	# *XI.: The psychotherapy of sexual disorders* Patrícia Polgár
Aim	The aim of this chapter is to acquaint the student with the psychotherapeutic methods necessary for the treatment of sexual disorders. The student will be able to recognize the most frequent sexual dysfunctions, and will become acquainted with the basic psychotherapeutic techniques used in their treatment.
Introduction	## Introduction In this chapter you will become acquainted with those more simple non-medication treatment methods, with which sexual dysfunctions can be assessed and treated in general medical practice. **Key words:** sexual dysfunction, arousal-phase disorder, orgasm disorder, cognitive behavioural therapy **Target group:** general practitioners, psychologists, psychology undergraduates and medical students
Literature	## Suggested study methods: Read the texts. Following this, answer the comprehension questions. If you were not able to answer all the questions, survey the problematic parts in the texts again. Total **amount of study-time necessary:** 6 hours ## Recommended literature: ## Content of chapter XI./1. The significance and kinds of sexual disorders XI./1.1. The epidemiology of sexual disorders XI./1.2. The kinds of sexual dysfunctions XI./1.3. General aetiological factors XI./2. An exposition of the more frequent sexual disorders XI./2.1. Female hypoactive desire disorder and sexual arousal disorder XI./2.2. Female orgasm disorder XI./2.3. Vaginismus XI./2.4. Erectile dysfunction XI./2.5. Premature ejaculation XI./2.6. Summary XI./3. Techniques employed in the psychotherapy of sexual disorders XI./3.1. The assessment of sexual disorders XI./3.2. Efficient therapeutic forms XI./3.3. Psychoeducation XI./3.4. Communicational training XI./3.5. Sensate focus exercises

	XI./3.6. Cognitive restructuring XI./3.7. Controlled masturbation XI./3.8. Summary

Introduction	**XI./1.: The significance and kinds of sexual disorders** According to the majority of surveys, the problems of sexual functioning are **extremely prevalent**: they occur **as symptoms of several somatic diseases, as side effects** of medications or other therapeutic interventions, but also as part of a relationship disorder or due to other **psychosocial causes**. Nowadays the mass media freely and openly discusses the different aspects of sexuality. In contrast with this, sexuality is relatively **scarcely mentioned** both in the psychiatric and general medical practice, and only a fraction of those struggling with these problems go to consult a specialist. In Maurice's experience patients would readily talk about their problems; doctors, in most cases, do not inquire about the symptoms on account of their embarrassment and inexperience, although sexual dysfunctions, in many cases, are curable (Maurice 1999).
Important	***XI./1.1.: The epidemiology of sexual disorders*** The most frequently cited and comprehensive epidemiologic survey has been done in the USA by Laumann and his colleagues, in 1992. According to their results **31% of men and 43% of women** have reported some kind of sexual problem (Laumann 1999). In Hungary, a representative survey about the sex life of Hungarians was conducted in 2002 by the Marketing Centre of the Psychological Institute of ELTE, in the course of which existing problems were also investigated. **47% of Hungarian men** reported existing sexual problems in the past year, which affected negatively the quality of life of most of them – nevertheless, only 9% of them ask for help from a specialist, or from their partner. **52% of** the **women**, who gave an answer, reported the existence of at least one sexual disorder, and 10% of the 52% marked four or even more (Urbán 2002).
Important	***XI./1.2.: The kinds of sexual dysfunctions*** Throughout the different ages and societies different sexual habits were deemed pathological or acceptable; the concept of "normal sexuality" is thus difficult to define. In the present chapter the disorders of sexuality is discussed according to the valid classification of DSM IV. (American Psychiatry Association 1994). When compiling DSM V. (which is as yet in the preparatory stage), the diagnostic criteria of certain sexual disorders will presumably get slightly amended. DSM IV. classifies sexual disorders based on **the point in which the sexual cycle becomes damaged** (American Psychiatry Association 1994). Disorders connected to the individual phases are completed with the syndromes concomitant with pains. [1_figure_XI_1_chapter.doc] Legend: *Table 1.: The classification of sexual dysfunctions according to DSM IV.* In the case of each syndrome it is important to treat separately whether the given disorder had existed **throughout the whole life** of the patient (primary disorder) or it is **acquired** (secondary); and whether it is **generalized** (it exists in all situations) or it is **situational** (it exists only in certain situations).

