The Wiley Handbook of Sex Therapy

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Edited by

Zoë D. Peterson

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Editor's Note: *All authors were asked to report any financial conflicts of interest associated with the information provided in their chapters. No author reported conflicts of interest beyond the very small financial sums associated with royalties from books that are cited in their chapters. The editor also has no financial conflicts of interest related to any content in this volume.*

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I am deeply indebted to all of the authors who contributed to this volume. In comparison to most of the chapter contributors, I am a novice sex therapist; thus, the biggest benefit to me in editing this book has been the opportunity to learn from the expertise of the chapter authors. I also am thankful to Courtney Jones for her help in indexing this volume and to the following individuals who helped to review and edit drafts of chapters for this handbook: Tiffany Artime, Sarah Buday, Marilyn Cashon, Philip Eiseman, Sara Gonzalez-Rivas, and Allison Kirschbaum. I am immensely grateful to Marilyn Cashon and Rex Peterson for their boundless support and countless hours of childcare. Finally, I offer my everlasting thanks to Brian Woodman and Kiran Peterson Woodman for their extraordinary patience and invaluable encouragement during this project.

1

Introduction

Zoë D. Peterson

What is Sex Therapy?

Sex therapists will tell you that one of the fundamental uncertainties that often drives clients into sex therapy is the worry: "Am I normal sexually?" I, in turn, often wonder: "Am I a normal sex therapist?" In my own work as a therapist treating sexual concerns, I sometimes use traditional sex therapy techniques such as sensate focus, but I also rely heavily on my broader training as a clinical psychologist and on my overarching feminist and constructivist psychotherapeutic theoretical orientation. Am I still doing sex therapy if I am not explicitly discussing the sexual response cycle, assigning sex-related behavioral homework, or helping my clients to discuss pharmaceutical treatment options with their doctors?

Thus, one of the most challenging aspects of editing this volume was determining what counts as sex therapy. As I set out to choose chapter authors and select the topics that would be addressed, I was forced to consider my own insufficiently-articulated viewpoints regarding questions such as, "Where does sex therapy stop and general psychotherapy begin?" and "What are the qualifications for a 'sex therapist'?"

I am certainly not the first to raise these questions about the definition of sex therapy. Tiefer (2012) pointed out that—broadly speaking—across time, sex therapies have included ancient love potions, bloodletting, Masters and Johnson behavioral techniques, Viagra, and YouTube kissing advice videos, among others (p. 312). Yet, she acknowledged that, in contrast to this broad expanse of sex *therapies*, the term "sex therapy" has become nearly synonymous with a dysfunction-focused behavioral or pharmaceutical treatment approach.

Similarly, Levine (2009) reported that he now rejects his former identity as a "sex therapist" because, to him, sex therapy is too narrow and simplistic. He argued that sex therapy has become tantamount to treating DSM-defined sexual dysfunctions with an overly simplistic, behavioral-technique-focused approach. He contended that sexual problems are far too broad and complicated to be explained and treated using a single theory or treatment approach.

Binik and Meana (2009) agreed that the term sex therapy originally referred to the techniques championed by Masters and Johnson (1970)—psychoeducation about sexual functioning, behavioral homework, and so on—but they maintained that, over time, sex therapists began to use the same techniques and theoretical orientations that were used to treat other psychological problems. The authors argued that "sex therapy" is just therapy. Given (1) the lack of clear distinction between sex therapy, as it is typically practiced, and general psychotherapy; (2) the lack of a unifying theory of sex therapy; and (3) the lack of regulation regarding who may call themselves a "sex therapist," Binik and Meana (2009) proposed that the treatment of sexual problems should be integrated into general psychotherapy practice rather than being treated as a separate subspecialty.

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What Problems do Sex Therapists Treat?

Indeed, there is perhaps an even more basic question that must be answered before we can define sex therapy, and that is, "What is a sexual problem?" The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013) codifies the sexual difficulties that are officially acknowledged by the field of psychiatry. The DSM sexual dysfunction diagnoses are exclusively focused on sexual performance: desire, arousal, orgasm, and pain-free intercourse. This focus on genital performance in the DSM-5 and in earlier versions of the manual has been heavily critiqued for being heterosexist and phallocentric; for promoting an anxiety-provoking, performance-oriented approach to sex; for ignoring cultural differences and gender-based power differences; and for sidelining essential facets of sexuality such as relationships, emotions, and pleasure (e.g., Apfelbaum, 2012; Kleinplatz, 2012; Tiefer, 2001).

Despite these cogent critiques, there is no denying that, for clients, it is often the symptoms of DSM sexual dysfunctions (e.g., lower levels of desire than they wish, erectile difficulties, orgasmic difficulties) that drive them into sex therapy. Of course, this raises a chicken-and-egg conundrum: Did these issues become the focus of the DSM diagnoses because they were the most troubling sexual issues for clients, or are clients most troubled by these sets of symptoms because they have been conceptualized and labeled as dysfunctional by the medical establishment and, in turn, by popular culture? In either case, clients do present with these difficulties, and as sex therapists, we frequently must address them in some manner. Depending on the sex therapist's viewpoint, this might involve suggesting medications or behavioral exercises with the goal of relieving symptoms; it might involve helping the client to re-think the assumption that firm erections and timely orgasms are the only path to sexual pleasure and connection; it might involve addressing the underlying psychological and relational distress that is seen as leading to the sexual symptoms; or it might involve some combination of all three of these. Thus, although some sex therapists reject the performance-oriented, genital-focused nature of the DSM sexual dysfunction diagnoses, all sex therapists will be forced to confront these in the therapy office.

There is no question, however, that the DSM sexual dysfunctions do not capture the full range or complexity of the sexual concerns that propel our clients to seek therapy. Levine (2010) categorized sexual difficulties as *disorders* (those identified by the DSM), *problems* (frequent sources of suffering that are not captured by the DSM disorders), and *worries* (concerns about sexual issues that detract from sexual pleasure). In many cases, problems (e.g., anger and resentment about a partner's infidelity, discomfort with or shame about sexual attractions) and worries (e.g., concerns about body image, fears that one is not sexually pleasing a partner) may actually be more distressing and have a more pervasive negative impact on sexual pleasure and enjoyment than relatively more straightforward disorders of physiological function. It is very often these problems and worries—rather than diagnosable disorders—that motivate clients to come to see a sex therapist.

What Techniques do Sex Therapists Use?

As noted by Kleinplatz (1996), Masters and Johnson's behavioral techniques have become synonymous with sex therapy; as she put it, these techniques are "the Kleenex" of sex therapy (p. 190). This tendency to equate sex therapy with symptom-focused behavioral interventions—such as sensate focus and the squeeze technique—obscures the fact that there are actually many different brands of sex therapy. In reality, sex therapists, like all psychotherapists, employ a variety of therapeutic techniques and are guided by a variety of theoretical orientations when they work with clients to address sexual problems. Despite this fact, with a very few

notable exceptions (e.g., Hall, 2012; Hertlein, Weeks, & Gambescia, 2009), little is written about theoretical approaches to sex therapy.

Many sex therapists advocate for a biopsychosocial approach to sex therapy. This approach recognizes the importance of integrating medical, psychological, and relational components of treatment. Despite the importance of an integrated approach to treatment, however, the label "biopsychosocial" is uninformative in revealing the theoretical assumptions that guide the psychological and relational work that occurs in psychotherapy. Thus, a therapist working from a "biopsychosocial approach" might treat the psychosocial aspects of the problems using behavioral, cognitive, systemic, narrative, or emotion-focused interventions.

What Should Sex Therapy Be?

I agree with Tiefer (2012) that "sex therapy is politics" (p. 31). For that matter, all therapy is politics, but this is especially apparent in the case of sex therapy because issues of sexuality and sexual behavior are so highly politically contested. Thus, how "expert" professionals define "a sexual problem" and "sex therapy" speaks to their values—and helps to shape the values of the broader culture—around what is and is not sexually "healthy" or "normal" and which treatments are legitimate for addressing sexual concerns. Given that, in this volume, I wanted to represent a diversity of individual values and politics related to what counts as "a sexual problem" and as "sex therapy".

However, to acknowledge my own values and politics, I also wanted to adopt an expansive definition of sex therapy as any therapy that values and promotes enjoyable sexuality as an integral part of overall physical and mental health. Levine (2009), in describing his rejection of the "sex therapist" label, said:

> Sex therapy has no relevance to the management of gender identity disorders, sex perpetrators, paraphilics, the sexually compulsive, sexual victims, sexual risk taking, nonsexual relationship conflict, the anxieties of sexual beginners, and so on, unless, of course, by sex therapy we mean all things involving any aspect of sexuality brought to our clinical attention. (p. 1033)

I hope that the version of sex therapy advocated in this volume does, in fact, have relevance to all of those important sexual issues noted by Levine. Of course, given the breadth of my aspirational definition, no single volume could fully discuss all types of sexual problems, sex therapy clients, or sex therapy techniques; thus, I think of this volume as a mere sampling.

Section I: Treating Specific Sexual Problems

As noted, sex therapists will inevitably treat sexual problems that correspond to the DSM-5 sexual dysfunctions. Not surprisingly, for many individuals, sexual desire (Althof & Needle, Chapter 3; Both, Weijmar Schultz, & Laan, Chapter 2), erections (Nobre, Chapter 4), orgasms (Carpenter, Williams, & Worly, Chapter 5; Rowland & Cooper, Chapter 6), and pain-free intercourse (Meana, Fertel, & Maykut, Chapter 7) contribute to pleasure, enjoyment, and satisfaction, and in turn, difficulty with these aspects of functioning detracts from sexual enjoyment. Thus, treatment of these diagnoses is addressed in Section 1 of this handbook. However, sex therapists also treat other issues that interfere with sexual pleasure, enjoyment, and satisfaction, such as difficulties in controlling unwanted (Grubbs *et al.*, Chapter 8) or illegal sexual behaviors (Berg, Munns, & Miner, Chapter 9), and lack of sexual passion (Mintz, Sanchez, & Heatherly, Chapter 10). Thus, these non-diagnostic problems are also addressed

in Section 1 of this volume. Further, throughout all sections of this volume, the rich case material unmistakably illustrates that the entirety of clients' sexual problems and concerns are not cleanly captured by the dysfunctions listed in the DSM-5.

Section II: Theoretical Approaches to Sex Therapy

Despite my contention that sex therapy is not synonymous with Masters and Johnson behavioral techniques, many (maybe most) sex therapists use at least some of the classic sex therapy techniques, and these are described by Avery-Clark and Weiner in Chapter 11; however, the authors also note that traditional sex therapy techniques, such as sensate focus exercises, have often been misrepresented and oversimplified. Their chapter reveals that even "simple" behavioral exercises involve thoughtful attention to complex psychological and relational factors.

Additionally, at noted above, sex therapists increasingly describe their approach as "biopsychosocial" to acknowledge the importance of biological, psychological, and relational contributions to sexual problems. However, in Chapter 12, McCarthy and Wald describe why they have abandoned the biopsychosocial approach in favor of a *psychobiosocial* approach—foregrounding the psychosocial and backgrounding the biological.

There is no doubt that cognitive and behavioral techniques are extremely popular approaches to treating sexual concerns, and this is evident throughout all the chapters in this volume. This is unsurprising, as cognitive-behavioral therapies currently represent the most popular psychotherapeutic treatment approaches for most mental health problems (Gaudiano, 2008). However, the remaining chapters in Section 2 describe how some sex therapists' theoretical approaches to sex therapy extend well beyond cognitive-behavioral therapy to integrate techniques from systemic (Hertlein & Nelson, Chapter 13), existential-experiential (Kleinplatz, Chapter 14), narrative (Findlay, Chapter 15), and emotionally-focused (Johnson, Chapter 16) therapeutic traditions.

Bancroft (2009) identified theoretical diversity as one of the strengths of sex therapy, and I agree. Mood disorders have been shown to be effectively treated using a variety of different theoretical approaches, including cognitive-behavioral therapy, mindfulness-based cognitive therapy, brief dynamic therapy, and emotion-focused therapy (Hollon & Ponniah, 2010). Why shouldn't we similarly expect that sexual problems would likely be responsive to a variety of different treatment approaches?

Section III: Sex Therapy with Specific Populations

Over time, sex therapy has been criticized for being limited in terms of its target population—typically young, able-bodied, white, middle-class heterosexuals (e.g., McCormick, 1994). Recent publications (e.g., Hall & Graham, 2013), though, have attempted to expand culturally-competent sex therapy practice, and as demonstrated in Section 3 of this volume, sex therapists are providing sensitive and affirmative therapy for extraordinarily diverse client populations.

In this section, the chapter authors highlight considerations in treating sexual problems in sexual (Cohen & Savin-Williams, Chapter 17) and gender (Spencer, Iantaffi, & Bockting, Chapter 18) minorities; clients ranging in age from children (Lamb & Plocha, Chapter 19) to aging adults (Hillman, Chapter 20); clients who face barriers to sexual wellness in the form of intellectual (Hough *et al.*, Chapter 21), psychological (Buehler, Chapter 22), physical health (Zhou & Bober, Chapter 23), and trauma-related (Hall, Chapter 24) challenges; and clients

with diverse sexual ethics, including those with conservative religious values (Turner, Chapter 25) and those who embrace creative and kinky sex (Nichols & Fedor, Chapter 26).

Section IV: Future Directions in Sex Therapy

Although some argue that sex therapy has remained stuck in the 1960s and 1970s with Masters and Johnson, in reality the psychotherapeutic treatment of sexual problems has moved forward in all kinds of ways. In some cases, this forward movement is guided by creative clinical experimentation, but in many cases, it is advanced by outstanding basic and clinical research findings. The final section of this book, Section 4, summarizes the empirical literature on four topics that represent highly promising future directions in the field of sex therapy.

In Chapter 27, Barker provides an overview of the theory and research on mindfulness interventions for sexual problems. Mindfulness is arguably not at all new to sex therapy. Indeed, as described by Avery-Clark and Weiner (Chapter 11), it is the cornerstone of sensate focus, one of the most traditional and widely-used sex therapy techniques. However, mindfulness as an explicitly articulated approach to treating a wide variety of sexual problems (not to mention other mental health problems, e.g., Baer, 2003) has recently received very encouraging empirical support, and thus the entire field of sex therapy is taking notice. Indeed, many authors throughout this volume mention mindfulness as a promising adjunct to other sex therapy interventions. In light of the strong empirical support for mindfulness interventions, these types of interventions seem likely to become an essential component of sex therapy going forward.

Given the controversial but undeniable movement toward a medicalized approach to conceptualizing and addressing sexual concerns (which is discussed—and sometimes bemoaned—throughout the chapters in this volume), sex therapists, regardless of their personal views on the issue of pharmacological treatments for sexual problems, will inevitably work with patients who are also using medication to treat their symptoms. Thus, Conaglen and Conaglen (Chapter 28) offer a framework for effectively incorporating partners into individualized medical treatments for sexual dysfunction. Their chapter provides guidance on how sex therapists might continue to incorporate the psychosocial aspects of sex therapy even in the face of an increasingly biomedical orientation towards the treatment of sexual concerns.

Finally, because traditional, face-to-face psychotherapy is expensive, time-consuming, and sometimes hard to access for individuals outside of urban areas, there is increased interest in the broader field of psychotherapy in promoting minimal contact therapies, such as technology-assisted and bibliotherapy interventions (e.g., Newman, Szkodny, Llera, & Przeworski, 2011). Because sex therapy is often focused on single, circumscribed sexual difficulties and because some individuals are very uncomfortable discussing sexual issues in a face-to-face context, some sex therapy clients may be particularly good candidates for these minimal-contact therapeutic interventions. The final chapters in this section describe the promising empirical research findings on biblio-sex therapy (van Lankveld, Chapter 29) and internet-based sex therapy (Connaughton & McCabe, Chapter 30) as treatments for a variety of different sexual concerns. Selective use of these types of minimal contact interventions may allow the field of sex therapy to expand by ensuring that sex therapy remains accessible and affordable to a wide range of client populations.

What are the Values of Sex Therapy?

Certainly the chapters in this volume illustrate the very real conflicts and divides within the field of sex therapy. For example, some authors celebrate new biomedical advances in the treatment of sexual problems (e.g., Conaglen & Conaglen). Other authors lament the

medicalization of sexual problems (e.g., Kleinplatz; McCarthy & Wald)—that is, the framing of complex sociocultural, psychological, and relational problems as simple medical conditions that can be treated with a pill. Some authors praise the continued influence and effectiveness of Masters and Johnson's traditional behavioral sex therapy techniques, including sensate focus and squeeze techniques (e.g., Avery-Clark & Weiner; Rowland & Cooper), while others argue that such approaches are too mechanistic, reductionist, and heavily focused on symptoms rather than promoting optimally enjoyable and pleasurable sex (e.g., Barker; Kleinplatz; Turner). Some authors argue that close, long-term, committed intimate relationships provide the context for the most passionate sex (e.g., Johnson); other authors problematize this position, suggesting that the security and closeness provided by long-term relationships can often result in an overfamiliarity that can contribute to loss of sexual passion (e.g., Mintz *et al.*).

These disagreements among authors about the nature of and solution to sexual problems are unsurprising, especially given the diversity in region, culture, and profession among the authors in this volume, and those in the field of sex therapy more broadly. Indeed, the authors in this volume represent seven different countries and include psychologists, social workers, endocrinologists, and gynecologists. Some authors are primarily researchers, and others are primarily clinicians. Given the extraordinary diversity of the authors, differing perspectives seem inevitable. Indeed, these conflicts within the field are not new, and some authors have suggested that the intensity of these differences of opinion has led to a damaging splintering of the field of sex therapy (e.g., Kleinplatz, 2012).

However, it is important to note that the disagreements reflected in this volume are generally a matter of degree rather than kind. For example, although some authors are clearly more open than others to integrating biomedical treatments into their sex therapy practice, no author in this volume advocates pharmaceutical interventions implemented in isolation from psychosocial assessment and intervention.

Further, by focusing on disagreements within the relatively small field of sex therapy, it is easy to overlook the many shared values espoused, to at least some degree, by every author in this volume. These values include the essential role of sex and sexuality in overall psychological health; the importance of providing clients with thorough and accurate information about sexuality and sexual functioning; the potentially damaging effects of repressive and shaming messages about sex from families, religion, and the broader culture; the multifaceted nature of sexual problems and sexual pleasure; and the relevance of sexual pleasure and enjoyment as a psychotherapeutic goal. In a cultural context in which middle-school teachers can be fired for saying the word "vagina" (Bethencourt, 2016) and state Houses of Representatives are attempting to pass measures to allow for legal discrimination on the basis of sexual orientation (Suntrup, 2016), these are clearly values with which not every therapist, doctor, or member of the general public would agree, so the fact that these values are consistently endorsed across every chapter of this volume is truly meaningful. To me, these values are the foundational components of sex therapy, and they are what unite our field even in the face of substantial disagreements about more specific conceptual and clinical questions. Thus, I ultimately agree with Pukall's (2009) simple conclusion that "what … makes 'sex therapy' special is that it deals with sex" (p. 1039).

Conclusions

Just as I don't believe that there is one narrow version of "normal" sexuality, I hope that this volume illustrates that there is no one way to be a "normal" sex therapist. There are multiple ways to be an effective sex therapist. This is important, in part, because the numbers of sex therapists are rapidly dwindling (Bancroft, 2009; Kleinplatz, 2012). The field of sex therapy

badly needs to attract clinical, counseling, and social work graduate students who are in the process of choosing their career path, as well as established mental health professionals who are looking to expand their practice in new directions. If these students and mental health professionals believe that sex therapy involves merely referring men with erectile dysfunction for Viagra prescriptions, telling women with vaginal dryness where to purchase lubricants, or training men with premature ejaculation in the squeeze technique, then sex therapy may only attract a small group of individuals who enjoy short-term, structured, and highly focused treatment approaches. These types of interventions may be an important part of sex therapy for some clinicians, but they do not reflect the range of challenging and multifaceted sexual problems that are encountered or the diverse and complicated interventions that are employed in sex therapy. Indeed, reducing sex therapy to exclusively behavioral or pharmaceutical interventions would be equivalent to reducing treatments for depression to mere behavioral activation; behavioral activation is important and often useful, but most therapists treating depression do far more than assigning behavioral homework, and some therapists may never assign behavioral homework as a treatment for depression.

When mental health professionals select to specialize in sex therapy, they need not and should not set aside their broader theoretical understanding of psychological problems, their advanced training in psychotherapy techniques, or their carefully honed therapeutic communications skills (e.g., empathy, authenticity). Those conceptualizations and skills—when combined with a genuine valuing of healthy sexuality as part of overall wellness—are essential for good sex therapy.

Therefore, I hope that this volume will provide some interesting new ideas and techniques for those who already identify professionally as sex therapists. I also hope that it will function as a starting place for students and psychotherapists who do not—or do not yet—identify as sex therapists, but who value sexual health and wellness as an essential part of general mental health and wellness and who thus hope to work better with sexual concerns as part of their general psychotherapy practice.

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Section I
Treating Specific Sexual Problems

2

Treating Women's Sexual Desire and Arousal Problems

Stephanie Both, Willibrord Weijmar Schultz and Ellen Laan

Phenomenology

According to the definition in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013), female sexual interest/arousal disorder (FSIAD) is characterized by a lack of, or significantly reduced, sexual interest and/or arousal, as manifested by at least three of the following symptoms (criterion A): (1) absent/reduced interest in sexual activity; (2) absent/reduced sexual/erotic thoughts or fantasies; (3) no/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate; (4) absent/reduced sexual excitement/pleasure during sexual activity in almost all or all sexual encounters; (5) absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual); and (6) absent/reduced genital or nongenital sensations during sexual activity in almost all or all sexual encounters. For a diagnosis to be given, the symptoms must be present for a minimum duration of approximately 6 months (criterion B), and they must cause clinically significant distress in the individual (criterion C; American Psychiatric Association, 2013, p. 433). Furthermore, in order to classify the complaints under this diagnosis, the complaints should not be better explained by a nonsexual mental disorder, severe relationship distress, or other significant stressors. Also, they must not be exclusively associated with the consequences of a medical condition, and when substance or medication use can explain the complaints, the diagnosis of substance/medication-induced sexual dysfunction should be made. The presence of another sexual dysfunction does not rule out a diagnosis of FSIAD because it is common that women experience more than one sexual dysfunction concurrently. For example, a sexual pain disorder may go along with a lack of sexual interest and arousal.

Thus, differently from the DSM-IV-TR (American Psychiatric Association, 2000), in which sexual desire and arousal disorders were described as two separate disorders, in the DSM-5 desire and arousal disorders are merged into one female sexual interest/arousal disorder. One of the reasons for merging the categories of female sexual desire and sexual arousal disorders in the DSM-5 was the observation that low sexual desire is often seen in combination with arousal problems (Brotto, 2010). Studies show that many women with a lack of sexual desire also have sexual arousal problems, and vice versa (Hendrickx, Gijs, & Enzlin, 2013; Segraves & Segraves, 1991).

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Also differently from the DSM-IV-TR, in the DSM-5 no distinction is made between low sexual interest/arousal disorder and sexual aversion disorder. In clinical practice these sexual problems are often differentiated such that low interest/arousal chiefly refers to a lack of interest in sex even though the sex itself can be experienced as neutral or positive, whereas sexual aversion refers to responding to sex with negative emotions such as disgust or anxiety (Borg, de Jong, & Elgersma, 2014). The DSM-5, however, includes the category of other specified sexual dysfunction, which applies to presentations in which symptoms cause clinically significant distress but do not meet the criteria for any specific sexual dysfunction. In the description of this category, it is explicitly stated that sexual aversion can be specified as the reason for the distress. Clinically, the distinction between lack of sexual interest/arousal and sexual aversion is relevant; in the case of sexual aversion, desensitization and counter-conditioning procedures are important in treatment, but in the case of low interest/arousal, these interventions are generally not necessary.

In practice, single women seldom present with the complaint of no sexual interest or arousal. Usually the complaint comes from women in a steady relationship and is related to differences in sexual desire between her and her partner. In the DSM-5, it is explicitly stated that a desire discrepancy, in which a women has lower desire for sexual activity than her partner, is not sufficient to diagnose FSIAD. Also, the DSM notes that a normative decline in sexual thoughts and response with age should be taken into account. But how much disinterest does a woman need to show in order to qualify for a sexual interest/arousal disorder? The DSM lacks objective criteria, which means that the diagnosis has to be based on the subjective judgement of the clinician, who must also consider factors that might influence sexual functioning, such as gender or age. Gender is known to be an important factor. On the basis of a review of a large number of studies on differences in sexual motivation between men and women, Baumeister, Catanese, and Vohs (2001) concluded that women generally have lower and less frequent sexual motivation than men. Women masturbate less, fantasize less about sex, have less frequent desire for sex, and report more complaints of not feeling like having sex.

Recently, a new disturbance has been described related to sexual arousal in women—the so-called persistent genital arousal disorder. This syndrome is characterized by spontaneous, unpleasant, and unwanted genital arousal in the absence of feelings of sexual interest or desire (Leiblum, Seehuus, & Brown, 2007). As data on the nature, prevalence, and possible treatment of this disorder are scarce, this chapter does not elaborate further on this arousal disturbance.

Prevalence/Incidence

Little or no sexual desire is the most common sexual problem reported by women. Recent prevalence studies, which still made use of the separate DSM-IV-TR criteria for hypoactive sexual desire and sexual arousal disorder, investigated the occurrence of symptoms of sexual dysfunction and also the degree of distress caused by the problems (Shifren, Monz, Russon, Segreti, & Johannes, 2008; West *et al.*, 2008; Witting *et al.*, 2008). Although these studies differed in their diagnostic criteria and study methods, the prevalence of low sexual desire in the general population of women was consistently found to be about 20–30%. When distress about the low desire was used as a necessary criterion for dysfunction, the prevalence rates decreased by about half. The prevalence of sexual arousal problems across studies was between 11–31%, but in combination with the criterion of distress, these rates also decreased sharply. These findings show that sexual interest and arousal problems are fairly common in women, but that only a proportion of the women experience real distress from them and thus would qualify for a sexual dysfunction diagnosis. In a study on a representative group of American

women, it was found that subjective distress over sexual problems could best be predicted by general emotional wellbeing and the emotional bond with the partner during sexual contact (Bancroft, Loftus, & Long, 2003). Thus, in many cases, sexual complaints could be a normal reaction to unfavourable circumstances.

Etiology

Models of female sexual arousal and desire

The DSM-IV-TR classification of sexual disorders was based on a linear model of sexual response, in which the phase of sexual desire precedes the phases of sexual arousal, orgasm, and resolution (Kaplan, 1977; Masters & Johnson, 1970). This model implies that sexual desire occurs spontaneously and that it is independent of the sexual arousal response. Various authors criticized this strict distinction made between the phase of sexual desire and the phase of sexual arousal, and emphasized that sexual motivation stems from the processing of sexual stimuli, which leads to sexual arousal as well as sexual desire (Basson, 2001; Both, Everaerd, & Laan, 2007; Everaerd & Laan, 1995). As noted above, based on this criticism and the high comorbidity of sexual desire and arousal problems, the categories of female sexual desire and sexual arousal disorders were merged in the DSM-5. According to this recent view, which corresponds with modern incentive motivation theories, the origin of sexual arousal and desire is the result of an interplay between a person's internal sexual response system and external stimuli (incentives) that activate this system. Not only the sensitivity of the system plays a role, but also the meaning and intensity of the real or imaginary stimuli.

It follows from this notion that sexual desire does not precede arousal, but is a consequence of arousal or a simultaneous occurrence. Sexual motivation is not seen as something that comes from within—as something that one can have a lot or a little of—but as something that manifests itself when certain conditions are met. The conditions necessary to activate the sexual process have three parts: (1) there must be an intact system that enables sexual responsiveness; (2) stimuli with a sexual meaning must be present that can activate the sexual system; and (3) the circumstances must be suitable to pursue sexual activity (Singer & Toates, 1987). In this process, motivation starts to emerge and becomes stronger as the three conditions are met to a greater and greater degree. In contrast, if one or more of these conditions are lacking or absent, then the sexual process breaks down.

Sexual activity is not always a consequence of a process in which sexual arousal and sexual desire are involved. In a large group of study subjects, Meston and Buss (2007) made an inventory of people's motives to have sex with a partner. Men and women reported a wide variety of motives, such as experiencing physical pleasure, showing affection, satisfying the partner, relieving boredom, or fulfilling a perceived obligation. Although the top ten motives of the men and women were closely matched, the men were more inclined towards physical motives, such as seeing an attractive body, whereas the women were more inclined towards relational motives, such as showing love. In the female sexual response model developed by Basson (2001), the need for intimacy plays an important role as a motive for sexual activity. Basson emphasized that, particularly in long-term relationships, a woman's willingness to be sexual derives from her wish for intimacy and that this can lead to sexual arousal and sexual desire. The rewarding value of the sexual interaction then determines the extent to which the woman will be receptive to sexual stimuli in the future.

The above-described recent views of sexual desire and sexual arousal are in line with an information processing model of sexual arousal (Janssen, Everaerd, Spiering, & Janssen, 2000).

In this model, two information processing pathways are distinguished. The first pathway concerns, in particular, the automatic and unconscious processes, whereas the second pathway concerns attention and regulation. Activation of genital sexual arousal (via the automatic pathway) largely occurs unconsciously and quickly, whereas the conscious significance attributed to the experience (via the conscious pathway) occurs relatively slowly. The genital response (i.e., blood flow to the genitals and vaginal lubrication) and the subjective conscious experience (i.e., feeling psychologically aroused) do not necessarily need to be in concordance. In women, relatively low concordance is generally found between genital responses and feelings of sexual arousal; feelings of arousal seem to be determined to a larger extent by the situational context than by the strength of the genital response (Laan, Everaerd, & Both, 2005). Lack of concordance between the genital response and the subjective response can occur when a stimulus activates not only sexual meanings (facilitating genital arousal), but also nonsexual or negative meanings (inhibiting subjective arousal).

According to the information processing model, biological as well as psychological factors can hinder the activation of the sexual system. Hormonal disorders can, for example, decrease the sensitivity of the sexual system, otherwise referred to as "arousability" or sexual excitability, while cognitive processes, such as negative thoughts or distraction, can repress genital or subjective sexual arousal (Barlow, 1986). Thus, the information processing model underlines the importance of the meaning of the stimuli. Although there are stimuli that by nature cause sexual responses and pleasurable feelings in most people—such as stroking the genitals—it is likely that the majority of sexual stimuli derive their meaning from learning processes (Brom, Both, Laan, Everaerd, & Spinhoven, 2014). Learning about sexual stimuli generally leads to positive sexual associations, but stimuli can also become associated with negative emotions. Therefore, the potential of stimuli to evoke sexual desire and arousal depends on the sexual learning history of the individual.

Arousability: the role of hormones and somatic disease

Oestrogens and androgens There is agreement in the literature that sex hormones (oestrogens and androgens) play conditional roles in sexual response (Davis, Guay, Shifren, & Mazer, 2004). However, it is not yet clear precisely how these hormones influence sexual functioning. In addition, it is not clear what critical threshold of sex hormones enables sexual responsiveness and what level represents a deficit.

The most important hormones for women are the oestrogens, including oestradiol. During menopause, oestrogen levels decrease sharply. Decreased oestradiol levels can cause complaints such as hot flushes, sleep disorders, mood swings, vaginal atrophy, and vaginal dryness. These symptoms can have negative effects on sexual functioning. There are indications that basic vaginal blood circulation is poorer in postmenopausal women than in premenopausal women (Both *et al.*, 2015; Laan & van Lunsen, 1997; Pieterse *et al.*, 2008). Low oestrogen levels have been shown to be correlated with poor basic blood circulation, but not with a weaker vaginal engorgement in response to erotic stimulation. Thus, when there is sufficient erotic stimulation, lower oestrogen levels do not necessarily seem to obstruct the genital arousal response.

In addition to oestrogen, women produce androgens, including testosterone. In the blood, a maximum of 3% of the total testosterone is freely available, while the rest is strongly bound to sex hormone binding globulin (SHBG) and is not biologically available. The amount of SHBG is related to factors such as the oestrogen level in the blood. High oestrogen levels lead to higher SHBG production, which reduces the biologically available testosterone fraction (Simon, 2002). Physiologically, the testosterone concentration gradually decreases in women starting at the age of 25 to 30 years (Davis, Davison, Donath, & Bell, 2005). In postmenopausal women, the testosterone levels are about half of what they were at the age of around

30 years. After iatrogenic menopause (e.g., as a result of treatment for breast cancer or of preventive (prophylactic) bilateral oophorectomy (the surgical removal of the ovaries) in case of BRCA gene mutation), androgen levels are often even more strongly decreased to about a third to a quarter of premenopausal levels (Lobo, 2001).

As women have low testosterone levels, it is difficult to obtain accurate measurements. The most sensitive analysis methods are expensive and time-consuming and therefore unsuitable for application in clinical practice. In addition, good reference values are lacking for (free) testosterone in women and it is doubtful whether the testosterone level is a reliable measure of androgen activity. For these reasons, it is recommended not to perform testosterone measurements routinely in clinical practice to establish whether women have androgen deficiency, but only in the case of specific medical conditions that are known to be associated with testosterone deficiency (Labrie *et al.*, 2006; Lobo, 2001). As oestrogen levels decrease sharply during the menopause, it is no longer possible to obtain reliable oestradiol measurements from postmenopausal women (Buckler, 2005).

Discussions are ongoing about the level of influence that androgens have on sexual functioning in women. There are indications that sexual desire and particularly arousability are linked with androgens, but the research findings are not unequivocal. A few studies indicated reduced testosterone levels in women with complaints of low sexual desire (Riley & Riley, 2000; Turna *et al.*, 2005), or observed an association between low testosterone and complaints such as a reduced feeling of wellbeing, lack of energy, depression, and low sexual desire and sexual satisfaction (Bachmann *et al.*, 2002; Davison, Bell, Donath, Montalto, & Davis, 2005). However, in large population studies no relationship, or only weak correlations, were found between androgen levels and the sexual functioning of women (Alexander, Dennerstein, Burger, & Graziottin, 2006; Gerber, Johnson, Bunn, & O'Brien, 2005). Deficiencies in freely available testosterone can arise due to low testosterone production, as observed in patients with pituitary dysfunction, ovarian dysfunction (e.g., premature ovarian failure, Turner's syndrome, preventive removal of the ovaries in the case of mutation in the BRCA gene, adrenal dysfunction associated with chemotherapy and radiotherapy, hypothyroidism, use of corticosteroids or anti-androgens (e.g., in the Diane contraceptive pill), or due to excessive SHBG under the influence of medication (e.g., oestrogens in oral contraceptives). In women after bilateral oophorectomy (removal of both ovaries), a relationship was found between reduced androgen levels and decreased sexual desire. In these patients, androgen substitution had positive effects (Shifren *et al.*, 2006). Over the past few years, various studies have been published in which transdermal testosterone administration in combination with oestrogens had positive effects on decreased sexual desire in women who entered premature menopause after bilateral oophorectomy (e.g. Braunstein *et al.*, 2005; Davis *et al.*, 2006). Recently, positive effects have also been reported in women after natural menopause (Shifren *et al.*, 2006) and in premenopausal women with low sexual desire (Schwenkhagen & Studd, 2009).

Very few psycho-physiological data are available on the effect of testosterone on the sexual arousal response in women. A small number of studies found that the administration of methyl testosterone increased the genital response, but did not affect subjective sexual arousal (Heard-Davison, Heiman, & Kuffel, 2007; Tuiten, van Honk, Verbaten, Laan, & Everaerd, 2002; Tuiten *et al.*, 2000). In a study on surgically postmenopausal women that measured brain activity in reaction to erotic stimulation, the activity in the limbic system was stronger after they had received oestrogens and testosterone than after oestrogens alone or no medication (Archer, Love-Geffen, Herbst-Damm, Swinney, & Chang, 2006). Subjective sexual arousal was not measured in this study. In summary, it can be concluded that androgens certainly influence the sexual arousability of women, but as yet, the only clear empirical evidence of a relationship between decreased testosterone levels and low sexual desire is in studies of women with bilateral oophorectomy.

Somatic disease and medical interventions Somatic disorders or medical interventions can lead to decreased sexual desire or disruption of the arousal response. In addition to physiological mechanisms, psychological factors related to chronic disease, such as fatigue, pain, or depression, can affect sexual functioning. Chronic diseases that are known to disrupt sexual functioning physiologically as well as psychologically are neurological disorders such as multiple sclerosis and transverse spinal cord injury (Rees, Fowler, & Maas, 2007); endocrine disorders such as hypothyroidism, hyperprolactinaemia, and diabetes mellitus (Bhasin, Enzlin, Coviello, & Basson, 2007); and renal failure (Basson & Weijmar Schultz, 2007). Recently, there is increasing attention on the negative effects of cancer and cancer treatment on female sexual function (Abbott-Anderson & Kwekkeboom, 2012; Incrocci & Jensen, 2013; Krychman & Millheiser, 2013; see also Zhou & Bober, this volume). Although multiple physical conditions have been associated with impaired *subjective* arousal and desire, currently only women with transverse spinal cord injury (Sipski, 2001), women with nerve damage as a result of oncological surgery to the uterus, and women with diabetes mellitus (Both *et al.*, 2015; Pieterse *et al.*, 2008; Wincze, Albert, & Bansal, 1993) have been found to show weaker *genital* arousal responses to sexual stimulation compared with healthy controls.

Various drugs that act on the neurotransmitter systems, such as antidepressives (selective serotonin reuptake inhibitors; SSRIs) and antipsychotics (dopamine antagonists), have negative effects on sexual desire and sexual arousal (Meston & Frohlich, 2000). A few antidepressants seem to have weaker antisexual side-effects than others (agomelatine, bupropion, moclobemide, mirtazapine), and there are indications that the addition of bupropion to pharmacological treatment for depression (Serretti & Chiesa, 2009) may be a promising approach to reduce antidepressant-induced sexual dysfunction (Taylor *et al.*, 2013).

Arousability: psychological factors

Stimuli and meaning The incentive motivation model emphasizes the importance of the attractiveness of the stimuli in the origination of sexual arousal and sexual desire. According to the information processing model, different cognitive processes can influence how sexual stimuli are interpreted, which can mean facilitation of the sexual arousal response, or indeed, its collapse. In studies that measured genital responses in physically healthy women with sexual arousal problems, it appeared that these women showed comparable increases in genital engorgement in response to erotic stimulation as women without arousal problems (Basson *et al.*, 2003; Levin *et al.*, 2016). However, women with sexual arousal problems reported fewer positive sexual feelings and more negative feelings in response to erotic stimuli than women without sexual problems (Laan, van Driel, & van Lunsen, 2008). This demonstrates that physically healthy women with sexual arousal problems are equally able to achieve genital sexual arousal as women without problems. Therefore, in physically healthy women, arousal problems are more likely to be related to inadequate erotic stimulation in everyday life or to negative evaluations of the sexual stimulus or the sexual context, than to disturbances in genital responsiveness.

Various mechanisms can have a negative influence on the attractiveness of sexual stimuli, such as habituation or associations with negative outcomes. For instance, experimental research has shown evidence of habituation of genital and subjective sexual arousal by repeated exposure to the same sexual stimulus (Meuwissen & Over, 1990). When a new stimulus was subsequently introduced, arousal increased again. In this respect, it is interesting that questionnaire research in women showed that a longer relationship duration correlated with diminishing sexual desire (Klusmann, 2002; Murray & Milhausen, 2012), and that starting a new relationship was accompanied by stronger feelings of desire (Avis *et al.*, 2005). Also, in qualitative research, women with sexual desire disorder report perceiving the institutionalization of

the relationship, overfamiliarity with their partner, and desexualization of the roles in the relationship as causes of their waning desire (Sims & Meana, 2010). It is possible that habituation and/or a lack of variety are involved in the origination of decreased sexual desire in longer relationships.

Another mechanism that may be involved is classical conditioning (Agmo, 1999; Brom, Both, Laan, Everaerd, & Spinhoven, 2014; Hoffmann, Janssen, & Turner, 2004). Laboratory studies on women have shown that the sexual arousal response to a specific stimulus can be positively conditioned by repeatedly pairing the stimulus with pleasurable sexual stimulation. Thus, stimuli can be given sexually activating characteristics using basic learning processes. This implies that, when a women has gained very little rewarding sexual experience, there will be very few positive associations, and consequently very few stimuli that can elicit sexual desire and arousal. Recently, support for this notion has been found in a study on premenopausal women with acquired low sexual desire, in whom sexual stimuli elicited fewer conscious and unconscious positive associations than in women without sexual problems (Brauer *et al.*, 2012). Sexual stimuli can also lose their attractiveness when sex repeatedly results in negative outcomes, such as anxiety, disappointment, or pain. A laboratory study showed that when an erotic stimulus was repeatedly followed by a pain stimulus, this suppressed the sexual arousal response and the subjective appreciation of the erotic stimulus (Both *et al.*, 2008).

A more negative attitude towards sexuality in general also coincides with more sexual problems (Nobre & Pinto-Gouveia, 2009). For example,the experience of sexual violence can lead to strong negative associations with sex. A history of sexual violence can play a role in sexual desire or arousal problems and particularly in sexual aversion. Negative opinions and attitudes regarding sex that originated during sexual development can also influence sexual functioning.

Mood and cognitions It is well known that depression is associated with low sexual interest and sexual response. There is evidence of lower self-esteem and higher rates of mood problems in women with low sexual desire compared with women without desire problems (Hartmann, Heiser, Ruffer-Hesse, & Kloth, 2002). In a US study it was found that women who presented with the complaint of low sexual desire had suffered almost three times as many depressive episodes in their lives as women without sexual desire problems (Schreiner-Engel & Schiavi, 1986). In a recent large observational study including 1088 premenopausal women with diagnosed hypoactive sexual desire disorder, in 34% there were current symptoms or a diagnosis of depression; of those, 56% used antidepressant medication. Women with sexual desire disorder and depression reported poorer sexual function compared with women with sexual desire disorder and no depression, and antidepressant use was associated with sexual dysfunction predominantly among women with unresolved symptoms of depression (Clayton *et al.*, 2012).

In questionnaire research, women reported that feeling depressed or anxious decreased their interest in sex (Lykins, Janssen, & Graham, 2006), while in laboratory studies, it has been confirmed that a depressed mood and negative sexual self-image can have inhibiting effects on subjective sexual arousal (Kuffel & Heiman, 2006; Middleton, Kuffel, & Heiman, 2008; ter Kuile, Vigeveno, & Laan, 2007). Laboratory studies also suggested an inhibiting effect of stress and fear of pain on women's genital and subjective arousal response (Brauer, ter Kuile, Janssen, & Laan, 2007; ter Kuile, Both, & van Uden, 2009), but there are also indications of a potentially facilitating effect of fear on the sexual arousal response (Palace & Gorzalka, 1990). The exact cognitive, affective, or physiological processes through which depression and anxiety influence sexual response are as yet unknown.

In the model developed by Barlow (1986), fear of failure in a sexual situation leads to a focus of attention on negative non-sexual stimuli instead of on sexual stimuli, which prevents

the progress of the arousal response. Thoughts related to fear of failure can include thoughts that the partner will be disappointed because the woman's arousal response does not occur fast enough, or thoughts that the partner will perceive the woman's body as unattractive. The degree to which a woman feels physically and sexually attractive is related to sexual self-confidence and sexual functioning (Dove & Wiederman, 2000; Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012). Cognitive distraction during the processing of sexual stimuli leads to weaker sexual arousal in women with and without sexual problems (Salemink & van Lankveld, 2006). On the basis of their clinical experience with sexual problems, Masters and Johnson described that "spectatoring" (i.e., when a person observes and judges him/herself from a third-person perspective during sexual activity) inhibits the sexual response (Masters & Johnson, 1970). Laboratory research showed that, in women without sexual problems, a so-called "hot focus" (i.e., the woman immerses herself as much as possible in the sexual situation and focuses her attention on her emotional and physical reactions) enhances feelings of sexual arousal (Both, Laan, & Everaerd, 2011). In addition, it appears that expectations influence feelings of sexual arousal: Women with and without sexual arousal problems experienced greater sexual arousal when they received positive feedback about their physical arousal response (McCall & Meston, 2007).

Relational context In women, there is a strong correlation between sexual desire and relational satisfaction. A large European study found that women with low sexual desire were significantly less satisfied with their sexual relationship and their relationship in general than women without desire problems (Dennerstein, Hayes, Sand, & Lehert, 2009). It is not possible on the basis of these data to determine whether low desire is a cause or a consequence of relational dissatisfaction, but particularly in women, sexual desire seems to be sensitive to the interpersonal aspects of the relationship (Impett & Peplau, 2003). Research into sexual desire in heterosexual relationships has found that people who more strongly pursued depth and pleasure in the relationship showed stronger and more consistent sexual desire (Impett, Strachman, Finkel, & Gable, 2008). In addition, on days with more positive relational interactions, there was more sexual contact. Thus, the dynamics in the relationship play an important role in the sexual motivation of women.

The way that people deal with differences in sexual desire within relationships is also influenced by norms and values related to sexuality and relationships. Whereas in the past sex was often viewed as a marital duty, nowadays it seems to be the norm that both partners have to be willing before there is any sexual contact. This norm, although an improvement over obligatory marital sex, can have an unintended inhibiting effect because desire is especially likely to originate during sexual interaction (Everaerd & Laan, 1995).

Interestingly, recent research on sexual desire in long-term relationships shows that individuals who are motivated to meet their partner's sexual needs (high in *sexual communal strength*) experience higher levels of sexual desire (Muise, Impett, Kogan, & Desmarais, 2013). In a daily experience study of long-term couples, individuals higher in sexual communal strength reported higher levels of daily sexual desire, and reported engagement in sex because meeting the sexual needs of their partner is satisfying for themselves. Importantly, however, *unmitigated sexual communion* (an exclusive focus on partner's need as opposed to own needs) was associated with negative feelings and lower sexual desire in both partners (Muise & Impett, 2014). Approach goals such as experiencing pleasure yourself or giving pleasure to your partner, as opposed to avoidance goals such as to avert own stress or a partner's disappointment or anger, are associated with heightened sexual desire (Impett *et al.*, 2008). These observations indicate that having sex to avoid negative consequences is not a fruitful approach to maintain sexual desire, while being motivated for sex to meet a partner's sexual needs can help keep the desire of both partners alive in relationships.

Assessment of Desire and Arousal Problems in Women

Initial interview

Owing to the fact that sexual functioning in women is strongly influenced by the relational context, as part of the assessment process, it is of great importance to talk to both the woman and her partner in order to map the problems of low desire and arousability; preferably, the couple should be seen together. It is worthwhile asking specific questions about situations or stimuli that could elicit sexual interest and arousal in the past. Subsequently, attention can be focused on the degree to which these situations or stimuli are lacking in present life and on whether the woman does not seek the situations or stimuli or perhaps even actively avoids them because they are not (or are no longer) acceptable or pleasant to her or her partner. For example, is the woman avoiding any intimate physical contact because she is afraid that the partner will then expect her to have intercourse that she does not desire? Is there hardly any time for emotional and physical intimacy due to lack of privacy or overfull agendas? Does the woman feel physically unattractive? In addition, it is important to ask the woman how she experienced sexual activity in the past and, if still sexually active, at the present time. Sexual interest can only be elicited when there are expectations of reward. To what degree and in what way was or is sex with the partner (and masturbation) a positive and rewarding experience and/or a negative and disappointing experience? Did the woman experience sexual violence in the past, which may have resulted in negative associations with sex? Specific attention should also be paid to relational satisfaction and the woman's feelings for her partner. For example, does she still find her partner attractive? Are there any problems in other relational areas that are influencing the woman's feelings for her partner?

