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Article

2005

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How to cite

BIANCHI-DEMICHELI, Francesco, ZUTTER, Anne-Marie. Intensive short-term dynamic sex therapy: a proposal. In: Journal of sex & marital therapy, vol. 31, n° 1, p. 57–72. doi: 10.1080/00926230590475288

This publication URL: <https://archive-ouverte.unige.ch/unige:29434>

Publication DOI: [10.1080/00926230590475288](https://doi.org/10.1080/00926230590475288)

Intensive Short-Term Dynamic Sex Therapy: A Proposal

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This article proposes a model of rapid intervention in clinical sexology. The approach uses a method developed by Davanloo, which consists of first identifying and clarifying the defense mechanisms at work and then placing them under pressure. This pressure provokes a heightened anxiety, an intensification of the defense mechanisms, and the development of an intrapsychic crisis disclosing painful emotions linked to past traumas and intrapsychic conflicts. Such stimulation of the unconscious can bring about somatic and sexual symptoms that reveal links between physical and psychic elements. The approach provides rapid access to painful emotions underlying sexual symptoms and allows the therapist to identify appropriate areas and levels of therapeutic intervention. This method helps to translate psychic and sexual realities in a simple, rapid, and efficient manner. It provides opportunities for awareness and comprehension to the therapist and the patient.

Sexual dysfunction is characterized by a disruption of the process of sexual response or by pain associated with sexual relations (American Psychiatric Association, 1994; World Health Organization, 1993). Sexual dysfunction may

We thank Odile Frank and Eliane Perrin who have generously contributed to this work. We also thank Ayda Sakbani and Rosemary Sudan for editorial assistance.

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be symptomatic of biological, intrapsychic, relational, or even social problems or by some combination of these factors (Kaplan & Saddock, 1997). Sexual function may be disturbed by stress, emotional problems, or ignorance regarding sexuality (Kaplan & Saddock, 1997).

Before 1970, the typical treatment for sexual dysfunction was individual psychotherapy. Later, different therapeutic approaches were introduced that are still currently in use, such as behavioral therapy, the dual-sex therapy of Masters and Johnson, the corporal approach, hypnotherapy, and group therapy (Fournier, 1984; Kaplan & Saddock, 1997; Masters & Johnson, 1971).

In the late 1970s, Helen Kaplan (1979) developed a therapeutic approach combining behaviorist methods with a psychoanalytic perspective. The integration of different psychodynamic and behaviorist techniques constitutes one of the most effective treatment methods today (Kaplan & Saddock, 1997).

The purpose of this article is to propose a practical, rather than a theoretical, model of psychological intervention to uncover psychic elements linked to sexual problems and thereby to integrate its somatic and psychodynamic dimensions.

In effect, we present here a rapid therapeutic intervention in clinical sexology. Its contribution lies in the concrete and practical link it establishes between a method of brief psychotherapy and the daily work with patients with sexual complaints.

METHOD

Menninger (1958) conceptualized a triangle of insight to schematically represent the relation between deep conflicts, anxiety, and defense mechanisms (Malan, 1981). In 1978, Davanloo (1980, 1990), using Menninger's triangle, developed a technique of brief, intensive psychotherapy. Our work is inspired by the method developed by Davanloo in 1980, which consists of identifying and clarifying the defense mechanisms at work (as defined in the Davanloo model), then placing them under pressure.

Application of pressure provokes a heightened anxiety and an intensification of the defense mechanisms. An intrapsychic crisis develops, bringing up painful emotions linked to past traumas or intrapsychic conflicts. As pressure is applied, we see anxiety mounting, the defense mechanisms intensifying, and, at times, sexual or aggressive impulses and expression of feelings. At this point, we begin examination of the interrelation of defense mechanisms, anxiety, emotions, and sexual symptoms. This method provides a rapid access to painful emotions that underlie sexual symptoms. Use of the triangle of insight affords a simple, rapid, and didactic therapeutic strategy.

CONTEXT AND DESCRIPTION OF THE TECHNIQUE

The origin of the sexual problem or symptom may be:

- biological
- intrapsychic
- relational
- social
- multifactorial

Psychological intervention helps to:

- Describe the psychological aspects of the sexual problem (impulses, emotions, anxiety, defense mechanisms)
- Formulate hypotheses about the dynamics of the sexual problem (relationship between the somatic and psychic)
- Propose, on the basis of these hypotheses, therapeutic interventions

The strategy is as follows.

Evaluation of the Patient's Motivation for Therapy and Clarification of the Problem That Brings the Patient to See a Psychologist

Clarification of the sexual problem calls for an interim functional diagnosis that takes into account somatic, intrapsychic, and relational aspects as its possible cause or consequence. For this, the following information is required: motivation for the consultation and the expectations of the patient; and motivation for the consultation and the expectations of the referring physician.

Clarification, Identification of the Presenting Problem, Including its Somatic and Psychological Aspects

At the beginning, the symptom or sexual problem often is dramatically evident either as a single somatic and functional element or as its consequence such as pain, inability to have sexual intercourse, infertility, and so forth. For clarity, these aspects include:

- a) Somatic aspects: the diagnosis, tests done or planned, past and current treatment, areas remaining to be investigated.
- b) Psychosomatic aspect: sexual manifestations that are evidently or hypothetically brought about by emotional or anxiety-related factors.
- c) Psychic reactions to these problems: how the patient lives with his or her problem and how he or she manages it.

