identity is viewed with great skepticism. Nowadays, this approach receives the most media attention (e.g., Meadow, 2018b; Singal, 2018; Yong, 2019), and it certainly dominates Internet discourse.

An important empirical question is whether these three approaches will result in different long-term psychosexual outcomes for children with GD. Steensma, McGuire, Kreukels, Beekman, and Cohen-Kettenis (2013) found that boys with GD who had socially transitioned prior to puberty were more likely to persist in their GD by midadolescence than boys with GD who had not, and that early social transition as a predictor variable accounted for unique variance in predicting outcome. In itself, this is an important finding. In contrast to prior samples of children with GD, many more children who now present clinically have already transitioned socially, so it will be possible to compare their rates of persistence with older samples, in which social transition prior to puberty almost never occurred (see, e.g., Rae et al., 2019). What is less clear at present is whether these different treatment approaches are predictive of variations in more general psychosocial and psychiatric adjustment and well-being.

As noted earlier, there appears to be a crucial difference between the DSM-5 criteria for GD and the ICD-11 criteria for gender incongruence. DSM-5 does not specify a lower-bound age for diagnosis, whereas ICD-11 does: no earlier than the age of 5 years and at least a 2-year duration history. I must confess that I find this puzzling.

I know of no child psychiatric diagnosis in the DSM-5 that requires a duration criterion of 2 years. It is true, however, that some diagnoses do specify a lower-bound age for a diagnosis. For example, a diagnosis of encopresis cannot be made in children under the age of 4 (or an equivalent developmental level) for reasons that are fairly obvious to anyone who has parented or looked after infants or toddlers. Perhaps the recommended 5-year lower-bound age for the gender incongruence diagnosis was based on the belief that gender identity per se is not stable until that age. That, however, depends a lot on what counts as stable (Zucker & VanderLaan, 2016).

If one cannot make a diagnosis prior to the age of 5 years, does this tie the hands of a clinician who sees children under that age? Not for the critics who don't want there to be a diagnosis at all. There is, after all, nothing to treat, so who cares about duration. But if parents would like their young child to receive therapy to help work through feelings of GD, would it be more difficult to make therapeutic recommendations if one is not allowed to give a diagnosis at the age of 3? Or, suppose the parents of a 3-year-old come to a clinician with the belief that their child is "trans" and want advice about whether it would be advisable to initiate a gender social transition (Green, 2017). Would it be ethical for the clinician to provide advice if a formal diagnosis cannot be given until the age of 5?

## Adolescents

Since the mid-1990s, one model of therapeutic care, developed by Dutch clinicians and researchers, has been to initiate the biomedical aspects of sex/gender reassignment in early to midadolescence rather than waiting for the legal age of adulthood. After psychological/psychiatric evaluation,

adolescents deemed appropriate for such treatment are prescribed hormonal medication (gonadotropin-releasing hormone agonists) to delay or suppress somatic puberty (prior to the age of 16 years). If the GD persists, then cross-sex ("gender affirming") hormonal therapy is offered at the age of 16 years, and, if the adolescent so desires, surgical sex change procedures are offered at a lower-bound age of 18 years (Cohen-Kettenis, Steensma, & de Vries, 2011; Zucker et al., 2011).

The rationale for this treatment protocol includes the following assumptions: (1) For most adolescents, there is little systematic empirical evidence that psychological interventions can resolve the GD, even if the adolescent desires it; (2) the use of hormonal blockers can be helpful to the adolescent, because it reduces the incongruence between the development of natal sex secondary physical characteristics and the felt psychological gender, thereby reducing stress; and (3) reduction of the incongruence makes it easier for adolescents to present socially in the cross-gender identity/role (when they so desire), which is also helpful in reducing stress during the gender transition process. Because the suspension of the patient's biological puberty reduces the preoccupation with it, it has also been argued that this affords the adolescent greater opportunity to explore his or her longer-term gender identity options in psychosocial counseling or psychotherapy in a more reflective and less pressured manner (see, e.g., Costa et al., 2015).

The sequence of this biomedical treatment is progressively irreversible. On the one hand, the use of hormonal medication to suppress or delay puberty is a reversible procedure; on the other hand, surgical interventions (e.g., in males, vaginoplasty; in females, bilateral mastectomy) are irreversible. Accordingly, if clinicians are going to support adolescents with GD in moving down a pathway that, in the end, results in a completely irreversible intervention, it is important to have a relatively high degree of confidence that the likelihood of regret will be low. One carefully executed study that followed this protocol demonstrated its effectiveness in reducing GD, with high satisfaction and little regret (de Vries et al., 2014).

In the Dutch model, several factors have been identified in deeming adolescents eligible for early biomedical treatment. According to Cohen-Kettenis, Delemarre-van de Waal, and Gooren (2008), these include the following: (1) the presence of GD from early childhood on; (2) an exacerbation of the GD after the first signs of puberty; (3) the absence of psychiatric comorbidity that would interfere with a diagnostic evaluation or treatment; (4) adequate psychological and social support during treatment; and (5) a demonstration of knowledge of the sex/gender reassignment process.

The use of hormonal blockers to treat adolescents with GD has been well received in the adolescent medicine literature (Hembree et al., 2017). There are, however, a number of uncertainties that require further explication. Perhaps the most acute issue is how to best identify adolescents deemed eligible for early biomedical treatment from those who are not (Zucker, 2019a). As noted earlier, one criterion used by the Dutch group is a history of GD from

early childhood on. Yet, in some clinics, there are many male adolescents with GD who showed very little or absolutely no evidence of GD in early childhood (Zucker et al., 2012a). In many respects, the presentations of these adolescents resemble the "late-onset" form of GD that has been described in the literature on adults (Lawrence, 2010). To this subgroup, we must now add the subgroup described recently by Littman (2018), comprising mainly adolescent females who also appear to show little evidence of GD or even gender-variant behavior in childhood. Many parents of these adolescents describe the gender dysphoria as "coming out of the blue." It is not clear whether this late-onset group should be deemed ineligible for early hormonal therapy or at least require some period of "watchful waiting" or psychotherapy prior to making a decision about biomedical treatment (see, e.g., Churcher Clarke & Spiliadis, 2019; Wren, 2019). Other adolescents have a history of pervasive cross-gender behavior during childhood but without apparent GD until adolescence. It is unclear whether a childhood history of pervasive cross-gender behavior without the explicit wish to be a member of the other gender would count as an example of "early onset" in the Dutch model.

Another issue that deserves consideration concerns the Dutch group's view on the role of psychiatric comorbidity in making treatment decisions about early biomedical interventions. It is, for example, unclear what is meant when it is stated that the presence of such comorbidity interferes with a diagnostic evaluation, or in what ways the presence of such comorbidity interferes with treatment. In recent years, this has become an even more important and acute clinical matter, as many clinicians and clinics are reporting a co-occurrence of GD with autism spectrum disorder, and there is concern that at least some of these adolescents may have unique issues with regard to informed decision making (see, e.g., Strang et al., 2018a).

There are several ways to conceptualize such comorbidity. In some instances, it may be that the GD has emerged as secondary to another, more "primary" psychiatric disorder, such as autism spectrum disorder or borderline personality disorder, or as a result of a severe trauma (e.g., sexual abuse). In such situations, it could be argued that the GD would dissipate if the more primary condition was treated. In other instances, it could be that the presence of other psychopathology (e.g., substance abuse) would interfere with the adolescent's ability to adhere to a biomedical treatment and there would be risks in trying to institute a regimen of hormonal therapy until stabilization is achieved. Last, there is the thorny issue regarding the extent to which the presence of other psychopathology (e.g., depression, suicidality) is due to the stress of having GD or is secondary to the social ostracism and rejection that results from it (Janssen & Leibowitz, 2018). On this point, one could argue that institution of treatment of the GD may reduce the secondary psychopathology.

Given that there are likely multiple reasons why adolescents with GD also present with other kinds of psychiatric issues, the clinician needs to formulate the extent to which these other difficulties are merely secondary to the GD, may actually be fueling it, or are related to other factors (e.g., a biological

predisposition, family psychopathology). This kind of case formulation can help the clinician decide whether biomedical treatments should be instituted after the diagnostic assessment or delayed until the other issues can be worked through.

In the past few years, there has emerged what I would like to characterize as an interesting and complex "resistance" to the model of "gender-affirming" care that emphasizes early biomedical treatment of GD for adolescents. The resistance has been launched, in part, by parents who question what they feel is a premature recommendation for hormonal suppression or gender-affirming hormone therapy, not to mention surgery. The most visible website that addresses these concerns is 4thWaveNow (*https://4thwavenow.com*), which was started by the mother of an adolescent female with GD, who subsequently "detransitioned" socially (*www.piqueresproject.com*). It is self-described as "a community of parents & others concerned about the medicalization of gender-atypical youth and rapid-onset gender dysphoria. . . . " Parents who are drawn to this perspective seem to share the belief that a variety of psychosocial factors or mental health conditions have led to the development of their adolescent's GD and that these issues should be explored first, before making any decisions about biomedical treatment. Many of these parents believe that their adolescent's GD matches the reports by parents described in Littman (2018).

There is very little systematic research on the prevalence of desistance or regret rates among contemporary samples of adolescents, although there are case report examples in the literature (e.g., Churcher Clarke & Spiliadis, 2019; Di Ceglie, 2018; Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011; Strang et al., 2018b). In my view, there might be two reasons for the paucity of such research. First, many of the published studies on adolescents who socially transition and receive biomedical treatment have been carefully evaluated and deemed eligible for the latter, as in de Vries et al. (2014), but less work has been done on adolescents deemed ineligible—for whatever reason. Some of these youth may wind up being lost to follow-up, but more research on this subgroup would certainly be desirable (for a nice exception, see Smith, van Goozen, & Cohen-Kettenis, 2001). Second, it is conceivable that with the recent surge in adolescents seen for GD and the increase in heterogeneity in their clinical presentation, we might well see higher rates of desistance and/or regret compared to earlier cohorts of such youth.

### Case 3: Jenny

Jenny was a 14-year-old natal female with a childhood history of cross-gender behavior, including the periodically expressed wish to be a boy. Jenny's parents never really considered that Jenny was unhappy as a girl and attributed her periodic wish to be a boy as "what a tomboy is like." Although Jenny eschewed wearing stereotypical feminine clothing, she had long hair and was perceived by others (peers and adults) to be a girl. Within the peer group, Jenny was not subject to any social ostracism because of her gender-variant behavior; in fact,

she excelled in various sports, such as ice hockey, and played on an all-girls' team. As Jenny began somatic puberty, she became aware that she was sexually attracted to other girls her age. Initially, Jenny said to herself, "Maybe I'm gay," but as time progressed, she indicated that this was not the case: "I started seeing myself more and more as a boy." She shared with her parents that she was feeling very uncomfortable with her breast development and that her monthly periods were an unpleasant reminder that she was born female. At the time of assessment, Jenny (now Johnny) had "come out" as transgender and, in ninth grade, was presenting in the male gender role. Johnny was, however, still playing on all-girls' sports teams, where he was accepted as "trans." In terms of general psychosocial functioning, Johnny performed well at school, had a solid peer group, and did not meet criteria for any other DSM-5 diagnoses. I did not detect any uncertainty on Johnny's part about the belief that living in the male gender role would be a way to reduce the GD feelings. After the assessment, it was recommended that Johnny commence a trial of hormonal suppression. When followed up at age 16, Johnny continued to live in the male social role and was satisfied with the effects of hormonal suppression, so it was recommended that Johnny now start on testosterone, in order to masculinize secondary sex characteristics, including facial hair, body hair, and voice quality. Johnny indicated a desire for chest surgery when older but did not report any particular interest in genital surgery.

### Case 4: Katie

Katie was a 15-year-old natal female with a childhood history of cross-gender behavior but without an expressed desire to be a boy. Her childhood was chaotic: When Katie was 4, her biological mother left the family without notice. She was raised primarily by her biological father, who was preoccupied with his own physical health and mental health (substance abuse, depression, etc.). At the age of 12, Katie was sexually abused by a male neighbor. Three years later, Katie still could not talk about it. During the assessment, her father fell asleep while the issue was being explored. Shortly after the abuse, Katie began to masculinize her phenotypic appearance and informed her father that she was thinking about a sex-change operation. In addition to her emerging GD, Katie began to manifest other behavioral and emotional issues: She would run away from home after arguing with her father, was often truant from school, and engaged in a lot of self-harming behavior. At the time of the assessment, Katie indicated that she was attracted sexually to girls and was trying to sort out whether she was "just a lesbian" or "really" transsexual. Katie commented: "I know why I want to be a guy. It's to protect myself. . . . I know it's related to the abuse." In Katie's case, we did not recommend hormonal treatment but instead recommended further psychosocial treatment to stabilize her from a psychiatric and psychological point of view, and to provide her with a therapeutic space to work through the trauma that resulted from the sexual abuse and explore further her gender identity and sexual orientation.

### Case 5: Mark

Mark was a 16-year-old natal male with no history of cross-gender behavior in childhood. He began to express a desire to be female at the age of 15. His sexual orientation was, if anything, for females, but Mark described himself as "asexual." He did not report any behaviors associated with fetishistic cross-dressing, and there was no history of taking his mother's undergarments or the clothing of other females. His parents noted that, in childhood, Mark had had a lot of social difficulties. Although a gifted youth, with a superior-range IQ, Mark had a lot of trouble with social cues and was very rule bound. He preferred to stay at home with his mother (who was a homemaker) and play with his older sister. He never had a best friend in childhood. During childhood, he was seen by several psychiatrists, who questioned whether he might have Asperger's disorder. At the time of assessment, Mark had developed sufficient social skills, so that he could interact with other gifted, "nerdy" youth. Much of their interactions revolved around online computer games. Mark had never actively cross-dressed in women's clothing or attempted to pass in the female gender role. At assessment, he wore his hair long, which often concealed his eyes, but this was as much to "hide" himself from others when he was anxious as it was to have a hairstyle similar to some teenage girls. He was unable to verbalize why he wanted to become a woman other than "I just don't fit in as a male." His father commented that he was puzzled as to how Mark could say that he "felt" like a woman, because he did not seem to understand the feelings of other people. The clinical impression was that Mark met criteria for an autism spectrum disorder. Hormonal treatment was not recommended. Mark agreed to a trial of psychosocial therapy in which his GD feelings could be explored further.

## Conclusions

As noted in the previous edition of this volume (Zucker & Brown, 2014), the number of referrals to specialized gender identity clinics has increased remarkably, and this continues to be the case. Thus, for the practicing clinician who wishes to work with this population, it is critical to gain some familiarity with the extant treatment approaches, including various standards of care guidelines (American Psychological Association, 2015; Bonifacio, Maser, Stadelman, & Palmert, 2019; Byne et al., 2012; Coleman et al., 2011).

In this chapter, I have summarized the literature on therapeutics, taking into account what is known about developmental trajectories. The Editors of this volume have asked that contributors provide a statement of their own views about best practice. I summarize my views here.

Whereas gender social transition and biomedical treatment for adolescents is probably the most common method to reduce GD, it should be recognized that not all clients wish to pursue such treatment and, for them, a supportive psychosocial therapeutic approach should be provided as a first-step

alternative. It is my view that for early-onset adolescents with GD, gender social transition and biomedical treatment is a sensible approach, particularly when there is no interfering psychopathology that clouds the clinical picture (cf. Smith et al., 2001). It is also my view that for adolescent males with late-onset GD and a co-occurring history of transvestic fetishism and/or autogynephilia, the same treatment approach is advisable, particularly in patients where there is no particular interest in exploring alternatives. For those who are uncertain, it is my view that there should be a trial of psychosocial therapy to rule out alternative ways of resolving the GD. For adolescents with the putative developmental history described by Littman (2018), my view is that what would constitute best practice is, to borrow from a film title, "up in the air."

For children, the field remains in a great state of flux regarding best-practice principles, with a tremendous range of clinical opinion. In addition, it is important to recognize that parents of such children also hold a range of opinions about what is in the best interest of their child (Zucker, 2019b). It is important, therefore, for the practicing clinician to gain some familiarity with the different therapeutic approaches in proposing a plan of care for individual children and their families. My own view is that for young children with GD, there should always be a period postassessment of either watchful waiting or psychosocial therapy that affords the child the opportunity to understand his or her gender identity better, with the possibility of adopting a gender identity that is more congruent with his or her birth sex. Of course, these types of approaches with very young children require parental consent, with a clear understanding of what the goals can and should be. I would view a gender social transition approach as an option only after other alternatives have been fully explored. The exception I would make to this position is for children who have already transitioned socially, prior to being seen for a clinical evaluation. Although there are anecdotal accounts that some of these children detransition on their own, at present, it is my opinion that such youngsters are probably more the exception than the rule (cf. Rae et al., 2019). For these youngsters, supporting gender social transition is probably in their best interest, although there are instances in which one might be more cautious, as in cases in which there is intense parental conflict as to which therapeutic approach is optimal and these youngsters appear to be caught in a loyalty bind such as that one might see in families in which there has been an intense and conflicted divorce.

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CHAPTER 19

# Improving Sexual Function and Pleasure in Transgender Persons

MATS HOLMBERG
STEFAN ARVER
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When one's deeply felt sense of gender does not match the gender of the body one is born with, a profound sense of disconnection can affect all aspects of life. Chapter 19 focuses on the unique experiences and challenges of being sexual when one is also transgender. Holmberg, Arver, and Dhejne review the recent medical and psychosocial literatures, and offer a treatment approach aimed toward improving the sex lives of their transgender clients. The interventions they outline are adaptations of sex therapy protocols used for cisgender individuals and couples, as the authors note that transgender and cisgender individuals share more similarities than differences. The authors conclude, "Since sexuality is important to most transgender and cisgender people, a similar knowledge base can be applied to both when addressing sexual health and sexuality related issues. Transgender-specific knowledge can be added to ensure that assessment and treatment approaches are sensitive and relevant to the unique aspects of the transgender experience." This perspective should encourage sex therapists to join a multidisciplinary approach to improving quality of life for transgender individuals, which includes improving the quality of their sexual experiences. Throughout this chapter, the reader is reminded that the treatment needs of transgender individuals do not end with gender-affirming endocrine or surgical interventions.

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The treatment needs of transgender individuals are not limited to, nor do they end with medical interventions such as hormones or gender-affirming surgery. We focus in this chapter on the sexual concerns of transgender adults that may be affected by gender incongruence, gender dysphoria, medical and social transitions, and gender-affirming treatments. Mental health professionals and sex therapists should join a multidisciplinary effort to improve quality of life for transgender individuals by understanding and improving their sexuality. We recognize that not all transgender individuals can access gender-affirming treatment and that, in many countries, there are not only significant barriers to treatment, but also, in some parts of the world being transgender is considered criminal, and in extreme cases, is considered a legitimate reason for the death penalty (Holmberg, Arver, & Dhejne, 2018). Our review of the literature and recommendations for assessment and treatment are therefore

necessarily limited to those countries in which gender dysphoria is recognized as a treatable condition and access to care is affordable, at least for some.

## Terminology

As our understanding of gender dysphoria and gender incongruence has evolved, so too has our language. "Transgender" is the umbrella term for people whose gender identity differs from their birth-assigned sex.[1] "Gender identity" refers to a deeply felt sense of gender, that may or may not be consistent with the sex one is assigned at birth (Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013; Winter, De Cuypere, Green, Kane, & Knudson, 2016). "Gender dysphoria" refers to the distress caused by incongruence between gender identity and birth-assigned sex. Some individuals with gender dysphoria require gender-affirming treatment to enhance gender congruence between their gender identity and their secondary sex characteristics. Individuals who were assigned female gender at birth but have a male gender identity sometimes call themselves *transgender men, trans men,* or just *men*. Analogously, individuals assigned male gender at birth with a female identity sometimes call themselves *transgender women, trans women,* or *women*. Furthermore, individuals who cross-identify are often called *nonbinary transgender individuals*. Since gender has historically been viewed in the binary categories of male or female, gender identity was likewise viewed as binary. However, gender identity is now conceptualized as existing on a spectrum, whereby female and male are two of many gender identities that also may include nonbinary identities. "Nonbinary" encompasses all identities that are not exclusively male or female. Examples of nonbinary identities are gender fluid and gender queer. "Transmasculine" is often used for nonbinary individuals who were assigned female gender at birth but whose gender identification leans toward the masculine, and "transfeminine" denotes assigned male gender at birth but gender identification leans toward the feminine. However, there are no universally agreed-on definitions of these terms, and the terminology changes over time. Therefore, one must ask for individuals' personal definition of their gender identification (Fraser & Knudson, 2017; Richards et al., 2016). "Cisgender" is the term used to describe individuals whose gender identity and birth-assigned sex are in agreement with one another.

## Prevalence

The proportion of adults in different countries that, in a health care setting, has received any gender dysphoria diagnosis (DSM or ICD) or gender-affirming

[1]The term "transgender" or "trans" may also extend to people whose gender expression (behavior, mannerisms, interests, appearance) differs from their birth-assigned sex and/or the societal and cultural expectations of their assigned sex.

hormone and/or surgical treatment ranges from 0.0007 to 0.028% (Goodman et al., 2019). For assigned males at birth, the corresponding numbers were 0.0007–0.036%, and for assigned females at birth, 0.0007–0.019%. However, not all transgender individuals seek treatment, or access to care may be restricted; therefore these numbers and sex differences may be biased or underestimated. Indeed, studies estimating the proportion of self-reported transgender identity in a population range from 0.1 to 2% among adults (Goodman et al., 2019). For adolescents, the corresponding numbers were 1.3–2.7% (Goodman et al., 2019).

The number of people reporting gender dysphoria has risen over the last half-century, and requests for assessment and treatment services clearly reflect this increase. In Holland, there has been a 20-fold increase in requests for transgender health care in the period from 1980 to 2015 (Wiepjes et al., 2018). In Sweden, the number of requests for legal and surgical gender reassignment from adults has almost tripled over the span of almost four decades: from 0.20 per 100,000 per year between 1972 and 1980 to 0.57 per 100,000 per year in the decade spanning 2001–2010. During this period, the ratio of birth-assigned genders for those requesting services was fairly stable at 1:1.66 (trans men:trans women) (Dhejne, Öberg, Arver, & Landén, 2014). While the increase in prevalence of self-reported gender incongruence and the rising number of individuals seeking and receiving treatment may be due to reduced stigma and easier access to care, it is also possible that these numbers reflect an actual increase in prevalence of gender incongruence.

## Diagnostic Considerations

The movement to depathologize gender incongruence, such that it is no longer considered a mental disorder, was documented by Zucker (Chapter 18, this volume). Gender dysphoria remains in DSM-5 (American Psychiatric Association, 2013) and is thus still classified as a mental disorder; however, the diagnostic criteria were changed to reflect that distress is the target problem, not the fact of gender incongruence itself. This has involved a name change, from "gender identity disorder" to "gender dysphoria." The diagnosis of gender dysphoria was also removed from the chapter "Sexual and Gender Identity Disorders," separating it from sexual dysfunctions in recognition of the fact that it is not a sexual problem and bears little resemblance to the sexual disorders represented in DSM-5. A separate chapter is now devoted to gender dysphoria in children, adolescents, and adults. Access to treatment, especially in the United States, was a primary consideration for the retention of this diagnosis in DSM-5. The inclusion of the specifier *if post transition* was meant to acknowledge that distress and thus the need for intervention may well continue after gender-affirming treatment (Drescher, 2010).

DSM-5 diagnostic criteria for adolescents and adults have two essential elements: gender incongruence *and* dysfunction or distress about such

incongruence. At least two of six indicators of gender incongruence are required for the diagnosis and are outlined in DSM-5 (American Psychiatric Association, 2013, p. 452). The second element requires a clinician's assessment of "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013, p. 453). In the recently approved ICD-11 (World Health Organization, 2019), diagnoses pertaining to gender identity disorders for adolescents and adults previously named "transsexualism," is now termed "gender incongruence," and has been moved from the "Mental and Behavioral Disorders" chapter and placed in the newly created chapter "Conditions Related to Sexual Health."

Unlike DSM-5, there are no distress or impairment criteria required for the diagnosis of gender incongruence. Rather, the diagnosis requires only the manifestation of two of the following: a strong dislike or discomfort with primary or secondary sex characteristics, a strong desire to be rid of these sex characteristics, a strong desire to have the primary or secondary sex characteristics of the experienced gender, and a strong desire to live and be treated as a person of the experienced gender (Reed et al., 2016). The duration requirement in ICD-11 is reduced to *several months,* based on the lack of empirical evidence justifying the 2 years required by ICD-10 and to allow greater access to care.

