Clinical Case Example Based Viewpoint

Sapiosexuality – an unexplored phenomenon

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Dating a smart guy is the coolest thing ever. Which is one of many reasons why it's not surprising that so many woman are identifying as sapiosexual these days.
The term 'Sapiosexual' emerged as a new dating buzzword few years ago, and it's since taken off. There are now forums devoted to it, facebook pages, and it's even been added as an official sexual orientation by dating sites. A sapiosexual is someone who is attracted to a person's intellect way more than their body. They get turned on by wit, intelligence, and a quick mind, and they'd rather listen to you flex your verbal dexterity than watch you flex your quads at the gym.
Words like 'sapiosexual' can give nuance to a personality and help people feel less overwhelmed by the dating world so they can specifically focus on what they truly want from a partner.

Certain characteristics of sapiosexuality include –

1. You find witty banter to be the best foreplay ever.
2. Your idea of a great date is roaming the aisles of a local bookstore and casually making (non-pretentious) recommendations to each other.
3. You know that smart does not just mean knowledge alone.
4. You are not impressed by one's credentials but impressed that he never mentions them.
5. You know that the person concerned can carry out a conversation on almost everything under the sun and can talk to people of any age group.
6. You are sure that the person you date uses grammatically correct sentences when you text him.
7. You never go for a movie and just like maintaining conversation in all your meetings.
8. He is not overwhelmed by the complex female mind.

We present herewith a case that presented to us which had shades of sapiosexuality and the treatment undertaken thereafter.

CASE DISCUSSION

A 28 year old unmarried female engineer working with a well-known IT company as a 'Q-Analyst' presented with a history of depression for which she was on pharmacological treatment (Escitalopram 20mg/day) since the past 3 years and had partial improvement (60%). At the start of treatment she attended individual sessions and group therapy sessions for 3 months for developing coping skills (positive affirmations and recovery activities). But she soon discontinued the therapy as was finding it difficult to follow up on regular basis due to heavy work schedule.
As there was only partial improvement in symptoms with continued guilt feelings, she was referred to us for therapy sessions after 3 years of start of symptoms. The therapy sessions were structured according to Melanie Fennell's guidelines:
• Setting the agenda.
• Review of events since previous session, feedback on last session, homework.
• Review of effect.
• Agenda items prioritized and discussed.
• Homework set collaboratively.

• Feedback.

In the first visit a detailed history of the patient was explored. She was the younger of two siblings. She was close to her mother, and with good interpersonal relations with other family members. Her parents appear to provide a secure base and were protective for her. Her father was a lecturer in a junior college and mother worked as a bank manager. The home atmosphere was always encouraging for academics. She was a scholar in school and college and her parents always encouraged her for studies. She completed her engineering with good grades and got selected for the company in the campus interview.

She was performing well in her first job where she was working in a team of seven colleagues. Over a period of 10 days she had attraction for her team leader who she perceived highly intelligent with good management skills even in challenging situations. She took an initiation to propose him and within no time she got into a physical relationship with him. She found herself sexually aroused whenever he used to discuss or introduce her new concepts and engaged her with intellectual discussions. Eventually after 3-4 months she lost interest in the relationship as she found that his behavior was quite predictable for her and that his intelligence no more amused her. She found him very monotonous and thus discontinued the relationship. She even dropped out of the project in which she was working with the person as he used to persuade her to continue the relationship. This marked the onset of the depressive symptoms when she was started on antidepressants.

In the next 2 months she got a job in another company. This time she decided not to have a committed relationship as she was still in dilemma regarding her relationship requirements. She felt that the last relationship was just infatuation. This time she was working in a big group of people and her job profile required her to interact with the clients directly. Soon she found herself allured to one of the client who was almost double her age and was not good looking but she perceived him as an extreme genius. He was creative in his approach and he was extremely dynamic. Over a period of 3 weeks acquaintance they had many work related brainstorming sessions when she found him a lot attractive and this led her to have sexual intercourse with him. This time she experienced guilt after the intimate relationship with him. She tried to stay away from him but found herself in bed with him following every intellectual debate. She was having mixed emotions and was feeling guilty, angry on self, helpless at times as she was unable to control her impulses. By this time, she was clear that there is no role of physical attraction or emotional bonding for her in this relationship. She was confused in the start and was unable to find out the triggers for her sexual arousals.