- d) The difficulties or conflicts that the patient has with him or herself, as expressed in psychic symptoms, problematic behavior, and anxiety.
- e) Relational difficulties in the couple and the family.

To arrive at a clear definition of the problem, it is useful to have the patient keep a journal to note each occurrence of the difficulty, its exact nature, time, and circumstances and to possibly rate its degree of severity. The following additional information is also useful:

- Has the patient had any sexual therapy in the past? What kind and with what results? Are there any residual feelings about it? What are these feelings?
- Are there any personal thoughts and beliefs (cultural dimension) or personal convictions about the symptom?

Formulating a Hypothesis about the Development and Functioning of the Symptom

At this point, various data streams must be integrated, their interrelationships sorted out, and a working hypothesis drawn up with the help of the patient. On the basis of the sexual symptom or problem, we will identify (Figure 1):

- impulses, expressed feelings, and emotions (I-F-E)
- anxiety (A)
- defense mechanisms (D), cognitive or behavioral, which find expression as one or more forms of sexual dysfunction (SD)

In our model, we place sexual dysfunction (SD) at the center of the triangle, because it is the focus of the patient's complaint. This central position in the triangle also signals that the symptom of sexual dysfunction is the result of a dynamic interaction between impulses, expressed feelings, and emotions (I-F-E), anxiety (A), and defense mechanisms (D). The sexual symptom also occupies a place with respect to the defense mechanism because it often has a clearly defensive function.

In the lexicon of psychoanalysis, a defense is defined as a set of operations that work to avoid or reduce any change likely to threaten the psychobiological integrity and status quo of the individual (Laplanche & Pontalis, 1967). The internal mechanism of defense of the Ego can be identified by the internal psychological processes of repression, projection, and sublimation and by transpersonal defenses through which it protects its inner psychic life by manipulating its relations with the world (Fournier, 1984). The sexual symptom may be the manifestation of such a symptomatic use of these defense mechanisms. It arises directly from an internal psychic mechanism that serves to manipulate relations with others to preserve the Ego (Fournier, 1984).

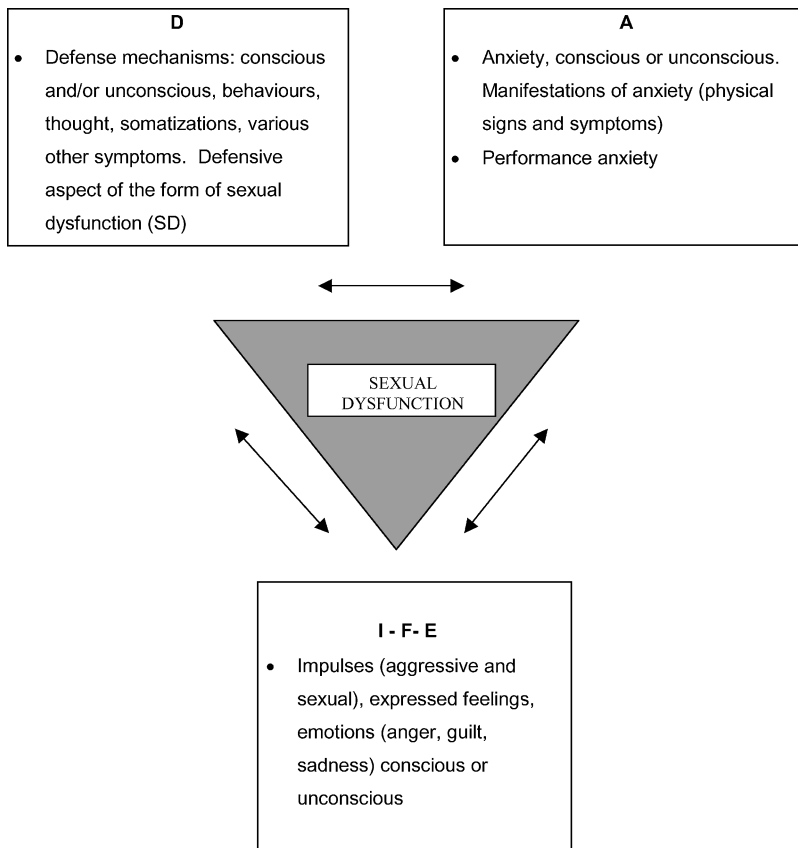


FIGURE 1. Triangle of insight.

As a general rule, the first triangle to be clarified is the one of the problem brought in by the patient (SD). A therapist is likely to find a series of triangles linked to one another, and their clarification brings up successive discoveries of other conflicts that can be clarified.

We clarify the three elements, D, A, I-F-E, and establish a link between them. Each stage of the work here needs to be formulated and discussed with the patient. This is collaborative work in which the patient is an active partner. His or her participation and confirmation are necessary to ensure the relevance of the work and the success of the therapy. It guards against a passive, dependent attitude with an expectation of a magic solution.

By unconscious anxiety, we mean the anxiety of which the patient is not aware but which is expressed clearly through body language.

