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Institute 110

Healing Fractured Couples: Problems with Men's Sexual Health.

Michael E. Metz, Ph.D.
Meta Associates
821 Raymond Avenue, Suite 440
St. Paul, MN 55114
Voice: 651-641-9317; fax 651-642-1908
www.MichaelMetzPhD.com

Learning Objectives

Participants will...

1. learn the components of the comprehensive biopsychosocial approach to understanding and addressing men's sexual health problems in couple therapy.
2. learn detailed, distinguishing internal characteristics of men who sexually act out --> shame and silence; fear of sexual failure; 10 things men and women learn for sexual health.
3. identify basic strengths of men's sexual health such as the 3 styles of arousal and 3 learnings for basic sex drive regulation.
4. understand the features of the 'Good-Enough Sex' model and how they are essential to men's and couple's sexual growth, healing, and satisfaction. Couple case illustrations.

My informal Institute "Goal"...

- ... is for you to gain a little more confidence addressing and helping men and couples fragmented by a problem with men's sexual health...

Workshop "business"

Session handouts: also available on my website: www.MichaelMetzPhD.com, "resources"

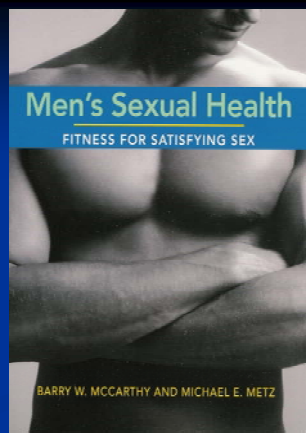
Powerpoints: available from website: www.AAMFT.com

Source for material for this workshop:
McCarthy & Metz's *Men's Sexual Health*,
Routledge / Taylor & Francis booth.

Barry W. McCarthy Ph.D.
&
Michael E. Metz Ph.D.

Men's Sexual Health: Fitness for Sexual Satisfaction.

Routledge, NY 2008



MICHAEL E. METZ, PhD

1. Psychologist and marital & sex therapist in private practice in Minneapolis / St. Paul, MN
2. 12 years faculty, University of Minnesota Medical School.
3. Directed the marital & sex therapy program, and the post-doctoral clinical/research fellowship in human sexuality.
4. Adjunct assistant professor, Marriage & Family Therapy Program, Family Social Sciences, University of Minnesota.
5. Clinical experience with:
 1. marital and sexual dysfunction;
 2. sex abuse victim;
 3. sex offending men; clergy abusers;
 4. transsexual reassignment;
 5. domestic abuse
 6. sexual orientation
6. Author of more than 50 professional publications on marital and sexual therapy, couple conflict dynamics, sexual medicine, aging; and authored of:
 1. *Men's Sexual Health* (2007).
 2. *Coping With Premature Ejaculation* (2003).
 3. *Coping With Erectile Dysfunction* (2004).
 4. *The Styles of Conflict Inventory (SCI, 1994).*

Health Perspective...

- Sexual problems offer an *exceptional opportunity* for the helping professional to offer support and to enhance the quality of life of the individual and couple.

Few medical or psychological problems so clearly offer the clinician not only the opportunity to relieve distress but also to *promote personal and relationship health and satisfaction.*

What is Your Model for Healthy Male Sexuality?

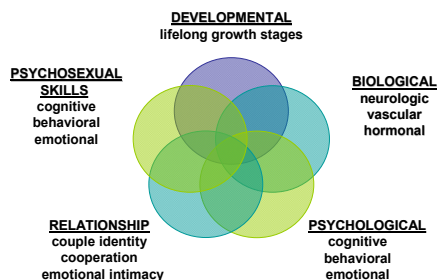
Men's Sexual Problems: If viewed as a "simple problem, simple cure..."

- Trivializes men and male sexuality and simplification opens the door to vilification, shame, blame, and provokes resistance in men to grow.
- Complexity will be discounted and meaning is overlooked.
- Sets focus on one-dimensional behaviors more than feelings (emotional) and meaning (cognitive) dimensions.

Why is Your Model Important?

1. One's model incorporates one's assumptions about what is "relationship dysfunction" and "relationship health"
2. One's model drives or determines one's approach to clinical formulations, treatment goals and objectives, and clinical interventions.
3. A relationship model's valence is fundamentally positive or negative (e.g., commitment vs. divorce) and it's focus more on the individual or the couple.

Sexual Health & Satisfaction Features of the Biopsychosocial Integrative Model



A - DEVELOPMENTAL ASPECT

1. Family history (parents, siblings, relatives).
2. Childhood relationships and sexual developmental histories.
3. Adolescent relationships and sexuality.
4. Community standards and mores.
5. Committed relationship developmental phases.
6. Midlife, aging, and adaptations.

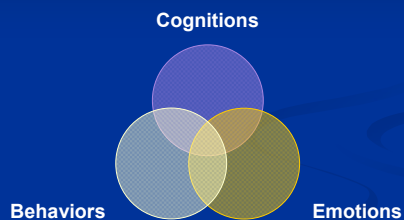
B - BIOLOGICAL DIMENSION

- The body is the “foundation.” It is essential to evaluate for any physical cause (identify or “rule out”).
- Patient education about physiology is the foundation for realistic expectations. Accurate knowledge is powerful.
- Knowledge of physiology can help couples “de-personalize” the problem.

C - PSYCHOSOCIAL DIMENSION

1. Psychiatric / mental health issues (e.g., bi-polar, dysthymia...)
2. The cognitive, behavioral, and emotional dimensions.
3. The interpersonal features and interactions.

The C-B-E Model: Cognitive-Behavioral-Emotional



The Impact of ED on the Couple

Man:

Cognition:

“I am a failure. I want to but I can’t please my partner. She is upset with me. I don’t know what to do. I will fail again anyway. What’s wrong with me? It is supposed to be automatic.”

Emotion:

anxiety, shame, frustration, embarrassment, anger, hopelessness.

Behavior:

profuse apology (shame), avoidance, silence, or defensiveness if approached; expressed irritation with self; resentment if “pushed.”

The Impact of ED on the Couple

Woman:

Cognition:

“I should turn him on. He’s not, so I am a failure. He’s quiet so he must be angry with me. I have to talk to him about it or it will get worse, never get better. I don’t know what else to do. It will fail again anyway. He feels terrible and it is my fault.” “I am not sexy, pleasing.” “He doesn’t love me...”

Emotion:

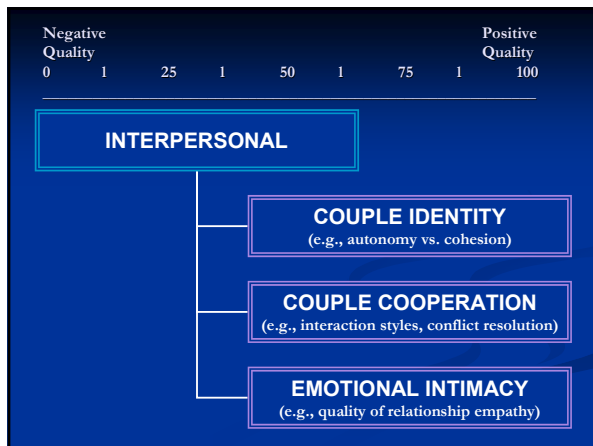
anxiety, irritation, loneliness, sadness.

Behavior:

engages the problem (e.g., “What’s wrong?”), attempts to soothe partner, criticism or avoidance, silence, or irritation if approached.

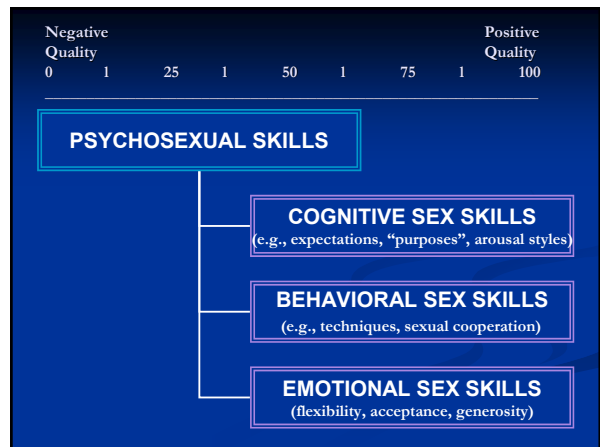
The Crucial Variable

- The “meaning” of the sexual behavior for the individual and the couple.



- ### 3 General Dimensions of Relationship Interaction
1. **Couple Identity** – balancing the composite of cognitive features such as autonomy vs. union, gender roles, interaction meanings, parenting values, etc.
 2. **Couple Cooperation** – interactive behaviors: Constructive vs. destructive engaging & avoiding styles during conflict.
 3. **Emotional Intimacy** – combined emotions: Positive vs. negative feelings and sentiments.

- ### D – PSYCHOSEXUAL SKILLS ASPECT
- The cognitive, behavioral, and emotional (C-B-E) dimensions of sex and sexuality.
 - The interpersonal or relationship interactions in the sexual dimension.



**ACCURATE
SEXUAL
KNOWLEDGE:

A POWERFUL
“TOOL”**

- ### Knowledge is Power...
- Some sexual behavior from representative sample data:
 - Michael, Gagnon, Laumann, & Kolata, (1994). *Sex in America: A definitive survey*. NY; Warner

Some Descriptive Sexual Data of Adult Men

1. Approximate average of 6 sexual partners in lifetime (women, 5).
2. > 75 - 80% are sexually faithful (80-85% women).
3. Average Couple Sexual frequency is 1- 2 x week.
4. Sexual dysfunction (SD) is "normal" (average) – most men (& women) experience a SD by age 40.
5. Physically healthy men are sexually functional life-long.

