MALE SEXUAL DYSFUNCTION

BEHAVIORAL DEFINITIONS

1. Describes consistently very low or no pleasurable anticipation of or desire for sexual activity.
2. Strongly avoids and/or is repulsed by any and all sexual contact in spite of a relationship of mutual caring and respect.
3. Recurrently experiences a lack of the usual physiological response of sexual excitement and arousal (attaining and/or maintaining an erection).
4. Reports a consistent lack of a subjective sense of enjoyment and pleasure during sexual activity.
5. Experiences a persistent delay in or absence of reaching ejaculation after achieving arousal and in spite of sensitive sexual pleasuring by a caring partner.
6. Describes genital pain experienced before, during, or after sexual intercourse.

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LONG-TERM GOALS

1. Increase desire for and enjoyment of sexual activity.
2. Attain and maintain physiological excitement response during sexual intercourse.

3. Reach ejaculation with a reasonable amount of time, intensity, and focus to sexual stimulation.
4. Eliminate pain and achieve a presence of subjective pleasure before, during, and after sexual intercourse.

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SHORT-TERM OBJECTIVES

1. Provide a detailed sexual history that explores current problems and past experiences that have influenced sexual attitudes, feelings, and behavior. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Obtain a detailed sexual history that examines the client's current adult sexual functioning as well as his childhood and adolescent sexual experiences, level and sources of sexual knowledge, typical sexual practices and their frequency, medical history, drug and alcohol use, and lifestyle factors.
2. Assess the client's attitudes and fund of knowledge regarding sex, emotional responses to it, and self-talk that may be contributing to the dysfunction.
3. Explore the client's family-of-origin for factors that may be contributing to the dysfunction such as negative attitudes regarding sexuality, feelings of inhibition, low self-esteem, guilt, fear, or repulsion (or assign "Factors Influencing Negative Sexual Attitudes" in the *Adult Psychotherapy Homework Planner* by Jongsma).

2. Report any signs of depression; participate in treatment of depressive feelings that may be causing sexual difficulties. (4, 5)

4. Assess the role of depression in possibly causing the client's sexual dysfunction and treat if depression appears causal (see the Unipolar Depression chapter in this *Planner*).

5. Refer the client for antidepressant medication prescription to alleviate depression that underlies the sexual dysfunction.

3. Honestly report substance abuse and cooperate with recommendations by the therapist for addressing it. (6)

6. Explore the client's use or abuse of mood-altering substances and their effect on sexual functioning; refer him for focused substance abuse counseling, if indicated.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently

defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Honestly and openly discuss the quality of the relationship including conflicts, unfulfilled needs, and anger. (11, 12)

11. Assess the quality of the relationship including couple satisfaction, distress, attraction, communication, and sexual repertoire toward making a decision to focus treatment on sexual problems or more broadly on the relationship (or assign "Positive and Negative Contributions to the Relationship: Mine and Yours" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. If relationship problem issues go beyond sexual dysfunction, conduct sex therapy in the context of couples therapy (see the Intimate Relationship Conflicts chapter in this *Planner*).

6. Cooperate with a physician's complete examination and follow through on any treatment recommendations. (13, 14)

13. Refer the client to a physician for a complete exam to rule out any organic or medication related basis for the sexual dysfunction (e.g., vascular, endocrine, medications).

14. Encourage the client to follow physician's recommendations regarding treatment of a diagnosed medical condition or use of medication that may be causing the sexual problem.

7. Verbalize an understanding of the role that physical disease or medication has on sexual dysfunction. (15)

15. Discuss the contributory role that a diagnosed medical condition or medication use may be having on the client's sexual functioning.

8. Take medication for impotence as ordered and report as to effectiveness and side effects. (16)

16. Refer the client to a physician for an evaluation regarding a prescription of medication to overcome impotence (e.g., Viagra).

9. Participate in sex therapy with a partner or individually if the partner is not available. (17, 18)

17. Encourage couples sex therapy or treat individually if a partner is not available (see *Enhancing Sexuality* by Wincze).