Important Literature	***XI./1.3.: General aetiological factors*** Human sexual behaviour is a complex phenomenon, which has anatomical-physiological bases, but which, at the same time, is under the influence of the natural and social environment (Szilágyi 2006). Nowadays, sexual disorders are classified among the psychiatric diseases, although experts in the topic unanimously **consider** the problem as being **interdisciplinary**. As for their origin, we habitually speak of disorders of organic or of psychological origin; nevertheless even problems of obvious organic origin are often accompanied by psychic factors. Similarly, neither in the case of a disorder of conspicuously psychic origin can we be sure of the absence of some organic cause, so in all cases both approaches have to be taken into account. **Literature** American Psychiatric Association, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth ed. American Psychiatric Association, Washington, DC. 1994. Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. Journal of the American Medical Association, 1999. 281: 537-544. Maurice W. L. Sexual medicine in primary care. St. Louis, Mosby 1999.

Aim	**XI./2.: An exposition of the more frequent sexual disorders** In this chapter the student will become acquainted with the definitions and main characteristics of the most frequent sexual dysfunctions. In addition, the student will become acquainted with psychological models of the most frequent female and male sexual dysfunctions. ***XI./2.1.: Female hypoactive desire disorder and sexual arousal disorder*** **XI./2.1.1. Diagnostic issues** The DSM-IV-TR lists the following categories here: ***Female hypoactive sexual desire disorder:*** "A lasting or recurrent deficiency or absence of desire regarding sexual activity and of sexual fantasies. The judgement of the deficiency is the duty of the clinician, taking the person's age, sex, living conditions and other sexuality influencing factors individually into account. The disorder causes significant suffering or interpersonal difficulties." ***Female sexual arousal disorder:*** "In the course of sexual activity, a lasting or recurrent inability to produce and maintain vaginal lubrication and expansion developing as a response to sexual arousal. The disorder causes significant suffering or interpersonal difficulties." (American Psychiatry Association 1994)

Topic related surveys indicate that in the case of women **there is neither a subjective nor an objectively measurable real difference between sexual desire and sexual arousal**, and that the diagnosis of sexual desire disorder and that of sexual arousal disorder show a significant comorbidity. For this reason an expert consensus has suggested DSM V. to combine these two diagnostic categories under the following name: "the disorder of sexual interest/arousal".

XI./2.1.2. Characteristics of the female sexual ~~excitement~~ arousal

Important

Female sexual desire is generally precipitated or triggered, and only in rare instances is it a spontaneously born urge. **Positive sexual experiences, among other things, are those, which later motivate** women to allow or positively seek the stimuli, which, from a neutral state, bring her into a sexually aroused state. Those women, who do not experience sexual desire spontaneously but only if triggered, are incorrectly labelled as "dysfunctional".

Thus often it is not a real disorder of sexual responsiveness which stands in the background of the disorder of sexual desire or that of sexual arousal, but rather 1. there is not enough positive experience / emotional attentiveness / curiosity for developing enough motivation for getting into sexual contact, 2. the stimulation is not of adequate extent, kind or intensity, 3. the circumstances are not convenient (Tiefer 2001).

XI./2.1.3. The model of female sexual ~~excitement~~ arousal

Important

In light of the above, Basson and his colleagues (Basson 2008) created, instead of the previous linear model (desire arousal – orgasm), the **circular model** of the female sexual response. Women rarely initiate sexual activity obeying spontaneous sexual desires; they are more likely to be motivated by a wide range of sexual and non-sexual motives: they would like to experience sexual pleasures, they would like to display their feelings to their partner, they want to give pleasure, they want to feel strong or desirable, they are bored, they would like to avert their attention from the negative thoughts, or just feel obliged to participate in the act. While being together, the proper sexual stimulation creates a state of arousal and the subjective feeling of desire. The rewarding value of the sexual activity then strengthens the future receptiveness.

XI./2.2.: Female orgasm disorder

Important

DSM IV. defines **female orgasm disorder** as follows:

"A lasting or recurrent delay or absence of orgasm following a maintained sexual arousal phase. Women manifest considerable variability regarding the intensity or manner of the stimulation exciting orgasm. The diagnosis of a female orgasm disorder is the clinician's duty, based on whether the person's capacity for orgasm is of lower degree than her age, sexual experience and the degree of the concrete sexual stimulation would substantiate. The disorder causes significant suffering or interpersonal difficulties."

