MAINTAINING OUR SEXUAL DESIRES DESPITE DIFFICULTIES: A WORKSHOP FOR COUPLES EXPERIENCING SEXUAL DYSFUNCTION

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By

Sepanta Fotovat

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The graduate project of Sepanta Fotovat is approved:

Martha Carr, Psy.D., LMFT

Date

Scott M. Williams, Ph.D.

Date

Stan Charnofsky, Ed.D., Chair

Date

California State University Northridge
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I would like to dedicate this project to my mother, Pooran. Without her constant support and encouragement, I probably would not be graduating with my Master's degree. My motivation for success in the future and my driving force to pursue higher education is all thanks to her. Her stories of her own educational journey and her dreams of wanting to go back to school was a real inspiration to me in that I wanted to accomplish that dream. As an individual of the Persian community, it is a stereotype to only pursue careers in law, medicine, and engineering. My mother has supported my dreams of becoming a therapist from day one and has never tried to steer me away from my passion to pursue anything else. Thank you, Mom, for making my education a priority, but most of all, for being the best mom anybody could ever ask for. This is for you! I love you.
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ABSTRACT

MAINTAINING OUR SEXUAL DESIRES DESPITE DIFFICULTIES: A WORKSHOP FOR COUPLES EXPERIENCING SEXUAL DYSFUNCTION

BY

Sepanta Fotovat

Master of Science in Counseling

Marriage and Family Therapy

It appears that sexual dysfunction among men and women is becoming more common nowadays than ever before, but it has also become an issue that can be uncomfortable to discuss. Not only are individuals of all ages susceptible to sexual dysfunction, but there is a wide array of contributing factors including medical conditions and childhood abuse. The purpose of this project is to identify various sexual dysfunctions apparent in men and women and give clients an educational overview of symptoms and tips prior to entering psychotherapy. This project is intended for clients in a heterosexual relationship who are exhibiting one or more sexual dysfunctions.
CHAPTER ONE

Introduction

Background

The treatment of sexual dysfunction has been dated back to the days of Muslim physicians in the Islamic world (“News Medical,” n.d.). These physicians and pharmacists were the first individuals to address the issue of sexual dysfunction. Long before the introduction of Sildenafil citrate (i.e., Viagra) in 1998, Muslim physicians resorted to a method of oral drug therapy in addition to either food or a secondary oral drug to deal with a variety of sexual problems. Most patients suffering from sexual dysfunction during these times were treated with the oral method, however, some patients were also treated via transurethral means (“News Medical,” n.d.).

A modern day re-examination of sexual dysfunction did not emerge again until the 1970s when Masters and Johnson's "Human Sexual Inadequacy" was published. This book was published in an attempt to shift the mindset of sexual dysfunction from being something pathological to being an issue that can be learned about and dealt with using the appropriate interventions (“News Medical,” n.d.). The idea of psychopathology associated with sexual difficulties, however, continued to remain in cases where the sexual issue was not able to be resolved following the use of educational treatment sessions (“News Medical,” n.d.).

Masters and Johnson viewed sex as a joint act between two people and therefore believed that treatment should involve both parties. They also believed that the underlying issue behind sexual difficulties was the sexual communication between partners and proposed that co-therapy would benefit struggling couples the most because they felt that a sole female therapist would not fully understand male issues and vice versa (“News Medical,” n.d.). Improvement of sexual
communication between partners was Masters and Johnson's main goal of their treatment plan, which consisted of sensate focus exercises to create more shared experiences. Through these experiences, sexual difficulties can be more easily explored and can be paired with the appropriate therapeutic approach ("News Medical," n.d.). Masters and Johnson saw sexual arousal and climax as a natural physiological response that can be accomplished assuming one is a healthy functioning adult and defined "dysfunction" as a transitory experience that affects the majority of people. Despite the automatic nature of the body to experience arousal and climax, there was still an awareness of the possibility that these experiences could be inhibited.

According to Simon (2011), women who have undergone menopause are twice as likely to have a sexual dysfunction than their premenopausal counterparts. This is not to say that premenopausal women are not at risk for a sexual dysfunction. In addition, the presence of sexual dysfunction in men increases with age, though age alone is not the sole determining factor (McVary, 2007).

**Purpose of the Project**

With this project the author hopes to help couples 1) identify the sexual dysfunction apparent in one or both partners, 2) provide possible solutions to assist in the dysfunction, and 3) provide additional strategies on how to cope with the dysfunction. This project is not intended to be a successful tool for every struggling couple, as every couple copes with dysfunction in various ways and many are reluctant to seek professional help. It is to serve as a means of psychoeducation for couples to ease their nerves about seeking a sex therapist.

**Limitations**

This project does not include same-sex or transgender couples struggling with sexual dysfunction, as it is difficult to obtain research on the topic, however, if same-sex or transgender
couples should seek out counseling for a sexual dysfunction, it is the therapist's ethical responsibility to be aware of countertransference feelings regarding these issues. In the case of a therapist not being able to perform his or her duties to help the same-sex couple, he or she should refer the couple to another therapist who may be a better fit (Bughra & Wright, 1995). In addition, this project does not discuss diagnostic criteria or treatment options for individuals who obtain sexual gratification by means of paraphilias (e.g., exhibitionism, fetishism, frotteurism, various forms of BDSM, etc.). Lastly, this project does not address the issue of "sexual addiction" as it is a controversial subject and no clinically correct term has been created to refer to this condition and the degree to which one may refer to themselves as an "addict" varies by client (Hall, 2011).

**Definitions of Terms**

Anorgasmia - the inability to or lack of orgasm

BDSM - acronym for Bondage, Discipline, Sadism, Masochism; used to describe individuals who obtain sexual gratification by means of administering or receiving pain

Dyspareunia - the feeling of pain during intercourse

Erectile dysfunction - the inability to attain and/or maintain an erection suitable enough for intercourse

Estrogen replacement therapy - a remedy used to help pre- and postmenopausal women increase vaginal lubrication, maturation, reduce pain associated with sexual intercourse, and increase sexual desire

Exhibitionism - an individual who reveals his or her genitalia to an unwilling observer

Fetishism - an individual who obtains sexual gratification by means of an inanimate object (e.g., foot fetish)
Frotteurism - the act of obtaining sexual gratification by means of rubbing onto or touching another person without their consent and is usually done in a public place

Hypoactive Sexual Desire Disorder (HSDD) - a diagnosis in which an individual can still respond sexually to his/her partner’s demands, but lacks an overall desire to engage in any kind of sexual activity

Hysterectomy - the surgical removal of the uterus

Kegel exercises - an exercise in which women have the option to insert their finger into the vagina and contract the pelvic floor muscles as if holding back urine and gas; used to assist in orgasm and its intensity

Masturbation - the stimulation of one’s own genitals for sexual pleasure; can be performed manually or via sex toys (i.e., vibrator, dildo, etc.)

Menopause - the permanent discontinuation of monthly menstrual periods

Oophorectomy - the surgical removal of the ovaries

Orgasmic disorder - the inability to climax during sexual intercourse; lifelong or situational

Premature ejaculation - an ejaculation that occurs soon before or at the very start of intercourse

Sensate focus - a gradual step-by-step process involved in sex therapy to help improve performance anxiety; typically begins with non-genital pleasuring

Sexual arousal disorder - the inability to respond normally during sexual arousal (e.g., insufficient lubrication)

Sexual aversion disorder - an intense fear and disgust of sex; often associated with sexual abuse

Sexual desire disorder - a lack of desire for sexual activity over a prolonged period of time

Sexual dysfunction - a problem during one or more of the four phases of the sexual response cycle that prevents an individual and/or couple from enjoying the act of sex
Sexual pain disorder - a sexual dysfunction that involves a great deal of pain during the process of intercourse; more prevalent in women than men

Sildenafil citrate - also known as Viagra; a pill taken orally to assist in erectile functioning and maintain an erection long enough for satisfactory sexual intercourse

Squeeze technique - an exercise used to assist in premature ejaculation; involves self-stimulation of the penis to full erection just before ejaculation, and then squeezing below glans of the penis

Testosterone replacement therapy - a remedy used to help men have longer erections and increased sexual desire; can also be given to women exhibiting a lower than normal testosterone level

Vaginismus - a sexual pain disorder that involves an involuntary spasm of the muscles surrounding the vagina that cause it to close making penetration difficult, painful, or nearly impossible

Vibrator - a battery operated "sex toy" used to assist in self-stimulation of a woman's clitoris to facilitate orgasm