Choice of Therapy/the Contract

The choice of therapy and the contract made with the patient indicate clearly: the triangle/s that will be the focus of the therapeutic work; the level of

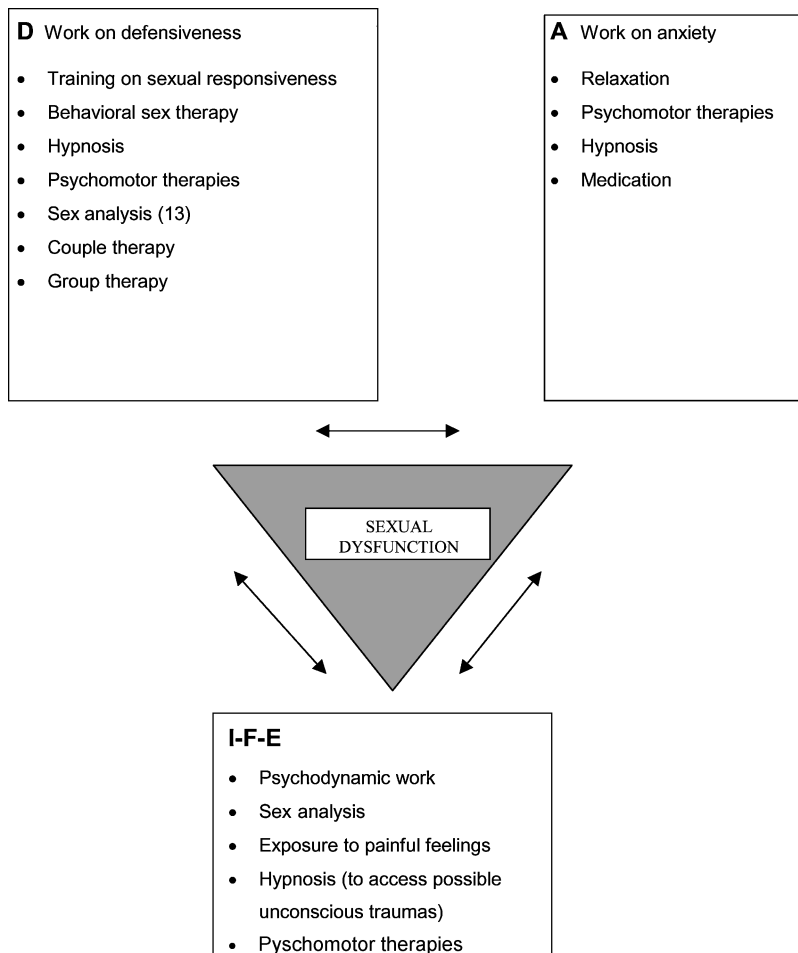


FIGURE 2. Therapeutic tools.

intervention (D, A, I-F-E); and the therapeutic tools. This is illustrated in Figure 2.

The choice of triangle, level of therapeutic intervention (D, A, I-F-E), and the technique used will be based on:

- reason for the consultation and motivation of the patient
- reason for the consultation recommended by the referring physician
- the operating hypothesis after clarifying the problem
- available therapeutic tools

It must be noted that, all along, the choice of therapy is regularly revised and adjusted in light of new elements that are revealed in the course of therapy.

If medication is used, it affects only the physiological aspect of the sexual response. Hence, medical treatment does not alter the I-F-E and, in certain cases, may even intensify the defense mechanisms or the appearance of psychosomatic manifestations.

CLINICAL CASES

Case 1. Mrs. C, Primary Vaginismus and Sexual Phobia, 52 Years Old, Married, No Children, Average Level of Schooling

ASSESSMENT OF THE PATIENT'S REASON FOR THERAPY AND CLARIFICATION OF THE PROBLEM THAT BRINGS THE PATIENT TO SEE A PSYCHOLOGIST

Referred by her gynecologist for a phobia regarding pelvic examination, which she absolutely refuses. She similarly reports primary vaginismus and phobia of sexual intercourse.

CLARIFICATION, DEFINITION OF THE PROBLEM INCLUDING ITS SOMATIC AND PSYCHOLOGICAL ASPECTS

Vaginismus works as a method of avoidance, a physical barrier that protects her sex phobia. She has received a full physical examination, and there is no apparent organic pathology.

FORMULATION OF A HYPOTHESIS WITH THE RESPECT TO THE DEVELOPMENT AND FUNCTIONING OF THE SYMPTOM (FIGURE 3)

Personal history. At the age of 14, the patient was forced to undergo a pelvic examination to verify her virginity. The examination was experienced as rape. Even though it revealed no loss of virginity, her father, with whom she has a very conflicted relationship, threatened her with a knife while accusing her of having had sexual intercourse. Married, at age 32 to a man older than herself, the patient has never had intercourse. Consequently, the couple have no children.

CHOICE OF THERAPY AND FOLLOW-UP

The patient revealed great anger toward her father, stating that he had ruined her life. As the therapist put pressure on the operative defense mechanisms, the patient's anxiety level increased, and she reported experiencing somatic symptoms (palpitations, perspiration, headaches, abdominal pain). Clarification of these symptoms enabled her to begin to connect with her emotions (anger, grief) and to express them.

