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Sex Therapy

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Sex therapy refers to a general approach for dealing with sexual performance problems, often referred to as *sexual dysfunctions*. As a form of psychotherapy, it was developed in the 1970s during the so-called "sexual revolution." It was based on the assumption that the majority of sexual problems experienced by individuals and couples are the result of misinformation about sex, faulty expectations, and performance anxiety. Despite early enthusiasm about its effectiveness, approaches to sex therapy continue to evolve and undergo revisions. More recently, sex therapy has been extended to include couples therapy, pharmaceutical interventions, and major reformulations of the nature of sexual difficulties and how they are described.

Historical Perspective

Historical records reveal that early civilizations were concerned about sexual problems, often attributing them to supernatural or metaphysical causes. Prescribed cures ranged from herbal remedies to spiritual invocations. A marked paradigm shift occurred in later centuries when sexual dysfunction came to be seen as a matter of health and illness rather than spiritual failings. In the late nineteenth century, Sigmund Freud's (1856–1939) psychodynamic theory afforded center-stage to sexual problems, focusing on the importance of early psychosexual development, unconscious conflict, and ensuing anxiety in their etiology. In Freudian theory, sexual hang-ups were the root cause of many if not most other psychological difficulties. The psychoanalytic "talking cure" called for long-term, intensive exploration of deep-seated conflict surrounding sex and related matters. This approach was unique because it required dealing with psychological causes of sexual problems and focusing on the whole person. However, it was time intensive, costly, and did not yield impressive results.

Within this historical context, the research by gynecologist William Masters (1915–2001) and his associate Virginia Johnson (1925–2013) on the human sexual response (excitement, plateau, orgasm, and resolution phases) was viewed as pioneering. Their 1970 book, *Human Sexual Inadequacy*, revolutionized the treatment of sexual dysfunctions, giving birth to the field of sex therapy by most accounts. Prior to their innovative approach, treatment of sexual dysfunctions was predominantly focused on resolving intrapsychic conflict in the Freudian tradition. Inner conflict was seen as the causal factor for long-standing psychopathology that created sexual dysfunction. Masters and Johnson challenged this model and instead emphasized the importance of anxiety, particularly anxiety surrounding sexual performance. Treatment shifted from a complete focus on the individual to the couple; because sexual dysfunction was a couples problem, therapy required the participation of both partners.

The therapeutic approach of Masters and Johnson was problem focused, time limited (lasting weeks or months rather than years), and avoided placing blame or responsibility for the problem on any individual. They argued that the vast majority of sexual dysfunctions were primarily due to psychological rather than medical causes. Therapy involved both a male and female clinician and focused on two main components: (a) education and correction and (b) anxiety reduction. Much of the therapy was delivered in the form of homework assignments to be carried out between sessions with the therapist. The underlying assumption of the treatment modality was that all clients,

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given the correct information and without undue pressure for sexual performance, have the capacity for normal sexual functioning. Removing anxiety should lead to the natural unfolding of healthy sexual responding according to this framework.

Part of the popularity of the Masters and Johnson approach was that it dovetailed nicely with the behaviorism movement which emphasized the role of conditioning in all psychological difficulties, focusing on the here-and-now and the importance of factors that serve to perpetuate or reinforce ongoing problems (as opposed to historical factors, such as childhood experiences). From the behavioral perspective, because all problems stem from faulty learning, they can be unlearned or counter-conditioned.

The Masters and Johnson model was the standard treatment approach for over 20 years. Their treatment modality boasted unprecedented success rates, 80% improvements in sexual functioning in 790 patients in a time span of 11 years. Over subsequent years, however, enthusiasm over the reported effectiveness rates was tempered by a number of criticisms, including failures to replicate those findings. Critics argued that Masters and Johnson failed to define success and amount of improvement, reporting only failure rates. They did not report detailed information on participant dropout rates, and the treatment descriptions were often lacking in detail. Their sample was biased, favoring intelligent, healthy, motivated, and high-functioning clients. Furthermore, misinformation and ignorance about sexuality were quite prevalent during that era such that education and permission giving might have sufficed for many individuals who struggled with sexual problems. Unlike today, there was a dearth of self-help information and few outlets for disseminating material on sexual health, much of which would have been considered taboo in any event.

In the few decades following the reported success of Masters and Johnson, several developments led to significant revisions in the assumptions behind sex therapy and in its actual practice. A contemporary of theirs, Helen Singer Kaplan (1979), noted the glaring omission of desire or libido in Masters and Johnson's phases of the sexual response. This is an important addition because problems with sexual desire, whether low or absent, have proven to be the leading sexual complaint by women of all ages. Desire problems are often recalcitrant because they cannot usually be traced to a single cause, instead being a function of physical factors, individual experiences and beliefs, relationship difficulties, and broader cultural influences, including gender stereotypes and double standards among others.

