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Back to the Basics: Origins of Sex Therapy, Sexual Disorder and Therapeutic Techniques

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Abstract

The development of sex therapy and the conceptualization of sexual disorders began with psychoanalytic underpinnings prior to 1960, and flourished with the development of specific behavioral therapeutic techniques presented by Masters and Johnson in1966 and 1970. Building upon these approaches, Helen Singer Kaplan integrated these two prominent movements with her book, The New Sex Therapy in 1974. During the 1970s, other techniques emerged for the treatment of sexual disorders including Gestalt, Rational Emotive and Humanistic Therapies. The progression and development of these theoretical orientations are presented in the current paper. The sexual revolution of the 1960s to 1970s prompted a prolific development of sex therapies, ranging from those that focus on disorder as a deviation from the 'normal' sexual response, to those therapies that aim at improving the sexual activities of all people. Therefore, this paper reviews the foundations of sex therapy up until 1975 and includes an exploration of how various theoretical orientations differ both in the conceptualization of sexual disorder, and in the implementation of specific therapeutic techniques. The conceptualization of sexual disorder and the emergence of a variety of therapeutic modalities for treatment of sexual dysfunction have been monumental in bringing attention to sexual issues. This time period laid the foundation for understanding sexual disorder as a significant issue in need of treatment, and for legitimizing the desire to improve one's sexual relationships and activities. An examination of these various psychosexual techniques allows us to have a conceptually clearer understanding of sexual disorder and sexual functioning and therefore helps to improve clinical practice.

Keywords: Sexual disorder; Sexual dysfunction; Sex therapy; Psychotherapy

Introduction

Many components of contemporary sex therapy started to appear in the 1950s and flourished for several decades. This paper explores the emergence of various conceptualizations and psychotherapeutic treatments for sexual dysfunction. Beginning with traditional psychoanalysis, which laid the foundation for sex therapy following with the techniques of Masters and Johnson, who are now considered the pioneers of modern sex therapy, the most common treatment for sexual disorders prior to the research of Masters and Johnson was long-term psycho-analysis [1]. Instead of targeting the presenting sexual symptoms, psychoanalytic techniques aimed to discover the unconscious conflicts that were perceived to be responsible for a person's sexual dysfunction. The foundation of psychoanalysis relied on the attribution of all types of neuroses to internal unresolved sexual conflicts [2]. Alternatively, Masters and Johnson (1966, 1970) were the first researchers to describe the "normal" sexual response cycle by researching average people that did not exhibit sexual dysfunction. By focusing on the presenting sexual symptom, Masters and Johnson were also able to identify specific evidence of sexual disorder. They labeled deviations from the response cycle as sexual dysfunctions (hypoarousal or aversion to sexual stimuli, and absent, delayed or overly rapid orgasm and ejaculation). It has been stated of Masters and Johnson that "someday the world will recognize that these two people have made some of the most significant contributions of all time to world mental health" [3].

During the 1960's and 1970's several other treatments for sexual dysfunction emerged, which can be placed on a continuum between the extremes of psychoanalysis (which looked beyond the sexual symptom to deeper unresolved intrapsychic issues) and Masters' and Johnsons' behavioral techniques (which focused directly on the alleviation of the presenting sexual symptom). Kaplan's development of the 'new sex therapy' is an example of a treatment that integrated both behavioral strategies and an examination of deeper psychological causes for sexual dysfunction (1974). Concurrently, many other techniques emerged for the treatment of sexual disorders including humanistic, Gestalt and rational emotive therapies. Other adjuvant techniques added to the successful development of sex therapy as a multidisciplinary practice (e.g. social skills therapy, hypnotherapy, mechanotherapy, pharmacology). While all sex therapies espouse to improve sexual functioning, their therapeutic goals may be narrow or broad, their conceptualization of sexual dysfunction different, and their techniques diverse.

Current conceptualizations of sexual dysfunction can be understood as a disturbance in the processes that characterize the sexual response cycle, or by pain associated with intercourse (DSM-IV-TR) [4]. Earlier understandings of sexual dysfunctions often included broader issues relating to the maintenance of marital relationships and even general mental health. By the 1950s, however, common sexual disorders that claimed the attention of clinicians focused specifically on sexual symptoms, (e.g. male erectile dysfunction, female frigidity, also known as disorders of hypoarousal). Other key disorders of focus were those involving pain (e.g. vaginismus), premature ejaculation, and the presence of anxiety in response to sexual stimuli. These disorders were conceptualized based on the deviation from what was thought to be normal or typical sexual functioning.

