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ARTICLE

Couple relationship problems and sexual dysfunctions: therapeutic guidelines

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SUMMARY

Sex is central to most intimate relationships, and there is inevitably a two-way interaction between sex and intimacy. Sex is a physical, a psychological and an interpersonal event, and treatment of sexual problems should take account of all three aspects. Couple relationship problems that can affect sexual interaction include pervasive hostility, poor communication, lack of trust and disparate levels of sexual desire. Therapists should be able to manage therapy sessions with both partners present, without taking sides, and treating the relationship, rather than either individual, as the 'client'. They should be able to balance the physical approach to problems with managing relationship issues and the partners' individual psychological problems. Techniques are recommended for understanding and modifying the couple relationship during therapy, as well as for dealing with specific sexual problems using a behavioural systems approach.

DECLARATION OF INTEREST

None.

The sexual relationship is a central part of most intimate relationships, whether these involve marriage, civil partnership, cohabitation or looser ties. It is inevitable that there should be a two-way interaction between these two components of the relationship, with the sexual aspect affecting the general relationship and the general relationship affecting sex. For example, if the partners are fighting for most of their time together there will be little opportunity for sexual interaction, and they may end up fighting also about the lack of sex in the relationship. However, for some couples who frequently quarrel, sex may be a way of achieving reconciliation, and the quarrelling may become addictive because it leads to good sexual interaction. Communication can be the key to solving such problems, and if the couple can discuss the issues in a calm and flexible manner they may be able to find better ways of organising their lives so as to have a good sexual relationship.

Sex is a physical, a psychological and an interpersonal act, indeed one that can be genuinely called biopsychosocial.

Physically, it involves the mechanisms of erection, ejaculation, lubrication and orgasm, as well as many cortical, subcortical, hypothalamic, hormonal and spinal mechanisms (Levin 2007). It can clearly be interfered with by many disease processes, including those that affect hormones, blood supply and central, spinal and peripheral nerves. It can also be affected by various medications, especially antidepressants.

Psychologically, the partners will each have a different experience of the sexual interaction, based on their ability to relax and overcome inhibitions, their earlier sexual and emotional history, their state of tiredness or anxiety, their physical health and each one's feelings about their partner. All these will make it more or less difficult to relax and enjoy what should ideally be a good experience for both.

Sociologically, the idealisation of sex in the media is currently causing many people to worry whether they are matching up to what is 'normal'. There are also, especially in immigrant couples, cultural expectations that the young couple should live with the extended family (Crowe 2005: p. 19), which means that their sex life may be curtailed by the lack of privacy.

Although most of the examples given here are of heterosexual couples, the principles can be applied equally to gay and lesbian couples, and the issues are very similar in all instances.

Sexual dysfunctions

Sexual dysfunctions are divided into various diagnostic categories, and although these are not totally satisfactory, the divisions used in ICD-10 (World Health Organization 1992) are probably the most widely accepted (Box 1). The difficulty is that many sexual problems are shared between both partners, whereas ICD-10 and the equivalent DSM-IV (American Psychiatric Association 1994) categories necessarily apply to individuals.

BOX 1 Main ICD-10 categories for diagnosing sexual dysfunctions

- Excessive sexual drive (F52.7)
- Failure of genital response (F52.2) (in males, erectile dysfunction; in females, poor lubrication)
- Sexual aversion and lack of sexual enjoyment (F52.1)
- Lack or loss of sexual desire (F52.0)
- Non-organic dyspareunia (F52.6)
- Non-organic vaginismus (non-consummation) (F52.5)
- Orgasmic dysfunction (F52.3) (male or female)
- Other sexual dysfunction, not caused by organic disorder or disease (F52.8)
- Premature ejaculation (F52.4)

(World Health Organization 1992)

In most relationships there is some tension regarding how often sex should be occurring. In my experience, the most common pattern, especially in younger heterosexual couples, is for the male partner to be keener on sex, while the female partner accepts it more or less readily, depending on the stage of her menstrual cycle, her feelings about her partner and her state of tiredness or anxiety. Another important factor can be the influence of childbirth on sexual life, with many constraints for the woman, arising from both physical discomfort and the strains of feeding and lack of sleep. Sometimes, the partner's help with the care of the baby can relieve the mother's stress and help the sexual relationship.

