Role of Multimodal Psychotherapeutic Approaches in Bisexual Adult Man: A Case Study

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Abstract
The objective was to see the effectiveness of multimodal psychotherapeutic approaches on depression, anxiety, stress, sexual arousal, and desire in bisexual adult man. There was a positive change in the level of depression, anxiety, stress, sexual arousal, and desire after the intervention in a bisexual adult man. Single case design was used. He was seen in an independent practice setting with once in a week, 90-min duration of sessions for 8 months. Hamilton Depression Rating Scale, Hamilton Anxiety Rating Scale, ICMR Psychosocial Stress Questionnaire, and Sexual Arousal and Desire Inventory were used. Orgasmic reconditioning, cognitive behavior therapy, mindfulness meditation, and sensate focus were carried out. Pretest, midtest, and posttest assessments were done. Two months follow-ups were carried out. Preassessment revealed that client had severe depression, very high stress, moderate anxiety and very high sexual arousal and desire, frequently masturbation, guilt feeling, and tingling sensation in genital area. Postintervention results revealed remarkable reduction in the level of anxiety, depression, stress, improvement in sexual knowledge and functioning, management of sexual arousal and desire, and achieving sexual satisfaction with his spouse. It can be concluded that multimodal psychotherapeutic approaches have been proven effective.

Keywords
Bisexuality, orgasmic reconditioning, cognitive behavior therapy, mindfulness meditation, sensate focus

Introduction
Sexuality is diverse and complex aspect. It can be understood through various ways, that is, thoughts, feelings, behaviors, imagination/fantasies, wishes, practices, and relationships. Sexual behaviors can be placed in a continuum from exclusively heterosexual to exclusively homosexual, where bisexuality is seen as a passing phase and the person has to make a choice between homosexuality and heterosexuality. It is not simple to define and conceptualize bisexuality because there are gray areas in understanding of sexuality and encompassing sexual orientation, identity, and behavior. Moreover, researchers have been trying to study bisexuality based on Kinsey’s influential era but they were unable to clarify many aspects of bisexuality and bisexual behavior.

Review of literature showed that homosexual or bisexual orientation does not cause psychological disturbances or disorders. Many individuals are healthy, well-functioning, and resilient. They are productive to the society and have satisfaction in their life as similar to other individuals. But some of them may experience mental health issues such as depression, anxiety, self-harm behavior, suicide, and substance abuse in comparison with their heterosexual counterparts. Various intervention methods such as goal-oriented behaviors and skills, cognitive restructuring (CR), positive behavior change, enhancing mastery and insight, strategic planning, active coping skills, increasing social support, and self-efficacy are found effective in enhancing physical and mental well-being of lesbian, gay, bisexual, and transgender (LGBT) people. Further, cognitive-behavioral therapy and gay-affirmative cognitive-behavioral therapy are also found effective in building personal resilience as a gay or bisexual man and enhancing learning strategies for...
reducing maladaptive minority stress reactions (internalized homophobia and rejection sensitivity). Similarly, acceptance
and commitment therapy has been increasing flexibility in
the mindset and emotion regulation among them, thereby
avoidance behavior reduces remarkably.14

Self-esteem, self-confidence, and a positive self-
concept have been found high in self-identified bisexual
individuals, but there are studies that found contradictory
results. Therefore, innovative LGBT-specific intervention
and treatment modules should be developed15 and are needed
in the present sociocultural context.

Although, there is a gradual change in the society,
awareness and societal acceptance have been increasing but
LGB people are still vulnerable for mental and physical health
problems largely. Because of these experiences and disparities,
specific cultural competency models should work out with them
for better outcomes. As we know, our society is a traditional
multicultural diversified integrated society. These people are
largely stigmatized and disempowered socially, culturally,
politically, legally, and economically.16 Therefore, a road map
was designed from a psychiatric perspective with respect to
psychiatric treatment of homosexuality.17 But there is still a
need of Indian psychiatric literature in this sensitive area.18

Gay affirmative counseling practice (GACP) and
numerous interactive exercises have been arisen for better
understanding, learning, and teaching ways to incorporate
GACP into HIV counseling sessions because these individuals
often feel marginalized within the straight and gay community
and are seen as confused, questioning, unable to make up
their mind, and promiscuous.19

Various forms of orgasmic reconditioning (OR) were
used with a variety of treatment as multimodal approach
form. Covert sensitization, masturbatory satiation, CR, social
and assertiveness skill training, and sex education are found
effective in self-referred sex offenders.20

Thus, mental health professionals are needed to have
comprehensive knowledge so that they can think whether
standard psychotherapy protocols would be effective for LGB
clients or whether they require tailor-made intervention program.