Some Descriptive Sexual Data of Adult Men

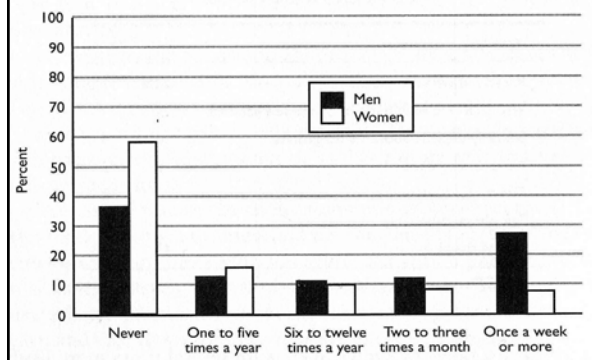
6. 68% of single men (48% single women) masturbate regularly.
7. 57% of married men (37% married women) masturbate regularly.
8. 27% of men (8% women) masturbate at least 1 time per week.
9. 94% of men have sexual fantasy more than several times per month (84% of women).

Table 13
Responses to the Question:
"How Often Do You Think about Sex?"

	"Every day" or "Several times a day"	"A few times a month" or "A few times a week"	"Less than once a month" or "Never"
Men	54%	43%	4%
Women	19	67	14

Note: Row percentages total 100 percent.

FIGURE 11:
Frequency of Masturbation



Men and Women's Frequency of Masturbation

	% of Men	% of Women
● Single who masturbate	→ 68	48
● Married who masturbate	→ 57	37
● Masturbate at least 1 time per week	→ 26	8
● "Always" or "Usually" orgasm with masturbation	→ 82	61
● Masturbation during the past year by education Level:		
● Graduate degree	→ 80	45
● Did not complete HS	→ 60	25

(source: Laumann et al., NHSL, 1994)

Reasons for Masturbation, by Gender

Reasons for Masturbation	Gender of Respondent (%)	
	Men	Women
To relax	26	32
Relieve sex tension	73	63
Partners unavailable	32	32
Partner doesn't want sex	16	6
Boredom	11	5
Physical pleasure	40	42
Go to sleep	16	12
Fear of AIDS/STD	7	5
Other	5	5
Total N	835	687

**Table 4x3:
The Appeal of Sexual Practices to Men and Women**

	%	%
	<i>Men</i>	<i>Women</i>
1. Vaginal intercourse	95	96
2. Watching partner undress	93	74
3. Receiving oral	79	73
4. Giving oral	77	68
5. <u>Group sex</u>	46	7
6. Lifetime anal intercourse (hetero)	45	55
7. Watching others do sexual things	40	17
8. Stimulating partner's anus with fingers	26	15
9. Using vibrator/dildo	23	17
10. Anus stimulated by partner's fingers	22	18

Laumann et al., 1994

128 / SEX IN AMERICA

**Table 9
Frequency of Orgasm During Sex with Primary Partner**

Panel A: By Gender, Age, and Marital Status

Social characteristics	Always	Usually	Sometimes	Rarely	Never
GENDER					
Men	75	20	3	1	1
Women	29	42	21	4	4
AGE					
Men					
18-24	70	22	6	0	2
25-29	73	21	3	2	2
30-39	77	20	2	0	1
40-49	79	18	2	0	0
50-59	72	19	3	2	4

LIFELONG DEVELOPMENT TASKS

10 THINGS

*Men Want to Learn
for Healthy Couple
Sexuality*

What Men Need to Learn for Sexual Health

1. VALUE SEX POSITIVELY:
SEX IS
INTRINSICALLY
GOOD.

Sex is How Two People Use their Bodies...

1. How two people use their bodies for *touch, pleasure, "animalistic" passion, fun and play.*
2. How two people use their bodies for *affirmation, mutual acceptance.*
3. How two people use their bodies for *cohesion, closeness, intimacy.*
4. How two people use their bodies for *consolation, support, solace, as life's "safe harbor".*

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A Superseding Theme

**Value Sex Positively
&
Promote
Men's Self-Esteem**

Men's Silence...

1. **SHAME** can be evoked:
 1. when male sexuality is judged as "bad" ...
 2. when he believes he should never "fail".
 3. When he believes his partner is dissatisfied.
 4. when he has a "secret" (masturbates, paraphilia, gender dysphoria...)
2. **HOPELESSNESS & POWERLESSNESS:**
 1. when sex performance "fails" again;
 2. when sex function is not "automatic" and "autonomous."
 3. fear of erectile dysfunction.
 4. When partner seems critical or rejecting.

Men's "Silence" About Honest Sexual Feelings

1. Men's "Silence" about honest sexual feelings as well as "concrete sex language" are significant barriers to men's sexual health and couple growth.
2. Shame fuels irritations, silence, avoidance, withdrawal:
 1. communication evasion.
 2. affection dodging.
 3. sexual interaction avoidance.

The Common Fluctuations in the Value of Sex.

- The vacillation of society's and individuals' value of sex is normal.
- The history of sex in societies is a cyclic balancing process -- sex being valued as positive and healthy vs. sex as a negative or dangerous.

Sexuality in History: Perspective

1. While there is a wide diversity of sexual behaviors, with remarkable variations in what is, or is not, officially sanctioned, the variety of sexual activity is constant.
2. The public acknowledgment of different sexual behaviors has varied, and there would appear to be a cyclic pattern to public expressions and acceptance of sexual behavior ("Hegelian dialectic").
3. History of sexuality is a developmental process:
 1. Biological understanding.
 2. Spiritual, theological, religious meaning.
 3. Psychological knowledge and meaning.
 4. Social – interpersonal understanding and meaning.
 5. Scientific knowledge.

Sexual Science & Medicine: The objective effort to understand

- Sexual science in history is a complicated developmental process:
 - susceptible to social biases and political pressures because sexuality is such a powerful energy and important part of life.
 - Contemporary sexual science struggles to balance knowledge amidst social biases, psychological anxieties and fears, political pressures, and past (and present) scientific "sloppiness."

Sexuality in Society & History: THE IMPORTANCE & VALUE OF SEX

The Hegelian Dialectic / Cycle

Vilifying	Positive Respect	Demystifying
bad	good	mundane
evil	holy	only a behavior
sick	meaningful	meaningless
dangerous	healthy	hollow

Sexual Self-Esteem

- **Accepting and affirming one's sexuality is the foundation for**
 1. sexual self-esteem.
 2. openness & honesty (not avoidance).
 3. sexual self-regulation.
 4. positive engagement with his partner.
- "Self-esteem is the reputation you have with yourself." (Brian Tracy)
- "Self-esteem is that deep-down inside the skin feeling you have of your own self-worth." (Denis Waitley)

What Men Need to Learn for Sexual Health

2. VIEW SEXUALITY AS:

DEVELOPMENTAL AND INTEGRATIVE

How the male sexual body works

- important for a man to have reasonable sexual performance expectations.
- foundation for understanding sexual medicine and sex therapy interventions.
- inoculation against fears of performance failure (e.g., ED, PE, etc.).

Basic Anatomy and Physiology of Male Sexuality

At the beginning....biologically...

- In utero, a male or female emerges from a sex undifferentiated embryo.
- At 6-8 weeks, with androgen intervention (Y chromosome activated?), the embryo differentiates as male. Without androgen, all undifferentiated embryos would develop female.

Infant boys and sexuality

- Erection is a natural physiological response. Even before you were born, you had spontaneous reflexogenic erections as a fetus!
- A newborn male baby has his first erection within a few minutes of delivery.
- All through life, every night during sleep, whether sexually active or not, healthy males have a ten to twenty minute natural, physiological erection approximately every sixty to ninety minutes, thus having three to five erections a night. These erections occur during "stage 1- REM" sleep (REM means "rapid eye movement" sleep).

Erection Process

1. The process of expanding (tumescence) the penis involves:
 1. vascular
 2. neurologic
 3. hormonal systems
2. Erection occurs when nerve impulses from the brain (psychogenic erection) and from genital stimulation (reflexogenic erection) combine to cause blood to flow faster into than out of the penis.
3. An erection happens by relaxing the microscopic muscles that surround the arteries in the penis causing dilation of the arteries.
4. A number of physical, psychological, relational, and situational factors can interfere with this natural functioning.

Five Phases of Male Sexual Response

1. Sex interest, desire.
2. Excitement, arousal.
3. Plateau, stable arousal.
4. Orgasm, climax.
5. Resolution, satisfaction.

Ejaculation Process -- A

- **Emission:**
refers to the collection and transport of secretions from the prostate, seminal vesicles, and vas deferens into the urethra in preparation for ejaculation.

This collection of semen into the posterior urethra or verumontanum forms a pressure-like chamber. According to commonly accepted theory, this chamber can enlarge or “balloon” as much as three times normal size causing a sensory response of ejaculatory inevitability.

Ejaculation Process -- B

Ejaculation:

- the process of expelling the seminal fluids through the urethra and out of the penis
- aided by the rhythmic contraction of the perineal striated muscles (“pelvic muscle”).
- occurs when a critical level of afferent input from the verumontanum reaches the spinal cord and causes a reflex mediated ejaculatory response.

Ejaculation Process -- C

- **Orgasm:**
refers to the subjective experience of pleasure typically associated with ejaculation. Orgasm is believed to be primarily a cortical experience.
- Note: Though emission, ejaculation and orgasm are integrated events, because of separate neurological mechanisms, erection may not be required for ejaculation, and ejaculation may not be required for orgasm.

New Model of Female Sexual Arousal

Rosemary Basson, MD:

- Women have a lower biological urge for the release of sexual tension than men.
- Women's sexual desire is often a responsive rather than a biological or spontaneous event, greatly influenced by subjective psychological excitement.
- **Orgasm** is not necessary for satisfaction and does not need to occur at each sexual encounter.

Three Forms of "Love" (H. Fisher, 2004)

Three *basic drives in nature* direct *different aspects of courtship, mating, reproduction, and parenting*:

- SEX DRIVE / LUST
- ROMANTIC LOVE
- ATTACHMENT

SEX DRIVE (H. Fisher, 2004)

- **LUST** is the lust, libido, sex drive, passion, compulsion or craving for sexual gratification to motivate individuals to seek sex.
- **Function:** Reproduction, procreation.
- Associated primarily with androgens (testosterone) and estrogens and related brain pathways in both sexes.
- Activation of caudate nucleus and hypothalamus -- the motivation centers in brain.

