CASE REPORT
Couple therapy with cognitive behavioural techniques for persistent sexual arousal syndrome

JANICE HILLER¹ & BRIGID HEKSTER²
¹Psychology Department, Goodmayes Hospital, Barley Lane, Ilford, Essex IG3 8XJ, UK,
²Child and Family HIV Services, South London and Maudsley NHT Trust, London, UK

ABSTRACT A case is described of persistent sexual arousal in a woman of 52, whose frequent masturbation caused severe distress and disruption to her relationship. Based on a psychological formulation, a combination of cognitive behavioural techniques was used in a couple therapy format, aimed at anxiety management, response prevention and addressing couple disharmony. Long-term conjoint therapy enabled the patient to resist the urge to masturbate and led to symptom reduction, with an improved sexual and emotional relationship between the partners. It is suggested that psychological therapies are a valid and useful treatment option for PSAS.

KEYWORDS: cognitive therapy; couples therapy; persistent sexual arousal; female sexual arousal disorder

Introduction
Recent articles have highlighted the relatively infrequent but potentially highly distressing problem of a state of unwanted sexual arousal in women. Leiblum and Nathan (2002) introduced the term Persistent Sexual Arousal Syndrome (PSAS) to describe this condition, in which women with no conscious desire for sexual expression are overwhelmed by continual sensations in the genitals from which they may be driven to seek relief.

PSAS is differentiated from hypersexuality, a syndrome which does involve a high level of desire for sexual activity (Leiblum & Nathan, 2002). Few cases have been reported in detail, and no reliable pattern of abnormal neurological or hormonal features has been identified, suggesting various causes for the strong feelings of vaginal congestion. Riley (1994) reported a patient who was unable to work due to frequent masturbation for a few days prior to menstruation, although the day after her
period started her sexual needs returned to a normal manageable level. Despite the fact that this lady was successfully treated with medication to suppress her menstrual cycle, there were no hormonal abnormalities. Leiblum and Nathan (2002) now consider this to be an example of PSAS, although at that time the term ‘premenstrual hypersexuality’ was used (Riley, 1994). By contrast, Hallam-Jones and Wylie (2001) described a woman for whom the sensations of sexual arousal were annoying and highly embarrassing, rather than seriously intrusive. Kegel exercises were suggested as part of her treatment, and it emerged that she exercised the same pelvic floor muscles on a daily basis while practising for belly dancing classes. Once these exercises were stopped the unwanted genital sensations ceased.

Interesting physiological data on PSAS were obtained by Wylie et al. (2006), who were able to monitor a woman with this unusual complaint in the laboratory. Their patient had unpleasant and intrusive feelings of sexual arousal which were greater when falling asleep. Detailed investigations provided objective evidence of increased vaginal blood flow when the woman dozed off and during sleep, indicating a central rather than peripheral cause for her increased genital sensations. Eventually after trying various pharmaceutical agents, risperidone was found to reduce the symptoms and decrease the patient’s disturbed nights.

The case described here is of a woman whose treatment was carried out in 1998. As this was before persistent sexual arousal in women was recognised as a condition, there was no physical examination or hormone assay. In retrospect, we feel she warrants a diagnosis of PSAS as she met all five of the criteria outlined by Leiblum et al. (2005a) from their internet-based survey. Our patient’s symptoms were severe, with serious disruption to the individual and her family, placing her in a subgroup at the high end of the continuum of distress. While not defining the syndrome, the degree of distress is nevertheless an important differentiating factor (Leiblum et al., 2005b). Due to the level of despair, and the degree of couple disharmony, long-term couple therapy was carried out (in the psychology department of an NHS hospital) over 18 months; initially weekly, then at longer intervals as progress was made.

Case report

Valerie, a woman of 52, was referred to our sexual health service following a domiciliary visit by a psychiatrist, who at that time diagnosed obsessional compulsive masturbation. Amitriptyline, a mildly sedative antidepressant was prescribed; initially $3 \times 50$ mg which had the benefit of helping Valerie to sleep. After a couple of months this was reduced to 100 then 75 mg at night. Valerie and her partner were assessed individually and together in the psychology department, and offered conjoint couple therapy with the aim of disentangling their complex relational issues, and reducing the unwanted persistent sexual arousal sensations.

