Sex Therapy
Practical Techniques

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In 2015, 458 Male & Female Patients presenting with Sexual Disorders

Age

- 21 - 40yrs: 50%
- 41 - 60yrs: 33.5%
- 61 - 85yrs: 10.5%
- 16 - 20yrs: 6%

50%
Are they male or female?

- Male: 52%
- Female: 48%
Our Patients

Ethnic Background

- White British: 70%
- British Asian: 18%
- Black British: 5%
- Other: 7%
Women
Female Sexual Dysfunction
(DSM 5 classification 2013)

- Genito-pelvic pain/penetration disorder
  - Sexual Interest/Arousal Disorder
    - Orgasmic Disorder

Must be at least 6 month duration and occur 75%-100% of the time and cause significant distress
DURING ASSESSMENT

1. Primary, Secondary or Situational
2. Predisposing Factors, Precipitating Factors or ‘Trigger Events’ & Maintaining Factors
3. Direct or indirect

- Medical condition
- Medication
- Menopause
- Surgery
- Pain
- Fatigue
- Bladder
- Bowel

- Current intimacy/sexual contact
- Relationship Issues
- Partner’s response/
- Functioning
- Changed roles
- Communication

- Thoughts
- Feelings (anxiety)
- Behaviours (loss, anger, adjustment ‘the new you’)

- Vagina (Lubrication, arousal, orgasm, desire, pain)
Vaginismus/Dyspareunia

Do they have periods? Do they use tampons? If no, have they ever tried to using them? What happened?
Have they ever had a smear test? If yes, what happened?
When and where do they experience pain? *(before, on penetration, during intercourse, after intercourse)*
How would they describe the sensations they feel? *(sharp, burning, stinging, painful, uncomfortable)*
Does anything make it better or worse?
Do they feel dry or well lubricated?
Have they experienced a similar feelings with examinations, tampon use or penetration with a finger/vibrator/penis?
Can she keep her legs open?
Has sex ever been pain-free? When was the last time?
Do they attempt penetration?
If they do have sexual intercourse, how often and how long does it last?
If they don’t have sexual intercourse are they still sexually intimate?
How does their partner react?
Does their partner experience any sexual difficulties?
How would they describe their experience of desire/arousal/orgasm

- Current contact
- Relationship Issues
- Partner’s response/
  functioning
• **Predisposing Factors**
   Childhood trauma, medical examinations, negative messages about sex, messages about pain, issues with tampon use, early failure, idiosyncratic masturbatory style, early exposure to pornography

• **Precipitating Factors or ‘triggering event’**
   Sexual failure, painful sexual experiences, tampon use, abusive relationships, exposure to pornography, rape, childbirth, medical examinations, medical conditions, redundancy, divorce, menopause, surgery, radiotherapy, chemotherapy

• **Maintaining Factors**
   Due to fear of failure or pain, avoidance of intercourse, sexual intimacy &/or relationships, examinations, tampon use, flashbacks, stress, depression, relationship distress, lack of quality time
The Contribution of the Pelvic Floor Musculature to Dyspareunia

Pelvic-floor muscle hypertonus has been demonstrated to contribute to interstitial cystitis (1), provoked vulvodynia (2), and generalised vulvodynia (3).

Studies have demonstrated that pelvic floor muscle hyperactivity is a part of an overall response to heightened anxiety (4). Genital pain may also trigger pelvic floor dysenergia (5).

5 Rosenbaum TY Physical Therapy Evaluation of Dyspareunia Chapter 6 in Female Sexual Pain Disorders eds Goldstein AT, Pukall CF, Goldstein I 2009
Vagina = Sex – Think Normality

• Treat any underlying causes for Dyspareunia
• Always suggest an effective lubricant and/or moisturiser (if appropriate systemic/local oestrogen)
• If no medical cause identified or if dyspareunia persists after treatment ASK more questions and Think PELVIC FLOOR Think ANXIETY/FEAR Think AROUSAL Think SEXUAL ACTIVITY
Vaginal Trainers (dilators)

- **Lubricants**
  - YES
  - Sylk
  - TLC
  - Durex 2 in1

- **Diaphragm Breathing**
  - 7 – 11

- **Pelvic Floor Exercises**
  - Relax, drop or tense

- **Moisturizers**
  - Hyalofemme
  - Replens
  - Yes

- **Local Estrogen**
  - Vagifem

- **Systemic HRT**
Key Points from the Basson’s model of female sexual response

• Innate sexual desire is common in younger women and in the early months/years of a relationship but generally becomes *more variable in the longer term*

• Women’s sexual desire/interest is often ‘contextual’

• Women’s sexual desire/interest can be ‘triggered’

• Women’s motivation to be sexual often stems from intimacy needs

• Women’s subjective arousal is complex – often only *only minimally influenced by genital feedback*
Practical Techniques