Review of literature showed that LGBT people may
often benefit from various therapies which would be designed
according to their need for improving mental health and
quality of life. Holistic approach of treatment would be
effective to bring real change in LGBT individuals’ lives.
Therefore, it was felt that multimodal intervention program
would be effective to address the various factors in bisexual
man to improve mental health. Hence, multifaceted approach
has been taken up in this direction.

Objective

To see the effectiveness of multimodal psychotherapeutic
approaches (OR, CR, mindfulness meditation [MM], and
sensate focus) on depression, anxiety, stress, and sexual
arousal and desire in bisexual adult man.

Hypothesis

There would be positive change in the level of depression,
anxiety, stress, and sexual arousal and desire after intervention
in a bisexual adult man.

Design

A single case design was used.

Measures

Multiple assessment was done.

Sample

Mr X was a 28-year-old, unmarried Hindu male, Science
graduate, hailing from middle socioeconomic status of urban
background, working as a Market Analyst in a company. Few
years back, he consulted clinical psychologist at behavioral
medicine unit, Mental Health Hospital, Bangalore for his
sexual orientation toward same sex person and feeling of
sadness. He wanted to change his sex. He was on medication
for a month. Later, his fear and sadness reduced, and he felt
confident and happy. He fell in love with a woman but his
relationship could not sustain more than 6 months.

His family wanted him to get married and settle down.
He started feeling anxious, stressful, had severe headache,
and sleep disturbances. He had conflict, that is, “Should I
disclose my sexual orientation to the family or not? How will
they feel and react?”

The school history revealed that he had average academic
performance. He started masturbation at the age of 12 or 13,
used to feel pleasure, had anal sex, kissing, and touching
private parts with same sex person (his brother’s friend)
during college. Gradually, he started smoking and drinking
alcohol “to be look man.” He realized that it does not prove
him a “man” and tried to reduce alcohol.

On mental status examination, he was cooperative,
motivated, and well orientated, and showed coherent speech
and relevant talk. He did not show presence of hallucination
or paranoid symptoms, delusion, obsessional symptoms, and
memory-related disturbances.

He was self-referred to rehabilitation psychologist
registered with Rehabilitation Council of India with chief
complaints of getting sexually attracted to same sex person,
frequently masturbation, desire to have sex, guilt feeling, and
sadness.

Tools and Techniques

Hamilton Depression Rating Scale, Hamilton Anxiety Rating
Scale, ICMR Psychosocial Stress Questionnaire, and Sexual
Arousal and Desire Inventory\textsuperscript{21} were used. Scoring procedures were followed based on their manuals, for example, ICMR psychosocial stress questionnaire has percentile norms. After obtaining raw scores, it was converted into percentile norms and interpreted accordingly in pre- and postmeasures.

A combination of intervention techniques was used as Diagnostic and Statistical Manual (DSM-V), which includes a separate, nonmental disorder diagnoses of gender dysphoria to describe people who experience significant distress with the sex and gender they were assigned at birth. In this regard, The American Psychological Association’s Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients encourages these individuals to accept their sexual orientation and their same-sex desires and behaviors.\textsuperscript{22}

Cognitive-behavior therapies were used for combating irrational beliefs and excessive anxiety precipitated by nonthreatening situations for lesbian, gay, and bisexual individuals. MM is paying attention in a particular way, on purpose, in the present moment and nonjudgmentally.\textsuperscript{23} OR is known as masturbatory reconditioning. The participant is instructed to masturbate exclusively to nondeviant fantasies and to totally avoid masturbating to deviant themes.\textsuperscript{24} The technique of sensate focus was initially developed as a sex therapy technique.\textsuperscript{25} It involves a series of behavioral exercises that couples do together in order to enhance their intimacy and connection.

**Procedure**

The subject was seen in an independent practice setting once in a week, 90-min duration of sessions for 8 months. The outline of the intervention program is given in Table 1.

Case notes recorded the progress of therapy sessions are illustrated here.

**Session 1–3:** Subject shared negative thoughts, “Whenever I see handsome male, I urge to have sex. I would like to have bisexual orientation, get married and have a family life but does not want to tell spouse about my sexual orientation. If I could not able the satisfy my spouse sexually? I feel sad on seeing people are getting married. I don’t want to tell anyone about my sexual orientation with same sex person (coming out).”

Therapy sessions showed that the subject’s goal was to have bisexual orientation and lead a happy married life. Psychoeducation on sexuality, acceptance of sexual orientation, and cost benefit analysis were analyzed.