She gradually came to realize that her defense mechanisms had distanced her from her husband and her hopes of ever having a child. This pain connected her with her grief about her failed relationship with an authoritarian father and a submissive mother who had never protected her against her father. During a session of hypnosis, the scene in which her

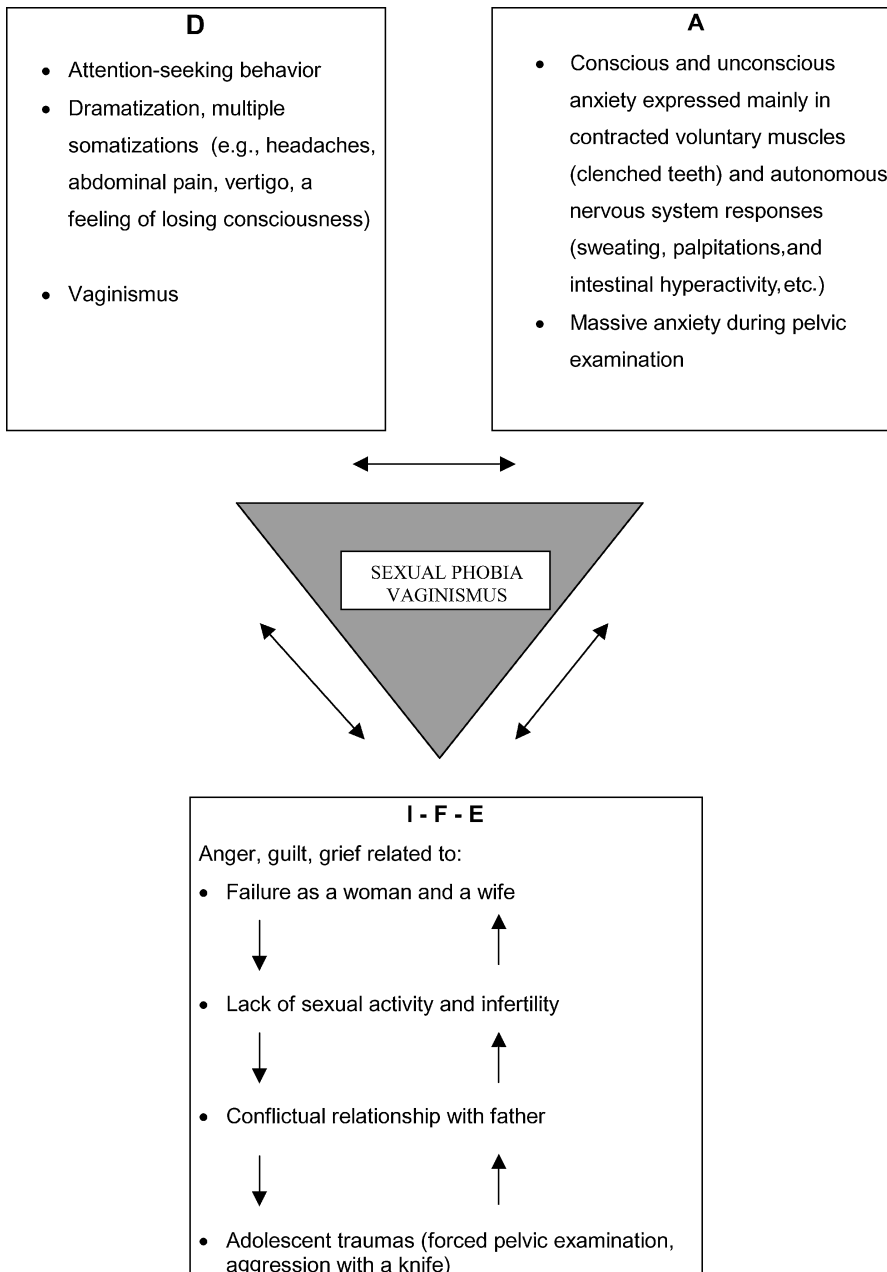


FIGURE 3. Case 1: Triangle of insight.

father threatened her with a knife came back to her. She immediately made the link herself between her phobia of penetration and this traumatic event. She recognized a symbolic link between the penis of her spouse and the knife of her father. Each time her husband tried to penetrate her, she felt the

same physical sensations as at the time of the aggression with a knife. Once the patient became aware of the origin of the phobia and of the anger and grief linked to the image of her father, she successfully underwent a pelvic examination. Three months later, she began to have satisfying intercourse with penetration (Figure 4).