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The Origin of Sex Therapy

Prior to the development of psychoanalysis, sexuality was viewed as a moral phenomenon, stemming from Victorian principles, which asserted that sexual activity should be solely a means for procreation [3,5]. Freud carried on the work of sexologists of his time, such as Kraft-Ebing, Hirschfeld and Ellis, by discussing the role of sexuality in health and by working to move sex from the moral domain to the psychological. Freud theorized that sexuality played a significant part in the development of general mental illness. He, therefore, played both a direct and indirect role in the sexual reform movement by asserting that sexuality plays a large role in all individuals' mental health [3]. While his specific therapeutic techniques were rarely successful in remediating sexual dysfunction, and some of his theories were largely discredited, Freud's work was foundational in creating an atmosphere amenable to the exploration of sexual disorder and for the subsequent emergence of sex therapy [3,6]. His work has permeated most aspects of modern thought and consequently still has considerable influence on psychotherapy in general.

Freudian psychoanalysis

Conceptualization of sexual disorder: The theoretical foundation of traditional psychoanalysis is based on the assumption that sexual disturbances arise from an individual's history, specifically their development through the psychosexual stages and the Oedipal Complex [7]. Freud himself attributed much of his patients' neurosis to the expression of sexually-based conflict between the impulses of id and superego, and feelings that emerged between child and parent (e.g. castration anxiety and penis envy) [2]. Thus, sexual dysfunctions (and neuroses in general) were considered to have originated from historically unresolved and unconscious sexual conflicts [7]. Furthermore, problematic attachment and tension with one's parents were viewed as perpetuating the development of unhealthy sexual beliefs.

Therapeutic techniques: Psychoanalytic treatment of sexual disorders consisted of long-term psychotherapy that aimed to uncover the hidden intrapsychic conflicts that were believed to be responsible for the development of adult sexual dysfunction. Therapeutic goals focused not on the symptoms of sexual dysfunction, but on the understanding of the person's 'mental life' [8]. Symptom relief was thought to come naturally with the resolution of underlying conflicts, as it was assumed that individuals who were able to confront their repressed conflicts (i.e. the original causes of their sexual dysfunction) would also find that their sexual problems were resolved [8]. Critics claimed that this supposition was largely unsupported and that Freudian psychoanalysis resulted in little improvement in patients' sexual functioning [6].

In contrast, Ellis [6] argued that assumptions such as Freud's, only served to intensify client's pathological beliefs about sexuality rather than to advance one's knowledge of sexual health and dysfunction. According to Ellis psychoanalysis prevents the therapist from doing three important and necessary things in treatment: 1) giving direct sexual information to clients, 2) supervising activity/homework assignments, and 3) showing clients active ways to challenge their negative assumptions about sexuality. Ellis [6] determined that it is because of these reasons, and the misguided hypotheses about the development of sexual dysfunction, that Freudian psychoanalysis was largely ineffective for the treatment of sexual dysfunction.

Post-freudian psychoanalysis

Conceptualization of sexual disorder: According to Bieber [9], sexual disorders arose from distorted beliefs or convictions about sexuality, which were established in childhood due to adverse influences on sexual development. These influences may have included destructive attitudes exerted by parents or other power figures, both in and outside the family. It was believed that sexual dysfunction was propelled by the clients' lack of insight into their distorted assumptions. The goal of psychoanalysis, then, was to rid the patient of their unformed or unconscious irrational expectations.

Under this theoretical orientation, sexual interest or desire can be considered in two ways: 1) the physiological response of sexual desire, and 2) the desire for close, intimate and emotional connections with others. According to Bieber, the object of psychoanalysis is the person's affective and interpersonal desire for intimacy. He divides sexual disorders into two categories: (1) interpersonal disorders which arise from adverse parental reactions to the child (e.g. fear, rejection or competition), and (2) prohibitive disorders arising from parental prohibitions towards masturbation, sexual curiosity, exploratory sexual play and promiscuity. The most common sexual disorders included difficulties falling in love, beginning and maintaining romantic or sexual relationships, sustaining an effective marriage, opposition to marriage, and fear or anxiety related to having children or becoming a parent [9]. Postpartum reactions are also included as sexual disorders and can be experienced by males or females. Sexual symptoms include spousal alienation, changes in sexual patterns such as increased frigidity and/or impotence, the occurrence of extramarital affairs and adverse reactions to children, such as rejection or competition [9]. Each of these disorders is to be remedied through long-term psychoanalysis, in which the individual's historically founded maladaptive beliefs about sexuality and sexual expression are corrected.