**Bridge**

The above terms will be used throughout this paper in more depth to provide a better understanding on the proper steps needed to be taken to treat sexual dysfunction. Chapter two will go into further detail as an extensive literature review discussing both female and male sexual dysfunctions along with DSM-IV-TR diagnostic criteria for each. Chapter three will act as an introduction to the workshop and what it entails, followed by chapter four which will address a summary and recommendations for further work with sexual dysfunctions. The layout for the workshop will be presented as a PowerPoint and will be provided in the Appendix.
CHAPTER TWO

Review of the Literature

Introduction

It has been stated that sexual dysfunction can significantly impact a man’s and a woman’s self-esteem, quality of life, and relationship satisfaction (Nappi et al., 2010). Currently, approximately 52% of men and 63% of women exhibit one or more sexual dysfunctions (Heiman, 2002). Aside from age, there are many contributing factors to sexual dysfunction. These can include (but are not limited to) medical problems such as cardiovascular disease, diabetes, and the consequences of smoking, a history of anxiety and/or depression, and emotional satisfaction with one’s intimate relationship (Heiman, 2002). Sarwer & Durlak (1997) conclude that after ruling out organic causes, the primary contributing and maintaining factor of dysfunction seems to be anxiety. Research is even indicating that one’s education levels and racial differences can impact sexual functioning (Laumann, Paik, & Rosen, 1999). According to Heiman (2002), a correlation has been found that the higher one’s education level is, the less likely that individual is to experience a sexual dysfunction. In addition, “though race and ethnicity effects [are] more modest, Hispanics [report] the least [sexual] dysfunction, followed by the White and then the Black samples, which [show] higher rates (Heiman, 2002).”

Sexual dysfunction is a common issue and is found in many individuals, yet research shows that it often goes unreported. McNab & Henry (2006) believe that possible reasons for delaying treatment of sexual dysfunction stems from feelings of guilt or shame. Stinson (2009) states a couple of reasons for the reluctance to report, including the idea that professional interventions will not help or that an individual’s sexual difficulty is not of concern to him or her. In general, the idea of sexuality has remained a controversial topic among health education.
Debates about how old or how young children should be before being introduced to sexuality, what specific topics are appropriate to be discussed, and whether or not it should even be introduced in the school setting continue to occur today. Underlying anxieties about sexuality exist and remain due to the socialization of our society deeming it to be wrong (McNab & Henry, 2006). According to Stinson (2009), out of 48% of women indicating sexual problems, 78% sought no professional help, 4% sought help from a psychologist, psychiatrist, or marriage and family therapist, and 18% sought help from a medical doctor.

Clients struggling to accept their sexual dysfunction need to know that there are ways to alleviate the emotional and physical stress associated with their condition. Sildenafil citrate (i.e., Viagra) was introduced to the market in 1998 to assist with erectile dysfunction in men and has been extremely successful over the years, however, an alternative form of Viagra for women has not yet been approved by the Food and Drug Administration (FDA) due to the complexity of female sexual response (Thielen, 2011). Research has shown that cognitive-behavioral therapy has been one of the most effective approaches to treat sexual dysfunction as it targets the psychological effects behind them, whereas Sildenafil citrate can only treat physiological responses (Heiman, 2002).

**Female Sexual Dysfunctions**

*Sexual Desire Disorders*

An individual who receives a diagnosis of a sexual desire disorder does not necessarily indicate that the individual is unresponsive to her partner’s sexual demands, but rather lacks an overall interest to partake in any kind of sexual activity. The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) further specifies this diagnosis as
Hypoactive Sexual Desire Disorder (HSDD) (Wincze & Carey, 1991). To qualify for a diagnosis of HSDD, one must display the following symptoms:

**Diagnostic criteria for 302.71 Hypoactive Sexual Desire Disorder**

A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify Type:*

- **Lifelong Type**
- **Acquired Type**

*Specify Type:*

- **Generalized Type**
- **Situational Type**

*Specify:

- **Due to Psychological Factors**
- **Due to Combined Factors** (American Psychiatric Association, 2000)

HSDD is considered to be one of the most common sexual dysfunctions among women and men in the United States. Unfortunately, however, due to “the lack of public education on sexual health, the myths surrounding sexuality, the lack of tools to accurately assess HSDD, and the lack of rigorous studies of the disorder, HSDD is considered the most difficult sexual
disorder to operationally define, evaluate, and treat” (McNab & Henry, 2006). Many individuals who receive a diagnosis of HSDD often reflect relationship issues (Crooks & Baur, 2011). Similar to Crooks & Baur’s (2011) statement of relationship issues being the underlying cause of HSDD, McNab & Henry (2006) also state that low sexual desire in women stems from their primary need for emotional intimacy rather than biological needs.

To assess the need for sexual satisfaction, Crooks & Baur (2011) provided a 25-item questionnaire with various statements using a Likert scale from 1-5 to indicate frequency. On a scale of 1-100, a score of 0-29 indicates that the couple is sexually satisfied, whereas a score of 30 or higher indicates sexual dissatisfaction. This activity will be further discussed in the Appendix. Another inventory used to assess HSDD is known as the Hurlbert Index of Low Sexual Desire (HISD) as proposed by Katz & Jardine (1999). The HISD inventory consists of 25 questions measuring libido and has been known to significantly correlate with “independent ratings of sexual activity, sexual desire, and subjective sexual arousal” (Katz & Jardine, 1999). Based on the undergraduate sample of 138 men and women ages 19-22, results for the HISD indicated that worry was involved in HSDD, however, it was not a strong enough relationship to conclude that HSDD is caused by worry.

HSDD, though difficult to treat, is treatable with the assistance of a sex therapist. A sex therapist can help a couple experiencing HSDD by practicing insight therapy in which the goal is to help an individual understand, become aware, and resolve any internal subconscious views one may have on sexual pleasuring and intimacy. This can include sensate focus exercises, encouraging self-stimulation, honest communication between partners, and improved skills on how to initiate sexual behavior as well as refuse undesired sexual activity (Crooks & Baur, 2011).
In addition to sensate focus exercises and open communication between partners, there are also medical remedies to assist in treating HSDD. Crooks & Baur (2011) suggest that the use of estrogen and testosterone replacement therapy in men and women is positively correlated with an increased interest in sexual activity, masturbation, arousal, and sexual satisfaction. Testosterone therapy, usually prescribed as a transdermal gel is available by prescription only and can be given to pre-menopausal with a below average testosterone level. Non-prescription methods to increase sex drive include various herbal treatments that promise longer erections and more satisfying orgasms. These remedies can be found in drug and grocery stores as well as the Internet and currently do not require approval by the Food and Drug Administration (FDA) (Crooks & Baur, 2011).

Sexual aversion disorder is a form of sexual desire disorder that results in a fear or disgust of sex. The DSM-IV-TR provides the following criteria to qualify for a diagnosis of sexual aversion disorder:

**Diagnostic criteria for 302.79 Sexual Aversion Disorder**

A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction).

*Specify Type:*

**Lifelong Type**

**Acquired Type**

*Specify Type:*
Situational Type

Generalized Type

Specify:

**Due to Psychological Factors**

**Due to Combined Factors** (APA, 2000)

In other words, sexual aversion disorder can be referred to as a sexual phobia that can result in a fear of contracting a sexually transmitted disease, a past traumatic sexual memory, or even anxiety of one’s performance (Katz & Jardine, 1999). Depending on the individual, this diagnosis can lead to irrational thought processes regarding sex. For these individuals, even the slightest thought of sexual contact causes intense physiological responses such as “sweating, increased heart rate, nausea, dizziness, trembling, or diarrhea” (Crooks & Baur, 2011). Katz & Jardine (1999) provided an assessment for sexual aversion disorder using the Sexual Aversion Scale (SAS) to 138 undergraduate men and women ages 19-22, which consisted of a 30-item standardized questionnaire. Their purpose in providing this questionnaire was to assess who would benefit from treatment for excessive sexual anxiety. Results indicated that sexual aversion disorder was primarily anxiety driven, which Katz & Jardine (1999) had originally hypothesized. Unfortunately, the exact prevalence of sexual aversion disorder is unknown, however, Brotto (2010) mentions that sexual aversion disorder is very likely to be conditioned. For example, it could be possible that sexual stimuli might have been paired with a traumatic sexual stimuli, thereby facilitating the aversive behavior.

