Incorporating Sexuality & Gender Concepts into Mental Health Practice

Treating Common Sexual Dysfunctions

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About This Series: Core Topics for Behavioral Health Providers

- BHECN's webinar series designed to educate behavioral health trainees about practical topics in behavioral health
- Expert presenters provide a mixture of principles and case based application
- All webinars are free of charge
- Final webinar until Fall semester

About BHECN

The Behavioral Health Education Center of Nebraska (BHECN), pronounced “beacon”, was established in 2009 by a legislative bill to address the shortage of behavioral health professionals in rural and underserved areas of the state.

MISSION: BHECN is dedicated to improving access to behavioral health care across the state of Nebraska by developing a skilled and passionate workforce.
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Historical approaches to sex therapy

Multiple explanations and understandings

1. **Havelock Ellis**: all sexual dysfunction results from childhood masturbation: we have a limited number of sexual response cycles in a lifetime
2. **Freud**: biological result of being stuck in developmental stages; require psychoanalysis to determine (treatment for frigidity is 2 hrs/twice a week)
3. **1950's**: anxiety is the basis of all dysfunction
4. **Masters & Johnson**: a) cognitive performance anxiety spiral and b) skill deficient model
   - Changed the way we thought about sexuality and dysfunction
5. **Kaplan**: do sex therapy and then deal with resistance with psychodynamic therapy

Post modern model of sex therapy

- Resistance is not therapeutic failure
- To remain ignorant about sexuality now is a deliberate effort
- Media and self-help sources of information
- Cases that now present for therapy have generally tried self-help and failed
- Must look at underlying issues in the context of sex therapy
- Five factor model
Five factors of assessment

I. Cultural history of families of origin

Why does negative inoculation “take” with some women and not with others?
What variables lead to negative/aversive attitudes?
What maintains belief systems?
Clinical sample vs. control group findings
Detailed information regarding early messages and experiences
LGBTQ experiences and messages

Systemic issues in the couple relationship

• In a genuine system, BOTH partners are involved in dysfunction
• Dysfunction is both causal and responsive
• Distortions in cognitive beliefs
• What is the value of the sexual dysfunction in the system?
  • Anxiety protection?
  • Distance/closeness regulation?
  • Power balancing?
  • Psychodynamic understanding

Operant issues in the relationship

• Day-to-day existence and functioning
  • Employment/education demands
  • Kids/care of aging relatives
  • Household management
  • Extended family
  • Recreational/sports commitments
  • Can’t get in touch with sexual selves
  • Ask: How did sex get to be so low on your list of priorities?
Physiological and medical issues

• Mind/body connection
• Always begin with thorough medical examination to determine/rule out medical causes
• Impact of medication or substances, including supplements
• Chronic conditions

How to do therapy (generic model)

1. Dual relationship the most optimum; both partners contribute, both must invest in change process
   Partner with higher desire may adjust downward for sake of relationship
2. Education and information component
   Watch receptivity to the information; accept or reject? Why?
3. Attitudinal changes required; why should they believe you?
   Complex part
4. Eliminate performance anxieties for both partners

How to continued

5. Improve communication skills
   Focus on abilities to express and receive information about self and relationship
   How to discuss sexual concerns?
6. Jump into relationship issues:
   Power and control, affectional needs, negative feelings, conflict resolution, trauma histories, etc.
7. Physical and medical issues need attention, resolution
Common Sexual Dysfunctions (DSM-5)

- Premature ejaculation
- Delayed ejaculation
- Erectile disorder
- Female orgasmic disorder
- Female sexual interest/arousal disorder
- Genito-pelvic pain/penetration disorder
- Male hypoactive sexual desire disorder
- Substance/medication-induced sexual dysfunction

Treatment Protocols

- Talk, talk, talk......information first, education
- Sensate focus exercises
- Specific behavioral recommendations
- Use of medication
- Physical therapy
- Psychotherapy, individual and couple