ROMANTIC LOVE (H. Fisher, 2004)

- **ROMANTIC LOVE** is characterized by *ecstasy, heightened energy, focused attention on a preferred mating partner, attraction, "limerence," infatuation, exhilaration, obsessive thinking and emotional craving for him or her.*
- **Function:** to motivate or enable individuals to select among potential partners, prefer specific features, and focus their courtship attention on genetically appropriate individuals.
- Associated with elevated levels of central dopamine (DA) and norepinephrine (NE) and decreased levels of central serotonin (5-HT).

ATTACHMENT (H. Fisher, 2004)

1. **ATTACHMENT** feelings of calm and emotional union with a long-term partner, yielding or surrender, security, and social comfort.
2. **Function:** to motivate individuals to sustain affiliative connections at least long enough to complete parental duties; care-giving, and emotional bonding for infant survival.
3. Associated with the neuropeptides oxytocin and vasopressin and their neural circuits. Oxytocin, produced in the pituitary and hypothalamus, is associated with stress reduction, calming and soothing (e.g., orgasm), memory, learning. Separation Anxiety is associated with a lack of oxytocin; occurs when there is a break in pair bonding.
4. In birds and mammals, characterized by mutual territorial defense, and/or nest building, mutual feelings and grooming, close proximity, separation anxiety, shared parental chores.

Gender Differences

1. SEX DRIVE

1. Male sex drive is stimulated to a greater degree by **visual stimuli** than the female sex drive (Ellis & Symons, 1990) (Hamann, Herman, Nolan, & Wallen (2004). Nature Neuroscience)
2. Women are more sexually aroused by romantic words, images, and **themes** in films and stories (Ellis & Symons, 1990).
3. Male sex drive is **more constant** while the female sex drive is more **periodic** but more intense (Basson, 2002).
4. Male sex drive is focused more directly on **copulation** while the female sex drive is embedded in a wider range of stimuli (Fisher, 1999).

Gender Differences

● ROMANTIC LOVE

- Both sexes express romantic love with approximately the same intensity.
- Both men and women are attracted to partners who are dependable, mature, kind, healthy, smart, educated, sociable, and interested in home and family (Buss, 1994)
- There are differences in what men and women find attractive in a mate:
 - Men tend to be more attracted to a partner's physical appearance – particularly signs of beauty and health.
 - Women are more inclined to be attracted to men with money, education, and/or position (Buss, 1994)

Gender Differences

● ATTACHMENT:

- Men are more likely to define emotional closeness or intimacy as doing things side-by-side.
- Women more often view emotional closeness or intimacy as talking face-to-face.

What Men Need to Learn for Sexual Health

3. SEXUALITY IS GROUNDED ON

Accurate Sexual Knowledge and Reasonable Sexual Expectations

Reasonable Sexual Expectations

1. He understands that the commercial marketing with sex is usually:
 1. superficial & simplistic
 2. plays on desires or inadequacies
 3. manipulative -- in order to sell products.
- ▶ He learns how his person and sexual body "work:"
 1. physiological □
 1. based on acceptance of sex drive;
 2. based on accurate knowledge of your body;
 2. psychological □ emotional integration.

"Sex in America" (NHSL) Findings

- "The general picture of sex with a partner in America shows that Americans do not have a secret life of abundant sex." (p. 122)
- "Contradicting the common view of marriage as dull and routine, the people who reported being the most physically pleased and emotional satisfied were the married couples." (p. 124)
- "Virtually all the people who were happy in general also said they were happy with their sex lives." (p. 130)

NHSL: Frequency of Sex

- 33% of Americans aged 18 to 59 have sex with a partner as often as twice a week:
 - 1/3rd = >2x+ week.
 - 1/3rd = a few times a month.
 - 1/3rd = a few times a year.

The Role of Sex in Marital Satisfaction

- When sexuality *functions well*, it is a positive, integral component in the relationship, contributing **15 – 20%** of satisfying, intimate feelings.
- When sexuality is *dysfunctional*, it plays an inordinately powerful role, from **50-75%**, draining the relationship of intimacy and good feelings.

What Men Need to Learn for Sexual Health

4. *The Ultimate Sexual Focus is* **SHARED INTIMACY.** **SEXUALITY IS RELATIONAL**

Sexuality is Relational

- He grows to view his partner as his “Sexual Friend.”
- He views their relationship as an “Intimate Team.”
- His perspective honors the importance of sex as one of a number of facets of intimacy.

12 Facets of Intimacy

- **Recreation:** sharing experiences of fun, sports, hobbies, recreation; sharing ways of refilling the wells of energy, leisure.
- **Aesthetic:** sharing experiences of beauty – music, nature, art, theater, dance, movies; drinking from the common cup of beauty.
- **Intellectual:** involves sharing the world of ideas; a genuine touching of persons based on mutual respect for each others intellectual capacities (reading, discussing, studying, respectful debating, etc.).
- **Commitment:** togetherness derived from dedication to a common cause, value or effort (e.g. working for a political cause).
- **Work:** sharing common tasks or projects, supporting each other in bearing responsibilities (raising a family, house/yard chores, cooking together, etc.).
- **Communication:** being open, honest, trusting, truthful, loving, giving constructive feedback, positive confrontation.
- **Crisis:** standing together in the major and minor tragedies which persist in life; closeness in coping with problems and pain.
- **Sexual:** sensual-emotional satisfaction; the experience of sharing and self-abandon in the physical merging of two persons; sensual-sexual fantasies and desires.
- **Emotional:** depth awareness and sharing of significant meanings and feelings; the touching of the innermost selves of two human beings.
- **Creative:** helping each other to grow, to be co-creators (not “reformers”) of each other.
- **Conflict:** standing-up with/to each other; “fighting” in non-des-truective (i.e., constructive) ways; facing and struggling with differences together.
- **Spiritual:** the “we-ness” of sharing ultimate concerns, the meanings of life, philosophies, religious experi-ence.

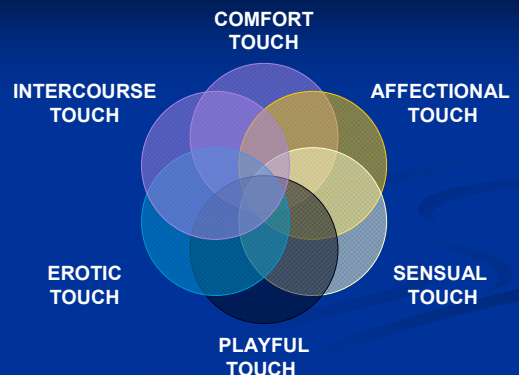
What Men Need to Learn for Sexual Health

5. VALUE SENSUAL TOUCH & EMOTIONAL PLEASURE **AS WELL AS PERFORMANCE**

The Importance of Touch: “skin hunger”

- **Controlled studies suggest that touch:**
 1. **reduces stress.**
 2. **diminishes irritation, frustration, anger.**
 3. **consoles and comforts.**
 4. **reassures or soothes fear.**
- **“Boys and men need loving too.”**

The 6 Kinds of Touch



What Men Need to Learn for Sexual Health

- Appreciate the value of each kind and level of touch.
- Balance the multiple kinds of touch.
- Blend touch desires with the partner.

What Men Need to Learn for Sexual Health

6. SEXUAL DESIRE & AROUSAL ARE SELF-REGULATED.

Sexual Self-Regulation

- Arousal regulation is at the heart of developing male sexual health.
- Arousal regulation requires self-care and “sophisticated training”:
 - 3 developmental, regulatory learning tasks.

The Big Three Sexual Health Learning Tasks

● Task 1 →

Accept and Respect the male “biological imperative” or “lust.”

Respect its power and the need for self-regulation. Regulate this drive with good physical healthy habits, exercise, and self-discipline.

The Big Three Sexual Health Learning Tasks

● Task 2 →

Accept and regulate the male biological tendency to objectify external sexual stimulation.

Accept the sexual health requirement to regulate this tendency toward sexual “objectification” by self-discipline of cognitive focus and conscious priority on personalization of one’s sexual relationship.

Understanding Sexual “Objectification”

1. The male body appears to be biologically-programmed and arousal-dependent on external sexual stimulation.
2. This natural “biological imperative” promotes sexual objectification (vs. personalization) --> arousal-dependent on external sexual stimulation.
3. Significant pornography misuse, infidelity, etc. may be manifestations of extreme objectification and over-reliance on “partner interaction” rather than “entrancement” arousal style.
4. Fears of sexual failure (inadequacy) structures and shapes excessive objectification of sex.
5. When “objectification” is imbalanced, it may render sex “mechanical,” overly performance focused, and “interpersonally shallow”.

The Big Three Sexual Health Learning Tasks

- **Task 3** →
Appreciate and manage the male tendency for “emotional sexualization”:
- This “emotional reductionism” overlooks general emotions such as loneliness, frustration, sadness, anxiety, irritability or obsessiveness, misinterprets them, and “funnels” or transforms them as sexual energy or represses them.
- Sexual Health involves developing an emotional sophistication of your feelings, and direct, healthy ways of emotional management.

The Healthy Sexual Regulatory Cycle

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- manages sex behavior (B)
- by regulating cognitive (C), and
- emotional (E) sex drive:
 - **Western style:**
 - “Control” hunger, desire.
 - Repression / suppression.
 - **Eastern style:**
 - “Accept” hunger, desire “happens...”
 - Willingness to let it “pass through...”

Self-Discipline / Self-Regulation

- “When you understand that discipline is self-caring -- not self-castigating -- you won’t cringe at its mention, but will cultivate it.”

(S. Stanton)

Compulsive Sexual Behavior

Manifestations of Regulation Problems: Compulsive Sexual Behavior (CSB) - 1

- ▶ Compulsive sexual behavior involves detrimental and excessive preoccupation with sexual content such as:
- 1. Excessive sexual fantasies (e.g., eye focus (“visual docking”) on a woman’s breasts, butt, or other physical characteristics (other than during love-making) for more than 5 seconds, or replaying a sexual fantasy to the point of distraction from work tasks or alienation from your sexual partner.
- 2. Extreme frequency of masturbation (e.g., 3 times per day) without the demonstrated ability (e.g., no masturbation for 1 month) to cease.
- 3. Inability to limit pornography (e.g., internet pornography to less than 1 hour per week).
- 4. Seeking the services of a prostitute.