Thus, based on the criteria, orgasm disorder may be diagnosed only in that case, when subsequent to the normal desire and arousal phases an orgasm does not come about. In reality, however, most women suffering from a lifelong, generalized anorgasmia, **scarcely experience proper sexual arousal**. Similarly, a considerable proportion of the women suffering from sexual desire disorder, struggle with the disorders of the arousal phase and the absence of orgasm as well; in other words, sexual activity gives them insufficient reward. Thus orgasm problems often entail arousal problems, and desire disorders may be caused by orgasm problems as well (ter Kuile 2010).

XI/.2.3.: Vaginismus

Important

According to the DSM IV., vaginismus is "the involuntary spasm of the outer two-thirds of the vagina, which renders sexual intercourse recurrently or permanently impossible. The disorder causes significant suffering or interpersonal difficulties." Vaginismus, like the majority of sexual disorders, may be primary, if the woman has never been capable of sexual intercourse, but may develop later in life too. An interesting fact about this syndrome is that although the diagnosis has a past of 150 years, the existence of the vaginal spasm has never been successfully proved by empirical examinations. It is probable that only a small proportion of the women nowadays diagnosed with vaginismus, do really have convulsive contractions in the muscles of their vaginas or lesser pelvises; in most cases it is rather pain and anxiety which prevents penetration. For this reason the expert committee preparing DSM V. has suggested the combination of the diagnoses of dyspareunia and vaginismus under the following name: "genital-lesser pelvic pain/penetration disorder", the diagnostic criteria of which would include incapability of sexual intercourse, genital or lesser pelvic pain felt at penetration, considerable fear of penetration and the contraction of the vaginal muscles as well (Binik 2010).

XI/.2.4.: Erectile dysfunction

Important

XI./2.4.1. Diagnostic issues

Erectile dysfunction has been defined by the DSM IV. as follows: "A lasting or recurrent incapability to produce or maintain a satisfactory erection during sexual intercourse. The disorder causes significant suffering or interpersonal difficulties."

The healthy erection is a complex process, which is the result of the total effect of several psychological, endocrine, vascular and neurological factors. Although erection disorder may occur as a symptom of many somatic diseases, in the background of a significant part of the complaints there are, partly or completely, psychic causes. The problem may be further aggravated by the fact that patients deem the absence or unsatisfactory quality of the erection a catastrophe, thus whatever had originally been the cause of the erection disorder, psychic factors, in the case of many patients, may further aggravate it. The assessment of the symptom also depends on factors like the particular culture, age of life and the degree of help received from the partner and the doctor (Hackett). Western media often suggests a highly unrealistic picture of the male anatomy and potency, which for males unable to equal the idea and ignorant of the real conditions, may be a source for further anguish.

XI./2.4.1. The cognitive model of erection

History

According to the results of Nobre and Gouveia (Nobre and Gouveia 2000), males suffering from erectile dysfunction **characteristically differ** from their well functioning fellows also in respect of their **attitudes regarding sexuality**, and of the automatic thoughts and feelings actually occurring in sexual situations. A component of their model is constituted by the **dysfunctional beliefs connected to sexuality**. In the course of their factor-analysis they have described three attitudes: 1. the "Latin macho" attitude (which deems as exemplary the characteristics of the "recognized" male role, that is an intensive sexual activity which is satisfying for the partner too, an effective and lasting erection, and, at the

same time, a restrained display of emotions), 2. the obligation to satisfy the partner, and 3. the catastrophization of the general consequences of sexual failure. The other component of the cognitive model of erectile dysfunction is the maladaptive schemata connected to being condemned to failure. Activation of the failure-schemata further impairs the processing of erotic stimuli and reduces the frequency of thoughts of sexual content (Nobre 2010). Automatic thoughts are characteristically connected to performance demand and anticipate failure (e.g. "Now I mustn't cause disappointment", "If I fail, I'm done for", "We'll never get anywhere, anyway") (Nobre és Gouveia 2000). Instead of joyful feelings, the sexual activity is characterized by negative feelings occurring in connection with the above thoughts (2. ábra).