18. Direct conjoint sessions with the client and his partner that focus on conflict resolution, expression of feelings, and sex education.

10. Verbalize an understanding of normal sexual functioning and contributors to sexual dysfunction. (19, 20)

19. Educate the client and partner about normal sexual functioning, sexual dysfunction, and cognitive, emotional, behavioral, and interpersonal factors that contribute to function or dysfunction.

20. Assign the client to read books (e.g., *Sexual Awareness* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *The New Male Sexuality* by Zilbergeld) that provide accurate sexual information and/or outline sexual practices that disinhibit and reinforce sexual sensate focus.

11. Demonstrate healthy acceptance by freely discussing accurate knowledge of sexual functioning. (21, 22)

21. Desensitize and educate the couple by encouraging them to talk freely and respectfully regarding sexual body parts, sexual thoughts, feelings, attitudes, and behaviors.

22. Reinforce the couple for talking freely, knowledgeably, and positively regarding sexual thoughts, feelings, and behavior.

12. Discuss low self-esteem issues that impede sexual functioning and verbalize a positive self-image. (23)

23. Explore the client's fears of inadequacy as a sexual partner that led to sexual avoidance; encourage realistic, positive thoughts regarding self as a sexual partner (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

13. Verbalize a positive body image. (24, 25)

24. Assign the client to list assets of his body; confront unrealistic distortions and critical comments (or assign "Study Your Body—Clothed and Unclothed" in the *Adult Psychotherapy Homework Planner* by Jongsma).

25. Explore the client's feelings regarding his body image, focusing on causes for negativism.

14. Communicate feelings of threat to partner that are based on perception of partner being too sexually aggressive or too critical. (26)

26. Explore the client's feelings of threat brought on by the perception of his partner as being too sexually aggressive or too critical of his sexual performance.

15. Identify challenge, and replace self-defeating thoughts and beliefs with positive, reality-based thoughts and beliefs. (27, 28, 29)

27. Probe automatic thoughts that trigger the client's negative emotions such as fear, shame, anger, or grief before, during, and after sexual activity.

28. Train the client in healthy alternative thoughts that will mediate pleasure, relaxation, and disinhibition (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

29. Use cognitive therapy techniques to help the client counter

self-defeating thoughts; identify and challenge self-talk, attentional focus (e.g., spectatoring), misinformation, and beliefs that perpetuate the dysfunction and replace with those facilitative of sexual functioning. EBT

16. List conditions and factors that positively affect sexual arousal, such as setting, time of day, or atmosphere. (30)

30. Assign the couple to list conditions and factors that positively affect their sexual arousal; process the list toward creating an environment conducive to sexual arousal.

EBT 17. Practice directed masturbation and sensate focus exercises alone and with partner and share feelings associated with activity. (31, 32)

31. Assign the client body exploration and awareness exercises that reduce inhibition and desensitize him to sexual aversion. EBT

32. Direct the client in masturbatory exercises designed to maximize arousal; assign the client graduated steps of sexual pleasuring exercises with partner that reduce his performance anxiety and focus on experiencing bodily arousal sensations (or assign "Journaling the Response to Nondemand, Sexual Pleasuring [Sensate Focus]" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBT

EBT 18. Participate in graduated exposure (desensitization) to sexual exercises that have gradually increasing anxiety attached to them. (33, 34)

33. Direct and assist the client in construction of a hierarchy of anxiety-producing sexual situations associated with performance anxiety. EBT

34. Select initial in vivo or imaginal exposures that have a high likelihood of being a successful experience for the client and instruct him on attentional strategies (e.g., focus on partner, avoid spectatoring); review with the client and/or couple, moving up the hierarchy until associated anxiety has waned (or assign "Gradually

Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma).

19. Engage in more assertive behaviors that allow for sharing sexual needs, feelings, and desires, behaving more sensuously, and expressing pleasure. (35, 36)

35. Give the client permission for less inhibited, less constricted sexual behavior by assigning body-pleasuring exercises with partner.

36. Encourage the client to gradually explore the role of being more sexually assertive, sensuously provocative, and freely uninhibited in sexual play with partner.