Therapeutic techniques: Specific treatment goals include identifying and resolving various irrational beliefs and moral judgments surrounding an individual's expectations of their sexual experiences. One example involves persons whose parents were unresponsive to their needs as children, who went on to develop maladaptive assumptions about their relationships with others. Through the development of a long-term, stable and warm relationship with the therapist, the client gains insight into healthy relationships, and thus is able to have a corrective emotional and interpersonal experience. This relationship is thought to help eradicate irrational beliefs about others. A second example involves a clients' belief that it is morally wrong to practice masturbation. The therapist gives the client permission to masturbate and through the development of good rapport with the therapist, the client begins to trust the therapists' instructions. However, if damage occurs to the rapport between therapist and client, all therapeutic progress will likely be lost [9].

Important considerations for the psychodynamic therapist include identifying his or her own irrational beliefs and biases. The therapist must make an effort not to communicate doubt, uncertainty, residual guilt, or inaccurate ideas of what constitutes "normal" sexual behavior, in order to prevent the transfer of his or her own problematic sexual beliefs to the patient. Furthermore, all topics brought forth by the client need to be adequately addressed in order to prevent the client's assumption that unaddressed topics are taboo or inappropriate to talk about directly.

Allen [10] reported that there were two schools of thought regarding concurrent sexual practice while undergoing psychoanalysis. One approach allowed patients to participate in sexual activity as soon as they felt capable, while requiring monitoring and altering of sexual behavior based on experience of success or failure. The other

approach prohibited the patient from engaging in sexual activity until complete reparation, which would bypass any detriments that incurred from possible experiences of failure. Considering that psychoanalysis can traditionally take many years, refraining from any sexual activities while undergoing treatment may be particularly difficult for clients to sustain.

Post-psychoanalytic contributions to sex therapy

Kinsey exposed the diverse sexual activities of 'normal' men (1948) and women (1953), in a time where there was no biological understanding of sexual urges or physiological processes involved in sexual behavior of the human. The laboratory-based research of Masters and Johnson that burgeoned in the late 1960's, complimented Kinsey's survey research [11,12]. Researchers such as Kinsey, and Masters and Johnson set out to examine the sexual behavior of typical people, but "any study exploring what is normal, is by definition defining what is not" [8]. Therefore, it soon became clear that there was a need to define specific sexual dysfunctions and to treat problematic sexual relations.

By the 1970's the Sexual Revolution was in full swing, bringing with it a surge of clientele who were eager to improve and even perfect their sexual relationships [13]. Many believed that sexual gratification was available to all individuals if only they sought direction to attain the goals of ultimate pleasure. The research of Masters and Johnson [14] was so well publicized that self-help books and magazines articles soon provided the education necessary for clients to start asking questions about how to enrich their sexual lives [1]. The 1970's became a time for the development and flourishing of many types of sex therapy.

Behavioral and directive therapies

Conceptualization of sexual disorder: After establishing the components of the "normal" sexual response cycle, Masters and Johnson laid the foundation for modern sex therapy with the publication of their book Human Sexual Inadequacy [15]. This book accompanied a new emphasis on cognitive and behavioral approaches to psychotherapy that proved to be of much shorter therapeutic duration than traditional analytic approaches [8,13]. Emphasis was placed on the non-biological factors present in the development of sexual dysfunction. The focus was entirely on the sexual symptoms, rather than the broad and past-oriented relational issues that were the focus of psychoanalysis. This orientation was based on the premise that in the absence of physiological or biochemical factors, sexual dysfunction exists due to breakdowns in communication, inadequate sex information, negative attitudes, and unrealistic expectations about sex [13].