With respect to sexual arousability, it is worthwhile enquiring about the subjective as well as the genital components of the sexual arousal response. To what extent now and in the past does/did the woman experience feelings of sexual arousal in sexual situations (e.g., during masturbation, intimate kissing, having her genitals stroked, stroking her partner)? To what extent does the woman become lubricated during sexual stimulation? In order to evaluate the extent to which sexual stimulation is adequate, it is important to establish what the couple or the woman actually does during sex or masturbation. Furthermore, there should be evaluation of whether there are feelings or thoughts that seem to stimulate arousal or, in contrast, hinder the process.

When there are indications that somatic or psychiatric disorders may (partly) form the background of the sexual problems, the woman can be referred for further medical or psychiatric tests. Obviously, the health professional must be alert to a possible depressive disorder. When somatic or psychiatric factors are involved, it should be considered whether their treatment needs to take priority. If there are other dominant problems, such as a depressive disorder, post-traumatic stress disorder, or serious relational problems, these should be dealt with first. If necessary, this can be followed by sex therapy to help the couple to reintegrate sexuality into their sexual relationship or to learn to cope with the existing limitations. If the woman is taking medication that can have a negative influence on the sexual response, the treating physician can be contacted to decide whether the medication can be adjusted.

Further diagnostic tools: questionnaires, physical examination, and/or laboratory tests

Information from the interview can be extended using questionnaires that measure sexual function, psychological problems, and relationship satisfaction. Suitable questionnaires are, for example, the Female Sexual Function Index (FSFI) (Rosen *et al.*, 2000) to measure problems

in the domain of sexual desire, arousal, pain, and orgasm; the Golombok Rust Inventory of Sexual Satisfaction (GRISS) (Rust & Golombok, 1986) to measure sexual dissatisfaction and problems in heterosexual women and men; the Symptom Checklist 90-R (SCL-90) (Derogatis, Lipman, & Covi, 1973) to measure psychological problems and symptoms of psychopathology; the Trauma Screening Questionnaire (TSQ) (Brewin *et al.*, 2002) for screening for post-traumatic stress symptoms; the Beck Depression Inventory (BDI-II) (Beck, Steer, & Brown, 1996) for screening for symptoms of depression; and the Maudsley Marital Questionnaire (MMQ) (Arrindell & Schaap, 1985) to measure relational functioning. To diagnose sexual interest/arousal disorder, standard physical examination and/or laboratory tests are not indicated. However, if there are comorbid complaints of sexual pain or, in older women, complaints of vaginal dryness that might indicate oestrogen deficiency, it is worthwhile taking a combined approach that comprises targeted psychological and physical examination. When an androgen deficiency is suspected, laboratory testing can be considered, although there is ongoing debate about the reliability and value of testosterone analysis in women.

Treatment Options

The incentive motivation model implies that sexual interest/arousal problems can be the result of decreased arousability of the sexual system, a lack of stimuli, and the presence of cognitive and affective processes that disrupt the onset of the arousal response. In the majority of women that seek help for complaints of low interest/arousal, the problems are not associated with hormonal disorders or specific somatic disorders; the women are mostly physically healthy. In these women, sexual interest/arousal problems, therefore, seem chiefly associated with inadequate erotic stimulation in everyday life or with negative evaluations of the sexual and relational context, which lead to inhibition of arousal and sexual desire. This implies that treatment should mainly be aimed at helping the woman and her partner to employ (new) sexual stimuli that can lead to arousal, strengthen the rewarding value of sex by promoting pleasant sexual feelings, decrease any negative feelings, and optimize communication and intimacy within the relationship.

Psychological treatment

Here, we describe psychological treatments for sexual interest/arousal disorder whose effectiveness is empirically supported: sex therapy and cognitive-behavioral therapy. It should be noted that very little effectiveness research has been conducted and that, therefore, very little can be said with any certainty about the effectiveness of various techniques and procedures (ter Kuile, Both, & van Lankveld, 2009). Effective treatments seem to have a broader approach, treat the couple instead of the woman alone, and apply techniques that not only focus on sexual interest, but also on improving arousal, orgasm, and sexual satisfaction. In case of sexual arousal problems, often extra attention is given to masturbation exercises, with the aim of teaching the woman and the couple step by step how to achieve adequate erotic stimulation (Laan *et al.*, 2005).

Classical sex therapy comprises sex education, a coitus prohibition, and subsequently a number of successive sensate focus exercises (Masters & Johnson, 1970; see also Avery-Clark & Weiner, this volume). These exercises allow the couple to start from scratch in building positive sexual experiences. During the sensate focus exercises, the partners take turns caressing each other. The active partner tries to give his or her partner sensory pleasure, and the receiving partner tries to relax and to focus on his or her feelings and bodily sensations. The touching exercises are hierarchically constructed, starting with whole body sensual touching excluding the genitals and breasts, followed by whole body touching including sexual

areas. Initially, sexual arousal is not the goal; when sexual arousal occurs, stimulation is paused until arousal subsides. Later on, sexual arousal and intercourse are introduced. At each step, the couple is encouraged to give each other feedback about the more or less enjoyable aspects of touching and stimulation. Important elements in these exercises are to combat spectator behavior, to decrease performance-targeted behavior, and to deal with the problematic cognitions and expectations that lie at the core of arousal problems.

Over the years, other therapists have extended this Masters and Johnson approach with various sex therapy, cognitive therapy, and partner-relationship therapy interventions (Hurlbert, 1993; Hurlbert, White, Powell, & Apt, 1993; Trudel, Marchand, & Ravart, 2001). Additional sex therapy interventions include exercises that encourage the identification of stimuli that may elicit sexual feelings; exercises that can help the woman to reach arousal and orgasm, such as masturbation exercises (Both & Laan, 2009); and coital techniques that allow for optimal clitoral stimulation (Hurlbert *et al.*, 1993). Cognitive restructuring aims at altering thoughts that can block sexual desire and arousal, for instance cognitions based on negative self-esteem ("I am unattractive"; "I am a rubbish partner because I don't feel like having sex"), restrictive cognitions with regard to intimate physical or sexual initiative ("If I kiss him, it will have to lead to intercourse"), and negative expectations about one's own sexual response ("I never become turned on quickly enough anyway"). In addition, attention can be paid to partner-therapeutic interventions to promote positive intimate experiences, to improve communication, to deal with negative emotions, and to negotiate wishes and desires. Communication exercises can be more general or specifically aimed at communication about sexuality.

Pharmacological treatment

When it is probable that hormone deficiencies are contributing to low sexual interest/arousal (e.g., for women with sudden problems following menopause or medical intervention), psychological treatment can be supported by supplementary hormonal treatment. The most common treatment for typical menopausal complaints and vaginal atrophy is systemic or local oestrogen suppletion; in women whose uterus is intact, this is combined with a progesterone preparation. This treatment, however, can unintentionally lower sexual arousability as exogenous oestrogens reduce the biologically available testosterone fraction by increasing SHBG (Simon, 2002). Tibolon (brand name Livial) is a pharmaceutical with oestrogenic, progestogenic, as well as androgenic characteristics that is registered for hormone suppletion therapy in postmenopausal women with oestrogen deficiency complaints. A combination of an oestrogen and testosterone seems to have a more positive effect on various aspects of sexual functioning and psychological wellbeing than oestrogen therapy alone (Alexander *et al.*, 2006; Laan, van Lunsen, & Everaerd, 2001; Nijland *et al.*, 2008).

In 2005, in Europe, a transdermal form of testosterone ("the testosterone patch," brand name Intrinsa) became available for women with bilateral oophorectomy plus hysterectomy who were also receiving oestrogens (Braunstein *et al.*, 2005). Because no data were available on the safety of long-term use of this testosterone patch, it was advised that the patches should only be initiated by a specialist, and regular evaluations of its effectiveness and safety were recommended. As noted before, there is extensive literature on the use of the testosterone patch in surgically postmenopausal women. However, in other groups of women who can be expected to have androgen deficiencies, such as women with premature ovarian failure or women with iatrogenic menopause due to radiotherapy or chemotherapy, the effect of the testosterone patch has not yet been studied. Women who have undergone bilateral oophorectomy to reduce the risk of breast cancer are not yet eligible for hormone suppletion, because knowledge is lacking on the long-term effects of the hormones on hormone-sensitive breast tissue. In 2012 the testosterone patch was, for commercial reasons, removed from the European market.

Recently, after previous denial, the American Food and Drug Administration (FDA) approved flibanserin (brand name Addyi) for the treatment of low sexual desire in premenopausal women. Flibanserin has mixed effects on the serotonergic and dopaminergic neurotransmitter systems, was initially developed as an antidepressant, and was later tested for prosexual effects. In a number of large trials including women with the diagnosis of hypoactive sexual desire disorder, it was observed that the use of flibanserin resulted in a significantly larger increase in monthly number of so-called "satisfying sexual events" compared with placebo (Derogatis *et al.*, 2012; Katz *et al.*, 2013; Thorp *et al.*, 2012). Although statistically significant, the effects of flibanserin are small; across the Phase 3 studies, an increase relative to placebo of 1 to 1.5 satisfying sexual events a month was observed. Therefore the clinical significance may be doubted. Also, it is a drug that has to be used daily and that has side-effects, such as dizziness, sleepiness, nausea, fatigue, insomnia, and dry mouth. The effects of long-term use are unknown. Based on the limited prosexual effect, the side-effects, and the lack of data on safety with long-term use, there has been a vehement discussion about the approval of the drug (Basson, Driscoll, & Correia, 2015).

Animal research has shown that the phosphodiesterase type 5 (PDE-5) inhibitors sildenafil (brand names Viagra and Revatio among others) and vardenafil (Levitra and Staxyn among others) appear to increase vaginal and clitoral blood circulation. In women without sexual problems, sildenafil also increased vaginal engorgement during erotic stimulation; however, feelings of sexual arousal were not intensified by the drug (Laan *et al.*, 2002). Sildenafil was found to have positive effects on feelings of sexual arousal and orgasm in a few studies of women with sexual problems (Basson, McInnes, Smith, Hodgson, & Koppiker, 2002; Berman, Berman, Toler, Gill, & Haughie, 2003; Caruso, Intelisano, Farina, Di, & Agnello, 2003; Caruso, Intelisano, Lupo, & Agnello, 2001), whereas in other, mostly unpublished studies, no effects were observed (Basson *et al.*, 2002). Studies in women with physical disorders (Caruso *et al.*, 2006; Sipski, Rosen, Alexander, & Hamer, 2000) and one study in women with sexual side-effects from antidepressants (Nurnberg *et al.*, 2008) showed that sildenafil could have positive effects in specific patient groups.

Recently, there have been indications that on-demand use of a combination of testosterone and vardenafil can have positive effects on the sexual arousal response in women with low sensitivity to sexual cues (van der Made *et al.*, 2009), while on-demand use of a combination of testosterone with a serotonin receptor agonist—which is thought to decrease sexual inhibition—can have positive effects in women more inclined to sexual inhibition (van Rooij *et al.*, 2013). A major advantage of the on-demand treatment is that it addresses the potential safety concerns of prolonged use of androgens in women.

In the future, it is probable that pharmacological treatment for women with sexual problems will reach the market. However, it should be emphasized that pharmacological facilitation of sexual interest and arousal will only be successful when the treatment also focuses on psychological and relational factors. When a woman has predominantly negative or very little rewarding sexual experience, there will be very few stimuli that can elicit feelings of interest and arousal. Furthermore, in a chiefly negative relational context, a woman may be reluctant to respond to sexual stimulation. Under these circumstances, stimulation of sexual arousability with medication cannot be expected to have much positive effect. Therefore it is strongly recommended to treat the couple rather than only the woman in the case of low sexual interest/arousal, and to embed medical-pharmacological interventions in partner relationship therapy, sex therapy, and cognitive interventions.

Case Presentation

The following case history illustrates treatment issues and possible strategies in treating women with sexual interest/arousal disorder.

Assessment

Miriam, age 40, was referred by the family doctor because of a lack of sexual desire. She had lived with Leo, age 42, for 11 years. Miriam reported that she did not experience any sexual interest anymore. In the first years of the relationship, they both experienced sexual desire, and there was satisfying sex on a regular basis. However, since they had decided to have children, their sexual relationship had changed. It took some time for Miriam to get pregnant, and during that time there was an increasing focus on having sex in fertile periods and not for pleasure. At the time of assessment, they had two children, ages 2 and 5, and their relationship was good. However, Miriam did not have sexual feelings anymore, and for the prior two years she had not felt like having sex at all. She also stopped self-stimulation, something she used to do on occasion. Actually, sex had become something negative and stressful. Sex on television, for example, elicited negative feelings, which made her quickly change the TV station. Two months before their initial visit, Leo told Miriam that he felt increasingly unhappy because he felt strongly rejected when Miriam did not respond when he tried to initiate sexual contact. They talked about the decrease in Miriam's sexual interest and tried to be understanding toward each other. They decided to seek help, and while awaiting their first appointment, there was no sexual contact at all. The prior 2 years they had had sex approximately once a month. Sexual contact was brief and "detached". It mainly involved coitus, and Miriam did not experience much pleasure or satisfaction from it. She reported that for the prior couple of years it had been hard to become sexually excited, although her body still reacted with vaginal lubrication and there was no pain. Leo was happy whenever there was sex, but he too experienced sex as not very passionate or satisfying.

Miriam reported that she felt physically unattractive since her pregnancies; she considered herself too fat, and she undressed with the lights off. She stated that she had always thought that sexual life would end with the start of motherhood. Miriam and Leo both had full-time jobs, as financial specialists, and in their free time they were busy with the care of their two young children. Miriam reported that, despite her very busy schedule, she functioned well generally, and her mood was good. After the birth of their first child, she had an episode of depression and used antidepressants for six months. Depressed mood was not an issue at the time of assessment. Miriam hoped that treatment would bring back her interest and joy in sex. Leo hoped that making love would be more erotic and passionate and emphasized that the quality of sex was more important to him than the frequency.

After the first visit, both members of the couple completed questionnaires on sexual functioning, relational functioning, depression, and other psychological complaints. The scores indicated sexual desire and arousal problems in Miriam and dissatisfaction about sex in both. No other relevant complaints were reported. During the second visit, Miriam and Leo reported that they felt better and that having expressed their troubles gave them much relief. The findings from the first session and the questionnaires were summarized. It was explained that a cognitive-behavioral sex therapeutic approach seemed most suitable for the sexual interest/arousal problems in the relationship. It was explained that individual sessions would focus on Miriam's negative body image and on her negative thoughts and expectations regarding sex, and these individual sessions would be combined with couple sessions focused on stepwise rebuilding of the sexual relationship, with an emphasis on interventions to increase sexual pleasure for both. It was stated that this would require more time for the two of them in their busy schedules, and it was recommended that they start by looking for some more time together for pleasurable nonsexual activities.

Description of therapy

During the first session, Miriam reported that they had started to go out for dinner regularly and that they both enjoyed that greatly. Miriam started with weekly homework assignments that required her to take baths or showers with a mindful focus on bodily sensations and to look at herself while naked in front of a mirror. She was asked to indicate which bodyparts she felt positive about, and which parts she had more negative feelings towards. Later, these exercises were expanded to

individual sensate focus exercises in which she was asked to touch her naked body and into exploration of erotic stimuli, such as gentle touching of her genitals and exploring erotic novels and female-oriented websites with erotic stories and films.

During this first period of treatment, Miriam started to feel more positive about her body. It appeared that being thin had always been very important to her, and that in the past, there had been a period during which she was too thin because she was extremely focused on her body and ate very little. Over the years, she learned to to eat enough, and she maintained a normal weight. There was, however, still a tendency to see herself as too fat. The mirror exercises helped her to accept the more "negative" body parts, and to pay more attention to the parts of her body about which she felt happy. She started to buy nice lingerie for herself and to wear high heels again, which gave her a sexy feeling. Also, she began to participate in sports again, something she had stopped after the birth of her children. We discussed her thoughts about being a mother and about getting older and whether that was associated with being less sexual. She was inspired by a movie she saw on televison about older people in Cuba who looked very sensual and were open and happy about their still-active sexual lives. She felt sexually excited by reading erotic stories, and she started to self-stimulate again. She also noticed sexual attention from an attractive collegue, which gave her a very sensual feeling and resulted in fantasies about sex with him. During the summer holiday, in which she felt more relaxed and sensual, she had very pleasurable sex with Leo. However, she also noticed that after this holiday, when their full schedules with work and children started again, there was less pleasurable contact within the relationship. She discussed this with Leo, and they made efforts to create more time for the two of them. Miriam reported that she experienced a positive change; sex was not a stressful or negative issue anymore, and she was able to become receptive to sexual contact. The couple had pleasurable sexual contact two times, one time on her initiative. Miriam indicated that she was happy with these changes, although she thought that Leo would like to have sex a bit more frequently. It was decided to begin couple sessions.

The break between Miriam's last individual session and Miriam and Leo's first visit together was longer than is typical or ideal. Miriam reported that she felt that they were almost back to where had they started. Leo expressed that he had noticed a positive change in that Miriam seemed to feel better about herself, but that regarding the sexual relationship, things had not changed much for him. Sexual contact was more satisfying but, in his view, still rather infrequent. Miriam agreed and expressed that she still felt uncomfortable initiating lovemaking, although she did feel more sexual than before. We discussed the possibility of starting stepwise couple sensate focus exercises. It was agreed that they would start with nongenital touching, and that both would take turns in initiating these touching exercises. In the next session, both were very satified with the exercise. The nongenital touching had been highly pleasurable for both. Miriam mentioned that she noticed she felt much more comfortable about being naked, even when the light was on. Apart from the touching exercises, they had had sexual contact that was experienced as pleasurable by both. Miriam initiated this contact a couple of times. They took more time than usual, and it was more passionate. Together they resolved to plan touching moments in their weekly schedule and to include the genitals in touching. The next session they admitted that they didn't do the exercises, but they made love several times. Leo said that lovemaking was much more intense and satisfying for him. Miriam added that she was able to get aroused and enjoy lovemaking too, but that she still felt a bit inhibited at times. It appeared that she became distracted by concerns about the children waking and entering the room and by concerns about failing to become sexually aroused. We discussed the effects of these thoughts and what kind of thoughts would be more helpful for her at such moments. The couple left the session with homework to each think of erotic activities they strongly enjoy, erotic activities they know they do not like, and activities they might like but never tried. They were asked to share these with each other, to talk about differences and similarities in their responses, and to think of activities they might try to further increase sexual pleasure together. This exercise was fun for the couple, and it also allowed Leo to express that he noticed some reluctance in Miriam to receive oral sex. They talked about the reason why (i.e., her fear of smelling unpleasantly) and how

to cope with this. At follow-up three months later, they reported that they both experienced sex as pleasurable but that deliberate creation of high-quality moments for intimacy and sex would remain important to keep their sexual relationship alive.

Discussion of the case

The fact that Miriam had previously enjoyed sex and the commitment of both members of the couple to do whatever work was necessary to achieve change may have contributed to the restoration of Miriam's sexual interest and pleasure. The sexual interest and arousal problems seemed associated with the temporary focus on sex for pregnancy rather than pleasure, Miriam's negative body image and fear of losing sensuality and attractiveness after pregnancy, and the depression and use of antidepressants in the period after the birth of their first child. The increased emotional intimacy in the relationship and the development of a more positive and sensual body image may have helped Miriam and Leo to regain passion in their sexual relationship.

State of the Art

According to recent views, the origination of sexual interest is the result of an interplay between a sensitive sexual response system and stimuli that activate the system. It therefore follows from this notion that sexual interest does not precede arousal, but is a consequence of arousal, or may be felt as a simultaneous occurrence. Research into the exact roles of biological, psychological and relational factors in sexual interest and arousal is still limited. At present, rather too much attention is being paid to possible pharmacological treatments for low interest/arousal problems at the expense of research on psychological and relational treatments. Because desire and arousal seem to be strongly associated with psychological and relational factors in women, further research into these factors is urgently needed. Empirical evidence for the effectiveness of psychological treatments for arousal problems and low sexual interest in women is scarce. A cognitive-behavioral therapy approach with explicit attention to the relational context and focus on improving sexual arousal and satisfaction appears to be successful. However, knowledge is still lacking about which treatment elements need to be included to bring about changes.

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3

Treating Low Sexual Desire in Men

Stanley E. Althof and Rachel B. Needle

Introduction

The clinical phenomenon of low sexual desire in men is subsumed under several different psychological, medical, and socially-defined nosological entities, including: hypoactive sexual desire disorder (HSDD), androgen deficiency syndrome, low sexual desire/interest, asexuality, inhibited sexual desire, and low sexual drive. Although some of these diagnostic and social categories may have overlapping characteristics or symptomatology, their etiologies, assessment, and treatment are different (Maurice, 2006). We will use the term low sexual desire to refer to men with a lack of interest in thinking about sex or being sexual by themselves or with a partner. Lack of sexual interest might be a lifelong phenomenon or acquired after a period of normal function. It can occur in all sexual interactions or be specific to a particular partner. Men with low sexual desire are likely to be avoidant of engaging in sexual activity and are often distressed by their lack of sexual interest, as well as by the impact of their low desire on their partner and relationship. This chapter will focus on the assessment and treatment of low sexual desire in men. We will include case vignettes to highlight specific assessment and treatment issues.

Prevalence

It is difficult to determine precise prevalence rates of low sexual desire in men for several reasons, including failure to clearly and consistently operationalize the term "low sexual desire", a tendency for professionals to misdiagnose other conditions as low sexual desire (e.g., incorrectly diagnosing erectile dysfunction as low desire), and a tendency for men to underreport low desire. In considering the prevalence of low sexual desire, especially self-reported low desire, one must recognize that the body of research encompasses several of the clinical and social entities listed in the introduction section. As of 2009, the prevalence of men who self-reported a lack of sexual interest was approximately 18% (with 9% reporting occasional problems, 5% reporting periodic problems, and 4% reporting frequent problems), compared with 33% of women (Laumann, Glasser, Neves, Moreira, & GSSAB Investigators' Group, 2009). Thus, although low sexual desire is less common in men than women, it is still a concern for a substantial group of men. Lack of sexual desire in men is sometimes a consequence of other sexual problems, such as erection or ejaculatory disorders; may be comorbid with other sexual dysfunctions; or may exist by itself (Laumann, Paik, & Rosen, 1999).

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

Defining Low Sexual Desire

According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013), male hypoactive sexual desire disorder (HSDD) is a sexual dysfunction that is characterized by deficient or absent thoughts or fantasies about and desire for sexual activity. To meet criteria for an HSDD diagnosis, these symptoms must have been present for a minimum of six months, must cause clinically significant distress in the individual, and cannot be better explained by another disorder or as a consequence of severe relationship distress or other stressors.

DSM-5 also instructs the clinician to specify whether the HSDD is: (1) lifelong (since the individual began engaging in sexual activity) or acquired (came about after a period of normal sexual function); (2) generalized (occurs in all sexual experiences and is not limited to certain types of stimulation, situations, or partners) or situational (occurs during certain sexual activities or with a certain sexual partner) and; (3) mild, moderate or severe.

DSM-5 suggests that five factors be considered in assessing male HSDD:

1 partner factors (e.g., partner's sexual problems, partner's health status);
2 relationship factors (e.g., poor communication, discrepancies between partners in desire for sexual activity);
3 individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement);
4 cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and
5 medical factors relevant to prognosis, course, or treatment.

Each of these factors may contribute differently to the presenting symptoms of different men with this disorder (American Psychiatric Association, 2013, p. 441)

Although the DSM-5 diagnostic criteria may seem straightforward, several points require clarification. In the real world, male HSDD rarely exists as a separate clinical phenomenon, and yet the DSM-5 requires that it "not be better explained by a nonsexual mental disorder or as a consequence of severe relationship distress" (American Psychiatric Association, 2013, p. 440). Therefore, men who are depressed and report symptoms of low sexual desire should not be assigned a diagnosis of HSDD. This is confusing because it can be unclear which came first—the depression or the low sexual desire. In other words, did the depression have an impact on desire, or desire on depression? Most likely the effects are bidirectional (Atlantis & Sullivan, 2012). Nonetheless, in clinical practice both issues must be addressed.

John, a married 42-year-old father of two children, had not been sexual with his wife for at least three years. He masturbated once weekly to conventional heterosexual fantasies; however, his lack of interest in his wife caused him to feel badly about himself and resulted in significant relationship discord. Prior to marriage, he frequented sex clubs and reported strong sexual urges but had no romantic interests. Additionally, he characterized himself as having lifelong "melancholia" but had never sought treatment for his sadness. How would you diagnose John's sexual problem?

Similarly, men should not be diagnosed with male HSDD if they have symptomatic androgen deficiency, defined as low total (<300 ng/dL) and free (<5 ng/dL) testosterone plus the presence of low libido, erectile dysfunction, osteoporosis or bone fracture, and/or two or more of following symptoms: sleep disturbance, depressed mood, lethargy, or diminished physical performance (Bhasin *et al.*, 2006). Clinically, not all men with androgen deficiency complain of low desire, and many with adequate levels of testosterone do complain of low desire.

If androgen deficiency is diagnosed, HSDD cannot be diagnosed but the low desire should still be addressed; however, if T levels are normal, the patient may fit the male HSDD criteria.

To further add to the confusion, it would not be surprising for clinicians to encounter symptoms of low sexual desire in a man who reports having a distressed relationship. As with depression, it is essential to understand the genesis of both complaints—recognizing that the relationship between the problems is likely bidirectional—and to develop a treatment plan that addresses both the discord and desire problem. However, according to DSM-5, the sexual problem may not qualify for a diagnosis of male HSDD if it is judged to be secondary to the relationship problem.

Peter, a married 45-year-old, sought treatment for low sexual desire following his discovery of his wife's affair with a professional golfer. Prior to the discovery of texts on her cell phone, he had good sexual desire, no erectile or ejaculatory problems, and believed he was in a good and loving relationship. The couple was seeking conjoint psychotherapy to help them resolve the infidelity and to help Peter recover his sexual interest. Would Peter merit the diagnosis of low sexual desire?

Additionally, asexuality may be confused with low sexual desire. There are those who believe that asexuality and low sexual desire are two separate clinical phenomena, asexuality being non-pathological while HSDD is considered a dysfunction (Bogaert, 2012; Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010). There appears to be significant overlap between asexuality and low desire, and more research is necessary to resolve this important clinical question.

Larry was 50 years old and had been in a platonic asexual relationship for five years. He was divorced after a three-year marriage due to discrepancies in the couple's sexual interest (his was significantly lower than hers). He deeply cared for his new partner but had never had any sexual interest in her. He masturbated to BDSM fantasies but only very rarely, and he was not depressed. His new partner was frustrated and angry at his lack of sexual interest and regularly threatened to end their relationship. Larry believed he was simply asexual rather than having low sexual interest. He was distressed because his partner was distressed. What diagnosis would you give Larry?

Conceptualizing Low Sexual Desire

Stephen Levine (2003) posited that sexual desire consists of three elements: (1) drive, (2) wish, and (3) motivation. In this model, drive is the biological component based on neuroendocrine mechanisms and evidenced by spontaneous sexual interest. Drive is apparent through the man describing sexual thoughts, fantasies, dreams, sensations, or characterizing himself as "feeling horny". The cognitive (or wish) component reflects the man's expectations, beliefs, and values about sex. For instance, men might say, "we *should* have sex twice a week" or "it's our anniversary; we *should* have sex tonight" or "when the kids are in the house, we *shouldn't* have sex." The words "should" or "shouldn't" point the clinician in the direction of a cognitive element. Finally, motivation is the emotional or interpersonal aspect of desire. It reflects the willingness of the man to engage in sexual behavior. It is influenced by the quality of his relationship; psychological functioning; and worries about health, children, and what the psychoanalysts would call the transferential aspects of the relationship. A man with low sexual desire often lacks motivation to seek out sexual activities, is not bothered when there is a lack of opportunity to engage in sexual activities, and is often reluctant if his partner consistently requests that he engage in sexual activities. Motivation is person-specific, thus, drive alone will not overcome the negative aspects of the relationship or mood that reduce motivation. Treatment interventions would target the aspect(s) of desire that are problematic. Recall the case of John who regularly masturbated but had no sexual interest in his wife. It appears that his drive is intact but that his cognitions and motivation may need to be addressed.

In support of the particularly important role of cognitions in the conceptualization of sexual desire (i.e., Levine's "wish" component), research findings from Nobre and colleagues (Carvalho & Nobre, 2011; Nobre & Pinto-Gouveia, 2006) regarding dysfunctional sexual cognitions and beliefs demonstrated that restricted attitudes toward sexual activity (e.g., it is not appropriate to have sexual fantasies during sexual intercourse) were the best predictors of diminished sexual desire in men. Additionally, other cognitions played a significant role in low sexual desire: Both the lack of erotic thoughts during sexual activity and the presence of erection concerns predicted a lack of sexual desire.

Beck (1995) suggested that the term "sexual desire" is too subjective and can be perceived or defined differently from person to person. Specifically, in a survey conducted in 1991, participants reported several ways of judging their own levels of sexual desire including genital arousal, sexual dreams, and frequency of intercourse. (Beck, 1995) Although some participants reported that sexual behavior (e.g., intercourse frequency) was a way to measure sexual desire, this may not be an accurate determination of sexual desire because some men and women still engage in sex without desire or, alternatively, choose not to engage in sexual behavior although they experience desire.

As you can see, much work needs to be done to more clearly define and conceptualize male low sexual desire, especially given that different conceptualizations of low sexual desire encompass multiple different elements, including a lack of biologically-based sexual drive or arousal, negative cognitions and beliefs about sex, lack of motivation for sex, and infrequent sexual behavior. Without clear, evidenced-based definitions, it is difficult to conduct research, as different researchers will employ different definitions and research different populations of men with sexual desire complaints and, not surprisingly, come up with different conclusions.

Assessment

As discussed above, low sexual desire in men can represent a complex amalgam of interrelated biological, psychological, interpersonal, and contextual variables that combine to produce distressing symptoms both for the man and for his partner. Psychosexual evaluation goes beyond traditional psychological assessment to examine the man's or couple's sexual history, current sexual practices, relationship quality and history, emotional health, and contextual factors (e.g., young children, work situations). Each of the aforementioned variables requires careful evaluation.

The biological

Aging, illness, medication, and surgery can affect sexual desire. A thorough history should include questions about health-related problems and medication usage. Most of us are familiar with selective serotonin and serotonin-norepinephrine reuptake inhibitor (SSRI/SNRI) antidepressants causing sexual dysfunction, most notably delayed orgasm, but impacts on sexual desire have been reported as well. Determining the impact of a medication is straightforward. If the patient had good sexual desire prior to starting the medication and noticed a significant change within a few weeks, the clinician should be suspicious about that medication's impact. Discussion with the patient and prescribing physician, a change in medicine, discontinuation, or a dose adjustment may be warranted.

Similarly, surgery that results in sexual dysfunction is likely to have a negative effect on sexual desire. Consider a 50-year-old, married male, who undergoes a radical prostatectomy. Prior to surgery he had no problems with desire, arousal or orgasm. Most likely, post-surgery, he will have erectile dysfunction, which may lead to diminished desire. Counseling the couple regarding medical options for erectile dysfunction and/or options for non-coital sexual behaviors may help to improve the situation for the patient and his partner.

When men complain of having little to no sexual desire under all circumstances (by themselves and with their partner), are in a loving relationship, and have not experienced major changes in their life circumstances, it may be worthwhile to obtain a testosterone level. If the man is sexually symptomatic and has low T, the proper diagnosis would be androgen deficiency, but in addition to testosterone supplementation, these men also may require some psychological intervention to assist with changes in mood, cognition, and relationship concerns.

The psychological

Psychological factors important in the evaluation of low sexual desire include: mood; sexual orientation; unconventional sexual fantasies; sexual secrets; pornography use; religious, cultural, transferential (e.g., she is just like my mother), and childhood factors (e.g., abuse); as well as the meaning to the man of being sexual.

There is a bidirectional relationship between depression and sexual dysfunction generally, and between depression and sexual desire specifically (Atlantis & Sullivan, 2012). Individuals with depression may have problems developing healthy sexual relationships and may experience marital discord or dissatisfaction (American Psychiatric Association, 2000). Conversely, low desire may contribute to relationship distress and low self-esteem, which further exacerbates depression. We recommend that clinicians routinely ask questions about mood, energy, sleep, appetite, outlook on the future, and suicidality, as well as asking about the impact of depression on low desire and the impact of low desire on depression. It is not difficult for patients to understand that their sadness may preclude interest in sex (although that is not always true for all men; Bancroft, 2009), and clearly many men appreciate that their lack of sexual desire may cause them to feel badly—even depressed.

Over the years, we have seen men in established relationships present with complaints of low sexual desire/interest. They are likely to acknowledge regularly masturbating but have little interest in partnered sexual behavior. Some of these men recognize the genesis of the problem, although they may be reluctant to share the secret with their partner or a mental health professional. For example they may no longer be attracted to their partner although they deeply care for him or her; they have become aware of their homosexual attractions but are in a heterosexual relationship; or their fantasies are unconventional (e.g., sadomasochistic), and they believe their partner is not willing to participate in these behaviors. Additionally, there is a subset of men who extensively use pornography and believe that it contributes to lack of desire towards their current partner. We consider these cases clinical dilemmas, which may or may not merit a diagnosis of low sexual desire. These complicated issues require creative solutions and a willingness to address the real underlying issue(s): sexual orientation concerns, narrow sexual fantasy lives, sexual secrets, preference for pornography, boredom or lack of sexual chemistry, extramarital relationships, and a mismatch between partners' wishes regarding the relationship.

We also have seen men whose religious/cultural beliefs inhibit their sexual interest. They have adopted beliefs that sexual desire is bad, that premarital sexual relations are sinful, or that sex for any reason except procreation is not acceptable. The majority of these men recognize the negative impact of such strong religious beliefs but are not able to free themselves of these burdens (see also Turner, this volume). These men are greatly conflicted, and lack of sexual interest is often the end result of these conflicts.

In his youth, Hank, aged 43 when he presented for treatment, was an altar boy in the Catholic church; attended parochial elementary school, high school, and college; and strongly believed in the Church's doctrines and teachings. His first marriage ended in an annulment because, after a few months, he was no longer interested in having sex with his wife. He came to my office complaining of low sexual desire

one year after beginning a new relationship. He rarely masturbated or engaged in intercourse because he believed that both behaviors were sinful. He understood his low desire to be an outgrowth of his religious beliefs but didn't think that marriage would solve the problem. He wanted to feel sexual desire in order to please his girlfriend and maintain the relationship.

Transferential issues, that is, the man projecting feelings belonging to others onto his partner, can also result in a man's loss of sexual desire towards his partner. Some men report losing sexual interest in their partner after she becomes pregnant or bears his children. Such men often believe that sex with their beloved contaminates her, or that sex is only for scandalous women—a set of beliefs often labeled as the Madonna-Whore Complex (Hartmann, 2009). These men often recognize their transferential responses, report sexual interest in others, and masturbate but avoid sex with their partner. A variation on this theme is observed in men who fear that intercourse with their pregnant partner will damage the fetus. These themes are not necessarily unconscious, and men often speak of knowing that their thinking is flawed and yet not being able to regain sexual interest towards their partner.

Men with a history of childhood sexual abuse also may report diminished sexual interest (Becker, 1989). They may not have been successful at separating what was done to them from being sexual with others. This is puzzling and disappointing for their partners and often has negative consequences for their relationship.

In the evaluation of men's sexual desire complaints, clinicians should look into the aforementioned psychological concerns with direct and empathic questioning. Often inviting the man's partner to an individual meeting sheds light on the issues surrounding his loss of desire and alerts the clinician to his/her concerns as well.

The interpersonal

When a man presents with "low desire", it is crucial to determine whether there is actually low sexual desire, a discrepancy in desire between partners, or an unwillingness to make love to his partner even though he has desire for other sexual outlets. Desire discrepancy does not necessarily mean that the partner with less sexual desire is dysfunctional; but rather that his partner may simply want to engage in sexual activity more often than he does.

Relationship issues can result in a man's loss of sexual desire. These issues include, but are not limited to, resentment towards his partner, lack of or loss of sexual chemistry with his partner, an affair, looking at his partner differently after having children, or requiring the partner to fulfill specific sexual needs that he/she is not fulfilling (McCarthy & McDonald, 2009). This information is important in determining the origin of low sexual desire and providing a holistic context for a patient's sexual functioning.

Contextual issues also may precipitate sexual desire problems. For example, financial hardship or losing a job may wound the man's sense of masculinity or self-esteem, resulting in loss of sexual interest. Stresses such as worries about ill parents and children may also diminish sexual interest. Finally, culture and values may play a role in levels of sexual desire, for example, by creating expectations that men should always desire sex or that men should only desire sex under certain circumstances (e.g., for the purposes of having children).

Treatment Options for Low Sexual Desire

Psychotherapy outcome studies for men with low sexual desire are scarce. In fact, there are no placebo-controlled, randomized outcome trials for psychotherapeutic interventions; yet, there are many evidenced-based studies of men with androgen deficiency who receive testosterone (T) replacement.

In their standard of care document for men with low sexual desire, Rubio-Aurioles and Bivalacqua (2013) recommended that the etiology should direct treatment decisions. We agree with their directive and suggest that clinicians utilize a biopsychosocial model to identify all the possible biological, psychological, interpersonal, and contextual factors that precipitate and maintain the man's low sexual desire. Next, the clinician—in partnership with the patient—decides in which order these factors should be addressed and develops a treatment plan, which might include biological, psychological, or combined treatments.

As discussed above, specific organic etiologies that can result in low sexual desire in men include androgen deficiency, antidepressant medications, and other endocrine disorders (e.g., hyperprolactinemia, hypothyroidism). Beginning T supplementation, switching to an antidepressant that has fewer sexual side-effects (i.e. bupropion, venlaxafine, or duloxetine), or "normalization" of the sexual effects of the endocrine disorder, may result in improved sexual desire.

Similarly, if the assessment points to relationship discord as a major etiological factor, couples therapy may be necessary in order to address the specific issues that may cause or maintain the man's low sexual desire.

If more psychological in etiology, sex therapy or traditional psychotherapy is the intervention of choice. Sex therapy is a specialized form of psychotherapy that draws on an array of technical interventions known to be effective in treating male and female sexual dysfunction (Althof, 2010). Sexual therapy techniques include behavioral/cognitive, psychodynamic, systems, relationship, and educational interventions. Treatment generally follows the principles of short-term psychotherapy, with the therapist and patient focusing on specific issues in an individual, couples, or group format.

Traditional psychotherapeutic techniques include support, interpretation, confrontation, cognitive reframing, and homework. Other components include affectual awareness that strives for recognition of positive and negative emotions related to sexual interaction and desire; reframing cognitive factors and distracting thoughts (e.g., "She will be angry with me because I don't want to make love tonight"); offering insight and understanding to the genesis of the problem; and finally behavioral interventions, in which a number of strategies (e.g., sensate focus) are utilized to gradually overcome obstacles to sexual interaction (Carvalho & Nobre, 2011; Montgomery, 2008). Additionally, McCarthy and McDonald (2009) recommended supplementing psychotherapy with a relapse prevention plan so patients will know how to manage missteps and setbacks

Educational interventions, values clarification, or suggestions may be useful in dealing with contextual factors responsible for men's low sexual desire. Restrictive attitudes, lack of privacy, limited accurate sexual knowledge, and poor skills may benefit from non-judgmental discussion of values or skill-building material such as books and literature, videos, illustrations, and anatomical models.

Conclusions

Limited information exists about the definition, prevalence, etiology and treatment of low sexual desire in men. This stands in stark contrast to the significant research and treatment efforts (pharmacologically and psychologically) devoted to low desire in women. The field needs to more clearly operationalize the construct of low sexual desire in men so that we can move forward with designing better assessment measures and treatments for this vexing problem.

Low sexual desire in men is not simply "low T", and by and large, injections, gels, or tablets will not restore men's interest in a sexual life. We need to appreciate the complexity of the problem and acknowledge the distress this dysfunction results in for the man and its impact on his partner and their relationship.

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4

Treating Men's Erectile Problems

Pedro J. Nobre

Overview of Male Erectile Dysfunction

Classification

Male erectile disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013), as a marked difficulty in attaining—or maintaining until completion of sexual activity—an erection or a marked decrease in penile rigidity on all or almost all sexual occasions (criterion A) that persists for a minimum duration of approximately six months (criterion B), causing clinically significant distress in the individual (criterion C). Erectile difficulties may occur across all sexual activities, partners, or stimulation types (generalized type), or may be present only in specific situations (e.g., sexual intercourse vs. masturbation) or with specific partners (e.g., usual sexual partner vs. occasional partner; American Psychiatric Association, 2013, p. 426). In non-generalized erectile dysfunction (situation- or partner-specific), etiology is typically psychological, while the generalized type suggests further enquiry regarding the potential role of organic factors. The disorder is also classified according to the associated levels of distress (i.e., mild, moderate, severe; see Table 4.1).

The DSM-5 classification of sexual disorders, in general, involved some changes in relation to the previous versions of the manual. This occurred following criticism related to the inconsistency of the definitions, lack of objective criteria, and lack of scientific evidence for the sexual dysfunction diagnoses as described in the DSM-IV (American Psychiatric Association, 1994). For example, the new DSM-5 classifications of sexual dysfunctions included a new temporal criterion, with a minimum of six months of persistent or recurrent difficulties as the threshold for assigning a clinical diagnosis. Additionally, severity and frequency of the symptoms were introduced as important markers, with clinical diagnosis being assigned only when the symptoms occur on at least 75% of sexual occasions. Finally, a list of other important factors was suggested for consideration when assigning a sexual dysfunction diagnosis:

1 partner factors (e.g., partner's sexual problems; partner's health status);
2 relationship factors (e.g., poor communication; discrepancies in desire for sexual activity);
3 individual vulnerability factors (e.g., poor body image; history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement);
4 cultural or religious factors (e.g., inhibitions related to prohibitions against sexual activity or pleasure; attitudes toward sexuality); and
5 medical factors relevant to prognosis, course, or treatment (American Psychiatric Association, 2013, p. 423; see also Segraves, 2010a, 2010b, 2010c).

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

Table 4.1 DSM-5 Diagnostic Criteria for Erectile Disorder 302.72 (F52.2; American Psychiatric Association, 2013, pp. 426–427).

A At least one of the three following symptoms must be experienced on almost all or all (approximately 75–100%) occasions of sexual activity:
  1 Marked difficulty in obtaining an erection during sexual activity.
  2 Marked difficulty in maintaining an erection until the completion of sexual activity.
  3 Marked decrease in erectile rigidity.
B The symptoms in Criterion A have persisted for a minimum duration of approximately six months.
C The symptoms in Criterion A cause clinically significant distress in the individual.
D The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:
  Lifelong: The disturbance has been present since the individual became sexually active.
  Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:
  Generalized: Not limited to certain types of stimulation, situations, or partners.
  Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:
  Mild: Evidence of mild distress over the symptoms in Criterion A.
  Moderate: Evidence of moderate distress over the symptoms in Criterion A.
  Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Prevalence and comorbidity

Epidemiological studies worldwide have consistently indicated that sexual difficulties are highly prevalent among men (Christensen *et al.*, 2010; Feldman, Goldstein, Hatzichristou, Krane & McKinlay, 1994; Fugl-Meyer & Sjögren Fugl-Meyer, 1999; Laumann *et al.*, 2005; Laumann, Paik, & Rosen, 1999; Mercer *et al.*, 2003; Mitchell *et al.*, 2013; Quinta-Gomes & Nobre, 2014; Richters, Grulich, de Visser, Smith, & Rissel, 2003). Laumann *et al.*'s (1999) findings suggested that sexual dysfunctions are an important public health concern, with almost a third of men (31%) from a population-based sample of the US reporting at least one significant sexual complaint. Additionally, in a state-of-the-art review, Lewis and colleagues (2004) indicated that 20% to 30% of adult men experienced at least one sexual dysfunction at the time of the study. Moreover, recent findings from the National Survey of Sexual Attitudes and Lifestyles indicated that 41.6% of men in the UK reported at least one sexual problem, with 9.9% experiencing significant distress related to their sex lives (Mitchell *et al.*, 2013).

As for the prevalence of erectile dysfunction, findings from two population-based studies conducted in Australia (Richters *et al.*, 2003) and the UK (Mitchell *et al.*, 2013) have indicated prevalence rates of 9.5% and 12.9%, respectively. However, the prevalence of erectile disorders is strongly associated with age. Lewis *et al.*'s (2004) literature review estimated rates of erectile problems between 1% and 9% in men younger than 40 and between 50–75% in men older than 70. This marked decrease in erectile functioning with age is consistently found in population-based studies (Feldman *et al.*, 1994; Fugl-Meyer & Sjögren Fugl-Meyer, 1999; Hyde *et al.*, 2012; Laumann *et al.*, 1999; Mercer *et al.*, 2003; Richters *et al.*, 2003). Although age is a risk factor for erectile dysfunction, education seems to have a protective effect, with well-educated men presenting lower rates of erectile dysfunction compared with less educated individuals (Feldman *et al.*, 1994; Laumann *et al.*, 1999, 2005), perhaps because increased education is associated with less adherence to problematic sexual myths that may contribute to erectile problems.

Besides epidemiological studies, findings regarding the prevalence of sexual dysfunction in clinical settings (e.g., sex therapy clinics) have consistently indicated that erectile dysfunction is

by far the most frequent complaint among men asking for help in clinical settings (see Simons & Carey, 2001, for a review).

The large majority of epidemiological studies were conducted with heterosexual samples; however, a few studies have looked at prevalence of sexual problems among gay men. In two recent comparison studies, the prevalence rates of erectile problems were not significantly different in samples of heterosexual and gay men (Bancroft, Carnes, Janssen, Goodrich, & Long, 2005; Peixoto & Nobre, 2015).

Erectile dysfunction is also commonly related to other sexual problems, with clinical observations suggesting a strong overlap between erectile difficulties, hypoactive sexual desire, and premature ejaculation (American Psychiatric Association, 2013; Rosen, 2000). Epidemiological studies support clinical observations indicating high correlations between erectile dysfunction and premature ejaculation (Laumann *et al.*, 2005) and between erectile dysfunction and low sexual desire (Fugl-Meyer & Sjögren Fugl-Meyer, 1999). Moreover, erectile dysfunction is also commonly related to other psychological conditions, particularly depression and anxiety disorders (American Psychiatric Association, 2013).

Psychological Models of Erectile Dysfunction

Barlow's cognitive-affective model

David Barlow and colleagues contributed invaluable work on the study of psychological factors underlying sexual dysfunction. Barlow's (1986) model was based on a broad group of studies—mostly conducted in the laboratory—examining the role of cognitive and affective factors in sexual functioning (Bach, Brown, & Barlow, 1999; Barlow, Sakheim, & Beck, 1983; Mitchell, DiBartolo, Brown, & Barlow, 1998; Weisberg, Brown, Wincze, & Barlow, 2001). Barlow's model emphasizes the interaction between autonomic arousal (sympathetic activation) and cognitive interference processes in contributing to sexual dysfunction.