[2_figure_XI_2_chapter.jpg]
Legend: *Figure 2.: The cognitive model of erectile dysfunction (Nobre 2010).*

XI/.2.5.: Premature ejaculation

Important

XI./2.5.1. Diagnostic issues

DSM IV. criteria of **premature ejaculation**: "Ejaculation – permanently or recurrently – occurs, against the person's will and to minimal sexual stimulation, prior to, during or right after penetration. When diagnosing the disorder, the clinician has to consider the factors influencing the time span in the ~~excitement~~arousal phase, such as age, the novelty of the sexual partner or the situation, and the frequency of sexual activity in the past period. The disorder causes significant suffering or interpersonal difficulties."

XI./2.5.2. The types of premature ejaculation

Important

Waldinger, having summarized the surveys of past years (Waldinger 2008), suggests the separation of the following four syndromes:

1. ***Premature ejaculation of lifelong existence*:** ejaculation occurs with almost every partner, at almost every sexual intercourse, right from the very first sexual act; premature: 30-60 seconds (80% of events) or 1-2 minutes (20% of events). The complaint is of lifelong nature. Presumably, there are neurobiological, genetic causes in the background of this dysfunction.
2. ***Acquired premature ejaculation*:** the complaint occurs at a certain age, with intercourses of normal duration before. The cause of the dysfunction may be a urological disease, a disease of the thyroid gland and/or psychic and relationship factors as well.
3. ***Normal variant*:** premature ejaculation occurs rarely, sporadically, occasionally. In these cases premature ejaculation cannot be deemed pathological.
4. ***Premature ejaculation-like disorder*:** men belonging to this group report on subjective experiences of premature ejaculation, the length of time, however, that elapsed from penetration till ejaculation does not differ from the normal average (3-6, occasionally 5-25 minutes).

XI/.2.6.: Summary

Summary

The discussion of sexual disorders in general medical practie is justified by their prevalence and their connection with somatic diseases. 52% of Hungarian women and 47% of Hungarian men report on some kind of sexual dysfunction.

Literature	The most frequent syndromes with women are female desire and arousal phase disorders, orgasm disorder and painful intercourse, and with men, erectile dysfunction and premature ejaculation. According to different surveys, a significant proportion of patients showing up in general medical provision would like to report on their sexual problems or get help from their doctors, but on account of their pessimism concerning the treatments or their fears regarding the reaction of the doctor they frequently do not mention their complaints. Ignoring these problems is not justified, however, since the majority of sexual dysfunctions can be successfully treated by pharmacotherapeutic or psychotherapeutic methods. **Literature** 1) American Psychiatric Association, 1994. DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, fourth ed. American Psychiatric Association, Washington, DC. 2) Basson R. Women's sexual function and dysfunction: current uncertainities, future directions. Int J Impot Res. 2008 Sep-Oct;20(5):466-78. 3) ter Kuile MM, Both S, van Lankveld JJ. Cognitive behavioral therapy for sexual dysfunctions in women. Psychiatr Clin North Am. 2010 Sep;33(3):595-610. 4) Tiefer L. A new view of women's sexual problems: why new? Why now? J Sex Res 2001; 38: 89–96. 5) Binik YM. The DSM diagnostic criteria for vaginismus. Arch Sex Behav 2010;39(2):278–91 6) Nobre P, Gouveia JP. Ercetile dysfunction: an empirical approach based on Beck's cognitive theory. Sexual Relationship Therapy 2000;15(4):351-366 7) Nobre P. Psychological determinants of erectile dysfunction: testing a cognitive-emotional model. J Sex Med 2010;7:1429-1437. 8) Waldinger M.D. Premature ejaculation: different pathophysiologies and etiologies determine its treatment. J Sex Marital Ther 2008;34:1-13.

Aim	**XI./3.: Techniques employed in the psychotherapy of sexual disorders** In this chapter we discuss the assessment of sexual disorders, the general aspects of psychotherapy, and analyse the efficiency of therapies. The student will become acquainted with the psychotherapeutic techniques used in the treatment of sexual dysfunctions, and the practical employment of them. ***XI./3.1.: The assessment of sexual disorders***
Important	In the course of the medical studies only few words are mentioned about how to talk about sexual issues with the patients. Based on Maurice's suggestions we recommend the following to be employed in general medical practice (Maurice 1999): 1. **We should ask for** the patient's **permission** to bring up the topic. If the patient

rejects the conversation, we should assure him that we understand, and that any time in the future he would feel like talking about the topic, he may safely bring the topic up.