How to begin

- Prior to the first session, have each partner complete an intake individually, either prior to or at the beginning of the session
- Examine the differences in perception between partners; how does each person view the problem
- Why each partner sees the issues differently is important
- No such thing as "the truth" in the problem
The first session
• Allow at least 90 minutes to two hours
• Begin the session with both partners to discuss the overall issues and frame the process for them
• Allow equal time (30 min.) to meet with each partner individually
  • There is always something people feel uncomfortable saying in front of the partner
• Inform each person that information will be used in sessions unless flagged as confidential
  • Ok, this will be kept confidential
  • You need to get to the place where you can bring it up
• Decide you can’t do effective therapy with these secrets, and won’t do therapy unless it can be effective

Male erectile dysfunction
• Greatest amount of attention paid to this problem, most due to medications now available and heavily advertised
• Cause is the lack of sufficient stimulation to produce arousal
• May be generalized (not limited to certain types of stimulation, situations, or partners) or
• Situational (only occurs with certain types of stimulation, situations, or partners)
• May be lifelong (present since the man became sexually active) or acquired (disturbance began after a period of erectile functioning)
• Strong age-related increase in prevalence, particularly over age 50
• Often associated with other medical or substance-related problems

Male erectile dysfunction
• Despite strong focus on medication, research suggested an integrated approach with therapy and medication use
• Combined medication and cognitive-behavioral sex therapy for best results
• Brief approach (4-6 weeks) with psychoeducation, homework assignments and combined medical and psychological approach most effective
• Use of sensate focus exercises with communication exchanges, visual arousal techniques (erotic videos)
• Therapist needs to be supportive and aware of frustration and potential early termination of treatment
**Premature Ejaculation**

- Slow/fast techniques; begin with stroking, progress to penetration with intent to maintain control of arousal and ejaculation
- Squeeze technique may be used
- Modify behaviors during intercourse to take focus off orgasm and increase couple’s sexual behavioral repertoire
- Man uses deep breathing techniques and abdominal muscle control to help regulate excitement level
- Some couples find techniques time and energy intensive; discuss thoroughly to avoid early termination of treatment

**Female Orgasmic Disorder**

- Marked delay in, or infrequency of, or absence of orgasm; or markedly reduced intensity of orgasmic sensations
- Not explained by nonsexual mental disorder, or the result of severe stressors (violence) or related to substance or medication use
- Lifelong or acquired; generalized or situational and causes distress (mild, moderate or severe)
- Most women require direct clitoral stimulation to reach orgasm; very few can orgasm with penile-vaginal intercourse alone
- May co-occur with sexual interest arousal disorder

**Female Orgasmic Disorder**

- Education and anatomy
- Self exploration
- Sensate focus exercises
- Use of vibrator
- Resolution of anxieties associated with sexual response
- Explore distractions
- Exercises to heighten sexual arousal transfer to partner
- Orgasm with intercourse if desired
Bridging techniques

- Have partner observe at various points
- Partner arouses self first, then mutual practice of masturbation
- She guides hand, gives feedback
- Have intercourse in positions that maximize clitoral stimulation
- Bridge from where you are to where you want to go

Female sexual interest/arousal disorder

- Lack of or significantly reduced sexual interest/arousal, including sexual activity, thoughts or fantasies, and reduced or no pleasure in sexual activities, with refusal of invitations for sexual activity
- Often associated with pain disorders, orgasm disorders, infrequent sexual activity, or relationship problems
- Evaluate for:
  - Partner factors: sexual issues, health status
  - Relationship factors: poor communication, conflict, discrepancy in sexual desire levels
  - Individual vulnerability factors: poor body image, history of sexual or emotional trauma or abuse, mental health conditions, or stressors,
  - Cultural/religious factors: attitudes about sexuality, prohibitions about sexuality
  - Medical factors: postpartum, fatigue, chronic pain conditions

Male hypoactive sexual desire disorder

- Persistent or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity
- Symptoms persisted for over six months and cause significant distress
- Sometimes associated with erectile problems or other sexual dysfunctions
Treatment issues

- Must be considered in relationship context
- Sexual history critically important to establish pattern
- Use of cognitive restructuring techniques helpful
- Bibliotherapy
- Discuss importance of physical/sexual connection in relationship satisfaction
- Address anger and anxiety issues of both partners
- Enhance affection and emotional bonding and reduce focus on intercourse as only goal
- Provide support and encouragement