The model is conceptualized as a feedback system, which is positive in the case of sexually healthy individuals and negative in the case of individuals with sexual dysfunction. The negative feedback system is characterized by the existence of an attentional focus oriented to nonrelevant stimuli (i.e., nonsexual stimuli). This problematic focus becomes progressively more efficient as autonomic arousal increases (due to worries about performance), inhibiting sexual arousal. On the other hand, sexually functional individuals have an attentional focus oriented to erotic stimuli and react to the progressive increase of autonomic arousal (determined by that attentional focus) with an increasingly efficient focus on the sexual stimuli, facilitating sexual arousal. Sbrocco and Barlow (1996) and Wiegel, Scepkowski, and Barlow (2007) further refined the original model, conceiving of sexual functioning as the result of self-regulation in a feedback system.

Nobre's cognitive-emotional model

Nobre and colleagues developed and tested conceptual models of sexual dysfunction in men and women (Nobre, 2009, 2010, 2013; Soares & Nobre, 2013). The models are based on cognitive-behavioral theories and supported by evidence-based data. In particular, the model for erectile dysfunction was developed based on systematic research conducted by Nobre and colleagues in the last two decades. The model includes predisposing factors (e.g., personality factors, such as neuroticism; trait-affective vulnerabilities, such as lack of positive affect; and dysfunctional sexual beliefs), processing factors (e.g., problematic cognitive schemas activated in response to negative sexual events), and maintaining factors (e.g., negative automatic thoughts and emotions during sexual activity).

At the predisposing level, findings have shown that general trait variables, such as personality traits and trait-affect, are associated with sexual dysfunctions in men and women. In particular, findings have shown that self-reported neurotic traits are significantly higher in men with sexual dysfunction compared with sexually healthy men (Quinta-Gomes & Nobre, 2011). Regarding trait-affect, higher levels of negative trait-affect, as well as lower levels of positive trait-affect, were found in men and women with sexual problems compared with healthy controls (Oliveira & Nobre, 2013; Peixoto & Nobre, 2012). Taken together, these findings suggest that neurotic traits as well as negative and low positive trait-affect may constitute general predisposing or vulnerability factors for the development of sexual problems. Moreover, findings regarding sexual beliefs have indicated that men with sexual dysfunction tend to report significantly higher scores on the Zilbergeld's (1999) list of sexual myths (e.g., "A man should be able to last all night" and "A man always wants and is ready to have sex"; Baker & de Silva, 1988). Additionally, Nobre and Pinto-Gouveia (2006a) found that men with sexual dysfunction are more likely to report problematic beliefs related to excessive sexual performance demands (e.g., "A real man has sexual intercourse very often" and "Sex without orgasm can't be good") and problematic beliefs about women's sexual satisfaction and their reaction to men's failure (e.g., "The quality of the erection is what most satisfies women" and "A man who doesn't sexually satisfy a woman is a failure"; Nobre & Pinto-Gouveia, 2006a). These demanding and unrealistic sexual beliefs may work as specific predisposing factors, making men more vulnerable to developing sexual difficulties.

Besides predisposing factors, the model also identifies cognitive processing factors, in particular cognitive schemas (ideas about oneself, others, and the future), that are responsible for the meaning assigned to events (Beck, 1967). The process of meaning assignment, in particular to negative sexual events, has been the subject of previous investigation. Studies on attributional style have suggested that men with erectile dysfunction tend to give more internal and stable attributions to negative sexual events compared with sexually healthy men (Scepkowski *et al.*, 2004). Moreover, Nobre and Pinto-Gouveia (2009a) found that men with sexual dysfunction, when exposed to negative sexual events, activated significantly more negative self-schemas compared with individuals without sexual problems. More specifically, men with sexual dysfunction tended to interpret unsuccessful events as a sign of failure and personal incompetence: "I'm incompetent," "I'm weak," "I'm a failure." Nobre (2009, 2010) hypothesized that these negative self-schemas activated by individuals during exposure to sexual situations are strongly linked to the type of sexual beliefs with which they present. Specifically, individuals with dysfunctional sexual beliefs (as described above) would be more vulnerable than other individuals to activating negative self-schemas whenever an unsuccessful sexual event occurs. The negative event would act as a precipitant for the activation of negative self-schemas (mainly self-incompetence schemas), with sexual beliefs and trait factors such as neuroticism and negative trait-affect playing a moderator role.

Finally, the model also includes maintaining factors with particular attention paid to cognitive and emotional responses during sexual activity. Studies on cognitive distraction have consistently shown the negative impact of distraction from erotic cues on sexual response and functioning (Abrahamson, Barlow, Sakheim, Beck, & Athanasiou, 1985; Beck, Barlow, Sakheim, & Abrahamson, 1987; Farkas, Sine, & Evans, 1979). Additionally, studies on the content of automatic thoughts during sexual activity have shown that negative sexual cognitions are associated with increased levels of sexual difficulties (Nelson & Purdon, 2011; Purdon & Holdaway, 2006; Purdon & Watson, 2011). More specifically, studies comparing men with and without sexual dysfunction have indicated that men with dysfunction report significantly more automatic thoughts related to erection difficulties and sexual intercourse failure, and significantly fewer erotic thoughts, compared with men without dysfunction (Nobre & Pinto-Gouveia, 2008). Nobre (2010) hypothesized that these negative automatic thoughts present during sexual activity are the result of the previous activation of negative self-schemas described above, and that they

play an important role as maintaining factors for sexual dysfunction. Regarding the role of emotions as maintaining factors, research has consistently suggested that depressive affect is negatively related to sexual arousal (Mitchell *et al.*, 1998; Nobre *et al.*, 2004). Studies conducted on the content of the emotional response during sexual activity (Nobre & Pinto-Gouveia, 2006b) have indicated that men with sexual dysfunction reported significantly more sadness, disillusionment, and fear, and significantly less pleasure and satisfaction, compared with sexually healthy men. Overall, these data seem to suggest that depressed mood (encompassing lack of pleasure, sadness, disillusionment) is strongly associated with sexual dysfunction. Nobre (2010) hypothesized that this depressed mood during sexual activity is strongly linked with the negative self-schemas activated by individuals with sexual dysfunction, impairing sexual response and playing an important role as a maintaining factor of sexual dysfunction.

Nobre's cognitive-emotional model was tested in terms of its ability to explain erectile dysfunction using a path analysis (Nobre, 2010). Results showed that the most important sexual belief was the "macho" myth. Men with strong beliefs about men's sexual infallibility (represented by the idea that men have high frequency of sexual activity, can satisfy all women, can maintain erections in any circumstance, etc.) are prone to activating cognitive incompetence schemas ("I'm incompetent," "I'm a failure," "I'm weak") when exposed to an unsuccessful sexual experience. Once activated, these incompetence schemas facilitate the development of thoughts focused on sexual performance, namely erectile response ("I must achieve an erection," "my penis is not responding"). Simultaneously, the activation of incompetence schemas—associated with this exclusive focus on the erectile response and on the consequences of an eventual failure—impairs the processing of erotic stimuli, lowering the frequency of sexual thoughts and images and increasing the emotional responses of sadness. This set of thoughts focused on performance and the possible negative consequences of failure, associated with lack of erotic thoughts and depressed mood, negatively interfere with the erectile response (see Figure 4.1).

Review of Research on Treatments for Erectile Dysfunction

Despite the accumulated knowledge of the role of psychological factors on sexual problems, and despite the development of conceptual models with particular emphasis on cognitive and affective processes, the transference of this knowledge to the development of evidence-based treatments for sexual dysfunctions, and particularly for erectile dysfunction, is still scarce. Despite the existence of a few treatment protocols based on cognitive-behavioral principles (Bach, Wincze, & Barlow, 2001; Hawton, 1989; Rosen, Leiblum, & Spector, 1994; Wincze & Carey, 2001), the most commonly used and empirically-validated treatment techniques are still based on Masters and Johnson's sensate focus, systematic desensitization, or other specific behavioral procedures (Heiman, 2002; Heiman & Meston, 1998; see also Avery-Clark & Weiner, this volume, for an overview).

A recent systematic review and meta-analysis of published studies on the efficacy of psychological treatments for sexual problems found 20 randomized controlled studies comparing psychological interventions with wait-list control conditions (Frühauf, Gerger, Schmidt, Munder, & Barth, 2013). Psychological interventions were classified according to seven categories: sexual skills training, sex therapy, cognitive-behavioral therapy (CBT), marital therapy, systematic desensitization, educational intervention, and other psychotherapy. Overall, findings indicated moderate effect sizes for improvements in symptom severity ($d = 0.58$; 95% CI: 0.40 to 0.77) and sexual satisfaction ($d = 0.47$; 95% CI: 0.27 to 0.70), suggesting that psychological interventions in general are effective treatments for sexual dysfunction, in particular hypoactive sexual desire disorders and orgasmic disorders (for which the reduction in symptom severity was most pronounced).

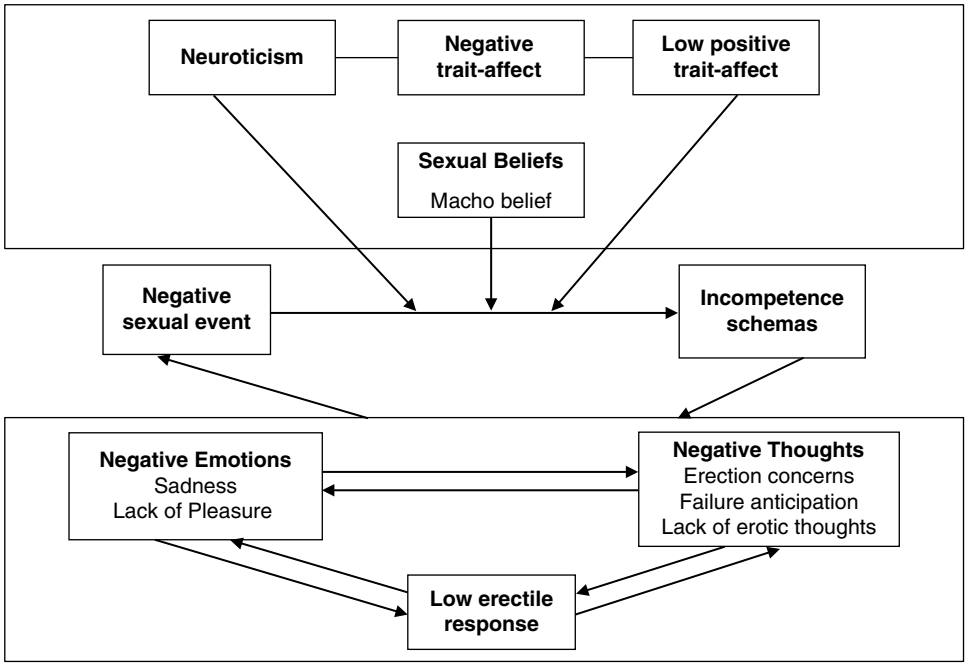

Figure 4.1 Schematic structure of the cognitive-emotional model for erectile dysfunction. Adapted from Soares and Nobre (2013, p. 290). Reproduced with permission of Taylor & Francis.

This meta-analysis included seven direct comparisons between psychological treatments for erectile disorder and wait-list control conditions. Of these seven comparisons, three were based on sex therapy techniques, one on marital therapy, one on educational intervention, and two on other psychotherapies. Findings suggested that overall effect sizes of the treatments for erectile dysfunction included in the meta-analysis were not statistically significant for improvements in symptom severity ($d = 0.53$; 95% CI: −0.08 to 1.14; $p = 0.078$; $n = 7$; $I^2 = 0.0\%$) or sexual satisfaction ($d = 0.38$; 95% CI: −0.17 to 0.94; $p = 0.143$; $n = 7$; $I^2 = 0.0\%$). However, if we look carefully at the effects of different types of treatment on symptom severity, we find a diverse pattern of results. Studies assessing marital therapy and educational therapy showed very small effect sizes ($d = 0.17$; 95% CI: −2.61 to 2.94; and $d = -0.04$; 95% CI: −2.81 to 2.73, respectively). Studies using sex therapy techniques (Masters and Johnson's sensate focus) showed small effect sizes ($d = 0.21$; 95% CI: −0.31 to 0.74, $n = 3$). Finally, studies classified as "other psychotherapies" showed large effect sizes ($d = 0.93$; 95% CI: 0.15 to 1.72, $n = 2$). The two studies included in this category used some form of cognitive-behavioral therapy. Specifically, Munjack *et al.* (1984) compared 12 biweekly sessions (six weeks) of rational emotive therapy (RET) with a wait list control group. Results showed that patients in the RET group reported significantly more sexual intercourse attempts, significantly reduced sexual anxiety, and significantly higher numbers of successful intercourse attempts compared with the wait-list control group. Moreover, McCabe, Price, Piterman, & Lording (2008) compared the effectiveness of an internet-based cognitive-behavioral intervention to a wait-list control group. The results indicated that men in the treatment group reported significantly greater improvements in erectile functioning and sexual relationship satisfaction compared with the control group.

In addition to these studies, the literature review conducted by Frühauf *et al.* (2013) identified two studies comparing a combination of psychological treatment and medication with

medication only for erectile dysfunction. In both studies the psychological treatments were based on cognitive-behavioral approaches, including behavioral (e.g., sensate focus) and cognitive techniques (e.g., cognitive restructuring). Banner and Anderson (2007) compared four weeks of sildenafil plus CBT with sildenafil alone and found that 48% of men in the integrated treatment group met the research criteria for success on erectile function, and 66% for success on sexual satisfaction, compared with 29% and 38%, respectively, for men on sildenafil alone. In a similar study, Aubin, Heiman, Berger, Murallo, and Yung Wen (2009) found post-treatment improvements for both the medication alone and combined treatment (sildenafil plus CBT) groups. However, the combined treatment led to a greater number of improved sexual function and cognition domains for both partners compared with medication alone. Moreover, over time (i.e., in a two-month follow-up), men in the medication-alone group showed decreased sexual function, whereas men in the combined treatment maintained gains in all sexual function domains. Similar findings were also observed in a pilot study conducted by Bach, Barlow, and Wincze (2004), such that a cognitive-behavioral intervention enhanced the benefits of sildenafil, with treatment gains being largely maintained at a four to eight week follow-up and at a four to ten month follow-up.

Taking these findings into consideration, and bearing in mind that CBT has proven to be the most efficacious treatment for a variety of psychological problems (Chambless & Ollendick, 2001) and has been shown to result in long-term effects superior to pharmacological treatments (Craske, Brown, & Barlow, 1991; DeRubeis & Crits-Christoph, 1998; Shapiro *et al.*, 2007), we think that a systematic test of the treatment efficacy of CBT for sexual dysfunction, as well as the study of the underlying mechanisms of change, may play an important role in developing better treatment options for erectile dysfunction.

Besides the more classic cognitive-behavioral interventions, mindfulness-based approaches have been recently used with promising results in the treatment of sexual dysfunctions (see Barker, this volume). Mindfulness-based treatments have shown psychological effectiveness across a wide range of clinical problems, ranging from chronic pain to psychological problems such as generalized anxiety disorder, eating disorders, ruminative thoughts, negative affect, and recurrent depression (e.g., Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004; Shigaki, Glass, & Schopp, 2006).

Mindfulness is broadly defined as the promotion of nonjudgmental attention to and awareness of the unfolding of experience moment-by-moment (Kabat-Zinn, 2003). Shapiro, Carlson, Astin, and Freedman (2006) suggested that the main components of mindfulness are intention (i.e., self-regulation, self-exploration, or self-liberation), attention (i.e., observing one's moment-to-moment experiences), and attitude (i.e., absence of judgment). Taking into consideration that attentional processes during sexual activity are central to sexual response and may facilitate the experience of subjective sexual arousal (Barlow, 1986; De Jong, 2009), there is a clear theoretical background to support the potential benefits of mindfulness-based approaches to sexual dysfunction.

Recent studies have suggested a positive effect of mindfulness on women's sexual health (Brotto, Basson, & Luria, 2008; Brotto & Heiman, 2007). Although these are only preliminary findings and there is still a lack of studies on men with sexual dysfunction, the integration of mindfulness into cognitive-behavioral treatment programs for sexual dysfunction, including erectile dysfunction, is promising.

Cognitive-Behavioral Therapy (CBT) for Erectile Dysfunction

CBT for erectile dysfunction is a treatment package combining cognitive and behavioral procedures (e.g., cognitive restructuring and stimulus control) with sex therapy techniques (e.g., sensate focus exercises and sexual skills training). Most CBT techniques used in the

treatment of sexual disorders are similar to those used for other psychological disorders. Cognitive-behavioral treatment protocols for sexual dysfunction use a common list of intervention techniques. The main components used are: (1) education, (2) sensate focus, (3) stimulus control, (4) sexual skills training, and (5) cognitive restructuring.

Education

Education is an important procedure in altering misinformation about sexuality. Incorrect information and sexual myths are common in individuals with sexual dysfunction, and play an important role in predisposing and maintaining the sexual difficulties. Several books address this issue, listing the most common sexual myths and explaining the underlying misunderstandings behind these myths (e.g., McCarthy, 1998; Wincze & Barlow, 1997; Zilbergeld, 1999). Sexual myths and problematic beliefs about sexuality should be assessed using self-report measures (e.g., Sexual Dysfunctional Beliefs Questionnaire; Nobre, Pinto-Gouveia, & Gomes, 2003) as well as through systematic enquiry during therapy. Some problematic beliefs can be easily challenged after exposure to evidence-based information from the therapist or from reading materials, whereas other are very rigid and need systematic cognitive restructuring in order to be challenged.

Sensate focus

Sensate focus is a technique proposed by Masters and Johnson (1970) that teaches clients a means of reducing their discomfort (e.g., anxiety, negative mood) when approaching a sexual situation, while also allowing a means to focus on sensual touch and remain in-the-moment. Similar to systematic desensitization, this process uses a gradual exposure to sexual activities, starting with non-demanding, non-genital pleasure exercises and continuing with more genital- and intercourse-oriented exercises. The main principle is to help clients focus on sexual enjoyment and pleasure rather than on performance. The idea is to expose clients to gradually more complex and more explicitly sexual exercises while keeping the focus on the physical experience rather than the worry about erections and arousal (see also Avery-Clark & Weiner, this volume).

Stimulus control

Stimulus control is a therapeutic procedure designed to help individuals to associate sexual events with positive and pleasurable situations. Because many clients present with a history of sexual activity in non-intimate and sometimes uncomfortable settings due to lack of time, privacy, and eroticism, it is important to change the usual circumstances in which sex happens to incorporate more intimate, private, and pleasurable stimuli. This technique could also be incorporated into the sensate focus procedure during the preparation of the first step involving non-genital touching. An appropriate environment is essential to create a comfortable and intimate atmosphere to start sensate focus exercises.

Sexual skills training

Most clients present with rigid and limited sexual skills, with typical sexual interactions usually oriented towards performance and goal achievement, focusing on the ability to gain and maintain an erection sufficient enough for intercourse and to achieve orgasm. This primary focus on performance prevents patients from focusing on pleasurable sensations. One strategy for modifying the rigid and limited pattern into more flexible and less restrictive sexual behaviors is to

discuss the ideal sexual situations and behaviors that one would like to perform but for some reason never tried. This may include sexual stimulation techniques other than intercourse (e.g., oral sex, mutual masturbation, etc.) as well as sharing or enacting sexual fantasies. The practice of these new sexual skills typically increases sexual arousal and enjoyment during sexual activity, diminishing the focus on performance and goal demands. These new sexual skills also may be incorporated into the sensate focus procedure, when deciding which sexual stimulus to include in the different phases.

Cognitive restructuring

Cognitive restructuring is the core component of cognitive therapy (Beck, 1967). The main goals of cognitive restructuring in sex therapy are to challenge dysfunctional sexual beliefs, modify the meaning assigned to negative sexual events (i.e., decrease activation of negative cognitive schemas), and change the negative automatic thoughts and emotions experienced during sexual activity. The central components of cognitive restructuring are: (1) evaluating the advantages and disadvantages of the sexual beliefs; (2) analysing the evidence for and against the beliefs; (3) testing the validity of thoughts in real-life settings; (4) formulating alternative beliefs; and (5) practicing alternative beliefs.

Evaluating the advantages and disadvantages of sexual beliefs One of the first techniques that could be used in the process of cognitive restructuring is to encourage the patient to analyse the benefits and disadvantages of the main sexual beliefs with which they present. This technique promotes the ability to gain cognitive distance from the usually unrealistic or problematic beliefs and to think critically about advantages and disadvantages from an outside perspective. For example, the belief, "A man who fails to maintain an erection may be abandoned by his sexual partner," may be seen as having the advantage of promoting a man's effort to prevent losing an erection and therefore satisfy the sexual partner, but at the same time may create additional performance anxiety that prevents erection maintenance.

Analysing the evidence for and against the belief Once the patient is educated on the basics of sexual response and has learned to question the usefulness of his own sexual beliefs, it is easier to encourage him to confront the evidence for and against the beliefs. The analysis of the evidence can rely on a logical debate (Ellis, 1962) in which the patient is encouraged to list a number of arguments for and against each of his sexual beliefs based on evidence and/or logical thinking. In addition, training in the identification of cognitive distortions or errors in the processing of information (Beck, 1967) related to sexual events is another useful technique in questioning the evidence for the sexual beliefs. Rosen *et al.* (1994) described a list of common cognitive errors presented by men with sexual dysfunction:

- all-or-nothing thinking ("I'm a complete failure because my erection was not 100% rigid");
- overgeneralization ("I had trouble getting an erection last night. I will never be able to get an erection during intercourse.");
- disqualifying the positive ("My partner says that I satisfy her sexually. She only says that because she feels sorry for me.");
- mind reading ("My partner must think that I'm a failure or a poor sexual partner");
- fortune-telling ("I will lose my erection during intercourse tonight");
- emotional reasoning ("I feel like I'm incompetent; therefore, I really must be incompetent");
- categorical imperatives ("I should be able to get an erection whenever my partner wants to have sex"); and
- catastrophizing ("If I lose my erection tonight, my partner will leave me").

Testing validity of thoughts in real-life settings Reality testing (also known as behavioral experiments) is the use of real-life situations to test hypotheses resulting from patients' dysfunctional beliefs. One very useful way of conducting behavioral experiments is the use of sensate focus exercises. Sensate focus promotes the involvement of partners in a variety of sexual activities without intercourse, thus providing opportunities to disconfirm most inaccurate sexual beliefs (e.g., "women's sexual pleasure and orgasm require a full erection and intercourse," "the only way to give pleasure to a woman is through vaginal penetration," "female orgasm is only possible through vaginal penetration," etc.).

Formulating alternative beliefs Once patients have learned to identify their own cognitive distortions and the lack of evidence for their negative sexual beliefs, it is important that they develop alternative and more accurate beliefs that make sense for them. One technique that may help patients identify alternative beliefs is the use of Socratic questioning. This technique is based on the teaching method used by the Greek philosopher and helps to guide the patient's process of self-discovery, reflecting on his own beliefs and facilitating the development of new alternative interpretations for his life events. For example, the belief that "A man who fails to get an erection is not a real man" may be reformulated into the new belief, "In certain circumstances—tiredness, preoccupation, lack of stimulation from the partner—even a real man may not get an erection."

Practicing alternative beliefs Once the patient has identified alternative beliefs, he should be given the opportunity to practice and exercise his "new role" as the defender of the alternative beliefs. For this purpose, the technique of point-counterpoint, also designated "rational-emotive role play", is useful. The technique consists of the dramatization of a dialogue between the patient and the therapist in which they alternate roles and represent the problematic and the alternative belief positions. The patient may begin by representing his usual role (defending the problematic beliefs) and then change with the therapist to the new role (defending the alternative beliefs). This technique is of central importance because it allows the patient to decenter from his usual point of view and to play a new role in which his job is to convince the former of the inaccuracy of his sexual beliefs. Additionally, the patient is encouraged to practice alternative beliefs and thoughts in everyday life whenever negative thoughts arise.

Brief Case Example

Mr X was a 33-year-old, single, college-educated, heterosexual man. He presented with a complaint of intermittent lifelong difficulty in maintaining erections. He had no relevant medical diagnoses and was not taking any medication. He worked in a company and described his work as challenging and satisfying. He was attractive and socially skilled, and he had no difficulties in establishing friendships with both men and women. He lived alone and had not had a sexual partner since he broke up with his previous girlfriend six months prior. Although the main reasons for the breakup were not related to the erectile difficulties, he thought that his sexual problems played a role and blamed himself for that. During the last six months he had avoided intimate contact with female partners (despite some opportunities).

He described being able to attain complete erections during masturbation and also sometimes during sexual activity with female partners. He said that, most times, the erection decreased during foreplay or just before intercourse.

Mr X described always being worried about his ability to perform sexually. He recalled being very perfectionistic about his sexual response and constantly monitoring his ability to achieve an erection—even before his first sexual intercourse experience. Mr X also described masturbating in a group with peers when he was 14 years old and comparing his erection with the others.

Mr X described his first sexual experience (without intercourse) with a female partner at the age of 14 as very demanding and stressful. He was always monitoring his sexual response and was afraid of not measuring up to her expectations. He avoided having sexual intercourse with a female partner despite feeling very pressured by peers to initiate his sexual life. He was so worried about not being able to achieve an erection during the first intercourse experience that he asked for clinical help at the age of 17.

At the age of 18, he had his first sexual intercourse experience, which he described as very pleasant and successful (which he attributed to the sex therapy that made him feel more confident). Since then, he had periods in which things were working fine sexually and periods in which erectile difficulties were present, damaging his relationships and clearly interfering with his life and sense of masculinity. He had presented to sex therapy a few additional times in the past and had also tried Viagra (which helped him in getting erections, but did not make him happy because he did not feel good about needing it).

His sexual script was very rigid and inflexible. Typically, his sexual interactions started with five minutes of foreplay (first he performed oral sex on his partner and then she performed on him) and continued to intercourse whenever he felt confident in maintaining his erection. He was usually on top in order to control the process. With Viagra, the mean length of intercourse until ejaculation was six or seven minutes; without Viagra it was between one and two minutes. He was very unsatisfied with both the length and the rigid sequence of activities, but he felt that this was the only way to be in control of the situation.

Information from questionnaire assessment

On the Sexual Dysfunctional Beliefs Questionnaire (SDBQ; Nobre et al., 2003), Mr X had high levels of agreement with several erroneous, demanding, and catastrophic beliefs, including:

- *Penile erection is essential for a woman's sexual satisfaction.*
- *Men who are not capable of penetrating women can't satisfy them sexually.*
- *The quality of the erection is what most satisfies women.*
- *A woman may have doubts about a man's virility when he fails to get an erection during sexual activity.*
- *A woman may stop loving a man if he is not capable of satisfying her sexually.*
- *A man who doesn't sexually satisfy a woman is a failure.*
- *The consequences of a sexual failure are catastrophic.*

On the Sexual Modes Questionnaire (SMQ; Nobre & Pinto-Gouveia, 2003), Mr X endorsed frequent negative automatic thoughts and emotions during sexual activity and a lack of erotic thoughts during sexual activity. On the Questionnaire of Cognitive Schemas Activated in Sexual Context (QCSASC; Nobre & Pinto-Gouveia, 2009b), Mr X's responses were consistent with activation of incompetence schemas (e.g., I'm incompetent, I'm a failure) whenever negative sexual events occurred.

Diagnosis and case conceptualization

Mr X presented with a clinical history of lifelong, situational erectile dysfunction associated with excessive fears of sexual performance failure, mostly during sexual activity with a partner. Mr X anticipated negative consequences of not performing sexually, even before initiating his sexual life with a partner. Although there were some periods of time when he was able to attain and maintain full erections, his recurrent pattern of fear of failing, accompanied by the distress associated with his sexual performance, were congruent with a diagnosis of lifelong erectile dysfunction. Although his difficulties were present in most sexual interactions with a partner, there were situations

(i.e., masturbation) in which he was able to achieve and maintain full and rigid erections despite the lack of pleasure, suggesting that his erectile dysfunction was situational rather than generalized. Finally, his life—particularly in regards to his romantic relationships—was strongly impacted by the presence of the erectile difficulties, and he experienced substantial levels of distress about the difficulties, suggesting that his erectile dysfunction was severe.

Regarding predisposing and maintaining factors, we may highlight the presence of extremely rigid sexual beliefs, particularly sexual self-demanding and "macho" beliefs (e.g., penile erection is essential for a woman's sexual satisfaction, men who are not capable of penetrating women can't satisfy them sexually, the quality of the erection is what most satisfies women) and beliefs about women's negative reactions and the catastrophic consequences of sexual failure (e.g., a woman may stop loving a man if he is not capable of satisfying her sexually, a man who doesn't sexually satisfy a woman is a failure, the consequences of a sexual failure are catastrophic). This list of highly self-demanding and unrealistic sexual beliefs combined with belief in the catastrophic consequences of sexual failure constituted a clear predisposing or vulnerability factor, which may help to explain the anticipatory fear of performance in Mr X's early sexual experiences. Moreover, these sexual beliefs also played a role in maintaining the sexual difficulties. In fact, the constant comparison of his highly demanding beliefs with his actual sexual performance prevented him from experiencing pleasure during sexual encounters. Additionally, these beliefs influenced the meaning assigned to negative sexual events. Mr X tended to interpret negative sexual situations as a sign of personal incompetence. This internal and global negative interpretation of unsuccessful sexual events was also an important factor in maintaining and magnifying the sexual difficulties. Finally, the presence of negative distracting thoughts (e.g., erection concern, failure anticipation) and negative emotions during sexual activity interacted with the erectile response, maintaining the negative cycle.

Treatment

Given the particular circumstances of Mr X's clinical case (life-long erectile dysfunction with very rigid sexual beliefs), and the fact that he had no sexual partner, the treatment approach was mostly based on cognitive restructuring techniques. Mr X was a young and intelligent man and easily understood most of the components of the cognitive-emotional model of erectile dysfunction. Discussion of the case conceptualization with the client was very fruitful. Mr X was able to give several personal examples that were congruent with a cognitive-emotional conceptualization of erectile problems. Moreover, a strong therapeutic alliance was established, and Mr X showed high motivation to be involved in the process of cognitive restructuring.

After identifying sexual beliefs, cognitive schemas in response to negative sexual events, and typical thoughts and emotions during sexual activity, the first sessions were mostly oriented to exposing Mr X to evidence-based knowledge about male and female physiology of sexual response and other information that disconfirmed most of his own sexual beliefs. Mr X was also encouraged to search for information and facts that challenged his core beliefs. Interestingly, Mr X developed ingenious forms of testing his beliefs, including creating online questionnaires with his main beliefs about the need for intercourse in women's sexual satisfaction and women's catastrophic reaction to men's failure, to be completed by anonymous women online. Additionally, he also followed the usual cognitive restructuring techniques presented above both within and in between sessions: (1) evaluating advantages and disadvantages of the beliefs, (2) analysing the evidence, (3) testing the validity of thoughts in real-life settings, (4) formulating alternative beliefs, and (5) practicing alternative beliefs. This systematic challenge of his problematic sexual beliefs was pursued by Mr X over the course of several months. At the end of that time, Mr X was able to present with more flexible and less catastrophic beliefs that made sense to him (e.g., a real man may sometimes fail; there are reasons other than sex that make women stop loving a man; although intercourse is fundamental to good sex, there are other activities to sexually please a woman).

Apart from the cognitive techniques, sexual skills training and sensate focus exercises were also implemented. Mr X was encouraged to involve himself in pleasurable sexual self-stimulation. The same rationale used in the couple's sensate focus approach was adapted to be used in sexual self-stimulation exercises, creating a private, non-demanding, and erotic environment, with special focus on the pleasurable sensations experienced during self-stimulation. Complementary sexual fantasy training was used to help Mr X develop the ability to integrate erotic and pleasurable fantasies into his sexual activity. These adapted sensate focus exercises combined with sexual fantasies and the use of erotic material was very important in changing his pattern of sexual activity from a self-spectating approach (i.e., focused on self-observation of his performance and erection) to a sensorial approach, increasing his sexual pleasure.

The combination of cognitive restructuring, behavioral exercises, and fantasy training was fruitful in the long term, increasing Mr X's sexual self-confidence. Ultimately, after 12 treatment sessions (over a period of approximately five months), he was confident enough to engage in sexual activity with a female friend. Although in the first sexual encounters he was still not able to maintain full erections during most of the interactions, he reported feelings of sexual excitement and the ability to please himself and his partner until they both experienced orgasm.

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5

Treating Women's Orgasmic Difficulties

Kristen M. Carpenter, Kristen Williams and Brett Worly

Introduction

Decades ago, Symons (1979) noted that female orgasm "inspires interest, debate, polemics, ideology, technical manuals and scientific and popular literature solely because it is so often absent" (p. 86). A universal definition of female orgasm has eluded scientists, philosophers, and clinicians alike, although it seems clear that it is characterized by a number of physiological reactions (e.g., vasocongestion or engorgement of the genitals; myotonia or rhythmic contractions of the vagina, uterus, and/or rectum) and subjective experiences (e.g., pleasure, altered consciousness) that vary both between and within individuals (see Mah & Binik, 2001; Meston, Levin, Sipski, Hull, & Heiman, 2004, for reviews). To complicate matters further, a woman may herself be unable to determine whether she experienced orgasm during a given sexual experience (Mah & Binik, 2001; Meston *et al.*, 2004). The enormous diversity in female orgasmic experience and the resulting difficulty in precisely defining and measuring it necessarily imposes limitations on the conclusions that may be drawn from the literature. Nevertheless, it is clear that orgasmic difficulties affect a substantial proportion of women at some point in their lives. Many of the primary treatments for orgasmic dysfunction were well-developed by the early 1980s (see Andersen, 1983, for a review) and remain the treatments of choice today (Meston, 2006); more recent research has focused on treatments for arousal and desire difficulties (see Both, Weijmar Schultz, & Laan, this volume), which may have downstream effects on orgasm.

The most recent iteration of the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5; American Psychiatric Association, 2013) defines female orgasmic disorder (FOD) as delay, infrequency, absence, or reduced intensity of orgasm in the majority (i.e., at least 75%) of sexual experiences. Symptoms must persist for at least six months and, importantly, must cause significant distress in the woman. These criteria represent a number of changes from the previous edition of the manual (DSM-IV-TR; American Psychiatric Association, 2000), which render the diagnosis at once more inclusive and more specific. Frequency and duration requirements have been more precisely defined in the DSM-5 compared with the DSM-IV-TR. For instance, in the DSM-IV-TR, a reduction in intensity of orgasm would not qualify for a diagnosis of FOD. Additionally, the DSM-IV-TR requirement that the lack of orgasm follows a normal arousal phase has been removed from DSM-5, as many have argued that a normal arousal phase is difficult to define and that its absence can be associated with concurrent orgasm difficulties (e.g., Andersen & Cyranowski, 1995; Basson, 2002a, 2002b; Graham, 2010). As with all sexual dysfunction diagnoses, etiological specifiers

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from the DSM-IV-TR (i.e., due to psychological or combined psychological and physical factors) have been removed from DSM-5 because the data suggest that the most frequent presentation is one in which both psychological and biological factors contribute. Thus, DSM-5 specifiers include: lifelong vs. acquired; generalized vs. situational; no past experience of orgasm in any context (i.e., primary orgasmic dysfunction); and mild vs. moderate vs. severe. Finally, the requirement for distress in the DSM-5 has been changed to include only distress in the individual client rather than individual *or* interpersonal distress as in the DSM-IV-TR.

Epidemiology

Estimates of prevalence (i.e., the proportion of people who have a disorder in a given time period) and incidence (i.e., the proportion of people newly diagnosed with a disorder in a given time period) of FOD vary widely due to inconsistencies in definitions and measurement across studies. Many studies utilize questionnaires that are not validated or do not assess all DSM criteria. A review of prevalence studies between 1990 and 2000 found estimates ranging from 4–24% in general populations from the US and Europe (Simons & Carey, 2001); only one of these studies, however, utilized DSM criteria for the disorder. The distress criterion, in particular, is often omitted, which significantly affects prevalence estimates given that many women report infrequent or absent orgasms without experiencing associated distress. For example, a study of a nationally representative sample of Swedish women found that only about 60% of women who reported orgasmic problems found them distressing (Öberg, Fugl-Meyer, & Fugl-Meyer, 2004). Data utilizing DSM-5 criteria are not yet available, but studies utilizing full DSM-IV-TR criteria (including the distress criterion) and population-based samples suggest a more conservative prevalence estimate of 3–10% in the US and Europe (Bancroft, Loftus, & Long, 2003; Christensen *et al.*, 2011; Fugl-Meyer & Fugl-Meyer, 1999; Hendrickx, Gijs, & Enzlin, 2014; Shifren, Monz, Russo, Segreti, & Johannes, 2008).

Etiology and Maintenance

Biological variables

Healthy female sexual function occurs with a careful balance of sympathetic and parasympathetic nervous system responses (Archer, Love-Geffen, Herbst-Damm, Swinney, & Chang, 2006; Davis, Guay, Shifren, & Mazer, 2004). Although desire can be triggered in the hypothalamus by dopamine (Bartels & Zeki, 2004; Gizewski *et al.*, 2006; Lorrain, Riolo, Matuszewich, & Hull, 1999), the noradrenergic system is involved in arousal with increases in heart rate and blood pressure (Exton *et al.*, 1999; Jeong *et al.*, 2005). Orgasm, in contrast, is mediated by endogenous opioids, serotonin, prolactin, and oxytocin, with rhythmic contractions of the perineal, bulbocavernosus, and pubococcygeus muscles, which surround the vagina (Meston *et al.*, 2004; Shifren & Schiff, 2010). Resolution is mediated by increased serotonin and decreased dopamine (Lorrain *et al.*, 1999). From an anatomical perspective, many changes need to occur in rapid succession without malfunction if a woman is to experience orgasm. Sexual arousal occurs with increased genital blood flow, labial and vaginal wall swelling, and release of lubricating excretions from the genital tract. Pelvic nerve stimulation leads to clitoral smooth muscle relaxation and arterial smooth muscle dilation, allowing blood to rush to the genitals and remain there. This increased blood flow causes increased protrusion of the clitoris through tumescence (Davis *et al.*, 2004). Given the many physiological and anatomical pathways associated with orgasm, it is not surprising that there appear to be genetic influences in FOD. Dunn, Cherkas, and Spector (2005) assessed monozygotic and dizygotic twin pairs and

found 34% heritability for trouble reaching orgasm with intercourse, and 45% heritability for difficulty achieving orgasm with masturbation.

Medical factors associated with FOD include previous pelvic surgery, surgical menopause (vs. being premenopausal), pelvic organ prolapse, and relatively poor overall health status (Montejo-Gonzalez *et al.*, 1997; Shifren *et al.*, 2008; Stimmel & Gutierrez, 2006). Previous pelvic surgery can be detrimental to sexual health due to adhesive disease and co-occurring neuropathy, which can lead to decreased sensation. Pelvic organ prolapse is associated with urinary, fecal, and flatal incontinence, decreased sensation, discomfort during penetration, and disrupted body image, all of which can contribute to FOD (Roos, Thakar, Sultan, de Leeuw, & Paulus, 2014). Many patients with pelvic organ prolapse are fearful that symptoms (e.g., incontinence, odour) might occur during sexual activity, and of possible negative reactions from partners, generating cognitive interference, embarrassment, and/or anxiety that can also interfere with orgasm.

A number of centrally acting medications interfere with sexual function, most notably antidepressants (selective serotonin reuptake inhibitors; SSRIs) and antipsychotics. A meta-analysis of studies assessing sexual dysfunction in individuals found that 12 of 15 antidepressants were significantly more likely to be associated with orgasmic dysfunction than placebo, with odds ratios ranging from 1.31 to 41.89 (Serretti & Chiesa, 2009). Rates of orgasmic dysfunction among patients taking antipsychotic medications range from about five to 25%, with the exception of thioridazine, which is associated with a substantially higher rate of orgasmic problems (Serretti & Chiesa, 2011). These results should be interpreted with caution, as the studies reviewed were limited by a number of methodological challenges. Nevertheless, the possible role of medication should be carefully evaluated when clients present with FOD, highlighting the need for interdisciplinary collaboration.

Psychosocial variables

Psychosocial factors associated with FOD are many and varied, although correlations are often small. One of the most reliable correlates of sexual function in general is relationship adjustment (Kelly, Strassberg, & Turner, 2004, 2006; McGovern, Stewart, & LoPiccolo, 1975; Speer *et al.*, 2005; Trudel, Villeneuve, Preville, Boyer, & Frechette, 2010; Witting, Santtila, Alanko, *et al.*, 2008). A recent investigation by Witting, Santtila, Alanko, *et al.* (2008) highlighted several of the known relationship correlates of orgasmic difficulties. The researchers administered items from the Female Sexual Function Index (Rosen *et al.*, 2000) and Female Sexual Distress Scale (Derogatis, Rosen, Leiblum, Burnett, & Heiman, 2002) to a population-based sample of 5,463 women, aged 18–49 years in Finland. Problems with orgasm were associated with variables such as partner mismatch in sexual interest (i.e., the woman's partner being more interested than she), several indices of the partner's lack of skill or interest in specific sexual behaviors (e.g., foreplay), relationship issues between a woman and her partner (e.g., the woman not finding her partner attractive, poor communication), and partner erectile problems. Adequate stimulation to cause orgasm is most likely to occur with direct clitoral stimulation; thus, there is a robust correlation between orgasm rates and frequency of sexual behaviors targeting the clitoris (Darling, Davidson, & Jennings, 1991; Dawood, Kirk, Bailey, Andrews, & Martin, 2005; Hite, 1976; Zietsch, Miller, Bailey, & Martin, 2011), including masturbation (Kelly, Strassberg, & Kircher, 1990).

Evidence for association with age and other sociodemographic variables is mixed and primarily from cross-sectional studies (Dawood *et al.*, 2005; Laumann, Paik, & Rosen, 1999; Leeners, Hengartner, Rössler, Ajdacic-Gross, & Angst, 2014; Shifren *et al.*, 2008; Witting, Santtila, Alanko, *et al.*, 2008; Witting, Santtila, Varjonen, *et al.*, 2008; Zietsch *et al.*, 2011). One large population-based study ($n = 31{,}581$) suggested that orgasmic dysfunction may increase with age through mid-life and then decline (Shifren *et al.*, 2008). However, at least

one longitudinal study evidenced no differences based on age (Leeners *et al.*, 2014), and several cross-sectional studies of women aged under 50 suggested that increasing age is associated with better orgasmic function. Other factors such as race/ethnicity, socioeconomic status, personality factors, sexual history, and sexual attitudes appear to relate to a lesser extent (Leeners *et al.*, 2014; Shifren *et al.*, 2008; Zietsch *et al.*, 2011), again with mixed results.

Assessment

In alignment with the etiological factors described above, consensus guidelines from the International Society for Sexual Medicine recommend assessment of the following factors in women who present with complaints of orgasmic difficulty: whether the woman is receiving adequate stimulation to experience orgasm (i.e., lack of orgasm during penetration with no other stimulation is not necessarily problematic); distress experienced due to the orgasmic difficulties; cognitive and affective factors (e.g., guilt related to sexual behavior, distraction during sexual experiences); relationship quality with the sexual partner; history of sexual trauma; and current medications (including complementary and alternative therapies) and medical conditions (Laan, Rellini, & Barnes, 2013). A thorough interview is required to determine whether a FOD diagnosis is appropriate and to identify factors that may contribute to the history (e.g., primary or secondary FOD) and maintenance of the disorder. However, self-report questionnaires may be useful as screening tools and as a starting point for the discussion. Examples of validated questionnaires with empirically-derived, clinical cut-off scores include the Female Sexual Function Index (FSFI; Rosen *et al.*, 2000; Wiegel, Meston, & Rosen, 2005), the Female Sexual Distress Scale (FSDS; Derogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Yali, 2008; Derogatis *et al.*, 2002), and the Sexual Function Questionnaire (Quirk, Haughie, & Symonds, 2005; Quirk *et al.*, 2002).

Of course, the assessment of sexual difficulties is iterative; clients often choose to share critical details only once they have become comfortable with the therapist. As with any psychotherapy client, it will be important to refine the case conceptualization as new information is presented during treatment. As outlined below, treatment will likely target several aspects of sexuality and sexual response simultaneously. The following questions can help guide the initial assessment:

- About how often do you experience orgasm at this time?
- Have you ever experienced orgasm? With your current partner? With other partners? Under what circumstances?
- When did your difficulties begin?
- What do you find pleasurable about sex? What do you enjoy most? What do you enjoy least?
- Do you experience any pain/discomfort during sexual activity?
- How often do you masturbate? What do you do? Do you experience orgasm that way?
- Does your partner stimulate your genitals with their hands or mouth? Do you enjoy that? What do you like about it? What don't you like? Do you experience orgasm that way?
- What intercourse positions are common for you? Which one(s) do you enjoy most? Are any positions particularly unpleasant?
- Does sexual activity typically include clitoral stimulation?
- Do you ever use a vibrator or other sex toy(s), either alone or with a partner? What, if anything, do you enjoy about that? Do you reach orgasm that way? If you have never tried toys before, is there a reason that you haven't?
- How do you and your partner talk about sex? Who initiates the conversations? Do you talk about sex outside of the bedroom? Have you talked more or less about sex at other times in your relationship or with other partners?

Both assessment and treatment of FOD require careful attention to religious and cultural factors. Culturally competent assessment and treatment of sexual problems is guided by therapist consideration of diverse values attached to sexuality, education in and respect for the client's belief system, vetting of all interventions in relation to the client's values prior to their implementation, and therapist flexibility in adapting interventions to align with the client's belief system (Meana, 2012). Thus, values around masturbation, partnered sexual activities, and use of sexual aids such as vibrators should be evaluated as part of the assessment.

Physical examination

Working with a knowledgeable gynecologist, who is comfortable discussing sexuality, can be extremely valuable. At a minimum, collaboration with a gynecologist is important to ensure physiological and anatomical etiologies have been ruled out. Other valuable referral resources include a vulvar disease specialist; endocrinologist with expertise in menopause; urogynecologist; pelvic floor physical therapist; and in the circumstance of SSRI-induced anorgasmia, a knowledgeable psychiatrist.

A physical examination of a patient with FOD should assess several critical components, beginning with the external genitalia. Patients with oral and genital irritation or lesions may have conditions such as herpes simplex or lichen planus. Patients with prominent eczema on exterior surfaces may have vulvar eczema. Patients with vulvar pathology may be treated with a steroid cream (e.g., clobetasol), but some more concerning lesions require biopsy to rule out vulvar intraepithelial neoplasia (a pre-cancerous condition). Those with gynecological infections should be treated with the appropriate antibiotic or antifungal medication. Damaged vulvar tissue also may indicate a condition such as lichen sclerosis or atrophic vaginitis with hypoestrogenization. Estrogen deficiency can result in irritation of the vulvar skin; thus patients can discuss the risks and benefits of hormone replacement with their healthcare provider. The perineum should be inspected for signs of healed laceration from previous episiotomy, which could be associated with pelvic floor muscle or nerve injury. The labia and clitoris should be palpated and tested for light sensation with cotton swab or the examiner's finger. Uncommonly, neuropathy can occur at the clitoris, and diabetic neuropathy versus autoimmune neuropathy must be evaluated.

Moving to the internal exam, the vagina should be inspected with a speculum for ruggae (skin folds) and for appropriate estrogenization (resulting in adequate lubrication and relatively thick vaginal walls). Vaginal discharge should be evaluated for possible infections of bacterial vaginosis, vulvovaginal candidiasis, trichomonas vaginalis, gonorrhea, or chlamydia. As above, infections may be treated with antibiotics or antifungal agents and inadequate estrogenization may be addressed through hormone therapy. The cervix should be palpated to inspect for cervical motion tenderness, which could indicate chronic pelvic inflammatory disease. The uterus and surrounding tissues should be palpated for masses and tenderness. Careful inspection of the anterior and posterior vaginal walls during a valsalva maneuver (the woman attempts to exhale while keeping her nostrils and mouth closed) both in stirrups and in the standing position can be helpful in assessing for pelvic organ prolapse. Pelvic organ prolapse may benefit from a pessary (internal support device); however, pelvic reconstructive surgery may be required and should be addressed by a surgeon trained in urology or gynecology.