Common sexual dysfunctions were classified based on deviations from the 'normal' sexual response cycle [14] and included erectile dysfunction, premature ejaculation, pain associated with intercourse (e.g. vaginismus), and cases in which sexual stimuli were interpreted as aversive. The development of sexual disorders was purported to occur because sexual encounters are regarded as anxiety provoking [13,15,16]. While anxiety addressed in psychoanalysis originated from unresolved intrapsychic issues, anxiety addressed by behavioral methods originated from concerns about performance. Masters and Johnson considered the underlying cause of one's anxiety as largely irrelevant [17].

Therapeutic techniques: While it is accurate to categorize the Masters and Johnson method as behavioral, it was actually the first method to integrate both educative and directive components into behavioral sex therapy [18]. This was a fundamental change from the traditional psychoanalytic orientations which viewed humans as instinctual beings with natural impulses towards sex that are interrupted by intrapsychic conflict rather than naivety or ignorance. Masters and Johnson maintained that people need to learn how to interact with each other in successful sexually intimate ways, and that most sexual problems result from a lack of education or misconceptions about sexuality.

Social psychology research that was being conducted in the 1970s had demonstrated that attitude, emotions, and behavior are all closely linked and that a change in any one of these is likely to initiate a change in the others [16]. Therefore, by changing the behavior associated with typical sexual encounters, individuals may also develop more positive attitudes towards sexual experiences. Interestingly, there is no active effort to change a client's attitude or "sexual value system"; a change in attitude is seen as a by-product of the change in behavior [16]. The combination of these brief and solution-focused methods was most effective [5,19]. Additionally, Schover and Leiblum [13] have suggested that behavioral techniques for sexual dysfunction were perhaps the most effective psychotherapy of this time.

One of the most commonly used behavioral techniques in sex therapy is that of systematic desensitization. In this technique, the therapist and client work together, creating a list of anxiety provoking sexual experiences. These experiences are ordered by intensity [17]. The list is to only include experiences in which the client engages in, or hopes to be able to engage in (irrelevant or unrealistic scenarios do not need to be included) [16]. The client is led into a relaxed state using deep muscle relaxation or pharmaceutical treatment, and the stimuli are then targeted systematically [17]. The active component behind systematic desensitization is pairing "a response antagonistic to anxiety…in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety response [20]. The bond between these responses is then weakened and the anxious response associated with sexual stimuli is eventually extinguished [20]. Typically the exposure is done through visual imagination. The use of imaginal exposure rather than in vivo exposure can actually be more effective, because imaginal exposure is conducted in the therapist's office under his or her supervision, while in vivo exposure occurs in the home, in the same anxious environment with many distractions [17]. As anxiety decreases in these sessions, it is assumed that sexual desire is reciprocal and, therefore, will increase automatically [16].

Elements of cognitive therapy surfaced as clients were instructed to engage in a thought stopping procedure [21], whereby they worked to replace anxious sexual thoughts with appropriate forceful assertive statements [13]. Furthermore, the act of receiving instructions from the therapist frees the client from any negative thoughts or moral judgments that they may have toward themselves [22]. Instead, the individual is viewed as being a 'good' and compliant patient. For example, if a man is worried that he may not achieve an erection when he attempts to have intercourse, he may be instructed to engage only in sensual activities that don't require an erection. Therefore, by following the homework instructions, his anxiety is alleviated.

Another important therapeutic technique is that of directed practice, which is often employed in conjunction with other behavioral techniques. Partners are asked to bear with the client while he or she is engaged in the therapeutic process [23]. Couples are encouraged to participate in sensual activities such as being naked with one another, or exploring acts of foreplay, but are instructed not to engage in anxiety provoking acts until the completion of the desensitization process. Therefore, the patient is able to learn that sensual experiences can be enjoyable without the constant pressure to 'perform'. Other directive components specific to the type of sexual disorder include the use of

manual techniques to treat problems such as premature ejaculation (e.g. the squeeze technique) vaginismus (e.g. vaginal dilators). Another technique is the focus on didactic and experiential education (e.g. teaching and/or use of sexual surrogates) and the use guided arousal exercises (e.g. sensate focus), sexual imagery and fantasy in order to increase physical sexual awareness and arousal [13,15,18,24].