A woman with sexual aversion disorder is highly recommended to seek psychotherapy to process any underlying feelings she may have regarding physical intimacy. Desensitization therapy and being able to comfortably talk about the trauma is crucial to the recovery process as
are relaxation exercises. In addition, it is important to remember that many women with sexual aversion disorder also display symptoms of panic disorder, therefore, medications such as antidepressants or tranquilizers can be used for treatment to control anxiety symptoms while talk therapy can be utilized to process feelings about sexual trauma ("All About Counseling", n.d.).

 Sexual Arousal Disorders

Female sexual arousal disorder is characterized a lack of responsiveness to sexual stimulation (Wincze & Carey, 1991). In other words, it can be classified as a persistent inability to maintain the lubrication-swelling response. This causes marked distress emotionally for women due to the fact that the first physiological response to sexual arousal is vaginal lubrication (Crooks & Baur, 2011). The DSM-IV-TR provides the following diagnostic criteria to qualify for a diagnosis of female sexual arousal disorder:

**Diagnostic criteria for 302.72 Female Sexual Arousal Disorder**

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify Type:*

  - **Lifelong Type**
  - **Acquired Type**

*Specify Type:*

  - **Generalized Type**
Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors (APA, 2000)

Stinson (2009) proposed a behavioral/cognitive-behavioral (BCB) intervention that is more useful for treating arousal disorders than desire disorders. BCB interventions involve changing the mindset of the client to reframe his or her pre-conceived negative thoughts about sexual activity into positive ones. Stinson’s (2009) intervention involved a sample of 18 women who complained of sexual difficulties prior to treatment. After 10 weeks of intensive cognitive behavioral treatment, more than half of the women reported treatment to be helpful in improving their sex lives. For female sexual arousal disorder, a key component to remember as far as treatment is to emphasize the emotional experience rather than the physical experience, which is why BCB is useful. Unfortunately, little research has been conducted as to the exact etiology of female sexual arousal disorder, however, based on the fact that many physiological responses rely primarily on our neurological systems, it is safe to say that impairments in this region can affect sexual arousal (Wincze & Carey, 1991).

Orgasmic Disorders

Formerly known as inhibited female orgasm, female orgasmic disorder is found to be rather common, with approximately 24% of women reporting this difficulty (Heiman, 2002). The DSM-IV-TR provides a formal diagnostic criteria for women to qualify for a diagnosis of female orgasmic disorder:
Diagnostic criteria for 302.73 Female Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify Type:

Lifelong Type

Acquired Type

Specify Type:

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors (APA, 2000)

Orgasmic disorders in women can either be lifelong, in which a woman has never experienced an orgasm by a partner or through masturbation, or situational, in which a woman can experience an orgasm through masturbation but not when stimulated by her partner (Crooks & Baur, 2011). Alternative names for lifelong and situational orgasmic disorders are primary and
secondary orgasmic disorders, derived by Masters and Johnson, and anorgasmia, which refers to the lack of orgasm (Wincze & Carey, 1991).

According to Crooks & Baur (2011), approximately 5-10% of adult women in the United States have never experienced an orgasm in their lifetime through partner stimulation or masturbation, however, the overall number of women who experience primary orgasmic disorder has significantly decreased since the 1960s. It has been stated that the decrease in this disorder may be partially due to the increase in self-help books and DVDs to educate women on ways to experience an orgasm, which were not available in the 1960s (Crooks & Baur, 2011). Although female orgasmic disorder can cause distress, it is important for women to be aware that experiencing an orgasm is something that can be learned. In addition, it is also important to remember that there are many women who believe that their inability to orgasm through means of penetration is a problem. Many sex therapists, however, seem to argue otherwise in that they believe that women who are able to enjoy intercourse and achieve an orgasm through masturbation, oral sex, or manual stimulation by their partner do not have a problem. For millions of women, an orgasm can be achieved through penetration with simultaneous clitoral stimulation (Crooks & Baur, 2011).

Fortunately, there are several options in which a woman can become orgasmic which involve the presence as well as the absence of her partner. Crooks & Baur (2011) suggest several self-stimulation exercises for women to do between therapy sessions to assist in her orgasmic ability. These are attempts to increase a woman's self-awareness for what might work for her and what feels pleasurable. For example, in the absence of her partner, a woman can take advantage of a vibrator as a form of masturbation. This form of masturbation can be quite beneficial for a woman because it is not as tiring as masturbation through manual stimulation. It is important for
a woman to explore her own body and try new ways to enhance her sexual pleasure. In addition to the use of a vibrator, performing Kegel exercises of the vaginal muscles can also help. During an orgasm, the pelvic floor muscles of the vagina contract involuntarily, however, Kegel exercises are a way to train those muscles to contract voluntarily, making orgasm for many women more pleasurable and intense. A step-by-step guide will be provided in the Appendix to educate women on how to perform Kegel exercises (Crooks & Baur, 2011).

It is important for a woman to be able to achieve orgasm on her own so that she can share with her partner about what types of stimulation she likes and what she does not like. The communication that is exchanged between partners during this process promotes closeness and emotional intimacy along with sexual enhancement. When a woman masturbates, she can do so in the presence of her partner so that he can see exactly how she touches herself to maximize her pleasure. This piece may be difficult for some women to do initially in front of her partner, however, Crooks & Baur (2011) suggest a woman to begin masturbating without her partner present and once she feels comfortable, he can come back in and both partners can then begin exploring each other’s genitals communicating to one another what form of pleasure and touching works best (Crooks & Baur, 2011).

*Sexual Pain Disorders*

Vaginismus is defined as an involuntary muscle spasm of the vagina upon penetration by the penis causing a great deal of discomfort in women and making it nearly impossible to engage in intercourse comfortably (Wincze & Carey, 1991). Most explanations for vaginismus include a history of painful intercourse, sexual trauma, a fear of intimacy, other relationship problems, and even homosexuality (Ward & Ogden, 2010). The DSM-IV-TR provides the formal diagnostic criteria for a diagnosis of vaginismus:
**Diagnostic criteria for 306.51 Vaginismus**

A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The disturbance is not better accounted for by another Axis I disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition.

Specify Type:

- **Lifelong Type**
- **Acquired type**

Specify Type:

- **Generalized Type**
- **Situational Type**

Specify:

- **Due to Psychological Factors**
- **Due to Combined Factors** (APA, 2000)

The involuntary muscle spasms associated with vaginismus can be examined during a pelvic exam to determine if the spasm is an issue that is stemming from the woman herself or if it has something to do with the couple. To overcome these muscle spasms, a woman must go through several steps of gradual progress involving insertion of a "foreign object" into her vagina. For example, Crooks & Baur (2011) suggest that a woman should explore her body to familiarize herself with it, take a warm bath, and engage in exterior genital stimulation to relax those muscles as much as possible. Once she has completed those initial steps, she can slowly
move from inserting a fingertip into her vagina, followed by one finger until she can insert 3 fingers into her vagina without experiencing any muscle spasms. Each stage of finger insertion can be simultaneously practiced with Kegel exercises so that her pelvic floor muscles can learn to contract voluntarily. Ward & Ogden (2010) even suggest that a woman use tampons instead of pads in an attempt to desensitize herself from penetrative sex. Dilators, although not as common, can also be used to facilitate relaxation of the vaginal muscles as they are cylindrical rods of varying sizes that can be inserted into the vagina.

After a woman has successfully completed the previous steps, she can then have her partner perform the same steps; first by inserting one fingertip, followed by one finger and so forth. If the woman is still not experiencing muscle contractions after her partner has inserted 3 fingers into her vagina, the transition continues by the man trying the exercise with his penis and the woman controlling the insertion. The man slowly inserts his penis without any pelvic movements or acts of pleasure so that the woman can become familiar with the feeling of her partner's penis. Pleasurable sensations and pelvic movements are only added later once both partners have successfully overcome the involuntary muscle spasms and once both partners have become comfortable with the penetration (Crooks & Baur, 2011).

In a study of 89 subjects ranging in age from 21 to 71 examined by Ward & Ogden (2010), two questionnaires were provided that included a series of statements that participants were to respond to on a scale from "strongly agree" to "strongly disagree" about their feelings of what caused them to develop vaginismus. Results indicated that most of the participants (approximately 74%) believed they had/have vaginismus because they fear pain, followed by approximately 53% being raised in an environment that enforced that engaging in sex is wrong, and finally, approximately 48% of participants believed they had/have vaginismus because of an
incident that occurred in their early childhood years. The results also showed that most participants experience a high level of guilt associated with this dysfunction. More specifically, about 90% of women felt guilty that they could not have a "normal" relationship with their partner in addition to almost 80% of women feeling helpless and angry with themselves (Ward & Ogden, 2010). The results of this study indicate that there is much guilt associated with vaginismus and that there are many possible causes, however, treatment is possible with patience among both partners and the willingness to communicate to one another.