The ICD and the DSM thus differ on how to classify gender incongruence. The DSM focuses on the distress and dysfunction aspect, with critics of this approach arguing that it is difficult to distinguish the distress about being transgender from distress and dysfunction related to the social consequences of being transgender. Furthermore, proponents of ICD-11 believe that access to care should be available for the transgender person who does not experience either distress or functional impairment, for example, a young person living in a family and social environment supporting gender fluidity (Reed et al., 2016).

## Sexuality

The transgender population is heterogeneous; hence, its members' sexuality represents a diversity of expression and experience. Attempts to stratify the population into subgroups based on onset (pre- or postpuberty) and sexual orientation suffer from historically biased data, as many patients altered their histories to fit treatment criteria in order to access care (Pimenoff & Pfäfflin, 2011; Walworth, 1997). With many barriers to treatment lifted and with greater access to care, more reliable data are forthcoming (Holmberg et al., 2018). Until such data are available, we will not highlight any subgroupings in the remainder of this chapter.

Gender dysphoria is not associated with any sexual orientation; thus, transgender individuals report attractions across the spectrum: androphilic

(sexual orientation toward men and masculinity), gynephilic (sexual orientation toward women and femininity), bisexual, pansexual (sexual orientation toward individuals irrespective of sex or gender), and asexual (Holmberg et al., 2018). It is important to note that sexual orientation can be fluid and dynamic (Diamond, 2008), and this is also true for transgender persons whose sexual orientation may change during transition (Auer, Fuss, Hohne, Stalla, & Sievers, 2014; Bockting, Benner, & Coleman, 2009; Cerwenka et al., 2014; Nieder, Elaut, Richards, & Dekker, 2016).

Transgender men and women may not be in relationships that are reflective of their sexual orientation, and this occurs more frequently in transgender women than in transgender men (Cerwenka et al., 2014). This could, of course, have an effect on sexual satisfaction, and decisions regarding gender-affirming treatment are sometimes influenced by fears of jeopardizing the relationship, as the following case illustrates:

> Kim, assigned male at birth but with a female identification, is in a relationship with Charles, a cisgender gay man. Kim has a female gender expression but, so far, has not undergone any gender-affirming treatment, although she would like to have breast augmentation. The reason Kim gives for delaying breast surgery is that she worries that gender-affirming treatment will end her relationship. Charles respects Kim but is unaware of her need for breast augmentation to ease gender dysphoria. Kim has not dared to tell Charles about her female identity and need for breast augmentation, since she is unsure of how this might affect his attraction for her. Does Charles see her as a man or as a woman? Is it important to Charles, a gay man, how others see Kim (in terms of gender) and therefore how they might judge their relationship? Sexually, Kim enjoys stimulating Charles to orgasm, but her reluctance to let Charles touch her penis or perform fellatio, and her refusal to be the top in penetrative sex, is straining their relationship. Both Kim and Charles feel sexually unfulfilled.

Some transgender men (53%), but fewer transgender women (37%), report being in a relationship at the time they seek services (Cerwenka et al., 2014). These percentages may reflect the fact that being in a relationship may delay accessing services for those who fear losing their partner, as previous vignette illustrates (Alegria, 2010). However, it is also true that it is difficult for transgender men and women to establish respectful and caring relationships (Holmberg et al., 2018). Over half of the 796 transgender participants in a Web-based survey reported being treated in an offensive way in their sexual relationships. In that same article, qualitative interviews were conducted with 20 transgender individuals, many of whom reported that offensive experiences included being treated as a temporary sexual object, as an arousing fetish, or as a sex toy, not as a person, by men who identified as heterosexuals (Lindroth, Zeluf, Mannheimer, & Deogan, 2017).

A history of traumatic sexual experiences with romantic partners, friends, family members, and strangers, in childhood as well as adulthood, is more prevalent among transgender than among cisgender persons (Bandini et al., 2011). While childhood sexual abuse was previously implicated as a factor in the etiology of gender incongruence (Devor, 1994), more recently, the argument has been made that minority groups, such as the transgender community, are more vulnerable to sexual abuse and assault (Andersen & Blosnich, 2013). As noted by MacIntosh, Vaillancourt-Morel, and Bergeron (Chapter 17, this volume), many forms of childhood maltreatment (emotional, physical, and sexual abuse and neglect) can impact adult sexuality. Understanding the impact of abuse and assault in the transgender population clearly requires further study.

Most transgender individuals report a lifetime history of being sexually active, with 80–92% of those with unmet gender-affirming treatment needs reporting partnered sexual activity and 59–89% reporting masturbation. Nevertheless, sexual dissatisfaction in this group of individuals is high, with 40% reporting unhappiness (Nikkelen & Kreukels, 2018). Sexual satisfaction in transgender individuals is often complicated by body dysphoria, a core element of gender dysphoria (van de Grift, Elaut, et al., 2017). Difficulty being nude with a partner or distress arising from being touched or touching oneself are common complaints resulting in obvious interference with sexual enjoyment. Many transgender individuals focus on satisfying their partner to the neglect of their own sexual pleasure (Lindroth et al., 2017).

In addition to a more general body dysphoria, genital dissatisfaction in transgender individuals affects their sexuality, as it does for cisgender persons (Komarnicky, Skakoon-Sparling, Milhausen, & Breuer, 2019). Transgender individuals who have unmet gender-affirming treatment needs report difficulty experiencing genital stimulation during partnered sexual activity (Cerwenka et al., 2014). Although half of this group engaged their genitals during sexual activity, only 12% of the transgender women and 15% of the transgender men reported deriving pleasure from genital stimulation during partnered sex (Cerwenka et al., 2014). While gender-affirming interventions typically increase body satisfaction, in the early stages of treatment, dissatisfaction may rise as patients address their previously ignored body dysphoria. Integrating the new body parts may take some time (Veale, Lomax, & Clarke, 2010).

## Gender-Affirming Treatment Effects on Sexuality

"Gender transition" is the process of adopting characteristics that match gender identity and may involve social (e.g., changing appearance, including style of dress and hair; changing name and pronouns), legal (e.g., arranging new identity documents), and physical (medical interventions such as hormone therapy and gender-affirming surgery) changes (Holmberg et al.,

2018). Gender-affirming medical treatments that target the physical aspects of gender transition have marked effects on sexuality. Although a complete review of gender-affirming hormonal and surgical interventions is beyond the scope of this chapter, the interested reader is referred to our recent article that describes these processes in more detail (see Holmberg et al., 2018).

### Endocrine Treatment

Feminizing endocrine treatment consists of oral, transdermal, or intramuscular administration of estrogen, usually combined with an androgen-suppressing substance. The goal of this treatment is twofold: (1) to increase estrogen to similar levels as in premenopausal, midcycle cisgender females (400–800 pmol/L), and (2) to suppress serum testosterone to female cisgender levels (Hembree et al., 2017). Successful reduction of testosterone, together with increased estrogen levels, supports changes in body composition, with decreased muscle mass and increased fat mass, initiation of breast development, softened skin texture, and reduced body hair. Spontaneous and nocturnal erections usually disappear, semen production and spermatogenesis cease, and ejaculate volume decreases, suppressing fertility (Hembree et al., 2017).

Endocrine masculinizing treatment in transgender men stimulates androgen-dependent pathways by increasing testosterone and suppressing estrogen levels to the normal male reference (50–180 pmol/L). Testosterone is administered either transdermally (50–100 mg daily) or by intramuscular or subcutaneous injections of depot testosterone preparations (~100 mg/week). Testosterone suppress gonadotropin secretion and therefore estrogen production from the ovaries. Increasing testosterone induces a variety of physical changes, including decreased fat mass, increased muscle mass, facial and body hair growth (along with increased risk of male-pattern hair loss), growth of the clitoris, and a deepening voice. It is important to note that testosterone treatment usually reduces vaginal lubrication, stops menstruations, and suppresses fertility (Hembree et al., 2017).

Briefly, endocrine treatment results in increased sexual desire in a majority of transgender men and reduced sexual desire in a majority of transgender women, although longitudinal data from the European Network for the Investigation of Gender Incongruence (ENIGI) study indicate that this effect may diminish over a 3-year time period (Defreyne et al., 2019). The influence of these changes on the individual's level of sexual satisfaction is dependent on many factors and is discussed in more detail later in this chapter.

### Gender-Affirming Surgery

Masculinizing and feminizing gender-affirming surgery usually improves body satisfaction (Nikkelen & Kreukels, 2018; van de Grift, Elaut, et al., 2017). For optimal results, it is important that the individual's sexual wishes

and hopes are an integral part of the process of surgical decision making (van de Grift, Pigot, et al., 2017).

Feminizing genital surgery in transgender women involves removal of the penis and the gonads, and creation of a vagina, labia, and clitoris. The anatomy of the male perineum and pelvis is such that there is a space between the prostate and rectum that enables formation of a neovagina. The penile skin flap technique is the most common surgical technique for construction of the vagina, whereby the skin of the penis, if sufficient, is inverted to form the vaginal wall. There are alternatives to penile skin for creation of a neovagina, and these include scrotal skin, bowel segments, or free skin grafts (Selvaggi & Bellringer, 2011). Daily dilation, either vaginal intercourse or the use of vaginal dilators, is often necessary to maintain the depth and width of the new vagina in order to ensure that it retains penetrative capability (Morrison et al., 2015). A small piece of the glans penis is saved and used for formation of a neoclitoris, with reasonably preserved genital sensitivity and sexual responsiveness (LeBreton et al., 2017; Sigurjónsson, Möllermark, Rinder, Farnebo, & Lundgren, 2017), while the scrotum can be used to create the equivalent of labia majora. Other options for feminizing surgery can include vocal cord surgery, facial feminizing surgery, and breast augmentation. Breast augmentation, in particular, has been shown to increase sexual well-being in transsexual women (Weigert, Frison, Sessiecq, Al Mutairi, & Casoli, 2013).

Masculinizing genital surgery in transgender men often includes removal of the uterus and ovaries, and optional vaginectomy, as well as creation of a neophallus. Two methods are generally used to create a new penis or a penis-like structure: phalloplasty and metoidioplasty. For phalloplasty, a flap from the inguinal region, anterolateral thigh, or forearm is used to form the contours of a penis (Morrison, Chen, & Crane, 2017). While this type of neophallus lacks erectile properties, erogenous sensitivity can be obtained through nerve anastomoses between flap nerves and the genito-femoral and clitoral nerves and via the clitoris, which is preserved behind the neophallus (Fang, Kao, Ma, & Lin, 1999). Erectile capabilities can be obtained using a rigid condom, a penile sleeve, or the surgical implantation of a semirigid or inflatable prosthesis. Approximately 25% of transgender men opt for a penile prosthesis postphalloplasty (Morrison et al., 2017). Many transgender men (62–99%) report that their desire to urinate standing up is a factor of importance when considering a phalloplasty (Hage, Bout, Bloem, & Megens, 1993; Jacobsson, Andréasson, Kölby, Elander, & Selvaggi, 2017), and according to a meta-analysis, this was achieved in 73% of patients (Remington et al., 2018).

Metoidioplasty is an alternative to phalloplasty resulting in the creation of a microphallus with erectile properties and erotic sensitivity, although, due to its small size, it is usually insufficient for full penetration (Vukadinovic, Stojanovic, Majstorovic, & Milosevic, 2014). With metoidioplasty, the development of the penis is accomplished when the testosterone-enlarged clitoris is further enhanced by luxation (separation) of the crura clitoris from its internal support. As with phalloplasty, the labia majora are used to create a scrotum

large enough to harbor testicular prostheses (Morrison et al., 2017; Selvaggi & Bellringer, 2011). Sometimes transgender men who have undergone metoidioplasty subsequently request phalloplasty (Hage & van Turnhout, 2006; Takamatsu & Harashina, 2009).

Nongenital masculinizing surgeries include liposuction and mastectomy. Chest dysphoria is not uncommon in transgender men who have not had a mastectomy. In a 2018 study of individuals assigned female at birth ages 13–25 years with chest dysphoria, 50–60% of those who had not undergone mastectomy reported problems with dating, forming intimate relationships, physical intimacy, or sexual activity, compared with just 2–3% in the group that had undergone surgery (Olson-Kennedy, Warus, Okonta, Belzer, & Clark, 2018). While mastectomy may improve general life satisfaction and feelings of self-worth (van de Grift et al., 2016), there is little evidence, at this point, to suggest a positive effect on the experience of sexual pleasure, sufficiency as sexual partner (van de Grift et al., 2016), or sexual quality of life (Bartolucci et al., 2015).

## The Experience of Sexual Dysfunction

In terms of understanding the genesis of sexual difficulties in transgender men and women, etiological factors can be grouped into three broad categories: (1) factors relating to the transgender experience itself that are present prior to gender-affirming treatment; (2) factors related to gender-affirming treatment, such as reduced sexual desire in transgender women undergoing hormone therapy or pain related to phalloplasty; and (3) posttreatment factors relating to difficulties adjusting to a new body (e.g., remaining gender dysphoria due to a poor result of the treatment, complications related to surgical treatment, low self-worth and sexual agency, and issues related to new sexual feelings and dealing with relationship issues).

Understanding sexual dysfunction in the transgender person requires understanding the transgender experience and how it may differ significantly from the developmental trajectory of cisgendered sexuality. The incentive motivation model is often used to describe sexuality in the cisgender population (Basson, 2001; Toates, 2009). According to this model, feelings of sexual arousal can motivate sexual behavior, stimulate desire, and lead to a pleasurable sexual experience and a rewarding orgasm. The classical conditioning component of this model would predict that a history of negative sexual experiences, or lack of positive experiences, can alter a sexual incentive to a negative value. For example, in the case of Kim, the transgender female discussed earlier in this chapter, orgasm resulting in ejaculation may be associated with negative rather than positive feelings, since the pleasure comes from an organ she might not regard as being hers, and would thus not function as an incentive for future sexual activity.

A healthy relationship with one's body is essential for healthy sexual functioning, but since body dysphoria is a key element of gender dysphoria,

it is likely to contribute to sexual dissatisfaction, if not dysfunction. The relationship with one's body begins in childhood, so the process of developing a healthy or positive relationship can be adversely affected by the experience of gender incongruence, especially if the onset begins prior to puberty, such that there is little or no time to enjoy one's body. Body dysphoria that begins or extends past puberty limits sexual experiences and thus limits sexual pleasure and sexual function. Transgender individuals report difficulty being nude and being touched by their sexual partners, so they may forego the stimulation required for adequate sexual response leading to arousal and/or orgasm).

Negative sexual experiences, which can interfere with the development of a satisfactory sexual life, may arise from being in abusive relationships, currently or in the past. Marginalized groups are more often victimized than others, and many transgender individuals have histories of sexual abuse or assault, which can inhibit sexual pleasure. In addition, having sex with someone who does not perceive your experienced gender can also limit sexual satisfaction. Returning to the example of Kim, her current sexual difficulties were likely related to her history of sexual relationships with androphilic males whose interest, desire, and pleasure in her masculine features were distressing to her.

### *Posttreatment Sexual Dysfunction*

For many transgender patients, gender-affirming interventions (hormonal and/or surgical) do not herald the end of their treatment needs. We would argue that this is a time during which their sexuality and sexual health may continue to require considerable support. On a purely biological and physiological level, gender-affirming treatment can have long-term effects on sexual function, while the reality of gender-affirming treatment and social transition can have considerable psychological and social effects, which in turn can substantially affect sexuality and sexual function.

## Sexual Desire

Many transgender women (~60%) experience a precipitous drop in sexual desire within 3 months of initiating hormone therapy (Wierckx, Elaut, et al., 2014). The timing of this change would seem to indicate a direct effect of decreased levels of testosterone. However, while a majority of trans women reported diminished desire, it is important to note that this is not experienced universally; others reported no change or even an increase in levels of their sexual desire. Increased desire may reflect the effect of improved satisfaction with one's body and/or genitals, as evidenced by higher levels of sexual desire being reported by transgender women after vaginoplasty compared with those on the wait list for the surgery (Wierckx, Van Caenegem, et al., 2014). Among those experiencing decreased desire, only one-third found this distressing. A reduction in sex drive is often welcomed among transgender

women (e.g., in those who have not yet undergone vaginoplasty) for whom a combination of a high sex drive and aversion to one's genitals can create a distressing situation. Once the distress criterion is considered, the incidence of hypoactive sexual desire disorder in transgender women is equivalent to that observed for cisgender women (20–33%, dependent on age). Although reduced testosterone levels is a plausible explanation for the reduction in desire in hormonally treated trans women, no study has shown a significant correlation between levels of total or free testosterone and sexual desire in this group (Defreyne et al., 2019; Elaut et al., 2008; Weyers et al., 2009; Wierckx, Van Caenegem, et al., 2014), mirroring the situation with cisgender women. Depression and the use of antidepressant medication, which may have possible sexual side effects, have not been adequately considered in studies of sexual desire in transgender women despite their prevalent use in this population (Holmberg et al., 2018).

The sexual desire of transgender men is also affected by hormone therapy (Constantino et al., 2013; Wierckx, Elaut, et al., 2011). Within 3 months of the initiation of endocrine therapy, most trans men report increased desire, as well as more frequent (Constantino et al., 2013) and more urgent and less controllable desire (Bockting et al., 2009). In a retrospective study of 138 transgender males, increased sexual desire was reported by 71%, while 12% of transgender men reported a decrease in their level of sexual desire, and 5% met the criteria for hypoactive sexual desire disorder (Wierckx, Van Caenegem, et al., 2014). Too strong sexual desire was reported by 14% of medically treated transgender men in a follow-up 4 to 6 years after initial contact (Kerckhof et al., 2019) while personal or relational distress as a result of frequently experienced desire previously was reported by 3.6% (Wierckx, Van Caenegem, et al., 2011). Genital satisfaction and/or satisfaction with gender-affirming surgery was not found to be as influential a factor on desire in transgender men as was overall body satisfaction (Wierckx, Van Caenegem, et al., 2014). No difference was reported in levels of desire between transgender males who opted for a penile prosthesis and those who did not (Wierckx, Van Caenegem, et al., 2011).

While hormonal status is one important prerequisite in the experience of sexual desire, the full picture is more complicated, with genital and body satisfaction being important mediators of endocrine influence.

## Sexual Arousal

Subjective feelings of sexual arousal follow a pattern similar to that seen for desire; in general, endocrine therapy increases the experience of arousal, desire, fantasy, and frequency of masturbation for trans men (Constantino et al., 2013; De Cuypere et al., 2005). Physiological arousal in the transgender individual depends on the genitals present (whether natal or surgically altered). A study of 38 trans men at least 1 year after genital surgery indicated that the majority were sexually active. The increased use and enjoyment of

their genitals and chest during sexual activity postsurgery may have at least partially accounted for the increased arousal and pleasure reported. The trans men who had metoidioplasty were more sexually satisfied than were those who had phalloplasty. However, the inability (without external aid, such as a penile sleeve) to have penetrative sex was disappointing for these transgender individuals (van de Grift, Pigot, Kreukels, Bouman, & Mullender, 2019).

Transgender women who have or who wish to retain their penis may continue to have spontaneous or responsive erections despite androgen depletion (Bettocchi et al., 2004). If erections are desired and wanted, their lack could cause distress, while for others, the erections provoke dysphoria. Many trans women do not have genital surgery because of cost or fear of negative outcomes or long waiting times, and especially in these cases, spontaneous erections may be unwanted and aversive.

Transgender women who have had vaginoplasty show physiological sexual arousal, as measured by vaginal photoplethysmography (Lawrence, Latty, Chivers, & Bailey, 2005). The ability to experience genital arousal may have a lag time of up to 6 months postsurgery, due not only to the need for physical recovery but also the need to adapt to a changed body (Buncamper et al., 2015). As measured on the Female Sexual Function Index (FSFI; Rosen et al., 2000), subdomain scores for arousal in a cohort of trans women was similar to that of cisgendered women reporting problematic sexual functioning with arousal, desire, or sexual pain problems. Lack of arousal, lack of lubrication, and the presence of pain are major concerns for many transgender women after surgery (Bouman et al., 2016; Buncamper et al., 2015, 2017; Imbimbo et al., 2009; Lawrence, 2006; Reed, Yanes, Delto, Omarzai, & Imperatore, 2015; van der Sluis et al., 2016; Weyers et al., 2009).

## Orgasm

A review of studies on the sexual adjustment of trans women leads to the conclusion that transgender women are able to achieve orgasm after vaginoplasty (Holmberg et al., 2018). Many trans women describe their postoperative orgasms as more intense, longer, smoother, and more pleasurable (De Cuypere et al., 2005; Hess, Neto, Panic, Rübben, & Senf, 2014). However, this is not always true, and there may be loss of orgasmic ability or attenuation of orgasmic sensations. In fact, distress related to orgasmic dysfunction was the most prevalent sexual complaint in a follow-up to the ENIGI study (Kerckhof et al., 2019). Some studies have confirmed orgasm-related secretions in transgender women, possibly related to the retained Cowper's glands or the remaining prostate and seminal vesicles (Alwaal, Breyer, & Lue, 2015). If the penis is retained intact, inadequate erections and absent ejaculation as a consequence of low testosterone may complicate the experience of orgasm (De Cuypere et al., 2005; Lawrence, 2005; LeBreton et al., 2017).

Orgasm is also possible for transgender men regardless of type of surgery (metoidoplasty or phalloplasty, with or without prosthetic implant), although

the prevalence of orgasmic ability ranges from 25 to 100% (Garcia, Christopher, De Luca, Spilotros, & Ralph, 2014; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005;Wierckx, Van Caenegem, et al., 2011; Vukadinovic et al., 2014). Orgasms are described as shorter and more powerful (De Cuypere et al., 2005) or more intense (Wierckx, Van Caenegem, et al., 2011). No studies have specifically explored the orgasmic experience of transgender men with vaginas; however, medical interventions are unlikely to negatively affect orgasmic response.

The ability to orgasm is intact for the majority of transgender individuals even after gender-affirming surgery (Holmberg et al., 2018). As is the case for cisgendered women, masturbation appears to be the easiest and also the most prevalent manner of experiencing orgasm for both transgender men and women (Rakic, Starcevic, Maric, & Kelin, 1996).

## Pain

Pain is a major concern for transgender patients postoperatively. Lack of arousal and insufficient lubrication are concerns for the transgender woman postvaginoplasty, but prevalence data regarding these problems are unreliable (Holmberg et al., 2018). Surgical complications that may result in pain include vaginal stenosis (loss of vaginal flexibility) and clitoral necrosis due to inadequate blood flow, so daily dilation to avoid stenosis and the use of lubricants during penetrative sex is necessary for pain attenuation (Holmberg et al., 2018).

Pain during sexual activity, including intercourse, is reported by over 50% of trans men, regardless of whether they had phalloplasty or metoidoplasty, and this is highly concerning (Frey, Poudrier, Chiodo, & Hazen, 2017; Hage & van Turnhout, 2006; Morrison et al., 2017). While there are preventive measures to alleviate pain in the neovagina, no such protocols exist after genital surgery in trans men. Clearly, this is an area in need of further study.

## Sexual Satisfaction

Gender-affirming treatments generally have a positive effect on the sexual satisfaction of transgender men and women. A comprehensive review of the literature revealed that in trans women, between 50 and 100% report increased sexual satisfaction after gender-affirming surgery. Factors associated with improved sexual satisfaction in this group included hormonal therapy, good vaginal function, clitoral sensation, and satisfaction with the appearance of the vulva and labia. Having a partner was also predictive of improved sexual satisfaction. Factors associated with low or diminished levels of sexual satisfaction were depression and surgical complications that result in pain with sexual activity (Holmberg et al., 2018).

In trans men, sexual satisfaction was reported by 34–100% of participants postsurgery. Increased frequency of sexual activity and orgasm was associated with sexual satisfaction. Transgender men reporting lower

satisfaction after surgery compared with preoperative satisfaction were also likely to report prosthesis pain or difficulty finding a partner (Holmberg et al., 2018). A review of the outcome literature on penile prosthesis implantation in trans men reveals that 36.2% reported a prosthesis complication (Rooker et al., 2019).

### Social Transition

Samples in most of the research on transgender sexual experiences include those seeking, undergoing, or having completed some form of gender-affirming medical intervention. Transgender individuals who either do not desire medical transition or do not seek services as a result of anxiety, cost, or unavailability remain an understudied population.