Treatment

Although pharmacotherapy for female sexual dysfunctions has received an enormous amount of interest in recent decades (Basson, 2009; Fooladi & Davis, 2012), cognitive and behavioral techniques remain the most effective and are recommended as first-line treatments for FOD by the International Society for Sexual Medicine (Laan *et al.*, 2013).

Psychoeducation

Psychoeducation is a necessary but insufficient component of treatment for FOD. In a cross-sectional college sample, knowledge of female sexual anatomy and function accounted for only 6% of the variance in orgasmic frequency in masturbation and none of the variance in partnered sexual behavior (Wade, Kremer, & Brown, 2005). Controlled trials of education alone are rare. An example from 1980 found that psychoeducation had no effect on orgasm in healthy, married women, despite an improvement in knowledge and attitudes about clitoral stimulation (Wilcox & Hager, 1980). Psychoeducation may include information on sexual anatomy; physiological sexual response; the impact of hormonal changes, aging, and medical comorbidities on sexuality and sexual function; effective methods of stimulation; and so on. It is an important foundation for intensive treatment of FOD, but is not enough on its own to address clinically significant orgasmic problems.

Cognitive-behavioral therapy

Andersen's (1983) review of FOD treatment trials beginning in the 1960s thoroughly documented the efficacy of directed masturbation, sensate focus, and systematic desensitization alone or in combination. These classic components of sex therapy remain essential tools in the treatment of FOD. Directed masturbation (Heiman & LoPiccolo, 1976) consists of a graduated series of self-exploration and pleasuring exercises. Clients are instructed in female sexual anatomy and then complete visual and tactile explorations of their own anatomy at home in order to discover where sensations are most pleasurable. Early exploration is followed by increasingly intense stimulation of these areas, potentially including the use of vibrators or the assistance of a partner. Sensate focus (see also Avery-Clark & Weiner, this volume) includes a partner throughout, beginning with touching exercises explicitly excluding the genitals and intended to teach clients their own preferences for sensations, their partners' preferences, and methods of communicating these preferences in the moment, as well as to build sexual tension in a low-pressure environment. Later assigned activities include partner touching of the genitals with client's verbal or manual guidance and sexual positions intended to maximize the client's pleasure. Systematic desensitization is useful when FOD is driven by anxiety surrounding sexual situations; it includes instruction in relaxation skills followed by confrontation with exposure to anxiety-provoking sexual stimuli. Once imagined exposures can be conducted without anxiety, the client is encouraged to engage in the anxiety-provoking sexual activities. Although all three of these treatment techniques mimic traditional exposure therapy, systematic desensitization most closely follows the exposure paradigm.

Few studies specifically targeting FOD with behavioral treatments have been conducted since the 1980s; recent research has focused more on desire, arousal, and sexual dysfunction more broadly. Reviews of the FOD treatment literature, however, suggest that directed masturbation is the most effective of the three treatment components described above, and that adding sensate focus may enhance its effects (Andersen, 1983; Heiman & Meston, 1997). More recent research indicates that the coital alignment technique (CAT) may be helpful for partnered women particularly interested in experiencing orgasm during vaginal intercourse (Hurlbert & Apt, 1995). The technique is a variation on the missionary position designed to facilitate clitoral contact during penile-vaginal intercourse through coordinated movement and genitally focused pressure/counterpressure. There are several instructional accounts available online, including instructional videos.

In addition to psychotherapies directly targeting sexual behavior, a number of evidence-based psychotherapies appear to improve orgasmic function among women or serve as valuable adjuncts to sex therapy. Many forms of couples therapy, for example, are effective in addressing problems within intimate relationships that can contribute to orgasmic dysfunction (see Lebow,

Chambers, Christensen, & Johnson, 2012, for a review). In addition to its relation to FOD itself, as discussed above, relationship satisfaction may interact with individual treatment targeting FOD to influence outcomes (Stephenson, Rellini, & Meston, 2013).

Two recent trials with survivors of gynecological cancer experiencing desire and arousal difficulties suggest that mindfulness-based methods are effective in improving orgasmic function, but no trials including women with FOD have been conducted (Brotto *et al.*, 2008, 2012). Indeed, mindfulness methods seem a natural fit given the negative impact of cognitive interference and "spectatoring" (i.e., self-observation and evaluation) on orgasm (Cuntim & Nobre, 2011; de Sutter, Day, & Adam, 2014; Dove & Wiederman, 2000; see also Barker, this volume). Both couples and mindfulness treatment protocols, including those cited above, often include standard cognitive-behavioral therapy techniques (e.g., identification of maladaptive cognitions, cognitive restructuring), which may contribute to their effectiveness.

Physical therapy/rehabilitation

Given pelvic floor involvement in orgasm, the pelvic musculature seems a natural target for intervention in FOD. Although Kegel exercises are widely recommended, there is no evidence of direct benefit for FOD (Chambless *et al.*, 1984; Lara *et al.*, 2012; Roughan & Kunst, 1981). That said, to the extent that Kegel exercises improve sexual arousal (Lowenstein, Gruenwald, Gartman, & Vardi, 2010; Messé & Geer, 1985), reduce anxiety/muscle tension, and/or improve a women's comfort during sexual activity, Kegels can serve as a beneficial adjunct to cognitive-behavioral therapy.

More recently, interventions targeting pelvic muscle function have focused on women with urinary incontinence. These conditions are regularly treated with Kegel exercises or sacral neuromodulation, an electrical stimulation of the nerves that control the pelvic floor, urethral sphincter, and other pelvic muscles. Preliminary evidence supports the use of pelvic floor muscle training (Beji, Yalcin, & Erkan, 2003; Zahariou, Karamouti, & Papaioannou, 2008), sacral neuromodulation (Pauls *et al.*, 2007; Zabihi, Mourtzinos, Maher, Raz, & Rodriguez, 2008), or a combination of these interventions (Rivalta *et al.*, 2009) to improve orgasmic function in women with incontinence, but no randomized trials exist and more evidence is needed. Neuromodulation targeting orgasmic function in women without incontinence has also been attempted. In a nine-day pilot trial of epidural neuromodulation for treatment-resistant FOD, Meloy and Southern (2006) recruited 11 women with primary or secondary FOD. None of the women with primary FOD experienced orgasm with treatment, but four out of the five women with secondary FOD experienced orgasm during the study period, returning to baseline functionality once the neuromodulation device was removed.

The Eros Therapy device is an FDA-approved clitoral vacuum that increases blood flow and engorgement (Billups *et al.*, 2001). Although it has not been tested in women with FOD, it has been found to improve orgasmic function in small samples of healthy controls, women with unspecified female sexual dysfunction, and women with sexual dysfunction following radiation therapy for cervical cancer (Billups *et al.*, 2001; Schroder *et al.*, 2005; Wilson, Delk, & Billups, 2001).

Pharmacotherapy

For those experiencing FOD associated with psychoactive medications, there have been a number of case reports and open-label trials supporting pharmacotherapy interventions. The addition of other medications to counteract the effects of psychoactive medications is a common practice (Ashton & Rosen, 1998; Balogh, Hendricks, & Kang, 1992; Balon, 1996); however, results from controlled trials indicate that most agents provide no benefit beyond placebo (Ito, Trant, & Polan, 2001; Meston, 2004; Michelson, Bancroft, Targum, Kim, &

Tepner, 2000; Michelson, Kociban, Tamura, & Morrison, 2002; Michelson, Schmidt, Lee, & Tepner, 2001; Modell, Katholi, Modell, & DePalma, 1997). One double-blind, placebo-controlled trial suggested sildenafil can improve orgasm among women taking SSRIs (Nurnberg *et al.*, 2008). Decreasing to minimal effective dosage or switching to a similar medication with a lower rate of sexual side-effects also is possible for some patients (see Seretti and Chiesa's (2009, 2011) meta-analyses on the magnitude of specific antidepressants and antipsychotics on orgasm function for guidance in this latter option). It is essential to be cautious when considering a change in a patient's psychiatric medications, however, as some successful regimens have been hard-fought victories after many failed attempts. Changing medications yet again may not be in a patient's overall best interest.

For those experiencing FOD not associated with psychoactive medications, pharmacological options are limited. There have been several placebo-controlled trials examining the effectiveness of pharmacological agents and supplements; to date, no clearly beneficial agents have been identified. A meta-analysis of hormone therapy for peri- and post-menopausal women found little evidence for improvement of orgasm function (Nastri, Lara, Ferriani, Rosa e Silva, & Martins, 2013). Although sildenafil has been associated with improvement in orgasm in some studies (Caruso, Intelisano, Farina, Di Mari, & Agnello, 2003; Caruso, Intelisano, Lupo, & Agnello, 2001), this is not a consistent finding (Basson & Brotto, 2003). Many women look for medication to relieve their orgasmic difficulties, but psychological and/or behavioral treatments remain the standard of care.

Case Example

The illustrative patient was treated as part of our program for female cancer survivors. Our program offers a cognitive-behavioral approach. Patients are typically referred by their treating oncology team or by a primary care provider.

Mary was a married, Caucasian female in her early 60s. She and her husband had been married for 40 years; he had been the only sexual partner she had ever had. She was mother to four adult sons and identified as Roman Catholic. Approximately one year prior to presentation at our clinical service, Mary had been diagnosed and treated for ovarian cancer. Treatment included total abdominal hysterectomy, bilateral salpingo-oophorectomy, and pelvic and para-aortic lymph node sampling. She received eight cycles of intravenous chemotherapy over the subsequent 24 weeks. Prior to initiating cancer treatment, she was employed full-time as a school counselor. She was receiving financial disability benefits throughout her cancer treatment. She presented to our clinic during the summer recess and so was not working during psychotherapy. Mary had been postmenopausal (approximately eight years) at the time of her cancer diagnosis; medical history was remarkable for hypothyroidism, which was well-managed with medication.

Mary reported that intercourse frequency had varied over the years as a result of having children in the home and other distractions, but that she and her husband engaged in sexual activity, typically including penile-vaginal intercourse, on average two to four times per week throughout their marriage. Mutual manual and oral stimulation also were regularly included in their sexual routine. She reported that she had not masturbated at any point her life due to religious beliefs prohibiting masturbation and feeling it was "unnecessary" given her rich sexual life with her husband. She reported a history of satisfactory sexual interest, arousal during sexual activity, and orgasm "almost always" during vaginal intercourse and other forms of clitoral stimulation. She stated she had begun to experience mild vaginal dryness and concomitant discomfort with penetration at the time of menopause, but that she and her husband regularly used water-based lubricants to address this—with perceived benefit. Mary and her husband abstained from sexual intercourse for several months following her surgery and resumed sexual activity while she was undergoing chemotherapy on off-cycle weeks when her energy was adequate. She described her husband as loving, patient, and

supportive. She described feelings of closeness and was satisfied with the emotional connection she felt to her husband during sexual activity, but she reported that she no longer experienced orgasm. Initially, she had attributed this to chemotherapy and expected that her orgasms would eventually return.

When Mary presented to clinic, she and her husband engaged in sexual activity one to three times per week; she continued to report satisfactory interest and arousal but absent orgasm. For Mary, the Female Sexual Function Index (FSFI) total score was 27 (in the clinical range), the Female Sexual Distress Scale (FSDS) score was 13 (slightly below the clinical cutoff score of 15), and she rated her sexual satisfaction as "somewhat inadequate." Depressive and anxious symptoms were low outside the context of her sexual life. Mary felt her relationship with her partner was beginning to suffer because she would "shut down" during sexual activity if she did not feel she was moving closer to orgasm. She reported that she would become distressed to the point of "sobbing" during and following sexual encounters. She stated that her husband was kind, gentle, and supportive but was "at a loss" and ready to "shut the door on [their] sex life." She missed the closeness she enjoyed following sexual activity throughout their marriage and was feeling hopeless that she would ever experience it again. Under DSM-5, Mary met criteria for female orgasmic disorder (acquired, generalized, severe).

We began a course of cognitive-behavioral therapy with the goals of reducing distress associated with sexual difficulties, increasing orgasmic capacity, and improving relationship functioning. Mary was seen for 12 sessions over approximately five months. Sessions 1 and 2 included a significant didactic component, with education on sexual anatomy and physiology, healthy sexual response, the impact of healthy aging and hormonal changes on sexual experience, and the impact of Mary's cancer treatments. Progressive muscle relaxation training was used to help reduce overall anxiety and improve control over muscles of the pelvic floor and throughout the body. Recommendations were made for improving vaginal health (e.g., use of vaginal moisturizers, Kegel exercises) with instructions for ongoing home practice.

Sessions 3 to 6 introduced the cognitive-behavioral model, as well as a series of self-exploration/mindfulness exercises aimed at increasing awareness of pleasant bodily sensations. These exercises were intended to serve as a precursor to directed masturbation; however, Mary expressed that, although she was comfortable with some bodily exploration, she was not comfortable with masturbation. We opted instead to shift to partnered sensate focus exercises, which continued through session 10. Throughout treatment, maladaptive thoughts were identified as a deterrent to sexual interest, motivation, and arousal. In-session and homework exercises focused on identification of maladaptive (overly negative, unrealistic, or otherwise distorted) automatic thoughts. Thought records were completed with (1) any and all sexual activity (or avoidance of sexual activity) and (2) mindfulness and sensate focus exercises. Mary evidenced a variety of negative and distorted cognitions related to her physical function and appearance: notions of being "weak," "damaged," "aged." It was clear that many aspects of her physical appearance and functioning served as a reminder of her cancer experience and her mortality. Sexual activity triggered these thoughts. It also became clear over several weeks of monitoring that she had significant worry related to the possibility of urinary incontinence during sex and anticipatory anxiety related to vaginal dryness and concomitant pain/discomfort with penetrative sexual activities. Issues of vaginal dryness and incontinence improved with continued use of vaginal health strategies. After two sessions of identifying maladaptive thoughts, we began cognitive restructuring work, which helped Mary to reduce catastrophic thinking, emotional reasoning, and a tendency to discount the positive in her sexual experiences. During this phase of treatment, an activity log was also introduced as a means of tracking mood and energy levels over the course of several weeks. The log served several purposes: (1) to identify times when Mary's energy level and mood were most conducive to a satisfying sexual experience; (2) to identify unnecessary drains on her scarce resources (i.e., time and energy); and (3) to promote taking time for self-care and nonsexual intimacy with her husband.

Sessions 7 to 9 focused on identifying conditions that made sexual activity more satisfying and developing strategies for enhancing communication with her husband, including principles of

assertive communication training, "softened startups" (Gottman & Silver, 1999*), and active listening. Sensate focus exercises continued, and we discussed the use of imaginal, written, audio, and visual aids to increase arousal in preparation for and during sexual activity. In session 9, we reviewed physical and other signs of sexual desire, interest, motivation, and arousal, and revisited the use of formal problem-solving approaches focused on pain management (e.g., expanding the behavioral repertoire with intercourse alternatives, changing positions, use of personal lubricants, and so on).*

Sessions 10 to 12 focused on goal-setting and relapse prevention. In session 10, we identified several goals for Mary to continue to work towards. Goals were divided into several categories, including caring and taking time for self, individual sexuality, emotional intimacy with partner, and physical intimacy with partner. Formal problem-solving was used to generate specific strategies for achieving each goal, with an emphasis on the skills acquired over the course of therapy (e.g., address spectatoring with additional mindfulness or sensate focus practice; enhance emotional intimacy with assertive communication practice). The final two sessions were dedicated to reviewing progress and problem-solving obstacles to achieving goals.

Mary indicated that it was important to her to continue penetrative sex throughout treatment, in spite of the difficulties she was experiencing; thus, all exercises were completed within her typical sexual routine. Mary experienced orgasm through manual and oral stimulation around session 6 and though intercourse by approximately session 8. At post-treatment, her FSFI score was 16, FSDS was 2, she rated her overall sexual life as "above average," and reported orgasm as occurring "more than half the time". Of note, Mary experienced a significant reduction in discomfort with her post-cancer body image as evidenced by a change of scores on body change stress (Impact of Treatment Scale; Frierson, Thiel, & Andersen, 2006*), from a score of 21 at baseline to 2 at post-treatment. Over the course of treatment, subjective complaints of cognitive interference during sexual activity diminished. Some of the maladaptive cognitions described above were still present in later sessions, but Mary was better able to identify them as inaccurate, exaggerated, or unhelpful and to generate alternatives.*

Conclusions

Although there is considerable diversity in the experience of orgasm among women, it is clear that orgasmic difficulties affect a substantial proportion of women at some point in their lives. Effective behavioral treatments for FOD were well-developed by the early 1980s and remain the treatments of choice. Additionally, the "cognitive revolution" within psychotherapy has provided a useful framework for understanding the efficacy of available treatments, as well as additional tools for addressing FOD and concomitant distress, anxiety, relationship concerns, and comorbid difficulties with desire and arousal.

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6

Treating Men's Orgasmic Difficulties

David L. Rowland and Stewart E. Cooper

Introduction

Orgasmic difficulties in men are diverse and include premature ejaculation, delayed ejaculation, inhibited ejaculation, retrograde ejaculation, low volume ejaculation, partial ejaculatory incompetence (i.e., diminished volume, force, or sensation), anorgasmic ejaculation (when ejaculation occurs without orgasm), and painful ejaculation. This chapter focuses on the two ejaculatory conditions most commonly reported in clinical settings, namely premature ejaculation and delayed/inhibited ejaculation, both of which relate to the timing/occurrence of ejaculation. Men with either of these conditions can often be treated successfully and achieve (or regain) a satisfying sexual life.

In the following sections, we discuss these two conditions separately, providing information about definition, prevalence, etiology, diagnosis, and treatment. Although we encourage taking an integrated or holistic approach to each problem—considering biological, psychological, relationship, and cultural issues—we also recognize that particular therapeutic tools may be more suited to or preferred by some patients and healthcare providers than others. In choosing a treatment approach, treatment efficacy and patient satisfaction are the two primary considerations.

Taking an integrated approach to the treatment of ejaculatory/orgasmic disorders requires that the healthcare provider recognize that sexual response and dysfunction are influenced by many factors. Therefore, effective treatment will most likely involve a biopsychosocial approach, one that requires the healthcare provider to have at least a rudimentary understanding of the multiple factors that impinge on sexual problems and healthy sexual relationships.

Distinguishing ejaculation from orgasm

Within the framework of the sexual response cycle, orgasm (and ejaculation) in men is both a biological (reproductive) and psychological (reward) endpoint (see Rowland, 2006). Arousability and arousal—distinct but interrelated constructs—are precursors to this endpoint. Arousability and sexual libido are psychological constructs used to explain variability in the intensity and frequency of sexual response, and they might best be conceptualized as the person's readiness to respond. This state of readiness depends on both internal (e.g., hormonally "primed" diencephalic brain structures) and external (e.g., appropriate partner and situation) stimulus conditions. Sexual arousal or excitement—the organism's actual response to the stimulus conditions—represents both a subjective/cerebral state of sympathetic activation and a

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peripheral physiological response (i.e., erection) that prepares the man for sexual activity. During sexual activity, increasing levels of sexual arousal reach a threshold that triggers the ejaculatory response, which then typically terminates the sexual episode for the man. The subjective (i.e., brain) perception of urethral distension and bladder neck closure occurring at the emission phase of ejaculation is associated with the sensation experienced as "ejaculatory inevitability". The perception of the striated muscle contractions responsible for semen expulsion during ejaculation, mediated through sensory neurons in the pelvic region, gives rise to the experience of orgasm.

Although ejaculation and orgasm in men are concomitant events, they are not synonymous. Ejaculation is a spinal and peripherally-mediated neural response, whereas orgasm is a brain-mediated response; that is, orgasm is a central "response to/perception of" the peripheral ejaculatory response. In men, these two events, because they nearly always coincide, are often presumed to be one and the same. However, rare instances occur whereby these events become dissociated. Ejaculation may occur without the experience of orgasm and/or orgasm may occur in the absence of ejaculation. However, because such dissociations are rare, in this chapter we deal with difficulties with orgasm as if they were difficulties with ejaculation.

Understanding Premature Ejaculation (PE)

The prevalence of PE in the general population of men has been estimated to be anywhere from 5–30%, depending on how the condition is defined, who makes the judgment (i.e., healthcare provider vs. self-report), the populations that are sampled, the timeframe indicated (currently or over the lifetime), the type of PE being assessed (lifelong or acquired), and whether distress about the PE—often manifested by treatment-seeking behavior—is considered a necessary criterion for diagnosis. Presumably then, the actual prevalence lies somewhere between these numbers, although most recent studies tend to place it closer to 5–10% than 30% (Althof *et al.*, 2014; Rowland & Neal, 2014).

Defining PE

Recognizing the need for an evidence-based definition, the International Society for Sexual Medicine (ISSM) recently developed a consensus definition for "lifelong" PE (PE that has been present during the man's entire sexual life), which has three essential components: an ejaculatory latency of about one minute or less after penetration, the inability to delay the ejaculatory response, and distress or other negative consequences to the individual and/or partner (Althof *et al.*, 2014). Recently, the American Psychiatric Association followed suit by including the one-minute cutoff latency to define PE, and including text indicating that ejaculation must occur "before the individual wishes it" and that it must cause "clinically significant distress", in the DSM-5 diagnosis for premature (early) ejaculation (American Psychiatric Association, 2013, p. 443). In contrast, the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) definition currently uses a 15-second cutoff (World Health Organization, 1992); whether the ICD-11 adopts the one-minute criterion in its anticipated revision is yet to be determined.

Although the one-minute cutoff has some empirical support, it might be viewed as an index of both "risk" and "convenience," more so than a true determinant of dysfunctional status. Specifically, this criterion captures the idea that the man with PE ejaculates shortly after penetration (the shorter the latency, generally the higher the risk for PE), and it is a convenient and discrete numeric (compared with something like 85 seconds or 110 seconds). However, the one-minute criterion has its own problems, as it somewhat arbitrarily excludes men who have longer latencies but otherwise meet the criteria for PE (Rowland & Neal, 2014).

Lifelong vs. acquired PE Healthcare providers have traditionally distinguished between lifelong and acquired PE. Lifelong has been present throughout the man's sexual life and typically has no clear etiology. Acquired PE occurs after some period of normal function and typically results from psychological or pathophysiological changes. The one-minute latency criterion mentioned above applies specifically to lifelong PE for the ISSM definition; for the DSM-5 definition, no distinction between latency requirements for lifelong or acquired is made. However, ISSM has also recently published a consensus definition for acquired PE, specifying parameters similar to those for lifelong PE with respect to the inability to delay ejaculation and distress to the individual and/or partner (Serefoglu *et al.*, 2014). However, an ejaculatory latency of about three minutes or less is suggested for acquired PE (in contrast to one minute for lifelong); notably, this cutoff reflects a consensus of expert opinion rather than an empirically derived value. This criterion was based on the rationale that men who had acquired PE, having experienced normal latencies for most of their sex lives, would find any significant reduction in or control over ejaculatory latency as distressing.

Most definitions also encourage the provider to specify whether the condition occurs in all situations with all partners, or is limited to certain situations or partners. Although such information is helpful to the healthcare provider in providing clues regarding etiology, it may have only moderate bearing on the treatment choice made by the patient or couple.

Risk factors for and etiology of PE

The biopsychosocial approach attempts to identify not only those factors that lead to a particular sexual problem, but also those that might impact treatment outcomes and satisfaction. Sexual problems such as PE typically involve one or multiple factors, including physiological, psychological, relationship, and cultural factors. Here we identify common risk factors associated with PE that the healthcare provider might explore during assessment with the patient or couple. These risk factors may occur independently or simultaneously in any given man at any given time, and exploring them with the patient or couple may help in understanding the nature of the dysfunction, how it affects the patient, how it affects his partner, and how it affects the relationship.

Physiological/pathophysiological risk factors Biological risk factors may be either physiological or pathophysiological. Physiological risk factors are those that are inherent to the system—part of the person's hardwired neurophysiology. Pathophysiological risk factors, in contrast, are disruptions of normal biological processes and include disease, trauma, medication, and other biological conditions.

The majority of men with PE do not exhibit a pathophysiological problem, but if they do, their PE condition is most likely acquired and often detectable through a medical history and examination. Examples of pathophysiological problems associated with PE include lower urinary tract symptoms (LUTS) and endocrine problems—particularly those related to thyroid function (Rowland & McMahon, 2008; Waldinger, 2008)—as well as changes brought on by medications, recreational drugs, and aging. It might be noted, however, that effects on ejaculatory response from these latter sources tend to be transient and inconsistent. Men with organic erectile dysfunction (ED) appear to be at greater risk for PE as well, although for such men, determination of which problem—PE or ED—is primary and which is secondary is crucial to a treatment program.

Physiological risk factors are more difficult to identify. They are part of the person's hardwired or inherent biological functioning and thus should show variation across individuals. It has been hypothesized (and in some instances, empirically demonstrated) that men with short ejaculatory latencies might be hypersensitive in terms of their penile sensory response, or hyper-responsive in terms of their autonomic and/or somatic neuromuscular response (Colpi,

Fanciullacci, Beretta, Negri & Zanollo, 1986; Fanciullacci, Colpi, Beretta & Zanollo, 1988; Motofei & Rowland, 2005; Paick, Jeong, & Park, 1998; Rowland, 2010). Although to date no indisputable evidence exists to support one explanation over another, most would agree that, as with any bio-behavioral response, natural variation occurs in ejaculatory latencies among men—presumably a positively skewed distribution—with some men ejaculating rapidly, others after a number of minutes and thrusts, and still others only after an extended period of time. Multiple physiological systems including sensory receptor sensitivity, neurochemical production, utilization, and degradation, and neuromuscular response could all contribute to such individual variation.

From the healthcare provider's perspective, pathophysiological and physiological factors have several implications. First, any man suspected of having developed PE recently should be referred for a medical exam that might include attention to urinary tract and endocrine abnormalities. Second, the healthcare provider might educate the patient regarding possible inherent (and naturally occurring) biological differences in the hardwiring of ejaculatory response, thereby removing some of the burden of guilt and responsibility often associated with this sexual dysfunction.

Psychological risk factors Psychological factors, including culturally derived, learned behavioral patterns, as well as the man's own performance expectations, anxiety, and guilt pertaining to partner interactions, may all influence a man's sexual response, including his ejaculatory patterns (Rowland, 2012). Furthermore, psychological and biological components may precede one another or offer reciprocal maintenance. Reciprocating effects from sexual failure or impairment might include lowered self-confidence, sexual self-efficacy, and relationship efficacy (Althof, 2007; Melnik, Glina, & Rodrigues, 2009; Perelman, 2006; Rowland, Adamski, Neal, Myers, & Burnett, 2015). Any of these may create a mindset of failure that maintains or intensifies the problem. Sometimes underlying learned response patterns used by the man to counter the problem actually worsen the condition, and may foster a sense of inability to regain control over the condition, for example, attempting to postpone ejaculation through non-arousing or distracting thoughts. Indeed, anxious attempts to control the ejaculatory response may sometimes result in less overall control.

From the healthcare provider's perspective, an understanding of the man's personal experience of his impairment is useful: how it makes him feel, how it affects his thoughts and feelings, how it affects his relationship with his partner, and so on. Furthermore, the healthcare provider could benefit from knowing about the patient's current or past history involving depression, anxiety, psychopathological disturbances, or unusual psycho-behavioral patterns, as these may help explain risk, etiology, or exacerbation of the PE symptoms or issues pertinent to the man's relationship with his partner.

Relationship factors Although PE is the man's problem, it may well affect his partner. The partner may share in the distress, self-doubt, and dissatisfaction associated with this condition (McCabe, 1997; Rowland & Cooper, 2011), and a lack of satisfying sexual encounters can negatively impact the dyadic relationship. In addition, a partner with her/his own sexual issues (e.g., sexual dysfunction, negative attitudes about sex, certain religious beliefs) may exacerbate the problem or, equally important, interfere with an effective treatment program.

From the healthcare provider's viewpoint, evaluating both the man and his partner to determine the impact of PE on the couple's relationship may be helpful; it is also important, if possible, to engage the partner in the therapeutic process so the partner becomes part of the solution. Finally, addressing both sexual and non-sexual relationship issues—which are often intertwined—usually results in more positive outcomes than merely addressing narrow response sets such as ejaculatory latency.

Cultural and other sociodemographic factors Gender and sex role expectations may place further burden on the man and his partner to behave in specific ways within the sexual and dyadic context. Indeed, research by Kinsey and his colleagues (Kinsey, Pomeroy, & Martin, 1948) noted differences in reported ejaculatory latencies across countries, as well as differences in attitudes and expectations surrounding men's ejaculatory response and timing across different ethnic and religious traditions (McMahon, 2007). Besides gender and sex role cultural expectations, other sociodemographic variables such as religion, socioeconomic status, nationality, geographical region, age, race/ethnicity, sexual orientation, and degree of physical and emotional ability may affect an individual's sexual performance and sexual performance expectations. Each person's sexual knowledge, attitudes, and behavior may be differentially affected, more or less, by each of these cultural and sociodemographic variables, in isolation and in interaction with each other.

From the healthcare provider's perspective, cultural influences on the perception of ejaculatory problems may be an important aspect of the development of PE. Social stigmatization, gender expectations both within and outside the dyadic relationship, religious beliefs about sexuality, and partner considerations may all affect how the man and/or his partner view the effects of the short ejaculatory latency and whether they are likely to seek medical or clinical advice.

Treating PE

Perhaps one of the greatest values the biopsychosocial approach brings to the treatment of sexual problems such as PE is an understanding of the complex ways in which one's physiology, emotions, thoughts, and behaviors interact to produce a functional or dysfunctional response. Thus, although no one really knows why some men seem unable to delay their ejaculatory response and others seem capable of doing so, the healthcare provider can probe the various psychobiological domains to determine where concerns and treatment goals lie and, following from that, what types of treatments are likely to be most effective. For PE, such treatment goals typically lie not only in the somewhat immediate problem of increasing the man's ejaculatory latency, but also in the broader goal of helping the couple to develop a more sexually satisfying and durable relationship. First, we discuss biomedical/physical treatment options separately from psychosexual therapy so there is an understanding of the variety and efficacy of tools currently available to healthcare providers. Then, in a later section, we suggest ways to integrate treatment modalities within a brief therapy context.

Assessment and diagnosis

Assessing and diagnosing PE in men involves two stages: (1) ensuring that the patient truly falls within the broad diagnostic criteria for PE; and (2) addressing specific elements critical to the man, partner, and relationship affected by PE-related problems, as noted above. Regarding the first stage, the healthcare provider should ensure that the ejaculatory latency is relatively short (less than a minute or two) and does not actually fall within or near the normal range for men (about six to ten minutes following penetration for most men). Men often complain of ejaculating before they wish despite the fact that their latency is typical. In addition, the healthcare provider should verify that the rapid termination of sexual intercourse results from an inability to delay ejaculation rather than from loss of erection or some other reason (e.g., hurrying sex due to fear of interruption from family).

Regarding the second stage, healthcare providers should obtain a medical and psychosexual history to rule out complications from medications, illnesses, surgeries, or other biological issues. Brief psychological and relationship histories, as well as assessment of current sexual

functioning, can help to assess the quality of the individual's sexual response cycle—desire, arousal, and orgasm—and may call attention to individual or relationship idiosyncrasies (Rowland & Cooper, 2011). Additional information gathered during assessment might include relationship quality with the partner, partner's sexual health and problems, cultural background, and developmental information about the patient's PE experiences. Understanding such issues will help in treatment planning as well as assessing the patient's or couples' level of motivation for change. Standardized assessment tools (see Table 6.1) may be used to assist in the assessment of the problem, but these should not substitute for a formal diagnostic interview.

Integrating available treatment options

Clinical experience and preliminary data suggest that multimodal approaches to treatment may result in the best outcomes for sexual problems (Althof, 2007; Melnik *et al.*, 2009; Perelman, 2006; Perelman & Rowland, 2006; Rowland, 2011; Rowland, Cooper, & Macias, 2008). For example, behavioral interventions to address short ejaculatory latency along with couples therapy to address relationship and sexual satisfaction may generate better and more enduring positive outcomes than either approach used in isolation. Additionally, the inclusion of biomedical options may offer both hope and a renewed sense of self-efficacy.

Currently, the healthcare provider has a variety of options available for the treatment of PE, including (1) pharmacological methods that decrease penile sensation and/or centrally inhibit

Table 6.1 Examples of useful assessment instruments for PE and relationship functioning.

Medical/psychological assessments	
Index of Premature Ejaculation (IPE)	Ten items assessing control over ejaculation, satisfaction with sex life, and distress in men with PE (Althof *et al.*, 2006, pp. 474–475, copyrighted, special access)
Premature Ejaculation Diagnostic Tool (PEDT)	Reliable, easy, and fast 5-item tool assessing diagnostic criteria for PE (Janini, McMahon, & Waldinger, 2013, p. 383) http://www.baus.org.uk/Resources/BAUS/Documents/PDF%20Documents/Patient%20information/PEDT.pdf
Premature Ejaculation Prevalence & Attitudes (PEPA)	Assesses basic PE parameters in five questions, including whether PE is considered a problem by the man and/or his partner (Patrick *et al.*, 2005, p. 361; Porst *et al.*, 2007, p 816.)
Male Sexual Health Questionnaire (MSHQ)	25-item questionnaire measuring erection, ejaculation, and sexual satisfaction with a focus on ejaculatory function; greater cultural sensitivity compared with some tools (Rosen *et al.*, 2007, pp. 805–809).
Relational assessments	
Dyadic Adjustment Scale (DAS)	Self-report measure of relationship adjustment, and partners' perception of satisfaction (Spanier, 1989) http://trieft.org/wp-content/uploads/2010/09/DAS+1.pdf
Golombok-Rust Inventory of Sexual Satisfaction (GRISS)	28-item questionnaire that assesses sexual satisfaction and dysfunction; may be used to track improvement over time as the result of medication or therapy (Rust & Golombok, 1985) http://www.psychometrics.cam.ac.uk/productsservices/psychometric-tests/GRISS
Self-Esteem and Relationship Questionnaire (SEAR)	Short questionnaire for measuring sexual relationship, confidence, and self-esteem (Cappelleri *et al.*, 2004) http://www.nature.com/ijir/journal/v16/n1/fig_tab/3901095t1.html

the ejaculatory response, (2) behavioral options that attenuate penile sensory input, (3) behavioral/cognitive/affective strategies that may both increase awareness of penile sensations and help establish a positive framework for change, and (4) relationship strategies that encourage patient–partner interactions and that focus on enhancing sexual enjoyment (Rowland, 2012).

Biomedical options

Biomedical treatments for PE have typically taken one of two forms: (1) anesthetizing substances or physical barriers applied to the penis that attenuate penile sensitivity and (2) orally-based neurotransmitter reuptake inhibitors—especially selective serotonin reuptake inhibitors (SSRIs)—that act primarily by affecting central serotonergic activity.

Topical ointments, creams, gels, and sprays Topical ointments, creams, gels, and sprays are local anesthetics that diminish sensation in the sensory organ, in this case the penis. These preparations—often available over-the-counter—typically contain lidocaine, prilocaine, or various proprietary preparations, and may more than double the ejaculatory latency for men with PE, as well as increase reported ejaculatory control and quality of life (e.g., Dinsmore *et al.*, 2007). The major downside, although preventable by using a condom, is diminished vaginal sensitivity and possible female anorgasmia in partners. However, this group of treatment options often provides an expedient and inexpensive means to increase the man's ejaculatory latency.

Neurotransmitter reuptake inhibitors This class of medications has been shown to have varying effects on delaying the ejaculatory response. Pharmacological agents for the treatment of PE have most often involved daily dosing, although a number of recent studies have demonstrated substantial efficacy when used "on-demand", with the man taking the drug several hours prior to anticipated sexual activity. Two types of drugs are most often used.

Selective serotonin reuptake inhibitors (SSRIs), known most for their antidepressant use, can effectively delay or inhibit ejaculation. Paroxetine appears to be the most effective SSRI compound, typically delaying ejaculatory response by up to five minutes. None of these compounds has received regulatory agency (e.g., US Food and Drug Administration [FDA]) approval for treatment of PE, although they have been prescribed "off-label", typically at lower doses than when used as an antidepressant.

Dapoxetine is the first compound developed specifically for the treatment of PE. This drug also acts as an uptake inhibitor (like the SSRIs) and, given its other pharmacokinetics (rapid onset and short half-life), is designed to be taken on-demand one to two hours prior to intercourse. Its efficacy appears to be moderate, increasing latency from about one to several minutes (Pryor *et al.*, 2006). Although dapoxetine has been approved for use in a number of European and Asian countries, at this time it has not been approved by the US FDA.

Treatment of PE and comorbid erectile dysfunction may also be attempted by combining anti-ejaculatory and pro-erectile drugs. About a third of men with PE also report problems with erection, and in these instances, it is important to determine which problem is primary and which is secondary. For example, if a man is ejaculating quickly in order to avoid losing an erection, then the erectile problem needs to be addressed. In some instances, PE and ED are concomitant, with no clear etiological sequence, and these men may be candidates for treatment with both an SSRI and a phosphodiesterase-5 (PDE-5) inhibitor, such as sildenafil (Viagra). Because SSRIs themselves can exacerbate an erectile problem, the addition of a PDE-5 inhibitor helps the man maintain his erection and reduce performance anxiety while delaying his ejaculation (Sommer, Klotz, & Mathers, 2005).

Psychobehavioral treatment options

Psychological therapy options may be seen as nested within the behavioral, cognitive, affective, and relational domains (Rowland & Cooper, 2011). These options can be implemented individually or fully integrated, depending on the severity of the PE and the extent of its collateral effects on individual and relationship functioning. In addition, these approaches may be integrated with pharmacotherapy, with their combination typically being more effective than medication alone (Althof *et al.*, 2014).

Behavioral approaches Behavioral approaches, which were first popularized in the form of Semans' (1956) and Kaplan's (1974) start-stop method as well as Masters and Johnson's (1970) squeeze method, continue to play important roles in the treatment of men with PE. Both the start-stop and squeeze methods involve periods of penile stimulation followed by stimulation withdrawal as the man reaches increasingly higher levels of arousal. Such methods are based on a learning paradigm in which the man (1) learns to recognize the sensations of impending ejaculatory inevitability and (2) successfully inhibits further stimulation until the sensation ceases. Both squeeze and start-stop methods can be used in conjunction with other behavioral adjustments designed to slow the man down and/or to speed the partner up. These methods might include specific types of foreplay that avoid direct penile stimulation and focus on arousing the partner, particular intercourse positions (e.g., partner on top), specific movements during intercourse (e.g., manual stimulation of the partner's genitals during quiescent non-thrusting intervals), as well as relaxation and deep breathing exercises that may slow hyperarousal. Some men may also benefit from a procedure utilizing masturbation exercises (e.g., using a handheld vibrator), with the intention of increasing awareness of sensations under moderate levels of penile stimulation (Jern, 2013).

Research on these methods suggests moderate benefit for most men, with success rates ranging from about 40–75% after six months (see Rowland & Cooper, 2011). However, men suffering from ante-portal ejaculation (ejaculation prior to partner penetration) or very short latencies (e.g., within 10–15 seconds following penetration) may not benefit from behavioral strategies without the inclusion of pharmacotherapy. Specifically, pharmacotherapy, when introduced early in the treatment process, may be used to build the man's confidence and, equally important, lengthen the ejaculatory latency in order to provide a greater pre-ejaculatory timeframe for recognizing the premonitory sensations of ejaculation.

Because these behavioral procedures are relatively straightforward, couples can often implement them using bibliotherapy (e.g., Metz & McCarthy, 2003) or internet counseling, or under the guidance of a non-specialist healthcare provider (see Connaughton & McCabe, this volume, and van Lankveld, this volume, for further discussion of minimal contact therapies).

Cognitive approaches Cognitive approaches generally play no direct role in lengthening ejaculatory latency, but they can be used to lessen the patient's negative disposition regarding his PE. Additionally, these interventions help to instill a positive attitude, which is important to successful treatment outcomes and overall satisfaction. For example, one set of cognitive techniques focuses on identifying and countering mental processes that may be exacerbating the PE, such as self-defeating thoughts or distorted expectations about sexual performance. Examples of self-defeating thoughts include: "My having PE now and in the future is inevitable because I had PE yesterday" or "My partner is worried that I will ejaculate before she/he is sexually satisfied." Examples of distorted expectations are: "I should always be able to bring my partner to orgasm in every single sexual encounter" or "Non-penetration-induced orgasms are inferior."

Furthermore, evidence-based strategies such as the "Decibels" and "Counters" techniques can be applied to assist men in reframing their cognitions surrounding their sexual problem

(see Rowland & Cooper, 2013, for a more detailed description). Briefly, in the Decibels technique (Ellis, 1992), the patient addresses a series of questions regarding his dysfunctional condition, including:

1 What irrational belief do I want to reduce?
2 What evidence exists for the falseness of this belief?
3 What evidence exists for the truth of this belief?
4 What are the worst things that could actually happen to me if I don't get what I think I must (or if I do get what I think I must not)?
5 What good things could I make happen if I don't get what I think I must (or if I do get what I think I must not)?

Somewhat similarly, using the Counters technique (Hackney & Cormier, 2009), the patient creates concise believable counter-statements that might be rehearsed frequently to offset distorted cognitions.

Other cognitive techniques focus on the use of self-instructions—known as coping thoughts (McMullin, 2000)—such as "just relax and enjoy" or "I can slow down and stop moving if I feel like doing so." Such self-directives may then be practiced both overtly during sexual encounters and covertly through imagery practice.

A final set of cognitive methods focuses on modifying PE-related affect, that is, having men with PE develop awareness of negative feelings during sexual interactions, which then might be recast into positive feelings. Mindfulness techniques provide one possible effective strategy for achieving this goal, not only enabling improved somatic/interoceptive awareness, but also reducing symptoms associated with sexual problems such as anxiety, self-judgment, and ruminating thought patterns.

Affective approaches Affective approaches have not typically been used in the treatment of men with PE, but may be considered when emotional problems interfere with treatment progress. The rationale for supporting interventions with this focus emerges from research indicating that emotions play a role in the development and maintenance of PE by increasing anxiety surrounding sexual interactions and reinforcing negative expectations (Rowland & Cooper, 2005). The main form of affective-oriented intervention is emotion-focused therapy (Greenberg, 2004; see also Johnson, this volume), which assists patients in experiencing and expressing emotions if their suppression is creating difficulties, or regulating emotions if overexpression is creating difficulties.

Relational approaches Relational approaches view PE as embedded in the man's relationship with his partner; thus the PE may be better treated with the partner included in the treatment. Such approaches are most relevant when sexual impairment has a broader impact on the couple's interactions (e.g., guilt, blaming, avoidance), but may also assist in bringing the man and his partner toward a closer understanding of each other's experiences as related to the dysfunction.

Relationship-based strategies may focus on communication within the couple or on behaviors they engage in with each other. Couples therapy can also be used to address broader issues within the relationship, including intimacy, quality of interactions, and overall satisfaction. Relationally-based techniques specific to PE may include permission-giving, specific suggestions, sensate focus exercises, start-stop or squeeze methods, stimulus reduction strategies, relapse prevention, or intensive couples therapy. A full range of couples counseling approaches may be used if relational issues beyond the PE are germane to treatment success.

Couples counseling may take any number of different forms, including communication (Gottman, 1993; Satir & Baldwin, 1983), cognitive-behavioral (McMullin, 2000), strategic

(Haley, 1990), and narrative (White, 2007; see also Findlay, this volume) therapies. Communication approaches, for example, seek to examine and alter the overt and covert messages between partners that affect their perceptions, thoughts, and feelings in order to validate each person's sense of self-worth. As applied to PE, such approaches would seek to alter each other's messages about their sexual bodies and experiences, with the goal of promoting congruence and validating each person's self-worth. Couples cognitive-behavioral therapy may be helpful in reinforcing positive behaviors within the couple's sexual and interpersonal exchanges. The strategic therapy approach, emanating from a systems perspective, would emphasize moving the couple beyond a homeostasis that sometimes occurs when they adapt to sexually dysfunctional interactions. The narrative approach could assist couples in creating a productive accounting for the dysfunctional response and make attempts to reduce or eliminate the problem by working towards change as a collaborative team.

In addition to these specific approaches, the therapist may also use a wide variety of techniques. Negotiating; altering the couples structure; using parallel questioning with each partner; generating interactions; altering coalitions; confronting discrepancies between thoughts, feelings and actions; reconstructing boundaries; reframing; giving directives; and using paradox and symptom prescription may all help the couple to construct a more helpful alliance for reducing their PE-related issues (Hackney & Courmier, 2009). Selection of the approaches and strategies to employ with the couple would be tailored to their dynamics and needs.

Although none of the above approaches directly addresses short ejaculatory latencies typical of PE, they may help the couple deal with relationship problems that result from or exacerbate the problem, and thus lessen the impact of therapeutic strategies. Given that professionally trained therapists are typically familiar with a broad range of therapeutic tools and approaches within their counseling practices, they could selectively apply elements of one or more approaches as necessitated by the specifics of the couple's situation.

Understanding Inhibited Ejaculation (IE)

Sometimes referred to as "retarded" or "delayed ejaculation," herein we categorize all situations in which men have difficulty reaching orgasm/ejaculation—whether merely delayed or fully absent—under the nomenclature of inhibited ejaculation (IE), recognizing that in some circles, IE refers specifically to the complete inability to reach ejaculation. The prevalence of IE is unclear, in part because data defining the maximum duration of "normal" ejaculatory latency are essentially nonexistent. Furthermore, larger epidemiological studies have not subdivided men into various types of diminished ejaculatory function. For example, the continuum (and/or overlap) from delayed to absent ejaculation has not been adequately explored.

Nevertheless, in the past, IE had been reported at fairly low rates in the literature, typically around 3–5%, and thus it had been seen as clinically uncommon. However, based on more recent clinical impressions, some urologists and sex therapists are reporting increasing incidence of IE (see Rowland *et al.*, 2010), leading to higher population estimates of up to 10–15% (see Lewis *et al.*, 2010). The prevalence of IE appears to be moderately and positively related to age—not surprising in view of the fact that ejaculatory function as a whole tends to diminish with age. However, no large-scale studies have systematically investigated the strength or reliability of this putative relationship

Defining IE

No clear guidelines are available for defining IE. DSM-5, which uses the terminology "delayed ejaculation," characterizes the dysfunction as a marked delay in ejaculation or marked infrequency or absence of ejaculation on at least 75% of occasions involving partnered sex; the

condition causes clinically significant distress and has persisted for at least six months. Using these general parameters, we suggest the following three conditions for IE as ones that parallel those for PE: (1) Given that median ejaculation times are around 7–10 minutes (±3–4 minutes), men who take more than about 15 minutes (i.e., more than about two standard deviations above the average) on at least 75% of occasions during partnered sex to reach ejaculation or who terminate intercourse without ejaculation due to frustration or exhaustion; (2) men who are unable to advance their ejaculatory response; and (3) men who are distressed or bothered by the situation or whose partners are bothered or dissatisfied, are candidates for an IE diagnosis.