Manifestations of Regulation Problems: Compulsive Sexual Behavior (CSB) - 2

- 5. Frequenting “strip bars” more than 3 times a year, especially going alone.
- 6. Significant financial expenditures, beyond your financial means.
- 7. Excessive or rigid sexual demands (rather than requests) with your partner.
- 8. Extra-relationship affairs.
- 9. Having more sexual interest in, and/or emotional vulnerability to, other women than your partner?

Compulsive Sexual Behavior (CSB) Individual features

1. "Sexual behavior is the fast track to unspoken, perhaps unrealized, feelings..." ("sexualization" of emotions).
2. "They hurt and turn to sex as a panacea for their pain."
3. CSB -> how people:
 1. pursue their needs in "a world that can be unyielding";
 2. find acceptance "in a world that can be disparaging";
 3. find control in a world that can be "disempowering".

(Cooper & Marcus, 2003)

The Compulsive Sexuality Cycle

Michael E. Metz, Ph.D.



Compulsive Sexual Behavior (CSB) Relationship features - 1

1. Sexual compulsivity is a relationship problem. (Cooper & Marcus, 2003)
 1. Fear of intimacy – being "seen" or known.
 2. Fear of losing emotional control – sadness, anger, love.
 3. Fear of being alone and fear of trusting enough to open up.
2. 95% of sexually compulsive men are unable to form close attachments. (Leedes, 2001; p. 216)
3. "When psychological intimacy occurs, we begin to weave the other person into our lives..." (Leedes, 2001; p. 216)

Compulsive Sexual Behavior (CSB) Relationship features - 2

- The partner's potential role contributing to his CBS:
 1. Emotional and/or sexual abandonment.
 2. Physiological illnesses.
 3. Unresolved relationship conflict.
- Such features often serve to "rationalize" his behavior.

Pornography, Prostitution, TV...

- Pornography
 - \$8 – \$14 billion a year industry (Byrne & Osland, 2000).
 - Average use in hotels: 4 minutes.
- Prostitution
 - est. 1.5 million customers a week.
 - \$14 Billion annual business.
- TV
 - 75% of family-hour programs contain some sexual content.
 - 61% contain sexual behavior (8.5 sexual interactions per hour (Freeman-Longo & Blanchard, 1998).

Pornography, Prostitution, TV...

- Prevalence:
 - 6 – 8 % "addicted" to sex. (Amparano, 1998)
 - 4:1 ratio of men to women.
 - Not defined by cultural and ethnic factors.

(Cooper, McLoughlin & Campbell, 2000).

Internet Users

Prevalence:

1. Of all internet users, 20% go to sexual content.
2. Of these 20%, as high as 17% of internet pornography viewers develop online problems.
3. Two-thirds (68%) of sex abusers also use the internet for sex purposes.

(Cooper, McLoughlin & Campbell, 2000).

The “Power” of the Internet

- Easy accessibility.
- Affordable.
- Unlimited variety of content.
- “private.”
- Non-embarrassing.
- “Invitational.”

Visual Pornography Continuum

1	2	3	4	5
Sensual Erotica	Nudity, explicit sex	Mutual sex acts	Dominant sex acts	Violent sex acts
<i>Examples:</i> Sensual art	Playboy	Penthouse, Screw	S & M “dominance”	rape “snuff” murder

Pro-Intimate ←-----→ *Anti-Intimate*

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UNDERSTANDING SOME MALE SEXUAL CONCERNS

- A. Sexual Dysfunctions**
- B. Sexual Difficulties & Special Issues**
 - A. Expectations
 - B. Loyalty issues
 - C. Sexual abuse
 - D. Orientation issues
- C. Sexual Disorders**
 - A. Sexual identity
 - B. Paraphilia
 - C. Sex offending
 - D. Sexual compulsivity

A. SEXUAL DYSFUNCTION

- The inability to perform the sexual act with mutual satisfaction.
- Traditional classification is rooted in the physiologic stages of human sexual arousal

UNDERSTANDING SEXUAL PROBLEMS: APA Diagnostic and Statistical Manual-IV (DSM-IV) (1994).

1. Disorders Usually First Diagnosed in Infancy, Childhood, Or Adolescence
2. Delirium, Dementia, and Amnestic and Other Cognitive Disorders
3. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified.
4. Substance-Related Disorders
5. Schizophrenia and other Psychotic Disorders
6. Mood Disorders
7. Anxiety Disorders
8. Somatoform Disorders
9. Factitious Disorders
10. Dissociative Disorders
11. SEXUAL and GENDER IDENTITY DISORDERS
 - Sexual Dysfunction
 - Paraphilias
 - Gender Identity Disorders
12. Eating Disorders
13. Sleep Disorders
14. Impulse-Control Disorders Not Elsewhere Classified
15. Personality Disorders
16. Other Conditions that May Be a Focus of Clinical Attention
17. Additional Codes

National Health and Social Life Survey (1994)

● Men's Sexual Complaints (31%):

● Premature Ejaculation	1 in 4	28.5 %
● Performance Anxiety	1 in 6	17.0 %
● Lacked interest	1 in 6	15.8 %
● Erectile Dysfunction	1 in 10	10.4 %
● Ejaculatory Inhibition	1 in 11	8.3 %
● Sex not pleasurable	1 in 11	8.1 %
● Pain with coitus	1 in 33	3.0 %

(N = 1,410, ages 19 – 59)

National Health and Social Life Survey (1994)

● Women's Sexual Complaints (43%):

● Low Desire	1 in 3	33.4%
● Inhibited Orgasm	1 in 4	24.1%
● Sex not pleasurable	1 in 5	21.2%
● Pain with intercourse	1 in 7	14.4%
● Performance Anxiety	1 in 10	11.5%
● Lubrication trouble	1 in 10	10.4%
● Climax too soon	1 in 10	10.3%

(N = 1,740, ages 19 – 59)

Gay and Lesbian Couples -- SD

- Prevalence of sexual dysfunctions are similar to heterosexuals.
- Variant sexual dysfunctions:
 - Men: painful anal intercourse.
 - Women: sexual desire.
- Special features:
 - coming out issues.
 - the burdens from the lack of full societal support (shame?).

B. SEXUAL DIFFICULTIES

Common Sexual Difficulties

1. Frequency of sex – 98% partners discrepancy.
2. Expectations of intercourse (e.g., length, style, positions, eye-contact...).
3. Variety and comfort with sexual practices
-> (e.g., foreplay, oral, length, anal, video use, S & M, apparel, sexual "dancing," sex "toys" (e.g. dildoes, vibrators).
4. Roles: leadership, initiation of sexual activities, arousal styles, seduction, avoidance.
5. Acceptability of masturbation with/without partner.
6. Adaptation to STDs (e.g., herpes) & medical problems.
7. The meaning of sex dysfunction – ED, PE, ISD, pain.

Sexual Difficulties as 'Couple Opportunities'

- Disagreements and difficulties require the couple to operate as an "intimate team."
- Conflict as the "opportunity for intimacy."
- Mutually satisfying problem-solving is necessary.

Special “Challenges”

1. **Sexual Disloyalty:** Sexual and emotional affairs.
2. **Sexual Abuse History:** History of sexual trauma that has not been well processed or accepted.
3. **Sexual Orientation:** Individual and relationship conflicts regarding sexual orientation.

Sexual Disloyalty - “Infidelity”

- **Prevalence:** (Laumann et al., 1994)
 - 16% women (est. range: 6-18%)
 - 18% men (est. range: 8-24%)
- **Predictive Effect:**
 - Woman’s affair = divorce in 2/3rd of cases.
 - Man’s affair = divorce in 1/3rd of cases.

Sexual Disloyalty: FUNCTIONS

1. Pleasure, gratification:
 1. Physical
 2. Emotional (e.g., appreciation)
2. “Flag” of Psychological Problem:
 1. Historical theme (s).
 2. Bipolar, OCD or other psychological problems.
 3. Emotional sexualization.
3. “Flag” of Relationship Problems:
 1. “Fire Alarm”.
4. Catalyst for Divorce.

Sexual Difficulties: Sexual Abuse

- Men’s shame to acknowledge.
- History of experiencing abuse:
 - trust issue.
 - feeling “used.”
 - fears of sexual arousal.
 - precursor of abusing?
 - contextual issues.
 - arrested sexual development.

Sexual Orientation Conflict in Hetero & Same-Sex Couples

- **Sexual Orientation:**
 - **Individual conflicts:**
 - coming out & acceptance
 - lifestyle issues
 - **Relationship conflicts:**
 - detrimental effects of social repression.
 - if heterosexually married, violation of marital “contract.”
 - inability for partner to “compete.”

C. SEXUAL DISORDERS: --> often secrets:

1. Sexual Identity Disorders.
2. Variant fantasy or arousal patterns.
3. Deviant arousal patterns.
4. Sexual compulsivity:
 - E.g., preference for masturbatory sex rather than couple sex, especially use of the internet and pornography.

Sex Offending (deviant sex behavior)

Sexual offense:

- A legal/social term used to describe a group of harmful sexual behaviors that involve another person and are in violation of state or federal law.
- Exploiting or abusing another:
 - medical/biological problem.
 - psychiatric disorder (e.g., bipolar disorder).
 - illegal paraphilia enactment (e.g., pedophilia).
 - other illegal behavior (e.g., "john").

Comprehensive Sex Offender Treatment

1. Prevention of recidivism:
 1. acute: e.g., opportunities for victim access
 2. chronic: e.g., intimacy deficits.
2. Manage abusive feelings and behaviors.
3. Awareness of damage caused by behavior.
4. Address emotional dissociation.
5. Development of empathy.
6. Alter sexual arousal patterns.
7. Improve social & relationship skills.
8. Resolve mental health problems (e.g., mood disorder, chemical abuse).

