HANDOUT

4/26/2012

SDs most often have a complex interplay of drugs/medication; disease/physical disorders; psychiatric/psychological problems:

'Recommended that psychological- / interpersonal factors have to be considered after proper consideration of medical and substance causes have been considered and examined'.

'Even when an organic cause is found psychological- / interpersonal factors will still be identified and need to be addressed'.

OBJECTIVES:
(Include the patient / partner / doctor)

- **Knowledge**

Inadequate knowledge - embarrassment, avoiding exploration and diagnosis, incorrect diagnosis, ineffective treatment, judgemental.

- **Self-confidence**

Uncomfortable with discussing sexual problems; some may be blatantly direct, some covertly imply their problem, problem exposed during history or examination or considering co-morbidity

- **Skills**

Address limitations, Approach re-assessment / management, need to bridge the gap, use comfortable terms, collaboration with other professionals in the field – psychologists, other medical colleagues, council

- **Desensitization**

Relaxed, helpful, major part of well-being

- **Communication**

Open communication, begin with less taboo sexual activities, not shy away

A. ASSESSMENT / EVALUATION

A. ('BOTH') GENERAL SEX THERAPY

A. SPECIFIC SEX THERAPY

A. ASSESSMENT / EVALUATION

History

1. General history

Physical, family, developmental, work, relationships, medication, surgical, substances

2. Sexual

Function, possible problems, trauma, attitude, contraception

3. Sexual Adjustment

Drive, motivation, preferences, myths, old wife's tales

Examination

1. Physical
2. Mental Status
3. Appropriate special investigations
4. Appropriate referrals if needed

Base-line functioning,
Don't suggest answers,
Attitudes toward partner / sex,
Interpersonal functioning, inadequacies,
Fears, misconceptions,
Habits, patterns,
Don't use ascending or descending hierachy,
Communication,
Consider household / culture / religion

DEFINE THE PROBLEM / DIAGNOSIS

B. GENERAL SEX THERAPY

1. 'ROUNDTABLE' – feedback, discussion, information, problem solving issues + EDUCATION – psychological / physical aspects
2. Improving COMMUNICATION
3. Attend to biological-, sociological-, PSYCHOLOGICAL-NEEDS AND PROBLEMS
4. SHORT-TERM BEHAVIOUR ORIENTATED
5. Stimulation and coital TECHNIQUES
6. Sensate Focus EXERCISES

Do not take sides / prevent power struggles (not a traffic cop) / no one is the cause...,
Educate,
Enhance communication,
Don't make it to 'serious business',
Rekindle 'old spirit', stress the sensual – not the mechanical,
Reflect rather than direct,
Consider household / culture / religion

Important issue to consider:

Both partners- DUAL THERAPY
= standard = brief conjoint sex therapy

Partner may have a sexual problem that contributes to the presenting problem:
Anorgasmia – PE / ED – Dyspareunia
- Partner's reactions / expectations – intensifies distress
- Prolonged avoidance .....negotiate.....
- Co-opting may improve the outcomes

Short-term Behaviour Therapy
Sensate Focus Exercises

Homework / Graded / Set Time-periods

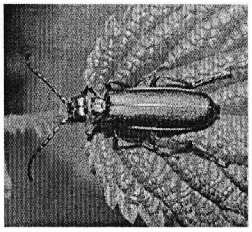
1. Enhance fantasies, think about your sexuality
2. Touching, tactile sensations, talking, sharing – no genital contact
3. Touching genitals – self then other – no further stimulation
4. Further play till intercourse is possible, comfortable, shared.

Communication
Education
Enjoyment / Fun

C. SPECIFIC SEX THERAPY

Low Sexual Desire

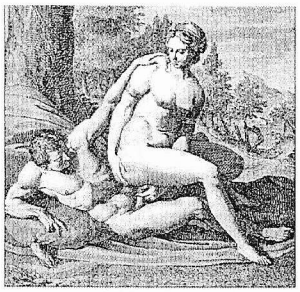
- **Treat the causes – medication, 'burn-out', substance abuse, mental status, abstinence**
- **Prevent power struggles**
- **Improve communication, motivation** (abstinence – supression of sexual impulses)
- **Improve fantasies**
- **Medication?** – Flibanserin (increase women selfreport of desire)
- **Hormone (Androgen) replacement therapy varied success / transdermal testosterone + estrogen**



Spanish fly, or cantharides

Sexual Aversion

- **Psychotherapy**
- **Anxiolitics, Antidepressants**
- **Asexual touching followed by graded step-up**
- **Partner with the aversion in control**
- **Complex / Multi-phased program**



By taking complete control of vaginal penetration, women can learn to overcome their fear of sexual activity (*Angelique et Medor* from *Aretino or The Loves of the Gods*, circa 1602, by Agostino Carracci)

Male Orgasmic Disorder

(Retarded Ejaculation)

- **Treat possible causes – Psychological issues, medication (Periactin)**
- **Stimulation techniques, control – 'Bridge manoeuvre'**
- **Sildenafil...../ Buproprion**

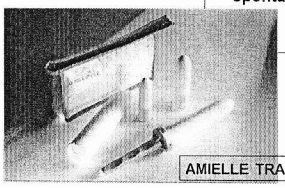
44% effective / 50% discontinue
– firm erection vs resuming love-making

"Giving men a firm erection is easy Getting couples to resume lovemaking is not so easy"

Female Orgasmic Disorder

(Inhibited Female Orgasm)

- Treat causes – medication (dryness mucus membranes, etc), anxiety..
- Self-stimulation, masturbation, vibrator, Kegel-exercise
- Clomipramine can induce spontaneous orgasms



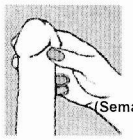
AMIELLE TRAINERS

Premature Ejaculation

Key: control of ejaculation

Treat causes –
medication,
performance anxiety,
conditioned response

- 'Squeeze' technique



(Seman's manoeuvre)

Step 1. Begin sexual activity as usual, including stimulation of the penis, until you feel almost ready to ejaculate.
Step 2. Have your partner squeeze the end of your penis, at the point where the head (glans) joins the shaft, and maintain the squeeze for several seconds, until the urge to ejaculate passes.
Step 3. After the squeeze is released, wait for about 30 seconds, then go back to foreplay. You may notice that squeezing the penis causes it to become less erect, but when sexual stimulation is resumed, it soon regains full erection.
Step 4. If you again feel you're about to ejaculate, have your partner repeat the squeeze process.

Premature Ejaculation

Key: control of ejaculation

Treat causes –
medication,
performance anxiety,
conditioned response

- 'Squeeze' technique
- 'Stop-start' technique

•Relaxed foreplay, man supine, almost point of ejaculation
•Stop relax, allow erection to subside 1/3.
•Wait 50 seconds
•Resume and repeat exercise +/- 4X

Premature Ejaculation

Key: control of ejaculation

Treat causes –
medication,
performance anxiety,
conditioned response

- 'Squeeze' technique
- 'Stop-start' technique

- Masturbation / Shift focus / Increase frequency
- Medication – specific groups useful

PE pharmacological options

1. SSRI – Paroxetine (strongest), Sertraline, Fluoxetine, Clomipramine – 90% effective / Daily use
2. On demand – 4-6 hours before…. Use side-effect of a drug to prolong the sexual response
3. Topical anaesthetics (Lidocaine) – moderate…
4. Dapoxetine (Priligy) – serotonin re-uptake inhibitor
5. Sildenafil – Comorbid ED