2. **We should be matter-of-fact** and ask direct, explicit and concrete questions. Patients misunderstand oblique, paraphrased or extremely open questions or may give similarly oblique answers.

3. We should use **everyday or medical language**, and avoid slang. If we are not sure, whether our patient understands the expressions in question, we should explain what we understand by them, stating exactly what the question is directed at.

4. **We should justify our questions** and at the same time **educate** the patient during questioning.

5. We should keep in mind the patient's worries regarding **secrecy**.

6. We should proceed **from the more general questions** towards the more sensitive topics.

7. **We should not judge** and create situations in which the patient needs to be ashamed of his problems.

8. We should always ask whether the problem is **lifelong or acquired**, and whether it is **generalized or situational**.

9. We should talk about the possible **treatment methods**. Patients frequently believe that there is no solution to their problems.

Important

Method

XI./3.2.: Efficient therapeutic forms

Freud was the first to talk about sexuality in a psychotherapeutic framework, though nowadays **the majority** of sex therapies **are based on cognitive behavioural therapy**. When assessing the efficiency of the therapy in clinical treatment, we need to consider that the primary aim of sex therapies in practice is not the attainment of **some kind of results** (e.g. strong erection exceeding a certain level, a minimum frequency of weekly orgasms etc.), but a sexual relationship which gives mutual pleasure.

[3_figure_XI_3_chapter.doc]
Legend: *Table 3.: Therapeutic methods of proven efficiency*

Important

Method

XI/.3.3.: Psycho-education

It is essential to provide accurate information to the patients regarding **the anatomy and functioning of the genital organs**. In instances when the patient is not in possession of certain basic facts, and is not acquainted with the changes concomitant with ageing or with the normal variations of anatomy, not to mention the genital anatomy of the opposite sex, a thorough education and a dissipation of misconceptions may, at the same time, **serve as a solution** for the sexual disorder. If we have insufficient time at our disposal or the patient is not open enough yet

for a talk, we may recommend him books or other educational literature, nevertheless it is good to provide him an opportunity, so that later, should it prove necessary, he may put questions to us in connection with his readings.

XI/.3.4.: Communicational training

Important

Method

In a significant part of the sex therapeutic cases **communicational problems** between the two members of the couple may be revealed. Among the reasons for the lack of communication we may find sexuality connected attitudes, social taboos, shame, and an absence of the ability of self-assertion. Patients are often unable to indicate their needs to their partners, because they feel their needs are not justifiable, or they are not in the possession of a satisfactory vocabulary, or they do not want to offend their partner by indicating that something does not give them pleasure. In case the sex therapy takes place **in the form of pair sessions**, the couple, even during the sessions, may get to know things about each other that they might have not uttered in front of each other before. In the course of discussing individual problems, both partners get the chance to disclose their feelings, thoughts and desires regarding that problem, and this way may dissipate the misconceptions that might have remained in the other party. Sensate focusing, one of the essential techniques of sex therapy, also attributes a significant role to the open dialogue between the participators.

XI/.3.5.: Sensate focusing exercises

Important

Method

Sensory-focus, or sensate-focusing exercises have been developed by Masters and Johnson (Masters and Johnson 1966). Its aim is to increase the attention paid to one's own and the partner's needs during intimacy. Participants are encouraged to direct **their attention towards the diversified sensation, and towards their experiences felt during sexual relations**, and not to deem orgasm as the sole aim of sexuality. The basis of the programme is constituted by a **temporary prohibition of coitus**, which lasts until partners develop a loose, pressure and anxiety free trust, the ability of directing attention towards bodily sensations, and efficient communication.

The exercises are comprised of four steps:

Important

Method

1. **Non-genital gratification.** On the first few occasions the couple's task is that, in comfortable circumstances, they should touch and stroke each other's body, taking turns, by strictly avoiding touching the genitals and the breasts. Intercourse in this phase is still forbidden; the aim is that participants observe and experience the induced feelings and indicate to their partner what they find pleasurable and what is unpleasant.

2. **Genital gratification.** If the previous phase has been experienced by the couple many times, they are able to participate in it without anxiety and they freely communicate their feelings, then in the next phase the touching of the genitals is allowed, but penetration is not. The task of the participants is that after touching all over the body, they should stroke their partner's genitals too, and they should experiment with different kinds of touches, but not in a way that excites orgasm. The partner gives feedback.