Lifelong vs. acquired IE As with PE, healthcare providers traditionally distinguish between lifelong and acquired IE. Lifelong IE has been present throughout the man's sexual life and typically has no clear etiology. Acquired IE occurs after some period of normal function and typically results from pathophysiological, psychological, or relational changes. In some instances, it is also relevant to specify whether the IE is specific to situations, partners, or type of activity (e.g., intercourse vs. masturbation) or a more general condition that occurs during any sexual situation.

Risk factors for and etiology of IE

Physiological/pathophysiological risk factors As with PE, biological risk factors for IE may be either physiological or pathophysiological. Men with IE based in a pathophysiological condition most typically have acquired IE, information that will probably emerge through a medical history and examination. Specifically, any procedure, disease, or condition that disrupts sympathetic or somatic innervation to the genital region has the potential to affect ejaculatory function and orgasm. Thus, spinal cord injury, multiple sclerosis, pelvic-region surgery, severe diabetes that leads to diminished penile sensitivity, LUTS, and medications that inhibit α-adrenergic innervation of the ejaculatory system (e.g., alpha blockers used to control high blood pressure) have been associated with IE. Nevertheless, a sizable portion of men with IE exhibit no clear pathophysiology that can account for the disorder.

No clear physiological factors are known to account for delayed or inhibited ejaculation. As with PE, natural variation occurs in ejaculatory latencies among men, with some consistently falling toward the right tail of the distribution. Multiple physiological systems including diminished sensory receptor sensitivity (e.g., due to aging); reduced neurochemical production, utilization, and degradation; and reduced neuromuscular response could all contribute to a tendency toward longer latencies, but evidence suggesting any particular component or system is scant.

From the healthcare provider's perspective, pathophysiological and physiological factors have two implications. First, any man having recently acquired IE should be referred for a medical exam that might include attention to the pelvic area, recent medications, or other disease conditions or states. Second, the healthcare provider might educate the patient and his partner regarding possible inherent (and naturally occurring) biological differences in the hardwiring of ejaculatory response, thereby removing some of the burden of guilt and responsibility often associated with this sexual dysfunction.

Psychological and relationship factors Both psychological and relationship factors may well account for long or increasing ejaculatory latencies. Psychological factors may involve specific emotions and cognitions that associate anxiety and negative performance expectations with sexual intimacy. Relationship factors may be associated with current interpersonal dynamics or with longer-term relationship developmental changes. In some instances, sex with the partner may be insufficiently arousing for the man to reach ejaculation, a situation that may involve any

number of factors operating individually or together. For example, the amount of penile sensation and psychosexual arousal may be attenuated due to diminished stimulation provided by the partner (e.g., loss of vaginal elasticity with aging). In some instances, the man may have a strong "autosexual" orientation that involves an idiosyncratic and vigorous masturbation style—carried out with high frequency—which does not "match" vaginal stimulation. As a result, vaginal stimulation may no longer be sufficiently arousing to induce ejaculation. In other instances, disparity between the reality of sex with the partner and the man's sexual fantasy used during masturbation is another potential cause of IE (Perelman & Rowland, 2008). This disparity may involve multiple factors, such as partner attractiveness and body type, sexual orientation, and the specific sexual activity performed. Such behavioral and cognitive patterns may well predispose men to experience problems with ejaculation, resulting from the lack of sufficient psychosexual arousal during coitus to achieve orgasm.

Finally, the evaluative/performance aspect of sex with a partner can create "sexual performance anxiety" for the man, a factor that may contribute to IE. Specifically, anxiety surrounding the inability to ejaculate may draw the man's attention away from erotic cues that normally serve to enhance arousal. Some such men may be over-conscientious about pleasing their partner and lose focus on arousing stimuli (Apfelbaum, 2000).

From the healthcare provider's perspective, it is useful to have an understanding of the man's personal experience of his impairment—how it affects his thoughts and feelings, how it affects his relationship with his partner, and so on. Furthermore, evaluating both the man and his partner to determine the impact of IE on the couple's relationship may be helpful. For the treatment of men with IE in particular, it is also important, when possible, to engage the partner in the therapeutic process, as she/he is an important part of the solution. Finally, addressing both sexual and non-sexual relationship issues—often intertwined—may result in more positive outcomes than merely addressing ejaculatory latency.

Treating IE

A holistic, biopsychosocial approach to the treatment of IE allows exploration of interrelated physiological, psychological, and relationship issues that affect sexual response and dysfunction. For IE, the immediate problem is that of increasing arousal in order to decrease the man's ejaculatory latency, but the broader goal involves helping the couple achieve a more sexually satisfying relationship. As with PE, we discuss biomedical/physical treatment options separately from psychosexual therapy. Then, in a final section, we suggest a more integrated treatment process.

Assessment and diagnosis

Assessing and diagnosing IE in men typically includes three steps: (1) ensuring that the patient truly falls within the broad diagnostic criteria for IE; (2) referring the man for a medical evaluation if pathophysiological factors are suspected, for example, if the IE is a recent development; and (3) addressing specific contexts critical to the man, partner, and relationship that may help in understanding the etiology, dynamics, and consequences of the IE problem. Regarding the first step, the healthcare provider should ensure that the ejaculatory latency is relatively long and indeed falls substantially beyond the normal range for men, or, alternatively, that the man terminates intercourse out of frustration or exhaustion. In addition, the healthcare provider should verify whether the long latency to ejaculation is specific to the partner (e.g., does not typically occur during masturbation) or is generalized to all sexual situations and activities.

The healthcare provider should obtain a medical history to rule out complications from medications, illnesses, surgeries, or other biological issues, particularly if the condition developed recently (i.e., suspected acquired IE). Brief psychological and relationship histories, as well as assessment of current sexual functioning and intercourse dynamics with the partner (how much and what type of foreplay, sexual positions, etc.), can help to assess the quality of the individual's sexual response cycle (desire, arousal, and orgasm) and may reveal individual or relationship idiosyncrasies, as well as identify personal or relational events that might help explain recent changes in the ejaculatory latency. Additional information to include in assessment might include questions about relationship quality with the partner, partner's sexual health and problems, cultural background, and developmental information about the patient's IE experiences. Understanding such issues will help in treatment planning as well as in evaluating the patient's or couple's level of motivation for change.

Integrating available treatment options

As noted previously, multimodal approaches to treatment may result in the best outcomes for sexual problems. For example, addressing long ejaculatory latency along with relationship and sexual satisfaction is likely to generate better and more enduring positive outcomes than just addressing latency. The inclusion of the partner is particularly important, as exercises designed to overcome IE often include a critical role for her/him.

Currently the healthcare provider has a variety of options available for the treatment of IE, including (1) behavioral options that increase and/or modify penile sensory input; (2) cognitive/affective strategies that enhance arousal as well as help establish a positive framework for change; and (3) relationship strategies that encourage patient–partner interactions that focus not only on enhancing arousal, but also on increasing the sexual enjoyment of both partners.

Pharmacological options In contrast to several pharmacological options for the treatment of PE, safe and effective medications are only now being investigated for IE, and as of this publication, none show extraordinary promise. In fact, pharmacological options have been used most often to counter the ejaculatory-inhibiting effects of other medications. For example, some full-strength antidepressants (e.g., paroxetine [Paxil]) make it more difficult for men (and women) to reach orgasm, so substitution with another antidepressant such as bupropion or buspirone may have a lesser effect (Rowland *et al.*, 2010).

With regard to IE not related to medication, few options are available. The anti-serotonergic agent cyproheptadine and the dopamine agonist amantadine have both shown, somewhat anecdotally, moderate success, but the potential adverse effects, lack of controlled investigation, and lack of regulatory approval prevent wide-scale use of these agents for IE treatment. As research continues to uncover greater understanding of the mechanisms that trigger the ejaculatory response, the likelihood of finding pro-ejaculatory agents will increase. In the meantime, IE appears to respond quite well to non-pharmacological strategies, including behavioral, psychological, and relationship therapies.

Psychobehavioral approaches

Similar to treating men with PE, therapeutic interventions for men with primary or secondary IE may be nested within behavioral, cognitive, and relational approaches (Rowland & Cooper, 2011, 2013). This section summarizes interventions in these three domains and is followed later in this chapter by the presentation of a structured brief treatment framework that providers can use with men with either PE or IE, relying on key process interventions that might be broadly applied to either orgasmic disorder.

Behavioral approaches Behavioral approaches to treat IE, whether primary or secondary, were first pioneered by Masters and Johnson (1970) and have continued to be a mainstay in the psychosexual treatment of men with this condition. As an underlying justification for the effectiveness of these techniques, many of those with IE report greater satisfaction from masturbation than from intercourse. Specifically, some men with IE report engaging in a high frequency of masturbation; others exhibit vigorous masturbation with idiosyncratic speed, pressure, duration, and intensity that is inconsistent with the experience of partnered sex. Men with IE sometimes show a combined pattern of styles—high frequency and vigorous masturbation—which may contribute to their inability to reach orgasm with a partner.

Disparity between the sexual fantasy used in masturbation and the real-life sexual experience with a partner may also contribute to IE (Perelman & Rowland, 2006). Sources of the disparity may involve the attractiveness and body type of the partner (which may have changed over time) and the specific sexual activity performed (which may be less arousing if it is less preferred by the man).

Such etiological factors indicate that the inability to reach orgasm in many men may result from insufficient psychosexual arousal during intercourse. Notably, this problem with lack of arousal may extend to men using PDE-5 inhibitors such as Viagra or Cialis. In such cases, men's ability to get an erection is enhanced by the medication; thus, lower levels of subjective arousal are required for an erection, and these levels may be insufficient for ejaculation and orgasm. As a consequence, strategies to overcome IE typically include steps to increase psychosexual arousal in the man.

A longstanding behavioral approach for IE is masturbatory retraining, integrated into sex therapy as a form of "dress rehearsal" for sex with a partner (Perelman, 2006). Initially, the goal of such masturbatory retraining is to determine sexual stimulation preferences and to use them to identify and experience sexual arousal and pleasurable sensations. At this stage, orgasm is not the sought endpoint, simultaneously lessening pressure and facilitating the association of partner touch and interaction with stimulation and arousal.

The end goal of masturbation retraining is to stimulate sufficiently high levels of psychosexual arousal within the experience of partnered sex, so the man is able to reach orgasm with his partner. At times, and especially for those men with IE who have a strong autosexual orientation, an interim phase may involve suspending all masturbatory activity—or permitting masturbation only with the non-preferred hand in order to counter particularly vigorous or idiosyncratic patterns—for a period of time (e.g., two weeks to two months) during the treatment process. Although a patient may resist this mandate if he has a strong autosexual orientation, both the therapist and partner can offer support and encouragement as the man learns to redirect his arousal toward partner cues and stimulation and away from autosexual cues. The patient and his partner may be encouraged to engage in mutual masturbation, using fantasy, various forms of erotica, and body movements more consistent with partnered sex. During such sessions, the partner can observe the kinds of stimulation the man with IE prefers, simulating those as a prelude to intercourse. At the same time, the partner's masturbatory activity can become a means for enhancing the man's own sexual arousal level.

Cognitive approaches Cognitive approaches also have application to treatment of men with IE. First, it may be important to "normalize" or reframe the situation. Specifically, some men with IE might benefit from understanding that time to ejaculation approximates a normal distribution, with some men naturally falling at the higher end of this distribution. Additionally, cognitive therapy methods may be included as part of the treatment process. As one example, men with IE may be overly focused on rigid performance expectations; on pleasing their partner (to the point of distracting from their own sexual arousal); or on fear of dissatisfaction, disparagement, or disapproval by their partner. Cognitive approaches, including the Decibels technique described under the treatment of PE, could be used to successfully counter such

thought patterns. Another cognitive strategy, thought-stopping, could prevent men from engaging in self-defeating predictions that often escalate anxiety and other unwanted behaviors (such as giving up or even avoiding intimacy altogether). Such strategies, when combined with positive self-talk or positive self-instructions, may enable the man to focus on actions and sensations that increase psychosexual arousal. Finally, men can learn mindfulness methods to enhance their awareness of somatic and subjective experiences of arousal and to reduce sexuality-related distress.

Relational approaches Relational approaches are critically important in the treatment of men with IE, so partners should be included whenever possible. From a relational perspective, a man's total sexual stimulation level represents the combination of physiological/tactile/sensory stimulation and emotional/relational processes; thus, arousal can be enhanced through changes to the relational interactions. For example, the couple may share sexual fantasies; the goal is to heighten sexual arousal during intercourse and to align, when possible, masturbation fantasies with intercourse fantasies. The partner might engage in behaviors and mannerisms aimed at increasing his/her seductiveness to the partner, and the couple might expand their sexual styles and sexual behavioral repertoire. At times, underlying issues associated with stress related to conception/procreation and with anger/resentment may need to be explored and worked through.

Whatever relational strategies are explored and decided upon by the therapist and couple, the willingness and collaboration of the partner is critical (Perelman & Rowland, 2008). Unless the partner is fully engaged as therapy progresses, the partner may feel that she/he is simply providing a substitute for the partner's masturbatory activity (e.g., adjusting sex to his preferred speed, enacting his preferred fantasies). Such feelings might well be valid, and the therapeutic process may require interim steps that address the partner's feelings of self-worth. The therapist, as well as the patient, needs to approach such issues with sensitivity and reassure the partner that greater intimacy and satisfaction for both partners is the ultimate goal.

A Multimodal Approach to Treating Men's Orgasmic Difficulties

An integrative, multimodal treatment approach for PE or IE may be implemented in a variety of ways. Such integrative treatment could involve pharmacological (if available), behavioral, cognitive, relational, and cultural intervention strategies as best fit the patient's needs. While avoiding specific formulas, herein we describe one approach that healthcare providers might emulate or borrow as they develop and implement a treatment plan for men and couples with PE or IE.

Specifically, we propose a four-phase process—involving approximately two to six sessions—of a modified PLISSIT model (Annon, 1976) to help men with PE or IE. A modified version of the PLISSIT model is suggested because this model is well known to most practitioners and because it engages the patient at increasingly deeper levels during each subsequent session, allowing the patient/couple to opt out at any point in the process if they are satisfied with their gains. Specifically, the PLISSIT model has four levels of intensity beginning with Permission, continuing with Limited Information, Specific Suggestions, and Intensive Therapy (Annon, 1976). Furthermore, the PLISSIT model provides the healthcare provider with an overarching structural framework for approaching treatment, tailored by the patient and the provider in an emergent fashion, to the patient's/couple's particular treatment issues and goals.

Brief therapy is suggested for two reasons:

1 Barriers to treatment (cost, effort, access) need to be kept low; this is particularly relevant for treating men's orgasmic concerns because only a limited percentage of men with PE or with IE muster the courage to seek help.

2 Most of the relevant issues and strategies related to orgasmic difficulties in men can be handled in a limited number of sessions (Althof, 2006).

Specifically, brief therapy may productively address PE or IE in men who would not be willing to consider longer-term medical or psychosexual treatment.

A sample treatment plan

A sample treatment plan is summarized in Figure 6.1.

Phase 1 This phase, usually completed in a single session, involves four parts:

1 Gathering relevant psychosexual, relationship, and medical information, including comorbidities, and making appropriate medical referrals (if necessary). Much of the patient's history can be obtained through questionnaires, formal assessments, and/or interview. Examples of useful instruments for assessing psychological and relational aspects of PE are provided in Table 6.1. No standardized instruments are available for IE, but an innovative healthcare provider could easily adapt one of the PE tools for use with men with IE. A standard practice is to have the patient and his partner complete several assessment tools prior to the initial session so the healthcare provider can focus on any unusual or revealing responses as part of the interview.
2 Educating the patient/couple about the sexual response cycle and dysfunctions; in other words, providing the Permission plus the Limited Information in the PLISSIT model. Specifically, the educational component might include a brief description of the components of the sexual response cycle; the physiology underlying these processes; the many ways in which the processes can be disrupted through medical, biological, cognitive, behavioral, relationship, and sociocultural factors; and permission-giving for alternative strategies for achieving sexual enjoyment. This information could be supplemented with bibliotherapy homework. Bibliotherapy can be a useful form of preliminary treatment to educate patients about the problem; normalize patient feelings, thoughts, and behaviors; and suggest behavioral techniques to affect ejaculatory latency (Kempeneers *et al.*, 2012; Perelman, 2006; Rosen & Althof, 2008). Four useful up-to-date bibliotherapy materials related to treatment of men with PE and IE are:
   - *Sexual Dysfunction in Men* (for both PE and IE; Rowland, 2012);
   - *Coping with Premature Ejaculation: How to Overcome PE, Please Your Partner, and Have Great Sex* (Metz & McCarthy, 2003);
   - *Practical Tips for Sexual Counseling and Psychotherapy in Premature Ejaculation* (Rowland & Cooper, 2011); and
   - *Retarded and Inhibited Ejaculation* (Perelman & Rowland, 2008).
3 Discussing treatment options and modalities. The healthcare provider may continue the session by reviewing the variety of treatment options, the value and limitations of each, and how they might be combined in mutually enhancing ways.
4 Setting goals, building a personal treatment plan, and managing expectations. The patient and healthcare provider will want to set realistic and achievable goals related to sexual response, individual psychological/sexual health, and relationship satisfaction.

Phase 2 In preparation for the second phase one to two weeks later, the patient will have reviewed the bibliotherapy materials about PE or IE and will have learned some specific techniques that might be helpful. From the standpoint of the PLISSIT model, this phase focuses on giving further Permission, providing additional Limited Information, and offering Specific

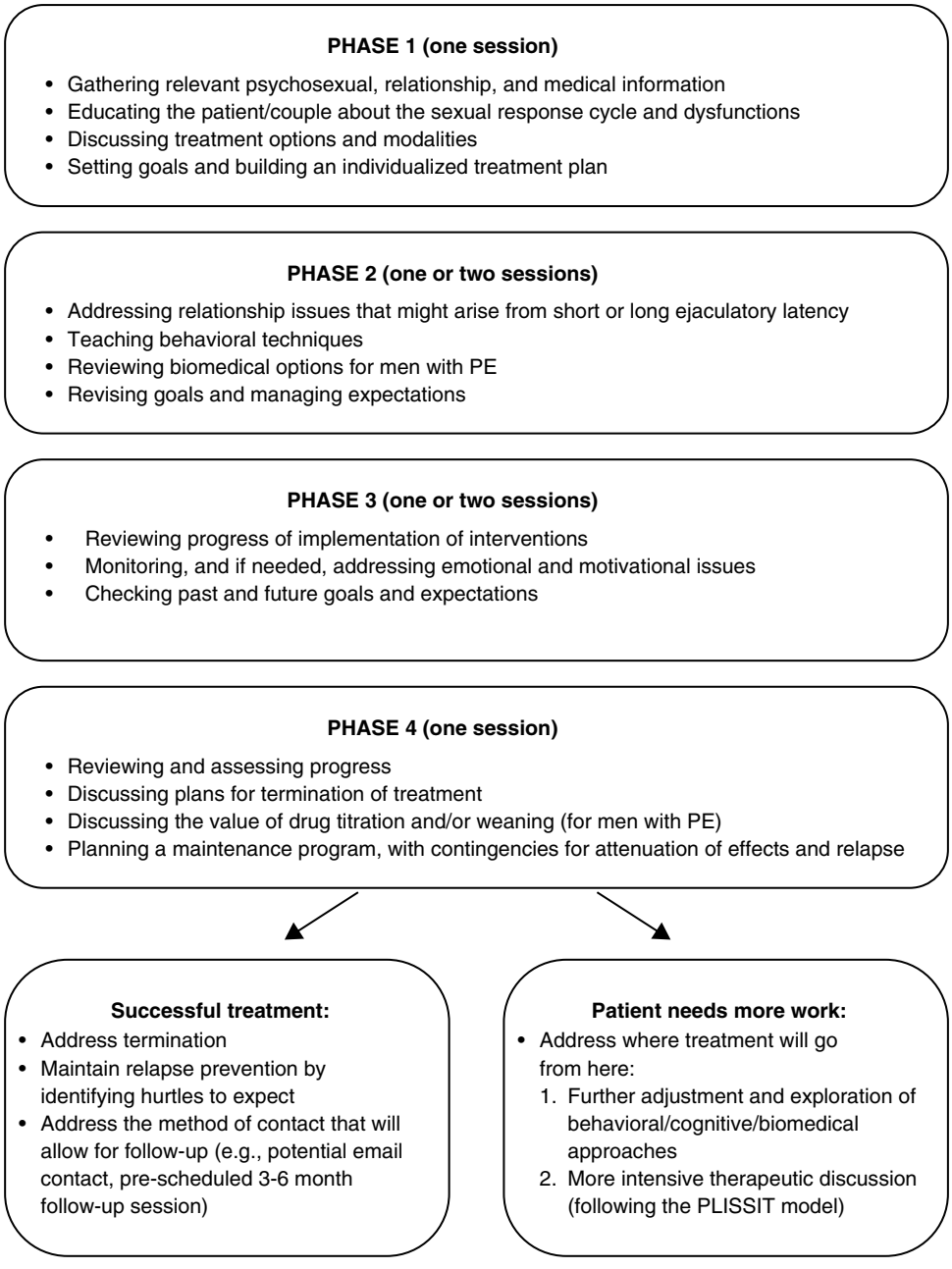

Figure 6.1 Integrative treatment flow chart for PE/IE.

Suggestions. The next one to two sessions might begin with the suggestion that the patient keeps a sex log to provide accurate information for all parties. A sex log may include any information deemed relevant by the healthcare provider, the patient, and his partner (see Table 6.2 for an example).

Subsequent to describing the sex log and its utilization, the provider and patient could focus on the following steps:

1 Addressing relationship issues that might arise from short or long ejaculatory latency, including strategies to improve the relationship through communication, acceptance, and mutual satisfaction. This might also involve expansion of the sexual repertoire. Discussion of relationship issues may reveal the nature and depth of the problems (e.g., lack of confidence, guilt, anger), or the relationship may not be problematic at all. In either case, practicing positive communication skills can be done proactively if the patient's partner is participating in the therapy, and assessment of the partner's support for the therapeutic process is important (DeCarufel & Trudel, 2006; Graziottin & Althof, 2011; Pridal & LoPiccolo, 2000). This initial focus on dyadic interactions may help to ensure a high functioning relationship, which is likely to optimize the effects of treatment.
2 Teaching behavioral techniques, including practical tips that focus on intercourse position, stop-start and squeeze exercises, foreplay strategies, sensate enhancement techniques, arousal enhancement, or masturbation retraining with attention to premonitory sensations of ejaculation. Patients/couples also can be provided with information about the general efficacy of these procedures, which have success rates of about 40–75%, depending on the couple's motivation and adherence. The patient/couple may want to discuss physical limitations or issues preventing them from using specific techniques. The healthcare provider also may spend time on nonsexual strategies, such as sensate focus and mindfulness, to increase relaxation, focus, and somatic awareness, which may help the couple to discover alternative strategies for mutual pleasure.
3 For men with PE, discussing the benefits and limitations of physical/medical interventions (i.e., condom, anesthetizing cream, on-demand SSRI, daily SSRI) with the goal of deciding which, if any, to try. If they have not yet tried a physical/medical intervention, the couple might select one or more options to "test drive" during the next several weeks. Discussion of how physical/medical and behavioral techniques can be integrated can guide the couple towards the most effective use of these treatment aids, with suggestions as to how they might be woven into sexual activity.
4 Revisiting goals and managing expectations. Depending on patient progress after the second phase, and at the healthcare provider's discretion, there may be differing lengths of time between the second and third sessions in order to accommodate patient needs. If it appears that more intense relationship exploration could be beneficial, the healthcare provider may provide a referral for couples therapy (Intensive Therapy in the PLISSIT model).

Phase 3 Phase 3 might involve only one or two sessions, unless the patient or couple opts for more intensive individual or couples therapy. This phase would address the following steps.

1 Reviewing progress thus far, including the efficacy of various behavioral techniques and, when applicable, physical/medical interventions. Much of this session continues to incorporate Specific Suggestions in the PLISSIT model. At this point, the patient and healthcare provider should assess whether treatment seem to be working, or whether there needs to be a shift in the treatment process to better help the patient. For men with PE, this assessment may include a discussion of the use of physical/medical options and whether the patient sees them as beneficial as a short- or longer-term strategy.
2 Monitoring and, if necessary, addressing on a limited basis any issues related to unrealistic expectations and negative thoughts and emotions. Therapeutic interventions could include countering cognitive distortions, processing negative feelings or thoughts, addressing inaccurate beliefs, and promoting sexual self-efficacy (Rowland, 2013).

3 Checking past and future goals and expectations, including whether and how treatment should proceed. At this point the patient/couple may be progressing well and need minimal further assistance such that maintenance will soon be the new and final focus, or they may not be doing so well and thus need a modified treatment plan. Patients who are doing well may suspend further sessions or schedule the final phase in several weeks, and those who are still having negative sexual experiences may schedule an interim working session (or two) before their final session.

Phase 4 This final phase might be scheduled two to three weeks later, unless additional working sessions are needed to discuss referrals for individual or couples therapy or to address issues that might have arisen during Phase 3. In the case of the latter, a follow-up session within one week may be preferred. Phase 4 is the final step in the process, so the session focuses on the following goals.

1 Reviewing and assessing progress, including ejaculatory latency, continued use of behavioral and physical/medical strategies, and general psychological (cognitive, affective) and relationship health. If the patient has not had much success thus far, two additional strategies might be considered: (a) further adjustment and exploration of behavioral/cognitive/biomedical approaches or (b) more intensive therapeutic discussion (following the PLISSIT model) concerning interpersonal or relationship problems that may be connected to the patient's sexual problems or preventing the full effect of the treatment process. Whichever strategy is pursued, the patient's feelings should be validated and processed, followed either by an adjustment to the patient's current treatment plan or by referral for individual, couples, or group therapy.
2 Discussing plans for termination of treatment, with attention to adherence to previously successful techniques, as well as longer term goals.
3 Discussing the value of drug titration and/or weaning (for men with PE). Specifically, the couple may want to try weaning themselves from SSRI medication if they are using it; because such medications must be used as part of each intercourse, the couple may want to attempt intercourse occasionally without this aid, relying exclusively on psycho-behavioral techniques.
4 Planning a maintenance program, with contingencies for attenuation of effects, relapse, and so on. Specifically, the patient and healthcare provider can discuss lapse/relapse prevention, hurdles to expect, and when the situation might warrant a "refresher" or "support" session (see McCarthy & McCarthy, 2009, for strategies to keep the sexual relationship vibrant).

Process issues Although our description of the progression through Phases 1 to 4 has focused on "content"—the information, skills, and techniques conveyed to the patient—within any counseling environment, the healthcare provider must pay equal, if not greater, attention to "process" issues. Process involves two elements: (1) the strategic use of verbalizations (Rowland & Cooper, 2011, 2013)—what Busse and colleagues (Busse, Kratochwill, & Elliott, 1999) defined as "message control" and "message process"—which guide the patient in defining goals and developing self-identified strategies to meet those goals and (2) the manner in which the content elements described above are implemented within the relationship between the healthcare provider and patient/couple. Process elements of integrative therapy most relevant to PE and IE are: (a) developing a positive healthcare provider–patient relationship; (b) expressing empathy, genuineness, and positive regard; (c) promoting motivation to change, a process that typically involves working through resistance; (d) identifying PE/IE-related affect, cognitions, and behaviors (including interactional patterns with partners); and (e) supporting self-efficacy. Each of these is described in greater detail in Rowland and Cooper (2011).

Case Study

Steven and Rochelle, a couple in their mid-40s, met when both were in college studying business. They married subsequent to graduation and had three children, who were aged 18, 15, and 10 years at the time of treatment. Both Steve and Rochelle had wanted this size of family and felt fortunate to have three healthy children, as they had friends who had experienced fertility issues. Steven was employed as a marketing executive with a mid-sized manufacturing firm, and Rochelle worked as the comptroller for a local hospital. As a dual-career couple, money was not a major issue, but with children and aging parents to care for, time for each other and the relationship was a limited commodity. The current quality of their marriage was neither highly conflicted nor highly satisfying. Along with a general diminishment of marital satisfaction over the prior few years, however, the quality of their sexual life had deteriorated significantly. This had manifested in issues of low sexual interest for Rochelle and a mix of IE and periodic erectile dysfunction (ED) for Steven. Recently, they had stopped having sexual relations and realized that this must be addressed if the marriage was to thrive and perhaps even survive.

Steven and Rochelle sought a referral from their primary physician to a healthcare provider (HCP) in a urology practice with a background in the treatment of sexual dysfunctions. The HCP utilized an integrative care approach that included an in-facility therapist with expertise in behavioral and psychotherapy methods for sexual and relationship problems. The couple contacted the specialized urology practice and an initial appointment was set for two weeks. A brief screening had taken place on this call to provide the HCP with an initial presentation of the treatment issues. The couple was informed that they would be receiving several questionnaires in the mail ahead of the assessment interviews, which they were to complete (independently) and bring with them. The particular questionnaires included a modified version of the Premature Ejaculation Prevalence & Attitudes (PEPA) measure (Patrick et al.,2005; Porst et al., 2007) such that IE rather than PE was the focus of the questions, the Male Sexual Health Questionnaire (MSHQ; Rosen et al., 2007), and the Golombok-Rust Inventory of Sexual Satisfaction (GRISS; Rust & Golombok, 1985).

Relevant psychosexual, relationship, and medical information, including comorbidities, were assessed during the initial meetings with the HCP and the therapist. The HCP focused on the historical and current medical and biological aspects of their sexual functioning, and the therapist focused on the psychosocial, relationship, and cultural aspects of these. The HCP and therapist jointly met with the couple to review their proposed treatment plan. This plan included educating the couple about the sexual response cycle and dysfunctions. They were given three supplemental readings to augment the in-session education, specifically Sexual Dysfunction in Men *(Rowland, 2012),* Sexual Dysfunction in Women *(Meana, 2012), and* Discovering Your Couples Sexual Style: Sharing Desire, Pleasure, and Satisfaction *(McCarthy & McCarthy, 2009). They were instructed to peruse these resources before the next treatment session. The HCP and therapist discussed possible treatment options with Steven and Rochelle. The couple elected to use medication (a PDE-5 inhibitor such as Viagra or Cialis) to help Steven regain confidence that he could keep his erection sufficiently long for prolonged intercourse due to his IE. In addition, they were offered a brief therapy regime to address both sexual enhancement and broader relationship satisfaction. The HCP and therapist each conveyed that, although the likelihood of improvement was high, the couple should expect occasional setbacks. Finally, the therapist instructed the couple in the use of a sex log (see Table* 6.2*).*

Steven and Rochelle came to the clinic for their second session two weeks later. They reviewed their sex log with the HCP and discussed the effects—wanted and unwanted—of the medications. Steven and Rochelle then met with the therapist. They used this time to address relationship issues that arose from particular incidents of long ejaculatory latency that they had experienced since the initial assessment session. Strategies to improve the relationship through communication, acceptance, and mutual satisfaction, including some ideas on expansion of the sexual repertoire, were covered in this session. To enhance their sexual functioning, the therapist helped the couple

Table 6.2 Example log of sexual experiences to be given as homework.

Sex Log								
Date	**Time of day**	**Time until ejaculation**	**Techniques or methods**	**Feelings (before, during, after)**	**Successes and/or challenges**	**Patient's satisfaction: rated (1-5)**	**Partner's satisfaction: rated (1-5)**	**Physical/medical intervention used (condom, cream, medication)**

learn behavioral techniques, including practical tips that focused on intercourse position (e.g., identifying a position that provides maximal stimulation for Steven), foreplay strategies (e.g., allowing Steven to guide Rochelle regarding the kinds of stimulation that are most arousing for him), masturbation retraining (e.g., including Rochelle in masturbatory exercises that use varying types of penile stimulation), and fantasy sharing (e.g., revealing sexual scenarios that Steven and Rochelle find particularly arousing). At the end of this second session, the couple faced a decision about whether to add more sessions to focus more deeply on their broader relationship issues or to keep the focus more on a restoration of their sexual functioning as a couple. Steven and Rochelle elected the latter, so the treatment plan was for the couple to return for two to three more sessions depending on progress made.

Steven and Rochelle returned three weeks later. They met with both the HCP and therapist to review progress, including the efficacy of various behavioral techniques and medical interventions. The couple had had a positive therapeutic response from the medication, but Steven complained of some unwanted side-effects; thus, adjustments were made in the dosage of medications used. For the counseling component, the therapist used the time with the couple to help them more deeply process their respective underlying cognitions and affects surrounding their sexual encounters and relationship. As a result of the prior sessions, Steven and Rochelle reported being more expressive and open about their wants and dislikes and more flexible in the ways they incorporated sexual touch and contact together, given their overly busy lives. At this time, they also were encouraged to use some of the techniques provided by McCarthy and McCarthy (2009) to rejuvenate their sexual interest.

Steven and Rochelle returned for the next session three weeks later. As before, they again met with both the HCP and therapist. The session began with a review and assessment of progress, including ejaculatory latency, behavioral and medical strategies, feelings of sexual interest and intimacy by each partner, and general psychological (cognitive, affective) and relationship health. The couple reported making gains regarding better and more open communication as well as feelings of stronger arousal and intimacy for both, but they acknowledged that, on two occasions, they had experienced setbacks in which the IE reoccurred during sexual encounters. Details of both the successes and the setbacks were discussed. Discussion took place as to whether to schedule a follow-up session or to continue on their own with medication and the techniques they had learned in the psychotherapy, calling for an appointment only if needed or desired. Steven and Rochelle elected the latter. The couple felt they had made sufficient progress to discontinue the therapy. The therapist used the remainder of this fourth session to help the couple address challenges of adherence to and compliance with previously attempted techniques, as well as longer-term goals. Attention to relapse prevention and the importance of having realistic expectations was covered, with added reference to the bibliotherapy resources. The HCP then met with Steven and Rochelle to discuss the value of drug titration and/or weaning from the medication and to plan a maintenance program, with contingencies for attenuation of effects. Both the therapist and the HCP included discussion of the couple's situation that might warrant a "refresher" or "support" session. With improved communication and intimacy, and significant progress regarding their sexual relationship and satisfaction, the couple left feeling optimistic about their longer-term outlook.

Conclusions

The brief therapy PLISSIT model as described here represents a conceptual composite rather than an empirically tested, formulaic treatment program for orgasmic disorders. That is, we have provided a series of progressive steps supported by various general treatment strategies and have included specific strategies effective in the treatment of PE and IE. Furthermore, the brief counseling model we have described assumes a traditional delivery format—namely face-to-face sessions. With the advent of electronic media, a significant portion of this

interaction could be accomplished through the internet, websites, or email. Indeed, internet counseling has provided a particularly effective way of reaching patients in remote places, patients who lack easy access to specialized healthcare providers, or patients who have limited financial resources (van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009). Prescribed email communications may provide an option for periodic updates that could obviate the necessity for additional sessions. We presume that a significant amount of the content described in the two- to six-session brief therapy model could, depending on the preferences of the therapist and patient, be handled through an online format.

Finally, the use of the sex log of activities fits well into the growing movement known as "practice-based evidence." Practice-based research relies on the ongoing collection and utilization of data to target problem areas and assess the overall effectiveness of the treatment in order to increase the likelihood of change. The idea is to constantly monitor and adjust the treatment approach as warranted by the data (Miller, Duncan, & Hubble, 2004). In addition, assessment of the patient–therapist alliance (a process issue) and the patient's satisfaction with the therapeutic process and outcomes provide important data-based endpoints, so these should be assessed as well.

In conclusion, the combination of a variety of therapeutic tools based on a biopsychosocial approach, a rigorous but brief counseling format that incrementally progresses to deeper levels of engagement, and an embedded assessment process could render the therapeutic approach for PE and IE both effective and cost-efficient.

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7

Treating Genital Pain Associated with Sexual Intercourse

Marta Meana, Evan Fertel and Caroline Maykut

Introduction

Until the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), women who experienced difficulties with penile-vaginal intercourse were generally diagnosed with either dyspareunia or vaginismus (DSM-IV-TR; American Psychiatric Association, 2000). Dyspareunia was the diagnosis given to those who reported persistent and distressing pain with intercourse, and vaginismus was generally diagnosed in women who reported that penetration (vaginal entry) was either impossible or close to impossible. Twenty years ago, the validity of these diagnoses started being questioned in the literature (Meana & Binik, 1994; Meana, Binik, Khalife, & Cohen, 1997). Was dyspareunia better conceptualized as a sexual dysfunction involving psychosexual disturbances, or as a pain disorder that interfered with sex only incidentally? Was vaginismus a categorically different disorder characterized by a purported penetration-blocking muscle spasm, or was it just the extreme end of a dyspareunia symptom continuum?

These questions spawned two decades of research initially focused on the sensory and neural properties of the pain experienced in dyspareunia and its parallels with other pain syndromes. Increasingly over time, the emphasis has shifted to the cognitive, affective, and relational components of painful intercourse. Once it was established that painful intercourse was clearly not a purely psychogenic phenomenon, explorations of its psychological and relational sequelae were in less danger of being misinterpreted as inferring etiology. Most of these investigations were conducted with women suffering from a specific type of dyspareunia (provoked vestibulodynia) believed to be the most common type in pre-menopausal women (Bergeron, Rosen, & Pukall, 2014). As for vaginismus, the failure to identify uniquely associated muscle-tone characteristics did not overshadow the fact that fear and avoidance of intercourse remained more prominent in women identified as having vaginismus than in women with dyspareunia (Binik, 2010a; Reissing, 2012). This body of research culminated in a proposal to move pain associated with intercourse out of the sexual dysfunctions section of the DSM and to create a new diagnostic category in the DSM-5: genito-pelvic pain/penetration disorder (GPPPD; Binik, 2010a, 2010b). The proposed move was not adopted. The new diagnosis was.

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

The Nature of GPPPD

Description

The new diagnosis of GPPPD emphasizes pain as a defining characteristic of this disorder, and collapses the DSM-IV-TR categories of dyspareunia and vaginismus. It requires the presence of at least one of four commonly comorbid symptoms: (1) difficulty with vaginal penetration during sexual intercourse; (2) marked genital or pelvic pain during intercourse attempts; (3) significant fear of pain as a result of vaginal penetration; and (4) tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (American Psychiatric Association, 2013). Although in the DSM-IV-TR dyspareunia was applicable to both men and women, GPPPD is, by definition, a female sexual dysfunction. As in the case of all of the other sexual dysfunctions in the DSM-5, the difficulty has to have persisted for a minimum duration of approximately six months; cause clinically significant distress; not be better explained by a non-sexual mental disorder, severe relationship distress, or other significant stressor; and not be attributable to the effects of a substance/medication or another medical condition. The diagnosis of another sexual dysfunction does not preclude the diagnosis of GPPPD. GPPPD has two specifiers that it shares with most other sexual dysfunctions. The first relates to whether the dysfunction is *lifelong* or *acquired* after a significant period without difficulty. The second specifier is the level of distress experienced (*mild, moderate, severe*).

Notably, because the diagnostic criteria for GPPPD are new, the research on prevalence, etiology, and treatment outcomes reviewed below utilizes samples of women who meet diagnostic criteria for dyspareunia or vaginismus or who complain of some genital pain without necessarily meeting diagnostic criteria. Research on samples of women that specifically meet criteria for GPPPD is not yet available.

Epidemiology

Prevalence estimates for painful intercourse vary widely depending on the population sampled and the timeframe specified, but it remains a very common disorder. In Laumann, Paik, and Rosen's (1999) nationally representative sample of women aged 18–59, 14.4% of women endorsed that they had experienced physical pain during intercourse over a period of several months in the past year. Since then, a number of epidemiological studies have yielded estimates ranging from 14–34% in younger women and 6.5–45% in older women (van Lankveld *et al.*, 2010). The prevalence for vaginismus symptoms (e.g., severe penetration difficulty and high fear/anxiety and avoidance of intercourse) is significantly lower (0.4–6%) (ter Kuile & Reissing, 2014).

Etiology

Previous versions of the DSM approached the question of etiology in sexual pain disorders from a categorical perspective, whereby the cause was considered to be psychological, physiological, or a combination of both, and the DSM included specifiers to denote these three possible causes. This perspective assumed an ability to tease apart cause from consequence, and it failed to distinguish originating factors from pain-maintaining factors whose causal force could far outlast the power of the original pain trigger. The research of the last few decades does not support this clean division; therefore, a biopsychosocial approach to the study and treatment of GPPPD and all of the sexual dysfunctions is recommended (Binik & Meana, 2009; van Lankveld *et al.*, 2010). In recognition of this complexity, the DSM-5 has removed etiology as a specifier for the sexual dysfunctions; yet it remains somewhat stuck in the dichotomy by attempting, in Criterion D, to exclude cases attributable to the effects of another

medical condition. As we shall see below, the most common type of genital pain, provoked vestibulodynia, could arguably be referred to as a medical condition.

Genetic, neurobiological, and medical factors Research on the genetics of genital pain associated with intercourse is in its infancy, but separate studies have found that approximately 30% of female sufferers report having relatives with the same complaint (Burri, Cherkas, & Spector, 2009). A susceptibility to inflammatory disorders and genetic polymorphisms have been identified for provoked vestibulodynia (PVD, formerly referred to as vulvar vestibulitis; Gerber, Bongiovanni, Ledger, & Witkin, 2002), considered the most common cause of genital pain in pre-menopausal women (Harlow, Wise, & Stewart, 2001). PVD is a subtype of vulvodynia (the term given to chronic pain around the entry to the vagina, usually of unknown etiology) characterized by a burning pain experienced when pressure is placed on the vulvar vestibule (entry of the vagina; Moyal-Barracco & Lynch, 2004). The pressure of any mechanical contact (e.g., tampon, speculum) with the area results in pain—it is not limited to sexual intercourse although, clearly, penile-vaginal penetration is likely to be very painful. The precise etiology of PVD is unknown, but both peripheral and central mechanisms are suspected (Bergeron *et al.*, 2014). Nociceptor proliferation and sensitization (i.e., an increase in number or sensitivity of nerve receptors for pain), lower touch and pain thresholds, vaginal and urinary tract infections, and early and prolonged use of oral contraceptives have all been associated with genital pain and PVD (van Lankveld *et al.*, 2010). Pelvic floor muscle disturbances (e.g., hypertonicity [a tightness of the muscles] or poor muscle control) have also been found in women with genital pain and difficulty with penetration, although pelvic muscle tension may simply be a defense reflex in response to anticipated pain (ter Kuile & Reissing, 2014). Postmenopausal reductions in estrogen can also result in changes in vaginal length, elasticity, and lubrication that may produce genital pain during sexual intercourse. Pelvic, rather than genital, pain during intercourse is most commonly associated with conditions such as endometriosis, pelvic inflammatory disease, interstitial cystitis, and polycystic ovarian syndrome. These conditions, however, typically result in chronic pelvic pain that is not exclusive to sexual intercourse (Meana, 2012).

Cognitive-affective and relational factors Much as in the case of other pain disorders, the intensity of pain and its functional interference with sexual intercourse have been associated with certain cognitive and affective styles. Chief among these are somatic hypervigilance, pain catastrophizing, and fear of pain. Also implicated are negative attitudes about sexuality, distraction from sexual cues, anxiety, negative causal attributions for the pain, feelings of low self-efficacy in coping with pain, and depressive symptoms (Desrochers, Bergeron, Landry, & Jodoin, 2008; Meana, 2012). The fear-avoidance model of chronic pain is increasingly being used to explain the negative feedback loop produced by GPPPD, wherein an initial pain experience produces fear and catastrophic thinking about the pain and what it means. This in turn leads to a somatic hypervigilance that magnifies all potentially negative sensations, increasing the fear and leading to avoidance and disability (Vlaeyen & Linton, 2000).

Relationship adjustment has not been reliably linked to genital pain, although relationship factors appear to play an important role in pain intensity, wellbeing, and sexual function (Smith & Pukall, 2011). More specifically, highly solicitous (e.g., partner halts all sexual activity at the first hint of the woman's discomfort) or negative (e.g., hostile or angry) partner responses have been linked to greater pain and worse sexual function. Facilitative responses (e.g., partner encourages and positively reinforces the woman's attempts to have sex) are associated with lower pain reports and greater sexual function (Smith & Pukall, 2011). Finally, a history of sexual, physical, and psychological abuse appears to be more common in women who report pain with intercourse or difficulties with penetration, although it is important to remember that the majority of women with genital pain do not have such a history (Harlow & Stewart, 2005; Landry & Bergeron, 2011; Reissing, Binik, Khalife, Cohen, & Amsel, 2003).

Treatment Outcome Research

There has been very little treatment outcome research on any of the sexual dysfunctions, including the DSM-IV-TR diagnoses of dyspareunia and vaginismus. Furthermore, methodological limitations abound in this research, including lack of control groups, variability in outcome variables and their specification, insufficiently well-described or standardized treatment protocols, and a paucity of long-term outcome assessment. There are fewer than a handful of randomized controlled clinical trials, and none have tested the concurrent multidisciplinary approach to treatment that is likely to have the optimal effect, given the biopsychosocial nature of genital pain. In addition, most of the treatment outcome research on pain during intercourse has been conducted on genital rather than pelvic pain associated with intercourse. This may be because the pathophysiology of pelvic pain with intercourse can be more immediately identified and addressed medically. Nevertheless, below is a brief review of the treatment research to date.

Medical, surgical and physical therapy treatments

For genital pain associated with PVD, lidocaine, a local anesthetic that can be applied to the vulva, has shown promising results for women in two prospective studies that lacked placebo control conditions (Danielsson, Torstensson, Brodda-Jansen, & Bohm-Starke 2006; Zolnoun, Hartmann, & Steege, 2003). Low-dose tricyclic antidepressants, often used in the treatment of other chronic pains, have shown efficacy in some studies, but performed no better than placebo in others (Foster *et al.*, 2010; Reed, 2006).

Despite the understandable reticence of many physicians to recommend surgical intervention given its highly invasive nature and the generally spotty history of surgical interventions for pain, vestibulectomy boasts success rates of 65–70% or higher (Landry, Bergeron, Dupuis, & Desrochers, 2008). Vestibulectomy is a surgical procedure that involves excision of the vestibular area with vaginal advancement (i.e., increasing the size of the vaginal opening), as necessary. It requires general anesthesia and lasts approximately 30 minutes. One randomized treatment outcome study compared vestibulectomy, group cognitive-behavioral sex therapy/pain management (CBT), and EMG biofeedback (Bergeron, Khalifé, Glazer, & Binik, 2008). Vestibulectomy effected twice the pain reduction of the two other treatments, although all three treatments evidenced improvements at six-month follow-up. Over two years after treatment, the gains in pain reduction remained greatest for vestibulectomy, as assessed by the cotton-swab test in the clinic (palpation of the vulvar vestibule with a cotton swab). Interestingly, however, women in the vestibulectomy condition did not differ from those in the CBT condition in terms of self-reported pain during intercourse.

Electromyographic (EMG) biofeedback training to treat genital pain with intercourse has had some success, although not greater than that of other treatments. EMG biofeedback training for genital pain generally involves the vaginal insertion of an EMG sensor that provides feedback to the woman on her actual muscle tension, and then, through a series of muscle-contracting exercises, trains her to control and adjust the tension at will. In a retrospective study, Glazer, Rodke, Swencionis, Hertz, and Young (1995) found that half of their 33 patients reported pain-free intercourse after the EMG intervention. Improvements were also found by Bergeron *et al.* (2008) and Danielsson *et al.* (2006), although gains did not differ significantly from CBT or lidocaine. More comprehensive pelvic floor physical therapy consisting of a home program of exercise and behavioral therapy, manual therapy, exercise, biofeedback, and electrical stimulation, appears to have a significant impact on the treatment of painful intercourse (Rosenbaum, 2007).