She continued with antidepressants and tried self-controlling methods which included taking an oath, masturbation, self-pleasurable sexual activities, watching pornography when having sexual urges. She was justifying herself by assuming that the last sexual encounter with the client was a co-incidence as she was emotionally vulnerable during that early period of breakup. She decided to set rules for herself but soon realized that she was unable to adhere to them, as she got attracted to a person while travelling in the train when he started talking to her about her favorite author's books. She found him brilliant while he presented the critical analysis of the writer and within three meetings they had sexual intercourse. This time she experienced helplessness as she again went for sexual intimacy even after all her efforts to abstain from the same and also because she was having no clue as to why she was falling for people without any emotional or physical attraction. This is now when she figured out that for her other person's intelligence played the most important role for arousal. Thus she began to avoid going to the office and tried to manage work from home. This she continued for a month after which she decided to quit the present job and join a new company so as to avoid contact with the old sexual partners. She managed to find a job of Q-analyst within a period of 15 days. This time she was extra cautious and used to experience anxiety before meetings, presentations, debates and discussions as she identified them as triggers for sexual arousal. But again this time she found herself involved in sexual relationship with one of the junior fellow and her immediate boss at the workplace. Common among both was smartness, intelligence and creativity. She would find their brain to be the most sexually attractive part. But as she had a realization of the mistakes she had been making here and now again and again, her depressive symptoms increased. She started having suicidal thoughts along with the feelings of shame, guilt and helplessness. She was also having extreme anxiety as was making out, simultaneously with two men working in the same office. One

fine day she got exhausted by emotional turbulence and tried to cut her wrist, but then soon realized that she needs help which stopped her from inflicting a major self harm.
She immediately followed up for dose adjustments and we increased her antidepressant dosages. We psycho-educated her regarding the desperate need for therapy in her case and successfully enrolled her for counseling sessions.

Early therapy sessions

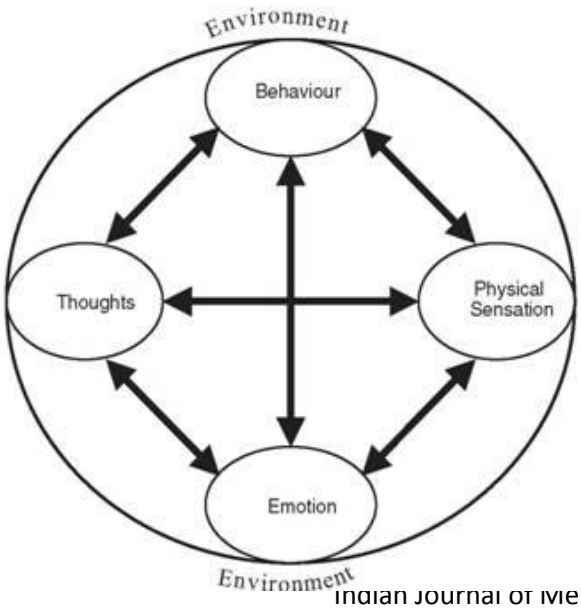
She came into therapy at a contemplation stage where she recognized her problematic behavior and possible harmful consequences of continuation of the same. After rapport building, catharsis was mediated carefully in the initial session. Empathic and reflective listening helped her feel comfortable.
In the second session she was briefed about her major concerns and the therapy design. To bring down the anxiety Jacobson's Progressive Muscle Relaxation (JPMR) technique was introduced. Following JPMR, Distress Management and Emotion Regulation elements from Dialectical Behavioral Therapy were introduced. She was introduced to the concept of Reasonable mind, Emotional mind and Wise mind.
At the subsequent sessions, we collaboratively constructed the following problem list, which was the focus of therapy –

- Sexual arousal after intellectual engagements and the possibility of multiple sex partners.
- Compulsive use of pornography and masturbation.
- Relationship difficulties with unhealthy social interactions.
- Dealing with extreme guilt and shame.
- Dealing with suicidal ideation and depressive features.
- Inability to adhere to job as result of anxiety.
- Social isolation.
- Lack of contact with family members, perpetuated by her own fears of rejection and of "causing trouble".

On completion of the problem list, she prioritized and listed her treatment goals (as outlined below).

- To develop the ability of saying no for sexual intercourse with acquainted people as a result of sapiosexuality.
- To decrease the work stress because of interpersonal difficulties.
- To learn healthy social skills in order to overcome social isolation.
- To overcome guilt & shame.
- To actively participate in decreasing depression and suicidal ideation.

We identified risky situations, in which the client was more likely to get sexually aroused. These included intellectual debates, observing other person handling a critical &/or difficult situation creatively, other person introducing new concepts or ideas to her. Several of these situations were explored and her cognitions, emotions, physical sensations and behavior during a risky situation were identified using 'Hot cross bun' model (see Figure 1).



This helped her understand the connection between her thoughts, emotions, physical response and behavior. We then outlined 'pay off matrix' assignment which focuses on the advantages and disadvantages of her behavior choices. She was able to identify positive and negative consequences of behavior; however, she minimized the negative ones. Using guided discovery, advantages and disadvantages of the present behavioral choices were listed out. This provided with an objective, rational and accurate view of her habit and allowed us to find healthy alternative strategies.