One 2018 study examined the sexual feelings and behaviors of a nonclinical sample of transgender individuals, including those who indicated no intention of undergoing gender-affirming treatment. This group of 125 transgender females and 98 transgender males were not highly sexually satisfied, with both trans women and men scoring low on indicators of sexual agency, and trans men scoring low on sexual pleasure. The authors of this study caution that the decision to forego gender-affirming treatment should not be perceived as an indication of body satisfaction, and they conclude that the experience of being transgender can, on its own, diminish sexual satisfaction (Nikkelen & Kreukels, 2018).

There is clearly a need for more research on the sexuality of transgender persons. There are, at present, no validated measures of sexual well-being for the transgender population, so the literature is often confused by the various measurements used to assess sexual function and satisfaction. The preponderance of research deals with clinical samples of transgender men and women, and the possibility exists that many individuals who identify as nonbinary may enjoy their sexual experiences. In addition, selection bias regarding those transgender individuals who agree to or volunteer for sex research may overestimate positive results. Many transgender persons report no sexual activity after gender-affirming treatment, and the reasons for this remain to be determined and addressed, especially if abstinence is related to lack of proper aftercare to address sexuality. An exploration of transgender sexuality in the context of relationships is also sorely lacking. The sexual satisfaction of the partners of transgender individuals has not been comprehensively studied, nor have relationship factors (important in cisgender sexual desire) been adequately considered.

## Assessment of Sexual Problems

It is important to remember that the transgender population is heterogeneous, and in most aspects, transgender persons share similarities with cisgender individuals. Sometimes the commonalities that transgender people share with

the cisgender population are forgotten, and assessment and treatment become too transgender specific (Holmberg et al., 2018). Since sexuality is important to most transgender and cisgender people, a similar knowledge base can be applied to both when addressing sexual health and sexuality related issues. Transgender specific knowledge can be added to ensure that assessment and treatment approaches are sensitive and relevant to the unique aspects of the transgender experience.

## Psychosocial Assessment

A good sexual history is the basis of a comprehensive assessment of sexual problems in all patient populations. Given that the questionnaires and scales often used clinically to assess sexual functioning and satisfaction are bigender normative and heteronormative, their use without appropriate modification may not only be irrelevant, but they may also alienate the transgender patient. At present, the clinical interview represents the best approach to assessment of sexual issues in the transgender population.

An awareness of the issues facing transgender persons will inform a clinical interview, and sensitivity to the language used will facilitate communication and the gathering of relevant and helpful information. Wherever possible, clinicians should use transgender-inclusive and non-normative language. Examples include consideration of how people identify ("How do you define your gender identity?"), what pronouns they use, and whether they have a "partner" (not husband or wife) or partners, allowing for the possibility of nonmonogamous or polyamorous relationships.

In terms of sexual orientation, transgender individuals define their sexual orientation according to their gender identity. Instead of asking about sexual orientation, it is more helpful and clarifying to ask what gender(s) they are attracted to and include nonbinary gender attractions in the context of the question as well. For example, as a follow-up to learning that the patient currently has a male partner, one might ask: "Are you attracted to men?"; "Do you have, or have you had, sexual partners who are or who identify as female or nonbinary?" Finally, asking about how they are identified by their partner(s), past or present, is important, as many transgender patients are in relationships that are incongruent with their sexual orientation (e.g., a transgender heterosexual female may find herself in a relationship with a homosexual male who is unaware or not respectful of her gender identification). If persons are identified by their partner or others according to their gender identity, they should also be asked whether the partner knows about their background, or how comfortable they are informing intimates/sexual partners of their background.

An important part of taking a sexual history with a transgender patient is engaging in a process of naming body parts. Transgender patients with body dysphoria may try to ignore disturbing aspects of their anatomy, and being made to pay attention to them during a clinical interview may exacerbate the

distress they experience. Nevertheless, a sensitive inquiry regarding a transgender patient's sexual experience requires a common language for sexual anatomy. An example of a relevant, respectful question is "What do you call the part of your body that in medical terminology is called a clitoris in cisgender women?" (Armuand, Dhejne, Olofsson, & Rodriquez-Wallberg, 2017). Clinicians should also use gender-neutral terminology when inquiring about sexual activities and sexual function. Examples are using *arousal* instead of *erection,* or *orgasm* rather than *ejaculation*.

It is important and relevant to ask patients how comfortable they are being touched, or letting others touch their bodies, or specific body parts. This can lead also to an inquiry about existing or remaining body and/or genital dysphoria, as well as an evaluation of patients' sexual self-esteem and sexual agency. For example, a transgender and gynephilic male without phalloplasty and with an intact clitoris may reveal that he has named the clitoris his "penis." Asking if he is comfortable with his partner stimulating his penis, and if he in turn is comfortable touching his partner's clitoris, can reveal much about genital dysphoria, sexual agency, and sources of sexual pleasure or lack thereof.

A thorough clinical interview and sexual history should include information about whether patients are able to live the sexual lives they want, whether they put up boundaries to touch and pleasure, and whether they feel safe during sexual encounters, as well as whether they engage in risky sexual behavior and, if so, what kind.

### Biological Assessment

In addition to a general health, endocrine status should be part of an initial evaluation. Hormone levels for the transgender patient should be in the reference range for healthy cisgender individuals. An examination to rule out postsurgical complications that might affect sexual function is also important. Scar tissue inflammation, rupture of sutures, or urinary fistulae may be some of the reasons for genital pain and sexual dysfunction. The use of medications with known sexual side effects should also be evaluated, including finasteride (sometimes used to treat unwanted hair growth or hair loss), selective serotonin reuptake inhibitors (SSRIs), prolactin-raising psychopharmacological agents (e.g., tricyclic antidepressants; some antipsychotics, such as risperidone and some SSRIs) and opioids (including those prescribed for postsurgical pain relief).

## Treatment Approaches

An interdisciplinary treatment approach is necessary to address the sexual health needs of the transgender individual. Medical, psychological, and sex therapy interventions, as well as support groups and community networks,

form part of the ideal comprehensive treatment team. The skill base necessary for psychotherapy and sex therapy interventions is similar to that required to treat the sexual health concerns of cisgender people. Modifications to existing treatments can be based on knowledge of transgender sexuality.

### Medical Interventions

Insufficient endocrine treatment resulting in subnormal steroid hormone levels (as compared with the cisgender reference range) is not uncommon in transgender patients (Constantino et al., 2013). Annual assessment of hormone levels is necessary to ensure adequate levels and to interpret clinical responses. Low-dose testosterone therapy may be a treatment option for transgender women suffering from low desire (Kronawitter et al., 2009).

The use of PDE5 inhibitors (PDE5Is) can be helpful in treating erectile dysfunction in transgender women who retain their penis and enjoy their erections (Buvat et al., 2011). In other cases, intracavernous alprostadil has been reported to produce a normal erectile response in transgender women (Bettocchi et al., 2004). As we noted previously, transgender men with a vagina can treat pain and vaginal dryness during penetration/receptive vaginal sex with dilation and lubricants, while vaginal dryness due to lack of estrogen may be treated with local estrogen, as is done for cisgender postmenopausal women (Naumova & Castelo-Branco, 2018).

### Physical Therapy

It makes sense that pelvic floor physical therapy would be effective in reducing pelvic muscular tension and genital pain in transgender persons, as it is helpful for cisgender persons (Basson & Gilks, 2018; Bø, 2012). Physical therapy is likely to be helpful in cases in which a narrow neovagina results in unsuccessful penetration and/or pain. However, to our knowledge, there are no studies investigating the role of physical therapy in improving the sexual experience of transgender individuals.

### Sex Therapy

Psychotherapy can be helpful in addressing self-esteem, internalized transphobia or transnegativity, depression, and anxiety in transgender individuals. These issues can be addressed in individual therapy, or in couple therapy, if relationship issues are also problematic (Giammattei, 2015). Sex therapy interventions that are effective for cisgender persons with sexual dysfunction are likely to be effective for transgender individuals and couples. Sensate focus has been found to have beneficial effects on the sexual functioning of transgender women after gender-affirming surgery, but these results have yet to be published in the peer-reviewed literature (Knudson, Dhejne, Murjan, De Cuypere, & Robbins-Cherry, 2017). There is a need for treatment outcome studies addressing the

effect of different treatment techniques on sexual function and satisfaction in the transgender population.

Based on our own clinical experience, psychoeducation, body acceptance, and peer support are valuable aspects of treatment for sexual issues in transgender individuals. Peer support has been shown to be valuable for the general health of transgender persons and would likely contribute to sexual health as well (Cipolletta, Votadoro, & Faccio, 2017; Ybarra, Mitchell, Palmer, & Reisner, 2015). Sex education, when it is provided to teens, is often cisgender normative and thus difficult to interpret for transgender youth. In fact, gender-normative sex education can increase gender dysphoria and anxiety. We strongly recommend that psychoeducation regarding sexual function in general and in transgender persons in particular, as well as social and sexual skills, should be included in sex therapy. Strategies for coping with body and genital dissatisfaction have been published in the literature and are available as self-help materials from some LGBT organizations (Bettcher, 2014; Lindroth et al., 2017). We have previously discussed the value of renaming gender body parts (e.g., natal clitoris as a penis, natal vagina as a front opening) as a step toward increased body satisfaction. Conceptualizing parts as acceptable based on their function ("It works. Why can't I use it? I enjoy it") is also helpful. Using sexual fantasy and being clothed or partially clothed can improve comfort and pleasure in solo and partnered sex. Focusing on the pleasure of pleasing one's partner is another coping strategy for maximizing sexual satisfaction and function in partnered sex. Importantly, having sexual encounters with a partner with whom one feels safe and who respects one's boundaries is essential.

The following case demonstrates treatment approaches to address the sexual concerns of a transgender man.

## Case Discussion: Improving Sexual Pleasure in a Transgender Man

Sebastian is a 31-year-old trans man assigned female at birth based on a female genital phenotype. He came for a consultation with the presenting complaint that he had difficulty enjoying sex with his girlfriend, Agnes, and feared that she would leave him because of this. Although Sebastian reported that Agnes was aware that he was seeking help, she did not come to the appointment with him, and it appeared that Sebastian, and by his account, Agnes, preferred that he solve his sexual issues on his own.

Sebastian was a slightly built individual who was perceived as male by everyone, and only his close friends, family, and girlfriend knew about his background. He was employed as a middle school history teacher, was happy with his job, and reported no financial difficulties. Sebastian was healthy and taking no medication (other than ongoing hormone therapy [testosterone] for the last 5 years), with no previous medical contact except for treatment of his

gender dysphoria. Sebastian was told by Agnes that she was happy in their relationship overall and felt seen and respected by him.

Sebastian and Agnes have lived together as a couple for almost 6 years, beginning their relationship before Sebastian started his social and medical transition. In the early stages of their relationship, Sebastian had confided in Agnes; thus, she was aware of his transmasculine identity before they started to date seriously. According to Sebastian, Agnes defined herself as bisexual and had no problem being very supportive of his transition. Both Sebastian and Agnes hoped that their sexual relationship would improve after his mastectomy, believing that if he were more comfortable with his body, he would be more open to sexual stimulation and orgasm. Unfortunately, that was not the case.

Sebastian reported being more gender congruent and less gender dysphoric after his mastectomy 3 years prior to coming for therapy. However, Sebastian was still not comfortable being naked or being touched by Agnes. While he was very pleased that he had a more male torso, Sebastian was ashamed of the mastectomy scars and therefore never showed his chest to anyone, including Agnes. He showered and changed his clothing quickly without looking at himself. He most often changed in a separate room from Agnes or in the dark. In addition to his worry about his scars, Sebastian still felt gender dysphoric regarding his genitals. He did not want to undergo phalloplasty due to the complicated nature of the surgery and the less than ideal surgical outcome.

In terms of his sexual history, Sebastian had very limited partner romantic and sexual experiences prior to his relationship with Agnes. Due to his lifelong body dysphoria, Sebastian had never touched or looked at his genitals directly. Prior to his relationship with Agnes, Sebastian had experienced casual sex with a few women, preferring mostly to stimulate them to orgasm. During the rare times Sebastian masturbated, he was able to achieve orgasm by rubbing himself over his clothes or squeezing his legs together tightly. Notably, he had been orgasmic with his girlfriend on the two occasions he had let her stimulate him, although he was upset and remorseful afterward. Sebastian always wore a T-shirt and underwear during sex and was never naked with Agnes.

The couple's sexual interactions primarily consisted of Sebastian stimulating Agnes with his mouth and hands to orgasm, as he had prior to his surgery. However, Agnes had recently begun to voice her wish for more sexual intimacy. As Sebastian heard her, she craved to have the intimacy of their naked bodies pressed against each other, and she wanted to be able to touch Sebastian's genitals and to satisfy him sexually. Sebastian was not particularly interested in these activities or in experiencing orgasm more often. His main distress and motivation for treatment was related to his fear that Agnes would leave him if he did not become a better sexual partner for her.

Although Sebastian was informed that therapy might be more effective if his girlfriend participated, he was adamant that he would only come to therapy on his own. After the initial consultation session, Sebastian agreed that the first goals of therapy were that he would be to be able to (1) become

more comfortable with his body, (2) tolerate being naked on his own, and (3) touch his own body and genitals in a sexually pleasurable way. If these goals were realized, the therapist hoped that Sebastian would consider talking to his girlfriend about couple therapy. Sebastian agreed to tell Agnes that he was starting therapy on his own and working on body acceptance in order to improve their sex life, and that this would require time and privacy to do therapy exercises at home. Furthermore, the therapist cautioned Sebastian that if this approach did not solve their problem, they should consider coming to therapy together.

The first task of therapy was to give appropriate names to the parts of Sebastian's anatomy that were problematic for him, an essential first step toward developing a new and more positive relationship with his body. Since the naming was initially difficult for Sebastian and he could not generate any ideas on his own, the therapist suggested options. Indicating the chest area, the therapist said that "a lot of people call this the chest, some people call this breasts, while others use 'my top part.' Would any of these words work for you?" Sebastian decided that he had a *chest with nipples*. Regarding his genitals, Sebastian was also asked what he would like to call the organ called the clitoris by many cisgender women. Again, the therapist suggested different words such as my pleasure point, my penis, my clitoris. After some discussion, Sebastian chose *my penis*. Naming the parts called labia and vagina by many cisgender women was the most difficult. Sebastian opted to call the labia *skin folds* and the vagina his *front hole*.

Once there was a shared language for his body parts, it was easier for Sebastian to acknowledge and talk about them. The next step was to work with modified sensuality exercises focusing on the body as whole. The first exercise was with clothes on (T-shirt and underwear) and Sebastian was to touch his entire body in sensual ways, concentrating on bodily sensations of pleasure but not with the aim of building to orgasm. This was followed by the same exercise, with clothes still on, again, to concentrate on pleasure but this time taking his time and building to orgasm.

The next step was to repeat the exercises without the T-shirt, but in the dark or blindfolded, so he would not be distracted by the sight of his scars. Sebastian was encouraged to explore different ways of touching his chest, including his nipples. The touching was first directed to be sensual, then increasingly sexual. This was difficult for Sebastian, but by breaking the exercise down into small steps, he was able to touch his nipples in ways that were sexually stimulating and to enjoy the sexual sensations that resulted. The final step was repeating the same set of exercises with his penis, first in the dark with his underwear on, next touching his penis directly under his underwear, and eventually removing his underwear entirely, so that he could stimulate his penis directly. In sessions, the therapist encouraged Sebastian during his home exercises to stroke his penis as cisgender men do, stimulating not only the glans but also the shaft. Before beginning the set of exercises focused on stimulating his penis, Sebastian was encouraged to look at sexually explicit

materials (videos or still photos) that depicted transgender men who had not undergone a phalloplasty either in partnered or solo sexual situations. This gave Sebastian permission to view himself as a sexual person, despite not having the genitalia he desired.

Each step and exercise was planned collaboratively, with Sebastian receiving direction and suggestions from the therapist as needed. During this time, the couple occasionally had sex but still followed their original pattern of Sebastian pleasuring Agnes but not allowing her to pleasure him. Sebastian was encouraged to show Agnes his newly learned way of touching his penis and to introduce the named body parts to her. After the 12th individual session, Sebastian agreed to ask Agnes if she wanted to come to therapy with him, the plan being that they would begin sensate focus exercises. However, Sebastian called to cancel his next appointment and said that he and Agnes decided not to come for therapy together. He stated that their sexual relationship was fine as it was and that he was happy with what he had achieved. He was told that he or they together were welcome back to therapy at any time they wished.

It was not entirely clear whether Sebastian ever incorporated any of his treatment gains into his sexual relationship with Agnes, so it is not known whether he was able to be naked or to be stimulated by her. It is also not clear why he decided not to come back; it is possible that shame, insecurity, and/or issues related to power and gendered norms in the relationship played a role. By coming to therapy by himself, Sebastian attempted to address the problem in a traditional male fashion and took care of the problem as men often wish to do (at least according to gendered ideas of maleness). He might have seen himself as the cause of the problem and therefore did not want to trouble his girlfriend. Sebastian stated at the beginning of therapy that he was afraid of losing his girlfriend if their sex life did not improve. Sex might have improved somewhat, perhaps enough so that he was no longer afraid of losing her. It is also possible that if they came to therapy as a couple, other issues might have arisen, which in turn might have threatened the viability of the relationship. Retrospectively, the therapy should have addressed Sebastian's fears regarding his relationship, or at least offered him the opportunity to talk about his fears. However, sometimes people who come to therapy focus on solving one problem, and from Sebastian's point of view, his problem was solved, so he did not have continue treatment, despite the therapist's perspective that more work could be done.

Had Sebastian and Agnes come together for therapy, a modified approach to sensate focus would likely have been helpful, with each step planned collaboratively with the couple. If Sebastian had not already done so, Agnes would be introduced to the names Sebastian had for his genitals and chest. Sensate focus could then have proceeded with some of the same modifications that were helpful for Sebastian: lights out, blindfold, touching over and then under clothes, slowly moving from nongenital to genital and chest touching. As sensate focus emphasizes nondemand touching (Avery-Clark, Weiner, &

Adams-Clark, 2019), Agnes would be able to touch hitherto forbidden parts of Sebastian's body, with no expectation or demands on Sebastian that he should be pleasured, aroused, or orgasmic. The emphasis on Agnes's pleasure when she touched Sebastian, not on his arousal or orgasm, would reduce Sebastian's stress, making it easier for him to be touched. Likewise, Sebastian would learn to touch Agnes in ways that pleasured him, such that his pleasure would be introduced into their sexual repertoire in an activity to which he was already accustomed. As in most applications of sensate focus, therapy would also help the partners improve their communication by facilitating conversations between them about their experiences during sensate focus.

Sebastian's reluctance to have his partner join him in therapy may reflect the concern of not only many transgender individuals but also many sex therapy clients, who worry about losing a relationship because of their sexual problems. Many do not want to be a burden on the relationship, or erroneously believe that the problem, while manifesting in a relationship, is theirs alone and therefore theirs alone to resolve. Even before initiating sensate focus, the therapist would want to learn Agnes's sexual history and to understand her concerns and challenges regarding sex, including her own sexual issues that predated or were independent of her relationship with Sebastian. Her issues and concerns would also be addressed in sex therapy, emphasizing the shared nature of their sexual difficulties. Most importantly, the therapist would need to help them set their own goals for their sexual relationship (which may or may not evolve over the course of therapy) rather than impose preconceived ideas about what "good sex" should be.

Sebastian had difficulty perceiving himself as a sexual person, in part because he had no models that reflected this. The encouragement offered to Sebastian to look at sexually explicit depictions of transgender men enjoying sex, who, like himself, had not had phalloplasty, was aimed at helping him see himself as a sexual being. An additional or alternative approach would have been to explore and address any shame Sebastian might experience regarding being a trans man, as well as any internalized trans-negative thoughts he might have. Body acceptance therapy similar to that for cisgender individuals (see, e.g., Fingeret, Teo, & Epner, 2014) could also have been a way to help him.

Sebastian had a supportive partner and motivation to improve his sexual relationship. Many transgender individuals may enter therapy with little or no sexual experience and no partner. Therapy may start at a much different place for these patients. Psychoeducation and support groups can be helpful adjuncts, in addition to a skilled, patient, and sensitive therapeutic approach.

Sex therapists can use their expertise and experience to help transgender individuals and couples improve their sexual satisfaction and pleasure. There is a literature regarding treatment focused on sensitively helping clients make the transition from sexual avoidance to sexual enjoyment and pleasure, for helping clients incorporate penile prostheses into their sexual repertoire, and for helping individuals who are unhappy with their bodies or who have had

physical alterations and scarring (e.g., related to medical treatments or injury) learn to enjoy them. The most important part of sex therapy, is listening without judgment or preconceived ideas about what sex should or should not be and helping clients achieve their own sexual goals.

## Conclusions

Transgender individuals have been subjected to many myths and misperceptions regarding their identity and their sexuality. Recently, research has begun to directly address transgender sexuality, so that clinicians may better understand transgender persons' unique treatment needs, as well as recognize that the transgender community is heterogenous and will have sexual issues similar to those found in the general population.

Medical interventions can improve sexual function in transgender men and women. However, whether this improvement enables a satisfying sex life is less clear, and in many cases it will require a multidisciplinary treatment approach. Sex therapists can become part of this effort by adapting sex therapy techniques for the transgender population. Current research in this area is either lacking or subject to methodological limitations, so it should be interpreted with caution. Nevertheless, there is reason to be optimistic, to continue research, and to adapt effective treatments to improve the sexual lives of transgender persons.

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SECTION C

# MEDICAL ISSUES

CHAPTER 20

# Sexuality and Cancer

SHARON BOBER
SANDY FALK

Surviving cancer is not synonymous with thriving after cancer. The treatment for many forms of this disease leave lasting side effects; predominant among them are sexual side effects. In addition to the physical changes that may result from treatment, other psychosocial effects that impact sexuality often include altered body image and integrity, diminished sexual self-esteem, and the introduction of a caregiver dynamic into an intimate relationship. These factors may wreak havoc on the cancer survivor's sexuality and sexual relationships. Using self-determination theory to ground the discussion, Bober and Falk in Chapter 20 focus primarily on prostate cancer in men and reproductive tract and breast cancer in women to demonstrate how sex therapy can be used promote recovery and rehabilitation. The lessons learned may well translate not only to other forms of cancer but may also have wider relevance for the important role of sex therapy in the recovery process from many disease states.

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There are over 15 million cancer survivors in the United States, a number that is expected to increase to over 20 million by 2026. With growing numbers of long-term cancer survivors, most sex therapists and sexuality educators will at some point work with clients directly affected by cancer. Cancer-related sexual dysfunction is one of the most prevalent and distressing consequences of treatment, impacting both men and women (Jackson, Wardle, Steptoe, & Fisher, 2016).

In contrast to other side effects of cancer treatment that tend to improve over time, untreated sexual problems typically persist or worsen (Krychman, Pereira, Carter, & Amsterdam, 2006). Over 50% of women treated for breast cancer (BC) report long-term changes in sexual function; almost all women who undergo cancer treatment for gynecological cancers report treatment-related sexual dysfunction for years, and the majority of prostate cancer (PC) survivors report bothersome and enduring sexual side effects (Elliott & Matthew, 2018; Krychman et al., 2006). Disruption in sexual function also extends to negative changes in sexual response, perceived body integrity, body image satisfaction, and sexual self-esteem. Not surprisingly, treatment-related sexual dysfunction is associated with increased psychological distress, including increased anxiety and depression, fear of recurrence, loss of self-esteem, and posttraumatic stress symptoms (Bober & Varela, 2012).

Cancer can also significantly impact partners–caregivers (Reese et al., 2018). Partners of PC survivors struggle with psychological distress at rates that exceed those seen in the survivors (Lambert, Girgis, Lecathelinais, & Stacey, 2013), and partners of BC patients report decrements in psychological well-being and quality of life (Reese et al., 2018). Regarding sexuality and intimacy, couples often need to rebalance relationship roles and responsibilities, especially when role change are characterized by an extended "patient–caregiver" relationship. Partners may be unsure about reengaging sexually and find themselves at a standstill. It is not uncommon for couples to stay closely connected during treatment, then fall into a pattern of avoidance when treatment is over. For example:

> Jennifer (Jen), a 39-year-old survivor of T-cell lymphoma, is married with two school-age children. She was treated with high-dose chemotherapy before undergoing stem-cell transplant (SCT) 2 years ago. When she and her husband tried resuming sexual activity in the year following transplant, they quickly discovered that intercourse was impossible.

