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ORIGINAL ARTICLE

Sexual fantasies and female hypoactive desire☆

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Summary In the clinical experience of sexual disease, we often have to investigate sexual fantasies of patients. Our group has felt the need to class the sexual fantasies as modern clinical rules, beginning from a retrospective examination of cases treated by medical sexual service. Then we tried to make uniform the ways to collect sexual reveries. We examined 326 clinical cases. Sixteen of them were rejected because of the absence or insufficiency in the medical history of sexual fantasies. By means of the analysis of 308 cases, we made a classification of fantasies according to various criteria: depending on time, depending to the type of sexual activity represented in them, the relationship established by partners and their ability to share individual fantasies, the role represented by him/herself within his/her imagination. Afterward we suggested a possible use of sexual fantasies, in the therapy of hypoactive sexual desire disease in women. The goal of treatment is therefore to enhance the sexual sphere, using the fantasies to bring back the erotism in the partner and in the relationship. To perform this, anticipatory fantasies can be created using in them the partner's itself. The aim of the therapy to overcome the decline of desire is to bring back arousal in the relationship, in the person involved and in the situation in order to obtain an improved sexual response. We analyzed 52 cases, four of them gave up the therapy after a few meetings, while the others ended it. Only nine of these 48 obtained a small improvement, whereas the others returned to the whole normality, tested also with FSFI. We are currently starting research on sexual fantasies in Italy. This for both an updated finding survey and to build a clinical tool like a repertoire of fantasies in order to facilitate the collection of sexual fantasies.

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Introduction

We can define sexual imagination as the faculty that man has to mentally eroticize himself through the creation of conscious mental representations with erotic charge. It is capable of activating a desire, a general and genital arousal to the point that for much fantasy is the real engine of sexual activity (Pasini et al., 1987).

Sexual fantasies are particularly important because they constitute the expression of our sexual ''habitus'' free from hesitation, personal conflicts and unencumbered by the rules imposed by the environment. Certainly, they are sensitive to the cultural context of reference and vary according to sexual identity and age (Fossi and Mascari, 2001). These fantasies generally derive their strength from more or less explicit sexual content, although sexual contents may not possess erotic charge. They can take the form of a single image, a representation of more rapid images (plurisegmental fantasies) or a structured setting (Pasini et al., 1987). In general, the sexual fantasy serves to fill a sexual-emotional specific need and is therefore more likely to be present at the time when the need becomes more pressing, with the aim to restore, temporarily, the intrapsychic homeostasis that satisfies basic psycho-emotional needs such as the need to be valued, the need for fusion and the need for security (Pasini et al., 1987).

Sexual fantasies can:

- represent an important aid in strengthening sexual identity;
- have compensatory function, compensating for the deficiencies of reality;
- have a defensive use;
- have an adaptive function: to correct any divergence of sexual responses of the subjects involved in a relationship, being able to harmonize them or compensate them;
- to activate, maintain and awake desire, sexual arousal, encouraging orgasm;
- improve the relationship with the body.

In any case it has been determined that sexual fantasies usually do not prevent sexual pleasure and have absolutely no indication of psychopathology (Fossi and Mascari, 2001). Our group has found their use particularly useful in the treatment of predominantly female hypoactive desire.

Clinical classification of sexual fantasies

Given the importance that imagination plays in sexual activity, our group believes that the use of imagination can become a very useful tool to better define the type of personality and relationship of the couple we are facing. This method is essential for the diagnosis but also during the treatment of sexual disorders.

This is the reason why we made a retrospective analysis of the cases considered in our sexological outpatients' clinic during the years 2009 and 2010. We examined 326 clinical cases. Sixteen of them were rejected because of the absence or insufficiency in the medical history of sexual fantasies. By means of the analysis of 308 cases we made a classification of fantasies according to various criteria. Depending on time, that is when the fantasies present themselves, they can be distinguished as:

- preliminary fantasies: sexual initiative and proposal;
- responsive fantasies: sexual response;
- receptive fantasies: sexual host (reception);
- anticipatory: apart from sexual activity;
- appetizing: the imminence of occuring sexual activity;
- intercurrent: present during sexual activity.

In relation to the content, a distinction in convergent and divergent was already made (Pasini et al., 1987). We have taken it and clarified.