**Session 4-5:** OR (direct masturbation) was focused with imaging about female and stopping masturbation with men. Relabeling, that is, to stop calling himself as homosexual, was emphasized and “I can enjoy sex with women, I can enjoy masturbation with women in real life also” was framed. It was asked to the client to practice at home.

**Session 6-16:** He was asked to continue practicing OR at home. He reported that he was reaching orgasm and ejaculation/penetration, and later achieving 70% to 80% satisfaction. He felt happy.

His family fixed his engagement with a girl and he started dating her. He felt happiness but at the same time he has worried too, that is, “Still I get sexually attracted toward male, I don’t want to break the trust of the partner regarding my sexual orientation but I am confused whether to tell her or not. If yes then how to tell? There are many negative thoughts arises in my mind.”

Psychoeducation was given to him on love and commitment, power and division of power, problems and conflict in couples, becoming parents, sexual relationship, and children’s development with regard to LGBT in the therapy session.

Table 2 shows the analysis of cognitive errors and CR.

As therapy preceded, subject reported reduction in intensity of negative thoughts; consequently, sadness,

| Session   | Description                                                                 |
|-----------|-----------------------------------------------------------------------------|
| Preliminary session | Rapport building                                                             |
|            | Case history                                                               |
| Preassessment | Administration of tools                                                     |
| Session 1–3          | Psycho education about sexuality and sexual orientation, acceptance, self-recognition, problem solving, coping behavior, and cost benefit analysis |
| Session 4–5          | Focused on orgasmic reconditioning (OR)                                     |
| Session 6–16         | OR, dysfunctional thought records, cognitive beliefs, and cognitive restructuring (CR), mindfulness meditation (MM) |
| Session 17           | Mid assessment                                                              |
| Session 18–32        | Sensate focus (conjoint sessions with spouse), CR, performance anxiety (anticipation of failure, guilt, and impaired self-image, for example, “I am not a complete man” and vicious cycle of fear of failure), MM |
| Session 33           | Postassessment                                                              |
| Follow-ups           | Two months                                                                  |
Table 2. Outline of the Cognitive Restructuring

| Situation | 1. Emotions/Feelings | 2. Rate degree of emotion (0%-100%) | 1. Automatic thought that preceded emotions | 2. Rate beliefs in automatic thought (0%-100%) | Cognitive errors and restructuring | Rate of feelings and automatic thoughts (0%-100%) |
|-----------|----------------------|------------------------------------|--------------------------------------------|------------------------------------------|--------------------------------|-----------------------------------------------|
| Not making a phone call to the fiancée for a single day | Mixed feeling of happiness and sadness, tension, anxiety, 70%-80% | Confused, find difficulty to communicate, she might get angry, she must be feeling bad that I am not showing interest in her, doubts about erection, what next in future, I am not doing justice, still I get attracted toward male, I thought everything will change after engagement but nothing changed, 90% | Mind reading, discount positive, fortune telling, must statement, jumping to conclusion, perfectionism | Strategies Evidence for or against it, alternative approach, here and now approach, problem-solving technique, downward arrow approach, acceptance therapy | 40%-50% reduction in negative thoughts and emotions |

Table 3. Negative Automatic Thoughts

| Situation | 1. Emotions/Feelings | 2. Rate degree of emotion (0%-100%) | 1. Automatic thought that preceded emotions | 2. Rate beliefs in automatic thought (0%-100%) |
|-----------|----------------------|------------------------------------|--------------------------------------------|------------------------------------------|
| First day, kissing spouse, trying to sexually intercourse, erection presented for 5-10 min, later erection came down | Happy: 60% | I can do: 40%-50% |
| Second day, feeling sexually aroused and done intercourse with spouse successfully | Happy and confident: 80%-90% | Able to do: 100% |
| Third day, tried sex with spouse, erection for 5 min, and later erection came down | Sadness: 70%-80% | Whether I am able to penetrate successfully or not: 50%-60% |

Drastically reduced guilt feeling, improved coping mechanism, and increased level of satisfaction. He said, “Now I am hopeful. I am going to marry her.”

Session 17: Midassessment was done.

Session 18-32: He got married and reported some of the negative thoughts and experiences to the therapist during his honeymoon period over the phone which are described in Table 3.

Sensate focus (conjoint sessions with spouse), the subject reported “my wife is very supportive and understanding the issues with sexual satisfaction and ejaculation. She herself came forward and told me to consult doctor regarding the same.”