Retrospective and prospective studies have indicated that physical therapy may result in pain reduction during gynecological examinations, reports of decreased pain during sexual

intercourse, and improved sexual function (Bergeron *et al.*, 2002; Gentilcore-Saulnier, McLean, Goldfinger, Pukall, & Chamberlain, 2010; Goldfinger, Pukall, Gentilcore-Saulnier, McLean, & Chamberlain, 2009). Studies on the efficacy of physical therapy for women whose symptoms resemble the old diagnosis of vaginismus are lacking, although one retrospective study indicated efficacy similar to that found in women with genital pain, with perhaps the need for more sessions (Reissing, Armstrong, & Allen, 2013).

In general, for symptoms of the old diagnosis of vaginismus—fear of pain and penetration as well as hypertonicity—there is no evidence from controlled studies supporting the efficacy of a number of the interventions that have been attempted, including medications to target the anxiety, injections of botulinum toxin, or surgeries to enlarge the vaginal opening (van Lankveld *et al.*, 2010).

Sex therapy/pain management

For the treatment of genital pain, the sex therapy interventions that have been investigated are primarily cognitive-behavioral in nature and focus on reducing pain, increasing desire and arousal, and enhancing relationship dynamics by targeting distorted cognitions, dysregulated emotions, maladaptive behaviors, and damaging couple interactions. Bergeron *et al.* (2008) compared a group cognitive-behavioral sex therapy and pain management intervention (CBT) against EMG biofeedback, vestibulectomy, and corticosteroid cream in two different randomized studies of women with PVD. In the first study, participants who received CBT reported significant improvements in pain at a six-month follow-up, and at a 2.5-year follow-up, an improvement equivalent to women who had undergone a vestibulectomy. In the second study, women in the CBT condition reported significantly higher global improvements in pain and sexual functioning than women assigned to the topical application condition. In their randomized clinical trial, Masheb, Kerns, Lozano, Minkin, and Richman (2009) also found that CBT resulted in significant improvements in pain and sexual function in comparison with supportive psychotherapy.

For women with the DSM-IV-TR diagnosis of lifelong vaginismus, a randomized controlled trial of group CBT and bibliotherapy revealed that both treatments were superior to no treatment, although results were not particularly impressive (van Lankveld *et al.*, 2006). Only 21% of participants in the CBT condition and 15% in the bibliotherapy condition reported successful intercourse, albeit compared to none in the wait-list control condition. Ter Kuile, Melles, Groot, Tuijnman-Raasveld, and van Lankveld (2013) tested a therapist-aided exposure treatment with 70 women diagnosed with lifelong vaginismus in a multi-center controlled study. The outcome of this exposure-focused treatment was far more positive, with 90% of participants reporting successful intercourse and significant reductions in distress and negative cognitions related to penetration.

Treatment success or spontaneous remission?

Varying levels of treatment success have been reported with a large number of treatments either delivered singly or in combination. Most of these reports emanate from non-controlled studies with insufficiently long follow-ups. Nevertheless, vestibulectomy and sex therapy/pain management can be said to be the most rigorously validated and the most efficacious treatments. But what do we know about the natural course of genital pain that interferes with intercourse? If we waited long enough, would participants in the wait-list control conditions also experience improvement? A recent study by Davis, Bergeron, Binik and Lambert (2013) prospectively collected pain, sexual function, and treatment data on two occasions, two years apart, from 239 women with PVD attending vulvo-vaginal clinics. Surprisingly, women improved over the elapsed two years in terms of pain and sexual function

measures, regardless of whether they had had treatment at all and regardless of the type of treatment received. Although this study had a number of limitations, the findings call into question common assumptions about the chronicity of PVD and the superiority of any one treatment over others to effect change. It also underlines the need for randomized, placebo-controlled trials with long-term follow-ups of at least two years. Of course, clients cannot wait for this research to be conducted or to discover whether or not their pain and its sequelae will remit over time. It is thus incumbent on us to treat them in a way that is as evidence-based as possible.

A Concurrent Multidisciplinary Assessment and Treatment Approach

The ultimate goal of the collective research on painful intercourse has been the optimal assessment and treatment of the many women who suffer from this distressing disorder, which can seriously interfere with a woman's enjoyment of sex, her sense of self, and her intimate relationships. The impact of this concerted effort has been significant. Although uninformed healthcare providers are surely still out there, a woman with GPPPD should be much less likely than 20 years ago to hear that the pain is "in her head" or that she has to resolve issues with her femininity or her relationship. Nevertheless, the assessment and treatment of GPPPD is complex because of the commonly multifactorial nature of the problem. Treatment outcomes also appear to be highly variable.

What follows is a guide to the sex therapist's role in a concurrent multidisciplinary approach to assessment and treatment that optimally involves the woman and her partner (either in a group or couple intervention) and a variety of healthcare providers working as a team. Conditions may not always allow for this ideal setup. Partners are not always willing participants, healthcare providers with expertise in GPPPD are not always readily available outside of large metropolitan centers, and health insurance limitations may curtail a woman's access to some services. Adjustments may be necessary in such cases, but this road map may help the sex therapist make inroads into the amelioration of the painful intercourse problem, broadly conceived.

Assessment

The assessment of GPPPD follows from what we know from the research to be important components of its experience: pain, cognitions related to pain and penetration, sexual function, and relationship dynamics. Starting the assessment with a focus on the properties, potential physical etiology, and functional profile of the pain is important for two reasons: Pain is usually the defining symptom, and it is validating for the client who might be sensitive to not having the pain taken seriously. For the sex therapist, this assessment is ideally conducted through a clinical interview with questions such as:

- For how long have you had this pain?
- Where exactly does it hurt when you have or attempt to have sexual intercourse?
- How intense is the pain on a scale of 1–10?
- What words would you use to describe the quality of the pain?
- When does the pain start (before, during, or after penetration)?
- How long does the pain last?
- Does the intensity of the pain vary depending on certain conditions (e.g., fatigue, menstrual cycle, level of arousal)?
- Do you have genital pain with other sexual or nonsexual stimulation (e.g., finger insertion, oral sex, tampon insertion, gynecological exam)?

The assessment of pain can also be facilitated by self-administered measures such as the McGill Pain Questionnaire (Melzack, 1975) and by asking the client to keep a pain diary (if the client continues to attempt sexual intercourse). In addition, the client should be referred to a gynecologist, who can more systematically locate the painful area via a cotton-swab palpation of the vulva and a pelvic examination, and who can rule out obvious physical pathology (vulvar or pelvic diseases). A referral to a physical therapist specializing in pelvic floor dysfunction is also useful to assess the potential involvement of pelvic floor tonicity (muscle tightness or weakness). Particularly anxious patients (those who might have received a diagnosis of vaginismus in the past) may have difficulty tolerating a gynecological/pelvic examination or a physical therapy assessment. In these cases, referrals may only be possible after sex therapy has rendered such examinations tolerable. It is also important to identify gynecologists and physical therapists sensitive to these difficulties, as a negative experience could set the client back significantly. Release of information from these healthcare providers is also helpful to consult and coordinate interventions. Ideally, all healthcare providers can work concurrently as a treatment team.

The assessment of the pain properties is likely to reveal certain cognitions related to pain, penetration, and sex. However, it is also useful to address these directly in the assessment. What are their (woman's and her partner's) causal attributions for the problem? What do they think the problem means, if anything? What do they fear? What do they think is going to happen in the long run? Is there anything they fear in the resolution of the problem? Self-administered measures can also be helpful here: more specifically, the Pain Catastrophizing Scale (PCS; Sullivan, Bishop, & Pivik, 1995) and the Vaginal Penetration Cognition Questionnaire (VPCQ; Klaassen & ter Kuile, 2009). The VPCQ measures maladaptive cognitions about intercourse, including concerns about control, genital incompatibility, and self-image.

The sexual function of both the client and her partner needs to be assessed for the perceived impact of the pain on their frequency of intercourse, frequency of non-penetrative sex, desire, arousal, orgasm, and satisfaction, as well as for pre-existing sexual problems. Treatment will likely have to target all aspects of sexual function simultaneously. In addition to clinical interview questions about the quality of their sex life, self-administered measures of sexual function such as the Female Sexual Function Index (FSFI; Rosen *et al.*, 2000) for women and the abridged International Index of Erectile Function (IIEF; Rosen, Cappelleri, Smith, Lipsky, & Pena, 1999) for men will allow comparisons to broadly defined norms.

Finally, general relationship adjustment as well as relationship dynamics around the painful intercourse problem are important areas to cover. The research indicates that partner reactions to the pain are of particular interest, given their impact on the sexual function of both partners (Rosen *et al.*, 2013). Solicitous and negative responses are associated with poorer function, and facilitative responses are associated with better function. These response types can be enquired about retrospectively, or couples can be asked to keep a diary of such responses as per the research that uses such measures (Rosen, Bergeron, Leclerc, Lambert, & Steben, 2010).

The burden of the assessment of a biopsychosocial phenomenon is a heavy one, as multiple factors need to be considered, not all of which will be within the realm of the sex therapist's expertise. This will require consultation with other specialists. It is also crucial that assessment be integrated throughout the therapy. First, treatment cannot wait for all assessment avenues to have been exhausted. Second, clients and their partners may not always be able to self-report on influencing factors at a preliminary assessment. They may not have yet developed the trust needed to disclose, or alternatively, the treatment itself may reveal factors of which the client and her partner were initially unaware. The initial snapshot of the problem is likely to morph with time, trust, and the revelations that emerge when couples focus on a problem often long avoided. Importantly, assessment and treatment also require careful attention to religious and cultural factors. Culturally competent assessment and treatment of intercourse pain, as well as of other sexual problems, is guided by therapist consideration of diverse values attached to

sexuality, education in and respect for the client's belief system, the vetting of all interventions by the client's values prior to their implementation, and therapist flexibility in adapting interventions to align with the client's belief system (Meana, 2012).

Treatment Stage I: empowerment and reconnection

The first stage of therapy essentially involves education, anxiety reduction, setting goals, targeting biomedical influences, and reconnecting as a couple. The length of this stage will vary from couple to couple, but three to four weeks is not unusual. The aim is to empower clients to address their problem and connect them to potential solutions and to each other.

Education Couples who present with GPPPD will generally be distressed, know little about their problem other than the ways in which it negatively impacts their intimacy, and know even less about available treatments. Education about the prevalence of GPPPD and its various types and treatments will make them informed healthcare consumers, and importantly, it will also be experienced as validating. As clients come to realize that they are not alone—that there is a whole body of research focusing on their problem—and that they have options, their anxiety tends to decrease. Further, explaining the multidimensionality of pain and its impact on sexuality may open clients' eyes to the many factors that can influence pain, without sensing a dismissal of their symptoms as merely a function of psychological problems. This educational component is important, as it establishes the rationale for some of the interventions to follow.

Education, however, is not just about the provision of information to clients. In the spirit of increasing their sense of control and self-efficacy, it is important to make the clients active participants in the discovery of their own version of GPPPD. Genital self-exploration is one way to do this. Often, women who experience pain with intercourse will avoid their genitals and consequently lose a sense of their own control over them. Instructing women to engage in genital self-exploration will help them to locate painful areas, experiment with muscle exercises, and develop self-efficacy about the function of their genitals. Monitoring their pain with multidimensional pain diaries (e.g., inquiring about pain, conditions under which it happens, reactions to it) will also educate women and their partners about the properties of the pain and the contingencies that affect it.

Goal setting As the therapist is likely to be the first person in their lives who is educated about their problem, there is a risk that there will be very high expectations about the therapist's ability to resolve the GPPPD. Expectations need to be calibrated early on, and reasonable treatment goals need to be set, even if these result in some initial tempering of excitement. Aligning expectations with outcome data is important. Pain reduction is clearly going to be one of the treatment goals, but improvements in other aspects of sexual function (desire, arousal, orgasm), and in satisfaction with sexual interactions independent of pain reduction, need to feature prominently in treatment goals, treatment plans, and client hopes.

Anxiety reduction The anxiety with which clients initially present is likely related to the general impact of their problem and also to their apprehension about what treatments may entail. Many clients with GPPPD have been avoiding sex for a long time, not to mention avoiding discussing it with their partners. Suddenly, they are initiating a treatment that will inevitably have them discussing the tricky issue openly and engaging in the painful activity at some point. This anxiety can be somewhat allayed by the therapist first acknowledging the apprehension, reinforcing the positivity of help-seeking, validating the experience of pain, demystifying the pain through the aforementioned education, and illustrating that anxiety is not an inevitable reaction to the problem. Empowering clients early on to confront their anxiety through relaxation techniques and to take small steps toward cognitive restructuring and

decatastrophization can put them in the driver's seat of what once felt like a runaway vehicle. Additionally, informing the client that much of the therapy will focus on increasing desire, arousal, and intimacy, rather than on increasing intercourse frequency, will undoubtedly relieve some anxiety. Of course, improving these aspects of their sexual function is likely to increase intercourse frequency, but the entry point in therapy is not intercourse-focused. It is quite the opposite.

Reconnecting as a couple Although many couples with GPPPD are relating well to each other in areas other than sex, it is not unusual for avoidance of each other on multiple fronts to have crept into the relationship. Physical affection often has decreased over time, as women fear that it might lead to painful sex, and their partners either feel the women wincing or do not want to be perceived as trying to initiate a feared activity. This avoidance can start to generalize and result in an unfortunate general disconnection. It is thus important to address the couple's decision to seek help for GPPPD as an important reconnecting step. They are coming together to address this problem openly and with courage. Encouraging physical affection and other ways of being close is a useful early intervention that will facilitate the more sexually focused interventions to follow. Early in treatment, it is important that the physical affection be enacted outside of sex or attempts at sex, so that it is not paired with the anticipation of painful intercourse.

Targeting biomedical factors Early in this first stage of therapy, clients should be referred to the appropriate healthcare professionals, as relevant. A referral to a gynecologist and a physical therapist specializing in the pelvic floor will be indicated in almost all cases where this has not already occurred. Taking measures to have access to the results of such consultations is also imperative so that treatment can be coordinated. As such appointments can take a while to occur, clients should be referred as early as possible in the psychotherapy treatment.

Treatment Stage II: the crossroads of pain, sex, self, and partner

The core treatment of GPPPD simultaneously targets pain, sexual function and satisfaction, cognitive and emotive ways of coping, and a couple's way of relating, especially around the issue of pain. The trajectory of how this plays out in therapy will vary from couple to couple. For some, the relational component will rise to prominence early, whereas for others any relationship issues will only manifest themselves when the pain starts to subside. Regardless of the therapy rhythm in any one couple, pain, sexual function, individual thoughts and emotions, and couple dynamics are likely to be juggled throughout the treatment. The interventions employed are mostly from the therapeutic arsenal of general psychology and consist primarily of cognitive calibration, emotional regulation, stimulus control, behavioral activation, and relationship skills-building. Coordination with other treatments being simultaneously delivered by other healthcare providers (e.g., gynecologist, physical therapist) is essential throughout the therapy.

Coordination with medical and physical therapy interventions One of the burdens on the sex therapist treating GPPPD is being educated about purported medical etiologies and their treatment. If the gynecological consult has resulted in a recommendation for either a medical or a surgical treatment component, the sex therapist needs to be familiar with the treatment, the treatment outcome research, and any controversies surrounding it. As previously mentioned, the therapist can then review options with the client and help her arrive at an informed decision. If and when the client opts for a certain procedure or medical regimen, the therapist can help the client to adhere to the treatment, adjust to its effects, or augment its efficacy by concentrating on other important aspects of sexual function, individual wellbeing, and

relational dynamics. Coordinating treatment with the physical therapist is also recommended, especially with regard to vaginal dilatation and Kegel exercises. In vaginal dilatation, the client is instructed to insert dilators of increasing size into her vagina over a period of time. This intervention works in multiple ways: as a form of systematic desensitization, as a way of empowering women to test their own genital capability, and as muscular exercise. Kegel exercises involve the contracting and relaxing of pelvic floor muscles to build strength. These exercises can also increase the client's awareness and control over genital processes. However, the physical therapist is in the best position to determine whether these exercises are appropriate for any given client's tonicity profile, when they should be prescribed, and how they should be performed.

Cognitive calibration Couples with GPPPD often present with thoughts and attitudes about sex and pain that are counterproductive and can significantly worsen the situation. Clearly, unwanted pain during intercourse is in nobody's sexual script, and it is perfectly understandable why this script deviation would be distressing. However, individuals and couples do present with sexual scripts that are exclusively intercourse-focused and dismissive of other types of sexual activity. They also often present with scripts that place a high premium on sexual spontaneity. Attachment to these narrow ideas about how sex should progress can be an impediment to the couple coping with GPPPD. Challenging these sexual scripts is thus an important part of the intervention. Also common are client and partner fears related to their desirability, to infidelity, and to abandonment. Because many couples avoid talking about this problematic aspect of their relationship, some of these concerns flourish in the absence of discussion and disconfirmation. Bringing all of these fears to light can be very useful, as most are likely to be either disconfirmed or significantly moderated. Even if the concerns happen to be accurate, it is better to confront them than to let them fester.

Two prominent cognitive styles that have been identified in women who experience pain with intercourse are hypervigilance and pain catastrophization. Hypervigilance involves acute attention to and monitoring of pain cues and genital sensations that could signal the onset of pain. Pain catastrophization is a cognitive predilection that infers the worst possible outcome (e.g., irreversible physical damage) when pain is experienced. Hypervigilance and catastrophization serve to magnify the experience of pain and its perceived negative consequences. Hypervigilance and catastrophization can also generalize beyond the pain so that the relationship itself is closely monitored for signs of possible impending abandonment, and minor altercations are interpreted as portents of the end of the relationship. Challenging these magnification distortions is an integral part of treatment that will help decrease emotional reactivity.

Another helpful cognitive strategy involves the use of sexual imagery and fantasy. Encouraging positive sexual cognitions can increase desire and arousal, which in turn can enhance pleasure and reduce pain. The anticipation of pain in women who have GPPPD serves as a major distractor from sexual stimuli. Refocusing cognitions on sexual stimuli before and during sex can have significantly positive effects. Desire and arousal can also be facilitated by helping a woman to work on her sexual self-concept. Women who are coping with sexual dysfunction can come to lose a sense of themselves as sexual beings. Working towards reinstating their sexual self-concept can have a very positive effect, and this may involve very different strategies for different women. For some it may involve buying lacy lingerie, while for others it may involve a membership at the local gym. The point is to get the client to start feeling that she is sexy.

Emotional regulation Couples presenting with GPPPD often present with one of two types of emotionally dysregulated patterns. Either they have high levels of expressed negative emotion that feel out of their control in relation to the pain with intercourse, or they suppress these feelings for fear of the impact of the negative emotion on their relationship or on their partner's feelings. Both scenarios tend to interfere with progress. It is thus incumbent on the therapist

to facilitate an awareness of the emotions that are actually being felt by both parties. This is a first step towards targeting the negative emotions that only serve to complicate the problem.

Emotionally focused coping (i.e., focusing on and venting negative emotions) and avoidant coping (i.e., denying or ignoring negative emotions) generally both have negative results. Fear, anger, anxiety, and depressive symptoms can make clients feel out of control when freely expressed, or they can lead to disconnection and avoidance when suppressed. Helping clients and their partners to modulate their emotional reactions can reduce stress and help them progress through the interventions. Although a number of relaxation and mindfulness therapies have been deployed to this intended effect, teaching clients to relate differently to emotions may be more effective and longer lasting. Leading clients to the realization that emotions are neither reliable indicators of reality nor inevitable outcomes can be a powerful intervention. Clients can be successfully instructed in the precepts that emotional reactions are within their control and that feeling something does not necessarily mean that it is accurate or true. The erroneously yet generally accepted idea that we cannot help what we feel can be disconfirmed, and the discovery can be transformational for clients.

While all clients present with the hope of a complete resolution to their problem, and all therapists hope that they will succeed in fulfilling that hope, the reality is that therapy is generally as much about accepting limitations as it is about embracing change. Acceptance is thus an important part of emotional regulation. Some clients will fail to achieve the sexual function they wish they had for reasons outside of their control. Not all negative appraisals are distortions. Some are true. Accepting certain realities while trying to maximize sexual satisfaction within these limitations is an important goal of therapy that should not be undervalued or dismissed.

Stimulus control and behavioral activation Although intrapsychic factors are crucial to treatment, external conditions and behavioral activation are equally important and have great causal force. The maximization of desire and arousal, especially in the context of pain, will require facilitative conditions and effective sexual stimuli. Optimizing the timing and context during which sex is attempted may be central. Many couples report that sex is initiated at the "wrong time" by one or the other partner—at the end of the day when both are tired, when one is stressed, when one is in a hurry, or when privacy is compromised by children or other factors. Couples coping with sexual difficulties are more likely to make timing and context errors, as they are frustrated and have lost their sense of what an appropriate time might be, given multiple failures. Helping the couple choose times when reasonable conditions are met will nurture desire, arousal, and orgasmic capacity, and will facilitate attention to the coping strategies needed to successfully deal with pain and discomfort. It is also important to encourage couples to prioritize time for sex, as sex can easily, incrementally, and imperceptibly fall between the cracks of all the other responsibilities that busy couples are trying to juggle in their everyday lives. This may involve scheduling time for sex, which bucks the commonly held sexual spontaneity script. On the other hand, there is a pretty good chance that the spontaneity script is not working very well for most clients presenting with GPPPD.

It is common that, by the time clients with GPPPD and their partners seek help, their sexual interactions are failing on multiple levels. In these cases, it may be helpful to engage in a type of sexual retraining that focuses on sensuality and removes the pressure of performance and penetration. Sensate focus, a technique introduced by Masters and Johnson (1970) and refined by Kaplan (1974), returns the couple back to the pleasures of sensual touch and then moves them through a series of structured exercises that gradually escalate up the sexual intensity continuum (see also Avery-Clark & Weiner, this volume). Sexual intercourse is usually discouraged and sometimes banned at the start of sensate focus. For the woman with GPPPD this takes the "threat" out of sexual activity, as she can concentrate on the pleasure of sensations without the anticipation of pain that will result from penetration. The anxiety typically experienced with sex

is reduced, if not eradicated, by the explicit turning away from penetration or orgasm as the goal. The couple then progresses, at whatever pace is optimal, through the steps of nongenital pleasuring, genital pleasuring, and intercourse or other orgasm-aimed sexual activity within a custom-tailored hierarchy designed specifically for them. The therapist needs to be cognizant of the client's understanding of and anxiety about this process; failure to explain the purpose of exercises or assigning the exercises at an overly accelerated pace can result in noncompliance, increased anxiety, and avoidance. Adherence to a well-designed gradated exposure to penetration will be particularly crucial for women with the fear and anxiety symptoms associated with vaginismus in the DSM-IV-TR.

Related to sensate focus is the expansion of the couple's sexual repertoire. Couples with GPPPD often stop having sex altogether when, in fact, the only activity that causes pain is vaginal penetration. Without diminishing the importance of sexual intercourse in the sexual lives of couples, there are many other ways of interacting physically that would maintain their intimacy as well as result in orgasm. Sexual activity does not have to be put on hold while couples work on coping with, reducing, or resolving pain with intercourse. Therapists can be helpful in opening up these avenues for clients and encouraging them to educate each other about nonpenetrative activities they like or would like to try. Quite apart from the issue of pain, the consensual broadening of sexual scripts and collaborative exploration of non-penetrative sex can render sex more exciting and increase desire and arousal.

Relationship skills-building Although the literature generally indicates that most couples with GPPPD (who are still together and presenting to therapy or research studies) have relatively normal relationship adjustment, relationship dynamics have now been shown empirically to have a significant effect on pain and on satisfaction. The relationship is a central target of treatment in general and in ways that are specific to the woman's experience of pain.

In terms of broad relationship dynamics, couples who are not sufficiently differentiated are not likely to cope well with GPPPD, as neither will be sufficiently securely attached to each other to truly empathize with their partner's experience. Each person in the couple will be focused on how their partner's problems negatively reflect on them. Through this self-focused lens, the partner's dilemma will be considered a threat to self. This can result in either a lack of compassion for the partner or in an indulgence of the partner's anxieties. Either case interferes with true intimacy and connection, which requires assertiveness, honesty, and empathy. Interventions that target this type of dynamic require the challenging of narcissistic and dependent interpretations of sexual interactions, generating mutual responsibility for dynamics, and promoting self-soothing to replace the reliance on the partner for one's wellbeing.

Increasing nonsexual affection and activating the lost romance in relationships are other general relationship interventions likely to have significant returns. Whether or not sexual problems exist, positive sexual experiences are facilitated by positive nonsexual experiences. Unfortunately, couples who either stop having sex or who have difficulties with sex often stop having positive nonsexual experiences, which only worsens the sexual situation. Increasing nonsexual physical affection and reactivating the romance in the relationship can go a long way towards creating conditions that ultimately increase desire and the willingness to navigate the difficulties of sex in the context of GPPPD. Although both men and women generally welcome interventions that increase the level of romance in the relationship, these have to be collaboratively designed with clients to ensure that the interventions are palatable to them. There is great variation in what couples find romantic.

Communication skills should also be prime targets for intervention. Couples with GPPPD are likely to be hiding much from each other. Assertiveness is often a problem. Women who experience pain may be avoiding expressing how much sex hurts or what positions hurt most in order to avoid hurting their partners' feelings. They could consequently be slowly

developing an aversion to sex. Partners may be pretending they are fine stopping all sexual activity at the first sign of discomfort, despite feeling a high degree of frustration. Even in couples without a specific sexual difficulty, sex is an interpersonally sensitive topic. Individuals feel a high level of vulnerability about disclosing their sexual experiences and a high degree of sensitivity about the possibility of hurting the partners' feelings when addressing their role in it. This communication inhibition can result in a prolonged, suffering silence that entrenches the difficulty or in an eventual emotional outburst that is highly upsetting to the partner and damaging to the relationship. Helping couples communicate about sex honestly, respectfully, and with a focus on correction rather than complaint is an important intervention.

Recent research has indicated that the most impactful aspect of relationship dynamics with regard to GPPPD is the partner's reaction to the pain. It is highly likely that clients will be unaware of these data and that learning about it will be helpful. It may not come as much of a surprise to clients that hostile or angry reactions to a woman's pain with intercourse do not have positive outcomes. It may, however, be more surprising to learn that overly solicitous responses, characterized by a partner stopping all sexual activity at the first sign of a woman's discomfort, also have negative outcomes, as they reinforce avoidance. Facilitative responses, in which the partner sensitively encourages the woman in her attempts to have intercourse despite challenges, appear to be most positive in terms of relevant outcomes. Instructing couples in the consequences of these varying reactions can only help.

Treatment Stage III: consolidation of gains and relapse prevention

Prior to the termination of therapy, it is useful to engage clients in a review of what transpired over the course of treatment so that there is a true recognition of what was learned and achieved, and so that there is some forethought in case some of the problems that were addressed do recur. As per McCarthy's (1993) guidelines, reviewing the origins of the problem is an important part of this process (see also McCarthy & Wald, this volume). Although the origins of GPPPD are rarely evident, the origins of attitudes and behaviors that were consequent to the onset of the pain are certainly identifiable. Helping clients to identify risk conditions early on can forestall a re-entrenchment of maladaptive thoughts and cognitions. While in therapy, couples discuss their concerns at least on a weekly basis. It is important that this does not end with therapy. It is recommended that the couple be encouraged to continue making time for these discussions to give them a regular barometer of how each of them is feeling. Other encouraged continuations are the prioritization of enjoyable time alone in which they are focused on each other rather than on their responsibilities, and engagement in sex play that does not have a performance goal. Finally, follow-up therapy and booster sessions should be offered in the event that clients feel a need for a refresher or if they feel they might again be sliding back into old, maladaptive habits.

Challenges to therapy for GPPPD

There are a number of challenges to the treatment of GPPPD. The coordination and cost of multiple health professionals in the multidisciplinary assessment and treatment of clients is one of these. This coordination may be complicated by the availability of informed providers and by the financial burden on the client. Defining treatment success is another challenge. While the complete resolution of pain with intercourse would clearly be ideal, it is often beyond the reach of interventions. In those cases, it behooves us to ask whether increasing the frequency of intercourse should really be the outcome measure of interest. Increasing sexual and relationship satisfaction may be, in most cases, a more appropriate goal, since behavior change does not necessarily indicate an increase in wellbeing. Another challenge is related to

the assignment of exercises to be completed by clients at home. Turning sex into homework is likely to be unproductive. The therapist's challenge is to engender a desire to engage in these exercises without making clients feel obligated to perform them. If obligation is felt, the therapist will create the very performance anxiety from which they are trying to help clients move away. The amount of structure in the treatment is yet another challenge that therapists and their clients will have to navigate. Some couples will initially want to schedule dates for their sensate focus assignments or for their romantic evenings. Others will balk at any mechanistic attempt to regulate their interactions. Both types of couples may become more flexible in their approach as the therapy unfolds. Letting clients express their preference and then change their minds is generally a good strategy. Finally, the age-old concept of secondary gain is an important one to keep in mind. It may seem counterintuitive that GPPPD would deliver any benefits to anyone. However, the couple's stability may in part be balanced on the dysfunction. The woman's pain may be hiding her partner's sexual dysfunction or alleviating his insecurity. The pain may also be masking another sexual problem in the woman, such as low desire or a nonsexual relationship dilemma. Although secondary gain rarely competes with the primary loss engendered by the problem, the possibility needs to be at least considered, lest it sabotage reasonable treatment efforts.

Case Study: Kari and Greg

The case of Kari and Greg illustrates some of the important considerations in treating GPPPD. Thirty-year-old Kari and her 35-year-old husband, Greg, presented to the therapy clinic reporting Kari's painful intercourse, which had been present since they first had sex five years previously, but which had worsened significantly over time. It had now been over eight months since they last attempted intercourse (or any other sexual activity), and both were increasingly distressed and impatient. Kari had reported the problem to her gynecologist, who had found no physical pathology and offered no treatment options. This confirmed Greg's suspicion that Kari was simply not attracted to him and that she did not really want to have sex with him. The clinical interview revealed nothing remarkable about Kari's history or psychological profile, but her description of the pain suggested this might be a case of provoked vestibulodynia (PVD). Kari and Greg were given information about PVD, and some of Greg's insecurities about Kari's attraction to him were addressed as likely inaccurate and unrelated to Kari's pain. Kari was referred to a different gynecologist, one familiar with genital pain, who confirmed the suspected diagnosis. The sex therapist then discussed treatment options with Greg and Kari, ranging from the minimally invasive application of lidocaine to the maximally invasive surgery, with a recommendation of cognitive-behavioral therapy (CBT)/pain management regardless of the somatic treatment chosen. Within that session, the couple decided that they would first attempt CBT/pain management, with adjuvant physical therapy for Kari. By the end of the pelvic floor retraining and 12-week CBT treatment focusing on education, anxiety reduction, cognitive restructuring, emotional regulation, sexual repertoire modification, and relationship dynamics around the sexual problem, Kari's pain was significantly reduced, Greg's attitude was much more facilitative than hostile, and their sexual satisfaction had increased. Nonetheless, they decided that any amount of discomfort with intercourse was unacceptable to them, and they decided to opt for a vestibulectomy. They decided to continue therapy after surgery as they felt that much good had come of the psychosocial treatment, including both pain reduction and relationship gains. The surgery went well, but the first six months did not result in pain reduction over what had been achieved with CBT alone. The couple's relationship dynamics, however, continued to improve, as did their sexual satisfaction with a more expanded repertoire of activities. One year after surgery, Kari's discomfort with intercourse was mild. The couple's hopes that intercourse would be completely painless were not fulfilled, but they felt satisfied that they had tried everything available. Both Kari and Greg were happy with the progress they had

made sexually and in terms of their relationship. The outcome was not quite perfect but much better than the state in which they had first presented, in terms of pain intensity, sexual satisfaction, and relationship adjustment.

Conclusions

This case illustrates at least four important considerations in the treatment of GPPPD: (1) the importance of a gynecological consultation with a practitioner familiar with genital pain and its treatment; (2) the centrality of a multidisciplinary approach; (3) the impact of such an approach on multiple facets of the couple's sex life and relationship; and (4) the often encountered elusiveness of a complete resolution to the pain.

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8

Treating Hypersexuality

Joshua B. Grubbs, Jan Paul Hook, Brandon J. Griffin, M. Scott Cushman, Joshua N. Hook and J. Kim Penberthy

Hypersexuality—also sometimes known as sexual addiction, hypersexual disorder (HD), sexual compulsivity, and hypersexual behavior—is a controversial concept in many settings. A number of empirical studies (e.g., Moholy, Prause, Proudfit, Rahman, & Fong, 2015; Prause, Staley, & Fong, 2013; Steele, Staley, Fong, & Prause, 2013), narrative reviews (Ley, Prause, & Finn, 2014; Reay, Attwood, & Gooder, 2013), and theoretical critiques (Moser, 2011) have questioned the existence of such a problem at all. Additionally, the diagnosis of HD fell short of inclusion in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013). In spite of these challenges, the diagnosis still maintains a great deal of support from researchers and clinicians alike (Kafka, 2014), and a large body of research suggests that there are times at which sexual behavior may become excessive or compulsive to the point of producing severe problems in a person's life (for a review, see Kafka, 2010; Kaplan & Krueger, 2010). Practicing clinicians often encounter excessive or compulsive sexual behaviors in their clientele (Mitchell, Becker-Blease, & Finkelhor, 2005; Mitchell & Wells, 2007; Reid, Garos, & Fong, 2012), with some evidence suggesting that advancing technologies have made such therapeutic encounters more common in recent years (Shapira *et al.*, 2003) because many individuals complain of compulsive sexual behavior involving technology (e.g., online pornography use). In reaction to the growing number of individuals who present with compulsive sexual behavior, hypersexual tendencies are often the subject of therapeutic interventions. As such, a need exists for effective guidelines and recommendations for the treatment of hypersexuality.

For the present work, it is important to note that there may be differences between the treatment of non-paraphilic hypersexual behavior (hereafter referred to as hypersexuality) and paraphilic hypersexual behavior (Kafka, 2010). Given the aberrant and unique nature of many paraphilias, treatment modalities may range from pharmacological interventions (Bradford, 2001), to psychotherapy (Nichols, 2006; see also Berg, Munns, & Miner, this volume, for treatments related to sexual offending), to much more intensive interventions (e.g., chemical castration; isolation; incarceration) for dangerous or illegal sexual predilections (Hall & Hall, 2007). Given the variability of these treatments and the special considerations that may be encountered for paraphilic behaviors, the present work is focused on the treatment of hypersexuality.

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Understanding Hypersexuality

As is the case with the treatment of most psychological disorders, properly defining the nature of hypersexuality is a central assumption of effective treatment. Indeed, prior reviews have noted that poor understandings and operational definitions of hypersexuality have severely hampered research into the treatment of hypersexuality (Franqué, Klein, & Briken, 2014). Historically, there has been debate as to whether hypersexuality is best considered an impulse control disorder (Stein, 2008), a behavioral addiction (Karila *et al.*, 2014), or a sexual dysfunction (Bancroft & Vukadinovic, 2004). Such debates have fueled research into the nature of hypersexuality, but they have not settled the issue. In recent years, there has been increasing convergence in understandings of hypersexuality (e.g., Carnes, Hopkins, & Green, 2014), largely due to the development and field testing of the proposed HD diagnosis for the DSM-5 (Kafka, 2013, 2014; Womack, Hook, Ramos, Davis, & Penberthy, 2013).

During the development of the DSM-5, a diagnosis of HD was proposed (see Table 8.1; Kafka, 2010, 2013) and tested in clinical settings (Reid *et al.*, 2012). Although ultimately excluded from the final edition of the manual, the diagnosis was well received by many clinicians (Reid *et al.*, 2012). Furthermore, research surrounding the development of the diagnosis led to advances in assessment and diagnosis of hypersexual behavior more broadly (e.g., Reid, Garos, & Carpenter, 2011; for a review, see Kafka, 2014). Accordingly, we seek to make treatment recommendations based on these converging understandings of hypersexual behavior. To this end, we conceptualize hypersexuality as involving three major domains that may be foci of treatment: behavioral, cognitive and emotional, and social/relational.

Behavioral basis of hypersexuality

At a basic level, hypersexuality is a behavioral disorder, which at its core involves some sort of sexual behavior that is often relatively normal—or non-paraphilic—in nature (Kafka, 2013). Under the proposed and tested DSM-5 guidelines for HD, recurrent, excessive engagement in sexual behavior is a key facet of the diagnosis (Kafka, 2010; Reid *et al.*, 2012). However, sexual

Table 8.1 DSM-5 proposed criteria for hypersexual disorder (based on Kafka, 2010, 2013).

1 Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:
   1 Excessive time consumed by sexual fantasies and urges and by planning for and engaging in sexual behavior.
   2 Repetitive engagement in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, and irritability).
   3 Repetitive engagement in sexual fantasies, urges, and behavior in response to stressful life events.
   4 Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
   5 Repetitive engagement in sexual behavior while disregarding the risk for physical or emotional harm to self or others.
2 There is clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.
3 These sexual fantasies, urges, and behavior are not due to direct physiological effects of exogenous substances (e.g., drugs of abuse or medications), to a co-occurring general medical condition, or to manic episodes.
4 The person is at least 18 years of age.

Specify if masturbation, pornography, sexual behavior with consenting adults, cybersex, telephone sex, or strip clubs.

behavior alone—even behavior that is far above average in frequency—is not sufficient to warrant a diagnosis of a disorder.

Humans, by nature, are sexual creatures (as are most living beings), and a wide range of sexual activity levels can be considered normal (Kafka, 2010). In premise, frequent sexual behavior is evolutionarily advantageous in that it increases the probability of genetic survival. Although societal norms regulate sexual expression (Baumeister & Tice, 2001; Gagnon & Simon, 2011; Haidt & Hersh, 2001) and modern technologies allow for a wide variety of sexual behaviors that do not directly involve procreative behaviors, the drive to pursue sexual gratification is still a natural and normal impulse. However, as is the case with many evolutionarily-derived reward systems (e.g., food, sexual behaviors; Kelley & Berridge, 2002), there is potential for the system to go awry and for previously advantageous behaviors to become problematic.

Building on this functional understanding of human sexuality, hypersexuality is excessive engagement in and preoccupation with sexual behavior to the point that functional impairment in multiple life domains results (Spenhoff, Kruger, Hartmann, & Kobs, 2013). This focus on functional impairment is a key component of understanding hypersexuality. Frequent and even excessive (by conventional standards or norms) sexual behavior may not be problematic, particularly if such behaviors do not cause problems in other life domains. Over the past several decades, most definitions have included some focus on functional impairment resulting from excessive sexual behavior as a key component of hypersexuality (e.g., Carnes, 2001; Kafka, 2010; Reid *et al.*, 2012). More concretely, hypersexual individuals often report that their sexual behaviors have led to problems such as relational conflict, psychological distress, vocational problems, or social isolation. As such, the most obvious indicator of hypersexuality is excessive sexual behavior that is causing problems in the individual's life.

Cognitive and emotional bases of hypersexuality

Moving beyond behavior alone, hypersexuality often involves compelling cognitive and emotional components. Central to the notion of hypersexuality is the perception of addiction, compulsion, or volitional impairment (Kafka, 2010). Hypersexual individuals often feel incapable of regulating their sexual thoughts, behaviors, and fantasies. Furthermore, beyond a perceived loss of control, hypersexuality often expresses itself in a cyclical manner in which sexual behavior is used to cope with psychological distress while ultimately resulting in anxiety, shame, and depression (Gilliland, South, Carpenter, & Hardy, 2011; Reid, Harper, & Anderson, 2009; Schultz, Hook, Davis, Penberthy, & Reid, 2014). Within the proposed HD diagnostic criteria, both aspects of this cycle are noted. Hypersexual behavior often arises as a means of coping with negative affect states, but, in turn, results in more negative affect states that maintain the behavior (Kafka, 2010, 2013). Therefore, the cognitive and emotional aspects of hypersexuality are related to both the perceived loss of control and the experience and management of psychological distress associated with such behaviors.

Social and relational bases of hypersexuality

Finally, hypersexuality is characterized by social, relational, and other environmental conflicts and consequences (Reid *et al.*, 2012). Although the consequences of hypersexuality may vary from person to person, these consequences often play a vital role in the development and expression of hypersexuality (Carnes, 2013). As previously mentioned, hypersexuality involves functional impairment as a result of excessive sexual behavior. Furthermore, a hallmark of most addictive or compulsive disorders is continued engagement in a behavior that is causing functional impairment or distress. Functional impairment in numerous life domains is also likely to promote negative emotional states (e.g., relational conflict leading to depression).

In response to these negative affect states, the hypersexual individual may then cope by using sexual behavior, leading to more conflict and impairment. As such, the social and relational consequences of hypersexual behavior are important for understanding the total nature of the disorder in the individual.

Summary and case example

In sum, hypersexuality is a pattern of dysregulated or compulsive sexual behavior that causes the individual profound impairment both intrapersonally and interpersonally. This may be best illustrated in the form of a case example.

> *Stan was a 50-year-old man, who had been married for 25 years. His work required him to travel extensively. During a recent work trip, Stan left his personal computer at home, during which time his wife looked at his email and discovered that he had been having an affair. Stan and his wife presented for marital therapy due to the affair. During the initial sessions, Stan reported a long history of excessive sexual behaviors (beyond the affair) involving the following activities while traveling for work: watching sexually explicit videos in his hotel room; attending gentleman's clubs; and soliciting sexual activity from call-girls, prostitutes, and massage parlors. He also reported that, while at home, he had been engaging in an extensive pattern of pornography use and masturbation. Additionally, he reported that he was constantly thinking about sex and planning for his next experience of sexual gratification. Per his report, he had kept all these activities a secret until presenting for therapy. Subsequent to these revelations, Stan was referred to individual therapy for hypersexuality, in addition to continued marital therapy. Although he believed that agreeing to therapy was central to saving his marriage, Stan did not believe he had a problem and was resistant to the idea that he struggled with hypersexuality. Initially, he reported extreme confidence in his ability to reduce his problematic sexual behaviors.*

From this example then, we see the three-fold nature of hypersexuality. First and foremost, hypersexuality tends to exhibit itself behaviorally in the form of excessive engagement in sexual activity. Secondly, hypersexuality tends to exhibit itself cognitively and emotionally in the form of an obsession or compulsion that consumes substantive portions of the individual's thoughts and causes distress. Although Stan did not initially report emotional aspects (i.e., distress) associated with his problems with hypersexual behavior, those issues became more apparent as his case progressed. Finally, hypersexuality tends to involve interpersonal or social consequences (e.g., marital conflict) as a result of the functional impairment. In the aforementioned case, Stan presented with behavioral dysregulation, cognitive obsessions, and profound relational consequences, strongly indicating a need for treatment of hypersexuality.

Assessing Hypersexuality

The basis for many effective psychotherapeutic interventions is a comprehensive assessment (Groth-Marnat, 2009). Proper assessment forms the foundation of evidence-based psychotherapy in general, and provides objective criteria for evaluation of outcomes. Furthermore, in some cases, assessment alone can provide valuable information that, by itself, is an impetus for therapeutic gain (e.g., Worthington *et al.*, 1995). Not surprisingly, proper assessment should also form the foundation for effective hypersexuality treatment (Kaplan & Krueger, 2010; Reid, Garos, & Carpenter, 2011).

Assessment domains

Returning to our three-fold conceptualization of hypersexuality, we recommend assessing hypersexual clients' behaviors, cognitive and emotional states related to their sexual behaviors, and social/relational consequences related to their sexual behaviors. This is also consistent with

past recommendations (e.g., Hook, Reid, Penberthy, Davis, & Jennings, 2014; Grubbs, Hook, Griffin, & Davis, 2015), stating that clinicians working with potentially hypersexual clients should assess both the *objective* and *subjective* indicators of hypersexuality, while also expanding assessment to include a focus on social and relational consequences.

At the outset of the treatment program, the clinician should assess the client's objective indicators of hypersexual behavior. The frequency of sexual behavior, the specific behaviors engaged in, and the duration for which the client has engaged in hypersexual behavior are all important indicators of the client's level of hypersexuality. Furthermore, an accurate assessment of a client's behaviors allows for objective evaluation of progress made over the course of treatment. Summarily, a primary therapeutic goal for the treatment of hypersexuality is a reduction in impairing or problematic sexual behaviors, and as such, an objective assessment of those behaviors is necessary for the evaluation of treatment progress.

The clinician should also assess the client's subjective feelings regarding his or her hypersexuality. A client's subjective feelings of distress or disorder are key foci of any therapeutic relationship, as subjective distress is often the primary reason for seeking therapy. This can be true of hypersexuality as well. For many individuals, subjective feelings of hypersexuality (i.e., feeling as if one is addicted to or compulsive in sexual behavior) are likely to be an impetus for seeking treatment. In addition, such feelings themselves are often problematic, even if the objective behavior pattern is not excessive or compulsive. For example, prior works have shown that some individuals are willing to label themselves as "addicted" to internet pornography, even in the absence of regular pornography use (e.g., Grubbs, Stauner, Exline, Pargament, & Lindberg, 2015; Grubbs, Volk, Exline, & Pargament, 2015). In essence, it is possible that some individuals may experience subjective feelings of hypersexuality that are disproportionate to their actual behavior. Potential risk factors for this include high religiosity and strict sexual values (e.g, Grubbs, Stauner, *et al.*, 2015), as well as neuroticism and obsessional tendencies (e.g., Egan & Parmar, 2013). Furthermore, such self-perceptions are associated with various indicators of psychological distress, both concurrently and over time (Grubbs, Stauner, *et al.*, 2015). As such, an assessment of the client's subjective feelings of hypersexuality and an awareness of the factors driving such feelings is important.

It is also plausible that a client may pursue therapy at the prodding of a significant other or family member (e.g., Canning Fulton, 2002; Kaplan & Krueger, 2010), even if they do not consider their own behavior to be problematic. In such a situation, the client might be experiencing little subjective distress regarding personal behavior, even if such behavior may be measurably excessive and causing substantive problems in their personal lives. Therefore, there are three likely scenarios that may be revealed through a thorough assessment: (1) An individual might report subjective feelings of hypersexuality and objective indicators of hypersexuality; (2) an individual might report subjective feelings of hypersexuality but no objectively hypersexual behaviors; or (3) an individual might report no subjective feelings of hypersexuality while still exhibiting markedly hypersexual behaviors. For these reasons, it is essential to assess both the objective indicators of hypersexuality and the subjective feelings of hypersexuality prior to beginning treatment.

We also strongly recommend assessing social and environmental consequences of hypersexual behavior. Continued engagement in a behavior pattern despite marked negative consequences of such a behavior is a hallmark of most addictive or compulsive disorders (Beck, Wright, Newman, & Liese, 2011). In the case of hypersexuality, failure to attend to the social consequences of the disorder may result in a variety of problematic outcomes. For example, at a minimum, compulsive sexual behavior might impede an individual's ability to develop mutually satisfying relationships with sexual partners, as was demonstrated in the aforementioned case example. Furthermore, failure to attend to the environmental consequences of hypersexuality may pose a public health concern. Negative public health outcomes may occur, for example, if hypersexual individuals choose not to engage in socially responsible behaviors

(e.g., being tested for a sexually transmitted infection) to protect their sexual partners, or if they choose to mislead their sexual partners about their HIV serostatus (Benotsch *et al.*, 2012; Martin, Benotsch, Cejka, & Luckman, 2014). Thus, assessing social and relational consequences allows for a more objective evaluation of the severity of the problem and may provide insights into the client's motivation to change.