Behavioral-analytic sex therapy

Conceptualization of the sexual disorder: The method espoused by Kaplan [25] detailed in her book, The New Sex Therapy, was an attempt to integrate straight-forward directive behavioral techniques with those that addressed deeper relational issues. The strength of her approach was that it accounted for many sexual dysfunctions, which are easily remedied with behavior therapy (explored in detail in Masters and Johnson's research on sexual inadequacy) [15], while also recognizing that not all cases of sexual disorder are adequately treated with behavior therapy. Kaplan moved beyond the focus of the sexual symptom, without ignoring it, to examine where clients may have extended or created emotional disturbances in non-sexual areas of their lives. In these cases, she began to examine how the sexual symptom was caused or strengthened by psychological experiences and stressors. Examples include previous trauma, experiences that led to performance anxiety, deep feelings of guilt, fear of selfishness, and insecurity that may prevent partners from expressing what they find sexually arousing. Therefore, Kaplan's new sex therapy both successfully remediated immediate sexual dysfunction and remediated underlying psychological causes when necessary.

Therapeutic techniques: Kaplan follows the general techniques described by Masters and Johnson [15], however, she stressed "when the two modalities are used in combination, when sexual exercises are combined with psychotherapy conducted with skill and sensitivity, psychotherapy becomes immensely important and, in fact, is indispensable to the success of the new sex therapy" [25]. For example, the therapist cannot continue solely with behavioral methods if they find that the problems of one partner obtrude on the progress the couple is making together. At this point there is a need for individual therapy [26]. In complex cases, Kaplan would call attention to the client's irrational beliefs, which are identified as the source of the psychopathology [25]. The therapist challenges these beliefs and unrealistic expectations by bringing them to the forefront rather than allowing them to go unaddressed [25].

Importantly, Kaplan viewed sex therapy as different "from other forms of treatment for sexual dysfunctions in two respects: first, its goals are essentially limited to the relief of the patient's sexual symptom and second, it departs from traditional techniques by employing a combination of prescribed sexual experiences and psychotherapy" [25].

The gestalt experiment in sex therapy

Conceptualization of sexual disorder: What is lacking so far and added through this approach is a model for understanding the various factors that bring a client to therapy. Sometimes client become overwhelmed when focusing on the sexual symptom and become "stuck". Mosher [27] purports that sexual dysfunction develops when individuals confront a sexual problem with an urge to "blindly charge ahead" or to "run away". Therefore, it is the person's response to the problem that is of focus rather than the sexual symptom, which originally motivated the client to seek therapy. The response to the sexual problem causes the couple to become 'stuck' at an impasse in need of repair [27]. The sexual episode is regarded as an ordeal rather than an enjoyable time filled with exciting opportunities to explore. The sexual experience becomes coloured by the person's fears and distressing experiences [27]. It is believed that by actually approaching the situation in a safe but urgent manner, the individual will gain insight and become aware of new solutions to implement. The focus of therapy is to bypass the specific sexual symptom by placing clients in an experimental situation in which they are forced to think of new sexual solutions and act accordingly.

The fundamental difference between the Gestalt approach and the behavioral and behavioral-analytic approaches is the notion that sex education and information can be beneficial for only *some* individuals. Gestalt therapists believe that only through discrimination and experimentation individuals can find out which valuable pieces of education and expert opinion actually fit their sexual experiences [27]. It is believed that most sexual dysfunctions are the result of a previous negative experience that must be targeted and worked through by direction of the therapist through a series of experiments; the previous experience is never ignored [27].

Therapeutic techniques: The therapist asks the client to describe their negative sexual experience or sexual symptom as if it were a nightmare [27]. It is the therapists' responsibility to become aware of the interruptions to success that occur within the described story. By questioning the client and encouraging them to develop alternative solutions to each component of the nightmare, the client becomes more assertive in their emotional responses to their sexual encounter. The client must "finish the past, in order to live in the present" [27].

A key feature in the Gestalt experiment for sex therapy is the creation of the "safe emergency" in practicing sex homework [27]. It is believed that successful sexual encounters can be staged if the client engages in the experience with a sense of urgency, which will facilitate the development of new solutions. It is important to balance this sense of urgency with elements that ensure safety for the client and prevention of performance anxiety. The amount of risk involved with such changes is monitored. An experiment is a chance for individuals to take a risky step towards a better sexual encounter, rather than a drastic leap into the world of the unknown. For example, the husband of a 'frigid' woman who is afraid of having intercourse may be instructed to engage only in sexual touching without any possibility for intercourse. Therefore she can experience some risk (sexual touching) without the possibility of the ultimate 'danger' (penetrative intercourse).