Presenting problem

For the previous three months Valerie had experienced feelings of sexual tension that had spiralled out of control and were only eased by frequent masturbation, at times
even in front of visitors. This was accompanied by shame, guilt and fears of wrecking her marriage. There had been a violent incident with her husband Henry, when he tried to forcibly prevent her from self-stimulation.

Valerie told us she felt no conscious sexual desire, but resorted to self-stimulation, to orgasm if possible, in an attempt to briefly relieve the genital arousal, which would then return almost immediately. Although anti-depressants had helped her to manage the compulsive aspect, so she felt less driven to masturbate, she remained highly anxious of unwanted and continuous sensations and fearful of Henry’s anger. Despite ongoing problems with her husband, Valerie’s ability to respond to him sexually had increased since starting HRT three years previously. Another stressor was the recent illness of her mother, on whom Valerie felt highly dependent. Valerie had always been anxious, and struggled to cope with running the home, looking after their children and finding space for herself.

During their marriage there had been periods of frequent and intense sexual contact, with Henry being sexually demanding at times and Valerie striving to meet his needs. After Henry’s retirement they were together much more and it became difficult for Valerie to relax, because if something annoyed Henry he refused to let it drop. Nevertheless the couple had experienced a ‘second honeymoon’ and they engaged in a phase of enjoyable sexual contact. Valerie became worried about resuming a more normal life again and felt a rising sexual tension, which she feared could not be satisfied if they started to spend time apart. Henry felt blamed for the current situation, and the couple were unable to go out or plan any social activities as Valerie was frightened of experiencing the urge to masturbate when it was not appropriate. Henry saw his partner’s masturbation as a rejection that excluded him from their sex life, and he eventually refused contact altogether.

Background

Valerie was the only child of a mother described as smothering and interfering, and a warm but ineffectual father, who had died many years ago. Her mother restricted her independence and prevented her from making her own decisions, including when she was allowed to use the toilet. Of significance in Valerie’s difficulty in controlling her bodily needs was an embarrassing incident at school when she dared not ask the teacher if she could leave the lesson and wet herself in front of the class. The mother’s continuing interference in their marriage was a source of ongoing resentment for Henry. In Valerie’s development she received no information about sex and her mother had told her that men had to get their own way. Valerie got the message that she had to please her husband at all costs.

Henry’s parents were no longer alive. Although his mother had been caring, his father was described as a constant arguer whom he was very frightened of upsetting. Henry remembers being fearful of his mother dying first and leaving him with such a dominating father. To his dismay, when his mother died in his teens his father remarried soon after. Henry felt excluded and unwanted by the new partnership.

The couple met while still teenagers and had no previous sexual partners. In their early years Valerie made every effort to fit sexual intercourse into their daily life
according to Henry’s wishes. As time went by and children came along Valerie’s mother continued to dictate how Valerie organised her life, and Valerie experienced Henry as becoming more demanding, aggressive and controlling too. In a sexual situation it became increasingly difficult for her to climax unless she stimulated her clitoris herself. Henry felt rejected and would not allow this, but Valerie felt that he was gaining control of her body if he stimulated her clitoris.

**Psychological formulation**

Both individuals in this highly charged relationship were fearful of loss, and had grown up scared of the power of their same-sex parents. They had also both suffered from the loss of a loving opposite-sex parent. In object relations terms they seemed to share an unconscious fantasy of making up for or repairing this loss in their coital union, which then became over-dependent and extremely sensitive to change.

Henry coped by becoming forceful and argumentative like his father, while his exclusion from the father’s second marriage was repeated in his strong sense of exclusion when his partner wanted to stimulate herself, thereby rendering him an unwanted outsider to the sexual act. Valerie was capable of sexual pleasure, but she had little sense of managing her own time, space and needs, including pelvic sensations. Her mother–daughter battles were re-enacted in the struggle with a demanding partner who coped with his insecure feelings by attempting to control her behaviour. For Valerie, a predominant fear was having genital arousal that she could not control, thereby leading to a humiliating incident. The resulting masturbatory symptom, representing a battle over her body, served to focus Valerie towards addressing her own anxiety levels, gaining a sense of mastery over genital sensations and claiming her bodily pleasure for herself.