When they attempted penetration, it was extremely painful, despite use of lubricant, and Jen's husband felt like he was "hitting a wall." They tried unsuccessfully once more, at which point they felt distressed and defeated. Although they never spoke about it directly, they had since stopped trying. Jen stated that she was "of course, grateful to be alive" but then became tearful as she described feeling both guilty and worried about the impact of losing intimacy in the marriage. Jen notes that her husband "has been a saint" through the process of her illness and treatment, but she wonders what he thinks about their sexual challenges, and she feels unsure how to talk about it with him.

Marty, a 68-year-old PC survivor, and his partner, Jake, just celebrated their 25th anniversary. Until his diagnosis, they were sexually active, and although Marty had some moderate erectile dysfunction before diagnosis, he could successfully use sildenafil (a phosphodiesterase type 5 inhibitor [PDE5I]) to have an erection adequate for anal penetration. However, after 6 months of androgen deprivation therapy and external beam radiation, Marty is demoralized because erectile function has not recovered sufficiently for penetrative sex, despite not having surgery. Marty has tried different PDE5Is to no avail, and he is distressed that the relationship has become largely companionate in nature.

## The Elephant in the Room

Despite the prevalence of cancer-related sexual dysfunction, there is a notable lack of communication about sexual health in the context of routine cancer care (Park et al., 2009). As was the case for both Jen and Marty, survivors are unprepared for treatment-related sexual changes and unsure of how to address problems (Park et al., 2009). Most oncology providers receive no training and feel unprepared and/or uncomfortable discussing sexual health. Although patients would like to discuss this topic, they do not for fear of making their providers uncomfortable (Park et al., 2009). Not surprisingly, cancer-related sexual dysfunction often becomes the elephant in the room. An additional consequence is that silence on the part of providers can implicitly convey a message that sexual side effects are not "discussable" because problems are not treatable; patients may assume that sexual problems are part of the "cost of cancer." Because survivors do not receive adequate resources to address sexual problems, it is particularly important for sex therapists and sexuality educators to have a working knowledge of the common causes of cancer treatment-related dysfunction, and an understanding of how problems may impact individuals and couples. Therapists can benefit from having (1) a model for addressing sexual dysfunction targeted for cancer survivors and (2) an awareness of when to refer to other providers to facilitate multidisciplinary treatment when needed.

## Inquiry and Assessment: Using Patient-Reported Outcomes

Survivors and couples seen by sex therapists and sexuality educators may undergo a thorough sexual history and evaluation of current function, but they may not receive adequate assessment of treatment side effects, which is essential to formulating an integrative understanding of the presenting problem. Especially when cancer-treatment is in the past, clients may themselves be unaware of how current sexual and/or relationship problems may be related to cancer treatment. For example, female survivors may not realize that bothersome genitourinary symptoms are related to treatment-induced estrogen deprivation, and male survivors who received pelvic radiation years earlier may not know that erectile dysfunction (ED) is a potential side effect of radiotherapy that may not be experienced for several years after treatment.

For this reason, targeted patient-reported outcomes (PROs) can provide a clearer view of postcancer sexual function. Responding to the lack of PROs validated with cancer survivors, the National Institute of Health's Patient-Reported Outcomes Measurement Information System (PROMIS) network created a comprehensive set of 81 items and 11 domains to measure sexual function and satisfaction after cancer (Flynn et al., 2013). However, PROMIS sexual function scales may be too time-intensive for routine practice, and PROMIS is premised on current sexual activity, which is problematic for many survivors who are not sexually active. With this in mind, a multidisciplinary group of experts in the field of female sexual health and cancer recently adapted a brief sexual health screening checklist to guide clinical inquiry with survivors (Bober et al., 2016) that does not assume sexual activity. Items include concern about vulvar/vaginal pain or discomfort not during sexual activity, vaginal dryness, difficulty reaching orgasm, and relationship worry.

For men, two measures, the UCLA Prostate Cancer Index/Expanded Prostate Cancer Index Composite (PCI/EPIC; Litwin et al., 1998) and the International Index of Erectile Function (IIEF; Rosen et al., 1997) have been identified as "standard setting" in the context of male cancer-related sexual dysfunction. EPIC is a 20-item measure of quality of life after prostate cancer, and the IIEF is a broader 15-item self-report measure that assesses erectile function, orgasm, desire, intercourse satisfaction, and overall sexual satisfaction. The IIEF is available in multiple translations and takes about 5–10 minutes to administer.

## The Biopsychosocial Model of Sexuality after Cancer

It is widely acknowledged that treatment-related sexual problems, like sexuality itself, are best viewed through a "biopsychosocial" lens (Bober & Varela, 2012). However, when sexual function is addressed in an oncology setting, the emphasis is primarily physical or biological. For example, treatment for

ED after prostate, bladder, or colorectal cancer is almost always focused on biomedical strategies to produce erections, such as pills, penile injections, and penile prostheses (Nelson, Scardino, Eastham, & Mulhall, 2013). Although these strategies may be mechanically effective, uptake is low, and 50–75% of men do not adhere to them over time. For women who receive pelvic radiation, intervention is almost exclusively limited to brief instruction about postradiation use of vaginal dilators. Although women are instructed to insert a cylinder-shaped device (dilator) into the vagina for several minutes at least once a week to help stretch vaginal tissue and prevent fibrosis, dilator adherence is notoriously low (Punt, 2011). In contrast, intervention could reflect the dynamic interaction among biological, psychological, and social factors. For example, at postradiation follow-ups, dilator use could be regularly assessed, and women could be asked about barriers such as pain, anxiety about bleeding, and lack of time or partner support. Referrals for additional coaching could be offered when identified challenges go beyond the scope of what the medical provider might feel comfortable addressing.

## Psychological Perspective: Bringing Self-Determination Theory to Sex Therapy

Self-determination theory (SDT) is a well-known theory of human motivation that articulates the universal need for autonomy and self-efficacy (Deci & Ryan, 2000). SDT emphasizes the extent to which behavior is regulated by the experience of volition and an accompanying sense of competence (i.e., self-efficacy) in contrast to behavior regulated by an experience of control, either by extrinsic pressures or internal forces, such as guilt or shame. The SDT framework is relevant for cancer survivors who face invasive and intensive treatments that can leave them feeling vulnerable and isolated, and with a loss of perceived competence about how to address sexual problems. Subsequently, the tendency toward avoiding intimacy and sexuality can reinforce this experience of isolation. Alternatively, sex therapy can promote self-efficacy and autonomy in the context of sexual recovery and rehabilitation. Particularly relevant to SDT is the idea that autonomy and self-efficacy can be either supported or thwarted, and therapeutic interactions that support autonomy and self-efficacy also facilitate healthy and effective behavior change that is more likely to be maintained over time (Deci & Ryan, 2000). For example, when Jennifer, the 39-year-old transplant survivor, talks about feeling both damaged and guilty that sexual activity may no longer be possible, it would be therapeutic to clarify that even though she had never learned about sexual health during treatment, (1) there are several options to approaching sexual health rehabilitation (support of autonomy), (2) there is a lot of information to help her restore both vaginal and sexual health (support of competence), and (3) sexual health side effects are some of the most common and distressing side effects of treatment (support of relatedness).

## Sexual Rehabilitation after Cancer: Assessment

We recommend explaining the biopsychosocial model to clients as part of setting the therapeutic framework and supporting perceived competence. It can be an enormous relief for survivors to formulate an understanding of how the multiple components of sexual function can all be disrupted by cancer treatment. This may be the first time they receive acknowledgment that problems are not "just in my head."

Next, as part of conducting a thorough sexual history, it is critical to establish a picture of sexual function before, during, and after cancer treatment. Because surgery, chemotherapy, radiation, and hormone therapy can all negatively impact sexual function, the type, duration, and timing of treatment should be assessed as part of the comprehensive intake. When sexual function was intact before treatment, it is essential to understand what has changed. For clients who had sexual problems before diagnosis, it may be that problems are the same or are now exacerbated by additional cancer-related consequences. In either case, the next step is to invite the client or couple to consider writing a new chapter regarding sexual function rather than attempting to replicate previous experience. Consequences of this invitation are twofold: First, it acknowledges that some changes may be permanent, such as loss of sensation or body alterations, and validates an experience of related grief and loss (Wittmann et al., 2015); second, it provides an important message that sexual recovery and sexual satisfaction are still possible, while allowing for the probability that sexuality and intimacy may be different than before. These messages also support a client's capacity to learn new skills and play an active role in determining the new path forward. Finally, it is important to explore previous attempts with sexual rehabilitation including barriers or concerns tied to these past experiences. It is not uncommon to find that individuals reach various conclusions that are mistaken in some way after a previously disappointing and unsuccessful attempt to reconnect sexually. For example:

> Paul, age 59, recently finished active treatment for colorectal cancer, including surgery, chemotherapy, and radiation. Although he had little interest in sexual activity during treatment, he now has more energy and has been looking forward to resuming sexual activity with his wife Becky; however, he has severe ED. He recently consulted a urologist and received information about penile injection therapy. He told the urologist that he was not keen to start with injections, and the doctor suggested trying a vacuum erection device (VED). Paul tried using the pump with Becky but felt very self-conscious and was embarrassed by his awkwardness. Becky, trying to be helpful, kept reassuring him that "it really didn't matter" and that she was just as happy to "snuggle without having to have sex." Paul knew she was trying to be supportive, but he found himself feeling frustrated and hurt when Becky kept saying "it didn't matter" that they could not have intercourse. To Paul, his complete loss of erectile

function mattered a lot. He did not feel like a real man, since he no longer could perform the way he used to. After several minutes of unsuccessfully trying to use the pump, Paul felt defeated, and they both went to sleep. Several weeks went by and neither partner felt comfortable talking about what happened. During that time, Paul felt wounded that Becky did not seem to care whether he ever got an erection again, which also made him wonder if she had ever really cared. Knowing that Paul felt embarrassed, Becky did not bring it up and distanced herself physically, because she did not want to make him feel worse.

As exemplified in this vignette, it would be counterproductive to focus on giving Paul information about erectile aids without addressing the complex relationship dynamics that resulted from this previous experience.

As part of the initial intake, it may also be useful to acknowledge certain coping mechanisms that are often adaptive for managing cancer treatment but problematic in the context of sexual health, such as the use of distraction and avoidance. When a cancer patient perceives a loss of control and increasing anxiety, it is not uncommon to rely on strategies that allow the person to distance or dissociate from his or her bodily experience (Civilotti et al., 2015). However, for survivors who are attempting to become sexually active again, it can be challenging to reconnect with physical and sensual experience without feeling uncomfortable or panicky. Especially for survivors who underwent traumatic or invasive treatment, it can be valuable to explore their previous experience of coping with distraction, avoidance, and dissociation. Survivors may not be aware of how this type of coping may be connected to their current experience of feeling uneasy being "back in the body." By explicating this pattern of "learned disconnection," the therapist challenges and debunks common assumptions that sexual problems are caused by lack of effort or difficulties relaxing. It also allows client and therapist to start developing an appropriate course of intervention that will directly address these challenges.

Finally, it is vital to create a treatment plan consistent with the goals and values of the client/couple. In addition to promoting choice and increased self-efficacy, it is essential for the therapist to help clients identify goals that are personally meaningful. This approach to treatment planning is meant to be collaborative, not prescriptive, and flexible; that is, clients can reassess and revise their goals as they move together through this creative rehabilitation process.

## Treatment Approaches with Female Cancer Survivors

Risk factors that predict female sexual dysfunction after cancer (Fobair et al., 2006), include baseline sexual problems, negative body image satisfaction, relationship discord, younger age, and relationship status. To begin, it

is important for sex therapists to know whether a female survivor has been evaluated by a physician for sexual concerns, and, if not, to identify issues that should be evaluated before proceeding with sex therapy. This may be pressing for cancer survivors considering the medical sequelae of their oncological treatment. Sexual health issues that should be evaluated with a pelvic examination include persistent vulvo-vaginal discomfort, pelvic pain, or pain with sexual activity before proceeding with therapy.

Cancer treatment depends on the type and severity of disease, but therapists should keep in mind that survivors of gynecological or colorectal cancers are likely to have been treated with pelvic surgery or radiation. Survivors of BC and some other cancers may be on endocrine therapy. Any cancer survivor may have been treated with chemotherapy. Surgery may alter anatomy or innervation (Aerts, Enzlin, Verhaeghe, Vergote, & Amant, 2009); radiation may result in vaginal scarring or fragile tissue (Correa et al., 2016); chemotherapy may result in premature menopause or increase risk of vulvodynia; endocrine therapy depletes estrogen, resulting in sensitive and fragile tissue (Krychman et al., 2006). Urinary or defecatory symptoms typically also have an adverse impact on sexual function.

Women who report any of the following symptoms during daily activity or during, or after, sexual activity warrant further medical evaluation with a pelvic examination: vulvo-vaginal discomfort or pain with sexual activity that does not respond to vaginal lubricants and moisturizers; vulvar pain with daily activities (e.g., sitting for long periods, wearing tight clothing); vaginal discharge or itching, bleeding, tearing of tissue, vulvo-vaginal sores or ulcers; sensation that the vagina is blocked or obstructed, even if this can be overcome as sexual activity continues; and urinary or fecal incontinence or urinary retention. These symptoms may indicate that the patient has a treatable gynecological condition, including genitourinary syndrome of menopause (GSM; Faubion et al., 2018) (formerly called vulvo-vaginal atrophy), a vulvar pain syndrome, or vaginitis. GSM is one of the most common causes of sexual dysfunction and is a result of any treatment including surgery, chemotherapy, radiation, and/or hormonal suppression treatment that results in treatment-induced menopause or exacerbation of genitourinary symptoms (Faubion et al., 2018). Women who undergo SCT may have more severe mucosal disease, such as vulvo-vaginal graft-versus-host disease (Park, Kim, Lee, Chung, & Lee, 2013) or lichen sclerosus (Burrows, Creasey, & Goldstein, 2011). Also, vaginal obstruction may result from several treatments, including severe hypoestrogenism, surgery, radiation, or graft-versus-host disease, or the patient may have a sense of obstruction due to increased pelvic muscle tone (vaginismus).

When working with female cancer survivors, it is imperative to be familiar with these symptoms and the need for multimodal intervention often required to adequately treat these problems (Faubion et al., 2018). First-line treatment for GSM is to use nonpharmacological remedies, including vaginal moisturizers and lubricants. Additionally, pelvic floor rehabilitation/pelvic

floor physical therapy and vaginal dilators have also been shown to reduce vulvo-vaginal symptoms and treatment-related vaginal atrophy (Carter et al., 2017). For women with severe symptoms of vaginal atrophy due to hormonal suppression or hormonal blocking therapy to lower risk of breast cancer recurrence, pharmacological options may be discussed in collaboration with medical providers, such as vaginal estrogen, vaginal dehydroepiandrosterone (DHEA), and the use of topical lidocaine to reduce insertional dyspareunia (Faubion et al., 2018). More information can be found in recent consensus-based treatment algorithms for cancer-related female sexual dysfunction that overview evidence-based treatment options (Carter et al., 2018).

When working with breast cancer survivors, it is often assumed that the surgical loss of one or both breasts traumatically impacts perceived body image and femininity, thus negatively affecting sexual function. Breast-conserving and reconstructive surgeries have become the norm for most U.S. women, with the hope of restoring intact, positive body image. However, research suggests a more complex picture after breast surgery (Aygin & Cengiz, 2018). Women are often surprised that even when mastectomy surgery is considered to be skin and/or nipple "sparing," mastectomy surgery does not "spare" sensation. For many women, the total loss of breast and nipple sensation is devastating, because nipple stimulation and breast sensation are critical elements of arousal. Reconstructed nipples are completely numb; they do not respond to hot/cold or to touch (Aygin & Cengiz, 2018). Women who undergo reconstruction with implants also report that implants can feel unnatural, heavy, or uncomfortable. Especially because of the emphasis on visual outcome of breast reconstruction, women may never be asked about their subjective experience. These changes may also be a source of unease for couples. For example:

> Millie, age 38, is a BC survivor who underwent double mastectomy and implant reconstruction. When Millie spoke with a social worker at her hospital, she revealed how she was struggling with sexuality, including her feelings about treatment-induced menopause and reconstruction. In her words, "I know it seems weird to say, but my husband just doesn't know where to put his hands, and I'm not sure what to tell him. He says my new breasts look great, but nipple sensation used to be such a big part of foreplay and now I just don't feel anything. When he touches my 'foobs' (fake boobs) I just think about how it used to be, and then I feel sad and empty. Honestly, I never thought before my treatment how much I would lose both upstairs and downstairs. I am never just 'in the mood' and sex is just painful in every way."

For Millie and her husband, sex therapy can help start a new chapter in their intimate life. Acknowledging this couple's understandable sense of loss, while simultaneously helping each partner identify physical, psychological and relational factors that can be addressed, the sex therapist can

provide an integrative perspective that is premised on building new skills and dynamics. For example, the sex therapist can help Millie access support to work on improving vaginal health, such as identifying a pelvic floor physical therapist, referring to a menopause specialist for consultation about pharmacological treatment to manage vaginal dryness, and/or encouraging Millie to experiment with a vibrator to increase blood flow and nerve stimulation to estrogen-depleted genital tissue. Moreover, sex therapists can additionally draw on other behavioral approaches for managing pain, such as using mindfulness-based cognitive therapy (Till, Wahl, & As-Sanie, 2017). In parallel to Millie being engaged in this individually focused sexual rehabilitation, the couple can simultaneously work on enhancing intimacy, including experimenting with nonpenetrative modes of sexual activity that are comfortable for both partners. For example, acknowledging the discomfort about her "fake boobs," they may need to decide jointly what does and does not feel acceptable. Instead of taking a primarily goal-oriented approach to sexual encounters, the therapist can encourage curiosity about new avenues for giving and receiving pleasure as they learn to expand their sexual repertoire. This approach is consistent with recent intervention research demonstrating that enhancement of both physical and emotional intimacy after BC, including learning new strategies that acknowledge permanent physical changes, is related to improvement in both sexual function and psychosocial well-being (Reese et al., 2019). In addition, drawing from a mindfulness-based approach to sex therapy, the therapist can reflect how negative self-talk is powerful and invite Millie, alternatively, to practice bringing a nonjudging focus of her attention to the present moment when she and her partner are physically close. Helping Millie cultivate an orientation of curiosity is another step that can be freeing in Millie's journey. It should be emphasized that female cancer survivors do not need to be partnered to address sexual health. In a recent sexual health intervention conducted with ovarian cancer survivors, participation in a single, half-day educational workshop, regardless of partner status or current sexual activity, led to significant improvements in overall sexual functioning and reductions in psychological distress that were maintained at 6-month follow-up (Bober, Recklitis, Michaud, & Wright, 2017).

## Treatment Approaches with Male Cancer Survivors

Forty percent of the male population in the United States will be diagnosed with cancer at some point, with PC being most prevalent, followed by lung and colorectal cancer. Fortunately, the relative 5-year survival rate with a diagnosis of localized PC is now approaching 100%. However, all active treatment options for PC, including surgery, radiotherapy, and/or androgen deprivation therapy (ADT; hormonal therapy that decreases the production of testosterone and blocks testosterone receptors), significantly compromise sexual function.

Sexual side effects of treatment are the most common cause of cancer-related distress among male survivors, especially when men do not expect these outcomes (Nelson et al., 2013). For example, men who undergo "nerve-sparing" radical prostatectomy may be disappointed that bilateral nerve sparing is not always feasible or that the recovery period for damaged nerves is 18–24 months under the best of circumstances. Other distressing surgical side effects are reduction in penile length and circumference. Men who receive either external beam radiation or brachytherapy (insertion of radioactive implants directly in the prostate gland), often believe that radiation will preserve sexual health in contrast to surgery. However, all radiotherapy is associated with ED (Stember & Mulhall, 2012). In contrast to surgery, sexual function is at its best immediately following radiation, because the functional impact of radiation on penile tissue is due to radiation-induced tissue fibrosis, which causes slow decline over time. Up to one-third of men treated with radiation become totally impotent by 3 years following therapy, and although brachytherapy outcomes are better than external beam radiation, sexual function will be compromised by both modalities (Stember & Mulhall, 2012). Moreover, 50% of all men with prostate cancer are now undergoing some form of ADT to lower testosterone levels either intermittently or permanently, and, of note, most men who undergo ADT will never have a return of baseline sexual function (Elliott & Matthew, 2018). ADT leads not only to ED, low libido, and diminished capacity for orgasm but also distressing metabolic side effects, including body feminization, hot flashes, mood swings, and weight gain. All treatments, including surgery, external beam radiation, and ADT cause loss of ejaculate. For some men, the loss of ejaculate is particularly distressing and related to loss of sexual pleasure.

Men who report sexual side effects are often immediately given an oral medication because medication is noninvasive, easily available, and generally effective in the normal population. However, for men who have treatment-related sexual dysfunction, especially men who are older and have history of ED prior to treatment, or who have neurovascular damage because of surgery, oral medications are often ineffective (Elliott & Matthew, 2018). Unfortunately, men are frequently given a prescription without the appropriate education that this first line of treatment may be unlikely to work. Not surprisingly, men may feel "doubly damaged" after trying a pill to no avail. Beyond oral medications, there are a variety of options, including extracavernous injection therapy, transurethral alprostadil, VEDs, and penile implants, with which many men often are not familiar. One role the sex therapist can play is in educating male survivors that there are medical providers, typically urologists, who specialize in male sexual medicine and can help them explore the range of proerectile options beyond oral medications.

There is now growing recognition that male sexual health after cancer is also multidimensional and that it is both shortsighted and insufficient to unilaterally focus only on erectile function (Elliott & Matthew, 2018). Referring back to the previous vignettes, it is clear that men and their partners can

benefit from exploring their beliefs about sexuality, pleasure, and masculinity, as well as addressing common misconceptions and lack of education about sexual recovery. For example, male survivors may not know they can experience orgasm without having an erection or without ejaculation, or they may not realize it is possible to have vaginal intercourse without a rigid erection. Given the cultural conceptions of male sexuality, the sex therapist can play a vital in role helping men and their partners expand their perspective on what good sex and pleasurable sex can look like after cancer. Important goals in working with men who undergo profound changes in sexual function include allowing men to expand their perspective around what might constitute a sexually satisfying encounter and to redefine the experience of what it means to be a whole man. Referring back to Paul, the colorectal cancer survivor who had such a negative experience when he tried to use a VED, sex therapy set up a reparative experience by giving homework to the couple that (1) allowed them to affirm their shared value around sexuality and intimacy and (2) offered a road map for restarting sexual recovery since the initial attempt felt like a failure. This involved the therapist clarifying the need for a non-goal-oriented perspective and offering an exploratory approach, such as sensate focus, in order for them to discover together what feels pleasing or arousing. One benefit of this approach was also to offer an opportunity to revisit use of sexual aids in a way that could feel like a shared endeavor and also be fun. Because there are millions of male survivors, like Paul, who will never recover baseline sexual function, there is an urgent need for sex therapists who can work with men and their partners on sexual recovery that allows men to broaden their sexual identity and promotes a more flexible and expansive sexual repertoire.

## Conclusions

An increasing number of excellent resources is available for both patients and providers through organizations such as the Scientific Network on Female Sexual Health after Cancer (*www.cancersexnetwork.org*), the International Society for Sexual Medicine (*www.issm.info/sexual-health-qa/what-kinds-of-sexual-problems-might-cancer-patients-face*), the American Cancer Society (*www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/fertility-and-sexual-side-effects/how-cancer-affects-sexuality.html*), and the National Cancer Institute (*www.cancer.gov/about-cancer/coping/self-image*). Although it is beyond the scope of this chapter to address assessment and intervention for all types of cancer-related sexual dysfunction, it is important to underscore that cancer-related sexual problems are almost always multidimensional. Most cancer survivors do not receive any help for sexual problems as part of routine survivorship care, and if they do, it is typically limited and strictly biomedical in nature. Sexual problems need to be assessed from a biopsychosocial perspective with intervention also addressing psychological/interpersonal challenges. Although more evidenced-based behavioral

intervention is needed, there is a growing indication that successful psychosexual intervention can be delivered in a variety of settings, both in person and online (Brotto et al., 2017). In addition, it should be acknowledged that there are now hundreds of thousands of people who are aware of being at high risk for cancer due to genetic predispositions. Increasing numbers of high-risk individuals are undergoing surgeries and other treatments to lower this risk. These "previvors" suffer from the same treatment-related sexual sequelae but get little attention because they do not have cancer. It is clear that the need for sexual rehabilitation after cancer-related treatment is growing rapidly. We believe that sex therapists are uniquely qualified to help coordinate integrative sexual rehabilitation and help survivors create a new and satisfying chapter in their sexual lives after cancer.