The therapist aims to foster an environment of playfulness and creativity, which are seen as an "antidote to sterile, intellectualized deliberateness" [27]. Clients are submerged in novel experiences in which they are thought to make "new meaning". In the words of Mosher, the "Gestalt experiment is a creative opportunity to invent and discover or to find and make a new meaning where heretofore there has been only an impasse of insoluble problem and meaninglessness" [27].

Rational Emotive Therapy

Conceptualization of the sexual disorder: Up until this point, the individual cognitions, internal attributions and emotional experiences of clients have been largely overlooked as playing a role in the development of sexual disorder. In Rational Emotive Therapy, sexual dysfunction is seen entirely as a result of distorted thinking and maladaptive emotional attributions to one's negative sexual experiences [28]. Clients are seen as needing basic education to counter their maladaptive beliefs and therapeutic tools to engage in reconstruction of the thoughts and emotions associated with their sexual symptoms [6,28]. The clients' attribution of negative and even catastrophic emotions to a problematic sexual experience is seen as a causal factor in

the development of a sexual disorder. This is contrary to psychoanalysis where negative sexual experiences are perpetuated by internal and unconscious conflicts and in behavioral treatments where the most important emotional reaction to failed sexual encounters is considered performance anxiety. In Rational Emotive Therapy, the problematic sexual symptoms are seen as perpetuated by one's beliefs, such as despair, depression and hopelessness [28].

Therapeutic techniques: Rather than allowing oneself to feel despair, depression, and doom at sexual failure, the techniques of rational emotive therapy relies on cognitive restructuring of one's emotions while imagining their worst fear: sexual failure. They are instructed to feel more appropriate emotions such as sorrow, regret, frustration, disappointment or annoyance in the context of sexual dysfunction. This process is known as "anti-awfulizing"; the client is instructed to dispute their irrational beliefs and guilt, and to accept that having a sexual dysfunction is common and likely not as catastrophic as they have imagined [6,28]. Once this process proves successful, the person is encouraged to imagine sexual success (sometimes with the aid of written or visual materials) and to think of the positive emotions associated with such an experience. Important key roles of the therapist are to aid in attacking the shame associated with negative sexual encounters (e.g. countering negative value judgments), to aid in assertion training (e.g. avoiding 'should' or 'must' statements) and to use basic verbal reinforcement of positive behaviors. The therapist also provides unconditional acceptance, as well as emotive or constructive feedback and assigns regular homework assignments that are consistent with those applied by behavior and directive therapists [28]. The techniques of Rational Emotive Therapy foreshadow the technique of cognitive-behavior sex therapy that will emerge more than a decade later.

Humanistic Sex Therapy

Conceptualization of sexual disorder

In response to the predominantly psychoanalytic and behavioral techniques presented up until this point, new techniques emerged which focused on the interpersonal nature of sexual difficulties. Humanistic sex therapy purported the need to focus on one's internal representations of self-regard and self-worth, as well as their interactions with others. The humanistic orientation to sex therapy avoids pathologizing sexual experiences and therefore focuses not on any specific sexual symptom or presenting problem. This approach is concerned with the nature of human experience and thus involves no clear pre-determined conceptualization of sexual disorder. All individuals are thought to be able to gain insight and understanding, which will enrich and enhance their sexual experiences [29]. Those who ascribe to a humanistic orientation claim that what is largely missing from other sex therapies is the empowerment of clients. If properly empowered, every individual can overcome any obstacle that they may encounter at any point in their sexual encounters. A person can improve on their existing state of functioning regardless of whether or not it is determined to be problematic [29]. In the case that a sexual 'problem' does exist, it was seen as resulting predominately from interpersonal conflicts rather than performance anxiety or intrapsychic conflicts.