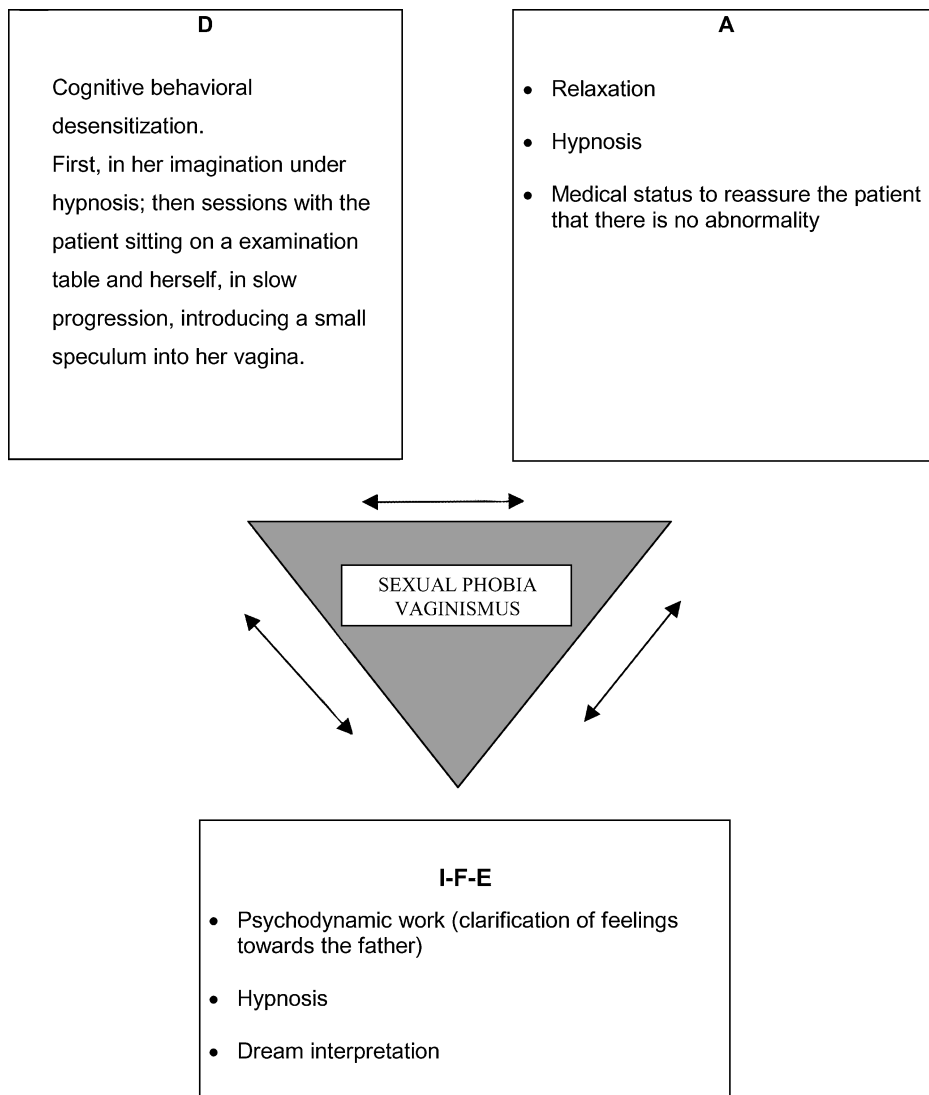


FIGURE 4. Case 1: Therapeutic tools.

Case 2: Ms. S, Abdominal Pain After Orgasm, 24 Years Old, Single, Nullipara, University Level Education

ASSESSMENT OF THE PATIENT'S MOTIVATION FOR CONSULTATION AND CLARIFICATION OF THE PROBLEM THAT BRINGS THE PATIENT TO SEE A PSYCHOLOGIST

Patient was referred by her gynecologist for violent abdominal pain after orgasm of more than three years' duration. The patient reported that the pain begins approximately 10 mins after clitoral orgasm by masturbation and lasts several hours. Many attempts at psychological therapy have yielded no results. Medical therapy also has been ineffective.

CLARIFICATION, DEFINITION OF THE PROBLEM, INCLUDING SOMATIC AND PSYCHOLOGICAL ASPECTS

The patient revealed loss of a very important relationship, which was accompanied by great suffering. We hypothesized that she experienced conflict between abandonment anxiety, the need for emotional closeness, and the need for a meaningful relationship. Sexual activity without a partner since then allowed her to avoid separation anxiety. Masturbation in this case represented avoidance of sexual relations with a partner that would involve emotional engagement. The patient reported experiencing feelings of guilt about masturbation and orgasm.

FORMULATION OF A HYPOTHESIS ABOUT THE DEVELOPMENT AND FUNCTIONING OF THE SYMPTOM: (FIGURE 5)

Personal history. The patient revealed a conflicted relationship with an idealized father that was experienced as both intrusive and inadequate (there was a troubling ambiguous physical closeness and lack of any respect for privacy by the father). At the same time, there was a defensive idealization of the image of the father.

The patient had engaged in a relationship with an older man that was both emotional and sexual. This satisfactory relationship began to deteriorate after her partner was unfaithful, after which they broke up. This loss reactivated the painful feelings associated with the relationship with her father who had "seduced and abandoned" her. These feelings arose in association with the sudden appearance of sexual difficulties.

CHOICE AND EVOLUTION OF THERAPY

With the pressure placed on defensive mechanisms and particularly on relational anxiety, the patient became aware of her intense fear of emotional closeness. She was able to express her sorrow about a boyfriend betrayal and became aware of the troubled relationship with her father.