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CHAPTER 21

# Sexuality in Men and Women with Spinal Cord Injury

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Coping with a spinal cord injury presents daunting physical and psychological challenges to affected individuals. Such injury results in sensory–motor and autonomic changes that transform all aspects of an individual's life. Even while coping with physical and medical issues such as paralysis and problems with locomotion, incontinence, and hypertension, the rehabilitation of sexual function is a high priority for many patients with spinal cord injury. Traditionally, such rehabilitation has been accomplished in specialized centers, but Courtois and Gérard in Chapter 21 suggest that interested clinicians who are comfortable with a cognitive-behavioral framework can accomplish much of this work from their offices. They describe the process of sexual rehabilitation after spinal injury as a series of stages during which remaining sexual function must be carefully assessed and lost abilities must be mourned, then replaced by newly developed sexual skills and capacities. Much of this work adapts traditional sex therapy and cognitive-behavioral techniques such as sensate focus, directed masturbation, sexual experimentation, diary keeping, cognitive reframing, and mindfulness. While such therapy is often demanding for therapist and client, it is highly rewarding.

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Spinal cord injury (SCI) following traumatic or nontraumatic events may result in either complete or incomplete lesions, and is associated with varying degrees sensory–motor deficit and autonomic dysfunction (e.g., urinary incontinence, hypertension). Among the autonomic dysfunctions, sexual disorders are the most concerning deficits, outranking locomotion for paraplegic individuals, and only exceeded in importance by hand function for tetraplegic individuals (Anderson, Borisoff, Johnson, Stiens, & Elliott, 2007a, 2007b). Although men and women with SCI experience sexual dysfunction, the majority remains sexually active, albeit less frequently than prior to the injury (Gomes et al., 2017). Most adapt to their new sexual lives, ultimately reporting sexual satisfaction, especially as the delay post-SCI increases (Valtonen, Karlsson, Siosteen, Dahlof, & Viikari-Juntura, 2006).

The process of sexual adjustment after SCI can be described as a series of psychological stages of adaptation. These stages are not necessarily sequential, nor do they occur for all individuals with SCI, but they do form a useful framework for describing the rehabilitation of sexual function after SCI. The first stage is characterized by questions about the extent of remaining sexual function (e.g., "Will I still have erections or ejaculate?" or "Will I still lubricate or have orgasms?"). A second stage reflects mourning over lost function and may be reflected in concerns about being an attractive or a competent lover. A final stage suggests the transition to a new sexual life and may be exemplified by increased attention to new sexual sensations and behaviors. These hypothesized stages of sexual adjustment lend themselves well to the different stages of cognitive-behavioral therapy (CBT). First-wave behavioral techniques enhance remaining sexual function post-SCI; second-wave techniques reframe and restructure cognitive distortions linked to SCI into more adaptive ones; third-wave mindfulness and acceptance and commitment therapy (ACT) interventions can help to increase the awareness of remaining bodily sensations and to develop realistic expectations for the pursuit of new intimate relationships. Before we describe these stages of adaptation and the possible interventions to facilitate progress, however, it is crucial to understand the limitations on sexual function imposed by the nature and extent of the spinal injury.

## Exploring the Sexual Potential of Individuals with SCI

Assessment of the physiological limits of sexual function after SCI is essential in order to curb the risk of treatment failure, help preserve the patient's motivation and hope, and reinforce the therapeutic alliance. This assessment typically involves first-wave CBT techniques inspired by Masters and Johnson's sensate focus exercises, which can be used to assess erection, ejaculation, lubrication, and orgasm capabilities. These components of sexual function are dependent on intact spinal reflexes and cerebral input (Giuliano, 2011). An initial goal is therefore to establish whether a patient's sexual potential relies mainly on *reflex* or *psychogenic* processes before attempting further sex therapy. This distinction, often irrelevant in individuals with an intact spinal cord, is crucial to assess in patients with SCI, because their neural connection between psychogenic and reflexive erection is severed or at best diminished.

## Exploring the Erectile and Ejaculatory Potential of Men after SCI

Recent data confirm that erectile function predicts sexual satisfaction in men with SCI (Gomes et al., 2017). The neurophysiology of erection is primarily described as a reflex under excitatory and inhibitory influences from the brain (Giuliano, 2011). This reflex, triggered by direct genital stimulation, comprises vascular and muscular processes responsible for penile tumescence and penile rigidity, respectively, and requires an intact spinal cord at the sacral level ($S_2$–$S_4$). Erection is often a reflex, but it can also be induced by psychogenic stimulation triggered by cerebral input derived from audiovisual, olfactory, and verbal stimuli, as well as sexual fantasies. This type of erection requires an intact spinal thoracolumbar (TL) pathway ($T_{11}$–$L_2$), which feeds into either the sacral pathway or the paravertebral sympathetic chain (Giuliano, 2011). When adequate stimulation is used (i.e., genital-reflex stimulation or psychogenic stimulation, depending on the lesion level), between 80 and 100% of men with SCI maintain some degree of erectile function (Everaert et al., 2010).

Based on this dual innervation of male genitals ($T_{11}$–$L_2$ and $S_2$–$S_4$), men's erectile potential after SCI is dependent on (1) the level of injury (cervical, thoracic, lumbar, sacral) and (2) the completeness of the lesion (complete or incomplete) (Everaert et al., 2010). Empirical studies indicate that higher SCIs are associated with better erectile function using genital self-stimulation alone and overall greater erection quality. Lower SCIs (e.g., conus terminalis lesions) translate into impaired erectile function using genital stimulation alone, but into preserved psychogenic erections, albeit with poorer erection quality (Courtois, Goulet, Charvier, & Leriche, 1999).

As with erection, the patient's SCI profile helps predict his ejaculation potential. Ejaculation is a two-step process involving the TL pathway ($T_{11}$–$L_2$) controlling the *emission* phase (i.e., production of semen via the internal reproductive organs), and the sacral pathway ($S_2$–$S_4$) controlling the *expulsion* phase of ejaculation (i.e., expulsion of semen through the urethral orifice) (Clement & Giuliano, 2016). Research on the ejaculation potential of men after SCI shows that (1) lesions located above the $T_{11}$ segments (i.e., preserving reflex activity) increase the likelihood of expulsive ejaculation (albeit often retrograde in men with SCI) (Sipski, Alexander, & Gomez-Marin, 2006); (2) lesions between the TL and sacral pathways decrease the potential for ejaculation (i.e., lost intraspinal connections between both pathways); and (3) lesions to the sacral pathway preserve the potential for psychogenic ejaculation as opposed to expulsive reflexogenic ejaculation, albeit often dribbling and premature (Courtois, Carrier, Charvier, Guertin, & Journel, 2013). Despite these potentials, empirical data indicate that natural ejaculations (i.e., via manual stimulation or intercourse) are rarely obtained after SCI, with rates ranging from 11.8% for men with complete SCI to 33.2% in men with incomplete SCI (Chéhensse et al., 2013).

First-line therapeutic interventions therefore involve psychoeducation about the dual innervation of the male genitals and first-wave CBT exercises to explore the remaining erectile and ejaculatory potential. Psychoeducation about erectile and ejaculation physiology (reflex vs. psychogenic erection, emission vs. expulsion, possible retrograde ejaculation) can be provided using a dermatome map (see Figure 21.1) or by drawing out the patient's lesion profile as estimated from his remaining sensations and motor function. To identify the optimal sources of erectile response (i.e., genital or psychogenic stimulation), specific at-home exercises using various stimulation sources are then recommended. Exercises are accompanied by diary keeping to track the patient's trials (i.e., date, time, stimulation source, duration of the trial), the response's quality (i.e., tumescence only, rigid and/or stable erection), and the patient's emotional (i.e., disappointed, frustrated, skeptical) and motivational state. Exercises and diary are revisited during subsequent therapeutic sessions in which unsatisfying responses can be discussed (and mourning of lost functions introduced), specific trials may be revisited, and issues about tumescence or rigidity or instability of erection may be addressed. Self-report instruments such as the International Index of Erectile Function (IIEF; Rosen et al., 1997) or the Erection Hardness Score (EHS; Muhall, Goldstein, Bushmakin, Cappelleri, & Hviddsten, 2007) may be used to assess function and progress in therapy.

The exploration of the ejaculation potential after SCI is best conducted in a hospital setting, where patients are assessed with penile vibrostimulation (PVS) devices, such as the Ferticare or Viberect (Brackett, Ibrahim, Iremashvili, Aballa, & Lynne, 2010) and additional midodrine treatment (Gutron, Amatine) after previous failure with PVS alone (Courtois et al., 2008; Soler, Previnaire, Plante, Denys, & Chartier-Kastler, 2007). A diagnosis of anejaculation

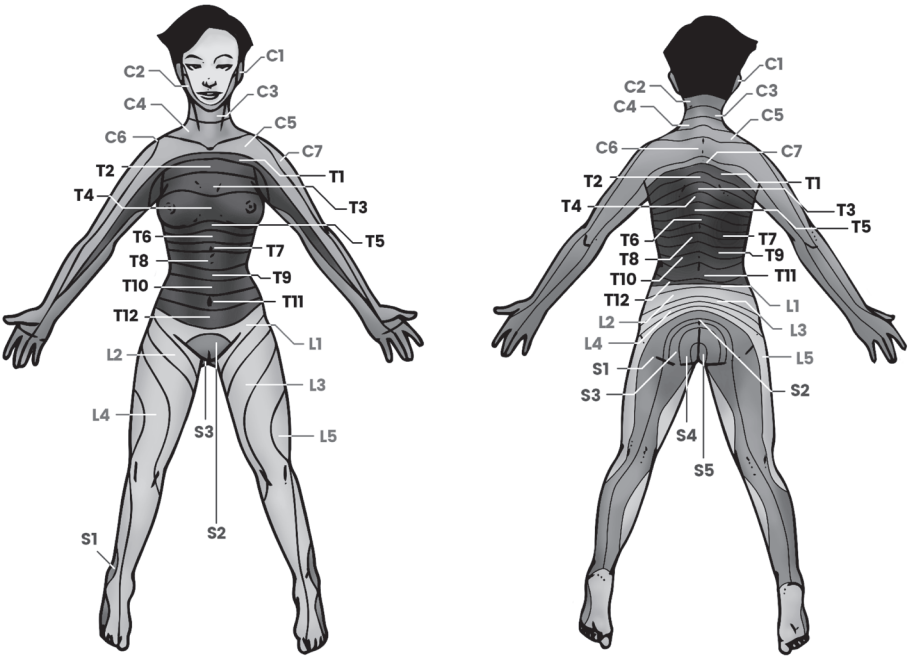


**FIGURE 21.1.** Increasing awareness of body sensations through body mapping following mindfulness and sensate focus exercises.

is never given unless retrograde ejaculation has been ruled out via analysis of a urine sample. The risk of autonomic dysreflexia (AD), which translates into a sharp and at times dangerous increase in systolic blood pressure (i.e., > 180 mmHg > 10 minutes) is also monitored, as it may require hypotensive medication (Courtois et al., 2012).

For at-home explorations of ejaculation potential, patients are provided with specific guidelines on the use of PVS devices and encouraged to record their experiences with a diary to describe the date of each trial, type of stimulation used (natural, Ferticare, Viberect, or Magic Wand), and quality of the response (i.e., presence or absence of ejaculation, urine observation for signs of retrograde ejaculation), and to monitor their bodily responses during stimulation and/or ejaculation. The purchase of a pressure cuff is recommended so that patients can monitor their blood pressure during at-home exercises and assess their own risk of AD. Monitoring of bodily sensations during these trials relies on the Bodily Sensations of Orgasm (BSO; Dubray, Gérard, Beaulieu-Prévost, & Courtois, 2017) questionnaire to help patients identify genital (e.g., genital throbbing) and extragenital responses (e.g., goose bumps), and the Orgasm Rating Scale (ORS; Mah & Binik, 2002) to assess their phenomenological experience of pleasure. Both questionnaires help to shift the patient's attention to the sensations experienced despite the SCI, as well as discuss progress throughout therapy.

## Exploring the Orgasm Potential of Men after SCI

Although SCI alters sensations, ejaculation may still be accompanied by some form of orgasm. Data from patients with SCI suggest that the neurophysiology of climax resembles mild AD (Courtois & Dubray, 2014), characterized by hypertension, spasticity, muscular contractions, and hot flashes. In general, men with SCI who maintain their ejaculatory potential typically report higher levels of sensations during climax than those who do not (Courtois et al., 2008). While physiological sensations are reported by able-bodied individuals during orgasm (Dubray et al., 2017), clinical experience indicates that men with SCI tend to score lower on items relating to genital sensations (e.g., penile sensations, hypersensitive glans) than their able-bodied counterparts, and sometimes report nociceptive sensations (e.g., headache, feeling of pressure) during orgasm.

Interestingly, unlike erection and ejaculation, the patient's neurological profile does not seem to predict orgasmic function; research indicates that men with complete SCI can still experience orgasm, while some men with incomplete lesions cannot (see Alexander & Marson, 2018, for review). Furthermore, the SCI literature highlights the existence of a discrepancy between ejaculation rates, which can reach 90% with adequate stimulation, and orgasm rates ranging from 41 to 65%, while an additional 13% of patients describe "dry orgasm" (i.e., without ejaculation, possibly during retrograde ejaculation) (Alexander & Marson, 2018). Aversive sensations are also described during climax after SCI (e.g., headaches, nausea), suggesting severe AD and calling for immediate medical attention (Krassioukov, Warburton, Teasell, & Eng [Spinal Cord Injury Rehabilitation Evidence Research Team], 2009).

While research concerning the factors influencing the perception of orgasm after SCI is under way (Gérard & Courtois, 2020), current data suggest that men with SCI can experience orgasm with or without ejaculation. These reports emphasize use of the BSO and ORS questionnaires to provide information about cognitive restructuring about bodily sensations still observed despite the SCI, and still present despite unobservable ejaculation (i.e., retrograde). The presence of cardiovascular (e.g., heart beating stronger) and muscular sensations (e.g., lower limb spasms) recorded during sexual activity via the BSO can indeed be used to redirect the patient's attention and reshape his inferences about his sexual experience into a more pleasurable one rather than focusing on his lack of genital sensations or contractions, which runs counter to his typical sexual script. These tools also provide clinicians with baseline recordings on which to assess progress in therapy.

## Exploring the Sexual Arousal Potential of Women after SCI

As with their male counterparts, the potential for sexual arousal (i.e., lubrication) in women after SCI is dependent on the (1) lesion level and (2) lesion

completeness. Electrophysiological studies indicate that women with complete SCI above $T_6$ retain reflexogenic lubrication following direct clitoral stimulation but lose psychogenic lubrication; women with incomplete SCI and intact $T_{11}$–$L_2$ segments retain psychogenic and reflexogenic lubrication; women with complete SCI at the sacral level retain psychogenic lubrication only (Sipski, Alexander, & Rosen, 2001). Studies also suggest that sexual arousal in women after SCI may be dependent on the stimulation site, whether clitoral, vaginal, or cervical (Komisaruk et al., 2004). Furthermore, fMRI studies indicate that the cerebral representation of the nipples lies adjacent to that of the genitals on the sensory cortex, suggesting that the breast is perceived as a genital organ by the brain (Komisaruk et al., 2011).

Based on this knowledge, clinical interventions promoting the sexual adjustment of women with SCI start with psychoeducation on the neurophysiology of clitoral, vaginal, cervical, and breast stimulation, followed by CBT-type exercises aimed at identifying optimal sources of stimulation to trigger reflexogenic (i.e., genital) or psychogenic perceptual responses. Guidelines are provided to ensure independent exploration of clitoral versus vaginal versus cervix stimulation. The use of a diary is recommended to record the type and quality of the responses (i.e., stimulation parameters, presence–absence of lubrication, presence–absence of vulvar–vaginal or cervix sensations) and the emotional and motivational states during the trials.

Since women, as opposed to men, lack visual genital feedback, at-home exercises with SCI are preceded by a sensory assessment of the vulva, ideally conducted in a hospital setting with a multidisciplinary team. It is also possible to carry out such an assessment in a nonhospital setting and with the help of a supportive partner. This sensory assessment developed by Courtois, Charvier, Belanger, et al. (2011) assesses remaining vulvar sensations (e.g., on the clitoris, labia) following stimulation with different sensory modalities, including light touch (e.g., using cotton swabs) such as that involved during foreplay, pressure (e.g., using Q-tips) such as that involved during penetration, and vibration (e.g., using a vibrator) such as that involved with sex toys. Women with SCI report finding this assessment particularly useful to help them recreate a mental map of their genitals after SCI. Ideally, the assessment is conducted with the use of a reclined mirror, so that women can follow the procedure, and research indicates that visual feedback enhances their subjective arousal (Sipski, Rosen, Alexander, & Hamer, 2000a).

At-home CBT exercises encourage the use of genital vibrostimulation with commercial vibrators (e.g., Lelo), alone or with a partner, experimenting with different vibration modalities. Clitoral vacuum suction devices (CVSDs) can also help explore clitoral and nipple sensitivity. A diary recording the type of stimulation, duration, and context (solo or partnered) of the trial, perceived sensations and potential orgasm (yes/no/maybe) is used for follow-up during therapeutic sessions. Questionnaires such as the Female Sexual Function Index (FSFI; Rosen et al., 2000) may be used as well for baseline measures of sexual function and to track progress.

## Exploring the Orgasm Potential of Women after SCI

Numerous empirical studies indicate that women can experience orgasm despite a complete SCI (see Alexander & Marson, 2018, for review). Orgasm rates have been reported in 47–55% of women with SCI (Alexander & Marson, 2018). Level of injury, rather than completeness, appears to modulate women's ability to experience orgasm after SCI; however, other unknown factors remain to be explored (Alexander & Marson, 2018). Importantly, several empirical studies point to significant changes in terms of orgasmic experiences after SCI: (1) *Latency to orgasm* is typically longer (Sipski et al., 2001); (2) *orgasm intensity* is generally weaker compared to pre-SCI experience (Ferreiro-Velasco et al., 2005); (3) *perceived sensations* during orgasm are significantly weaker and fewer than those reported by women without SCI (Gérard, Charvier, & Courtois, 2019).

First-wave CBT intervention begins with psychoeducation about orgasm characteristics after SCI (i.e., changes in latency, perceptual intensity), followed by specific exercises (solo and partnered) to encourage women to experiment with various positions and stimulation types. The use of commercial vibrators and CVSDs is recommended. Recent data indicate that CVSDs increase lubrication and frequency of orgasm, and decrease sexual distress for women with SCI (Alexander, Bashir, Alexander, Marson, & Rosen, 2018). The use of the BSO questionnaire and the ORS is also recommended to record subjective and physiological experiences during the trials, along with a diary to assess the context-positive and/or -negative experiences, all of which provide insightful cognitive restructuring avenues.

## Medical Treatments Accompanying First-Wave CBT

The inability to have intercourse is the most common reason for referral in patients with SCI. When residual sexual response is not sufficient for intercourse, then medical treatment is often useful. Clinical practice with patients with SCI supports the superior efficacy of combining pharmacological and psychotherapeutic intervention as compared with using separate treatment. The use of phosphodiesterase type 5 (PDE5) inhibitors (sildenafil, tadalafil, vardenafil) to treat erectile dysfunction after SCI has long been supported by clinical studies (see Lombardi, Macchiarella, Cecconi, & Del Popolo, 2009, for a review). If these are not successful, then intracavernosal injections (ICIs; papaverine, alprostadil, or bi/trimix) are considered second-line treatments. Empirical studies, including one double-blind randomized controlled trial (RCT), support their efficacy for men with SCI presenting with erectile dysfunction (ED; see Chochina et al., 2016, for review). In addition, there is limited support from uncontrolled studies of the use of vacuum pumps (e.g.,

ErectAid) and penile rings to treat ED (Biering-Sørensen et al., 2005). Ejaculation treatments include PVS and midodrine to maximize ejaculation and orgasm (Courtois et al., 2008). Regrettably, there is little published empirical data on the pharmacological management of women's sexual difficulties after SCI (Alexander et al., 2011; Courtois et al., 2011b; Sipski et al., 2000b). Interventions are essentially limited to lubricants, sex toys, and vibrators (Alexander, Aisen, Alexander, & Aisen, 2017).

## Second- and Third-Wave CBT to Maximize Sexual Adjustment for Men and Women with SCI

Mood disorders, sensory losses, body image, and relational difficulties are often associated with SCI and affect sexual functioning. Second- (i.e., cognitive restructuring) and third-wave CBT approaches (i.e., mindfulness-based cognitive therapy [MBCT], ACT) are often useful in treating these problems. Though little empirical data are available to support the efficacy of these interventions in patients with SCI (Hearn & Finlay, 2018; Hocaloski, Elliott, Brotto, Breckon, & McBride, 2016), data from other populations support their benefits (Arora & Brotto, 2017).

### Mood Disorders, Grief, and Mourning

Epidemiological data suggest that younger male and female patients with SCI are at elevated risk for depression and anxiety disorders after hospital discharge (Sauri et al., 2017). Because depression and anxiety are known to affect sexual functioning (Cobo-Cuenca, Sampietro-Crespo, Virseda-Chamorro, & Martin-Espinosa, 2015), screening patients with SCI for the presence of mood disorders with standard self-report instruments (i.e., the Beck Depression Inventory [BDI], Beck Anxiety Inventory [BAI]) is appropriate.

Our experience suggests that symptoms of grief and mourning regarding lost physical functions can give rise to cognitive distortions leading to negative anticipation, disappointment, and rumination about sexual failures. Second-wave CBT techniques using CBT worksheets to record a specific event and accompanying thoughts/distortions and emotions may help patients transition from internalized thoughts such as "I am no longer a competent lover" or "I can no longer experience a satisfying sexual relationship" to more positive thoughts, such as "With adequate stimulation, I am capable of obtaining satisfying sexual responses" or "Despite my limitations, I can give and receive sexual pleasure."

### Body Image and Sexual Self-Esteem

Individuals with SCIs are faced with the overwhelming task of adjusting to significant body changes, both externally (e.g., weight gain, muscle atrophy)

and internally (e.g., urinary incontinence, spasticity). In a seminal study, nearly 90% of men and women reported a significant alteration of their "sexual sense of self" after SCI (Anderson et al., 2007b). While little research has investigated the role of diminished sexual self-esteem and body image changes on sexual rehabilitation (Kreuter, Teft, Siösteen, & Biering-Sørensen, 2011; McCabe & Taleporos, 2003), empirical research in non-neurological populations documents their influence, particularly on orgasm (Dove & Wiederman, 2000; Quinn-Nilas, Benson, Milhausen, Bucchholz, & Goncalves, 2016). Clinical experience also suggests that concerns about body image influence sexual self-esteem and often lead to cognitive distortions for individuals with SCI during sexual activities (e.g., anticipation and catastrophizing about incontinence, rumination about weight gain due to immobility). Interventions should therefore include instruments such as the Body Esteem Scale (BES; Franzoi & Shields, 1984) to assess interfering cognitions techniques. Upon noting the patient's experience of specific body areas (e.g., negative affect toward abdomen, thighs, genitals), therapists can discuss the patient's relationship to his or her body after SCI, highlight positive body areas as per the BES, and reframe alternative sexual scripts.

### Diminished Body Sensations and Neurogenic Pain

While training with residual sexual potential provides initial positive feedback on remaining functions, diminished bodily and internal sensations remain a source of sexual concern for men and women with SCIs. The literature highlights the positive relation between preserved genital sensations and sexual function postinjury, particularly with respect to orgasm; it also documents the development of new areas of arousal above the injury level (Anderson et al., 2007b). Clinical anecdotes further suggest that, over the years, the lesion site may become a zone of arousal, perhaps as a case of neuroplasticity. Conversely, chronic and/or neurogenic pain is also documented following SCI, with most individuals experiencing pain in the lower limbs, as well as pain in the neck and shoulders for tetraplegic individuals (Turner, Cardenas, Warms, & McClellan, 2001). Such chronic pain is often refractory to medical treatment (Turner et al., 2001) and significantly interferes with sexual activities.