Box 2 gives examples of factors that can affect sexual adjustment in a couple relationship. The list is by no means exhaustive, or indeed mutually exclusive. I have many years of experience helping couples who have sexual difficulties, but I still see new cases with unfamiliar aspects. It also sometimes happens that a couple will attend with an apparently non-sexual problem, which acts as a 'passport' to therapy in which the sexual difficulty becomes prominent.

Couple therapy

The therapist

The management of sexual dysfunctions in a couple relationship requires a certain amount of experience in this type of therapy. The appropriate techniques are best learned on specialist sexual and relationship training courses such as those run by Relate (www.relate.org.uk) and psychosexual therapy clinics. In the UK, therapists in this field have various professional backgrounds (e.g. psychiatry, psychology, nursing and counselling) but they usually belong to the College of Sexual and Relationship Therapists (previously known as the British Association for Sexual and Relationship Therapy). They work to a code of ethics which includes the need for regular supervision of their work (College of Sexual and Relationship Therapists 2007). It is probably not ideal for individuals without this type of psychotherapy experience to undertake the work, although other forms of experience, such as psychodynamic, humanistic or cognitive–behavioural therapy, can make it possible to see couples without much alteration of one's technique. In an ordinary community psychiatric setting, the best practice would probably be to find a resource to which the patient or couple could be referred, for example Relate or a local psychosexual clinic.

The ground rules for this type of therapy, using a behavioural systems approach, have been described by Crowe & Ridley (2000). This is a practical approach to couple relationship therapy which combines established behavioural techniques (such as negotiation between partners and communication training) with systemic techniques (such as inducing arguments between partners, timetables for sexual activity and family genograms). My summary of treatment methods

BOX 2 Partner factors that can affect the sexual relationship

- Resentment and anger
- Constant hostility
- Excessive politeness (e.g. in non-consummation)
- Lack of sexual knowledge or experience
- Difficulty in communicating about sex
- Lack of trust
- Inability to 'close the bedroom door'
- Lack of time or opportunity
- Different levels of sexual desire
- Unrealistic expectations of sex
- Cultural factors (e.g. having to live with the extended family)
- Unequal relationship (e.g. 'patient and carer' or 'persecutor and victim')
- Childbirth and infant care
- A recent affair involving one partner
- A paraphilia (e.g. fetishism) in one partner
- A history of traumatic sexual experiences (as an adult or child)
- The effects of ageing and difficulty in accepting them

in this article will centre on seeing the couple together, but a similar approach can be used when only one partner is seen.

The couple as client

A therapist faced with a couple presenting with a sexual dysfunction is in a very different position from one who sees only one patient. In a sense the couple, rather than the two individuals, becomes the client, and the therapist has to concentrate on their relationship as the focus for therapy. It is essential to avoid taking sides. This means giving each partner the chance to be heard, and not allowing one of them to become the acknowledged spokesperson for them both. It is almost impossible to avoid feeling more sympathetic to one than the other, but the therapist must allow for this and be disciplined enough to let both have their say. In taking the history, the sexual interaction becomes a vital part of the story, but not the only part: the general relationship is also of great significance. It is always useful to know about the individuals' family and personal history, but this should take second place to the understanding of their past and current interaction.

One useful technique that allows the therapist to avoid side-taking is to encourage the partners to talk to each other about the problem (de-centring). This brings out the less talkative one, while also giving the therapist insight into how they interact without intervention. It may become clear, for example, that one partner is quite dominant, and the therapist may be able to alter the balance by encouraging assertiveness in the quieter partner.