The development of oral medications, such as sildenafil (trade name, Viagra), in the late 1990s triggered another paradigm shift in sex therapy: the beginning of the era of "sexual pharmacology" (Leiblum, 2007). These discoveries followed the growing awareness over the past decades that, contrary to the claims of Masters and Johnson, erectile dysfunction frequently involves a medical etiology, especially in older men. Today, oral medications represent the first-line approach to dealing with erectile dysfunction, and clients often ask for these by name. Despite the appeal of medications as "quick fixes," it is widely recognized that these are most helpful as one component of an integrated therapy regimen. Although sexual pharmacology is widely available, routinely prescribed by primary care physicians, and relatively effective in restoring erectile functioning for many patients, medications do not resolve relationship conflict or issues pertaining to ineffective sexual techniques. Restoring reliable erections, for example, will not improve ineffective communication between partners. Furthermore, several studies have shown that a large number of patients eventually discontinue the medications for reasons ranging from worries about side effects to concerns about cost. For these reasons, clinicians caution that sexual pharmacology should not be viewed as a panacea for sexual health. To date, there are no approved pharmacological treatment options for female sexual

dysfunctions, which may be due to the fact that male erectile dysfunction has historically received more attention from professionals and patients alike.

The ubiquity of sources of information, advice, and self-help tips in contemporary media has had a mixed impact on problems with sexuality and how they are addressed. The internet, the full influence of which is immeasurable, offers a profusion of information about sex. Although the accuracy of information provided by the various media is often questionable, contemporary sex therapists agree that clients today are much more informed about sex and its problems than in the past. However, media depictions of sex have simultaneously expanded and narrowed what is viewed as normal and ideal. The widespread dissemination of sexuality explicit media, including pornography, has revived some of the older notions about sex as a performance, setting unrealistic standards for viewers. Consequently, sex therapy clients today commonly present with a fair amount of knowledge about sexual functioning and problems, but they also cling to unrealistic expectations about sexual performance. Compared to the early years of sex therapy when a lack of information about sex was prevalent, clients today often have too much information, albeit often distorted.

Current Practices

Most sex therapists practice a combination of techniques informed by cognitive behavioral therapy and systemic approaches. Common interventions include sexuality education, permission giving, nondemand pleasuring and other strategies to reduce pressure to perform, skills building (i.e., communication and assertiveness training), and couples counseling. Comprehensive sex therapy also addresses past traumas and any factor deemed to play a role in maintaining a sexual problem. It is recognized that coexisting psychological difficulties, such as depression, must be resolved for a satisfactory outcome.

There are a number of therapy techniques that are widely used interventions for specific sexual dysfunctions. Sensate focus is perhaps as close to a standard sex therapy technique as there is. Credited to Masters and Johnson, sensate focus consists of a series of nondemand pleasuring homework exercises, the purpose of which is to teach couples to focus on the sensual experience of intimacy rather than on performance (e.g., reaching climax). Sensate focus is ultimately designed to lower performance anxiety. Couples are instructed to begin with sensual massage exercises without genital touching in the first phase. At each phase, the emphasis is placed on sensations rather than outcomes (such as whether the male achieved an erection or not). Genital stimulation is introduced in the next phase of sensual touching exercises. To ensure that the emphasis remains on sensations and intimacy, couples are instructed to abstain from sexual intercourse until the final phases, generally after several weeks of homework. In the latter phases, when intercourse is resumed, couples are reminded to stay focused on sensations to discourage any emphasis on performance.

Techniques to address the cognitive aspects of performance fears are routinely used. Interventions to deal with dysfunctional beliefs and unrealistic expectations include bibliotherapy and cognitive restructuring. Couples are commonly assigned readings of sexual functioning, gender differences, and eroticism. Cognitive restructuring is useful for individuals whose beliefs and expectations about sexual intimacy are distorted. In such cases, dysfunctional beliefs are identified, challenged, and replaced with more adaptive beliefs. It is often necessary to modify individuals' scripts pertaining to sex, gender, and intimacy. Evaluating couples' views of the meaning and value of sex in their relationship is essential to identifying problem areas and contributing factors. Couples differ in the meaning they assign to sexual difficulties; some manage to enjoy a rewarding and intimate relationship in spite of a sexual dysfunction.

Masturbation homework exercises have proven useful for the treatment of several sexual difficulties, including inhibited orgasm and early ejaculation. Directed masturbation is the intervention of choice for female orgasmic disorder. A semistructured protocol involving education, self-exploration, and solitary self-pleasuring is followed. After the woman has had some success with these steps, the partner is invited to participate in the exercises. For early or premature ejaculation, the *stop–start technique* is the preferred sex therapy technique for achieving some control over ejaculation. In a series of steps, the male receives stimulation, either from his partner or himself, until he approaches the point of ejaculatory inevitability, at which point the stimulation is suspended. Once the feeling of arousal subsides, usually within a few minutes, stimulation is resumed. The sequence is repeated several times per encounter over several weeks in order to help the male recognize the sensation of impending climax and to help him learn to postpone ejaculation. After achieving some success with the masturbation exercises, couples are instructed to continue the stop–start training, as this strategy is known, during intercourse.