Sexual dysfunction is a common problem in post-menopausal women. Simon (2011) discuss a longitudinal study of 197 Australian women ages 45-55 to assess overall sexual functioning. Results of this study indicated that upon menopause, there was a significant decrease in sexual response, a decrease in frequency of sexual activity, libido as well as an increase in relationship problems with a woman's partner and dyspareunia. Dyspareunia is more common in postmenopausal women, however, premenopausal women can also experience it.

The DSM-IV-TR provides the following diagnostic criteria for dyspareunia:

**Diagnostic criteria for 302.76 Dyspareunia**

A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify Type:*
Lifelong Type

Acquired Type

Specify Type:

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors (APA, 2000)

Estrogen plays a huge role in the sexual functioning of pre- and postmenopausal women. According to Simon (2011), estrogen is needed to facilitate regular blood flow to genital tissues in the vagina to prevent vaginal dryness as well as influence various neurotransmitter systems in the brain involving the amygdala, hypothalamus, and hippocampus which regulate a woman's sexual desire and mood. Because of the significant loss of the estrogen hormone, postmenopausal women are twice as likely than premenopausal women to experience one or more sexual dysfunctions (Simon, 2011). This loss can cause a postmenopausal woman to experience vaginal dryness, pain during intercourse, diminished sexual desire, and difficulty becoming aroused. It often times also leads to a loss of the elasticity and shortening of the vaginal wall causing more pain upon contact with the penis. Decreased uterine contractions also occur during climax, reducing the intensity of orgasm (Simon, 2011).

According to Crooks & Baur (2011), a nonprescription product known as Zestra (an oil applied to the vulva and clitoris) has been shown to increase a woman's sexual response. Simon (2011) recommend various remedies for women including vaginal moisturizers and lubricants, and continued sexual activity. Though estrogen therapy has been found to increase sexual desire
and enjoyment as well as improve vaginal maturation, there are also side effects of which can include breast tenderness, an increased risk of stroke, and an increased risk of developing breast cancer when used in addition to a progestin (Simon, 2011). Simon (2011) also state that there is no preferred method for estrogen therapy and that both oral and transdermal methods contain their own advantages and disadvantages. Vaginal estrogen therapy (administered via tablet, ring, or cream) are available in lower doses to reduce the risk of side effects. A chart with three different types of vaginal estrogen therapies including composition, trade name, and dosing per label will be provided in Appendix A.

**Male Sexual Dysfunctions**

*Sexual Arousal Disorders*

Swindle, Cameron, Lockhart, & Rosen (2004) define erectile dysfunction (ED) as “the persistent inability to achieve or maintain an erection sufficient enough for satisfactory sexual performance.” Based on the definition and concept alone, one can conclude that a man experiencing ED can have various shifts in mood, behavior, and can significantly impact his self-esteem. Physiological as well as psychological factors can influence the presence of ED in men. For example, some physiological factors that can contribute to ED include diabetes, depression, heart disease, and hypertension, while some of the psychological factors include anxiety, depression, and anger. As estrogen deficiency can affect the sexual functioning in women, men with testosterone deficiency can also be affected sexually. In addition, certain lifestyle patterns such as a lack of exercise or smoking can also be risk factors for ED (Swindle, Cameron, Lockhart, & Rosen, 2004). The DSM-IV-TR identifies specific criteria for a man to qualify for a diagnosis of ED:
Diagnosis criteria for 302.72 Male Erectile Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify Type:

   Lifelong Type
   
   Acquired Type
   
Specify Type:

   Generalized Type
   
   Situational Type

Specify:

   Due to Psychological Factors
   
   Due to Combined Factors (APA, 2000)

ED is an extremely common sexual dysfunction among men and the occurrence increases with age. For example, a man in his fifties is twice as likely to experience ED than a man in his twenties. In addition, a recent statistic shows that one in five men over the age of 20 is diagnosed with ED (Crooks & Baur, 2011). Previous attempts at addressing the issue of ED have included keeping a record of erection patterns during sleep, measuring penile blood flow to assess if the dysfunction is stemming from vascular impairment, and injections of medication.
Psychological factors associated with ED can be addressed in most forms of sex therapy, as the goal is to reduce and eliminate performance anxiety, a major cause of ED (Crooks & Baur, 2011). As with other sexual dysfunctions, couples can engage in several steps to work towards improvement and ultimately elimination of their dysfunction altogether. When a couple seeks professional help for ED, one of the first suggestions made by a therapist is to encourage sensate focus exercises through non-genital touching. The purpose of sensate focus exercises is not for the penis to become erect and ejaculate, but rather to simply enjoy the sensation of being touched. This is a form of cognitive-behavioral therapy that takes the anxiety away from feeling the need to climax at a specific time and place. Cognitive-behavioral therapy also helps when a couple moves from sensate focus exercises to genital stimulation exercises outside of intercourse to pleasure the man. For example, during oral stimulation, once the penis becomes fully erect, his partner should stop what she is doing and allow the erection to subside, allowing room for cuddling and other non-genital stimulation. Once the penis has returned to its pre-erect state, his partner can resume oral stimulation of the penis again. This intervention is used to ensure the man that once an erection subsides it is able to become erect again. Eventually, both partners can move on to intercourse with the man on his back and his partner lowering herself onto his penis with gentle pelvic movements to maintain the erection. Treatment for ED involves a sense of "selfishness" on the male in that the focus should be entirely on his pleasure. Should couples experience any problems during these steps, they are always free to go back a step and return to non-genital sensate focus exercises and other non-demanding pleasure exercises (Crooks & Baur, 2011).

Men who exhibit ED due to a physiological issue can also seek various forms of medical treatments. As estrogen deficiency can affect the sexual functioning in women, men with
testosterone deficiency can also be affected sexually. Seidman & Roose (2006) state that testosterone deficiency affects approximately 5% of men. In their double-blind randomized study of a sample of 30 depressed men over the age of 35 being injected with testosterone and a sample receiving a placebo, results showed levels in the upper/normal range thereby increasing sexual functioning (Seidman & Roose, 2006).

Among the most common are erection-enhancing pills known as Sildenafil citrate, more commonly known as Viagra. The pill's initial release in 1998 was originally targeted for older aged men, however, there has been a shift in the age group and purpose of consuming. Viagra's function along with similar medications such as Levitra and Cialis is to "[prolong] the vasodilator effects of nitric oxide in the body. Blood vessels in the penis expand, and erections result from the increase in blood flow" (Crooks & Baur, 2011). Although Viagra assists greatly in maintaining a man's erection, research over time has shown that a combination of ED medication along with sex therapy is significantly more effective than medication or sex therapy alone (Crooks & Baur, 2011). McVary (2007) state some psychosexual treatments for ED to include sensate focus exercises, scheduling of physical intimacy, awareness of sensory experiences, and facilitating open communication between two partners regarding sexual interpersonal difficulties.

As with any medication, there are side effects that can come with the consumption of Viagra, Levitra, or Cialis and one should consult with a physician beforehand. In addition, it is crucial that one does not take these medications with alcohol or other recreational drugs as it can lead to risky sexual behavior, which is common among college students. The most common side effects include such as nausea, facial flushing, nasal congestion, and headaches. Results of many studies that have been conducted involving Viagra have shown that a man who is able to become
fully erect is only secondary to his relationship with his significant other, indicating that communication and a love for one another is the top priority (Crooks & Baur, 2011).

Other forms of treatment for ED include penile devices, testosterone therapy, and penile injections (McVary, 2007). Injection therapy is typically given to men who do not have a response to Viagra. McVary (2007) states that testosterone replacement therapy is typically recommended for men with ED who exhibit a chronically low testosterone level. In a meta-analysis of 16 studies, a significant improvement in ED was more common in men who displayed hypogonadism who received testosterone treatment than in men who received a placebo treatment (57% vs. 16.7%). Additionally, nine more studies of which included data on causes of ED reported that the response rate was significantly higher among men with primary testicular failure (64%) than among those exhibiting a secondary cause of ED (44%) (McVary, 2007).