Although little research is available on third-wave CBT interventions with the SCI population (Hocaloski et al., 2016), mindfulness training and ACT might offer promising avenues for targeting the perceptual challenges encountered by these individuals. Research conducted in non-neurological patients points to the benefits of mindfulness training for enhancing bodily and physiological perceptions of sexual arousal (see Arora & Brotto, 2017, for review). ACT interventions targeting chronic pain also show significant benefits for pain acceptance and psychological flexibility, as well as for anxiety and depression (Hughes, Clark, Colclough, Dale, & McMillan, 2017). Clinical interventions may therefore include psychoeducational material about the malleability of bodily sensations after SCI and encourage patients to reconnect

with their body using a mix of first-wave CBT (sensate focus activities) and third-wave mindfulness training, while tracking changes and sensations with the BSO questionnaire and a visual body map (see Figure 21.1) (Dubray et al., 2017).

Self-report instruments such as the Five Facets of Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006), the Sexual Five-Facets Mindfulness Questionnaire (FFMQ-S; Adam, Hereen, Day, & de Sutter, 2015), and the Multidimensional Assessment of Interoceptive Awareness (MAIA; Mehling et al., 2012) also provide valuable tools to obtain baseline levels of mindfulness in the context of sexual activities and for follow-ups throughout treatment. Corollary pain management with ACT interventions may allow for disconnecting pain from its emotional components, and moving away from anticipation, disappointment, anger, and rumination.

### Sexual Desire and Dyadic Adjustment

Considering the challenges faced by individuals with SCI, it is not surprising that the literature highlights a decrease in sexual desire post-injury in both women (Kreuter, Siösteen, & Biering-Sørensen, 2008) and men (Cobo-Cuenca et al., 2015). To date, there are no empirical data specifically supporting any medical or psychotherapeutic treatment of sexual desire in men and women after SCI. Studies conducted with other medical populations (e.g., oncology patients) point at the benefits of mindfulness-based interventions (see Arora & Brotto, 2017, for a review); clinical experience suggest that such interventions may be as beneficial for the SCI population.

Some studies have focused on relationship quality post-SCI as a potential predictor of sexual functioning (Kreuter et al., 2011). Data derived from limited samples using nonvalidated outcome measures suggest that partners of individuals with SCI tend to report decreased interest in sexual activities (Kreuter, 2000). Clinical experience with the SCI population and research on people with sexual disabilities (Kreuter, 2000; Kreuter et al., 2011) suggest that such changes could be due to partners taking on a caregiver role. Because affective expression and dyadic consensus appear to play an important part in relationship quality after SCI (Tramonti, Gerini, & Stempaccia, 2015), partners of individuals with SCI should be included in the therapeutic process.

Although SCI, similar to other major life-changing events (e.g., death of a loved one, parenthood), results in a difficult adaptation period for many couples, longitudinal research suggests that divorce rates 5 years after SCI are not significantly higher than those of the general population (Kreuter, 2000). Psychosocial factors such as social integration, education, and occupation appear to be better predictors of marriage longevity than medical factors such as lesion level and degree of disability (Devivo, Hawkins, Richards, & Go, 1995; Karana-Zebari, de Leon, & Kalpakjian, 2009). Research also shows that gender and race are significant predictive factors for relationship dissolution (Arango-Lasprilla et al., 2009). For example, African American couples

are more likely to separate after SCI (Arango-Lasprilla et al., 2009) than Hispanic or European American ones. Also, women with SCI experience a higher divorce rate than do men with SCI. Our experience suggests that relationships formed after SCI tend to be associated with better marital adjustment than relationships formed before injury. Such relationships are often marked by strong dyadic communication and the development of a pleasure-oriented sexuality, including genital-oriented behaviors.

## Case Discussion

John, a 24-year old tetraplegic man with a cervical *in situ* lesion (i.e., complete SCI without motricity or sensation below the neck) resulting from a car accident 18 months previously sought consultation for anejaculation and anorgasmia after SCI. He had recently moved into his own apartment upon regaining some autonomy and was currently enrolled in an undergraduate accounting program, which he started following rehabilitation. Before SCI, John had had several sexual encounters with different partners and reported one significant romantic relationship, which ended after his SCI. During his hospital stay, he started a sexual relationship with Vanessa, the sister of his rehabilitation roommate, who was not handicapped. He sought consultation to try to improve his and Vanessa's sexual satisfaction.

John did not report any problem with erection, and both the clinical interview and the IIEF questionnaire revealed full, stable, and satisfying erections upon self- and partnered genital stimulation. However, there was no ejaculation, and the patient described headaches during extended periods of stimulation or intercourse. Having lost his usual pleasurable sensations in the genitals, as well as his ejaculation, he described himself as anorgasmic and was distressed about this. He also reported feeling embarrassed about his anejaculation during his recent sexual experiences with his new partner, despite her reassurance that she did not mind and did obtain her own pleasure. John was also concerned with his motor limitations that limited his sexual behaviors, though he was able to bring his partner to orgasm.

Psychoeducation was provided concerning the neurophysiology of erection to explain the maintenance of genital-reflex erections and the possibility of retrograde as opposed to anejaculation. This was a likely explanation for his reported headaches, since this symptom is a common sign of AD, which occurs frequently after ejaculation following SCI. John was invited to complete the BSO and the ORS to assess the sensations that he could perceive during sexual activity despite his apparent anejaculation. At-home BSO scores revealed the presence of many sensations, including sweating and hot flashes, increased heart and respiration rates, strong spasms in the abdomen (and penis), legs, and arms, followed by a relief of spasms, which John attributed to the energy required for intercourse. ORS scores indicated limited pleasure and feelings of connectedness during the interaction. The presence of physiological

sensations was addressed in subsequent sessions, which allowed for a deeper reflection on sexual scripts and orgasm. We also discussed the extent of his ORS answers, which opened another avenue of reflection around emotional and sexual intimacy. However, John reported being continuously preoccupied with his lack of physiological response (i.e., anejaculation).

Consequently, he was offered a Ferticare PVS test in the hospital to identify possible retrograde ejaculation. PVS yielded observable responses including red skin spots, numerous spasms, and a significant rise in blood pressure indicative of ejaculation, despite the lack of seminal expulsion. A urine sample observed under microscope confirmed the presence of semen, which reassured the patient greatly. The results were used to draw his attention to the fact that he could experience sensations despite his lack of observable ejaculation, and that he should rely on his internal feelings, such as increased lower limb spasms and blood pressure, rather than visual feedback, to appraise his arousal level.

Over the next few weeks, at-home masturbation and sensate focus exercises were suggested to help John evaluate his sensations and arousal. He was encouraged to keep a diary and track his progress with the BSO and the ORS, so that we could revisit his successes and failures in our therapy sessions. He initially reported stronger and wider-ranging sensations during solo stimulation than during partnered interactions. We explored this discrepancy in therapy and identified a tendency toward rumination and spectatoring in his sexual interactions. Discussions around masculinity and sexual performance helped debunk several common sexual myths that John believed, such as "I'm not strong enough" or "Both my partner and I must reach orgasm every time, with me ejaculating." We were also able to reduce John's performance anxiety by adapting interventions such as cognitive defusion (Hayes, Strosahl, & Wilson, 1999) and mindfulness. This helped him build tolerance toward his emotionality and eventually recenter his attention on his physical sensations and Vanessa's experience rather than on his lack of sensations in the genitals. Over time, John's BSO and ORS scores reached relatively similar levels in solo and partnered contexts. He was also gradually able to explore new sexual positions using pillows and wedges, both in lying and sitting positions. His sexual scripts and sexual repertoire broadened as he started exploring with Vanessa new areas of arousal above the level of injury (e.g., neck, ears). He eventually reported stronger sexual feelings and emotional closeness with Vanessa.

Although anterograde ejaculation was never regained, John was able to perceive feelings of retrograde ejaculation (i.e., shivers, spasms, tachycardia, hyperventilation, hot flashes) and eventually reported feelings of climax during sexual activities and more acceptance of his post-SCI body. Vanessa was included in a few psychoeducationally oriented therapy sessions, which allowed the couple to clarify some mutual concerns. Vanessa was reassured about the low probability of hurting John or creating further injury during sexual intercourse and was validated for checking for possible signs of redness

or rash after intercourse to avoid the possibility of pressure sores. She was also encouraged to help John explore new sexual positions and attempt new, nonsexual activities (e.g., camping) but was cautioned against assuming a caretaker's role. Despite John's retrograde ejaculation, there was still some possibility of conception, and the use of contraceptives was encouraged. The couple was informed about fertility options, such as a home self-insemination procedure and assisted reproductive techniques. After about 6 months of fairly regular therapy sessions, both John and Vanessa reported significant improvement in their sexual and couple relationships, and therapy was terminated by mutual consent.

## Conclusions

Sexual rehabilitation in men and women with SCI is a dynamic and stimulating field of clinical practice. While specific knowledge of sexual medicine is paramount to work efficiently with this population, clinical rehabilitation of sexual function relies heavily on a variety of CBT approaches used with other populations presenting with sexual difficulties. Given the trauma often associated with SCI, clinical work also relies on existential approaches to address issues of grief and life trajectory. Overall, patients should be informed that sexual adjustment tends to improve as the time elapsed after the SCI increases. Clinicians are encouraged to pay special attention to the partners of men and women with SCI, as both research and clinical experience show that optimal sexual rehabilitation is often incompatible with partners' wearing the caregiver's hat.

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CHAPTER 22

# Persistent Genital Arousal Disorder

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Persistent genital arousal disorder (PGAD) is described by Pukall and Goldmeier in Chapter 22 as a "condition characterized by prolonged, persistent, intrusive, unwanted, and distressing genital arousal sensations that occur in the absence of feelings of sexual desire." Although the emphasis in the literature on PGAD has been on women, there are now reports suggesting that this problem also affects men. Although no formal diagnosis or diagnostic criteria exist for PGAD in DSM-5 or ICD-11, the authors present new assessment guidelines that will allow clinicians to recognize this problem and differentiate it from hypersexuality and genital pain syndromes. Distress is a key symptom of PGAD, and suicidal ideation is not uncommon. While symptom reduction is most often the primary goal of a multidisciplinary treatment approach, alleviating distress and shame is a necessary and needed focus of therapy. Given that PGAD makes participating in and enjoying sexual interactions extraordinarily difficult, it is when the goal of therapy turns to restoring sexuality that the unique expertise of a sex therapist is most needed.

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Persistent genital arousal disorder (PGAD) was first recognized by Leiblum and Nathan (2001) as "persistent sexual arousal syndrome," a condition characterized by prolonged, persistent, intrusive, unwanted, and distressing genital arousal sensations that occur in the absence of feelings of sexual desire (Pukall, Jackowich, Mooney, & Chamberlain, 2019). These symptoms can occur in response to sexual and nonsexual triggers—or they may appear "out of the blue" (Jackowich, Pink, Gordon, Poirier, & Pukall, 2018a)—and they tend to persist even after reasonable orgasmic response. They are sometimes described as painful (Jackowich, Pink, Gordon, Poirier, & Pukall, 2018b; Pukall et al., 2019) and, in the case of painful PGAD symptoms, may be diagnosed as pudendal neuralgia (i.e., a genito-pelvic pain condition that results from damage to or irritation of the pudendal nerve; Khoder & Hale, 2014).

The prevalence of PGAD in the general population is unknown. Based on estimates from a sexual health clinic in the United Kingdom, Garvey, West, Latch, Leiblum, and Goldmeier (2009) estimated that PGAD affects approximately 1% of women. In a sample of 1,641 undergraduate students at a Canadian university, Jackowich and Pukall (2017) found that 0.6% of women and 1.9% of men endorsed PGAD criteria to at least a moderate degree. It is not clear why this study presented higher rates of reported PGAD symptoms (and associated distress) in men versus women, which is in direct contrast to the focus of the clinical literature (i.e., on women, see below). It is possible that the relatively young men in this sample felt less control over their feelings of sexual arousal, and as a result, more distress due to potential embarrassment of their more visible arousal response (i.e., erection).

To date, women have been the focus of most empirical research and case studies; however, a handful of case studies describe similar symptoms in men as well (Dikici, Gunal, Arslan, & Kayici, 2015; Kamatchi & Ashley-Smith, 2013; Serefoglu, 2016; Waldinger, Venema, van Gils, de Lint, & Schweitzer, 2011). Given this imbalance, the research we cite in this chapter focuses on women with PGAD, yet the assessment and treatment sections of the chapter apply to individuals of all gender/sex expressions.

## Diagnosis and Assessment

Although no formal, specific diagnosis for PGAD exists in DSM-5 (American Psychiatric Association, 2013) or the recently approved ICD-11 (World Health Organization, 2019), the most recent nosology and nomenclature effort for female sexual dysfunctions from the International Society for the Study of Women's Sexual Health (ISSWSH) includes criteria for PGAD that are based on expert opinion (Parish et al., 2016): persistent or recurrent, unwanted or intrusive, distressing feelings of genital arousal or being on the verge of orgasm not associated with concurrent sexual interest, thoughts, or fantasies with a duration of 6 months or more. These feelings can be associated with

1. Limited resolution, no resolution, or aggravation of symptoms by sexual activity with or without aversive and/or compromised orgasm.
2. Aggravation of symptoms by certain circumstances.
3. Despair, emotional lability, catastrophizing, and/or suicidality.
4. Inconsistent evidence of genital arousal (e.g., vaginal lubrication) during symptoms.

Distress is a key component to diagnosing PGAD. In those with PGAD, distress levels are typically moderate to high; average of about 7 on a scale of 0 (*no distress*) to 10 (*extremely high distress*) (Jackowich et al., 2018a; Leiblum, Brown, Wan, & Rawlinson, 2005), as is symptom catastrophizing (Jackowich et al., 2018b). The strongest predictors of distress include high levels of intrusive and unwanted feelings of genital arousal; constant symptom presentation; feelings of unhappiness, shame, and worry; decreased sexual satisfaction (Leiblum et al., 2005); high sexual conservatism; and low dyadic adjustment (Carvalho, Veríssimo, & Nobre, 2015). Suicidal ideation, and high levels of worry, stress, and depression have also been reported (Jackowich, Pink, Gordon, & Pukall, 2016; Leiblum et al., 2005). Indeed, in one study examining general psychological function in women with PGAD, Carvalho, Veríssimo, and Nobre (2013) found that affected women fare significantly worse than nonaffected women on most aspects assessed (e.g., depressive and anxiety symptoms).

It is important to note, though, that some individuals who report experiencing spontaneous and persistent genital arousal are not distressed by these sensations. They may feel indifferent toward them (Leiblum & Chivers, 2007) or they may welcome and enjoy the feelings, which they can either dismiss or act on by engaging in sexual activity (Leiblum, Seehuus, & Brown, 2007). In these cases, a diagnosis of PGAD would not be made. To complicate matters, some women with frequent feelings of genital arousal may sometimes be distressed about their condition but welcome it at other times. In terms of other differential diagnosis considerations, one must rule out hypersexuality, lack

of distress, and, in males, priapism (characterized by a persistent and painful penile erection).

With respect to the PGAD versus hypersexuality distinction, much interest in PGAD has focused on its conceptualization to ensure clarity in terms of its differential diagnosis. Shortly after Leiblum and Nathan (2001) labeled the symptom constellation as "persistent *sexual* arousal syndrome," they replaced it with "persistent *genital* arousal disorder" in light of the fact that most sufferers did not experience it as a sexually related condition (Goldmeier & Leiblum, 2006). Indeed, many individuals with PGAD report avoiding sexual activity or stimuli that may trigger the symptoms (Jackowich et al., 2018a). The term "PGAD" emphasizes the genital nature of this condition and attempts to limit conflation with conditions characterized by persistent subjective sexual desire or arousal (Leiblum, 2006) such as hypersexuality, characterized by frequent and repetitive sexual urges, fantasies, or behaviors (Kafka, 2010). Sexual fantasies are subjective events that are closely tied to the experience of sexual desire—a component that is typically not reported by those with PGAD when they are experiencing active symptoms. Repetitive sexual behavior, such as masturbation, may be a clinical feature of both PGAD and hypersexuality. However, the motivations for engaging in repetitive sexual behavior must be queried; an individual with PGAD will primarily engage in repetitive sexual behavior to quell the distressing symptoms, whereas an individual with hypersexuality is motivated by sexual desire. The differentiation between PGAD and hypersexuality may be difficult, because feelings of sexual desire can occur in response to some degree of genital arousal.

In addition, some researchers have avoided using the term "arousal" in describing the symptom complex consistent with PGAD given that individuals may presume that genital arousal sensations are wanted, pleasurable, positively experienced, and concordant with feelings of sexual desire (Pukall et al., 2019). For example, several researchers highlight the dysesthetic (i.e., unpleasant atypical sensation) component of the genital sensations (Komisaruk & Goldstein, 2017; Parish et al., 2016; Pukall et al., 2019). In addition, some have emphasized the painful component of PGAD (Jackowich et al., 2018b; Markos & Dinsmore, 2013; Pukall et al., 2019), suggesting a possible link with other genito-pelvic pain conditions (e.g., vulvodynia), at least for a subset of those who describe their PGAD symptoms as painful. Although in need of research, these new conceptualizations offer an alternative perspective from which to examine PGAD; this perspective may lead to efforts to clarify mechanisms involved in the expression of PGAD, which can have implications for treatment. However, the cause of PGAD is currently unknown (and is likely multifactorial) despite the numerous etiological theories (e.g., peripheral dysregulation, vascular changes, Tarlov cysts, pharmacologically induced) that have been proposed, mainly via case studies (Jackowich et al., 2016).

By the time clients with PGAD are seen for an assessment, it is important to recognize that many of them will have engaged unsuccessfully with a number of health care providers before finding someone who knows about

the condition and can provide a treatment plan (Jackowich, Pink, Gordon, & Pukall, 2017). Ideally, a comprehensive assessment of a client with PGAD requires input from at least three knowledgeable health care providers: one psychologically trained, one medically trained, and one trained in pelvic floor physical therapy. The assessment likely spans several appointments and discussions among all involved, and treatment (see below) should be coordinated by one of these health care providers. Figure 22.1 illustrates the areas that should be covered during the assessment and suggests treatment options for areas of clinical significance.

There are no formal assessment tools for PGAD. The initial clinical interview should be undertaken by a health care provider, preferably, a psychologist with expertise in sexuality/sexual medicine or a sexual medicine provider with training in psychosocial and sexual issues. Sufficient time should be allotted for the appointment, and effort should be made in order to provide a validating environment (e.g., assure the client of your knowledge of the condition, engage in clear and respectful communication), because some people with PGAD have already approached health care providers who either did not take them seriously or had never heard of the condition (and were therefore unable to help). After gathering general sociodemographic and background information about the client, a detailed symptom and psychosocial history should follow.

Questions should cover, at a minimum, the following domains: symptom characteristics; sexuality; cognitive, emotional, behavioral, and interactional correlates of the sensations; and medical, musculoskeletal, and trauma-related content. Questions related to symptom characteristics should focus on the following:

- The general presentation of the symptoms ("Tell me about the symptoms you are experiencing"). Women with PGAD may report a variety of symptoms, including those related to physiological sexual arousal (e.g., genital arousal, erect nipples, lubrication)—which is the most commonly endorsed category—followed by orgasm symptoms (e.g., spontaneous orgasm, feeling on the verge of orgasm), urinary symptoms (e.g., urinary frequency), and pain symptoms (e.g., pain in the vulva or clitoris at rest, pain during penetrative sexual activities) (Jackowich et al., 2018a).

- Location ("Where in your body do you feel the sensations?"). Note that the clitoris, vagina, labia, and the area above the pubic bone are the most common genital locations of PGAD sensations (Waldinger, van Gils, Ottervanger, Vandenbroucke, & Tavy, 2009a; Waldinger, Venema, van Gils, & Schweitzer, 2009).

- Symptom distress ("On a scale of 0–10, where 0 is *no distress* and 10 is *extremely high distress,* how would you rate the level of distress that you experience in response to your symptoms?"). Research indicates that distress

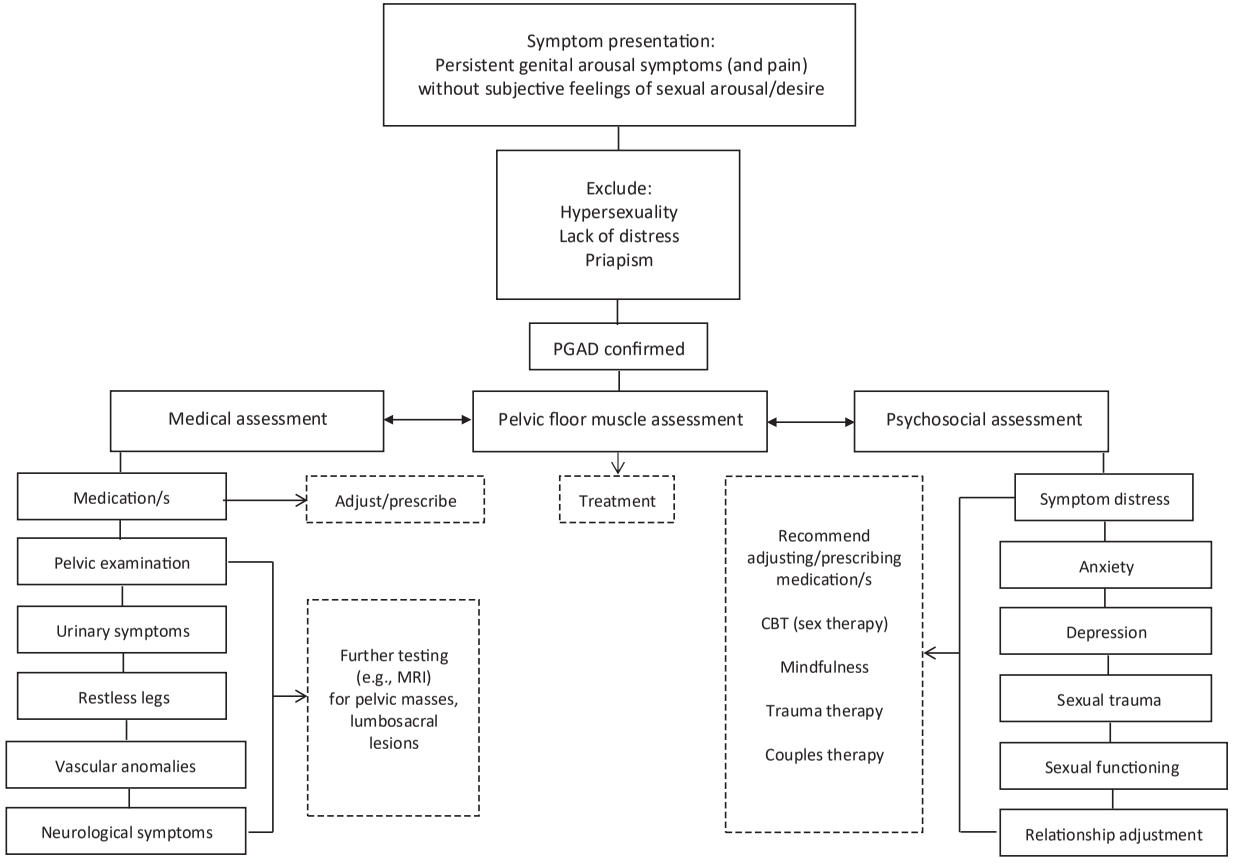


**FIGURE 22.1.** Assessment and treatment algorithm for PGAD. This figure illustrates the areas that should be covered during the assessment (solid boxes) and suggests treatment options (dashed boxes) for areas of clinical significance.

levels in PGAD samples are moderate to high (about 7 on the aforementioned scale) (Jackowich et al., 2018a; Leiblum et al., 2005).

- The quality of the sensations ("How would you describe the sensations?"). Research indicates that a large proportion of women with PGAD report tingling and throbbing sensations (Jackowich et al., 2018a; Leiblum et al., 2005; Leiblum, Seehuus, & Brown, 2007; Waldinger et al., 2009b), as well as feelings of imminent orgasm (Waldinger, Venema, et al., 2009) and vaginal heaviness and wetness (Jackowich et al., 2018b).

- The intensity of the sensations ("On a scale of 0–10, where 0 is *no sensation at all* and 10 represents *orgasmic sensations,* how would you rate the level of your sensations?").

- Onset ("When did you first start noticing the sensations?"). Although some women with PGAD report that their symptoms have been present since early childhood (i.e., before the age of 5 years), the average age of onset is about 37 years (range, 6–66 years); most also describe a sudden (vs. gradual) pattern of symptom onset (Jackowich et al., 2018a).