Finally, we recommend assessing the client's definition of successful treatment. The process of setting and clarifying tenable goals is a key facet of all successful psychotherapy (Safran & Muran, 2000). Clear, agreed-upon goals between client and therapist foster a therapeutic alliance and provide guidelines for the course of therapy (Ackerman & Hilsenroth, 2003). In the case of the hypersexual client, this process of assessing, setting, and clarifying goals is potentially of even greater importance than with other clients. Hypersexual clients are often ambivalent about the changes they want to make (Reid, 2007). Given that each client may have a different subjective definition of healthy sexual behavior, the end goal of therapy is likely to be different for each client. Additionally, assessing the client's goals for therapy allows for the therapist to gauge the tenability of these goals. For most clients, cessation of all sexual behavior is not likely to be a desirable or achievable goal (Carnes, 2013), but cessation of problematic behaviors while allowing for healthy sexual expression may be much more realistic. These clarifications at the outset of therapy are likely to be key to successful therapy outcomes.

Assessment strategies

At a bare minimum, we strongly recommend that practicing clinicians conduct a thorough diagnostic interview with a focus on evaluating the client's symptoms as they compare with established criteria for diagnosing hypersexuality. Despite not being included in the final DSM-5, the criteria developed for the proposed diagnosis of HD are an excellent guide for assessing for hypersexuality in both objective and subjective domains. Using the standard diagnostic format, the proposed and tested DSM-5 guidelines provide a reliable checklist of behavioral, emotional, and social indicators of hypersexuality.

Moving beyond diagnostic criteria alone, there is also much to be gained by using structured assessments of hypersexuality. Numerous such instruments are available (for reviews, see Hook *et al.*, 2014; Womack *et al.*, 2013), but not all are created equal. Rather than review all available instruments, we would like to highlight a few particularly helpful measures. Some instruments, such as the Hypersexual Behavior Inventory (HBI; Reid, Garos, & Carpenter, 2011), provide comprehensive assessments of behavioral, cognitive/emotional, and social/relational manifestations of hypersexuality. The HBI maps well onto the proposed HD diagnostic criteria, and has proven useful in clinical settings (Reid, Garos, & Carpenter, 2011). Additionally, the Sexual Addiction Screening Test - Revised (SAST-R) is also commonly used as a general measure of hypersexual tendencies (Carnes, Green, & Carnes, 2010; Carnes *et al.*, 2014). This measure assesses numerous dimensions of hypersexual tendencies and also maps onto the proposed diagnostic criteria for HD (Karila *et al.*, 2014).

For many clients, there also may be a need for a more specific inventory focused on the most frequent hypersexual behavior. For example, for many individuals, hypersexuality may be primarily manifested in excessive pornography use. Indeed, in a field trial of the HD diagnosis, Reid, Garos, and Fong (2012) found excessive pornography use to be the most common form of hypersexual behavior encountered by practicing clinicians. As such, there are times in which an inventory of problematic pornography use may be particularly useful as a supplement to a more general measure of hypersexual behavior. Inventories such as the Cyber-Pornography Use Inventory-9 (Grubbs, Volk, *et al.*, 2015), which assesses the subjective components of perceived addiction to internet pornography; the Pornography Consumption Inventory (Reid, Li, Gilliland, Stein, & Fong, 2011), which evaluates both subjective feelings of addiction to pornography and objective behaviors associated with pornography use; or the

Pornography Craving Questionnaire (Kraus & Rosenberg, 2014), which evaluates how strongly the individual feels drawn to use internet pornography, might be particularly well-suited for such clientele.

Case example

Returning to the example of Stan, the importance of proper assessment can be seen:

> *At the outset of therapy, Stan met the full proposed criteria for HD. He had displayed a pattern of dysregulated and excessive sexual behavior for several years. Sexual activity and thinking about sexual activity consumed the majority of his time. Although Stan did not think that he had a problem at the outset of therapy (i.e., he denied subjective feelings of hypersexuality), further assessment revealed that he did not feel that he had the will power to regulate his sexual behavior. He also reported that previous attempts to resist his sexual urges had failed. Although he understood his sexual behaviors were placing his marriage at risk and causing emotional pain for his wife, he indicated that he felt unable to change. Additionally, over several sessions, Stan revealed that he often used sexual activity as a means to cope with stressful life events or negative emotions. Collectively, these symptoms matched the diagnostic criteria for HD. Additionally, further assessment of Stan's goals for therapy revealed a primary motivation of saving his marriage, with little awareness of his own personal problems in self-regulation. More simply, Stan initially identified a goal of reducing his own behavior to keep his wife, rather than to treat his hypersexuality. Although the motivations for change identified by Stan and the therapist differed, the initial goal of reduced hypersexual behavior was agreed upon, and a therapeutic alliance was built around changing those behaviors.*

In this example, we see a client presenting with objective indicators of hypersexuality that met full criteria for a diagnosis of HD. Even so, the aforementioned client initially rejected any subjective indicators of hypersexuality, denying that he even had a problem. In cases such as this, the importance of assessment is readily apparent. By taking an inventory of Stan's presenting problem and goals for therapy, an effective basis for treatment was established.

Treating Hypersexuality

Over the past several decades, there have been a number of proposed treatments for hypersexuality (for reviews, see Hook *et al.*, 2014; Grubbs, Hook *et al.*, 2015). Previously studied methods have involved individual therapy (e.g., acceptance and commitment therapy [ACT] or cognitive-behavioral therapy [CBT]; for a review, see Franqué *et al.*, 2014), group therapy (CBT, peer support, relational therapy; e.g., Hook, Hook, & Hines, 2008; for a review, see Hook *et al.*, 2014), pharmacotherapy (for a review, see Naficy, Samenow, & Fong., 2013), and intensive in-patient treatment (e.g., Hartman, Ho, Arbour, Hambley, & Lawson, 2012). Similarly, there are a number of manuals and guidebooks on the treatment of hypersexuality (e.g., Carnes, 2013; Carnes & Adams, 2013; Hall, 2012). Although treatment recommendations vary across studies and across manuals, there are similarities between methods that allow for a greater understanding of successful treatment.

Building on past work, we encourage the implementation of a comprehensive relational-CBT approach to treatment that focuses on the behavioral, cognitive/emotional, and social/relational aspects of hypersexuality in order to promote the total recovery of the client.

Behavioral treatment strategies

Problematic behavior is often the most tangible focus of therapy with a hypersexual client. The client's pursuit of therapy is likely the result of behaviors that the client or the client's loved ones find problematic. Furthermore, it is likely that clients will identify the primary goal of

therapy as a reduction or elimination of certain sexual behaviors that they perceive to be problematic. To this end, therapy must focus on implementing concrete behavioral plans that promote the cessation of problematic behaviors. For example, in the case of the hypersexual client who frequents adult nightclubs or pays for sexual services, a behavioral plan might focus on avoiding traveling in certain areas that readily provide such opportunities and setting definitive time limits on trips away from the home, so as to prevent the opportunity to engage in such behaviors. In the case of the client who excessively uses internet pornography, eliminating private access to internet-connected devices, installing web-filtering services, and avoiding internet use for non-essential activities may all be part of an effective behavioral plan.

In establishing a behavioral plan for the hypersexual client, extinguishing sexual behavior altogether is not likely to be a productive or realistic goal. In contrast to most other addictive disorders, total abstinence from all sexual behavior whatsoever is rarely the goal of effective treatment for hypersexuality. Rather, a reduction in maladaptive sexual behaviors, a sense of volitional control over sexual behaviors, and engagement in healthy sexual behaviors are more tenable goals (Carnes, 2013). Furthermore, the promotion of healthy sexual behavior is often a key facet of effective treatment for hypersexuality (Carnes, 2013). In sum, behavioral interventions must be structured so as to promote healthy sexuality and extinguish those behavior patterns that are giving rise to functional impairment. Healthy sexuality may look different for different clients. For some individuals, this may mean total abstinence from sexual activity not involving their partner; for others, healthy sexuality may mean structured boundaries around sexual activity that prevent it from interfering with other life domains. For example, whereas some clients may identify viewing pornography as problematic in any capacity, others might be able to limit such behavior to structured time periods that allow them to experience a reduction in any harm caused by their behavior. In the vast majority of cases, the goal of effective treatment is not to stifle all sexual expression.

Cognitive and emotional treatment strategies

Cognitively and emotionally, treatment must focus on both the causes and consequences of hypersexual behavior. Identifying and modifying maladaptive thought patterns that contribute to hypersexual behavior is often a first goal of therapy. Carnes (2001) identified four key maladaptive core beliefs that many hypersexual clients hold. These core beliefs are as follows: (1) "I am basically a bad, unworthy person"; (2) "No one would love me as I am"; (3) "My needs are never going to be met if I have to depend on others"; and (4) "Sex is my most important need." Although the applicability of these beliefs to all hypersexual clients has been the subject of some debate (e.g., Barth & Kinder, 1987), these core beliefs have proven helpful in guiding various treatments for hypersexual behavior (e.g., Adams & Robinson, 2001; Carnes, 2013; Hook *et al.*, 2008). Furthermore, given the lack of any empirical research supporting these specific core beliefs, it is worth noting that any number of problematic core beliefs about the self and the world could also be effectively addressed during treatment. Ultimately, cognitive therapy in general is predicated on the notion of modifying maladaptive core beliefs (Beck, 2011; Young, Klosko, & Weishaar, 2003). The same is true of comprehensive cognitive-behavioral therapy for hypersexuality.

Although behavioral interventions for hypersexuality are an essential and foundational aspect of treatment, they often do not address the core issues that underlie hypersexual behavior. Ultimately, many hypersexual clients act out sexually due to the previously delineated core beliefs. Modification of problematic sexual behaviors may well improve the client's functioning, but addressing the underlying beliefs is likely to be essential in maintaining therapeutic gains over time. To that end, therapy for hypersexuality must focus on addressing each of the maladaptive beliefs that contribute to the client's problematic sexual behavior. First and foremost, therapy should focus on helping the client to become aware of the core beliefs that underlie

problematic sexual behavior. Although clients may be aware of some vague sense of distress or dysphoria, it is unlikely that they are fully aware of their core beliefs. As clients become more aware of the link between their core beliefs and their sexual behaviors, they also will become more aware of their need to change their conceptions of self in order to change their behavior patterns. Using standard cognitive therapy techniques, the therapist can focus on helping the client to view himself or herself as (1) a good and worthy person; (2) a lovable person who is capable of loving others; (3) a vulnerable but secure person who can depend on others; and (4) a person whose needs for intimacy and healthy attachment are balanced with their needs for sexual gratification.

In addition to modifying maladaptive core beliefs, hypersexuality treatment must also focus on promoting adaptive coping skills in the wake of stressful life situations. The promotion of adaptive coping mechanisms for negative emotional states is not unique to treating hypersexuality, as it is a tenet of many psychotherapy approaches. Hypersexual behavior often occurs in response to negative affect states and dysphoria (Kafka, 2010). Additionally, hypersexual individuals are often particularly prone to negative affect states (Dhuffar & Griffiths, 2014; Reid *et al.*, 2009) and may be lacking in basic coping skills for handling such states (Reid, Temko, Moghaddam, & Fong, 2014). As such, promotion of adaptive coping mechanisms is often an essential facet of successful psychotherapeutic intervention. Prior work has shown that hypersexual individuals often struggle with self-forgiveness (Hook *et al.*, 2015), mindfulness (Reid, Bramen, Anderson, & Cohen, 2014), and self-compassion (Reid, Temko, *et al.*, 2014). As such, therapeutic interventions that promote such skills are recommended (e.g., for self-forgiveness, see Cornish & Wade, 2015; for mindfulness, see Barker, this volume; for self-compassion, see Neff & Germer, 2013).

Therapy must also focus on helping clients to cope with the consequences of their behaviors. The nature of hypersexuality is cyclical (Carnes, 2001); the patterns of using sex to cope with negative emotional states are perpetuated by the emotional consequences—chiefly shame—of excessive sexual behaviors (Reid *et al.*, 2009). To that end, therapy must focus on promoting adaptive coping to deal with the shame that may result from hypersexual behavior. Shame is characterized by total negative evaluation of the self in the wake of a perceived failure (Tangney, Miller, Flicker, & Barlow, 1996). In general, shame is associated with diminished self-efficacy and diminished desire to change (Baldwin, Baldwin, & Ewald, 2005). This is also true specifically in the case of hypersexual behavior, as shame (e.g., notions of the self as a failure or as worthless in the wake of a misdeed) is associated with an unwillingness to seek help and change (Dhuffar & Griffiths, 2014; Gilliland *et al.*, 2011). By contrast, regret and guilt (e.g., negative emotions over the deed committed, but not globalized negative self-views) over sexual behavior may serve as motivation for future change (Gilliland *et al.*, 2011). As such, promoting healthy self-concept and self-worth, even in the wake of problematic behavior, is likely to be a necessary part of effective therapy. As self-concept improves and shame is reduced, self-efficacy to change also will likely improve.

Effective therapy for hypersexuality also involves working toward coping with setbacks and relapses into addictive or compulsive behavior patterns. Although maintaining a sense of control over one's behavior is a goal of all therapy for addictive or compulsive behavior, effective therapy also involves adaptive coping in the wake of relapse (Marlatt & Donovan, 2005). Although relapse is not inevitable, it is a common occurrence in addiction treatment generally and in hypersexuality treatment specifically (Carnes, 2013). Effective therapy for any problematic behavior involves anticipating the possibility of relapse, implementing changes to prevent relapse, and effectively coping with relapse if it does occur (Marlatt & Donovan, 2005). Normalizing the possibility of relapse and guiding the client through the relapse experience is vital to successful long-term therapeutic outcomes. Additionally, helping the client learn from the relapse to better understand the thoughts, behaviors, and emotions that led to the relapse will enhance the client's chances of avoiding relapse in the future (Carnes, 2013).

Social and relational treatment strategies

Socially and relationally, treatment may need to incorporate the client's partner/spouse, family members, or others who have been harmed by the client's hypersexual tendencies. The purpose of including significant others into the therapeutic relationship is multifaceted. Primarily, the social and relational consequences of hypersexuality often directly impact those close to the client in severe ways (Reid & Woolley, 2006). Spouses and partners of hypersexual individuals often report a great deal of distress over their partner's behavior (Reid, Carpenter, Draper, & Manning, 2010). Additionally, preserving a relationship is often a key motivation for the hypersexual client in seeking therapy (Kaplan & Krueger, 2010). As such, effective therapy for the hypersexual client may involve both individual therapy and a separate line of either couples or family therapy with affected others. Notably, these styles of therapy are very different with very different goals. Simply including a client's family in an individual session is not true family therapy. To fully address the ramifications of HD, a separate therapy specifically focused on the family itself (rather than just the identified patient) may be warranted. Although the focus of couples therapy would not only be a reduction of problematic sexual behavior in the hypersexual partner, promoting a healthy relationship and working through the damage caused by hypersexual behavior may be essential in providing the support that the hypersexual client needs to adequately change his or her behaviors. Additionally, the partner of the hypersexual individual also may need to be referred to individual therapy to provide support in coping.

Finally, in addition to individual therapy, structured group therapy and peer-support groups such as 12-step groups may be useful supplements in an individual's recovery (Hook *et al.*, 2008; Salmon, 1995). In particular, prior research has found that structured group interventions for hypersexuality can be effective in reducing self-reported hypersexual behaviors (for a review, see Hook *et al.*, 2014). Due to the social/relational nature of hypersexuality, group therapy interventions allow hypersexual clients to enter into relationships with others in order to (a) help manage their hypersexual behaviors, (b) explore the underlying cognitive and emotional issues related to their addictive or compulsive process, and (c) develop healthy, nonsexual intimate relationships with others (Hook *et al.*, 2008).

Summary and case example

Returning to the case of Stan, we can see how this comprehensive relational-cognitive-behavioral approach might be implemented:

> *At the outset of therapy, Stan expressed extreme confidence in his ability to successfully engage in therapy. However, when asked to abstain from all sexual activities not involving his wife for 60 days, he stated that this would be impossible and expressed no belief that he would be able to be exclusively sexual with only his wife for that amount of time. Even so, strict behavioral guidelines were implemented at the outset of therapy (e.g., no pornography use, no solicitation of sex). Over the course of the first several sessions, Stan became aware of how little control he actually had over his sexual behaviors. He began to realize that even short periods of abstinence were extraordinarily difficult for him. As he became increasingly aware of this difficulty, he also became more aware of the links between his behaviors and his cognitive and emotional states. He began to divulge cognitive and emotional struggles that he had experienced throughout his life. Stan recounted a history extending into his childhood of suppressing his emotions and avoiding emotional intimacy. He described very strained and volatile relationships with both his mother and father that left him afraid to be vulnerable with other people. Additionally, he indicated that he had learned at a young age to "look out" for himself and his own needs, as no one could be trusted to take care of him. As he revealed these core beliefs of mistrust and fear, he also began to divulge his own insecurities of feeling unlovable and incapable of loving others. Through these revelations, Stan began to understand that his problematic sexual behavior had begun as a means of protecting himself from the emotional distress caused by his core beliefs. The comfort and pleasure afforded by sexual activity had provided a brief respite from his emotional pain stemming from his*

childhood. Over time, these behaviors had become so habitual and so regular that they had become a core aspect of how he coped with any stress or displeasure. As he became aware of these core beliefs and maladaptive coping techniques, therapy began to focus on promoting self-awareness in Stan's emotional life and establishing adaptive coping mechanisms.

In addition to individual therapy, Stan was referred to a men's therapy group for hypersexuality. This group allowed Stan the opportunity to speak with others who were in various stages of recovery for the same issues he was facing, providing Stan with a safe environment to speak about his emotional experiences, struggles with self-regulation, and frustrations with the recovery process. During this period of treatment, Stan also spent some time in couples therapy with his wife to work on relationship and sexual issues. His wife also attended individual therapy to process her thoughts and feelings regarding Stan's behavior and her marriage, as well as some of her own struggles to set boundaries with Stan.

Through the course of 12 months of individual therapy, as well as concurrent group therapy, Stan successfully achieved abstinence from maladaptive sexual behaviors for a period of six months. After reaching this milestone, Stan left individual therapy but continued with group therapy. Some kind of ongoing therapy group or 12-step peer support group often is recommended after individual therapy has ended, as individuals struggling with hypersexuality often need continued support to maintain the gains achieved in treatment.

Conclusion

Regardless of debates about the existence or proper definition of hypersexuality, hypersexual behavior is a phenomenon that many clinicians encounter. To that end, there is a need for efficacious intervention strategies for the management of hypersexual behavior. We conceptualize hypersexuality as a disorder manifested in three domains: behavior, cognition and emotion, and social relationships. Effective therapy for hypersexuality incorporates proper treatment for each of these domains. First and foremost, adequate assessment of hypersexual behavior, subjective feelings of hypersexuality, the consequences of hypersexuality, and the goals of treatment is essential to forming a solid foundation for therapeutic intervention. Building on adequate assessment, treatment must focus on reducing problematic behaviors, changing maladaptive thought patterns, promoting adaptive coping skills, and working through the social and relational consequences of hypersexuality. Additionally, individual therapy may be supplemented by group therapy or support groups for hypersexual behavior. By effectively treating behavior, thoughts and emotions, and relational aspects of hypersexuality, therapy can provide hypersexual clients with the ability to regulate their behaviors, develop a healthy sex life, and more fully enjoy their lives.

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9

Treating Sexual Offending

Dianne Berg, Rosemary Munns and Michael H. Miner

Sex Offender Treatment: A Sexual Health Model

It is uncommon for a book on sex therapy to include a chapter on sex offender treatment. In general, sex offender treatment is thought to reside within the realm of criminal justice and/or corrections treatment. However, we will argue that sex offender treatment can be thought of as a form of sex therapy.

One reason that sex offender treatment is generally considered corrections treatment is because most of the concepts common to sex offender treatment are drawn from the criminology and corrections domain (e.g., Good Lives Model, Relapse Prevention, Risk-Needs-Responsivity Principles). The sex offender treatment program at the Program in Human Sexuality began in the mid-1970s and comes from a different perspective; that is, we view sexual offending within the context of sexual development, and like other forms of maladaptive or disordered sexual behaviors, it can best be understood from a multidimensional and developmental perspective. Although this underlying perspective is different from the criminology perspective, it is not incompatible with the current movement toward more positive psychology perspectives on sex offender treatment (see Ward & Fisher, 2006). Ward and Fisher (2006) described what has come to be known as the "Good Lives Model" and asserted that individuals committing sexual offenses are not particularly different from the rest of us, in that they are motivated to obtain the same things: particularly, intimate relationships, a sense of autonomy, and enjoyable physical activities. According to these authors, it is not the sex offender's goals that are maladaptive, but the means by which they attempt to meet these goals. The Sexual Health Model (Robinson, Bockting, Rosser, Miner, & Coleman, 2002) provides a framework for explaining how sexual needs can be met in adaptive or maladaptive ways. Specifically, Robinson *et al.* (2002) conceptualized sexual health as consisting of ten interactive "arms", and maladaptive sexual behavior as indicative of problems in one or more of these arms. The arms of the Sexual Health Model comprise the following: talking about sex, culture and sexual identity, sexual anatomy and functioning, sexual healthcare and safer sex, challenges, body image, masturbation and fantasy, positive sexuality, intimacy and relationships, and spirituality (see Figure 9.1). This model guides an assumption that sexual offending behavior may be influenced by the failure to attain numerous developmental tasks, the failure to develop certain interpersonal skills, and the internalization of a range of maladaptive attitudes and beliefs.

We see the problem of sex offending as maladaptive sexual behavior and place a premium on treatment as needing, not only to repair maladaptive sexuality, but also to develop healthy sexuality. In addition, because we believe that a cornerstone of healthy sexuality is the ability to have truly intimate connections with oneself and other people, we expect our clients to develop

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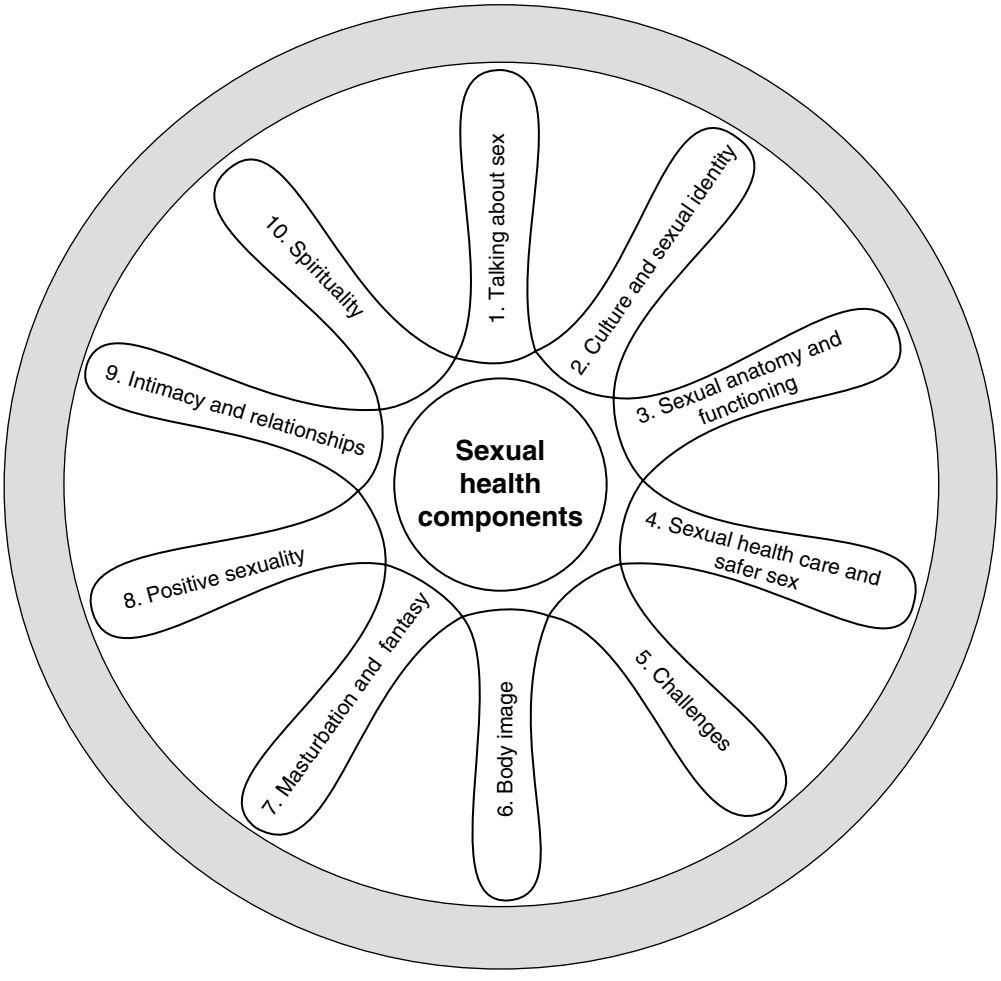

Figure 9.1 The ten components of the Sexual Health Model. From Robinson *et al.* (2002). Reproduced with permission of Oxford University Press.

those connections. Our intervention, which begins from the Sexual Health Model (Robinson *et al.*, 2002), is also rooted in two other major traditions of psychological thought: cognitive-behavioral therapy and systems theory. Consistent with the relapse prevention models developed in the late 1980s, sexual offending behavior can be seen as the result of a maladaptive decision-making process that places immediate positive consequences above possible long-term negative outcomes (Marlatt & Gordon, 1985; Nelson, Miner, Marques, Russell, & Achterkirchen, 1988). Additionally, sexual offenses do not just happen—they are the consequence of a pattern of behavior, thoughts, and feelings (Nelson *et al.*, 1988). The Sexual Health Model is also consistent with the more recent adaptations of relapse prevention, in that we do not take the narrow view that all risk situations are negative. Instead, consistent with Ward and Hudson's (2000) self-regulation, or Pathways, model, we see sexual offending behavior as motivated not only by negative affect, but also by approach goals, such as the desire for intimacy, coupled with the belief that sexual offending behavior (e.g., exposing, child molestation) will provide it. A second major underlying framework for our intervention is systems theory. That is, we believe that networks of relationships significantly affect how individuals

feel, cope, and behave (Hills, 2013), and that problems within these interpersonal interactions previously supported the factors that lead to the offending behavior (e.g., failure to use social supports, lack of interpersonal intimacy, lack of assertive communication skills). Thus, changes in these interactions are necessary in order to maintain any behavior change resulting from treatment (Dallos & Vetere, 2012), and behavior change is facilitated when the individual has a network of friends and family that support and reinforce the changes (Wagner, Burg, & Sirois, 2004). In the following sections, we will outline those important structural components that operationalize the above conceptual and theoretical framework. They include mandatory participation in *conjoint* sessions for all sex offenders, and for those sex offenders who have significant others, mandatory participation of those significant others in a *partner's group*. Also, because of the explicit focus on sexual health throughout the treatment program, we will discuss how sexual health is emphasized within treatment program core assignments as well as the intentional incorporation of content from the Sexual Attitude Reassessment (SAR) framework (Held, Cournoyer, Held, & Chilgren, 1974; Segraves, 1984).

It is worth noting that the treatment program that we describe in this chapter is an outpatient program that has always excluded sexual offenders with extensive violent offending behavior (e.g., use of weapons). Thus, our clients tend to have fewer antisocial and criminal traits than might be seen in a prison-based or civil commitment program. We acknowledge that this may limit the applicability of what we present here.

Conjoint Therapy

The components of our treatment program are weekly group therapy, bi-weekly individual therapy using a "conjoint model," and a bi-weekly partner's group. The first component we will discuss is what we call conjoint therapy. All offenders in the sex offender treatment program are *required* to bring another individual to all individual therapy sessions with their primary therapist. They are directed to bring someone that can best help them address the issue they want to work on in that particular session. Thus, offenders get to choose who will accompany them to a conjoint session, including family members, partners, friends, group members, clergy, coworkers, and so on. This requirement makes an offender think about who he/she is choosing to bring and the purpose of bringing this particular person for this particular session (e.g., mother vs. partner vs. best friend from kindergarten vs. group member). Thus, conjoint sessions not only build the basic blocks of relationship skills that aid in intimacy development, but also encourage an offender to be *invested* in and *intentional* about his/her treatment. A sure sign that offenders are not being intentional about their treatment is when they bring in their mother to a session where they are exploring their masturbation patterns or when they bring in a fellow group therapy member to a session where they are exploring perceptions of their childhood.

In conjoint therapy, even though there is another person in the session, the therapeutic focus is on the offender. Unlike a couples therapy session, where the therapeutic focus is on both people in the couple, in a conjoint session, the other person (even when it is a partner) is there to (a) provide feedback, (b) offer observations, (c) give important perspectives, (d) witness therapeutic work, and (e) provide a practice ground for the development of emotional intimacy and interpersonal connection. Conjoint therapy challenges the offender's skewed perception that he/she can have a special relationship with the therapist that can mirror the special relationship he/she had with his/her victim. To further achieve this goal, what the offender shares in conjoint therapy will not be just between the client, the therapist, and the conjoint person, but will often be brought back to group for further exploration. Thus, the pattern of keeping secrets, manipulation, and dishonesty that often supports sex offending behavior is directly addressed. Conjoint therapy also helps reduce shame by providing the opportunity for the

offender to practice allowing others to see who he/she really is, thus providing evidence to challenge the belief, "if you really know me, you'll reject me," with which offenders often struggle. In addition, conjoint therapy challenges skewed perceptions and distortions that are a part of the offending pattern. The tasks required to have another person attend a conjoint session set the stage for building basic relationship skills that are required for further levels of emotional and sexual intimacy. Just to get someone "in the door," the offender has to learn to (a) think ahead and be considerate of another's schedule, and (b) ask for help (i.e., ask someone to do something for him/her). This is important because, as the offender experiences people taking time to come to sessions, a version of the negative belief "I am not worth it; I am a burden," which is part of most offenders' offending pattern, begins to lessen. Interestingly, in terms of building basic relationship skills, there is also a particular benefit when a conjoint person does not show up for a session, because when the offender is encouraged to address this absence with the person, it gives the offender the opportunity to work on assertiveness and emotional expression skills, which are often avoided.

One of the overall goals of conjoint sessions is that, over the course of treatment, all of the conjoint sessions culminate in the construction of a support system that has the capacity to address a range of intimacy needs. Through these conjoint sessions, offenders "teach" their support people how to both support and challenge them effectively. Through these conjoint sessions, an offender learns whether each of his/her "support people" actually understands what it means to be a support person and is actually invested in doing so, as well as whether the offender has given the support person the knowledge needed to hold the offender accountable. In other words, has the offender given the support person permission to support and challenge effectively, and over time does the therapist see this actually happening in the here-and-now of the conjoint session?

For example, during a group therapy session, it becomes clear that an offender has been using marijuana with someone he has been referring to as a "support person." Using marijuana (or any kind of illicit drug) is a violation of his probation. The group encourages him to bring this "support person" to a conjoint session to discuss this. In observing their interactions, it becomes clear that the offender is not able to assert himself with the "support person" when the support person engages in behaviors and encourages the client to engage in behaviors that are part of the offending pattern and against probation guidelines. The offender is challenged to consider that this person does not meet the support and challenge criteria effectively.

It is this process that supports the development of a pro-social support system, which research has found increases positive adjustment (Colvin, Cullen, & Vander Ven, 2002), and discourages involvement with deviant peer groups, which research indicates increases re-offending (Akers, 2000; Benda & Toombs, 2002; Pratt & Cullum, 2000). Below are some examples of conjoint sessions.

A client who was extremely isolated appeared to have distorted beliefs about the level of intimacy he had developed with "friends" during adolescence. This became very clear when he invited his brother to a session and the brother shared his perspective that the offender's relationships were superficial and often were a setup for the offender to be manipulated. This led to a better understanding of how the distortions that were part of his offending pattern developed. Without the brother attending the conjoint session, this perspective would have been lost. Additionally, in the process of the session, this client was challenged to develop a deeper intimacy with his brother when the therapist encouraged the offender to tell his brother what it meant to him that his brother took time out of his work day to come to the session.

In another example, during a conjoint session with his mother, an offender was encouraged to tell his mother that he had always felt "less than" because his older sister got preferential treatment. The therapist encouraged the client to ask about the mother's perspective on this issue, and the mother was able to validate and say that she understood his perspective. The mother then went on to share that she had also

felt like an "outsider" because of the special relationship between her husband/his father and the older daughter/his sister. This led to further discussions of how the client's family system works, including the ways that the client took undue responsibility for the conflict this brought between his parents. Thus, in one 20-minute discussion with his mother, a negative self-perception that was a part of his offending pattern since he was quite young began to shift.

It is particularly powerful when group members attend each other's conjoint sessions. If facilitated effectively, the session can become an extension of the group therapy process in two ways. First, an issue addressed during group therapy can be explored at a deeper level in a subsequent conjoint session. Second and alternatively, an issue addressed in a conjoint session can be brought back to group where the group member who was present can help emphasize or facilitate the client sharing. When one has a group member facilitating this disclosure process, it is a much more powerful intervention than when the therapist nudges the client. In fact, it is expected that the highlights of a conjoint session will be taken back to the group for further processing.

During the group check-in, a client who had a treatment goal of engaging in a healthy coming-out process mentioned being sexual with another man (something he had never mentioned before), and due to other factors happening in the group, this was not able to be followed up on during group. However, in a subsequent conjoint session, the group support person said, "Hey, you have never talked about being sexual with someone else before in group. Tell us what happened." This led to discussion of the fact that he brought this up in order to comply with group check-in guidelines but didn't take time or elaborate any more about it because he was not able to see the relevance to treatment goals. As he was encouraged to talk about it, it became apparent that the client was sexual with this man with no discussion or acknowledgement of this in their subsequent interactions. Not only did this fit into his pattern of not recognizing/not bringing up issues that are relevant to treatment, but it also provided the opportunity to stress that healthy sexuality includes being able to talk about sex and sexuality with one's sexual partners.

While this crossover between group and conjoint therapy sessions may appear problematic in terms of confidentiality, because the conjoint work is an inherent aspect of our treatment program, all the offenders are aware of, and agree at the start of treatment, that clinically relevant material will be shared in this way.

If applicable, offenders are strongly encouraged to bring their sexual or romantic partners into conjoint sessions. Because of the level of intimacy and investment, a partner's issues and concerns often become part of the content of the conjoint session in a way that does not occur with other types of support people (family, friends, and group members). Over time, conjoint sessions with partners begin to move towards couples therapy where the dynamics of the relationship become the central focus. At this point, it is customary for the therapist to engage the couple in a formal discussion in order to clarify the ways that conjoint differs from couples therapy, and ensure agreement to make this shift in the treatment. A common goal early on in treatment is to help the offender tolerate his/her partner's anger/pain and take responsibility for how his/her offending pattern has disrupted the partner's life. As the offender learns about his/her offending pattern, he/she becomes instrumental in bringing the partner on board with therapy goals and helping the partner to understand that changing the dynamics in their relationship will not only help change the offending pattern, but will also help the couple be stronger. As discussed in the partner's group section below, partners are also gaining understanding of the offenders' offending patterns. Once both have a foundational understanding of the offending pattern and are able to see their unique contribution to the pattern, the focus shifts towards building healthy sexuality in their relationship by addressing the components of the Sexual Health Model (see Figure 9.1). This involves the use of traditional sex therapy techniques such as sensate focus exercises. The following is an example of how traditional sex therapy is incorporated in sex offender treatment.

This offender was arrested for having sexual contact with a minor female babysitter. He had a long history of intrusive sexual behaviors with women of any age, so an aspect of his pattern was a sense of entitlement regarding his sexual needs. This pattern of intrusiveness and entitlement was also evident in his partner relationship, leading his partner to develop a pattern of sexual avoidance. The offender would make sexual remarks and unwanted advances several times a day, believing that eventually she would be sexual with him. Instead, the partner's sexuality completely shut down. Conjoint therapy with the partner began by discussing this dynamic, and over the process of months, the offender began to understand that this pattern of intrusiveness and entitlement was pushing his partner away rather than helping him to get his intimacy needs met. In the conjoint sessions he was able to take responsibility and become accountable regarding this pattern with her and understand that he needed to stop these intrusive and entitled behaviors in order for his partner to even be able to talk about sex and sexuality. He was able to follow through with these changes, which resulted in the partner beginning to develop trust. At this point, sensate focus exercises were introduced (see Avery-Clark & Weiner, this volume) to address the fact that they had not been sexual for the past several years. The couple is now openly talking about their wants and needs in terms of sexuality, as well as engaging in sexual behavior that is satisfying to both of them. Their level of intimacy is no longer centered around sex, which means that they now have more freedom around nonsexual touch and are learning how to have a healthy sexual relationship within the context of emotional intimacy.

Partner's Group

In early renditions of the partner's group, the group was voluntary and the purpose was based on support group principles. However, it became clear that as the offender got healthier, the partner was still engaging in "pre-treatment" relationship patterns and dynamics. Focusing only on support did not provide the necessary changes in the system. Thus, we made the following programmatic changes: (1) Partner's group would be required for all offenders who had a partner; (2) primary therapists in the offender treatment program would facilitate the partner's group; (3) therapeutic goals would align with the goals of the offender's treatment process; and (4) the important interplay between partner's group and couples/conjoint therapy would be stressed.

It is not unusual for partners to have an adverse reaction to mandatory attendance. They do not understand the purpose and feel like they are being punished when they "did not do anything wrong." The dysfunctional dynamics between the offender and partner often make it difficult for the offender to explain to his/her partner the purpose and benefit of attending group. Partners are often very angry with the offenders for how much the offense has disrupted their lives. Therefore the most important therapeutic task when a partner joins the group is to help him/her understand how this group will be helpful to him/her and his/her relationship with the offender. Over time, as the following goals are worked on, partners begin to see the value of having a place where they can share the unique experience of being a partner of someone with sex offending behavior. Existing group members assist in this process by validating new members' emotions and sharing what they have gained from being in the group both personally and relationally. Some partners start the group process with the goal of determining whether they want to stay in the relationship. As a part of this decision-making process, they learn about the short- and long-term consequences that come from being in a relationship with a sex offender—consequences such as limitations on travel, social events, and family gatherings, as well as the requirements of probation and the financial impact. Another goal is to help partners understand the process of sex offender treatment by explaining the core assignments. In particular, partners need to learn about offending patterns. This process begins with helping partners understand that offending does not just suddenly occur. It develops from the offender's experiences and responses to those experiences over time. Information is provided by the therapist about the purpose and format of offending patterns. Examples of different patterns are presented and discussed. In order to complete group, partners have to demonstrate

an understanding of their offending partner's pattern. A related goal is for the partners to develop an understanding of how they interact positively and negatively with their offenders' pattern. In order to address relationship dynamics with the offender, a further goal is for partners to develop an understanding of their own core beliefs in order to see how those influence their own patterns of thinking and reacting. The final goal of partners' group involves developing a self-care plan. Partners often are in the pattern of being overly responsible and the care-taker of their offender. Thus, much of the group process involves group members supporting each other to change the pattern of care-taking and develop their own interests and lives. Partners are also asked to develop an action plan, should they see their offender in his offending pattern.

Partner's Group meets two times per month for 90 minutes. Group starts with a brief check-in where all members are asked to share what they are working on in their relationship and what they are working on to build their own life. Partners then use the rest of the time to discuss recent relationship interactions, to work on changing relationship dynamics, and to get support for difficulties related to legal issues and stigma.

Treatment Process and Tasks

As noted previously, treatment uses three specific structural components: conjoint therapy, partner's group, and sex offender treatment group. The integration of these components is through assignments and specific therapeutic interventions. Treatment starts by providing the patient with a brief description of the core assignments. Then the focus becomes more about their cycle of offending, which identifies and explores their offending pattern. Clients are expected to role-play their offending situation in order to help the group and the offender see the key patterns of behavior, thoughts, and feelings happening at the time of offending. This information can then help the client with beginning cycle work, where they map out behaviors/thoughts/feelings, before/during/after the offending. At this point there is a clear dovetailing between the conjoint sessions and the group therapy process because the offender is encouraged to bring in group members as key support people within the conjoint session. These group members can be the most helpful with exploration of cycle patterns. This naturally leads to the offender beginning to feel increased connection, support, and intimacy with other group members. Often offenders begin to see the value of having people who know about their situation to talk to outside of their individual and group therapy sessions. Over the course of treatment, cycle work (understanding thinking and behavior patterns) becomes the framework. Thus as clients bring current issues to group, these are processed by challenging them to think about how what is happening now may be part of their "cycle". For example, one of the core patterns in a particular offender's cycle is how feelings of inadequacy and anger/resentment about missed opportunities feed his desire to escape by attempting to get positive attention through exhibitionism in public places. Thus, when this client came in resigned, resentful, and angry about how he wasn't going to get to apply for a job he was interested in because the job schedule conflicted with group, an exploration of his thoughts and feelings helped to clarify for him that this was another example of his life pattern of not going after something that he wanted and then being angry and resentful towards himself and the perceived barriers that keep him from meeting his goals. In both individual and group sessions, he was instructed to think about how he was currently repeating an old pattern which had already been labeled as "woulda/coulda/shoulda" and what he could do now to no longer repeat this detrimental cycle pattern. Through this process, he was able to understand that he had options, and he asked whether he would be able to switch treatment groups if he attained the job. Because this was a core example of real-life change in thinking and behavior, the treatment team agreed he could switch, and he went on to apply for the job.

The psychosocial/sexual history is another core assignment of our treatment program. There are multiple goals for this assignment including (1) having offenders begin to understand how their interpretation of events started to form their beliefs about themselves, others, and their environment; (2) having offenders develop insight into how those beliefs influence their decisions and behavioral patterns over time; (3) developing intimacy and connection with group members, and decreasing a sense of isolation as others relate to their formative experiences by saying, "I felt the same as you"; (4) providing the offender with a corrective emotional experience through the here-and-now of the group process; and (5) developing an understanding of and taking responsibility for the impact of their behaviors on others. The focus is on accountability, not just towards the victim, but encompassing the larger impact their negative behaviors have had across multiple systems in their lives, including their siblings, their parents, their children, their partners, their friends, and their community.

Clients start by writing the history of their lives so that they have some information to work from as they begin to share their history with the group. It is interesting to see how each offender interprets this assignment by what he/she determines is important to present and how he/she presents it. For instance, it is not uncommon for a client to begin relating their history from when he/she entered school or later. This tells us important information about his/her level of insight and assumptions about the significance of early events (prior to age 5–6 years) in defining who he/she is, who others are, and how relationships work. Therefore we use this assignment as an opportunity to teach the offender how important it is to be open to others' perspectives, and that perhaps the offender's interpretations of events led him/her to develop beliefs and assumptions that are unhealthy. We guide him/her to consider that it may be healthier to see the world from multiple perspectives. It is powerful for the offender to hear from other group members who may have had similar experiences but formed different interpretations.

Offenders who have difficulty remembering their history and/or connecting any sort of emotionality to their history are asked to bring in pictures of earlier years and to contact family members for their memories and perspectives of these early years. We have found that when gently challenged, many more memories come to light. This can be very unsettling for some clients. Thus, this is a time where the group process really helps by reassuring the offender with supportive and encouraging statements like, "you'll get there," "this was a really hard thing for me to do," and "I was surprised by what I started to remember."

As the offender moves forward chronologically, we address family of origin issues with specific, individualized assignments. The goal of these assignments is to continue to shed light on behavior and relationship patterns and how those relate to their offending cycle. In particular, abuse experiences that shaped their beliefs about themselves are addressed. As part of their history, we focus specifically on their sexual development in childhood, through puberty and the teenage years, and into adulthood, addressing what they learned about who they are sexually and how their beliefs and sexual behaviors formed, based on their early experiences.

> *One offender who struggles with exhibitionism shared that he thought his first "offending experience" was when he was 5 years old. While playing in the woods, he had to go to the bathroom. Rather than return home to do so, as he took his pants down to pee, he noticed the positive sensations of having his genitals exposed to the air. Through empathy, validation, and relating their own childhood experiences, the group helped him to see that what he was labeling as "offending" would be considered a normative childhood sexual exploration and that it was not helpful to him to feel guilt or shame about this experience.*

The sexual history assignment culminates in addressing what is healthy sexuality for each offender currently, including the important area of masturbation and fantasy. Our program does not think about sexual fantasy or arousal as either "deviant" or "normal." Rather, through

open discussion and exploration of an offender's sexual arousal and fantasy patterns, our goal is to separate arousal and fantasy from behavior and to decrease shame and stigma associated with that arousal and those fantasies that have been labeled as deviant.

What is particularly tricky is how to approach masturbation and fantasy within our sexual health framework. The goal is to have the offender understand how his/her arousal, fantasy, and masturbation patterns fit within his/her patterns of offending, without judging the fantasies themselves. Thus, it is likely that a fantasy that would be considered normative can be just as unhealthy for a particular client as a fantasy that would be considered deviant. Therefore, the offender needs to think about and explore the function of his/her fantasy. How does the fantasy operate to get him/her the things he/she needs? Who does he/she get to be in his/her fantasy that he/she doesn't get to be in "real life?" For example, one offender obsessively fantasized about the need for sexual touch and sex in order to be loved. His frame was, "If I can get women to engage in sexual conversation and behavior with me, it means I am loved." This led him to engage in behaviors such as constantly making inappropriate comments and unwanted advances towards women. In treatment, one of the goals was to help him "rewire" how he thought about the connection between intimacy and sexuality. Over time, he came to realize, "I don't need sex to feel loved and important. I like to have sex, but now I feel loved and important regardless of whether I am 'getting sex.'" Having him distinguish the need for connection and emotional intimacy as different than sexual contact was core to changing his offending patterns as well as developing healthy sexuality. Now he is no longer obsessive in terms of the amount of energy he spends in sexual fantasy. He has also shifted his fantasy content towards arousal, intimacy, and connection rather than promoting the belief that "sex makes me feel powerful, important, and loved."

An obvious question within a sex offender treatment program that uses a sexual health frame is how to address pedophilic arousal and fantasy patterns. We start by being very clear that shame is not a helpful deterrent and, in fact, is likely to promote pedophilic offending behavior through the pathways of secrecy and stigma. In our treatment program, an offender who has pedophilic sexual fantasies and arousal is encouraged to see these as "just the way that it is" (i.e., inherent to their sexuality) at the same time that we very clearly stress that pedophilic and/or hebephilic *behaviors* are not acceptable due to both illegality, social norms, and the level of harmfulness. Thus, we help an offender with pedophilic arousal patterns to (1) acknowledge the attraction and its longevity; (2) increase his/her awareness of when he/she is in situations that create pedophilic arousal; (3) accept that behaviors driven by pedophilic arousal, such as the use of child pornography, are harmful to youth rather than the distorted belief that because there is no contact, there is no harm; (4) understand how masturbating to these fantasies could not only ultimately lead to re-offending, but also take him/her to that place in his/her offending pattern where he/she again feels isolated, shameful, unimportant, and inadequate; (5) build alternative strategies to meet his/her needs by reaching out to support systems where he/she genuinely feels less isolated, more adequate, and more important. All of this creates an internal motivation to not only avoid the negative aspects of the offending patterns, but also to build healthy and positive habits that involve true intimacy with other people.