**Orgasmic Disorders**

Crooks & Baur (2011) identify premature ejaculation (PE) as one of the most common sexual dysfunctions among men. It can be defined as a man who ejaculates within a minute of intercourse or even just before intercourse, and is unable to delay the ejaculate, therefore impairing his and/or his partner’s pleasure. PE is prevalent in approximately 22% of sexually active males (Steggall, Fowler, & Pryce, 2008). According to the DSM-IV-TR, a man qualifies for a diagnosis of premature ejaculation if he meets the following criteria:

**Diagnostic criteria for 302.75 Premature Ejaculation**

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that
affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Specify Type:

- Lifelong Type
- Acquired Type

Specify Type:

- Generalized Type
- Situational Type

Specify:

- Due to Psychological Factors
- Due to Combined Factors (APA, 2000)

Several different views regarding the etiology of premature ejaculation include hypersensitivity to penile stimulation, a representation of a man’s poorly developed sensory awareness, or a man’s numerous sexual encounters as an adolescent/young adult (e.g., sexual intercourse with prostitutes, sexual intercourse in the back seat of a car, etc.) that do not fit into the category of lovemaking in a “relaxed” setting (Wincze & Carey, 1991).

Among some of the most common treatment options for PE include sensate focus exercises which include mostly non-genital stimulation of both partners and the stop/start or squeeze technique. The squeeze technique is an exercise used to assist in developing control of a man’s ejaculation and involves self-stimulation of the penis until fully erect, and right before
ejaculation, the man stops it by squeezing just below the glans of the penis; the exercise is repeated several times to promote ejaculatory control (Steggall, Fowler, & Pryce, 2008). Behavioral treatment approaches have also been used frequently in the treatment of PE with success rates of approximately 60-90%, however, after 3 years of treatment it has been shown that the success rate drops to about 25%. With this drop, it is still recommended to incorporate behavioral treatment plans in the treatment of PE, however, success rates can vary depending on the severity of the dysfunction (Steggall, Fowler, & Pryce, 2008). Steggall, Fowler, & Pryce (2008) provide an excellent at-a-glance reference guide to help therapists assign the appropriate treatment option for any degree of severity of PE, as can be seen in Appendix A.

The opposite of a man with PE is a man who exhibits male orgasmic disorder, defined as the inability of a man to achieve orgasm during sexual intercourse with his partner (Crooks & Baur, 2011). According to the DSM-IV-TR, a man qualifies for a diagnosis of male orgasmic disorder (formerly known as inhibited male orgasm) if he displays the following symptoms:

**Diagnostic criteria for 302.74 Male Orgasmic Disorder**

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify Type:*

**Lifelong Type**
Acquired Type

Specify Type:

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors (APA, 2000)

It is stated that approximately 8% of men experience this difficulty, indicating that it is rather uncommon. From an outside perspective, it would appear that a man with male orgasmic disorder would be the perfect lover because he has the ability to remain erect for a long period of time, however, this can become a significantly distressing if a couple is trying to have a child. For a woman, it can make her feel that her partner’s orgasmic disorder is her fault and that she needs to be doing something more in order for him to ejaculate; for a man it can cause feelings of distress that he is not a “real man” and he cannot experience the intensity of an orgasm (Ribner, 2010).

The following two explanations have been developed in exploring why some males exhibit an orgasmic disorder; one being that a male was raised in a strict home causing him to feel guilt and shame regarding sex, a male’s fear of abandonment by the woman if he ejaculates inside of her, and a possible unresolved Freudian oedipal complex. The second explanation for a male orgasmic disorder consists of a male preferring masturbation over intercourse, experiencing insufficient sexual arousal, a fear of sexually transmitted diseases and impregnating a woman, and finally, cultural and religious beliefs (Ribner, 2010). Societal messages that involve the concept of self-control (e.g., “don’t touch a hot stove,” “don’t look at another woman while on a
date,” etc.) can also influence a man’s ejaculatory response in that he has been so conditioned to “stay in control” that he is not able to experience the freedom and intensity of orgasm (Ribner, 2010).

As with other sexual dysfunctions, there are treatment options for men experiencing male orgasmic disorder. A couple coming in for sex therapy with male orgasmic disorder as the issue will usually be informed to begin treatment with several days of sensate focus exercises. Since sensate focus exercises focus on non-genital pleasuring, a man should not be able to have an orgasm, however, if his partner desires orgasm, the couple may engage in any kind of sexual activity that is agreed upon between both parties. Once the couple has spent some time engaging in sensate focus exercises, they can move on to the male masturbating to reach orgasm in the presence of his partner, followed by the next phase in which the male's partner helps him try to accomplish orgasm in a sexual activity that is highly arousing for both of them. A sex therapist should reassure the couple that it may take some time before the man can ejaculate successfully from his partner's stimulation. The final phase of treatment involves a man being able to ejaculate by means of penetration. The key to this phase is to become sexually aroused by other means of stimulation and complete the experience through penetration, in which the male should be able to ejaculate shortly after. If ejaculation does not occur shortly after penetration, the couple may return to other means of stimulation until the man comes close to ejaculation, and then resume penetration. The role of a sex therapist in assisting a couple experiencing male orgasmic disorder is to provide a safe environment in which he or she can assist the male in discovering any underlying personal and/or couple issues that have contributed to the dysfunction (Crooks & Baur, 2011).
Disabilities

Finally, individuals with disabilities such as spinal cord injuries (SCIs) and cerebral palsy (CP) have difficulty engaging in sexual activity. According to Crooks & Baur (2011), although an SCI itself does not necessarily have a negative impact on sexual arousal or desire, the physical impairment associated with SCI can affect the ability for one to experience arousal and orgasm. The damage to the spinal cord significantly affects neural pathways between the brain and body, confirming reasons for difficulty in enjoying sexual pleasure. According to Crooks & Baur (2011), "86% of men and women with SCIs feel sexual desire, more than half experience arousal from physical stimulation, about 30% become aroused from psychological stimulation, and 33% experience orgasm or ejaculation." The key to helping the sexual troubles of couples in which a partner has an SCI involves the concept of cognitive restructuring. With this cognitive behavioral approach, a sex therapist would help the couple in finding alternative ways of pleasuring one another such as exploring other areas of the body that respond sexually to touch such as the underarm, breasts, and neck. This is known as sensory amplification; the ability to have a heightened sexual response in certain areas of the body (Crooks & Baur, 2011).

Individuals with CP experience severe lack of muscular control, which affects balance, facial expressions, and overall body movement (Crooks & Baur, 2011). Though sexual arousal itself is not affected by CP, muscle contractions can cause an individual to jerk into awkward positions making intercourse painful and masturbation difficult without assistance. Some possible solutions to help individuals with CP involve trying different positions such as putting one's legs on a pillow to ease severity of muscle spasms and focusing on genital or non-genital pleasuring (Crooks & Baur, 2011).
How to Prevent Sexual Dysfunctions

It is important for individuals to receive regular physical and gynecological exams as a means of monitoring their overall health and sexual functioning. Chronic illnesses such as cancer, diabetes, and multiple sclerosis (MS) can negatively affect sexual functioning due to impairments in neurological, hormonal, circulatory systems in the body. Crooks & Baur (2011) state that "good health habits = good sexual functioning" meaning that a healthy diet and exercise can maintain a good sex drive as well as avoiding the use of tobacco and other recreational drugs. An excess amount of fat around the abdomen can reduce testosterone levels in men and can lead to a higher chance of developing ED. Results of a study researched by Crooks & Baur (2011) indicated that in a sample of 22,000 healthy men over the age of 14, men who were obese were 90% more likely to develop ED than their male counterparts who engaged in regular exercise; the men who exercised regularly were 30% less likely to develop ED. Crooks & Baur (2011) show a list of common recreational drugs and their effects on sexual functioning, which can be found in Appendix A.

How to Find the Right Therapist

Several references are available for couples needing assistance in finding the right sex therapist suitable for their needs. Crooks & Baur (2011) suggest couples to contact the American Association of Sex Educators, Therapists, and Counselors or the American Board of Sexology. A couple should definitely consider choosing a therapist who has a specialization in sex therapy and possesses a master's degree. It is always important to obtain information regarding a therapist's credentials and if he or she has attended sex therapy workshops and has had ample supervision. Aside from credentials, the most helpful way to select a therapist is to pay close attention to how the communication is between the client and the therapist. If a client feels that a
therapist cannot connect with him or her, then he or she can ask for an appropriate referral, however, clients need to also understand that it is best to see a therapist for a few sessions before deciding to make a switch. (Crooks & Baur, 2011).
CHAPTER THREE

Introduction to the Workshop

Introduction

This project will be a workshop titled "Maintaining Our Sexual Desires Despite Difficulties: A Workshop for Couples Experiencing Sexual Dysfunction" and will be presented as a PowerPoint. The purpose of this workshop is to provide an overview of sexual dysfunctions to prepare and make it easier for couples to seek therapy and to facilitate a support system within the group as multiple couples will be attending this workshop. The workshop will identify the sexual dysfunction apparent in one or both partners, provide possible solutions to assist in the dysfunction, and provide additional strategies on how to cope. With the tips that will be provided in this workshop, the goal will be to make it easier for couples to seek professional therapy, therefore, references will be provided at the end of the workshop for couples who are interested.