Fantasies can be distinguished according to the type of sexual activity represented in them.

Another classification considers the relationship established by partners and their ability to share individual fantasies. According to this new criterion, we can identify several fantasies:

- shared: if they are accepted by both partners and therefore made explicit;
- shareable: if the fantasy created by one of two partners has the possibility to be made explicit without emotional-relational difficulty;
- private: when the individual fantasies have no chance, at that time of the relationship, to be explained to his/her companion, for fear of offending or fear of being judged.

Another important element is the role represented by him/herself within his/her imagination:

- actor within the scene;
- spectator of what is represented;
- director of the scene;
- designer, chooses settings and writes the screenplay;
- creates the cast, sets out the various characters necessary for the realization of the fantasy;
- operator, assigned to the ''shooting'' of the scene, preferring the best shots for him/her.

Of course multiple roles may be taken.

Analysis of fantasies

In dealing with sexual disorders, it is important to analyze the possible advantages such a person derives from the sexual disorder. Resistance to change is particularly strong when the disturbed sexual conduct almost ensures a vital role in the psychic economy of the subject, it is beneficial to the relationship, or it is supported by problems the partner has (Dettore, 2001). This analysis cannot be reduced to an interdisciplinary approach. From the year 2008, in our sexological activity based on an integrated cross-disciplinary approach, the group meets up at least once a month. During these meetings, we realized that the sexual imaginary medical history is extremely useful.

Often hidden behind the sexual disorder are anxieties that are essential to identify in order to arrive at an accurate evaluation of the real psychic-sexual function. It is therefore important that the history of the imagination could be done gradually and placed in the most suitable moment of the therapy, considering the characteristics of the subject (Pasini et al., 1987). A survey of the erotic imagery can detect a rich imaginary or otherwise deficient production. In the latter case we must make sure such failure is attributable to an actual lack of erotic imagination, or attributable to a difficulty to record his own fantastic productions.

A further consideration must be given to the way in which fantasies are presented. In fact, these may occur spontaneously, be stimulated by environmental inputs or finally, deliberately provoked by the subject. As highlighted by one of our previous analyses (Boncinelli, 2004), desire is an essential element that supports the entire sexual response and is useful to have as a measure. In this sense, the presence and intensity of sexual imagery can provide a measure of the magnitude of desire itself. We also know how many sexual fantasies may promote positive effects (Boncinelli, 2004). In the anticipatory fantasies (apart from sexual activity), the fantasies act to raise the level of desire and testosterone (Valentino et al., 2007; Genazzani and Pluchino, 2010; Genazzani et al., 2007, 2011). In the appetitive fantasies (occurring in the imminence of sexual intercourse), we have an increased desire together with an increase of excitation. Finally with intercurrent fantasies (during sexual activity) we can assure high desire and arousal and favor orgasm (Pasini et al., 1987). Faced with all these evidences the investigation of fantasies becomes increasingly important.

Clinical methodology

In our meetings, we tried to standardize the way of collecting sexual fantasies medical history. When investigating the imagination of a person it is necessary to measure the quantity and quality of these types of fantasies during adolescence, fantasies prior to the onset of the problems brought to the consultation, the evolution of possible fantasies after the disorder and current fantasies. The anamnesis of fantasies should also contain accurate information about the presence and frequency of fantasies, the association to specific moments of sexual activity, the presence in situations beyond sexual practice, the existence of a favorite fantasy or fantasies used for many years, excitatory fantasies, preorgasmic and orgasmic fantasies. Moreover, the manner in which they occur, the effects that accompany it (hostility, aggression, domination, tenderness, submission) and the degree of involvement of the subject in his/her own imagination. Our group questioned about what could be the best way to learn about the fantasy repertoire of a person or a couple. That is to emerge fantasies during the therapeutic relationship. During meetings we ask to reflect and write them, or in some case we propose a card with a semi-structured repertoire of fantasies.