Feelings of anger and guilt vis-à-vis her father became clearer: the guilt was linked to a latent erotic relationship with him and to its acceptance to avoid abandonment. Her anger was linked to the abandonment. With the work focused on the conflict with the father and the anxiety of abandonment,

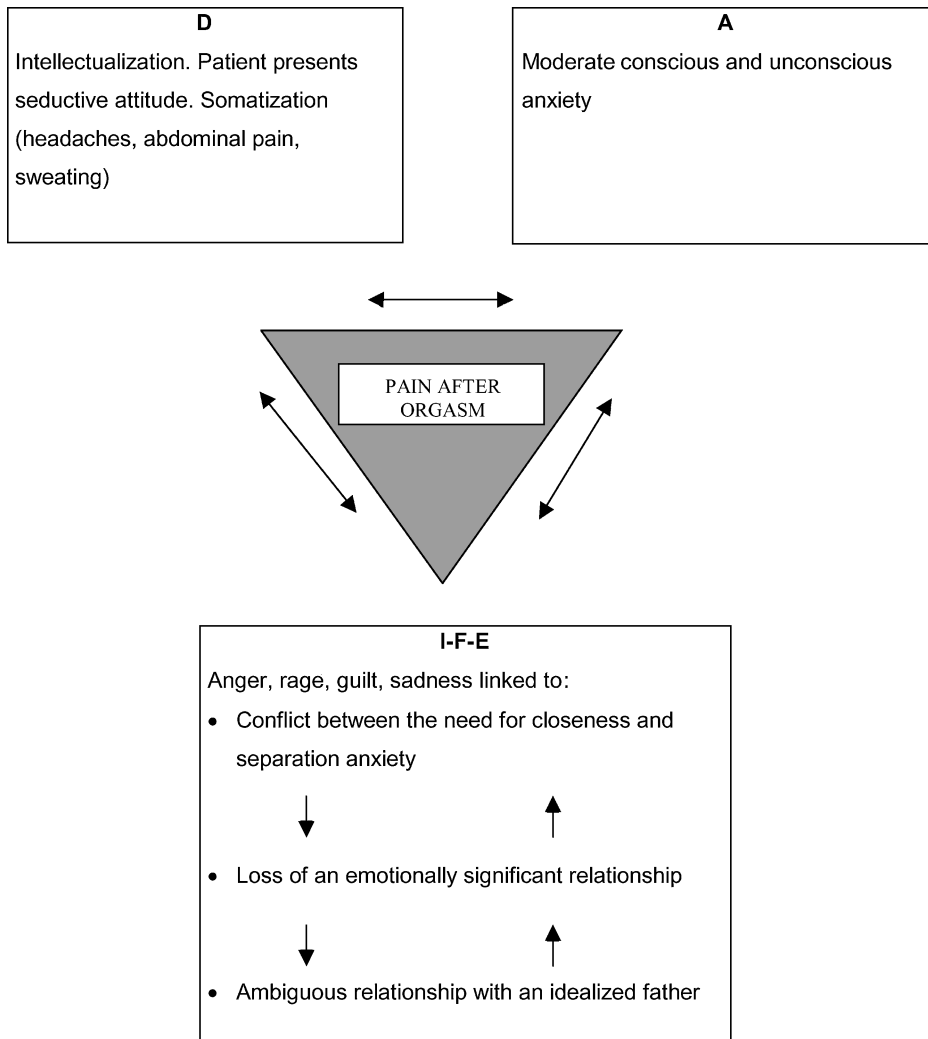


FIGURE 5. Case 2: Triangle of insight.

the patient became aware of her guilt feelings about pleasure and of her separation anxiety and began to reexperience these painful feelings. At the same time, postorgasmic pain began to diminish significantly, then disappeared (Figure 6).

Case 3. Mrs. G. Anorgasmia and Lowered Sexual Desire, 30 Years Old, Married, Nullipara, Elementary Level Education

ASSESSMENT OF THE PATIENT'S MOTIVATION FOR CONSULTATION AND CLARIFICATION OF THE PROBLEM THAT BRINGS THE PATIENT TO SEE A PSYCHOLOGIST

Patient was referred by an infertility clinic for a significant decrease in libido and inability to reach orgasm. The patient presented no previous physiological or psychological problems.