- Temporal pattern and duration ("Do the symptoms vary during the course of the day and evening or are they relatively constant? How long do they usually last?"). Based on research, most women with PGAD report a constant (vs. intermittent) symptom presentation; if intermittent, a large proportion of women state that their symptoms last between 1 and 6 hours (Jackowich et al., 2018a).

- Triggers ("What seems to set off your symptoms? What makes them worse?"). Women with PGAD describe many symptom triggers, some of them in response to sexual (e.g., feeling sexually desirous) and nonsexual activities (e.g., sitting, driving), and others in response to emotional (e.g., anxiety, stress) and physiological (e.g., full bladder) states (Jackowich et al., 2018a).

- Alleviators ("What seems to help reduce the intensity of the sensations [and distress associated with your symptoms]? By how much?"). The most frequently reported alleviators include distracting activities (60%), sleep (46.1%), masturbation (38.3%), relaxation techniques (32.2%), cold application (30.4%), and partnered sexual activity (30.4%) (Jackowich et al., 2018a). Please note that some activities (e.g., sexual activity) may be triggers for some people and alleviators for others.

- Interference ("Please tell me how the symptoms interfere with typical activities of daily living, such as sitting"). Research indicates that 44–85% of women with PGAD report interference with life activities (e.g., sitting, social

outings, working) and cognitive–emotional states (e.g., concentration, mood) (Jackowich et al., 2018a).

- Information pertaining to previous treatment attempts and outcomes and any other strategies for managing symptoms (e.g., masturbation).

Questions related to sexuality (e.g., desire, frequency of, and satisfaction/distress with sex; motivators for solitary and partnered sexual activity, orgasmic experience) should also be asked, and, if relevant, the client's past and current sexual relationships (e.g., areas of conflict and strength) should be explored. Surprisingly, there are few data on sexual (dys)function and no empirical data on relationship adjustment in women with PGAD. What exists regarding sexual function suggests that those with more (vs. fewer) PGAD symptoms have worse sexual function (i.e., lower scores on overall sexual function, desire, and sexual satisfaction; higher pain scores; Leiblum, Seehuus, & Brown, 2007), which mirrors many women's clinical presentations: We note that the vast majority of women, particularly those who are older, do not want to engage sexually because it may precipitate or worsen their PGAD symptoms; in addition, they also tend to report little or no sexual desire. However, we are also aware of clients who want to experience pleasure during sexual arousal.

Given the complexity in the experience of arousal in clients with PGAD, the topic of sexuality should be explored in detail to delineate pleasurable and nonpleasurable sexual activities, and what factors play a role in terms of this threshold. Asking questions such as the following may aid in this exploration:

- Does sexual arousal with the partner always trigger PGAD symptoms? If not, when does the PGAD get triggered, and when does it not?
- Are there certain body areas that, when stimulated, lead to pleasure without triggering PGAD symptoms? Similarly, are there certain sexual activities that lead to pleasure?
- If all instances of sexual arousal in the person with PGAD lead to an exacerbation of PGAD symptoms, does stimulating the partner also result in an increase? Is the idea or thought of "sexual activity" problematic in that it is a general trigger regardless of the specific situation?

Cognitive, emotional, behavioral, and interactional correlates of the arousal sensations (suicidal ideation; mood; thoughts that accompany the symptoms [e.g., catastrophizing]; anticipatory anxiety related to events that may trigger symptoms; avoidance; past or current obsessive–compulsive features; and interpersonal conflict) should be carefully assessed. Oftentimes, these correlates can be directly addressed in therapy through a variety of techniques, such as psychoeducation, thought records, and behavioral experiments.

Medical (including bowel and bladder function, comorbid conditions, past and current treatments), musculoskeletal (e.g., injury to the lower back and hip area), and trauma-related (e.g., childhood abuse and/or intimate partner violence) information should also be collected. Women with PGAD report having been diagnosed with, on average, five other medical/genito-pelvic pain conditions, such as irritable bowel syndrome, chronic pelvic pain, pudendal neuralgia, and posttraumatic stress disorder (PTSD; Jackowich et al., 2018a). In one study, a past history of sexual abuse was present in up to 50% of women with PGAD (Leiblum, Seehuus, Goldmeier, et al., 2007).

The medical examination should be carefully explained to clients beforehand, along with an explicit discussion regarding their complete control of the examination (e.g., they can stop at any point). It is important to note that during a physical examination of the genitals, manual pressure can elicit hypersensitivity and orgasm in affected women (Waldinger, Venema, et al., 2009). Ideally, a comprehensive pelvic examination should include a lower genital examination to assess sensory changes, and palpation for neuromas in the path of the dorsal clitoral nerve (Bedell, Goldstein, & Burrows, 2014) and the presence of any pelvic varices (i.e., dilated veins), with referrals to specialists in imaging when appropriate (Jackowich et al., 2016). Additional information may be obtained via other tests as indicated (e.g., magnetic resonance imaging [MRI] of the pelvis and lumbosacral areas to identify Tarlov cysts or structures pressing on the pudendal nerve). Pelvic floor muscle function should be thoroughly assessed by a pelvic floor physiotherapist (Rosenbaum, 2010).

## Approaches to Treatment

There are no empirically validated treatment algorithms for PGAD (Jackowich et al., 2016; Kruger, 2018), leaving health care providers with a "try and see" approach in most cases; indeed, there is no solid information regarding what treatment to start first and whether treatment, if it consists of different modalities, should be sequential or concurrent. It may be useful to tell the client that management largely includes medication, psychological interventions, and pelvic floor physical therapy, with the options guided in part by the client's preferences and level of distress. Approaches should also be tied to information gained in the assessment when possible; for example, if the symptoms started with the onset of a particular event (e.g., cessation of selective serotonin reuptake inhibitor [SSRI] treatment, injury to the pelvic floor musculature, life stressor), then this association must be carefully considered.

Typically, medically trained health care providers prescribe or adjust medication in order to help reduce the intensity of PGAD symptoms (and pain, if present) and to address mood disturbances. Medications may include tricyclic antidepressants, antiepileptics, SSRIs, serotonin–norepinephrine reuptake inhibitors (SNRIs), dopaminergics, and antipsychotics; for those with pain, specialized treatment in pain clinics may also be useful (Kruger, 2018). Pelvic

floor physical therapists usually focus on rehabilitation of the pelvic floor musculature, including pudendal entrapment syndromes (for a review, see Butler, 2018). Although some case studies attest to the efficacy of medications and pelvic floor physical therapy (Jackowich et al., 2016), there are no "proven" treatment options for those with PGAD due to the lack of large-scale studies. However, many agree that symptom-related distress must be specifically addressed in those with PGAD; recommending an online PGAD support group can aid in reducing feelings of isolation, and referral to a knowledgeable mental health care provider for coping skills can aid in symptom reduction.

Indeed, given the significant level of distress in many of those with PGAD, many health care providers view psychological intervention as an essential component of treatment (e.g., Facelle, Sadeghi-Nejad, & Goldmeier, 2013; Goldmeier, Sadeghi-Nejad, & Facelle, 2014).

## Psychological Intervention to Reduce Pain and Distress

The role of the psychologist/sex therapist is to help the client manage and cope with the symptoms of PGAD and symptom-related distress. Cognitive-behavioral therapy (CBT) has demonstrated efficacy for reducing pain intensity and distress in women with genito-pelvic pain (Pukall & Bergeron, 2018); thus, CBT for unwanted, distressing, and persistent arousal symptoms—as well as the cognitive and affective correlates of the symptoms—should be considered for those with PGAD.

In the first phase of CBT, psychoeducation surrounding the multidimensional view of arousal symptoms—highlighting the influence of biological, psychological, and social factors—is provided. In addition, information about the effects of the symptoms on sexuality and activities of daily living, and on the role of psychological factors (e.g., catastrophizing about the symptoms) in the maintenance of symptoms, is explored and discussed. At this point, clients may be invited to complete a five-factor model to help identify the unique, specific influences of their thoughts, behaviors, bodily sensations, and emotions on factors within a larger context (i.e., the situation) that can play a role in symptom expression. In addition, clients should be encouraged to keep a regular symptom diary framed with the five factors (and others, as appropriate; e.g., menstrual cycle phase) in order to raise awareness about which ones influence their symptoms and to promote self-efficacy and perceived control over the symptoms. The expectation with the symptom diary is to discern, over time, a pattern that may be able to be influenced by awareness and specific targeting in therapy.

The second phase of CBT involves targeting existing coping strategies that may be leading to increased symptom severity, such as symptom catastrophizing and hypervigilance; indeed, women with PGAD have been shown to catastrophize with respect to their genital sensations (Jackowich et al., 2018b), and higher (vs. lower) catastrophizing levels in chronic pain populations have been linked to worse outcomes (Wertli et al., 2014). In addition, exercises

to help induce relaxation, such as deep breathing, can be recommended and practiced, after which focusing on negative thoughts and emotions with the goal of defusing catastrophizing thoughts can be incorporated. Including mindfulness practice may be beneficial; it has been shown to help clients with chronic pain and dysesthesias (Majeed, Ali, & Sudak, 2018) by teaching them to "sit" with the unpleasant sensations via acceptance and self-compassion. The final phase of CBT focuses on skills consolidation and maintenance of gains, with follow-up sessions recommended when possible.

The approach we have just described applies when distress is present but is not the central aspect of a person's experience—in these cases, the focus is on symptom reduction. In many cases, distress is the central presentation of the client with PGAD, and as a result, the CBT approach focusing on symptom reduction may need to be less predominant (but still present) while the distress itself is targeted via CBT and components of other modalities (e.g., distress tolerance, a common emotion regulation strategy in dialectical behavior therapy [DBT]). Therapy would then focus on exploring the reasons for the heightened distress (e.g., trauma) while also addressing other potential contributing factors (Pukall & Bergeron, 2018). In cases of sexual trauma, a combined mindfulness and eye movement desensitization and reprocessing (EMDR) approach (or other trauma-focused therapies) may be useful as an adjunct to treatment.

## Restoring Sexuality

Many individuals with PGAD may not have, at least initially, a goal related to sexuality given that their main goal is usually to experience symptom reduction. Based on our clinical experience, only a minority of people with symptoms of persistent genital arousal experience (pleasurable) sexual desire, arousal, and activity—either all the time or some of the time. It is possible that these individuals are more likely to have intermittent (as opposed to constant) symptoms, such that they are able to engage in pleasurable sexual activity between periods of symptomatic experiences; it is also possible that they are able to respond to their persistent genital arousal with feelings of sexual desire.

It is important to involve the person's partner in therapy to ensure that the partner understands the nature of PGAD (e.g., it is not a "sex addiction"; the partner is not "causing" the symptoms) and its complexity (e.g., the degree of "wantedness" of the arousal symptoms, PGAD's functional effects on activities of daily living, the stigma associated with the condition). In the couple context, the effects of the PGAD symptoms on the partner may be explored, and relationship dynamics that play a role in increasing symptom-related distress can be addressed directly. Working on sexuality in therapy with the partner contributing is beneficial in many ways (e.g., learning of the partner's desires and perceptions) that can aid in establishing goals. Treatment options for the client and partner depend on their interest in having sex, as well as on

the way that PGAD manifests in the sexual relationship. These options can range from no sexually arousing activities to engaging in sexually arousing activities for the partner only (or limited sexually arousing activities for the client with PGAD) to limiting sexually arousing activities to periods of time in between heightened PGAD symptoms, to engaging in sexually arousing activities, knowing that the symptoms of PGAD will likely worsen. In the latter case, discussing strategies to help reduce the symptoms (e.g., deep breathing, distraction, cold application) can be beneficial.

## Case Discussion

Ann, a 55-year-old woman, e-mailed a sexual health clinic with a brief description of her symptoms, which consisted of unbidden genital arousal over the last 2 months. In this message, she reported that her family doctor discounted her symptoms, refused to examine her, and treated her for thrush, which did not help alleviate her symptoms. She also stated that she "couldn't carry on" and experienced suicidal ideation, but she mentioned that because of her religion, she would not act on these ideas. An appointment was set in a week's time, and she was encouraged to seek medical attention at her local emergency department should her suicidal ideation worsen or manifest as a plan.

At the intake appointment, Ann described how her symptoms had appeared gradually over a few days and consisted of vaginal "twitching," increased spontaneous vaginal discharge, and an unpleasant feeling of genital arousal that seemingly also had a pain component. These sensations were focused on the clitoral area but radiated at times to the vulva. They were unrelated to sexual desire, and were present most of the day; sitting worsened the sensations, and standing and walking resulted in slight relief. Ann rated the severity of her sensations as 9 out of 10 and her distress as 10 out of 10. Her symptoms made her feel highly anxious, and she particularly ruminated about her symptoms at bedtime, which prevented her from falling asleep, sometimes for up to 3 hours. Although she had never before masturbated, she decided to clitorally stimulate herself to orgasm a number of times but found no relief. A more detailed inquiry regarding her cognitions about her symptoms yielded feelings of loss of control, fear of dying from the illness, shame, and not being able to have a future. There were no features of clinical depression.

Ann was brought up in a Catholic family, with no sex education at home or school. She had studied zoology and anatomy at university and had subsequently taught anatomy to medical students. She met her husband, who was her first sexual partner, at age 25, and had a happy marriage, enjoying sexual activity with orgasms. She sometimes felt she needed more than one orgasm to fully relieve sexual tension. Ann had suffered postpartum depression after her second son was born by means of a painful forceps delivery. The depression was successfully treated with antidepressants. She had lifelong fluctuating

generalized anxiety with very rare panic attacks. She was mildly hypermobile (i.e., slightly more flexible than expected) and had recently started "spinning" at the gym. There was no history of domestic violence, but she reported that 20 years earlier, her boss at the time had repeatedly, over a year, rubbed himself against her in an isolated part of her work environment. She had been disgusted and frightened by this behavior, but she also remembered that she inexplicably became genitally wet during these encounters. She had never told anyone about this situation. She did not have any formal symptoms of PTSD.

The physical examination showed allodynia (i.e., a painful response to a typically nonpainful stimulus) in the periclitoral area, and MRI scans of the lower back and pelvis were normal. Doppler ultrasound of the pelvis showed multiple varices, which are often associated with PGAD symptoms. Ann agreed to take a low dose of amitriptyline for the allodynia. The pelvic floor physical therapist conducted a thorough assessment and concluded that Ann had a hypertonic (i.e., high muscle tension) and tender pelvic floor. Ann attended eight sessions of pelvic floor physical therapy, which consisted of manual therapy, soft tissue release, and biofeedback for the hypertonicity and tenderness. At the last physical therapy session, Ann reported that the combined amitriptyline and physical therapy helped reduce her anxiety, and she stated that her PGAD symptom severity dropped from 9 to 5 out of 10. Her distress was also reduced from 10 to 8 out of 10.

Ann felt that her past nonconsensual experiences contributed to her PGAD symptoms. She opted to start with mindfulness of the body and gentle yoga as a prelude to trauma therapy for the past assault. She then completed 10 sessions of EMDR focusing on the nonconsensual experience; after this course of treatment, her PGAD intensity level had decreased to 4 out of 10 and her distress rating was a 5 out of 10. Subsequently, time was spent challenging Ann's negative cognitions around her PGAD symptoms and diagnosis, which she came to understand as catastrophic in nature.

In addition, given that Ann was very fearful of restarting her sex life with her husband because she believed that sexual activity would trigger "full blown PGAD symptoms," eight sessions were specifically devoted to sex therapy. Although Ann considered asking her husband to attend the sex therapy sessions with her, she decided to attend therapy on her own, because she felt that she would be able to continue her symptom reduction more reliably without "added pressure and high expectations" from her partner. Psychoeducation focused on sexual response cycles, with an emphasis on contextual cues in aiding with Ann's interpretation of wanted versus unwanted feelings of sexual desire and arousal; mindfulness exercises centered on the experience of her symptoms in a nonjudgmental fashion; and discussions focused on the concepts of spontaneous and responsive desire, her awareness of internal and external cues in the experience of sexual desire and arousal in order to increase her level of sexual concordance (agreement between the subjective and genital feelings of sexual arousal), and factors that increased and decreased her feelings of subjective arousal. At the end of treatment, Ann rated her PGAD

symptom severity as 2 out of 10 (her distress severity was now 3 out of 10), remarked that her PGAD symptoms were only present a few days a week for an hour or two, noticed a significant decrease in her anxiety, and was able to enjoy sexual activity with her husband.

## Conclusions

PGAD is a complex, multifactorial condition consisting of the experience of distressing and unwanted feelings of genital sexual arousal. It is best treated with a flexible and multidisciplinary approach that includes sex therapy, medicine, and pelvic floor physical therapy. Distress is a key symptom of PGAD and it is often quite high; suicidal ideation is common. Early access to treatment with knowledgeable health care providers within a validating context is needed. In clients with PGAD, sexuality must be carefully assessed at intake as well as throughout treatment in order to examine clients' goals related to pleasurable sexual activity. For those clients who wish to restore their sexuality, the goal is to decrease distress associated with unwanted feelings of genital sexual arousal and increase the association between wanted subjective and genital feelings of sexual arousal. It is important to note that some clients may not have a goal related to the restoration of sexuality, and in these cases, it is recommended that they be informed that focusing on this aspect in the future is possible should their goals shift.

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## CHAPTER 23

# Conclusion

## *Where Is Sex Therapy Going?*

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From its first edition in 1980, *Principles and Practice of Sex Therapy* (Leiblum & Pervin, 1980) has observed a tradition of stepping back from individual treatment-focused chapters to reflect on sex therapy as a discipline. A sense of momentum has always been recorded, and we find ourselves noting the same. In the fifth edition, we observed that changes in the practice of sex therapy were accelerated in concert with advances in sexual medicine. Sex research has also been one of the major forces behind this continued evolution, and more and more of this research comes from countries outside of the United States. Not only geographically but also within the larger field of mental health, sex therapy is no longer an isolated discipline, as it is increasingly incorporating interventions from therapeutic orientations and modalities as diverse as family systems, emotionally focused therapy, and existential psychotherapy, in addition to the cognitive-behavioral approaches that have been its bedrock.

A state of perpetual transition may be the hallmark of a healthy discipline adjusting to and incorporating new knowledge. It may also indicate a failure to effectively chart a unified direction—an identity crisis of sorts. Yet there is no doubt that sex therapy is enjoying unprecedented popularity. There has been a proliferation of professional organizations focusing on sex

research, sex therapy, and sexual medicine—the Society for Sex Therapy and Research, the International Society for the Study of Women's Sexual Health, the International Society of Sexual Medicine, the International Academy of Sex Research, and the World Association of Sexual Health, to name just a few. Many countries or regions have their own branches of these organizations or their own independent associations, such as the Sexual Medicine Society of North America, the College of Sexual and Relationship Therapists (England), the Canadian Sex Research Forum, as well as the American Association of Sexuality Educators, Counselors, and Therapists and the Australian Society of Sex Educators, Researchers and Therapists, to name just a few. Membership in these organizations is robust and diverse in terms of professional affiliations. While there are some suggestions that professionals who call themselves sex therapists should share at least some basic core competencies, at present, in most parts of the United States and Canada, almost any licensed health professional may claim to practice sex therapy. In some parts of the world, traditional healers are consulted for sexual problems, and many times these healers have no professional training, license, or other credential (Hall & Graham, 2012).

This diversity leads to inevitable definitional questions. What indeed is sex therapy if it is practiced by people with widely different professional backgrounds, training, and orientations? Of course, the same may be said for psychotherapy in general, but since sex therapy has thus far failed to articulate a core set of practices, the lack of clear definitions regarding the practice and the practitioners makes the situation even more confounding.

It was not always so confusing. The heady early days of sex therapy held the promise of targeted interventions for clearly defined sexual problems with easily assessed outcomes. Masters and Johnson had taken sexual function and dysfunction out of the morass of religion, morality, and psychodynamic constructions, and into the supposed clarity of behaviorism and stimulus control. The journey from dysfunction to function was sequentially mapped, with the estimated arrival time much earlier than that indicated by previous treatment approaches.

Over the ensuing 50 years, research and practice in a number of disciplines effected numerous modifications to the traditional models proposed by Masters and Johnson (1966) and later Kaplan (1977) and Lief (1977). The accumulation of empirical data invariably resulted in downward revisions of inflated original outcome predictions. Sexuality and the treatment of its problems appeared to be not so simple after all. The complexity that traditional sex therapy had eschewed would not be denied (if not psychoanalyzed), and its sources would be far more numerous than imagined. This multifactorial complexity is evidenced in the literature, from the very questioning of an archetypal sexual response and associated constructs to deliberations about what constitutes successful treatment outcome. The acknowledgment of complexity may mean a reconfiguration of sex therapy that elevates its relevance or results in its fragmentation. A review of factors that are driving or complicating the

current transition is here offered in the hope that we can collectively rise to the very real challenges facing our still young, though somewhat weathered, discipline.

## Questions about Construct Utility

Questions persist about the nature of the basic and foundational constructs of sexology. The very notions of function and dysfunction have been reevaluated as potentially problematic imports from a medical model that cannot capture the nuances of human sexuality. The concept of sexual function has been criticized as reductive in its emphasis on the mechanics and hydraulics of sex. The concept of dysfunction has been called into question for failing to encompass gender differences in sexual function and for altogether missing the possibility that both sexual difficulties and associated distress may be culturally defined and influenced (Hall, 2019; Tiefer, 2001).

Constructs within the traditional sexual response model are also teetering under scrutiny. Research indicates that sexual desire, once considered a biological drive that springs up spontaneously and has sexual activity and/or orgasm as its goal, is much more unwieldy. With few reliable physiological, cognitive, and behavioral referents in women, sexual desire is now a construct undergoing reconsideration as a simple motivational state with clear goals (Meana, 2010). Furthermore, the difficulty reported by both men and women in differentiating desire from subjective or even physiological arousal has raised concerns about the utility of distinguishing between the two (Brotto, Heiman, & Tolman, 2009; Graham, Sanders, Milhausen, & McBride, 2004; Janssen, McBride, Yarber, Hill, & Butler, 2008). Even when a clear demarcation can be made between desire and arousal, such as that proposed by Meston, Stanton, and Althof in Chapter 2, their temporal sequence in the triphasic model of the sexual response is now in doubt. Clinical case reports and empirical data emanating from research on the incentive model of the sexual response suggest that arousal may often precede desire (Basson, 2007; Carvalheira, Brotto, & Leal, 2010; Goldhammer & McCabe, 2011). Whether this rearrangement of the sequence is warranted or simply further evidence that desire and arousal are hard to tease apart remains a question.

The third phase of the triphasic sexual response, orgasm, appears to be a little sturdier, although attempts to define this construct have failed to reach consensus (Mah & Binik, 2001; Levin, 2004). When this failure is coupled with the minimal empirical research on orgasm, the perception of sturdiness may be illusory. Survey data convey the rather depressing news that the "orgasm gap" continues to exist, with women, in comparison to their male partners, experiencing less frequent and reliable orgasms (Armstrong, England, & Fogarty, 2012; Garcia, Lloyd, Wallen, & Fisher, 2014). Meanwhile the debate is still ongoing about what constitutes a reasonable or "functional" time frame for the expected male orgasm, with indications that this

physiological process is affected considerably by cultural factors (Nicolosi et al., 2004). The sexual pain disorders have posed the most challenging conceptual problem. They have underlined the difficulty in establishing how we define a sexual dysfunction in the first place. The research of the past 25 years has effectively demonstrated that, in most cases, dyspareunia constitutes a pain disorder whose connection with sexuality is mostly incidental (Binik, Meana, Berkley, & Khalifé, 1999). The hyperalgesic genital area happens to interfere with sexual intercourse. This interference can undoubtedly result in myriad sexual and relational difficulties, but there are few data to suggest that its origins are psychosexual. The question then becomes: Why is dyspareunia considered a sexual dysfunction instead of a pain disorder that happens to interfere with sexual function, as undoubtedly many other pain disorders do (Binik et al., 1999)? This raises an even broader question as to what the sexual dysfunctions share, other than their nonunique interference with sexual activity and the experience of pleasure therein. After all, what does premature ejaculation (PE) really share with dyspareunia other than an interference with sexual activity and pleasure? Couldn't this interference with sex also be claimed by headaches and lower back pain, which are not categorized as sexual dysfunctions? Anxiety (about sex, sexual performance, and/or intimacy), once thought to be the common denominator of sexual dysfunction, has given way to a biopsychosocial model that postulates multiple contributing factors, many of them unique to each dysfunction.