Development of Project

This project will be developed through an extensive literature review derived from peer reviewed journal articles, books, and the DSM-IV-TR. The literature review will include several effective interventions for addressing male and female sexual dysfunctions. With the help of thorough research, this project will develop as an educational preparatory workshop to provide for couples prior to entering psychotherapy for formal treatment. The foundation for development of this project holds a cognitive-behavioral perspective in that it will attempt to ensure couples of the normality of their dysfunction and not associate it with negative connotations; to bring couples peace of mind that help is available.
Intended Audience

This project is intended for heterosexual couples of all ages who are experiencing one or more sexual dysfunctions, whether physical or psychological. It is not intended for individuals who obtain sexual gratification by means of paraphilias or other forms of BDSM. Practicing sex therapists can also benefit from attending this workshop as new and improved findings are constantly being discovered on this topic, keeping therapists up-to-date with the latest information. Although this workshop can be beneficial to therapists, clients are the main focus.

Equipment and Environment

This project will be presented in a PowerPoint format and will require the use of a projector, a remote to change slides, and a microphone to prevent audience members from experiencing difficulty hearing the presenter. The workshop should be held in a large lecture hall or classroom so that participants can move their desks during the activity portion where they will discuss their feelings regarding the Index of Sexual Satisfaction. This workshop should be advertised by means of providing ads in the local newspaper as well as in places such as hospitals, churches, doctor's offices, and schools, etc. to reach out to individuals of all ages.

Project Outline

A. Introduction

1. Confidentiality
2. What is a sexual dysfunction?
   a. Contributing factors
   b. Feelings associated with sexual dysfunction
3. Activity and discussion

B. Female Sexual Dysfunctions
1. Hypoactive Sexual Desire Disorder (HSDD)
   a. Definition
   b. Causes
   c. Solutions

2. Sexual Aversion Disorder
   a. Definition
   b. Causes

3. Female Sexual Arousal Disorder
   a. Definition
   b. Causes
   c. Solutions

4. Female Orgasmic Disorder
   a. Definition
   b. Causes
   c. Solutions

5. Vaginismus
   a. Definition
   b. Causes
   c. Solutions

6. Dyspareunia
   a. Definition
   b. Causes
   c. Solutions
C. Male Sexual Dysfunctions

1. Erectile Dysfunction
   a. Definition
   b. Causes
   c. Solutions

2. Premature Ejaculation
   a. Definition
   b. Causes
   c. Solutions

3. Male Orgasmic Disorder
   a. Definition
   b. Causes
   c. Solutions

D. Disabilities

1. Cerebral Palsy
   a. Definition
   b. Solutions

2. Spinal Cord Injuries
   a. Definition
   b. Solutions

E. Conclusion

1. Finding the Right Therapist
a. Resources

b. Educational qualifications
CHAPTER FOUR

Summary and Recommendations

The purpose of this project was to provide education to couples of all ages who are experiencing a sexual dysfunction. It was designed to provide these couples a safe place to ask questions and receive referrals for future work in psychotherapy. The workshop focused primarily on the symptoms and potential causes for male and female sexual dysfunctions. In addition, the workshop provided some activities to engage the audience and share their feelings about the activity. Overall, this project served as a means of making the audience aware that sexual dysfunctions are common and can occur at any age for a variety of different reasons, empowerment for couples for taking the first step in seeking help for themselves, and validation of couples’ fears and feelings about seeking therapy.

Further work needs to be done on the topic of sexual dysfunctions. There needs to be more research done on the topic of sexual dysfunction among same-sex couples as currently there is limited research. There is also a need for more awareness and acceptance of sexual dysfunctions to make it easier for couples to seek out psychotherapy and to get rid of the stigma that states if one has a sexual dysfunction then he or she has a serious problem. This can be done by having more support groups and workshops available for couples and should be available every day of the week (including weekends) to accommodate working individuals. In the future, hopefully more individuals will be interested in specializations in sex therapy so that clients have a wider variety in choosing a therapist that is most suitable for them. If awareness is raised and more research is conducted on sexual dysfunctions, couples will be less reluctant to seek out help. General medical doctors should also receive more education on sexual dysfunctions so that they can provide some options for couples instead of turning them away.
References


Table 2: Available Low-Dose Vaginal Estrogen Formulations (Simon, 2011)

<table>
<thead>
<tr>
<th>Type</th>
<th>Composition</th>
<th>Trade Name</th>
<th>Dosing per Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Ring</td>
<td>Estradiol</td>
<td>Estring® (Pfizer)</td>
<td>One ring per 90 days with 2mg estradiol; releases 7.5lµg/day</td>
</tr>
<tr>
<td>Vaginal Tablet</td>
<td>Estradiol Hemihydrate</td>
<td>Vagifem® (Novo Nordisk)</td>
<td>One 10-µg tablet/day or 25.8µg tablet/day for 2 weeks, then 1 tablet twice weekly</td>
</tr>
<tr>
<td>Vaginal Cream</td>
<td>Estradiol</td>
<td>Estrace® vaginal cream</td>
<td>2-4g/day for 1-2 weeks, then 1g/day (0.1 estradiol/g)</td>
</tr>
<tr>
<td></td>
<td>Conjugated Equine Estrogens (CEE)</td>
<td>Premarin® vaginal cream (Wyeth)</td>
<td>0.5-2.0g/day (0.625mg CEE/g)</td>
</tr>
<tr>
<td></td>
<td>Synthetic Conjugated Estrogens - A (CE-A)</td>
<td>SCE-A vaginal cream (Duramed)</td>
<td>1.0g/day (0.625mg synthetic CE-A/g)</td>
</tr>
</tbody>
</table>

Table 2: An intensity-graded approach to treatment of premature ejaculation that combines cognitive-behavioral and medication interventions. (Stegall, Fowler, & Pryce, 2008)

<table>
<thead>
<tr>
<th>Level of disorder</th>
<th>Suggested cognitive-behavioral interventions</th>
<th>Suggested integration of use of medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Education Permission giving</td>
<td>Optional</td>
</tr>
<tr>
<td>Moderate</td>
<td>Sensate focus exercises Stop/start or squeeze methods</td>
<td>Suggested</td>
</tr>
<tr>
<td>Severe</td>
<td>Intensive training and support</td>
<td>Recommended</td>
</tr>
</tbody>
</table>
Table 14.4: Sexual Effects of Some Abused and Illicit Drugs (Crooks & Baur, 2011)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Chronic alcohol abuse causes hormonal alterations (reduces size of testes and suppresses hormonal function) and permanently damages the circulatory and nervous systems.</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Reduces testosterone levels in men and decreases sexual desire in both sexes.</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Adversely affects small blood vessels in the penis and decreases the frequency and duration of erections.</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Causes erectile disorder and inhibits orgasm in both sexes.</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>High doses and chronic use result in inhibition of orgasm and decrease in erection and lubrication.</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Causes decreased desire, erectile disorders, and delayed orgasm.</td>
</tr>
</tbody>
</table>
MAINTAINING OUR SEXUAL DESIRES DESPITE DIFFICULTIES

A WORKSHOP FOR COUPLES EXPERIENCING SEXUAL DYSFUNCTION

By: Sepanta Fotovat

Before We Start...

- Confidentiality
- Respect one another
- Encourage participation and questions
What is a Sexual Dysfunction?

- A disturbance in sexual desire that negatively affects one or more of the 4 phases of the sexual response cycle (excitement, plateau, climax, resolution) in men and women
- Psychological Factors
- Physiological Factors

Common Contributing Factors

- **Men**
  - Age
  - Lack of Exercise
  - Smoking
  - Previous Sexual Experiences

- **Women**
  - Age
  - Lack of Emotional Intimacy
  - Anxiety/Depression
  - Sexual Abuse/Trauma
• Rejection
• Fear
• Anxiety
• Anger
• Sadness

How many of you have experienced these feelings?

Activity
Activity Instructions

- Take 10 minutes to pair up with your partner and answer these questions individually using the Likert scale provided.
- Scoring ranges from 0-100; a score of 0-29 is indicative of a sexually satisfying relationship and a score of 30 or higher is indicative of a sexually dissatisfying relationship.
- Answers to questions 1, 2, 3, 9, 10, 12, 16, 17, 19, 21, 22, and 23 must be reverse scored (e.g., if you answer 5, it must be changed to a 1).
- After these items have been reverse scored, the final score is added up and subtracting 25 only if there are no omitted questions.