**Treatment**

Our integrated therapeutic approach was based on the above formulation, and included psychoeducation to explain the source of Valerie’s genital sensations, as well as cognitive-behavioural techniques to encourage management of her overwhelming need to try to reduce the sensations through self-stimulation. Early on we negotiated that Valerie could stimulate herself without complaint or interference from her partner. This intervention set the scene for anxiety management techniques of self-soothing and distraction, which were introduced to enable Valerie to leave longer gaps between masturbation. Despite Valerie’s wish to reduce her medication further, Henry insisted she should remain on a level he thought was beneficial, as he could not cope with an increase in her restlessness and arousal symptoms. The concept of tolerating the symptoms without resorting to self-stimulation was a form of response prevention that allowed the feelings to subside and also increased Valerie’s confidence in making choices for on her own. She was encouraged to reassure herself that the sensations would pass and to occupy herself with a different activity.

Couple therapy sessions were characterised by Henry’s prolonged accounts of Valerie’s withdrawal from him and her indecisiveness. Henry would often interrupt
what his partner was saying with the belief that he could read her mind and speak for her. To encourage greater understanding of these aspects of their relationship and alter their communication, we explored their individual and shared development. Henry was relieved when Valerie came to recognise the significant role her mother had played in undermining her confidence, and this served to free him from repeating the pattern. Another intervention was to set boundaries on the amount of sexual contact so that Valerie did not feel that she had to be available at all times, and would be able to say no without engendering Henry’s anger. There was much discussion of how Valerie could make space for herself in the home and generally take control of her own activities. This included speaking for herself, as well as coping in her own way and time with the unwanted genital arousal feelings. We addressed Henry’s fear of losing her as she became more independent by encouraging joint activities.

Outcome

As more appropriate emotional and sexual responses became apparent in their interactions the tension between them decreased. Gradually, with Valerie being allowed to manage her masturbatory needs, her anxiety, shame and self-blame diminished and she felt more confident about her decisions. Sexual contact between the couple was introduced with the agreement that Valerie could stimulate herself during intercourse, encouraging Henry to learn to accept this without feeling excluded. Consequently Valerie felt closer to him and less anxious about not having her needs met in the relationship. The couple reported being able to play more sexually, with Valerie at times allowing Henry to give her a clitoral climax. Valerie continued with a maintenance dose of 10 or 20 mg of amitriptyline, which she claimed helped her to sleep.

Therapy was cut down to fortnightly sessions, and then monthly follow-ups until the couple became more confident about coping without ongoing support.

Discussion

Persistent sexual arousal syndrome represents one end of a spectrum of female arousal disorders, which has absence of subjective or physical arousal at the other (Leiblum, 2003). This case of persistent sexual arousal was treated with an integration of cognitive-behavioural and psychosexual approaches in a flexible couple therapy format, based on thorough formulation. Considerable success was achieved, suggesting that the formulation was a valid basis for the treatment model, and for the techniques used to decrease both the patient’s anxiety and her urge to masturbate. Psychological therapy also reduced anxiety and tension between the couple, which served as maintaining factors. At the same time the formulation does not constitute a causal explanation for Valerie’s persistent arousal. Nevertheless, the nature of the build-up to heightened physiological arousal is of interest. For the woman in Hallam-Jones and Wiley’s (2001) example, daily abdominal contraction exercises appeared to trigger pelvic floor muscles and thereby activate her sexual arousal circuits. In Valerie’s case there was prolonged sexual contact during the months prior to the
onset of her symptoms. High anxiety levels (linked to her mother’s illness and Henry’s retirement) seemed to combine with frequent sexual stimulation to cause a physiological state that did not remit.

There is much still to learn about the neural, physiological and psychological factors linked with persistent sexual arousal in women, and Leiblum et al. (2005a) point out the lack of empirical research to date. Achieving alleviation of symptoms through the various combined techniques described here suggests that psychological treatment is a useful and valid approach. No doubt future investigations will indicate the prevalence of PSAS and develop models to increase our understanding of this complex condition.

References


Contributors

JANICE HILLER, B.SC, M.PHIL, Consultant Clinical Psychologist in Sexual Health, Redbridge Psychological Services, NELMHT.

BRIGID HEKSTER, Clinical Psychologist, South London and Maudsley NHT Trust.