Couples therapy often focuses on communication training, problem solving, and negotiation strategies. For couples whose relationship is conflicted, couples therapy may need to precede any sex therapy intervention. Couples who communicate effectively typically require less intensive therapy and have better sex therapy outcomes. As practiced today, couples therapy is often informed by systems theory and cognitive behavior therapy principles. In systems theory, the concept of emergent qualities posits that any relationship is more than the sum of its parts: a relationship has unique properties that transcend individual contributions. The focus on therapy would be on the system and its dynamics rather than on the client with the "problem." The framework is compatible with that of Masters and Johnson who viewed the couple as the client.

Unlike the early years, sex therapists today are likely to treat a broad clientele who come from varied cultural, racial/ethnic, religious, and socioeconomic backgrounds. Clients are more likely to have health problems, to be older, and to have done some of their "homework" in seeking answers to their questions about sexual functioning and problems. Many have, in fact, unsuccessfully tried home remedies. Sexual orientation and gender identity concerns are not uncommon. Body image problems issues are regularly addressed. Many clients of both genders are survivors of childhood sexual abuse. Having more than one sexual complaint is almost the norm (a lack of desire, for example, often accompanies problems with arousal and with climax). Relationship problems too are quite pervasive among clients seeking sex therapy. Increasingly, there is recognition that sex therapists, like their clients, do not operate in a vacuum; both live in a cultural and historical context that profoundly shapes their views of sexuality, intimacy, gender, and what is "normal" and realistic. Even the assumption by Masters and Johnson that the sexual responsiveness of men and women is basically equivalent has been challenged and revised (Leiblum, 2007). Indeed, it is increasingly clear that there are important gender differences in the experience of sexual desire, motivation, arousal, and pleasure. Feminist therapists have long argued that the practice of sex therapy has been male-centered, sexist, and dismissive of women's needs, including the right to refuse unwanted sex.

Issues and Controversies

One of the major criticisms of sex therapy has been its lack of cohesive theoretical background. As practiced historically, the sex therapy model seemed largely based on the early post hoc observations of Masters and Johnson of their own experiences with clients. Sexual ignorance, misinformation, and performance anxiety were readily embraced as the difficulties underlying virtually all sexual dysfunctions. Leading clinicians during the behavior therapy Zeitgeist enthusiastically

reframed these problems as products of faulty learning despite a relative absence of research support for these assumptions. Subsequent writings have been criticized as based on a number of assumptions that are loosely tied together.

Related to its weak theoretical background, some critics, including sex therapy insiders (see Binik & Meana, 2009), have argued that sex therapy does not merit the status of a distinctive therapeutic approach. In fact, sex therapists have borrowed concepts from virtually every school of psychotherapy, only adding to the lack of coherence in sex therapy. As a result, contemporary sex therapy is practiced as an amalgam of techniques drawn from diverse psychotherapeutic schools used to treat a wide range of problems with sexual functioning. More evidence of this identity crisis for sex therapy is the notable absence of sex therapy coursework from most therapy training programs.

One concern is that sex therapy often has a singular narrow focus, such as restoring erectile function, rather than promoting optimal sexuality, however the couple might define it. One-size-fits-all approaches are usually oversimplified and unsatisfactory. Rather than focusing on performance, sex therapy should help couples explore the subjective meaning and experience of being sexual (Kleinplatz, 2012). Even more problematic is the paucity of treatment outcome studies. The limited findings do not measure up to the "cure rates" reported by Masters and Johnson. Aside from their unmatched reported success rates, recent effectiveness rates would not meet modern standards for evidence-based therapies. Virtually none of the treatment outcome studies are randomized controlled trials. Furthermore, as a specialty, sex therapy has been insulated from advances in psychotherapy research. The importance of common factors in psychotherapy outcomes, including the critical role of the therapeutic alliance, has seemingly been ignored by sex therapists until recently.

Multidisciplinary approaches are becoming the norm in psychotherapy, and sex therapy is no exception. Rather than trying to isolate "organic" from "psychogenic" etiologies, sexual dysfunctions are best conceptualized from a biopsychosocial perspective, which requires a coordinated and integrative treatment approach by all disciplines, including medicine and psychotherapy. Because the etiology of most sexual difficulties involves multiple interacting factors, such as health complications, relationship issues, life stressors, and psychological problems, no single specialty can offer all of the answers. Integrative treatment requires a coordinated regimen drawing upon advances in sexual pharmacology, sexuality education, couples therapy, and insight-oriented therapies, among others.

As currently practiced, sex therapy has a decidedly Western slant or bias. In some regions of the world, any form of therapy is viewed with skepticism, especially if improved sexual functioning is the objective. Culture is the backdrop for individuals' and couples' views on sexuality, intimacy, gender, relationships, and love. Expectations about what is normal and reasonable are profoundly influenced by historical and cultural context. Although many conditions affecting physical health, such as cancer and heart disease, might be universally viewed as problematic, the same cannot be said for what are considered sexual dysfunctions in contemporary Western contexts.

SEE ALSO: Behavior Therapies; Biopsychosocial Model; Cognitive Therapies; Psychoanalytic and Psychodynamic Therapies: Long Term and Short Term; Sexual Dysfunctions

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