Therapeutic techniques

Humanistic sex therapy is associated with the core Rogerian ideas of unconditional positive regard, a focus on the present rather than past or future and a holistic mind-body view [29]. Other areas of focus were on the romantic relationship, such as encouraging direct interpersonal feedback and emphasizing honest and open communication [29]. Efforts were made to engage couples and individuals in group treatment for sexual problems. Another goal of treatment was the enhancement of sexual experiences in 'normal' individuals who do not identify particular problems and through the process of mind-body and imaginal/fantasy work [6,30]. A significant strength of this model is the goal of attainment of healthy and positive sexual relationships. This is consistent with the general approach behind humanistic psychology that humans are fundamentally good and healthy, rather than driven by impulses.

One example of a techniques used in the group setting is education and instruction in using appropriate physiological terms for sexual organs (e.g. penis, vagina, intercourse). This technique is thought to aid group discussion and intimate discussion during sexual encounters. Clients are asked to anonymously share their fears and hopes and to learn how to initiate and refuse participation in intercourse or specific sexual acts in a sensitive and gentle manner. Couples are instructed to share 'turn-ons' and 'turn-offs' as well as engage in sensate focus and homework exercises, which are similar to those found among other therapeutic techniques [30]. Group therapy is particularly helpful for the treatment of sexual disorder in individuals who are not partnered at the time of therapy. Anyone who is seeking improvement in his or her sexual activities would be a good candidate for Humanistic sex therapy

Conclusion

By 1976, there were over a dozen well known types of psychotherapy that originated from a variety of theoretical orientations [31]. Most therapists, regardless of orientation, report that clients are often uninformed, or hold irrational and damning ideas about sexual activity [9,15,16,21,27,28,32]. The common approach to sexual dysfunction involves disarming the client of their harmful and uninformed beliefs about sexual activity. Furthermore, sexuality has been viewed as a component of intimate relationships that can affect all realms of a person's private life. A common ground of all of these theoretical orientations is that sexuality is an important area of psychosocial functioning that affects all people.

Differences among treatments include the relative emphasis, or lack thereof, that is placed on the specific sexual symptom. While traditional psychoanalysis saw sexual interactions in one's past as the basis for a person's general psychopathology, the sexual symptom was not of import to the treatment process. Furthermore, sexual disorders were also seen as broadly encompassing relational issues and to reach so far as to include a person's opposition to marriage or post-partum reaction to the birth of a child. Behavioral treatments focused entirely on the sexual symptom and often overlooked the relational aspects of sexuality, prescribing directed practice and education as a fix to sexual problems that may have been based on deeper interpersonal issues. The New Sex Therapy attempted to provide a balance by addressing both the narrow (i.e. focus on the sexual symptom) and the broad (i.e. focus on interpersonal or historical factors) conceptualizations of sexual disorder. Gestalt sex therapy focused on problem solving and experimentation as a strategy to improve sexual experiences. Rational Emotive Therapy integrated many of these concepts with didactic and pragmatic teaching about solutions to sexual problems. Interestingly, humanistic sex therapy soon became more focused on enriching and enhancing sexuality rather than on remediation of sexual disorder. Rather than treating the sex therapy client as a patient with a sexual 'problem' or dysfunction, sex therapy was made to be available to any and all persons that may be in need of expert advice on a universal phenomenon.

Specific sexual dysfunctions were not added to the DSM (Diagnostic

and Statistical Manual) until 1980 [4]. These definitions were altered with the development of DSM-IV and will likely change again with the publication of DSM-V. The addition of these disorders to the DSM allowed for medicalized treatment rather than the largely pioneering psychologically based treatment of Masters and Johnson. While some strength have emerged from the medical model (e.g. pharmaceutical treatments of erectile dysfunction, endocrine and hormonal treatment, surgical procedures) very few "new" sex therapy modalities or psychosexual techniques have emerged in the last few decades. The discipline of sex therapy today still has its roots in the analytic and behavioral schools of thought. It is not enough to just make sure one's relationship is working well. It is also inadequate to simply address the sexual symptom as is often done within the behavioral and medical models. A biopsychosocial model of sexual functioning is still the best model of the treatment of sexual disorder and enhancement of sexual functioning. Acknowledgement that much of what is practiced clinically today has not strayed far from the methods that were introduced in the 1960s and 1970s reminds clinicians to look back to the sources of their current methodology. An examination of these various psychosexual techniques allows us to have a conceptually clearer understanding of sexual disorder and sexual functioning and therefore helps to improve clinical practice.

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