3. "Non-demanding intercourse". Here the male is already allowed to place his penis into the vagina, but he doesn't move it, rather they calmly wait, and the intensity and the duration of the penetration is controlled by the receptive party.

The aim is still not the reaching of orgasm, but the acquiring of joint experiences about the functioning of the bodies of both parties.

4. **True intercourse** comes into question only if the couple have acquired enough positive experiences during the previous three exercises, and are able to adequately communicate their needs.

XI/.3.6.: Cognitive restructuring

Cognitive restructuring is a fundamental element of cognitive behavioural therapy. Its aim is **the identification and transformation of negative automatic thoughts** occurring in problematic situations**, and the substitution of them with positive thoughts**. The first step of cognitive restructuring is the assessment of negative attitudes feeding on sexuality related general, and often childhood, experiences or the prejudices of the particular cultural circle, as well as the negative automatic thoughts currently emerging in sexual situations.

Important

Method

[4_figure_XI_3_chapter.doc]
Legend: *Table 4.: Examples of dysfunctional attitudes and negative automatic thoughts*

The automatic negative thoughts keep the patient from paying attention to the pleasures of the sexual activity, to the erotic stimuli and to his/her own bodily sensations. Through **questioning and restructuring the schemata** we may free the patient from the negative thoughts and may develop a more realistic approach to sexuality. In the course of erotic fantasy exercises and the above detailed sensory-focus exercises the patient learns and practises how, during sexual activity, to direct his attention to his own bodily experiences, erotic thoughts and the feedback from his/her partner and deal with the negative automatic thoughts.

XI/.3.7.: Controlled masturbation

This method had originally been developed by LoPiccolo (LoPiccolo 1978) for the treatment of primary female orgasm disorder. The aim of the exercises is for the woman to accept, during self-stimulation, her feelings regarding her own body, to get acquainted with her reactions, to practise the proper stimulating techniques and to acquire experiences of the pleasure-gaining nature of sexuality. As a first step, the patient receives education regarding the anatomy and physiology of the female genitals, and learns to identify the different parts of her own genitals. In the following steps she experiences the touching of the genitals, identifies the areas that are the most suitable for gaining pleasure, and discovers different methods of stimulation. **Besides self-exploration, the aim** of the sequence of exercises **is to develop a positive attitude towards the patient's own body.** Further steps contain the involvement of films and readings of sexual content, and, occasionally, of sexual aids. If the patient is able to reach orgasm on her own, she is encouraged to show and teach also her partner the techniques developed on her own.

Important

Method

XI/.3.8.: Summary

~~**The aptitude of taking a sexual anamnesis and complaints belongs to the**~~

Summary	~~**scope of competence of the doctor. Taking the anamnesis starts with asking the permission of the patient, then requires the following guiding principles: to the point questions, everyday language, comprehensible explanations, discretion, optimism. It is important to judge, whether the problem is situational or generalized, and whether it is primary or secondary.**~~ **The aptitude of taking a sexual anamnesis and complaints** belongs to the scope of competence of the doctor. Taking the anamnesis starts with asking for the patient's permission. The guiding principles are: to-the-point questions, everyday language, comprehensible explanations, discretion, and optimism. It is important to be able to decide whether the problem is situational or generalized, and whether it is primary or secondary. Although methodology somewhat differs from disease to disease, a common element of sex therapies is **education**, since many symptoms are based on misconceptions. A similarly common characteristic is the **promotion of** sexuality related **communication**, which both the therapeutic situation and the sensory-focus exercises provide opportunity for. An important element of sex therapies is the identification and **questioning of** sexuality related **negative attitudes** and schemata, and of negative automatic thoughts **within a cognitive therapeutic framework**. The above approach proves to be efficient in the case of the treatment of erectile dysfunction and, combined with **controlled masturbation**, of female orgasm disorders. In certain diseases, besides the above mentioned, special techniques are employed as well: such as the **systematic desensitisation** performed by the fingers or a tool in the case of vaginismus, and the **compressing and stop-start techniques** employed in the treatment of premature ejaculation.
Literature	## Literature 1) Masters WH, Johnson VE. Human sexual response. Boston, Little Brown 1966. 2) Maurice W. L. Sexual medicine in primary care. St. Louis, Mosby 1999. 3) LoPiccolo J., LoPiccolo L. Handbook of sex therapy. Michigan, Plenum Press, 1978.