Building on positive experiences and looking for compromise

An important aspect in cases with sexual dysfunction is to look into positive experiences of sex in the recent or more distant past, so as to help the couple to find ways of re-creating the conditions that held then. It is also useful to ask specific questions about the factors that interfere with a good sexual experience, such as lack of time, arguments, worry about children or family members, and staggered bedtimes. Any differences in needs for types of pre-sexual stimulation or longer periods of foreplay should be explored. The focus of therapy should always be on the future, with an emphasis on home-based activities in the next week rather than dwelling on the problems of the past.

In framing exercises to carry out at home, a good rule is to achieve a compromise between what each partner wants, even if this is not what the 'spokesperson' or the referral letter seem to suggest.

BOX 3 Therapeutic interventions for sexual problems in couples

- Improved communication about sex and about general matters
- Clear boundaries around the couple relationship
- Time alone to improve privacy and encourage intimacy
- Altering bedtime arrangements
- Compromise and ability to negotiate
- Increasing assertiveness in a diffident partner
- Use of timetables to overcome differences in sexual needs
- Sensate focus
- Use of medication for erectile problems
- Use of vaginal trainers for vaginismus
- Use of techniques to manage ejaculatory problems

For example, a man may expect the therapist to help his wife to want sex as enthusiastically as he does, but the therapist should consider what both partners may feel comfortable with and aim for a compromise. Realistic expectations on the part of both therapist and partners are some of the most positive steps that can be taken in helping the couple to achieve a sustainable, ongoing sexual relationship.

The general aims of therapy are summarised in Box 3. The overall goals are to increase positive communication of the partners, to allow them to negotiate more effectively over both sexual and non-sexual issues, and to give them specific advice and homework exercises to overcome the dysfunction.

Homework exercises for sexual dysfunctions

In addition to improving the general relationship, it is usually helpful to give some specific advice on the sexual problem itself. This is not only because the couple may need advice, but also to reassure them that the therapist is focused on the same goal as they are.

Sensate focus and genital sensate focus

It is quite common to begin the exercises with 'sensate focus' (Masters 1970). Sensate focus is a useful technique for most sexual dysfunctions, and may be used in combination with specific approaches for erectile dysfunction, female arousal disorder, premature ejaculation, delayed ejaculation, dyspareunia and vaginismus. Sensate focus involves home-based sessions in which the couple undress, lie down together and have prolonged non-genital foreplay with a ban on

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intercourse. It may be preceded by relaxation exercises (Crowe 2005), and the combined process helps them to relax and enjoy the physical contact but without experiencing 'performance anxiety', the anticipation of failure that often makes the problem worse. They persevere with this for some weeks, and are then encouraged to proceed to 'genital sensate focus', in which the foreplay involves the genitals. Later still, they move on to the specific techniques for their particular problem and finally to attempted intercourse (still starting with sensate focus, if necessary).

Addressing the dysfunction itself

Depending on the sexual problem being treated, various techniques can be recommended, usually in combination with the use of sensate focus.

Erectile dysfunction

Phosphodiesterase type-5 (PDE-5) inhibitors (e.g. sildenafil, tadalafil and vardenafil) are a valuable adjunct to treatment of erectile dysfunction. They increase the likelihood of a strong erectile response to sexual stimulation (whether psychological or physical). Vacuum pumps can be recommended for men who are sensitive to the PDE-5 inhibitors or who are unresponsive to their effects. It is less common at present to recommend intracavernosal injection of prostaglandin, although this is a well-established and reliable way of producing an erection (Wylie 2007).

Premature or delayed ejaculation

For premature ejaculation, sensate focus can be combined with the 'stop–start' technique. The man is instructed to stimulate himself and, just before ejaculation becomes inevitable, to stop the process and allow the urge to abate. He can then continue stimulating until the next ejaculatory urge occurs, and thus delay ejaculation. The process is then incorporated into the couple's sexual intercourse.

The approach is similar for delayed ejaculation, but in this case the instructions are to try to produce an ejaculation by 'superstimulaton' of the penis, at first by self-stimulation (as this is usually easier) and later by mutual stimulation using the partner's hand, followed by attempted insertion at the moment of ejaculation. This is a more difficult problem to treat than premature ejaculation, and can be associated with infertility.