- **Couple Exercises** (what did they do before they had a problems, time, planning, touching, talking, picnics, electronic free evenings)

- **Intimacy/Fun/M&M** (baths, showers, candlelight, games, eye-masks, fantasy)

- **Clear Boundaries** Increase Relaxation /Decrease Anxiety

- **Trainers/dilators (with partner)** Confidence/PF Retraining

- **Vibrators (with partner)** Desensitisation/Distraction/ Arousal /Relaxation

- **Positions** Relaxation/Control

- **Trigger point & Vulval massage** Desensitisation
www.thedirtynormal.com
www.omgyes.com
www.vaginismus.com
www.vulvalpainsociety.org
www.lovelanguages.com
www.cci.health.wa.gov.au
www.arhp.org/factsheets

*Overcoming Anxiety* by Helen Kennerley
*Sex without pain* by Heather Jeffcoat
*Sensate Focus in Sex Therapy* by Linda Weiner and Constance Avery-Clark
Men
Male Sexual Dysfunction
(DSM 5 classification)

- Erectile Dysfunction
- Delayed Ejaculation
- Premature Ejaculation
- Hypoactive sexual desire disorder

- Must be at least 6 month duration and occur 75%-100% of the time and cause significant distress
DURING ASSESSMENT

1. Primary, Secondary or Situational
2. Predisposing Factors, Precipitating Factors or ‘Trigger Events’ & Maintaining Factors
3. Direct or indirect

Medical condition
Medication
Surgery
Pain

Current
intimacy/sexual
contact
Relationship Issues
Partner’s response/
Functioning
Communication

Thoughts
Feelings
(anxiety)
Behaviours
(negative)

Penis
(Erections, morning, nighttime, sufficient for penetration)
Masturbation
Erectile dysfunction
(Ask specific questions esp. about masturbation)

- Check masturbation and on-line sexual activities (no.fap. App)
- ‘Testing out’
- ‘Wax & Wane’
- Stop negative behaviours & challenged negative thoughts
- Breathing exercises
- Pelvic Floor exercises
- Regular intimacy/sexual contact with clear boundaries/medication

‘A Man with a Plan’
Treatment Advice

Several attempts for optimum success

Dose optimisation for 3 months or daily dosing for 2 months
www.diabetes.nhs.uk

More direct sexual stimulation is needed for older men and those with organic disease/post surgery

Alternative Treatments may need to be considered (vacuum device as an exerciser) and testosterone checked
She isn’t enjoying this

I don’t want to hurt her

I’ll pretend to be asleep

I’m a failure

Stay hard

Elevated sympathetic tone, increased noradrenaline/adrenaline concentrations and contraction of the penile smooth muscle cells.

Kirana E, Porst H. Erectile Dysfunction. The EFS & ESSM Syllabus of Clinical Sexology 2013
Premature Ejaculation
(Ask specific questions esp. about masturbation)

- Masturbatory re-training
- Use lubricant
- Glans massage
- Slow down stimulation
- Breathing exercises
- Pelvic Floor exercises/relaxation
- Regular intimacy/sexual contact (check frequency)
- SSRI’s
- Priligy
DSM-V: Definition of Delayed Ejaculation

1. An inability to orgasm and ejaculate during sex with a partner about 75-100% of the time, with either a delay in ejaculation or infrequent or absent ejaculation. Despite the presence of adequate desire, arousal and stimulation’ that the clinician, taking into account the person’s age, judges to be adequate in focus, intensity and duration.

2. The symptoms described above have persisted for at least six months

3. The symptoms produce marked distress in the individual

4. The delayed ejaculation is not better accounted for by another mental disorder, use of a medication known for causing ejaculatory delay or failure, or due to stressors within or external to the relationship. The ejaculatory delay is not considered pathological
‘In men with no organic disease or injury the *most common presentation* is an inability to ejaculate during intercourse but no difficulty with masturbation’

*There is a growing body of evidence which suggests excessive exposure to pornography may reduce sexual desire, impair arousal, and otherwise produce sexual dysfunction though a stimuli overexposure and desensitization process* (Brand, Laier, Pawlikowski, Schächtle, Schöler & Altstötter-Gleich, 2011)
**Delayed Ejaculation**

*(Ask specific questions esp. about masturbation)*

- Masturbatory re-training
- Change/Reduce/stop
- Relaxation/Massage/stroking/showers/baths
- Use lubricant
- Speed up or slow down stimulation
- Breathing exercises
- Pelvic Floor exercises
- Increase arousal/fantasy
- Regular intimacy/sexual contact
Meditation Apps

Smiling Mind
Headspace
Calm
Stop Breath Think
• www.yourbrainonporn.org
• www.nofap.com
• www.sauk.org
• www.atsac.co.uk
• www.sexualadviceassociation.co.uk

• Trauma Release Exercises (TRE)

• Coping with PE — Metz & McCarthy