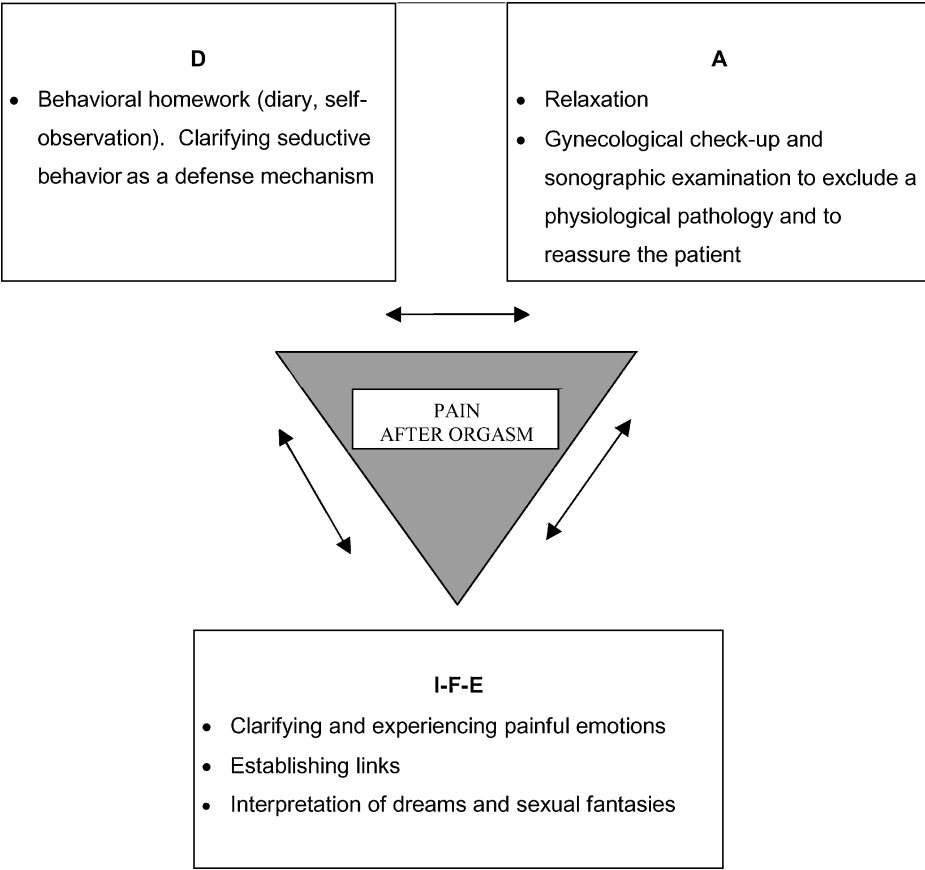


FIGURE 6. Case 2: Therapeutic tools.

CLARIFICATION, FORMULATION OF THE PROBLEM, INCLUDING SOMATIC AND PSYCHOLOGICAL ASPECTS

The patient complained about the stress linked to the beginning of procedures for assisted reproductive therapy. For more than a year, she has experienced considerable loss of libido and secondary anorgasmia. She was not taking any medication.

FORMULATION OF A HYPOTHESIS ON THE DEVELOPMENT AND FUNCTIONING OF THE SYMPTOM

The patient evidenced a high level of anxiety and dysphoric feelings. (Figure 7)

Personal history. For three years, the patient has tried unsuccessfully to have children naturally. She has undergone three cycles of artificial insemination. She reported that her sexual life was fully satisfactory until three years ago, when she had intercourse daily. Her gynecologist was unable to

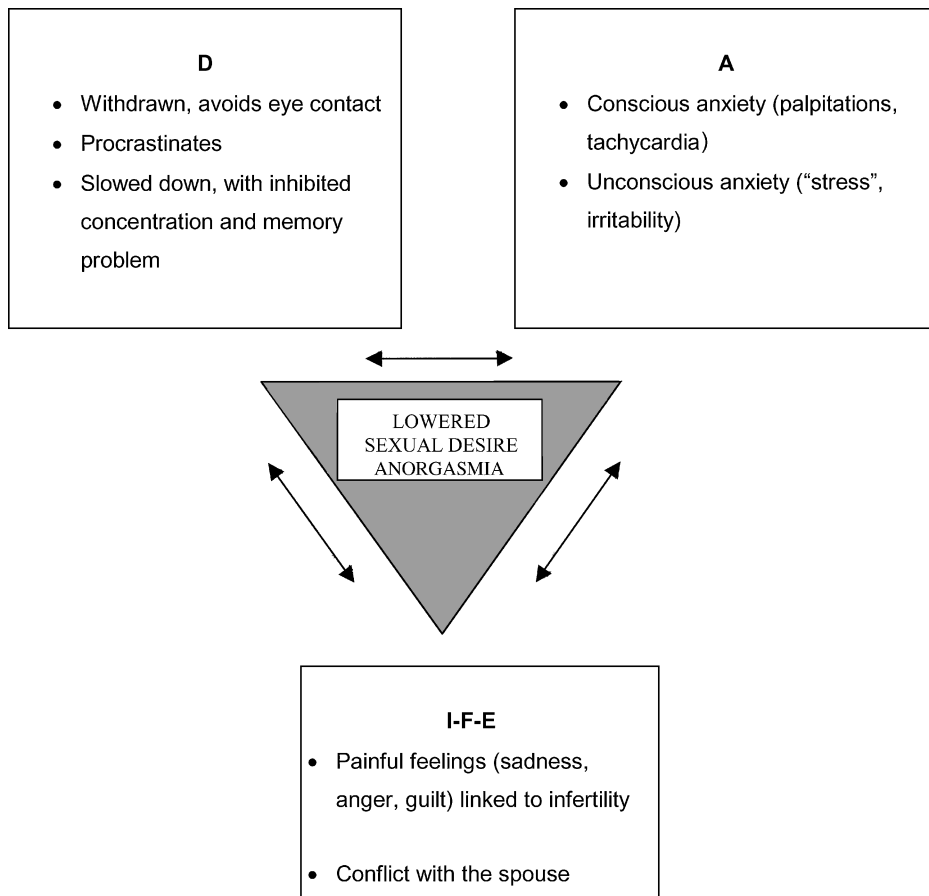


FIGURE 7. Case 3: Triangle of insight.

find the origins of the infertility, and her husband blamed her for not having "given him a child." She suddenly developed dyspareunia, a decrease of sexual desire, and a secondary anorgasmia with decreased sexual activity.