## Diagnostic Dilemmas

Despite these questions and concerns about the triphasic model of human sexual responding upon which the traditional diagnostic nosologies rest, the North American categorization of the sexual dysfunctions has not remarkably changed. The DSM-5 (American Psychiatric Association, 2013) work group essentially tinkered with existing diagnoses to create a greater differentiation in sexual desire disorders between men and women, while collapsing across dysfunctions for which differentiation has been problematic (hypoactive sexual desire disorder [HSDD] and female sexual arousal disorder into sexual interest/arousal disorder in women [FSIAD]; dyspareunia and vaginismus into genito-pelvic pain/penetration disorder [GPPPD]). Whether the gender differentiation or dysfunction collapsing is an effective clinical response to the complexity of the sexual experience only research and field trials will tell. Some have argued that complexity calls for more rather than fewer distinctions (Derogatis, Clayton, Rosen, Sand, & Pyke, 2011). Sexual aversion is a case in point where the behavioral manifestation of avoidance belies the underlying issue of disgust, an emotional response not well accounted for in the diagnostic criteria of the other sexual dysfunctions. Lack of research into sexual aversion resulted in it being collapsed into the category of GPPPD or understood as a phobia. Yet many, such as Borg, Both, ter Kuile, and de Jong

in Chapter 10, feel that the clinical presentation of sexual aversion requires a separate diagnosis. So, too, are clinicians concerned about the loss of a separate diagnostic category for lifelong vaginismus, arguing that its clinical presentation and unique treatment requirements deserve a unique diagnosis (see Ter Kuile & Reissing, Chapter 9).

We are aware that while changes were made to the diagnostic criteria for many, if not all, of the sexual dysfunctions, the DSM-5 made more substantive changes to the diagnostic classification involving female sexual dysfunction. This may be related to pharmaceutical industry interest in finding a medication to treat low desire in women, which in turn stimulated research on female sexuality. It is rather paradoxical that in the search for a cure for female HSDD, the diagnosis itself disappeared.

ICD-11 (World Health Organization, 2018), in a rare departure, now differs from DSM-5 in terms of the classification of sexual problems. Sexual dysfunctions, including the sexual pain disorders and gender incongruence, are represented in a new chapter entitled "Conditions Related to Sexual Health." According to the World Association for Sexual Health (2018), "the proposed new classification bridges the mind/body divide, which has long been a prominent feature of medical care related to sexual dysfunction" (para. 1). They argue that removing sexual dysfunctions from the mental and behavioral disorders sections "allows practitioners to address these issues more holistically, in a less stigmatizing and less myopic way" (para. 1). Some have worried that this change will lead to greater medicalization of sexual dysfunctions (Parameshwaran & Chandra, 2018). Nevertheless, the World Health Organization (2019a, para. 1) in the release notes for ICD-11 has reaffirmed its commitment to a biopsychosocial model of sexuality, clearly stating: "Sexual response is a complex interaction of psychological, interpersonal, social, cultural and physiological processes and one or more of these factors may affect any stage of the sexual response." Sex therapists have been rather subdued in their response to this change, which entailed removing sexual dysfunctions from the chapter on mental, behavioral, or neurodevelopmental disorders, which is the chapter that encompasses most other psychological and psychiatric conditions, including mood disorders, anxiety conditions, and paraphilias. The subdued response may reflect indifference or an acceptance that the sexual dysfunctions are indeed fundamentally different from other anxiety-related conditions. Whether this change will result in the marginalization of psychological-based interventions as some fear, or whether it will remove the stigma of sexual dysfunction and allow more people to access help, as others hope, remains to be seen. Gender incongruence has also moved to the chapter on sexual health, with the notation that it is not considered a disorder in and of itself, but rather a condition that may require intervention.

ICD-11, unlike DSM-5, continues to have two separate diagnostic categories for female HSDD and female sexual arousal disorder. The background to this decision is recounted by Meston et al. in Chapter 2 and is related to the influence of sexual medicine on the ICD-11 workgroup. The sexual

disorders working group for DSM-5, on the other hand, comprised primarily psychologists who specialize in sex research and sex therapy. Guidelines that were put in place to reduce financial conflicts of interest (real or perceived) for which DSM-IV had been criticized (Cosgrove & Krimsky, 2012) effectively prevented sexual medicine professionals from being a part of this group. When psychologists study and treat female sexual problems, and when women report on these issues, it may well be that their experience is one best represented and addressed by FSIAD, which, according to DSM-5, is not simply the combination of arousal and desire states but a more nuanced representation of women's experience of the early stages of sexual pleasure. However, ICD-11 has continued the separation of desire and arousal disorders, maintaining as well the adherence to the triphasic model of sexual responding and the parity with men's sexual dysfunction. The treatment implications of these diagnoses differ. While the U.S. Food and Drug Administration (FDA) has now approved two medications for the treatment of female HSDD, psychologists and sex therapists are excited about the potential for mindfulness-based treatments for FSIAD. If we cannot agree on diagnoses, then our treatment may be likewise fragmented.

## Encompassing Multidimensionality and Diversity

Perhaps some dissent regarding the diagnoses of sexual dysfunctions attached to the triphasic model of sexual response is long overdue. The idea of an archetypal sexual response that crosses individual, gender, age, sexual orientation, relationship longevity, health/ability status, or cultural boundaries has definitely come under siege in the past decade. The aforementioned proposition that men and women may have differing sexual responses has been a catalyst for the consideration of diversity beyond gender. Even within gender, individuals speak of significantly different experiences and endorse different models of the sexual response as reflective of their experience (Connaughton, McCabe, & Karantzas, 2016; Ferenidou, Kirana, Fokas, Hatzichristou, & Athanasiadis, 2016). The ages of individuals and of their relationships may be central to the "morphology" of their sexual response. This may also hold true for individuals who identify as having a kink orientation, or who are polyamorous, although these groups are understudied and underrepresented in most mainstream sex research. Although this type of diversity is probably endemic to many psychophysiological phenomena, the simplicity that had been attributed to the sexual response probably delayed what should have been relatively obvious considerations of its diversity across individuals and groups.

Cultural diversity has been difficult to address, as there are precious few cross-cultural data or even data from different ethnic groups within the cultural landscape of North America. The few studies we do have are plagued by a Western-centric focus. This is certainly true of surveys asking and finding that Western-defined sexual dysfunctions exist elsewhere in the world. However, the importance placed on these dysfunctions varies. In many parts

of the world, sexual dysfunctions that interfere with reproduction are deemed worthy of treatment, whereas dysfunctions that interfere with pleasure, especially for women, are not universally considered problematic (Hall, 2019). Although not cross-cultural in the comparative sense, the growing number of studies on sexuality and sexual dysfunction from various countries across the world is beginning to fill the knowledge gap and is contributing to a growing consciousness in sex therapy of the potential diversity of sexual response and expression. The search for one model that captures the experience of all individuals seems less of a concern and maybe even a dubious endeavor.

In direct response to this complexity, the DSM-5 Work Group on Sexual Dysfunctions has removed the overly simplistic and often categorical etiological specifiers in DSM-IV and DSM-IV-TR (American Psychiatric Association, 1994, 2000; i.e., due to psychological or combined factors). Instead, the descriptive text emphasizes contextual factors (e.g., culture, relationships, stressors) for all dysfunctions. The consideration of individual vulnerability, relationship, medical, and sociocultural and religious mediators is a testament to the growing, though dispersed, body of research indicating that sexuality is heavily influenced by multiple contextual factors (e.g., Bancroft, 2009). It also acknowledges the difficulty (and possible futility) in distinguishing between psychological and physical etiological factors in a literature that has found single-cause pathways elusive.

ICD-11 likewise highlights the importance of cultural and psychosocial factors in the diagnosis of sexual dysfunction. One of the etiological specifiers is cultural factors: "This category should be assigned when, in the clinician's judgment, cultural factors are important contributing factors to the sexual dysfunction or sexual pain disorder. Cultural factors may influence expectations or provoke inhibitions about the experience of sexual pleasure or other aspects of sexual activity. Other examples include strong culturally shared beliefs about sexual expression, for example a belief that loss of semen can lead to weakness, disease or death" (World Health Organization, 2019b, para. 1).

The descriptive text in both classification systems that mentions contextual factors appears to be little more than a reminder to clinicians to consider the multiple forces potentially acting on or affected by the sexual difficulty. The assessment of cultural influence may be awaiting sex research to provide direction regarding the factors of importance to consider in the diagnosis of sexual dysfunction. Clinicians may be awaiting guidance on how to assess and develop treatment plans once we have left the relative safety of the universal sexual response.

## Treatment Implications

The multidimensionality of sexuality necessarily calls for assessment and treatment strategies that can account for all the potential dimensions at play when an individual encounters sexual difficulties. The data now shows that

sex therapy adds demonstrable value to the treatment of many sexual problems, even when the first line of treatment is medical (e.g., Cormio et al., 2015). As many of the chapters in this book attest, the collaboration between sexual medicine specialists and sex therapists appears to be more firmly rooted than ever before in the consensus that a combined treatment approach is superior to most interventions in isolation.

So it appears that sex therapists and sexual medicine specialists are not such strange bedfellows after all. It is hard to know how the numbers compare with those of the pre-sexual medicine era, but it is quite possible that the popularization of medical treatment for sexual dysfunction has mitigated what otherwise may have been a reduction in the number of clients who sought sex therapy for lack of any other choice.

If nothing else, the rise of sexual medicine has accelerated the movement of sex therapy toward interdisciplinarity, and this is a roundly positive development from a patient care perspective. The expansion of treatment options puts appropriate pressure on the sex therapy enterprise to demonstrate effectiveness, and on sex therapists to expand their knowledge base, so that they can collaborate with other health professionals.

As the preceding chapters have shown, combination treatments for erectile dysfunction (ED) and PE are state of the art. The treatment for the sexual pain disorders now calls for the involvement of physical therapists, as well as gynecologists and, possibly, dermatologists. Curiously, these interdisciplinary approaches are still relatively new to the treatment of sexual problems. Sex therapy has lagged well behind the treatment of other psychological difficulties (e.g., depression, anxiety), which have involved combination therapy for decades (Althof & Rosen, 2010). The delay may be in part explained by the faux simplicity of early models of the sexual response or, alternatively, by the historic reticence of nonpsychological fields to consider sexual function as an integral part of health. Regardless, all relevant disciplines are relatively new to the interdisciplinary treatment of sexual problems, and there is much to learn about how to do it well. The most important guideline may be that the multiple disciplines coming to bear on a problem do so concurrently. The theory behind combination therapy posits that the best outcome is likely to occur when treatments are concurrently rather than sequentially administered, allowing for a positive interaction of the different strategies. For example, the phosphodiesterase type 5 inhibitors (PDE5Is) may provide the physical trigger that encourages the client to entertain and address, through sex therapy, the psychological and relationship factors that in turn facilitate or even make possible the erectile function. Without the PDE5I-facilitated erection, the client might have had little patience for what felt like indirect psychological and couple interventions. Without the psychological and couple work, the erection may have been beside the point, even if attained. Such an approach is best described as "interdisciplinary," rather than "multidisciplinary," as it concurrently capitalizes on the contributions of multiple disciplines. One of the burdens of interdisciplinarity is the expansion of our knowledge base to

include a working, if not in-depth, familiarity with the expertise of our health care co-providers, and vice versa. Another is the investment of time needed to coordinate and integrate client care. These are not insignificant concerns, and they require a commitment to the interdisciplinary model and a willingness to share in both the success and the failure of our outcomes. Theory and research, however, increasingly point to interdisciplinary treatment of sexual problems as the appropriate and expected standard of care. This interdisciplinary spirit is evident in the professional conferences of many sex research, therapy, and medicine organizations in which the exchange of knowledge across disciplines is happening.

## Access to and Cost of Interdisciplinary Treatment

Perhaps the biggest threats to the transition that sex therapy is attempting to make into interdisciplinarity are cost and access to services. Teams of health care providers specializing in the treatment of sexual problems are likely to be mostly confined to large urban centers. Even within these, sex therapists are not very numerous. This makes it likely that the interdisciplinary approach will remain an ideal outside of the reach of many clients. Furthermore, in countries in which both medical care and sex therapy are costly, the majority of individuals may not be able to afford the kind of interdisciplinary treatment we believe to be optimal.

Although at first glance it may seem as if this problem is outside the power of sex therapy to address, the Internet may provide partial solutions to the problems of access and cost. It was clear over 30 years ago that technology (Binik, Meana, & Sand, 1994; Binik, Servan-Schreiber, Freiwald, & Hall, 1988) could provide help where services were either not available or where there were other barriers to accessing treatment. Research into interactive Internet-delivered sex therapy is growing and shows promising results (Hummel et al., 2018). Over half of the 705 New York City–based therapists who list sex therapy as a specialty on the popular Web platform *Psychology Today* also provide this service online. This will undoubtedly help provide access to sex therapy for people in more remote locations. There are, for comparison, only 16 sex therapists listed in all of Alaska (according to the *Psychology Today* web platform). There are likely other types of applications yet to be investigated that may be able to fill some of the holes in the interdisciplinary net. For example, in addition to providing direct service, sex therapists or sexual medicine specialists may also provide consultation to each other where access to their expertise would otherwise not be available. This will require that sex therapists and their collaborators collectively think about ways to deliver services that at first may appear unusual or even counterintuitive. Innovation in health care delivery is a concern across health areas (Hwang & Christensen, 2008). It is a speeding train that sex therapy cannot afford to miss.

## The End of Isolation?

The clinical isolationism that once defined sex therapy in the larger landscape of psychotherapy appears to be over. Mindfulness meditation, eye movement desensitization and reprocessing (EMDR), and various cognitive-behavioral therapy (CBT) strategies continue to be incorporated into sex therapy. Emotionally focused therapy, narrative therapy, and existential therapy are also being adapted by sex therapists to treat sexual problems. Sex therapy is no longer just for dysfunction, but is increasingly directed toward treating the sexual ramifications of infidelity, disability, illness, and trauma. Sex therapy is an appealing approach for sexual minority groups who may feel misunderstood and disenfranchised by mainstream psychotherapy, which historically and mistakenly identified their sexual differences as the cause of their unrelated psychological complaints. Sex therapists, correctly or not, are often identified as therapists who will know about sex and therefore understand and respect sexual differences.

While sex therapy has incorporated many mainstream psychotherapy interventions, the reverse does not appear to be true. There is still a glaring lack of graduate coursework in psychology devoted to understanding human sexuality and its importance in people's lives. Academic journals devoted to clinical mental health and psychotherapy rarely include articles on sex therapy. This may reflect the specialty status of sex therapy or the marginalized status of our profession within the larger psychotherapy field. So while we may laud sex therapy for incorporating treatment techniques and strategies from other psychotherapeutic modalities, we need to be aware that perhaps we are still behind the curve and playing a rather tedious game of catch-up. For example, the movement to adapt cognitive-behavioral interventions cross-culturally has resulted in the development of empirically validated and effective treatment approaches for a variety of psychological disorders (Zane, Bernal, & Leong, 2016). Before we continue to export sexual medicine and sex therapy around the world, we should perhaps look at how it has been effectively done by others.

## Reconceptualizing Treatment Outcome Variables

A research and theoretical literature questioning definitions of sexual function and dysfunction and its constructs, their generalizability, and the extent to which they are sociopolitically determined is inevitably going to raise questions about appropriate treatment outcome variables. If we are not sure what the sexual problem is or whether there is even a sexual problem, it can be questionable to speak categorically about solutions. Some cases are clear: A woman presents with dyspareunia or a man presents with PE, and both are incapable of having desired intercourse. A reduction in her pain or its resolution and the extension of his ejaculation latency would be evidently reasonable

goals. Other instances are trickier. Is the goal of sex therapy to increase a woman's supposed low desire? Why not decrease her husband's higher desire?

The point here is that in cases of either clear dysfunction (e.g., pain) or questionable dysfunction (e.g., desire discrepancy), sometimes we do succeed in improving "function," and sometimes we do not, because improvement is outside the reach of available treatments (e.g., some cases of provoked vestibulodynia; normal differences in sexual drive). What we can always target, however, is the individual's and couple's level of adjustment to circumstances and the ways in which they process their problem and their relationship dynamics.

On some level, the ultimate goal of sex therapy is increasing sexual satisfaction. Although sexual satisfaction and sexual function are positively correlated, we have known for years that, at least with women, the association is less than hardy (Ferenidou et al., 2008). Rosen and Bachmann (2008) went so far as to deemphasize function in a conceptual paradigm that focused on the relationship of sexual satisfaction to overall health and happiness. Psychological well-being, relationship adjustment, intimacy, and partner responsiveness are strong predictors of sexual satisfaction over and above sexual function (Gadassi et al., 2016; Pascoal, Narciso, & Pereira, 2013).

The current focus on sexual satisfaction is also emerging in discussions about eroticism and the meanings attached to sexuality on the part of both researchers and clinicians. The work of Kleinplatz and colleagues (2018) on "optimal sexuality" is decidedly free of references to "function," and their respondents describing great sex are more likely to speak of "transcendence" than lubrication. Sexual function may even be a problem, as Kleinplatz (2006, p. 345) proclaims, "Nothing kills desire more than doing what works—relentlessly." Leonore Tiefer (2009) bemoans our abandonment of the art of sex for its mechanics. Esther Perel (2006) privileges eroticism over function when discussing the sexual problems of long-term relationships with floundering sex lives. It is noteworthy that the eroticism that these authors allude to was actually present in early sex therapy interventions, such as sensate focus, which sought to deemphasize function and focus on sensuality. Perhaps we have come full circle, or perhaps those early interventions inadvertently stifled eroticism with their directives and homework exercises.

In some ways, the idea of a universal sexual response contributed to the notion that there is one "normal" or "healthy" way to have sex. A focus on improving "function" as defined by the triphasic model may have inadvertently messaged many nonconforming individuals that they were psychologically abnormal, deviant, or dysfunctional. Both DSM-5 and ICD-11 have adjusted their diagnostic criteria for paraphilic disorder to limit the diagnosis to nonconsensual activities or severe distress. Many sexual behaviors once considered paraphilias (e.g., BDSM) do not meet that criterion by virtue of their popularity (Herbenick et al., 2017; Holvoet et al., 2017). The growing acceptance of polyamory (Rubel & Burleigh, 2020) likewise highlights the continuing influence of societal mores on the diagnostic process. Treatment of unusual or paraphilic activities is no longer focused on suppressing expression

of the sexual interest, but rather on acceptance and incorporating the sexual interest into a more pleasurable or erotic experience.

## Lack of Sex Therapy Outcome Research

As most of the chapters in this volume attest, there is a troubling lack of sex therapy outcome research. A review of the randomized controlled trials of the past 20 years reveals an impressive number of studies investigating the impact of pharmacological agents on sexual function, a much smaller number comparing pharmacological or other nonpsychological interventions with sex therapy, and a handful focusing exclusively on some version of sex therapy or combination therapies. The current reasons for this are relatively clear. Pharmacological interventions are far easier to administer and likely to be funded by an industry interested in promoting the use of its products. In contrast, there is no organized profit motive for sex therapy research. Nonindustry funding for sexuality research continues to be minimal. It is simply not a priority area for governmental funding (at least in the United States). This, however, does not explain why, in the heyday of sex therapy and ample U.S. federal funding, such research was not carried out. Perhaps sex therapists believed their own rhetoric about simple and easy cures. On the other hand, there does appear to be significant and recent therapy outcome research mostly outside the United States. This started and continues with studies on the sexual pain disorders (e.g., van Lankveld et al., 2006; Masheb, Kerns, Lozano, Minkin, & Richman, 2009; Bergeron et al., 2001; ter Kuile et al., 2009; Brotto et al., 2019) and to a lesser extent includes other dysfunctions such as sexual desire (Frühauf, Gerger, Schmidt, Munder, & Barth, 2013) and PE (De Carufel & Trudel, 2006). Nevertheless, if sex therapy continues to claim success in treating sexual dysfunctions, it will need to provide evidence of that ability, especially in light of the involved and evolved nature of current sexual complaints.

The intricacy of psychological interventions for sexual problems may, however, also pose a significant challenge to the identification of effective interventions. Generally, sex therapy includes cognitive reframing, emotional regulation, stimulus control techniques, and relationship skills building. Researchers interested in isolating active ingredients are hard-pressed to parse these treatments, and replication invariably requires manualization. However, these challenges are no different from those encountered by treatment outcome researchers for any number of psychological disturbances.

Importantly, the proliferation of pharmacological studies has had some benefits outside of the testing of its agents. It has spawned the development and standardization of numerous self-administered measures that are now widely used both in research and clinical practice. Outcomes in these studies have also been expanded from mere function to satisfaction and well-being. All of this speaks well about the impact of sex therapists on the development

and investigation of pharmacological agents, but is it enough? Sex therapy is likely to remain on the sidelines if it does not reenter the randomized clinical outcome study arena.

It is possible that, even without outcome data, sex therapy will survive as long as people continue to seek help in figuring out their sexual problems and dilemmas, as long as people find it gratifying and useful to consult with smart, caring people about issues they cannot share with anyone else. In terms of psychotherapy, surveys show that client satisfaction with general psychotherapy often outstrips its demonstrated efficacy in symptom reduction (Lunnen, Ogles, & Pappas, 2008). If this is also true of sex therapy, it may reflect a failure of outcome research to effectively measure psychotherapeutic change or adequately measure sexual satisfaction over and above sexual performance. This is potentially easy to remedy given the development of several psychometrically sound inventories to measure sexual satisfaction (Byers, 2005; Meston & Trapnell, 2005; Štulhofer, Buško, & Brouillard, 2010). There is a movement in psychotherapy outcome research to evaluate how extensively a patient feels changed after therapy (Sandell & Wilczek, 2016). This could also be a promising outcome measure for sex therapy research.

## Conclusions

So we return to the question posed in title of this chapter: Where is sex therapy going? Perhaps the more important question is: Are we making progress? A perpetual state of agitated, outward-reaching transition may be exactly where we need to be to ensure that we do not recede into the shadows of insularity and marginalization.

We have bemoaned sex therapy's claim to specialization and have wondered whether this turf entrenchment has resulted in less rather than more progress. Sexuality is barely covered in general psychology graduate programs and it has all but disappeared from medical training (Miller & Byers, 2010). These are not heartening developments. If sex therapy has overstated its claim to specialization, then this may have inhibited general psychologists from engaging in the treatment of sexual problems, which may be more prevalent than depression or anxiety.

The certification of sex therapists may also be working against the principles of interdisciplinarity. Most licensing for the health professions is general in nature and occurs at the state and provincial levels. Individual practitioners can then decide to claim areas of particular competence based on their training and experience. We do not *certify* individuals as being depression or anxiety specialists, as the treatment of these disorders is expected of the general mental health practitioner. Considering that most sexual dysfunctions may be at least as prevalent as depression or anxiety disorders, it is hard to rationalize special certification for the treatment of sexual difficulties, except for the important fact that, unlike the mood disorders, training in sexuality

and sexual disorders is lacking in the education of general psychotherapists. However, the insistence on certification is likely to dissuade many other health care providers from assisting their clients with sexual problems, when, in fact, the treatment of sexual problems draws liberally from the arsenal of general psychotherapy interventions (Binik & Meana, 2009). These attempts at formalizing specialization, although possibly driven by concerns over quality control, may in the end only serve to marginalize sex therapy and restrict the help available to clients.

Wherever we are going as a discipline, it is clear that we should not be going it alone. Perhaps sex therapy stands out as the ultimate integrative and interdisciplinary psychological intervention with tendrils into more disciplines than other mental health areas. With physical therapy, urology, gynecology, dermatology, and endocrinology as common collaborators, sex therapy could position itself at the vanguard of interdisciplinary treatment. It has yet to do so. The ongoing failure to properly articulate what sex therapy does and how it does it could result in a true marginalization of a practice with much to offer for very mainstream problems.

Wherever we are going, we need to start sooner: educating and training mental health professionals in the early stages of their graduate and postgraduate studies about the treatment of sexual problems.

Wherever we are going, we are definitely not *there* yet. But on our journey, we may be a bit more humbled by the knowledge that we need the expertise of others and that the treatment of sexual dysfunctions is no different from the treatment of any disorder with a DSM diagnostic category. It involves whole individuals with complex lives and histories, and it targets perhaps the most socioculturally loaded of human experiences: sexuality. May the state of transition never ease up. May we always keep moving.

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