Extracted from Crooks & Baur, 2011

Discussion

- Feelings about activity?
- What came up for you?
- How do you think you can improve those feelings?

<table>
<thead>
<tr>
<th>MAD</th>
<th>SCARED</th>
<th>SAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>angry, furious, enraged, disgusted, annoyed, frustrated, peevish, resentful, uptight, put out, bored, disappointed, hugged, self-pity, “poor me,” combative, cruel, hate</td>
<td>fearful, panicky, afraid, petrified, terrified, threatened, insecure, inadequate, inferior, timid, uneasy, worried, apprehensive, unsure, shy, nervous, anxious, jealous</td>
<td>hopeless, sorrowful, empty, upset, down, helpless, discouraged, hurt, gloomy, useless, grief, despair, distraught, miserable, pessimistic, dull, unhappy, deserted</td>
</tr>
<tr>
<td>GLAD</td>
<td>LONELY</td>
<td>ASHAMED</td>
</tr>
<tr>
<td>happy, calm, content, cheerful, joy, amused, excited, eager, warm, pleasant, tranquil, serene, peaceful</td>
<td>lost, isolated, distant, separated, deserted, left out, detached, forgotten, solitary, abandoned, secluded</td>
<td>embarrassed, guilty, no good, remorse, weird, rejected, humiliated, disgraced, mortified, shame, indignity</td>
</tr>
</tbody>
</table>
Female Sexual Dysfunctions

Hypoactive Sexual Desire Disorder (HSDD)

- A persistent disinterest in engaging in sexual activity
- Affects approximately 1 in 10 women
- Common feelings include frustration, hopelessness, shame, disappointment, and bitterness
- Diagnosis does not apply if symptoms are a side effect of another medication or general medical condition

Extracted from Nappi et al., 2010
What Causes HSDD?
(Physiological Factors)

- An imbalance of neurotransmitters affected by sex hormones (estrogen, androgen, progesterone) in the brain
  - Dopamine – increases sexual desire and excitement
  - Norepinephrine – affects arousal and orgasm
  - Serotonin – overactivity of this system can decrease desire and delay orgasm
- Oophorectomy – removal of the ovaries
- Hysterectomy – removal of the uterus
- Menopause – hormones decrease; less androgens and estrogen

Extracted from Nappi et al., 2010

What Causes HSDD?
(Psychological Factors)

- A couple’s incompatibility in their preferences of frequency, timing, and type of sexual activity; can be referred to as desire discrepancy
- Problems in one’s relationship (e.g., lack of communication, fear of judgment)

Extracted from Crooks & Baur, 2011
Solutions for HSDD

- Sensate focus exercises – focusing on non-genital pleasuring
- Open, honest, and non-judgmental communication between partners
- Estrogen and testosterone replacement therapy

Sexual Aversion Disorder

- An intense fear and disgust of sex and sexual activity
  - Often associated with sexual abuse
  - Fears about contracting a sexually transmitted disease (STD)
  - Extreme performance anxiety
- Also referred to as a sexual phobia
- Physiological responses to the thought of sexual contact
  - Sweating
  - Dizziness
  - Diarrhea
  - Nausea
- Causes
  - Exact cause unknown
  - Possible causes
    - Sexual abuse
    - Aversive behavior is conditioned
      - Sexual stimuli paired with another sexual stimuli that is painful or traumatic

Extracted from Katz & Jardine, 1999
Solutions for Sexual Aversion Disorder

- Desensitization therapy
  - Trauma-focused cognitive behavioral therapy (if cause is due to sexual abuse)
    - Trauma narrative → write out details of the trauma and process feelings
- Relaxation exercises
- Some people with sexual aversion disorder may also experience symptoms of panic disorder
  - Antidepressant medications to control anxiety symptoms and talk therapy to work out underlying issues surrounding physical intimacy

Female Sexual Arousal Disorder

- Defined as the lack of responsiveness to sexual stimulation (e.g., lack of vaginal lubrication)
- Causes marked distress and/or interpersonal difficulty

- Causes
  - Exact cause unknown
  - Little research has been conducted on exact cause
    - Impairments in neurological functioning can possibly be the cause for this disorder

Extracted from Stinson, 2009
Solutions for Female Sexual Arousal Disorder

- Behavioral/Cognitive-Behavioral interventions (BCB)
  - Reframing negative thoughts into positive ones
    - Importance of focusing on the emotional experience vs. the physical experience
    - Approximately 10 weeks
    - Encouraging positive communication between partners

Female Orgasmic Disorder

- Formerly referred to as inhibited female orgasm
- Also known as anorgasmia
- Defined as a persistent delay in or absence of orgasm
- Affects approximately 24% of women
- Can be either lifelong or situational
  - Lifelong – primary
  - Situational – secondary

*Extracted from Wincze & Carey, 1991*
Discussion – Faking Orgasms

- Most common reason for faking an orgasm
  - Not wanting to hurt partner’s feelings
- Other reasons for faking an orgasm
  - Wanting to get sex over with
  - Hiding a deteriorating relationship
  - A need for partner approval
- This leads to a cycle of deception → the partner being deceived continues to perform the act that leads to “orgasm” and the partner faking orgasm continues to deceive to prevent partner from finding out that he/she has been faking
- Creates emotional distance during a time when emotional closeness should be occurring

Solutions for Female Orgasmic Disorder

- It can be learned!
- Self-stimulation exercises to perform in absence or presence of partner
  - Exploration of the body
  - Vibrator
    - Not as tiring as manual stimulation
  - Kegel exercises
    - Contracting pelvic floor muscles of the vagina
    - Improved muscle tone
    - Has been shown to result in increased sensation during intercourse and increased genital sensitivity

Extracted from Crooks & Baur, 1991
How to Perform Kegel Exercises

- **Step 1**
  - Locate the muscles surrounding the vagina. This can be done by stopping the flow or urine to feel which muscles contract.
  - Also can be done by contracting the anal sphincter as if to hold back gas
    - More effective
- **Step 2**
  - Insert a finger into the opening of the vagina and contract the muscles you located in Step 1. Feel the muscles squeeze your finger.
- **Step 3**
  - Squeeze the same muscles for 10 seconds. Relax. Repeat 10 times

Extracted from Crooks & Baur, 2011

How to Perform Kegel Exercises (cont.)

- **Step 4**
  - Squeeze and release as rapidly as possible, 10-25 times. Repeat.
- **Step 5**
  - Imagine trying to suck something into the vagina. Hold for 3 seconds.
- **Step 6**
  - This exercise series should be done three times a day
    - Approximately 6 weeks of regular exercise
    - Promotes closeness, sexual enhancement, and emotional intimacy

Extracted from Crooks & Baur, 2011
Vaginismus

- Defined as an involuntary muscle spasm of the vagina causing pain upon penetration of the penis causing significant discomfort in women
- Spasms can be monitored during a pelvic exam to determine exact cause (e.g., a fear stemming from the woman, issues within the couple)

Extracted from Ward & Ogden, 2010

Solutions for Vaginismus

- Self-exploration of the body
  - Similar to Kegel exercises
- Warm baths, exterior genital stimulation to relax vaginal muscles
  - Gradual transition from inserting a “foreign object” into the vagina
    - 1 fingertip → 1 finger → 3 fingers
    - Should not be able to experience any muscle contractions
    - Each stage can be practiced simultaneously with Kegel exercises
  - Possibly switching from pads to tampons

Extracted from Crooks & Baur, 2011
Solutions for Vaginismus (cont.)

- Once a woman has mastered the previous steps without muscle contractions, she can try the same series of steps with her partner
  - 1 fingertip → 1 finger → 3 fingers
    - Next step: try the exercise once more with a slow insertion of the penis instead of fingers
    - Pelvic movements are not recommended until the woman has familiarized herself with the feeling of her partner’s penis against the vaginal walls. This can resume once both partners have become comfortable with the penetration.