What Men Need to Learn for Sexual Health

7. HE LEARNS FLEXIBLE SEXUAL AROUSAL

The Male Issue of "Familiarity"

- Sexual Over-Familiarity ("predictable," "routine" "monotonous") may produce "boredom" with the covert fear of sex dysfunction (ED; HSE, EI).
- This "familiarity" issue is sometimes futilely addressed with:
 - Demands for excessive sexual variety.
 - Excessive use of pornography.
 - Sexual compulsivity.
 - Sexual acting out.
 - Loss of sexual desire.

Basic Components of Sexual Flexibility

- 5 Basic Purposes for sex --> flexible sexuality pursues multiple purposes.
- 3 General Sexual Arousal Styles --> Flexible sexuality blends the multiple arousal styles (e.g., sexual arousal varies from partner interaction to entrancement arousal, and role enactment).
- Flexible sexuality realistically embraces variability of sexual quality.

The 5 Positive Purposes for Sex

1. **Reproduction** (bio)
2. **Tension / anxiety reduction** (bio-psycho)
3. **Physical pleasure** (bio-psycho)
4. **Self-esteem** (bio-psycho)
5. **Relationship intimacy** (social/interpersonal).

Arousal Styles: Differences in Focus

1. "**Partner Interaction**" focus on the partner. Person is active, eyes open, looking at the partner, talkative (romantic or "sweet" talk), and energetic. This is the sexual style on TV and in movies -- passionate and impulsive sex.
2. **Sensual "Self-entrancement"** focus on one's own body. Person utilizing this style typically closes one's eyes, goes within, becomes quiet, and looks detached and passive. Routine and stylized touch help this person to become aroused.
3. "**Role Enactment**" focus on role play, fantasy, variety, and experimentation, such as dressing in sexy lingerie, role playing being "tough" or "hard to get," acting out a scene from a movie or fantasy, having sex in new places (e.g., vacation), using "toys" (massage oil, vibrator, dildo) to find excitement and arousal through sexual playfulness.

The Quality of Sex in Well-Functioning, Satisfied Married Couples

- 35 – 45% Very Good Quality.
- 20 – 25 % Good Quality (at least for 1 partner).
- 15 – 20 % Okay; Not Remarkable.
- 5 – 15 % Mediocre, Dysfunctional.

(Sources: Frank, Anderson & Rubinstein, 1978; Laumann, Michaels, Gagnon, et al., 1994)

What Men Need to Learn for Sexual Health

8. Cooperation for Intimacy

Sexual Health and satisfaction work best when you and your partner work together as an "intimate team" for mutual closeness, pleasure, stress reduction, soothing comfort, mutual self-esteem, playfulness and joy.

Features of Relationship Satisfaction

Sexual health and satisfaction is directly influenced by the quality of relationship conflict resolution.

When each partner feels emotionally satisfied, the resolution perpetuates itself because it feels good, is an improvement, a better way.

Features of Relationship Satisfaction

All Conflict Resolution has as its Goal Mutual Emotional Satisfaction

In satisfying relationships, conflicts are resolved with emotional satisfaction for each partner. The goal is to work out wise solutions that are emotionally pleasing for BOTH partners -> "Win-Win" resolutions. On the other hand, when one person wins and the other loses, both will eventually lose and the resolution will fail.

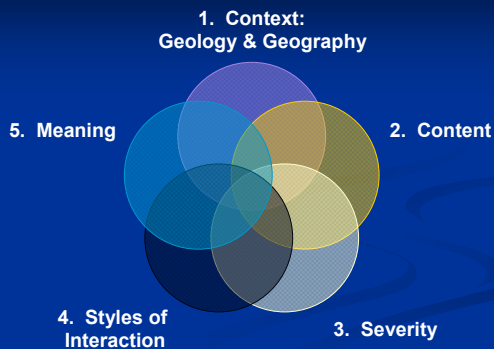
Conflict as an Opportunity for Intimacy

Constructive Conflict Resolution and Intimacy

Conflict presents the ordinary, day-to-day opportunity for couples to deepen their emotional and sexual intimacy.

- Learn about your partner's complexity and uniqueness.
- Reinforce respect and admiration for each other.
- Develop more confidence that future conflict can be positively resolved.
- Create positive feelings and comfort with each other that facilitate their sexual desire for each other.
- Develop a greater sense of pride in their relationship.

The 5 Features of Relationship Conflict



5. The Meaning of Conflict

The meaning of conflict refers to the idiosyncratic importance of disagreement for this couple – “Why” is this couple struggling together, and what does the disagreement mean to each member of the couple? What is the “function” of the conflict?

--> Discovering the meaning of the conflict is the preeminent goal for understanding a couple's disharmony and helping them make changes.

Common “Meanings” of Conflictual Interactions

1. “I want to and try to share my feelings, but I usually feel rejected... debated... judged... “fixed.”
2. “I just want to be accepted for who I am, not who he/she wants me to be...”
3. “I want some appreciation... I always feel I am never good enough. It is always something more...”
4. “He/she thinks he/she can read my mind, my intensions, but he/she is not only wrong but interprets me negatively.”
5. “It always gets turned around to his/her feelings – it's always about him/her – and I don't have a chance.
6. He/she always criticizes me!”
7. “My partner no longer loves me...”

What Men Need to Learn for Sexual Health

9. INTEGRATE SEXUALITY INTO DAILY LIFE.

Integration of life events into lovemaking.

- Sex is a regular part of life.
- The healthy sexual couple integrates the daily events of life and blends this with the partner's, to create the couple's unique, realistic, sexual style.
- Sex “fits” real life:
 - sex fits into one's daily life; daily life fits into sex. Caring Sex -- sex is commonplace with moments of tenderness, experimentation, playfulness, passion and wildness, and reflection.

Integration of life events into lovemaking

--> Living daily life provides the opportunity to experience sexual interactions in a subtly yet distinctively personalized and enriched way:

- sex on vacation.
- during pregnancy.
- during times of loneliness.
- after the wedding of your best friend.
- after a parent's death.
- during times of career stress.
- after a class reunion.
- during periods of success
- during periods of failures.
- amidst childrearing.
- family illnesses.

Marital Sex

- Rather than “routine,” boring, lethargic, and perfunctory, healthy sexuality is honest and realistic; it “fits” your realistic lifestyle amidst careers, kids, and routines, as well as at times providing an “escape.”
- Satisfying marital sex is respectful, tender, playful, and occasionally wild & experimental.
- Married couples enjoy stable sex with benefits like comfort, relaxation, trust, pleasure, cooperation, and emotional intimacy.

What Men Need to Learn for Sexual Health

10. EMBRACE THE STANDARD OF OF “GOOD-ENOUGH SEX”

Metz, M. E., & McCarthy, B. W., (2007). “The Good-Enough Sex Model for Couple Sexual Satisfaction.” *Sexual and Relationship Therapy*, Vol. 22 (3), 351-362.

McCarthy, B.W. & Metz, M. E., (2008). “The Good-Enough Sex” Model: A Case Illustration. *Sexual and Relationship Therapy*; 23 (3), 227.

12 Dimensions of the “Good-Enough Sex” Model

1. Sex is a good element in life, an invaluable part of an individual’s and couple’s long-term comfort, intimacy, pleasure, and confidence.
2. Relationship and sexual satisfaction are the ultimate developmental focus and are essentially intertwined. The couple is an “intimate team.”
3. Realistic, age-appropriate sexual expectations are essential for sexual satisfaction.
4. Good physical health and healthy behavioral habits are vital for sexual health. Individuals value their and their partner’s sexual body.
5. Relaxation is the foundation for pleasure and function.
6. Pleasure is as important as function.

12 Dimensions of the “Good-Enough Sex” Model

7. Valuing variable, flexible sexual experiences (the “85 percent approach”) and abandoning the “need” for perfect performance inoculates the couple against sexual dysfunction by overcoming performance pressure, fears of failure, and rejection.
8. The five purposes for sex are integrated into the couple’s sexual relationship.
9. Integrate and flexibly use the three sexual arousal styles.
10. Gender differences are respectfully valued and similarities mutually accepted.
11. Sex is integrated into real life and real life is integrated into sex. Sexuality is developing, growing and evolving throughout life.
12. Sexuality is personalized: Sex can be playful, spiritual, “special.”

What Men Need to Learn for Sexual Health

“Good Enough Sex” is:

PLAYFUL

Sex as Mature Playfulness

- The occasional presence of play is a reliable indicator of relationship and sexual health, because for play to occur, certain other aspects of intimacy must be functioning well:
 - trust.
 - mutual acceptance.
 - pleasure is more important than performance.
 - priority upon the relationship (“special”).
 - freedom to be oneself.

Couple Reports of Sexual Playfulness

- A 34 year old male lawyer wrote:
- "We spend time tickling each other which is sometimes sexual and sometimes not. We will touch each other 'sexually' while doing normal everyday things. We will 'accidentally' touch each other. We chase each other in the house. I will sneak up on her while she is changing. I will expose myself at times in the house when we are alone. My wife will give me a sneak peek when she teases. We take showers together and will sometimes wash each other with sexual overtones."

(Metz, ME, (2004). The Role of Adult Play in Intimacy.)

Couple Reports of Sexual Playfulness

- A 36 year old father: "Lately we haven't played much because we have had two unplanned pregnancies. I worry about the financial burden of this (providing for family) and feel I have to be real concerned about my job..."
- One's personal history can inhibit comfort and skill at play as this 41 year old woman felt intense pressure to please her partner because two previous relationships had ended because of what she believed was her sexual inadequacy:
 - "We don't play in our sexual relationship. I have always taken sex too seriously to be able to think about being sexually playful. Clearly, I need to do some work on this."

(Metz, ME, (2004). The Role of Adult Play in Intimacy.)

Couple Reports of Sexual Playfulness

- A 32 year old female teacher said:
- "I love to dress up for my husband in lacy clothes one time, then my regular underwear another. I also sometimes beg him in a playful way (I get down on my knees and BEG dramatically!) to dress for me in his tuxedo or leopard skin briefs...that I have to have him this way... It's a spoof and a tease! But it really feels like we're willing to please each other....that's why I think I so love this... I also prize the way we can giggle and smile sometimes when we're making love. I feel so special then..."