After about two years of these sexual problems, which brought about severe depression and loss of self-esteem, a male factor (low sperm count, low motility, and abnormal morphology) was discovered as the unique cause of the couple's infertility. The patient then experienced great anger toward her husband, and the sexual problem persisted afterwards for more than a year.

CHOICE AND EVOLUTION OF THERAPY

Pressure placed on the defense mechanisms made the patient aware of her anxiety and painful feelings. She was taught a technique of deep breathing and of control of muscular tension to manage the anxiety. Her painful emotions linked to the couple's conflict and sexual symptoms were treated during

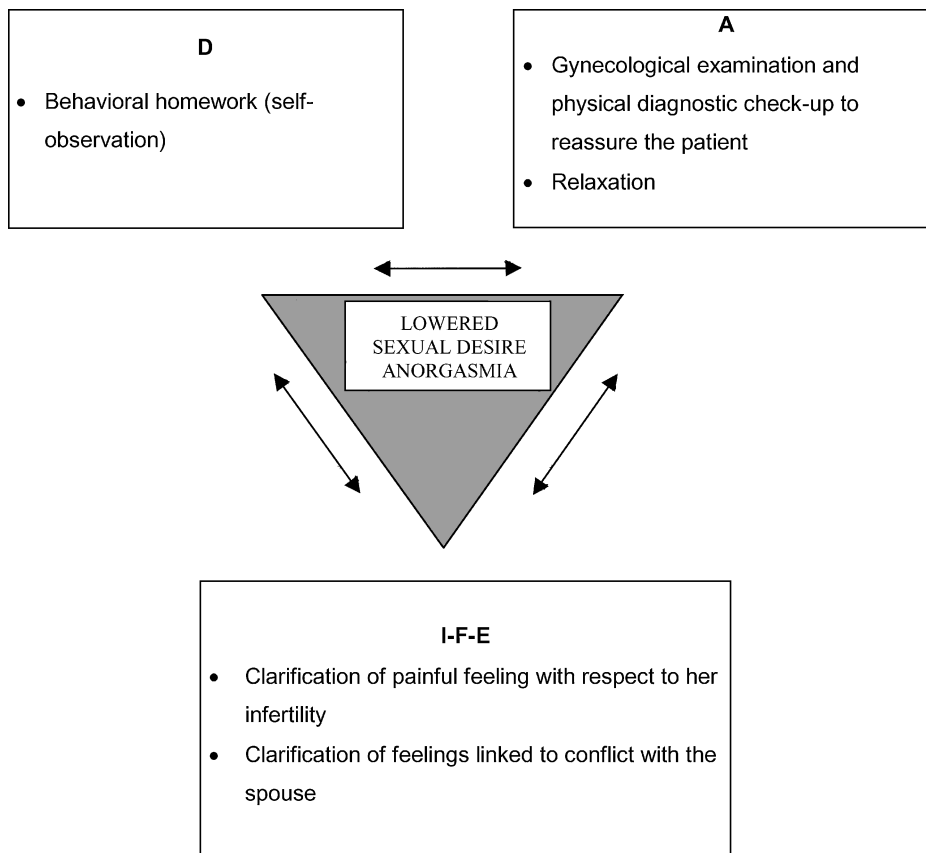


FIGURE 8. Case 3: Therapeutic tools.

behavioral couple sex therapy sessions. There was eventual disappearance of the sexual symptoms (Figure 8).

DISCUSSION

This approach is based on the method of psychotherapy developed by Davanloo, who employed Menninger's triangle of insight (Davanloo, 1980, 1990, 2000). This highly schematic model of triangles clarifies the interpretation of psychic reality simply, rapidly, and effectively. Detailed observation of the patient's behavior first permits clarification of manifestations of anxiety and defense mechanisms. Then, pressure on the defense mechanisms increases anxiety and the defense mechanisms themselves, and elicits emotions.

This stimulation of the psychic reactions allows patients to become aware of:

- their anxiety and its physical manifestations
- defense mechanisms, which begins to be activated
- impulses, expressed feelings, and emotions that surface
- the link between these three elements
- the function and possible origin of the sexual problem

This method of brief psychotherapy, which confronts the patient with his or her defense mechanisms, manages to bring about psychological reactions in one session. It then becomes possible to clarify the different components of the psychic reaction: the defense mechanisms, the anxiety, the impulses, and the emotions that are brought out in the therapeutic relationship. The therapist can then trace links between past and present reactions to significant others and draw up hypotheses on the possible meanings of the symptoms. Awareness of painful emotions and of aggressive and sexual impulses clarifies the nature of the intrapsychic conflicts and can reveal the function of the sexual symptom (Fournier, 1984).

The work on clarification also helps with the choice of therapeutic intervention. The therapist can choose to intervene in the defensive, anxious, or impulsive aspects, bearing in mind that these three aspects are constantly interacting. Whatever the focus of intervention, this model helps to maintain the dynamism of the psychic reaction and the focus on the symptom.

In conclusion, this model affords an integration of the somatic and psychodynamic dimensions that characterize sexual problems. For both the therapist and the patient, it is a model of conceptualization and interpretation of great didactic and therapeutic value. It allows the use of various therapeutic techniques, such as cognitive, behavioral, hypnosis, and psychoanalytic, as it integrates them into a global a psychosexual dynamic.

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