Dyspareunia

- Defined as persistent genital pain associated with sexual intercourse
- Twice as likely to occur in postmenopausal than premenopausal women due to the loss of estrogen

**Causes**
- Loss of estrogen
  - More apparent in postmenopausal women
  - Slows down blood flow to genital tissues
  - Can contribute to loss of sexual desire, vaginal dryness, and difficulty in becoming sexually aroused

*Extracted from Stinson, 2009*
# Estrogen Therapy Methods

<table>
<thead>
<tr>
<th>Type</th>
<th>Composition</th>
<th>Trade Name</th>
<th>Dosing per label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Ring</td>
<td>Estradiol</td>
<td>Estring® (Pfizer)</td>
<td>One ring per 90 days with 2mg estradiol; releases 7.5μg/day</td>
</tr>
<tr>
<td>Vaginal Tablet</td>
<td>Estradiol Hemihydrate</td>
<td>Vagifem® (Novo Nordisk)</td>
<td>One 10-μg tablet/day or 25.8μg tablet/day for 2 weeks, then 1 tablet twice weekly</td>
</tr>
<tr>
<td>Vaginal Cream</td>
<td>Estradiol</td>
<td>Estrace® vaginal cream</td>
<td>2-4g/day for 1-2 weeks, then 1g/day (0.1 estradiol/g)</td>
</tr>
<tr>
<td></td>
<td>Conjugated Equine Estrogens (CEE)</td>
<td>Premarin® vaginal cream</td>
<td>0.5-2.0g/day (0.625mg CEE/g)</td>
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<tr>
<td></td>
<td>Synthetic Conjugated Estrogens - A (CE-A)</td>
<td>SCE-A vaginal cream</td>
<td>1.0g/day (0.625mg synthetic CE-A/g)</td>
</tr>
</tbody>
</table>

Extracted from Simon, 2011

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# Male Sexual Dysfunctions
Erectile Dysfunction (ED)

- Defined as the persistent inability to achieve or maintain an erection sufficient enough for satisfactory sexual intercourse
- Can cause mood/behavior issues and impact self-esteem
- Occurrence increases with age

Causes
- Poor eating habits
- Lack of exercise
- Hypertension
- Diabetes
- Heart disease
- Smoking
- Anxiety
- Depression
- Anger

Solutions for ED

- Cognitive-Behavioral Therapy
  - Sensate focus exercises
    - Exploring each other’s bodies through non-genital touch
    - Purpose is to enjoy the sensation of being touched rather than to have the penis become erect and ejaculate
  - Reducing the effects of performance anxiety
  - Gradually transitioning from non-genital to genital stimulation
    - Fallatio (i.e., oral sex) – a man’s partner can stimulate his penis orally until it becomes erect, stop, resume with non-genital stimulation, and can continue oral genital stimulation once the penis has returned to its pre-erect state
    - Purpose is to reassure a male that once his penis has subsided from erection, it can become erect again

Extracted from Swindle, Cameron, Lockhart, & Rosen, 2004

Extracted from Crooks & Baur, 2011
Solutions for ED (cont.)

- Erection-enhancing pills
  - Sildenafil Citrate (i.e., Viagra)
  - Others – Levitra and Cialis
- Prolongs the effect of nitric oxide in the body
  - Causes blood vessels in the penis to expand, resulting in erection of the penis due to the increase in blood flow
- A combination of erection-enhancing pills and sex therapy has been found to be most effective in treating ED

Side Effects of Erection-Enhancing Pills

- Blurred/loss of vision
- Nausea
- Facial flushing
- Nasal congestion
- Headaches
- These pills should not be taken with alcohol or other recreational drugs
  - Contact primary care physician if erection lasts for more than 4 hours

Extracted from Crooks & Baur, 2011
Herbal Treatments

• Available without a prescription
  • FDA approval not required
• Sold in grocery and drug stores
• Heavily marketed on the internet

Extracted from Crooks & Baur, 2011

Other Solutions for ED

• Penile devices
  • Most common is a vacuum erection device which traps blood in the penis with an elastic band wrapped around the base and induces penile rigidity
  • Typically given to men who do not have a response to Viagra or testosterone therapy
• Testosterone replacement therapy
  • Typically given to men with a chronically low testosterone level
• Injection therapies
  • Typically given to men who do not have a response to erection-enhancing pills like Viagra

Extracted from McVary, 2007
Premature Ejaculation (PE)

- Defined as a man who ejaculates within a minute of or just before intercourse and being unable to delay the ejaculate
- Approximately 22% of men experience PE

Solutions for PE

- Sensate focus exercises
- Stop/start or squeeze technique
  - an exercise used to assist in developing control of a man’s ejaculation
  - involves self-stimulation of the penis until fully erect
  - right before ejaculation, the man stops it by squeezing just below the glans of the penis
  - repeated several times to promote ejaculatory control
- Ejaculate more frequently
- Masturbation or intercourse
- Change sexual positions
  - Woman-above
- Medication
  - Selective serotonin reuptake inhibitors (SSRIs)

Extracted from Steggall, Fowler, & Pryce, 2008
How to Do the Stop/Start Technique

- A man’s partner begins by stimulating his penis manually or orally until he is about to orgasm, and then stops stimulation until pre-ejaculatory sensations subside
- 15-30 minute sessions
- Ejaculation is allowed to occur at the last cycle of sessions
- As a man’s ejaculatory control improves, the couple can move on to intercourse

Extracted from Crooks & Baur, 2011

How Severe is your PE?

<table>
<thead>
<tr>
<th>Level of Disorder</th>
<th>Suggested Cognitive-Behavioral Interventions</th>
<th>Suggested Integration of use of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Education and Permission Giving</td>
<td>Optional</td>
</tr>
<tr>
<td>Moderate</td>
<td>Sensate Focus Exercises and Stop/Start or Squeeze Methods</td>
<td>Suggested</td>
</tr>
<tr>
<td>Severe</td>
<td>Intensive Training and Support/Relapse Prevention/Planned Follow-up Work</td>
<td>Recommended</td>
</tr>
</tbody>
</table>

Extracted from Steggall, Fowler, & Pryce, 2008
Male Orgasmic Disorder

- Formerly known as inhibited male orgasm
- Defined as the inability to achieve orgasm during sexual intercourse
- Apparent in approximately 8% of men

Causes

- Upbringing of the male (e.g., the topic of sex is associated with feelings of guilt and shame)
- Cultural and religious beliefs
- Fear of abandonment by the woman if the male ejaculates inside of her
- Preferring masturbation over intercourse
- Fear of STDs and impregnating a woman

Solutions for Male Orgasmic Disorder

- Step 1
  - Sensate focus exercises for several days or more
  - Any kind of sexual activity that is agreed upon by both parties can resume if male’s partner desires orgasm
- Step 2
  - Male should be able to masturbate in presence of his partner to try to reach orgasm
- Step 3
  - Male’s partner should be able to assist him in trying to reach orgasm during a sexual activity that is highly arousing for both parties
  - Males should be reassured that this process may take some time
Solutions for Male Orgasmic Disorder (cont.)

- Step 4
  - Final phase – ejaculating by means of penetration
  - Success in this phase comes from engaging in other sexually arousing activities and completing it with penetration
    - If ejaculation does not occur shortly after penetration, couples can return to other means of stimulation and try again

Extracted from Crooks & Baur, 2011
Cerebral Palsy (CP)

- Severe lack of muscle control
  - Can affect facial expressions, overall body movement, and balance
- Muscle contractions (causing jerking of the body) interfere with sexual pleasure
  - Difficulty with masturbation
  - Painful intercourse
- CP itself does not interfere with one's ability to become sexually aroused
  - Possible solution – keep legs elevated on a pillow to ease severity of pain

Extracted from Crooks & Baur, 2011

Spinal Cord Injuries (SCIs)

- Spinal cord damage affects neural pathways between the body and the brain
- Physical impairment can interfere with one’s ability to experience sexual arousal and orgasm
  - SCIs themselves do not necessarily impact sexual desire negatively
- Cognitive restructuring
  - Reframing the situation from negative to positive → sensory amplification
  - Developing the ability to experience a heightened sexual response
  - Primary focus on pleasuring one another through other parts of the body that respond sexually to touch (e.g., underarms, breasts, neck)

Extracted from Crooks & Baur, 2011
Finding the Right Therapist

- American Association of Sex Educators, Therapists, and Counselors
- American Board of Sexology
- Yellow or white pages for therapists in your local area
- Level of education
  - Master’s degree
  - Specialization in sex therapy
    - Extent of training and supervision
- Communication
  - Can he or she relate to you?
  - Level of comfort

In Conclusion...

- Good health habits = good sexual functioning
  - Healthy diet
  - Exercise
  - Avoiding tobacco and other recreational drugs
- Communicate openly and honestly with each other so that both partners’ needs are met
- Both partners must have patience with one other

Extracted from Crooks & Baur, 2011
Thank You!
😊