(Metz, ME, (2004). The Role of Adult Play in Intimacy.)

Mature Couple Playfulness

- Play acknowledges:
 - the complexity and ambiguity of life
 - the multiple levels of reality
 - the priority is on interpersonal connection
- Play involves cooperation, comfort, feeling safe and secure, unconditional acceptance, trust, union, and delight.
- Sexual playfulness enhances and strengthens intimacy, and respects the capacity of sexuality as transcendent or spiritual experience.

Sexuality, Play & Spirituality

- Deep respect for the capacity of the human experience of sex.
- Transcendental experiences with sexuality.
- Roman Catholic "Sacramentality."
- Prayer / philosophy and sexuality – celebrating the meaning of life & death.

INTEGRATIVE SEXUAL THERAPY

Understanding and Treating Male Sexual Concerns

Basic Sex Problem Assessment: Types & Severity

1. Determine each & all of the biopsychosocial SD "types":
Initial uses
Maintaining causes
Detrimental effects

To miss a cause, effect, or contributing feature will undermine treatment success.
2. Determine the SD severity level to guide the level of treatment detail.

Diagnosing #1: Determine the "Types" of SD

Although by observation,
SD is one observable phenomenon

- erection difficulty, inhibited orgasm,
absence of desire, premature ejaculation,
pain with intercourse, compulsive
masturbation...

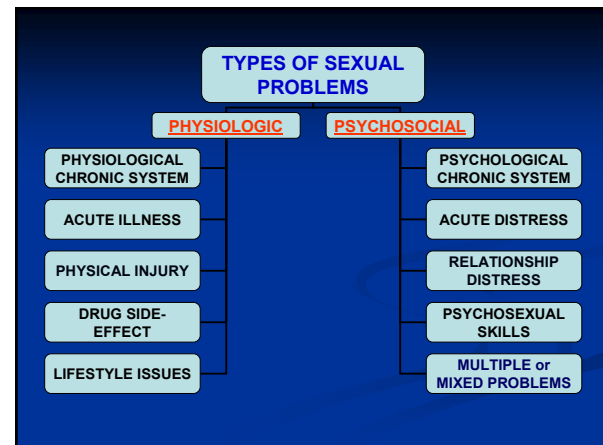
there are multiple possible "types"
--> *causes & effects.*

10 Sex Problem Types Based on Etiology and Impact

- ▶ Evidence in the biopsychosocial Research and Clinical literature suggests 10 possible "types" (causes/effects) of sex problems.

(Metz, Pryor, et al., 1997; Metz & Pryor, 2000)

- ▶ Biogenic SD (5)
- ▶ Psychogenic SD (4)
- ▶ Multiple or "Mixed" SD (1)



Diagnosing #2: Comprehensive Diagnosis

DETERMINE THE SEVERITY OF THE SEX PROBLEM.

Severity determines
the level of clinical detail for
successful treatment.

Sexual Disorders: Severity

- Sexual disorders are not dichotomous; each is complex, multicausal, and multidimensional.
- Sexual disorders vary in severity and level of distress on a continuum:

← mild moderate severe →

Comprehensive Assessment Sexual Dysfunction & Sexual Problems

Comprehensive Assessment of Sexual Dysfunction

- 1. Couple Interview.**
SD verification, meaning of ED, couple dynamics, and begin TX.
- 2. Individual Interview.**
Care to distinguish ED and ED
- 3. Sexual History (both partners).**
Cognitions, behaviors, feelings about sexuality
- 4. Determine the Sexual Dysfunction / Sex Problem Severity (e.g. PESI).**

Comprehensive Assessment of Sexual Dysfunction.

- 5. Consider physical examination.**
the history of present illness and past medical history will provide further clues about where to focus the physical examination.
- 6. Consider medical testing:**
*neurologic
vascular
endocrine (e.g., diabetes)*

Comprehensive Assessment of Sexual Dysfunction.

- 7. Judicious use of psychological and relationship testing.**
 - psychological features (MMPI-2; Millon MCMI-3, etc.)
 - relationship features (MSI; SCI; DAS; L-W MAS, etc.)
- 8. Differential Diagnosis of the Type(s)**
“The SD Diagnostic Decision Tree.”

The SD Diagnostic Decision Tree

Comprehensive Diagnosis of SD Types

- 1. Use the diagnostic decision tree to determine the MULTIPLE “types” (causes & effects) in order to design comprehensive treatment.**
- 2. To miss a cause, effect, or contributing feature will undermine treatment success.**

Differential Diagnosis of SD Types

INITIAL DIFFERENTIAL:

1. Onset of SD
 1. lifelong
 2. acquired
2. Context of SD
 1. generalized to all situations
 2. situational

Assessing Sexual Dysfunction for Sources

Onset: "LIFELONG" SD HAS
3 POSSIBLE SOURCES:

1. Physiologic System SD – Biogenic
2. Psychological System SD - Psychogenic
3. Sexual Skill Deficit SD - Psychogenic

Assessing Sexual Dysfunction for Sources

Onset: "ACQUIRED" SD HAS
6 POSSIBLE SOURCES:

1. Acute Illness - Biogenic
2. Drug/Pharmacological - Biogenic
3. Physical Injury – Biogenic
4. Lifestyle Issues – Biogenic / Psychogenic
5. Acute Psychological - Psychogenic
6. Relationship Distress – Psychogenic

Differential Diagnosis of SD Types

Step 1: *If lifelong onset and generalized context*

1. History / evidence of physiological predisposition to SD.
2. Neurologic, endocrine, vascular testing?
3. No evidence of psychopathology.

Yes = **Physiological System SD**

Differential Diagnosis of SD Types

Step 2: *If lifelong onset and generalized context*

1. History / evidence of chronic psychological character pattern or psychopathology that predisposes to SD (e.g., bi-polar; schizophrenia...).
2. Evidence from objective psychological testing.

Yes = **Psychological System SD**

Differential Diagnosis of SD Types

Step 3: *If lifelong onset and generalized context*

1. Evidence of unrealistic sexual expectations, cognitive/behavioral inability to physiologically relax during sex, focus on pleasure in his own body, employ pacing strategies, and mutually interact sexually with the partner.
2. No evidence of psychopathology.

Yes = **Psychosexual Skills SD**

Differential Diagnosis of SD Types

Step 4: *If acquired onset and either context*

1. Is there a current physical illness known to cause SD?

Yes = **Physical Illness SD**

Some Medical Illnesses Associated with SD

Alcohol abuse	Diabetes mellitus
Sleep disorders	Peyronie's Disease
Hypothyroidism	Polyneuropathy
Lipid abnormalities	Cancer
Systemic Lupus	Cancer treatments
Parkinson's Disease	Hypopituitarism
Multiple sclerosis	Epilepsy
Chronic renal failure	Hypogonadism
Cardiovascular disease	STDs
Toxemia	UTIs / urethritis
Prostatitis	cerebral tumor
Arteriosclerosis	Endocrine abnormalities

Differential Diagnosis of SD Types

Step 5: *If acquired onset and either context*

1. Has there been a physical injury, pelvic surgery, or neurologic trauma that may reasonably cause SD?

Yes = **Physical Injury SD**

Differential Diagnosis of SD Types

Step 6: *If acquired onset and either context*

1. Are there lifestyles issues such as significant overweight, sleep deprivation, smoking, alcohol abuse, poor physical conditioning or excessive conditioning that may reasonably cause SD?

Yes = **Lifestyle Issues SD**

Differential Diagnosis of SD Types

Step 7: *If acquired onset and either context:*

1. Has the man begun taking a chemical agent known to cause SD (e.g., antihypertensive, epinephrine) or withdrawn from an agent (e.g., opiates)?

Yes = **Drug Side-Effect SD**

Differential Diagnosis of SD Types

Step 8: *If acquired onset and either context*

1. Is there self-report and objective psychological test evidence that the man is experiencing current non-sexual psychological stress?

Yes = **Psychological Distress SD**

Differential Diagnosis of SD Types

Step 9: *If acquired onset and either context*

1. Is there evidence from interview and history of relationship distress associated with SD.
2. Is there relationship test evidence of current relationship distress associated with SD (e.g., DAS, LW-MAS, MSI, SCI)?

Yes = **Relationship Distress SD**

Differential Diagnosis of SD Types

Step 10: *If acquired onset and either context*

1. In addition to the presenting SD, is there also a complaint of another SD?
2. Or, In addition to the man's SD, does the partner report a sexual dysfunction?

Yes = **"Mixed" SD or**

Multiple Sex Dysfunctions.

Individualized Treatment Summary Sheet: PREMATURE EJACULATION: PAUL & JENNY

TYPES:

- Bio-Neurologic System PE
- Psychological System PE
- Psychosexual Skills Deficit
- Physical Illness PE
- Physical Injury PE
- Pharmacologic side-effect
- Individual Psychological Distress PE
- Relationship Distress PE
- Mixed PE

SEVERITY: PESI = 74 (range 0 – 100, higher = more)

INTEGRATIVE SEX THERAPY

Biological and medical therapies.

Psychological therapies.

Relationship therapies.

Medical Options

- Pharmacologic agents
- Therapeutic devices
- Surgical interventions

Male Pro-Sexual Medications for ED

- **Levitra, Viagra and Cialis** (PDE5) help initiate and maintain erection by relaxing the corpus cavernosum smooth muscle in your penis.
- **Yohimbine (Yocom)**, an extract from an African tree, has been used for a number of years as an aide to erections by affecting the corpus cavernosum in the penis.

Antidepressant Medications

- Antidepressants may relieve ED that is common with depression by alleviating the depression. SSRIs are frequently prescribed to slow ejaculation for men with PE.

Male Pro-Sexual Medications for ED

● Antianxiety Medications

Antianxiety medicines may also be useful. Medications that are effective in treating generalized anxiety and panic attacks can help some men when ED or PE results from performance anxiety. These medications include Librium (chlordiazepoxide), Ativan (lorazepam), Valium (diazepam), and Xanax (alprazolam).

● Medications Applied to the Penis

PGE1: The most commonly used application is prostaglandin E1 (PGE1), which you inject into the base of the penis a few minutes before sexual activity. **Alprostadil:** Medicated Urethral System for Erection (MUSE) is a device used to insert an alprostadil suppository into the urethral opening.