Vaginismus

Sensate focus is a good starting point for vaginismus. The woman is then asked to use vaginal trainers (graded plastic tubes) or her own fingers, with a lubricating gel, in sessions on her own to relax the vaginal muscles and achieve penetration without the fear that accompanies attempts at penile penetration. It is helpful at a later stage to bring the partner in as a collaborator in handing her the trainers, and to encourage the couple to see it as an enjoyable activity which they can do together.

Dyspareunia

In cases of dyspareunia (pain on attempting sexual intercourse) it is usually necessary to exclude organic causes, of which there are many, by arranging a consultation with a gynaecologist. If this shows that there is no physical cause, the same approach as for vaginismus is helpful, but the couple must always be careful to avoid unnecessary discomfort.

Lack of sexual arousal

A lack of sexual arousal in the woman is not as easily categorised as the other sexual problems. The difficulty is that, whereas in men loss of erection can be distinguished from loss of interest, there is a strong overlap in women between loss of desire and lack of arousal. The situation is complicated by the wish of the pharmaceutical industry to develop medication for the treatment of lack of arousal (Moynihan 2010). In therapy, it is better to use a more psychological and interpersonal approach to female dysfunctions, with an emphasis on the non-sexual aspects of the relationship. As yet, no medication or other physical treatment has been shown to be effective in the treatment of female arousal problems.

Therapy in practice

The techniques outlined above are only a relatively small part of therapy for sexual dysfunctions. The therapist must keep the general relationship in mind when sexual issues are being discussed, and it often happens that the sexual problem is being maintained by conflict in the general relationship. The therapist has to remain constantly aware of the communication patterns of the couple, and make sure that they really understand each other's stresses and pressures in life. The following vignette exemplifies this.

Vignette 1: Sharing a parenting burden

> A couple presented in which the woman took all the responsibility for the teenage children and their homework. She developed a great deal of anxiety over this and was never in the mood for sex when it came to the couple's bedtime. The therapist suggested that the husband should oversee the homework of one of the children. This freed up

MCQ answers
1 d 2 c 3 c 4 d 5 a

the wife, who was then able to fit in her evening activities as well as the other child's homework, and was more amenable to the idea of sex in the late evening.

Sometimes an extended family member monopolises one partner's time. In general, the advice in these circumstances is for the couple to put their own relationship first and the family second. The same principles apply across the whole gamut of competing interests, such as late drinks sessions after work, separate social activities outside the home, voluntary work and sporting interests. The problem can also arise when partners spend excessive time on the internet or telephone. The advice generally is for the 'absent' partner to ask the other whether this spending time on their own pursuits is affecting their sexual relationship. In many cases, they find that their partner is less keen on sex than they had thought.

Vignette 2: Closing the bedroom door

An illustrative case is of a young childless couple in which the wife's mother was in the habit of phoning the wife at 11.30 each night. The calls lasted about 40 minutes, by which time the husband had become frustrated at the lack of opportunity for sex and had gone to sleep in preparation for his busy day at work. The solution was for the wife to insist that the mother phoned an hour earlier, and for the wife to cut short the calls whenever possible without causing offence.

Different needs for frequency of sexual activity

In treating couples who disagree about the frequency of sexual activities, it is often helpful to use techniques from the behavioural systems approach to therapy (Crowe 2000). If the male partner is enthusiastic about sex but the female partner is reluctant (but still experiences pleasure when sex occurs), it may be useful to try the 'sexual timetable' approach. In this method, the couple are asked to work out a compromise frequency of sexual intercourse, and then to carry out a specific homework task involving planning on which days sex should occur, but also on which days it should not. In keeping to the timetable, the conflict is taken out of the question and the reluctant woman can relax on the days when sex is not planned and be prepared for the days when it is to occur. Most men find this arrangement tolerable, although they sometimes think it a little bizarre, and can usually perform on the designated days without difficulty. Once the situation is accepted by both partners, they usually find that they do not need to be as strict about enforcing the timetable but can agree without conflict roughly how often sex will take place.