During the session, she looked motivated and cooperative. She shared her interest, daily routine, and negative feelings and thoughts about sexual intercourse with her husband (subject) and level of satisfaction such as “Why his erection come down suddenly, whether I am not giving my best, things will be fine after some time but now it is happening repeatedly. I am very nervous and sad.”

She looked receptive and expressive about her feelings to the therapist. Active listening and empathetic attitude were used to establish rapport with her.

It seemed that anticipation of failure, guilt, and impaired self-image, for example, “I am not a complete man” and vicious cycle of fear of failure are causing performance anxiety. Therefore, sensate focus and CR were done. The couple followed three stages of sensate focus, that is, nongenital, genital, and vaginal containment as per the guidelines mentioned in the sex therapy manual. Homework/assignment was given to them. Later, they reported that they were finding the technique as a slow and gentle process of reducing performance anxiety and stress around sexual activity.
Data Analysis

Qualitative analysis was done.

Results and Discussion

Table 4 shows results of postassessment that are subject’s thoughts of worthlessness, hopelessness and helplessness, depressed mood, suicidal thought changed into hopeful and positive thoughts, drastic reduction in uncertainty about future, insecurity, nervousness, inability to relax, palpitation, choking sensation and dryness of the mouth on anxiety scale, reduction in fear of sexual abuse and worry about self-marriage, and sex-related stress. He felt better in interpersonal relationship at workplace, responsibility within family, and relatives. It seemed that intervention program empowered him to cope with adverse or negative emotions by enhancing his coping mechanism and explored his issues in adaptive and healthy way. He was able to draw his attention on his personal resilience as a bisexual man. He showed reduction in depressive symptoms, alcohol use problems, and improved self-efficacy.

The empathetic and nonjudgmental attitude of the therapist toward the subject created safe space to open up and sharing feelings and negative thoughts such as, “I am not a complete man”, “Nothing will change,” “social stigma or fear of discrimination in the society,” and so on were addressed by CR. Consequently, he learnt to identify, label, evaluate, and correct his distorted thoughts and beliefs and replacing them with less self-punitive and being more realistic. Moreover, he increased his awareness and accepted inner experiences with the help of MM, which is also an important factor in adaptive emotion regulation in terms of coping with stress.

Not only the abovementioned techniques helped but the sensate focus also played very important role in building trust and intimacy within their relationship, to give and receive pleasure, positive emotions, physical feelings, and responses while reducing any negative reactions. The intervention program helped both of them to overcome fear of failure and building a more satisfying sexual relationship.

Numerous studies showed that individuals with bisexual orientation show lower levels of perceived social support, higher levels of depression and suicidal thoughts, anxiety, and stress-related disorder in comparison with lesbian, gay, and heterosexual individuals.26-28 These individuals feel discrimination at workplace, violence and negative health outcomes,29,30 as well as stress about their sexuality whether to disclose or conceal.31,32 They find themselves as if they do not have a place in society and nowhere to turn for social support,33-35 whereas research also showed that social support helps to develop stronger and positive bisexual identity, improves their coping skills for dealing monosexism and biphobic messages effectively, and enhances their well-being.36-39

There are various aspects (sexual orientation and gender identity, its determining factors, needs of the individual, acknowledgment and acceptance about sexual orientation, and stages of coming out ) that need to be addressed for providing quality care to the LGBT people. They can heal from shame and slowly integrate with their sexual identity. It could be achieved through empathic, supportive, and nonjudgmental attitude toward them.

Conclusion

It can be said that multimodal approach is not only an effective method in bisexual man for reducing the level of depression, anxiety, stress but also an effective tool for management of sexual arousal and desire thereby achieving sexual satisfaction.

Case Postscript

The subject called the therapist for the appointment after 6 years of the treatment for adjustment issues between his wife and his mother. He also introduced his 3 years old biological daughter.

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| Measures | Scores on Hamilton Depression Rating Scale | Scores on ICMR Psychosocial Stress Questionnaire | Scores on Hamilton Anxiety Rating Scale | Sexual Arousal and Desire Inventory |
|----------|------------------------------------------|-----------------------------------------------|--------------------------------------|-----------------------------------|
| Pre      | 25: Severe depression                     | 49: Very high stress                           | 23: Moderate anxiety                 | Frequently watches pornography, sexually attracted toward male, good sleep after masturbation/fantasize about sex, depressed, guilty feeling, anxious, breathe faster, impatient |
| Mid      | 15: Mild depression                       | 37: Moderate stress                            | 18: Mild anxiety                     | Happy, stimulated, excited        |
| Post     | 7: Very low depression                    | 14: Very low stress                            | 10: Mild anxiety                     | Forget everything else, pleasure, happy, satisfy |
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