20. Implement new coital positions and settings for sexual activity that enhance pleasure and satisfaction. (37, 38)

37. Assign the client to read books (e.g., *Sexual Awareness* by McCarthy and McCarthy; *The Gift of Sex* by Penner and Penner; *In the Mood, Again: A Couple's Guide to Reawakening Sexual Desire* by Cervenka; *The Joy of Sex* by Comfort) that outline sexual practices that disinhibit and allow for sexual experimentation.

38. Suggest experimentation with coital positions and settings for sexual play that may increase the client's feelings of security, arousal, and satisfaction.

21. Male partner implement masturbation prior to intercourse and/or the squeeze technique during sexual intercourse and report on success in slowing premature ejaculation. (39)

39. Prescribe pre-intercourse masturbation for the male partner to make use of the refractory period and/or instruct the client and partner in use of the squeeze technique to prevent premature ejaculation; use illustrations if needed (e.g., see *The Illustrated Manual of Sex Therapy* by Kaplan); process the procedure and feelings about it, providing corrective feedback toward successful use (recommend *Coping with Premature Ejaculation* by Metz and McCarthy).

22. State an understanding of how religious training negatively influenced sexual thoughts, feelings, and behavior. (40, 41)

40. Explore the role of the client's religious training in reinforcing his feelings of guilt and shame surrounding his sexual behavior and thoughts; process toward the goal of change.

41. Assist the client in developing insight into the role of unhealthy sexual attitudes and experiences of childhood in the development of current adult dysfunction; press for a commitment to try to put negative attitudes and experiences in the past while making a behavioral effort to become free from those influences.

23. Verbalize a resolution of feelings regarding sexual trauma or abuse experiences. (42, 43)

42. Probe the client's history for experiences of sexual trauma or abuse.

43. Process the client's emotions surrounding an emotional trauma in the sexual arena (see the Sexual Abuse Victim chapter in this *Planner*).

24. Verbalize an understanding of the influence of childhood sex role models. (44)

44. Explore sex role models the client has experienced in childhood or adolescence and how they have influenced the client's attitudes and behaviors.

25. Verbalize connection between previously failed intimate relationships and current fear. (45)

45. Explore the client's fears surrounding intimate relationships and whether there is evidence of repeated failure in this area.

26. Discuss feelings surrounding a secret affair and make a termination decision regarding one of the relationships. (46, 47)

46. Explore for any secret sexual affairs that may account for the client's sexual dysfunction with his partner.

47. Process a decision regarding the termination of one of the relationships that is leading to internal conflict over the dishonesty and disloyalty to a partner.

27. Openly acknowledge and discuss, if present, homosexual attraction. (48)

48. Explore for a homosexual interest that accounts for the client's heterosexual disinterest (or assign "Journal of Sexual Thoughts, Fantasies, Conflicts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

28. Resolve conflicts or develop coping strategies that reduce stress interfering with sexual interest or performance. (49)

49. Probe stress in areas such as work, extended family, and social relationships that distract the client from sexual desire or performance (see the Anxiety, Family Conflict, and Vocational Stress chapters in this *Planner*).

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	302.71	Hypoactive Sexual Desire Disorder
	302.79	Sexual Aversion Disorder
	302.72	Male Erectile Disorder
	302.74	Male Orgasmic Disorder
	302.76	Dyspareunia
	302.75	Premature Ejaculation
	608.89	Male Hypoactive Sexual Desire Disorder Due to Axis III Disorder
	607.84	Male Erectile Disorder Due to Axis III Disorder
	608.89	Male Dyspareunia Due to Axis III Disorder
	302.70	Sexual Dysfunction NOS
	995.53	Sexual Abuse of Child, Victim
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
302.71	F52.0	Male Hypoactive Sexual Desire Disorder
302.72	F52.21	Erectile Disorder
302.74	F52.32	Delayed Ejaculation
302.75	F52.4	Premature Ejaculation
302.70	F52.9	Unspecified Sexual Dysfunction
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

EBT indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.