Up to now we have opted for the first two modes, but with the aid of the Italian federation of scientific sexology (FISS) we are developing research throughout the country to have an updated repertoire of fantasies of Italians. The use of fantasy certainly does not always resolve all problematics that may be encountered in the clinic, but it certainly can be a possible tool to address specific diseases and in sex therapy can be a useful tool in building a therapeutic project (Boncinelli, 2006). After making a careful analysis of fantasies together with the person, we try to make a list of fantasies that are more meaningful for the patient. And then we suggest finding a moment during the day to dedicate him/herself to the activation of the fantasies. This methodology allows us both to complete the diagnosis and to make sure that the person gets used to creating fantasies for therapeutic purposes therefore often creation becomes in itself therapeutic. In this way, the fantasies are activated as a real therapeutic tool.

Therapeutic intervention in female hypoactive desire disorder

The decrease of sexual desire was the most frequent disorder in our sexual female case history. Hypoactive sexual desire disorder presents itself as a deficiency or absence of persistent or recurrent fantasies and desire for sexual activity. These problems can be primary, secondary, situational or global. The diagnosis is based on the difficulties experienced by the patient, on a comparison between the experience of the patient and what we consider a normal frequency of sexual desire in relation to age, profession, gender and lifestyle of the subject (Boncinelli, 2006, 2009). The loss of sexual desire leads to the experiencing of negative feelings and emotions, such as irritation, anger and indifference in situations that normally would lead to sexual involvement (Boncinelli, 2009; Ellis and Symons, 1990). In our monthly meetings we tried to standardize the way of operating. In 2011 we decided to reanalyze the medical histories of the previous 2 years period of patients suffering from hypoactive sexual desire disorder. A quite uniform therapeutic strategy resulted from the analysis of therapeutic methodology used in 52 cases. In an integrated multi-task therapy, sexual fantasies can be used, bearing in mind that with lower desire the production of imaginative activity will be reduced. In this case the technique will aim to rehabilitate people to regain a creative activity that was lost or was poorly possessed previously. You can refer to adolescent fantasies, or to those prior to the start of the problem and if it is possible retrieve, modify and promote fantasies that still exist (DSM-IV, 1996; Buss, 1995). We must be clear about what are the poor elements important for desire. In our clinical experience, a major cause of the problem in women is the lack of alliance with their body. Or it may be important to bring back the eroticism and intimacy in the couple, promoting affection and a romantic component. Sometimes on the contrary, in a too stereotyped and crystallized relationship, it can be useful to introduce new elements suggesting fantasies of transgression for more excitement and pleasure (Buss, 1995; Friday, 1996, 2000; McCarthy, 1999). To achieve this it is important to review with the patient or the couple their list of priorities, where often only rationally sexuality and the time devoted to it are important, while actively and emotionally this does not happen. Then suggest spending some time on anticipatory fantasies,

starting from those still sporadically present or from the most intense of the past. Achieving this we can suggest to reproduce the most exciting ones in the pre-intercourse phase. Finally intercurrent fantasies can also be used to support desire and arousal during intimate activities. The goal of treatment is therefore to enhance the sexual sphere, using the fantasies to bring back the erotism in the partner and in the relationship. To perform this, anticipatory fantasies can be created using in them the partner's itself. Later, bringing to mind the anticipatory fantasies, the patient can reach sexual arousal with appetitive fantasies and maintain involvement with intercurrent fantasies. This can be accompanied by an explanation of the fantasies to make them more shareable and possible within the couple. The aim of the therapy to overcome the decline of desire is to bring back arousal in the relationship, in the person involved and in the situation in order to obtain an improved sexual response.

We analyzed 52 cases, four of them gave up the therapy after a few meetings, while the others ended it. Only nine of these 48 obtained a small improvement, whereas the others returned to the whole normality, tested also with FSFI.

Conclusion

Our group was recently interested in sexual imagery. We have debated and proposed a classification and used it as a tool for diagnosis and sex therapy. In particular, it appeared very useful in cases of hypoactive desire. Certainly the use of imagination in clinical practice requires good collaboration with the patient and a capacity of the subject to easily contact his/her erotic imagination. In addition, the sensibility of the treated field requires a careful analysis of the psychological, cultural, and sociological characteristics of the individual. This is to prevent a paradoxical effect, where instead of getting an increase in sexual desire, there is a worsening of rigidity and a therapeutic escape, which may be associated with traumatic experiences (Friday, 2000). We are currently starting research on sexual fantasies in Italy. This for both an updated finding survey and to build a clinical tool like a repertoire of fantasies in order to facilitate the collection of sexual fantasies.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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