Some Pharmacologic Options for PREMATURE EJACULATION

Oral Agents:

- **Serotonergic antidepressants:**
 - e.g., sertraline, paroxetine, fluoxetine
- **Tricyclic antidepressants:**
 - e.g., Clomipramine (Anafranil); amitriptyline (e.g., Elavil)
- **Anxiolytics (anti-anxiety):**
 - e.g., alprazolam (Xanax).
- **Neuroleptics (anti-psychotic):**
 - e.g., thioridazine (Mellaril), 10-25 mg. - judicious use only.

Desensitization Applications:

● Creams / Ointments

- e.g., ethyl amino benzoate, benzocaine, nupercaine lidocaine solution with condom (e.g. Detane, Mandelay, Performax).

Pharmacologic Agents for “Quieting”

SEXUAL DISORDERS

● Compulsive Sexual Behavior

- **Psychiatric (e.g. bipolar mood disorder)**
 - Neuroleptics
- **Psychological / emotional problems**
 - SSRIs
 - Anxiolytics
 - N-Acetyl Cysteine (NAC) – in clinical trials: gambling.
- **Sex Offending (e.g., naltrexone; depoprovera)**
- **Gender Dysphoria – off-label subclinical lithium?**
- **Transsexualism – hormonal reassignment?**

Combination Treatments

- Some physicians experiment with combination treatments that include several medications and interventions designed to overcome physical (e.g., vascular, neurologic) and/or psychological (performance anxiety, depression) limitations.
- For example, PDE5 oral med combined with a vacuum device or MUSE (ED) and SSRI (PE) may be helpful in a severe case.

Non-Surgical Medical Devices

- **Rejoyn:** Nonsurgical prostheses include splints such as Rejoyn, a soft rubber brace that holds the flaccid penis rigid. The brace exposes the tip of the penis to allow for pleasure.
- **Vacuum Constriction Devices:** Vacuum constriction devices draw blood into the penis, causing an erection, and trap the blood there in order to maintain the erection for intercourse. These devices include a plastic tube that fits over the penis in order to create an airtight cover. A vacuum is created around the penis by motor or manual pumping. When erection occurs, a fitted rubber band is placed on the penis at the base to retain the erection.

Surgical Medical Options

- **Surgical Penile Prosthesis for ED**
Rigid or flexible rods, and inflatable devices may be surgically implanted into the penis to make it mechanically erect.
- **Penile Vascular Surgery for ED**
When there is clearly irreversible damage to the penile arteries and veins, penile vascular reconstruction surgery may be attempted. The results of such surgery are usually poor. Such surgery is considered experimental, but its effectiveness may improve with increased medical knowledge and surgical experience.
- **Penile Neurotomy for PE ?**
Penile nerves are surgically cut to stop penile stimulation as an effort to treat PE. (Opinion: This is both unnecessary and unethical).

TREATMENT ILLUSTRATIONS

- case # 1 MALE SEXUAL DYSFUNCTION
 - erectile dysfunction (premature ejaculation).
 - highlights psychosexual skills.
- case # 2 SEXUAL COMPULSIVITY
 - blending sexual and intimacy meanings.
 - highlights relationship therapy.

THE THERAPIST'S ROLE & RESPONSIBILITIES:

1. Provide the forum for cooperative couple work: balance.
2. Provide fairness: "do no harm."
3. Provide clinical leadership – formulate constructive goals with couple.
4. Relationship satisfaction is the Ultimate Goal.
5. Provide realistic optimism and hope.
6. Facilitate empathy and sexual satisfaction.
7. Promote couple capacity, skills.
8. Take care of yourself.

SD Treatment: BASIC CONCEPTS - 1

1. Reasonable sexual expectations are essential.
2. While male sex problems are performance issues, they are fundamentally relationship issues. (For men without a partner, involve the "virtual partner.")
3. The primary goal is to increase intimacy, pleasure, and satisfaction rather than the sole behavior goal.

SD Treatment: BASIC CONCEPTS - 2

4. Individualize treatment to this man and couple, to address the type (s) and severity: The level of detail in psychosexual skills work corresponds to the severity of the SD.
5. It is essential that the couple realize that one technique alone will not usually be effective or sufficient; several techniques must be integrated. Most men require integrating 4 or 5 psychosexual skills.
6. Learn the skills adequately (not perfectly) and coordinate them skillfully. Follow the principle of "good enough sex."

Case Illustration

● SEXUAL DYSFUNCTION

Erectile Dysfunction (Premature Ejaculation)

JASON & MARY

(*Highlighting psychosexual skills*)

CASE ILLUSTRATION: MARY & JASON ERECTILE DYSFUNCTION

- PRESENTING PROBLEM:
 - JASON = "I can't satisfy my wife sexually..."
 - MARY = "He needs to fix this... If I say anything, he just goes away..."
- DEMOGRAPHICS:
 - JASON (34) = H.S. teacher; good health; no meds except anti-allergy medications.
 - MARY (31) = "I'm only a housewife." good health.
 - 2 children = 5 year old daughter, 2 year old son.
- Other:
 - Jason's father died 1-1/2 years ago.
 - Couple shares 1 bottle of wine on weekend.
 - Intake survey suggests Mary dislikes oral sex and John occasionally also prematurely ejaculates (< 15 strokes).

Quick Assessment of “Types” Use the “Decision Tree”

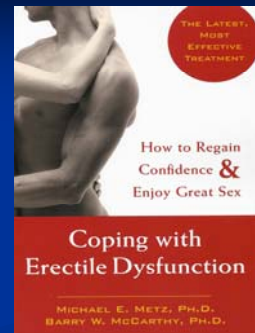
- What possible types?
- Influence your assessment?
- Guide your treatment?

Michael E. Metz Ph.D.
Barry W. McCarthy Ph.D.

Coping with Erectile Dysfunction: *How to Regain Confidence & enjoy Great Sex*

New Harbinger, Oakland, CA. 2004

(translations: Italian; Korean; Turkish,
and Vietnamese languages.

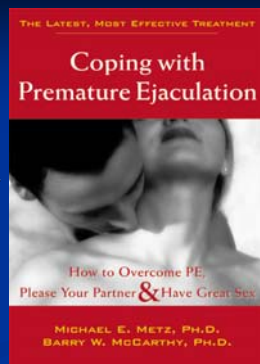


Michael E. Metz, Ph.D.
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Coping with Premature Ejaculation: *How to Overcome PE, Please Your Partner & Have Great Sex.*

Oakland, CA. New Harbinger Publications,
2003.

Translations:
Italian (2005)
Korean (2006)
Turkish (2007)
Vietnamese (2009)



ERECTILE DYSFUNCTION

PHASE ONE: Developing Relaxation and Comfort

- **Step 1: Increasing Sexual Comfort.**
Goal: Develop tranquility and assurance with your partner.
COUPLE EXERCISE: Talking about Sexual feelings.
- **Step 2: Training Your Mind and Body for Relaxation.**
Goal: Learn relaxation, the foundation for pleasure and eroticism.
INDIVIDUAL EXERCISE: Deep Breathing.
INDIVIDUAL EXERCISE: Physical Relaxation.
- **Step 3: Relaxing Your Pelvic Muscle (PM).**
Goal: Identify and learn to consciously control your pelvic muscle
INDIVIDUAL EXERCISE: PM Basic Training
INDIVIDUAL EXERCISE: The PM Continuum.

ERECTILE DYSFUNCTION PHASE TWO: Enhancing Your Arousal and Erotic Flow

- **Step 4: Relaxed Couple Pleasuring.**
Goal: enjoy relaxed, non-erotic, sensual touch.
COUPLE EXERCISE: Touch Quality
COUPLE EXERCISE: Relaxed Pleasuring.
- **Step 5: Your Cognitive Map for Erotic Flow.**
Goal: Develop awareness of the range of your sexual arousal.
INDIVIDUAL EXERCISE: Developing Your Erotic Continuum

ERECTILE DYSFUNCTION PHASE TWO: Enhancing Your Arousal and Erotic Flow

- **Step 6: Partner Genital Exploration and Comfort.**
Goal: Learn more about your own sensations and your partner's; enjoy calm, relaxed touch and physical relaxation in an otherwise erotic situation.
COUPLE EXERCISE: Partner Genital Exploration
COUPLE EXERCISE: Playful Nicknames for Your Special Sexual Parts.
- **Step 7: Couple Arousal Training: Easy Erections.**
Goal: Learn to enjoy your easy erection, then choose to let it go, then comfortably and confidently regain it.
COUPLE EXERCISE: Soothing genital touch
Finding your Calm, Easy Erection
Choosing to Wax and Wane

ERECTILE DYSFUNCTION
PHASE THREE: Enjoying Confident and Flexible Intercourse.

- **Step 8: Progressive Intercourse.**
Goal: Integrate the skills and become confident with erections during intercourse.
COUPLE EXERCISE: Initiating Intercourse
COUPLE EXERCISE: The "Stuff-It" Method
- **Step 9: Intimate and Flexible Intercourse.**
Goal: Enjoy intercourse, encourage your partner's pleasure, and develop alternative (non-intercourse) scenarios.
COUPLE EXERCISE: Enjoying Intercourse
COUPLE EXERCISE: Developing Flexible Scenarios.
- **Step 10: Sexual Playfulness.**
Goal: Create fun and enjoyment with sex.
COUPLE EXERCISE: Alternative Scenarios.

**Growth Maintenance / Relapse Prevention:
Some Ideas**

1. Hold couple meetings (review & reminders).
2. Have a formal 6-month TX follow-up meeting.
3. Set aside "pleasuring sessions." (non intercourse)
4. Write down and review your reasonable expectations.
5. Schedule intimate couple time (walk, talk, dinner).
6. Allow for growth – e.g. the levels of touching.
7. "Good Enough" sex varies – disappointing to great.
8. Hold touch "saturation" sessions.
9. Schedule sessions to comfortably "experiment."