Vignette 3: A sex timetable

An illustration is given by a young couple where the woman enjoyed sex when it happened, but refused more often than she accepted. The man was the dominant partner, made all the social arrangements and was verbally more fluent. The woman had been labelled as 'frigid' by her partner and her general practitioner. Sex had been happening less than once a month, and the husband was expressing great frustration. The timetable was suggested by the therapist and welcomed by the wife, whereas the husband was sceptical. The couple also undertook other homework exercises, including sensate focus and foot massage for the woman. The timetable recommended sex once a week, and they kept to it religiously. Their general relationship improved and the wife took a stronger role in domestic matters. In fact, when at follow-up they were asked whether they still needed to keep to the timetable, they opted to do so indefinitely.

If the female partner is enthusiastic about sex but the male partner is reluctant, it is often the case that when the partners argue, the man swallows his anger and acts as a diplomat rather than a fighter. The unspoken resentment on the man's side can lead to reluctance to initiate sexual activity, and the situation may be worsened when the woman criticises him for not wanting sex. Although a sex timetable is theoretically possible for such couples, it is usually more difficult for the man to be sexually aroused on the 'appointed day'. It is probably better to increase the man's assertiveness by encouraging arguments or heated discussions between the couple about trivial issues during sessions (Crowe 2000). In this technique, the therapist asks the man to raise his voice and to stick to his position in the discussion, allowing the couple to 'agree to differ' rather than insisting on a decisive end to the discussion. This enables the man to increase his general assertiveness and to deal with resentments without excessive withdrawal. Of course, the therapist does not take sides in the conflict.

Vignette 4: Inducing arguments

In a typical case, the husband had been very passive and placating to his dominant wife. In therapy, he was encouraged to be more assertive in trivial arguments (a change which she had welcomed). His sexual desire for her and his erection both improved, and he said in a later session that his sex life was 'too serious to be taken seriously'. He meant by this that he had been trying too hard to please his wife sexually, and this had caused him to fail.

Overall guidelines for therapy

In treating any sexual problem in a couple, the core therapeutic skills are an ability to empathise with two partners at the same time, to avoid taking sides, to be positive and optimistic in approach, to

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think of the future as well as the past, and to use specific techniques to help the couple to resolve their sexual and relationship problems. The therapist must be tolerant of variations in sexual practice and sexual needs, and able to discuss sexual matters without becoming embarrassed, imposing their own ideals or taking a judgemental attitude. The goals of therapy are essentially those of the couple, but it may be necessary to find a compromise if the two partners seem to have disparate goals. Therapy should be relatively short term and time limited, and the therapist should always bear in mind the need to refer either partner on to other specialists (e.g. a urologist or gynaecologist) for physical investigation and treatment if necessary. The key requirement of this type of therapy is to recognise the need for a balance between issues of relationship, issues of personal psychological adjustment and issues of physical illness. It is truly a biopsychosocial field of endeavour.

Suggested further reading

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MCQs

Select the single best option for each question stem

1 Erectile disorder can be successfully treated with:
- a antidepressants
- b testosterone skin patches
- c vitamin E
- d PDE-5 inhibitors
- e psychoanalysis.

2 Good treatment for female sexual disorder includes:
- a hormone replacement therapy
- b use of contraceptive pill
- c relationship therapy
- d PDE-5 inhibitors
- e testosterone implants.

3 Behavioural systems couple therapy includes:
- a insight-giving by interpretation
- b favouring one partner only
- c sexual timetables
- d use of antipsychotics
- e recommending physical exercise.

4 After childbirth:
- a female libido is increased
- b frequency of sexual intercourse is greater
- c breastfeeding increases female sexual interest
- d female libido is lower
- e intercourse should be painless.

5 Sensate focus includes:
- a body massage
- b prolonged exposure therapy
- c assertiveness training
- d genital stimulation
- e cognitive techniques.