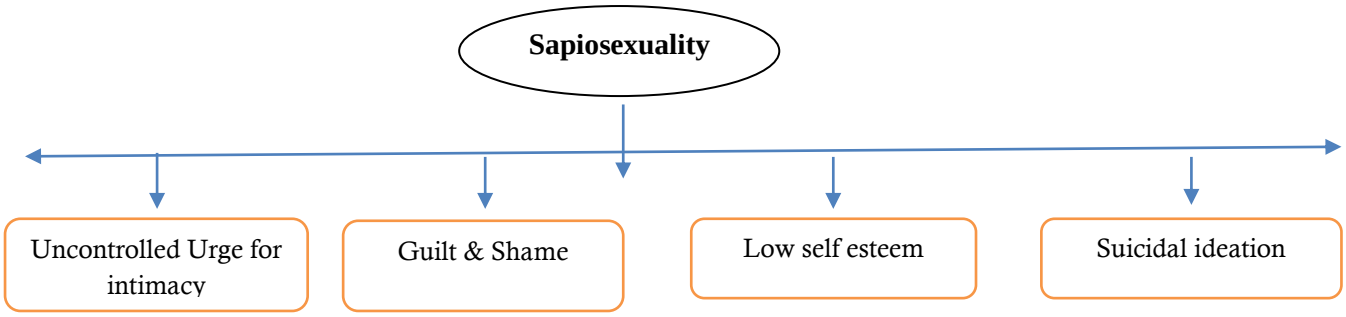
Given the likelihood of relapse at some stage in the future, we discussed the essentials to be done during such a crisis and we decided to do 'stress proofing'. This involved 'blueprinting', identifying challenging situations, possible coping strategies and developing the ability to deal with setbacks.

Middle phase of therapy

Middle part of therapy focused on the healthy behavioral choices. We worked on the chain of thoughts related to concerned behaviors and the root of anxiety and depression. She was then able to understand the connection between depression-anxiety-suicidal ideations and sapiosexuality.

Homework was an important component in therapy. Client completed an activity schedule as part of homework assignment for the following week. In this, she rated her mood during each hourly activity. Later we looked for connections between activity and mood. We noticed that her mood was generally better when she kept herself busy.

We then explored the pattern of unhealthy sexual behaviors and the chain of thoughts which lead to self-deceptive choices of behaviors. We found that sexual arousal after intellectual activities lead to multiple sexual partners, unsafe sexual practices and cybersex, which in turn negatively affected the self-image leading to extreme guilt and shame. In order to overcome the sexual arousal she started practicing self-stimulating activities which involved Pornography and Masturbating. Also because of unsafe sexual practices and multiple sexual partners she would have thoughts of getting pregnant, contacting sexual transmitted diseases and disclosure of relationship, which in turn evoked extreme anxiety was also negatively affecting her self-esteem. Reshaping Cognitive Distortions about sexual behaviors was the important task we dealt with.



We then reflected upon her relationship with her colleagues, which she was initially reluctant to discuss. She admitted to feelings of sadness and loneliness. She stated that "she wouldn't be getting any acceptance, unless she overcame this part of behavior (i.e. sapiosexuality). We identified her underlying assumption — 'If I remain sapiosexual, then I'm a bad person; if I practice good values, then I am a responsible person.' We noted Rama's obvious discomfort while discussing her own sapiosexual incidences and he admitted that she found it difficult; it was a "sore point". We agreed that this issue would be best discussed at a later date, perhaps during more long-term psychotherapy, and that a time-limited trial of CBT was probably not the most appropriate setting. Nevertheless, it was important to identify this issue as a problem, empathize with her and offer her an opportunity to come back to it at a later date.

The final part of therapy

Issues of low self-esteem following the guilt and compulsive self-pleasurable sexual behaviors were dealt with exploration of Beck's cognitive model of low self-esteem,* and collaborative work through for identification of her dysfunctional assumptions beliefs. We endeavored to explore her thinking further by using the Daily Thought Record (DTR), which consisted of listing of situations, emotions, automatic thoughts, rational responses and outcomes. Open-ended questions with discussions helped her formulating rational responses.

Over follow up sessions the client was surprised to find changes in her beliefs, automatic thoughts and emotions. She learned regulation of mood without engaging in self-deceptive behavior.

Outcome following only six sessions of CBT showed clear improvement in her mood and overall social functioning. HAM-D scores decreased from 31 (severe depression) at the start of therapy to 14 (mild depression) at the sixth session. Her level of hopelessness also improved: BHI scores decreased from 16 (severe range) to 7 (mild range). A score of 9 or more on the BHI could be predictive of psychological distress associated with deliberate self-harm.

She learned to identify her negative automatic thoughts, underlying assumptions and core beliefs which caused self deceptive behaviors and negative mood states. This self analysis helped her in bringing positive changes in self.

The advantage-disadvantage analysis improved her ability to be assertive and say no to unhealthy behaviors, which led to an improvement in her self-esteem. The activity schedule helped her realize that her mood improved with recovery activities and that she was less likely to react to sapiosexual triggers if she consciously kept herself busy.

Identifying high risk situations and subsequent avoidance of these minimized her risk of relapse. We together designed the relapse prevention plan for her.

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