When Skills Treatment is "Floundering"

1. Enjoy being a detective: Sleuth!
2. Be realistic about your treatment expectations based on the "types" {cause (s), effect (s)}, and severity.
3. Use all your resources – especially your knowledge and intuition.
4. ASK your patient (s) for ideas.
5. Be Flexible and creative.

"Floundering" → Levels of Clinical Attention

Incremental Approach:

1. Biological
2. Psychological:
 1. Emotions / Feelings (e.g. resentments).
 2. Behavioral compliance
 3. Cognitive dimension during sex arousal
3. Relational
 1. Identity (relationship cognitions)
 2. Cooperation (conflict resolution behaviors)
 3. Intimacy (relationship feelings)
4. Re-evaluate assessment of causes/effects with the Sex Problem "Decision Tree".

Case Illustration

● **INTERNET PORNOGRAPHY**

● **JOHN & SARAH**

(Highlighting Relationship Therapy)

Case Illustration: JOHN & SARAH

● **Presenting:**

Sarah set up intake to address John's "gawking" at women, watching sexy female workout videos, as well as visiting internet pornography sites weekly. She knows he masturbates 1 time a week, usually after watching porn on the internet, in addition to their having sex twice a week.

CASE ILLUSTRATION: JOHN & SARAH

- **PRESENTING PROBLEM:** (CONT.)
 - SARAH: "He prefers pornography to sex with me;" arguments about spending. Parent well together.
 - JOHN: "Get her to stop trying to run my life..."
- **DEMOGRAPHICS:**
 - JOHN = technical consultant; good health; no medications; hockey league.
 - SARAH = corporate human resources professional; good health; no meds except anti-allergy medications.
 - 4 children, 5 – 13 years old; 3 girls and 1 boy.
 - Value support of their religious community.

CASE ILLUSTRATION: JOHN & SARAH

- **Relationship History**
 1. Met when each 23 year old through a blind date.
 2. Much talk and much "great" sex; in early months, 3 times a day.
 3. She felt "a slut" but sex was "great"; continued for several (2-3) years.
 4. 4 children cared for by relatives and sitters.
 5. He had professional hockey aspirations; his wife told him he was "silly". He played in city leagues.
 6. 2 years before couple therapy, he was "laid off" from job for 7 months; felt wife resented her having to work. He was childcare provider.

CASE ILLUSTRATION: JOHN & SARAH

Relationship History (cont.)

7. Wife 1 time during his unemployment told him: "You are a blue collar piece of shit!" He rejoined with "You're a bitch..."
8. Sex declined and he felt unattractive. In addition to playing league hockey, he began working out to MTV and sexually explicit (Playboy) videos at home.
9. At his new job "befriended a woman who befriended me". Lunch and phone calls although "nothing ever happened."
10. Wife he felt "invaded my privacy" when she monitored his cell phone records.
11. Each in private meetings with therapist indicated no secrets, no affairs; no skeletons in the closet.
12. 3 months prior to seeking therapy, she lost her job which continued to be the case during therapy.

CASE ILLUSTRATION: JOHN & SARAH

Current Sex functioning:

- During intake: she reported:
 - difficulty having orgasm recently (moderate concern) and dissatisfaction (moderate, 4 of 10).
- During intake: he reported:
 - premature ejaculation (severe distress, 9 of 10) (wife did not, 1 of 10);
 - strong performance anxiety (9 of 10);
 - high dissatisfaction with sex (9 of 10); and
 - occasional Erectile Dysfunction (ED) (3 of 10).
- Couple has sex approximately 1x week.
- John masturbates about 2 x week; Sarah does not.

TREATMENT BASICS - I

- Relationship conflict about the man's (or woman's) sexual behavior addresses:
 1. concerns about sexual adequacy.
 2. sexual self-regulation issues.
 3. polarized meanings about the sex behavior (cognitive dimension).
 4. secondary damage to the non-sexual relationship.
- Effective treatment requires:
 1. Clarifying and respectfully bridging sexual meanings.
 2. Changing, blending and integrating cognitions/behaviors.
 3. Healing secondary emotional damage.

TREATMENT BASICS - 2

- **Individual therapy:**
 - JOHN --> for self awareness and relationship support.
 - self-knowledge without the risk of partner's critique;
 - Awareness to eventually invest self-knowledge in couple therapy to accept issues, heal hurt, design preventive couple plan ("We cannot love what we do not know...Aristotle).
 - SARAH --> for self-care, reflection on sex gender differences, and relationship support.
- **Couple Therapy:**
 - Stability
 - Explore the relationship features of the dysfunctional male behavior.
 - Contributing factors
 - Negative effects
 - Address the cognitive-behavioral-emotional features of the couple conflict.

The 3 “Bs” of Relationship Healing: Bridging – Blending – Bonding.

- **Bridging:**
 - openness to the other’s experience and meaning.
- **Blending:**
 - acceptance of similarities & differences.
 - mutual acceptance and accommodation.
 - mutual behavioral conflict resolution.
- **Bonding:**
 - empathy.
 - on-going “intimate team”.

(c. Michael E. Metz, Ph.D. 2008)

BRIDGE – BLEND – BOND

I. BRIDGING PHASE:

1. Stabilize the distress to prevent further harm.
2. Neutralize negative emotional negotiations.
3. Each individual regulation of sexual and emotional energies;
4. Make explicit their respective cognitions and feelings – “meanings” – in order to set the foundation for blending and healing meanings later;
5. Orient partners to reasonable and healthy sexual relationship features;
6. Set basic goal: variations of commitment to becoming more of an intimate team...

Features of Therapeutic Healing Process

A. Stability – Establish interaction “controls” with the couple.

- a) Temporarily living “as if” things okay.
- b) Clarify this is short-term to ensure environment for healing.
- c) Rules at home – temporary avoidance.
- d) Behaviors: e.g., basic tasks only...
- e) Frame: “differentiation” boundary.
- f) Clarify mutual sexual expectations.

Features of Therapeutic Healing Process

B. Neutralize “Negative Emotional Negotiation”

- a) MAN = minimizing or expressing repentance:
 - a) *Silence.*
 - b) *Minimizing:*
 - a) “It’s over... let’s move on...”
 - b) “It’s only sex...”
 - c) *Repentance, begging, placating, acquiescing:*
 - a) “I’ll do anything...(to stop your distress).”
 - b) BS Trap: unrealistic promises: “I promise...;”
 - c) “I’ll never do it again...”
 - d) *Projective Blame:* “We had no sex for 6 months!”
 - e) *Coldness* --> “If I apologize, I’ll get a life sentence.”

Features of Therapeutic Healing Process

B. Neutralize “Negative Emotional Negotiation”

- a) WOMAN: expressing shame, catastrophe or rigidity:
 - a) *“Blame to shame”:*
 - a) “How could you hurt me, or our family so...:”
 - b) “I can’t believe you did/do this...”
 - c) “I thought I knew you...” “You’re a sex addict!”
 - d) “It’s your problem...; don’t make it about me”
 - b) *Threats:*
 - a) “It’s an affair! Our marriage is over...”
 - c) *“Hostage taking”*
 - a) “I’ll never forgive you... until you ...”
 - d) *Coldness* --> “If I empathize with you, I’ll condone your ‘bad’ behavior.”

BRIDGE – BLEND – BOND

II. BLENDING PHASE

7. creating mutual empathy with disciplined (regulated) communication;
8. appreciation of gender differences (desire) – and similarities (connection);
9. understanding individual meanings regarding the sex behavior at issue.

Features of Therapeutic Healing Process

Facilitate mutual understanding:

- A. Help couple see overview of the process and why.
Frame = "relationship opportunity"
 - A. Sex Positive value.
 - B. Mutual understanding of "sexual meaning"
- B. Summary "explanations" (requires communication skills)
 - A. His sexual self-understanding, "meanings" (e.g., loneliness; under-developed or "collegiate" sex; relationship alienation; resentment of her; work stress).
 - B. Her "meanings" (e.g., infidelity; inadequacy issues).
- C. Blending as process goal:
 - A. Mutual empathy as an "Intimate Team"
 - B. Opportunity for deeper intimacy.
 - C. Blending mutual meanings with comfort.

BRIDGE – BLEND – BOND

III. BONDING PHASE:

10. Facilitate couple conflict resolution that is mutually satisfying for each partner, based on blended meaning.
11. Mutually blend their sexual meanings appropriate to their values and unique relationship;
12. Heal from the distresses and deepen their relationship intimacy.
13. Facilitate relationship and sexual playfulness.

TREATMENT BASICS

IV. RELAPSE PREVENTION PHASE:

14. Understand the difference between "lapse" vs. "relapse".
15. Determine the essential cognitive, emotional, and behavioral strategies to maintain gains.
16. Pre-arrange formal follow-up.

USEFUL FEATURES: John & Sarah

1. Partners integrate their sexual meanings.
2. Couple address their distinct fears of "inadequacy":
 1. inoculate vs. his fear of "over-familiarity"
 2. Inoculate vs. her fear of sexual "deficiency"?
3. Decide on sexual behaviors that work for both:
 1. A behavioral "verifiable" plan:
 1. What are markers – DVD frequency; couple sex frequency...
 2. What are minimum intimacy requirements.
 3. What are relationship flags of regression?
 2. Specific features are integrated into the relationship:
 1. Couple church group 1 x week.
 3. Partners monitor emotional – "emotional sexualization" ...
 4. Couple develops sexual flexibility:
 1. balance 5 purposes for sex.
 2. blend the 3 arousal styles.
 3. Developed alternative sexual scenarios.
5. Couple mindfully adopts the Good-Enough Sex" model.
6. Woman ensures sexual "regularity" (min. = 2x wk.)

Relationship & Sexual Satisfaction

- an emotional dimension
(i.e., feeling "good," contentment),
- grounded on the cognitive dimension
(i.e., "meaning") to the individual and the couple,
- about the behavioral dimension
(i.e., adequate cooperation and realistic function).

Thank You for Coming...

- Dedication, *Men's Sexual Health* book:
- "To all the men and women; parents; and healthcare, clergy, media, and teaching professionals who are promoting positive, health sexuality..."
Michael E. Metz