One offender, who was convicted of using child pornography, presented as angry at and defensive towards the "system" because he was convicted of behavior that he saw as protective (i.e., he saw child pornography as a way to avoid actual sexual activity with a child). His anger stemmed from his intentional decision in early adulthood to give up any chance of a romantic relationship so he would never be in the position to parent a child, therefore decreasing the risk of actually engaging sexually with a child. Thus his beliefs were, "I am giving up my life. My life sucks no matter what. Nothing is going to change that. I am isolated and alone. I don't have friends. No one cares about me." He believed, "I gave up my whole life to protect children, and now I have lost the one thing that I had left to help me meet my needs." Through the course of treatment, as he came to the realization that children are harmed in the making

of child pornography, he had to give up the belief that he was actually protecting children. He also began to realize that his belief system and way of living actually reinforced the need to continue to use child pornography because its use had become his only source of intimacy. Thus, as he started to have intimate relationships within the group, his urges to use child pornography decreased.

As illustrated in this example, we focus on fantasy content when the content of the fantasy is such that it promotes a lack of intimacy. This is not to say that we believe that these types of fantasies are bad or unhealthy *per se*, but within the context of the offender's offending pattern, the question is whether this fantasy promotes the offending pattern or serves the treatment goal of opening up new, more healthy fantasy and arousal patterns that help to increase intimacy with others.

The Incorporation of Sexual Health Curriculum

In keeping with the philosophy that sexual offending is rooted in maladaptive sexuality, it is central to our treatment to weave themes related to sexual health repair and development through the treatment process. In addition to exploring sexual health themes through two of the core assignments as described previously, during weekly group check-in, questions are incorporated about group members' sexual functioning and behavior over the past week. This provides an opportunity for the group (1) to have ongoing discussions about normative sexual development; (2) to contextualize sexual experiences about which offenders often feel shame; and (3) to develop a group culture that talks openly and respectfully about sexuality. Lastly, we also incorporate a sexual health curriculum in a manner that is fundamentally grounded in the SAR movement (Wollert, 1978; Held *et al.*, 1974; Rosenberg & Chilgren, 1973). This sexual health curriculum, developed out of the previously described sexual health model (Robinson *et al.*, 2002) is designed to develop healthy sexuality, which we operationalize as having the ability to (a) communicate sexual needs and express them appropriately, (b) resolve any sexual identity issues, (c) engage in healthy masturbation practices, and (d) develop harmony of sexual beliefs and values with sexual behavior. The following is a definition of sexual health put forth by Robinson *et al.* (2002, p. 45):

> Sexual health is an approach to sexuality founded in accurate knowledge, personal awareness, and self-acceptance such that one's behavior, values, and emotions are congruent and integrated. Sexual health involves the ability to be intimate with both self and a partner, to communicate explicitly about sexual needs and desires and to have appropriate sexual boundaries. Sexual health includes a sense of sexual self-esteem as well as freedom from sexual dysfunction, unwanted pregnancy, STIs and sexual assault, coercion and manipulation. Sexual health affirms sexuality as a POSITIVE force, enhancing other dimensions of one's life.

Looking at this definition and thinking about our sex offender clients, it is clear that most of them have extreme difficulty in many of these areas. They tend to have a lot of inaccurate information about sexuality with little awareness of the limits of their knowledge. For the most part, as treatment progresses, the clients realize that the sexual offending behaviors they have engaged in may never have been—and definitely in the present are not—congruent with their values or beliefs. They also tend to have extreme difficulty with emotional intimacy and do not really feel sexually competent. It is rarely the case that sexuality has been a positive force that has enhanced their life.

In keeping with the definition above, Robinson *et al.* (2002) developed the Sexual Health Model as a way to describe the important components of sexual health. The sexual health curriculum used in the sex offender treatment program is built around the spokes of the sexual health wheel (see Figure 9.1 and Appendix A for a brief description of each spoke). A combination of mini-presentations, structured activities, sexually explicit media, experiential

exercises, and discussion questions is used to create modules pertaining to each of the spokes, and care has been taken to make sure the content of these modules is specific to sex offending issues, realities, and treatment goals.

In the past five years or so, we have been exploring how best to incorporate this sexual health curriculum into the treatment program. After some trial and multiple errors, it is now clear that bringing the curriculum into the offenders' ongoing treatment groups about once a quarter (four times a year) works the best. Not only does this mean that the offenders are already in an emotionally safe and comfortable environment because they are already accustomed to exploring complex topics with each other, but the therapists in a given group know their clients very well and therefore can adapt the curriculum material and tailor it to the needs of their specific group members. Also, and perhaps most importantly, within a couple of weeks of the presentation in the treatment group, the same curriculum material is presented in the partner's group, and for that particular group the offender joins his/her partner in their partner's group. Thus, for those offenders who are in a couple, the couple is directed to apply the sexual health material to their actual relationship dynamics in the here-and-now of the group, as well as to continue the discussion and application of the materials to their relationship outside of the therapy setting.

As an example, let's look more deeply at one particular module: Challenges to Sexual Health. This module begins with a discussion of how sexuality is influenced by discrimination and oppression related to sexual orientation, gender identity, and lack of conformity to stereotypes related to masculinity and femininity. In particular, we discuss the extent to which sex offenders experience discrimination and social stigma (e.g., media portrayals, living restrictions). We focus on helping them to think about the impact this has had on them and how they can be resilient and recover in spite of the social stigma and oppression they face as sex offenders. The offenders are also asked to explore the challenges they have in terms of mental health and substance use/abuse. They need to explore and understand how these have contributed to difficulties in developing healthy emotional and sexual relationships, as well as the direct role these may have played in their offending pattern (e.g., drinking every night in order to decrease inhibitions while soliciting minors on the internet). History of physical and sexual abuse is another challenge discussed in this module. Because of the stereotypes around masculinity, men tend to have increased barriers to disclosure of abuse (Dorahy & Clearwater, 2012; Romano & De Luca, 2001; Spiegel, 2003). Thus, we discuss definitions, prevalence, and myths associated with abuse. We highlight the importance of abuse recovery work as a part of their ongoing treatment and encourage them, throughout their treatment, to examine the links between abuse experiences and offending patterns. The last challenge discussed in this module is compulsive sexual behavior. We discuss the function and types of compulsive sexual behavior and encourage the offenders to explore the extent to which compulsivity is a part of their offending patterns.

The above is an example of how each spoke of the Sexual Health Model provides the basis for structured sexual health modules as well as ongoing goals and issues addressed throughout the process of sex offender treatment. Consistent with our overarching model for sex offender treatment, sexual health and the resultant intimate relationships are important outcomes; we believe that these outcomes support a lifestyle in which sexual offending behavior is unlikely to occur.

Summary and Conclusions

In this chapter, we have described sex offender treatment guided by the Sexual Health Model (Robinson *et al.*, 2002). This differs from many others in that the goal is not only to eliminate reoffending; it is to help individuals who have committed sexual crimes to develop a healthy

sexuality and a productive lifestyle. Drawing on concepts from cognitive-behavioral therapy and consistent with current trends in systemic and family therapy (see Hills, 2013), our treatment integrates an emphasis on understanding the maladaptive attitudes and decision-making processes that lead to sexual offending behavior, with the development of a supportive and intimate social support system. Treatment progresses through a number of stages and processes that integrate understanding of offense-specific issues, general lifestyle issues, developmental processes, and the building of social networks.

This chapter described the use of conjoint therapy, the integration of relationship dynamics through both a required partner's group and couples counseling, and the emphasis on healthy sexuality, both throughout the therapeutic process and through regular group psychoeducation. The process described here integrates concepts from sex therapy and positive sexuality and is consistent with the recent discussions within the sex offender treatment field of risk-needs-responsivity principles (Hanson, Bourgon, Helmus, & Hodgson, 2009). That is, our intervention is individually tailored to address those issues that put each individual at risk for sexually maladaptive behavior, both criminal and noncriminal. Our intervention also addresses those systematic factors that have historically supported, or at least been complicit in, allowing the maladaptive behavior. The goal is to help the offender to develop a support system that promotes adaptive, prosocial behavior.

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Appendix A The Ten Components of the Sexual Health Model

(adapted from Robinson *et al.*, 2002)

1 *Talking About Sex* A cornerstone of the Sexual Health Model is the ability to talk comfortably and explicitly about sexuality, especially one's own sexual values, preferences, attractions, history, and behaviors. We believe that such communication is necessary for one to effectively negotiate safer sex with one's sexual partners and is a valuable skill that must be learned and practiced.
2 *Culture and Sexual Identity* Culture colors one's sexuality and sense of sexual self. It is important that individuals examine the impact of their particular cultural heritage on their sexual identities, attitudes, behaviors, and health. The relationship between identity and intimacy should be explored, recognizing each individual's needs for autonomy (to be unique, feel special, and have privacy) versus belonging (to fit in, feel connected, and be loved).
3 *Sexual Anatomy and Functioning* Sexual health assumes a basic knowledge, understanding, and acceptance of one's sexual anatomy, sexual response, and sexual functioning, as well as freedom from sexual dysfunction and other sexual problems.
4 *Sexual Healthcare and Safer Sex* Health covers a broad perspective encompassing knowing one's body, performing regular self-exams for cancer and STDs, and responding to physical changes with appropriate medical intervention.
5 *Challenges: Overcoming Barriers to Sexual Health* Challenges to sexual health such as sexual abuse, substance abuse, compulsive sexual behavior, sex work, harassment, and discrimination are critical in any discussion of sexual health.
6 *Body Image* In a culture with so many sexual images focused on a type of physical beauty unattainable for many, a positive body image is an important aspect of sexual health. Challenging the notion of one narrow standard of beauty and encouraging self-acceptance is relevant to all populations.
7 *Masturbation and Fantasy* In our culture, the topics of masturbation and fantasy are saddled with a myriad of historical myths associated with sin, illness, and immaturity. Because sexual health is founded on accurate information, it is important that such myths be confronted (Coleman, 2002).

8 *Positive Sexuality* A developmental approach to sexual health over the life span recognizes the reality that all human beings need to explore their sexuality in order to develop and nurture who they are. The importance of exploring and celebrating sexuality from a positive and self-affirming perspective is an essential feature of the Sexual Health Model. Positive sexuality includes appropriate experimentation, affirming sensuality, attaining sexual competence through the ability to get and give sexual pleasure, and setting sexual boundaries based on what one prefers, as well as what one knows is safe and responsible.

9 *Intimacy and Relationships* Intimacy is a universal need that people try to meet through their relationships. Intimacy can take many forms; knowing which intimacy needs are important for the individual is helpful in getting these needs met.

10 *Spirituality* Our definition of sexual health assumes a congruence between one's ethical, spiritual, and moral beliefs and one's sexual behaviors and values. In this context, spirituality may or may not include identification with formal religions, but needs to address moral and ethical concerns and deeper values in order to find a way to better integrate one's sexual and spiritual selves.

10

Treating Lack of Sexual Passion in Relationships

Laurie B. Mintz, Jackeline Sanchez
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Do you remember how it used to be?
We'd turn out the lights and we didn't just sleep
Do you remember the way it felt?
You mean back when we couldn't control ourselves
I miss the way that it felt back then
I wanna feel that way again
Lyrics from "Remind Me" by Kelley Lovelace,
Brad Paisley, and Chris Dubois

The country songwriters quoted above are not the only ones to lament their lost passion. In 2007, DatelineNBC.com conducted a survey to which 27,500 individuals responded in less than 48 hours. Sixty-eight per cent reported problems with lack of passion in their relationships. Specifically, 13% reported "sex is dead," 22% reported "sex is comatose and in danger of dying," and 33% reported sex is "asleep and in need of a wakeup call" (Schnarch, 2010, p. 48). This chapter details the varied causes and associated interventions for this widespread lack of sexual passion. First, however, it is important to define what the problem is, who is suffering from it, and how it intersects with other concerns outlined in this volume.

What Couples with Low Passion Say

Couples distressed by lack of passion commonly attribute this to one partner's low sexual desire. The "identified patient" in passionless partnerships often makes statements like, "I am never horny anymore" or "I couldn't care less if I never have sex again." The higher-desire partner often feels confused, rejected, and dejected; some such partners continue to ask for sex, while others cease to initiate altogether. Often, these couples stop having sexual encounters or have them so infrequently that they would be deemed by experts to have a low- or no-sex partnership (i.e., having sex less than 10 times per year; McCarthy & Thestrup, 2008). Just as

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often, however, the couple occasionally engages in sex despite one partner's loss of physical desire. When these couples do engage in sex, there are two possible outcomes:

1 Some report that it is "good once it gets going," causing the lower sex partner to think, "We should do that more often"—a sentiment soon lost amidst the stressors of daily life.
2 Other couples have sexual encounters that are mediocre at best—lacking in sexual ecstasy, emotional connection, or both.

Nevertheless, couples with these passion problems do not necessarily have deep-seated relationship problems (Meana, 2010), and in fact, most say that they love one another. The late, well-known expert on the topic, Sandra Leiblum (2010a), noted that large numbers of men and women complain of diminished passion "despite good health, good will, and even good relationships" (p. xii).

Who are these Passionless Couples?

Clinical, scientific, and popular press writings have focused mainly on heterosexual couples in which the woman has low sexual desire, particularly women who are middle-aged and white (Bradford & Schwartz, 2014) or who are working mothers of young children. There are some writings on lesbian couples suffering from lack of passion, or what is often referred to as "lesbian bed death" (Nichols, 2004). There also are writings on low desire among men in heterosexual couples, with some claiming that this is an underreported phenomenon (Weiner-Davis, 2003), and others (Basson, 2010; McCarthy & Breetz, 2010; Schnarch, 2010) stating that, in such cases, the man's low desire is often due to another sexual concern (e.g., erectile dysfunction) or a sexual secret (e.g., a fetish), and that the prognosis is poor. Of note, there is a dearth of writings on gay male couples struggling with lack of passion. It is unclear whether this is because this concern is uncommon among long-term gay male partners, or if it simply has not been a focus of professional attention. Given the state of the literature, much of what is contained in this chapter has been gleaned from the literature on heterosexual couples in which the identified patient is the women. Research and clinical writings on more diverse (e.g., race, ethnicity, religion, income level) low-passion couples are sorely needed, as are writings that more specifically detail cultural factors associated with diminished passion. While urging the field in this direction, our aim is to use the currently available literature to present a broadly applicable treatment model for clients with diminished passion.

Overlap with DSM-Defined Disorders

Because those who present with lack of passion generally attribute this to one partner's low desire, it is important to understand what distinguishes this chapter from those dealing with what the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013) defines as Female Sexual Interest/Arousal Disorders (FSIAD; Both, Weijmar Schultz, & Laan, this volume) and male Hypoactive Sexual Desire Disorder (HSDD; Althof & Needle, this volume). First, the DSM-5 states that if interpersonal factors, contextual factors, or other significant stressors are responsible for the symptoms, then the diagnosis of FSIAD and HSDD should not be made (American Psychiatric Association, 2013). Importantly, it is these very causes and their associated treatments that this chapter will cover. Secondly, this chapter focuses on clients who are struggling with desire

issues only, and not those who also have consistent problems with arousal once sexual activity is underway. Among women, this distinction has recently been codified in the changes from the prior edition of the DSM (DSM-IV-TR; American Psychiatric Association, 2000) to the current version (DSM-5; American Psychiatric Association, 2013). The prior DSM-IV-TR included a diagnosis of female hypoactive sexual desire disorder characterized by reduced or absent sexual fantasies and desire for sexual activity accompanied by distress. However, based on criticisms that these criteria did not account for the finding that, for many women (particularly those who are older or in a long-term relationship), sexual desire follows or occurs concurrently with sexual activity and arousal (Brotto, 2010b), a broader diagnosis made its way into the DSM-5. In addition to a lack of interest in sex, this newly-introduced diagnosis of FSIAD includes criteria regarding lack of excitement and pleasure, lack of response to sexual cues, and lack of sensations during sexual activity. This chapter pertains only to women who have a lack of interest in sex and not a lack of responsiveness to sex; in other words, it does not pertain to women who would be diagnosed with DSM-5 FSIAD. Likewise, despite the fact that, in the DSM-5, men are diagnosed as having HSDD based on lack of desire and distress concerning this, it is often erroneous to label a man as having HSDD if he does not experience desire at the outset of a sexual encounter but nevertheless has a healthy sexual response once sex is underway (Brotto, 2010a). In short, then, this chapter pertains to couples in which one or both partners exhibit a lack of interest in sex due to varied stressors, but who become aroused once sex is underway. Finally, although some clients present for lifelong issues with lack of passion (often seeking treatment at an important juncture such as when attempting to conceive a child), this chapter pertains to those couples who used to have a passionate sex life, no longer do, and yearn for its return.

Variability is the Hallmark and Individualized Treatment is the Goal

Although this chapter focuses on clients who used to have passionate sex and long for its return, the exact nature of their problem and what has caused and is maintaining their problem is quite varied (Kingsberg, 2010; Leiblum, 2010a). One couple may be having few sexual encounters—and wishing for more—despite the fact that their actual encounters feel loving and exciting for both involved. In another couple, the frequency of the sex may be low and the actual encounters may feel monotonous (even when resulting in arousal and orgasm). Likewise, one couple may have ceased to have sexual encounters because one partner has poor body image, and another may have done so because of stress or exhaustion in one or both partners. Each case is unique, and there is no one-size-fits-all treatment (Leiblum, 2010a). Thus, for low-passion couples, "therapy must be individualized—custom tailored to match the etiology and life situation of each case" (LoPiccolo, 2011).

This need for individualized treatment may help to account for the fact that, in an edited volume of clinical cases on low-sexual desire (Leiblum, 2010b), the views of the authors were often contradictory. Across the 13 authorities writing for this volume, "… it is not uncommon to read one author's assertion that a therapist should not do X, only to find another elaborating how X facilitates sexual desire" (Levine, 2012, p. 408). However, rather than providing a review of this often-contradictory clinical literature, this chapter will attempt to pull this literature and existing empirical studies (e.g., Brotto, Basson, & Luria, 2008; Mintz, Balzer, Zhao, & Bush, 2012) together into a single treatment model. The model begins with assessment and proceeds through treatment, following the well-known multilevel PLISSIT model (Annon, 1974) of treating sexual concerns. Indeed, we contend that previous contradictory viewpoints can be resolved when viewing such diverse suggestions as representing differing levels of this stepwise model. We call this our *PLISSIT for Passion* model.

PLISSIT for Passion

Developed by Jack Annon in 1974, yet still relevant today, PLISSIT describes a stepwise model of intervening with sexual concerns with the progressively more intensive intervention steps of Permission (P), Limited Information (LI), Specific Suggestions (SS), and Intensive Therapy (IT). Permission refers to the therapist simply giving approval for the client to do what he or she is already doing, thereby alleviating unnecessary guilt, anxiety, or concerns about normality. Limited Information refers to the therapist providing accurate factual sexual information to clear up clients' common unrealistic expectations and erroneous notions about sexual functioning. Specific Suggestions refers to the therapist providing practical ideas and exercises tailored to the individual case. Finally, Intensive Therapy is a long-term intervention aimed at addressing the underlying causes of a sexual problem. In the PLISSIT model, the least invasive form of treatment is offered first. According to Annon (1974), 80–90% of sexual problems can be resolved using the first three steps. We contend this is particularly true for lack of passion due to individual, relational, and life-stage stressors, although a caveat is in order: The PLISSIT model assumes that Intensive Therapy is provided only when intervention via the lower three levels has not been effective, when in actuality, Intensive Therapy may be offered in concert with Limited Information and Specific Suggestions (Taylor & Davis, 2007). Prior to presenting our PLISSIT for Passion model, however, preliminary information on modality of treatment is needed.

Modality of treatment

Various modalities for treating lack of passion have been reported in the literature, including group, couple, and individual therapy, as well as self-help forms of treatment. Nevertheless, in terms of modality, two central decisions deserve attention: (1) sex vs. relationship focus in therapy and (2) individual vs. couple sessions.

Focus on sex vs. relationship When sexual and relationship problems co-occur, some authors advocate treating the sexual problem first and contend that the relationship will improve as a result (e.g., Perel, 2010), while others advocate treating the relationship first and contend that the sex will improve as a result (Hall, 2010; Schnarch, 2010). We resonate with those who advocate treating both simultaneously. We agree with LoPiccolo (2011) who pointed out that "… focusing just on the relationship issues often repairs the damage done by the low drive [of one partner] but doesn't raise the low drive. In a similar manner, attempting to work [only] on the low drive … [is often] … not very successful." Underscoring this sentiment, we find that sometimes relationship issues are the source of the diminished passion, and sometimes the low passion results in relationship issues. Generally, the more long-standing the relationship and low-passion issues are, the harder it is to untangle this chicken-and-egg question. Thus, like Meana (2010), we work simultaneously on both relationship and sexual problems without spending time trying to figure out the detailed connection between them.

Focus on individual vs. couple sessions Some sex therapists prefer to treat couples rather than individuals (Basson, 2010; McCarthy & Breetz, 2010; Schnarch, 2010). Basson (2010) went so far as to contend that if the complaint is low sexual desire in one partner, it is necessary to treat both partners, further noting that when the non-identified patient is reluctant or unwilling to enter treatment, the reason is usually a poor emotional relationship and the prognosis is poor. On the other hand, Hall (2010) stated that "… one can work systemically with only one member of the couple" because "if one person changes, the nature of the dyad must change as well" (p. 70). If an individual seeks treatment, our strategy is to ask whether he or she would

consider conjoint treatment, explaining that, because sex is a couples issue (no matter who is perceived as the source of the problem), it is best treated in couples therapy. Nevertheless, like Hall (2010), we respect the client's wishes and find that aspects of lack of passion can be treated individually if that is the client's preference.

When conducting couples therapy, practitioners also need to consider whether it is desirable to meet with one or both of the individuals alone in addition to meeting with the couple together. Meana (2010) pointed out the benefits (e.g., reducing triangulation) and risks (e.g., missing out on important information and the opportunity to provide individual coaching on sexual skills) of only seeing the couple as a unit. Our approach is to inform couples that, although we conceptualize their relationship as our client, we sometimes find it useful to have individual sessions. Also, although some therapists allow confidentiality of material presented in such individual sessions (e.g., McCarthy & Breetz, 2010; Risen, 2010), like Meana (2010) we have clients sign an informed consent which stipulates, "Information disclosed during your individual session may be revealed to your partner at a subsequent joint or individual session." We carefully explain the types of information that would and would not be disclosed, using Risen's (2010) categorization of *private* versus *secret* sexual behaviors and feelings. Private information does not have an impact on the couple's sexual relationship but nevertheless may be hurtful to share (e.g., "My best ever sex was with my old boyfriend."). Secrets are those that are currently having a negative impact on the couple's sexual relationship or that would have such an effect if discovered (e.g., a fetish or an ongoing affair). We also tell clients that sometimes distinguishing between private information and a secret is difficult, and that we will discuss the determination in detail with the revealing party. We also inform clients that we will "work with the revealing party on the least harmful way to deal with the revealed secret." In short, our consent stipulates that we cannot work effectively with a couple in which secret information is revealed, and that we thus reserve the right to disclose information revealed during an individual session and/or to terminate couples counseling (with or without revealing the reason for termination). Of course, if such termination is needed, we provide referrals for both individuals.

In over 25 years of doing therapy, the first author has found that clients with private thoughts and feelings are often relieved to discuss them. Indeed, when conceptualized within our PLISSIT for Passion model, the revelation of such private thoughts often results in Permission-giving and Limited Information. An example is a male client who revealed occasional fantasies about other women during sex with his wife, stating that his guilt about this was driving his sexual avoidance. When the therapist shared that this was a fairly common concern, and engaged in an open, non-judgmental discussion of the benefits and risks of this practice, the client began to feel less guilty and to seek out sex with his wife more often without revealing that he sometimes engaged in this behavior.

Conversely, we find secrets are often either not revealed (e.g., a client who was having an affair and never revealed this during individual sessions but was later caught by his wife), or if they are revealed, the client does so because he or she wants assistance in revealing it to their partner (e.g., a male client who had an aversion to his wife's smell and thus was avoiding sex with her). Nevertheless, despite the strategy of individual sessions without a promise of confidentiality working for both us and Meana (2010), each therapist must make the decision that is most comfortable to him or her. Still, the therapist must make these decisions, and the complexity of these decisions is important to bear in mind during both assessment and treatment.

Assessment in the PLISSIT for Passion model

Although there are useful standardized instruments for assessing desire complaints, a good clinical interview is most important (Leiblum, 2010a). Nevertheless, practitioners vary in the formality of their assessment process. On one end of the continuum are McCarthy and Breetz

(2010) who recommend a four-session assessment process in which both partners are seen in the first session, followed by individual sessions with each partner, followed by a couples session during which feedback is provided and treatment agreed upon. On the other end of the spectrum is Hall (2010), who advocates an initial assessment, which itself is part of the treatment process and in which education is first provided. Like Hall, we advocate an initial assessment, moving as swiftly as possible to providing information and suggestions, and using client reactions to these interventions as a source of continual assessment. We utilize an "assessment/feedback/intervention process" (McCarthy & Thestrup, 2008, p. 143).

> *To illustrate, Jerry and Lily were a recently married couple who presented due to Jerry's complaint that sex was dull and that Lily was not sexually adventurous. They both claimed deep devotion and love. Lily was a sexual abuse survivor, and so, despite her having been in intensive therapy to deal with the abuse, both viewed Lily as the identified patient. After an initial brief intake session, sensate focus was assigned as homework, with the first step being the head caress (Keesling,2006). They returned the next session reporting that Jerry could not do the exercise because he was unable to maintain eye contact with Lily. This report helped the therapist discover Jerry's discomfort with intimacy and his belief that sex and intimacy were distinct phenomena. Although this led the therapist to work on intimacy and family-of-origin issues with Jerry in both couple and individual sessions, sex therapy was not abandoned altogether. Heeding the warnings of McCarthy and Thestrup (2008), we did not use a failed sex therapy exercise as a signal to refocus therapy exclusively on individual or relationship dynamics. Instead, we processed the impasse, using the information to simultaneously redesign and individualize the sexual exercises while attending to individual and relationship dynamics. In the case of Jerry and Lily, we forfeited the head caress and moved to sessions where they built intimacy by writing down and sharing sexual fantasies while concurrently working on Jerry's intimacy issues. Thus, by introducing exercises early in treatment (i.e., in the second session in this case), we gathered important information that allowed us to adjust our treatment approach.*

Despite our recommending an assessment/intervention/feedback loop, readers may wonder what questions to ask in an initial interview. We strive for an open-ended, non-judgmental approach to gathering information that allows clients to tell their sexual stories (McCarthy & Thestrup, 2008; Risen, 2010), while bearing in mind that the couple may have had few previous productive discussions about sex and may be quite uncomfortable (Risen, 2010). We generally begin first sessions with a statement that normalizes concerns, instills hope, and opens the door for discussing the concern. A typical opening line might be:

> I understand from my phone call with Sally that you are here because your sex life isn't what you want it to be. I also want you to know that almost all couples have sexual difficulties at some point in their relationships, but not everyone is as proactive and brave as you to seek help. So, I am really glad you are here today. Let's start by having you tell me just what your concern is and what led you to seek help for it now.

We then listen carefully to the client's story, allowing the story and our knowledge of the causes of lack of passion to guide our questions. To illustrate, because we know that often individuals with low desire engage in sex despite this, we ask if this is the case and if the sex is enjoyable once underway. As another example, because we know that young children at home can limit opportunities for sexual encounters, we ask couples with young children when and where they engage in sexual encounters. Finally, we often enquire about masturbation. If women with low sexual desire report masturbation, this is a clue that the problem may be more partner-specific. For men, this information is less relevant in that most men with low desire report continuing to masturbate (Janssen, McBride, Yarber, Hill, & Butler, 2008). To reiterate, assessment is guided by the clients' presentation and our knowledge of the varied causes of diminished passion.

Causes of diminished passion

Our PLISSIT for Passion Model is appropriate for diminished passion stemming from individual, relational, and contextual stressors. Brotto, Petkau, Labrie, and Basson (2011) reported that such factors did not distinguish those women with DSM-5 defined FSIAD (problems with desire and arousal) and those who had problems with desire only (those to whom this chapter pertains). However, those with FSIAD had more serious past and present psychiatric symptoms, more negative early childhood histories, and more negative sexual histories than those who had issues with an absence of interest in sex only. Thus, while practitioners should assess for these more serious and pervasive contextual factors, they are not detailed below. Additionally, negative beliefs about sex stemming from upbringing or cultural mores are not included because we find that they generally underlie more ongoing issues with sexual functioning, and this chapter pertains to those who *used to* have passion and no longer do. We also exclude domestic violence (Hall, 2010) because, unlike other relationship issues, we believe this must be attended to as a primary and distinct issue prior to addressing sexual concerns. Finally, we do not specifically list poor communication as a cause because we find that this concern cuts through all other relationship concerns. However, for this same reason, we list communication skills training as a Specific Suggestion. Before describing the individual, relational, and contextual stressors that can cause diminished passion, some rule-outs must be detailed.

Rule-outs

Illness, medication, and hormone levels Diminished passion can be an early sign of a potentially serious underlying medical issue (e.g., thyroid problems, diabetes, high blood pressure, cardiovascular disease). Additionally, those recovering from certain illnesses (e.g., breast cancer; Krychman & Spadt, 2010; see also Zhou & Bober, this volume) predictably struggle with issues related to body image, sexuality, and desire. Also, chemotherapy and other medications (e.g., blood pressure medications, tranquilizers, and antihistamines) decrease libido. Some birth control pills decrease sex drive, as do selective serotonin reuptake inhibitor (SSRI) antidepressants, although one antidepressant medication (Wellbutrin) has been found to increase sex drive in premenopausal women (Segraves, Clayton, Croft, Wolf, & Warnock, 2004). We thus refer all clients for a medical workup and medication evaluation with a physician well-versed in sexual medicine. Such physicians can also evaluate clients for a possible androgen insufficiency, which could be responsible for low desire.

Indeed, clients often have read about hormonal reasons driving low desire, and hope for a quick cure-all (Hall, 2010; Mintz, 2009). It is thus useful for therapists to have basic knowledge regarding androgens and sexual desire so that—while refraining from offering medical advice—they can discuss the topic in an informed manner. To illustrate, it is useful to know that, among women, the correlation between androgen levels and sexual desire is unclear (Basson, 2010; Leiblum, 2010a) and that, although there are credible cases of androgen deficiency driving low passion in women (Korda, Goldstein, & Goldstein, 2010), most experts maintain that cognitive, relational, motivational, and lifestyle factors play a much more important role (Leiblum, 2010a). Thus, hormonal treatment generally is not an effective first-line treatment for women (Bradford & Schwartz, 2014). Likewise, increasing testosterone has a variable effect on men's sexual desire (Brotto, 2010a). Nevertheless, it is important to rule out hormonal and medical causes of diminished passion.

Other sexual concerns Sometimes low desire is due to, or co-occurs with, another sexual concern. In men, it is most likely to be erectile dysfunction, ejaculatory inhibition, or generalized

performance anxiety (Phillips, 2013). Also, according to McCarthy and Breetz (2010), many men with low sexual desire are harboring a secret, often pertaining to variant sexuality, such as a fetish which, when revealed, needs to be treated independently. Low sexual desire in women also can be due to another sexual problem, and this is most often low subjective arousal (Brotto, 2010b; McCarthy & Breetz, 2010) or sexual pain, including that caused by normative biological processes such as vaginal dryness associated with both breastfeeding and menopause.

> *Janet was a 55-year-old menopausal woman who sought service for what she labelled as a "dislike of sex," which was causing marital problems. Upon questioning, she revealed that she enjoyed oral sex but that intercourse was painful. The therapist provided information on normative thinning of the vaginal walls during menopause and suggested the use of a high-quality water- or glycerin-based lubricant. Janet was also referred to her physician for evaluation for vaginally-inserted estrogen cream. After using both this prescription and lubricants, intercourse became pain-free and her desire for sex returned. No further treatment was needed.*

It is thus critical to ask questions regarding other aspects of sexual functioning (e.g., sexual pain, lubrication, erection, orgasm) to ascertain whether the lack of passion is traceable to such other concerns. Likewise, if progress is eluding a couple, it is useful to consider whether there is a sexual secret that an individual session may assist in uncovering. Some clinical writings describe closeted gay men in heterosexual relationships presenting with low sexual desire for their heterosexual partner (Bancroft, 1987). Sandfort and de Keizer (2001) also noted internalized homophobia as a cause of low sexual desire among gay men.

Individual, relational, and contextual factors and stressors

The most common causes of non-DSM-defined issues with diminished passion are individual, relational, and contextual stressors (Mintz, 2009; Treadway, 2010). Stressed individuals are often distracted and unable to relax and focus on sex. Stress also contributes to insomnia, and lack of sleep diminishes sex drive. Physiologically, stress results in the secretion of the hormone cortisol. As cortisol increases, testosterone, which is partly responsible for both women's and men's sex drive, decreases (Daly, Seegers, Rubin, Dobridge, & Hackney, 2005). Perhaps because women have about 10% of the testosterone that men do, women's sex drive fluctuates more in response to external stressors than does men's (Baumeister, 2000; Menahem, n.d.; Risen, 2010; Weiner-Davis, 2003). Diverse stressors that can impact sexual desire are detailed below.

Poor body-image In a survey of women between 35 and 55 years of age, most said that they considered themselves less attractive now than ten years ago, and 21% disliked their bodies so much that they could not even name one feature that they considered attractive (Koch, Mansfield, Thurau, & Carey, 2005). Both women and men avoid sex because of body shame. Importantly, body shame does not have a linear relationship with weight. We have had clients who would be classified as overweight or obese who had passionate sex lives, and normal and underweight weight clients who avoided sex, held their bodies tightly during sex, and required lights off and covers on. One partner's poor body image and resultant sexual self-consciousness can fuel a lack of couple passion, even if the other partner feels attracted to the person who is unhappy with her or his appearance.

Lack of attraction Sometimes one or both individuals lose attraction for their partner. Often, lost attraction is related to a physical change in one spouse, such as weight gain. This issue is difficult for couples to broach, with the unattracted partner often feeling guilty and labeling

their concern as superficial and the object of the lost desire often feeling defensive and hopeless. Some couples who enter therapy for lack of passion have already discussed this issue, and reached an impasse. For others, this is an issue that is first broached in individual sessions.

Affairs Another issue that is sometimes discussed prior to entering therapy and sometimes revealed during individual sessions is past or current affairs. Affairs are a major relationship stressor, following which a rebuilding of both trust and couple sexuality needs to occur.

Infertility Women undergoing fertility treatment often feel their bodies have failed them. For heterosexual women, intercourse can remind them of this and can come to be thought of as a means to accomplish an elusive but important goal, instead of something done for pleasure and connection. These issues can last for years after infertility treatments, even successful ones.

Miscalibrated intimacy and distance Often couples who struggle with lack of passion report a general disconnection in their partnership (Johnson & Zuccarini, 2011; see also Johnson, this volume), although interestingly, men's sexual desire has been found to be less affected by relationship discord than is women's (Brotto, 2010a). Sometimes lack of connection can be due to "… distressing emotions and cascading attachment distress" (Johnson & Zuccarini, 2011, p. 219), and at times, it is simply due to lifestyle issues (e.g., two individuals with busy lives who give each other the dregs of their days). Conversely, although disconnection can drive lack of passion, several experts point to just the opposite. Being too connected and undifferentiated from one another (Nichols, 2004; Perel, 2006, 2010; Schnarch, 2009, 2010)—or in other words, the "overfamiliarity or inevitable enmeshment" (Meana, 2010, p. 105) of long-term relationships—can also drive lack of passion. This notion was summed up by a client quoted in Mintz's (2009) book who said, "My problem is that we are so close, he is like family. I tell him everything and I have bared my soul to him. He is like a brother and it's backfired because you aren't supposed to have sex with your brother" (p. 36). Reconciling these seemingly opposite causes (i.e., too much and too little connection), we contend that a miscalibration between intimacy and distance can cause diminished passion (Meana, 2010).

Stage of relationship There is a body of science about the changing stages of love. What science tells us is that physical desire generally lessens more for women than for men as a relationship matures (Basson, 2010), but that for both sexes, the early, intoxicating, high passion stage is shortlived (Lehmiller, 2014; Menahem, n.d.). However, as stated by Katehakis, Bliss, Reich, and Bader (2014), people often do not realize that the biochemical high of early attraction is time-limited and that it is normal for relationships to become increasingly mundane and practical over time. Not knowing of the normative nature of this change, Katehakis and colleagues pointed out that many individuals look for blame in their relationships or their partners.

Boring or "bad" sex Although couples in long-term relationships often develop a sexual routine that reliably results in arousal or orgasm, this routine can become monotonous. Additionally, poor sexual techniques by a partner, coupled with lack of sexual communication, can result in diminished desire and passion.

> *Eileen was a woman who in her younger days became aroused and reached orgasm quickly. However, with age and stress, she found she was taking longer and longer to become aroused. Rather than tell her partner about this need for more prolonged stimulation, she simply began to avoid the sex she was no longer enjoying.*

Stating the obvious, good sex leads to more sex, and unsatisfactory sex can lead to an avoidance of sex.

Life-stage and lifestyle stress Being too tired is the top reason that women blame for their loss of desire (Ellison, 2006). In a survey of 2,600 women, one of the top three life concerns listed was being too busy for sex (Ellison, 2001). Although all life stages can be fatiguing, the early parenting years are particularly so, with many new mothers saying that they feel too exhausted for sex. Although this is common and expected, it is a slippery slope, and the early parenting years are often the start of a low-passion relationship (Mintz, 2009). Another aspect of parenting that can diminish passion is the heavy care-taking load that is involved; some new mothers, in particular, report that at the end of a long day of taking care of babies and young children, they perceive their partner's sexual advances as one more care-taking demand. Conversely, their partners often say that they feel hurt or slighted by being lowered in priority for time and affection. Related life-stage and lifestyle issues that can fuel low passion include too much work and too little self-care, as well as being constantly on one's cellphone and laptop. Finally, in dealing with the demands of daily living, many couples report feeling like good roommates and life-business partners rather than sexual and intimate partners; to reference the subtitle of Perel's (2006) book, couples find it difficult to reconcile the erotic and domestic.

Accumulated resentments Resentments and anger built up over time in a relationship can fuel diminished passion (Perel, 2010). Of course, lack of passion and mismatched sexual desire can itself be the source of the resentment. Commonly, we find resentments pertain to division of labor in the household, with one person feeling that they are carrying more than their share of the burden. In particular, we find these complaints commonly occur in heterosexual couples with children. According to a March 13, 2010 *Newsweek* article by Kathleen Deveny, most two-income heterosexual couples without children divide the household chores evenly, but post-children, men actually do fewer household chores, and a substantial percentage of new fathers actually start spending more time at work—perhaps because of breadwinner expectations or because they feel slighted by their partner's attention on the new baby. Regardless, resentments over chores diminish passion.

Age-related changes Both men and women experience normative age-related changes in sexual functioning. As men age, they need more stimulation to get and maintain an erection, and their desire decreases (Brotto, 2010a). As women reach menopause, they often experience vaginal dryness and a decreased libido (Bancroft, 2002); both changes are at least partly related to changes in testosterone and estrogen levels (Davis, 2000). Additionally, natural and surgical menopause symptoms of hot flushes, mood swings, and insomnia can reduce libido. Nevertheless, some women report that sex drive increases and sex gets better as they age, perhaps because they better know their own bodies and are less afraid to say what they want sexually (Phillips, 2013).

Other psychosocial stressors The stressors that can diminish passion are limitless. Lack of passion and low desire can no doubt stem from the "complexity and challenge of contemporary life" (Treadway, 2010, p. 167). Financial stressors, child-rearing stressors (e.g., balancing one's own work schedule with the school and extracurricular activities of children; risky teen behaviors), and caring for aging parents are just a few of the many stressors of daily life that can curtail passion. Additionally, some authors have discussed lifestyle habits associated with diminished desire. Brotto and Woo (2010) pointed to poor nutrition. Mintz (2009) noted that alcohol and caffeine over-use can be associated with vaginal dryness in women and erectile dysfunction in men, issues previously noted to co-occur with diminished passion.

Interventions in the PLISSIT for Passion Model

Our PLISSIT for Passion model entails assessing for causes of diminished passion and utilizing a metaphorical sexual band aid (e.g., Limited Information and Specific Suggestions) prior to conducting metaphorical sexual surgery (e.g., Intensive Therapy). This approach involves relying on the assessment/intervention/feedback loop to guide the sequence of interventions, bearing in mind that interventions from different domains can be delivered simultaneously. Interventions are detailed below, with particular focus on Limited Information and Specific Suggestions, as they are the mainstay of the model, with the need for and nature of Intensive Therapy varying by case.

Permission

We concur with Taylor and Davis (2007) that Permission-giving should be present in all stages of treatment. These authors conceptualized Permission-giving as constantly checking in and discussing reactions to interventions, thereby providing ongoing permission to raise new issues.

Limited Information

Low-passion clients benefit from receiving information about the commonality of what they are dealing with, the sexual response cycle, and myths surrounding sexual desire and passion. Much of the information that is useful to share with clients has already been detailed. Although these examples are non-exhaustive, it is critical to explain to clients that it is perfectly natural for sex drive to decrease with chronological and relationship age. We also educate clients to not always expect fireworks and that "ho hum sexuality" (Treadway, 2010, p. 179) is acceptable during specific life stages and when dealing with stressors. Indeed, clients often find information on the effects of stress on libido to be useful. Clients also benefit from information debunking the myth that children should not change a sexual relationship. We encourage clients to think of early parenting years as the "Do No Harm" stage of a relationship, telling them that although it is natural for the focus on the couple's relationship and sex to decrease during these years, enough attention must be paid to the relationship so that no lasting harm is done during these years (Mintz, 2009). Additionally, like Tiefer and Hall (2010), we explain to clients that sexual preferences and expectations are culturally determined, and that we will be encouraging them to define a sexual style that works for them. Also like these authors, we try to de-escalate existing tension by explaining that sexual differences can be thought of and negotiated like any other disagreements (e.g., where to spend the holidays). In short, much of the information we provide is aimed at clearing up misinformation about sexuality and correcting resultant unrealistic expectations.

Especially beneficial is informing clients that sex does not have to begin with physical desire (i.e., feeling horny). We tell clients that research demonstrates that a majority of women (and some men) in long-term relationships stop feeling spontaneously horny. We inform clients that some research shows that this happens for a great percentage of individuals as early as one or two years into a long-term relationship, often coinciding with the fatigue and multiple demands associated with having children. We further explain that most individuals don't know that this loss of desire is to be expected and thus end up feeling that something is wrong with them when it is not. Clients learn that sexual activity can begin with behavioral, cognitive, or emotional receptivity to sex rather than physical desire for sex. Along with providing this information, we debunk the myth of spontaneous sex, instead promoting the perspective that all good sex (even in youth and the early stages of a relationship) is intentional, anticipated, and orchestrated (Mintz, 2009).

Specific Suggestions

The provision of information detailed above sets the stage for Specific Suggestions, and in actuality, Limited Information and Specific Suggestions are frequently presented together. Key examples include debunking the myth of spontaneous sex while suggesting scheduled sex dates, or explaining the role of good communication in both marital and sexual satisfaction while teaching communication skills. Another example is suggesting clients cuddle and think sexy thoughts, while simultaneously informing them that these activities have been shown to increase testosterone, the hormone responsible for sexual desire (Goldey & van Anders, 2011; van Anders, Hamilton, Schmidt, & Watson, 2007). These and other key Specific Suggestions are detailed below.

Thought stopping and substitution Because the low desire partner often thinks of sex as a "chore" and something to do for one's partner, it is useful to help this individual recall the many positive benefits of sex (e.g., it feels good; it helps me relax; it makes me feel closer to my partner). Teaching clients to use thought-stopping techniques for negative thoughts about sex (e.g., "It's the last thing I want to do") and to replace these negative thoughts with a personalized sex mantra that reconceptualizes sex as for oneself can be quite useful. Examples of personalized sex mantras developed by our clients include "I like sex!" and "Sex is fun for ME!"

Sexual focus and fantasy Because individuals suffering from low passion often report ceasing to think and fantasize about sex, increasing sexual thoughts and fantasies can be beneficial. Some clients profit from simply drawing their attention to sensual and sexual interactions (e.g., noticing people flirting with one another), while bringing an open curiosity to what elicits sexual stirrings (Hall, 2010). Other clients benefit from purposeful sexual fantasizing (Menahem, n.d.). We sometimes suggest that clients set their cell phone alarms (at a pre-determined frequency, ranging from once per day to once per hour), and when the alarm goes off, we suggest that they stop what they are doing and take a "five-minute sex break" in their mind, thinking about a past sexual encounter, a future sexual encounter, or something arousing that they would never actually do. When suggesting fantasy, both Permission-giving and providing Limited Information about the difference between fantasy and reality is important.

Mindfulness Individuals suffering from stressor-induced lack of passion, as well as those struggling with performance anxiety, report distractibility during sex (e.g., having invasive thoughts about items on one's to-do list or whether their partner is enjoying him/herself). Thus, mindfulness practices are often suggested (Brotto & Woo, 2010; Mintz, 2009; Weiner & Avery-Clark, 2014). Although a review of mindfulness is beyond the scope of this chapter (see Barker, this volume, for a more thorough discussion), suffice it to say that mindfulness entails focusing totally on what is happening in the moment, while noticing and releasing distracting thoughts rather than judging them. Mindful sex entails "focusing completely on … in-the-moment physical sensations" (Mintz, 2009, p. 84). However, it is important to let clients know that this is more difficult than it sounds and that it takes practice. Mintz (2009) suggested that clients develop a daily mindfulness practice (e.g., five minute daily mindfulness meditation) and that they practice a mindful focus in daily major tasks (e.g., talking to one's children) and minor tasks (e.g., washing dishes) as a first step, and then transfer these skills to sexual encounters. Daily mindful practices can also decrease the stress driving low desire. Indeed, learning mindfulness has been found to be effective in increasing desire among women with low desire (Brotto *et al.*, 2008), and there is no reason to believe that this strategy is not equally pertinent to men.

Self-care Because low-desire individuals are often busy, stressed, and tired, suggesting they add self-care time to their already-taxed schedules is often met with resistance. When suggesting self-care, it is thus useful to provide information that self-care enhances sexual functioning and individual and relationship wellbeing. For women, in particular, assistance differentiating selfishness and self-care can be beneficial. In suggesting self-care, practitioners will need to individualize suggestions to each client's circumstances. However, based on research findings that yoga enhances desire (Dhikav *et al.*, 2010) and that cardiovascular exercise decreases anxiety (Long & van Stavel, 1995), diminishes depression (Daley, 2008), increases sexual satisfaction (Gerber, Johnson, Bunn, & O'Brien, 2005), and increases sexual arousal (Hamilton, Fogle, & Meston, 2008), these are particularly excellent suggestions. In helping clients to carve out time for self-care, it is useful to assist them in examining time spent on obligatory energy-draining activities that potentially can be reduced. Of note, for couples suffering from too much closeness, developing individual self-care activities has the additional benefit of increasing differentiation. Likewise, if body image issues or lost attraction is an issue, an exercise program can help.

Couple nonsexual time Low-passion couples are often busy, stressed-out individuals who give each other only the low-energy parts of their days. Thus, helping couples to find nonsexual, connected, enjoyable time together can be useful. Although a typical homework assignment is a "date night," this solution doesn't work for many clients due to finances, difficulty finding babysitters, or fears of what they will talk about. Thus, therapists are encouraged to suggest other nonsexual couple activities. Examples from our clients include drives in the country while singing old rock and roll favorites together with the windows down, taking a ballroom dance class together, and having a weekly movie night at home together. Although sex-stereotypic, it is often necessary to help women realize that connected time does not always need to entail deep conversations, and to assist men to understand that connected time can entail such discourse. Strategies include helping clients both *be* together and *do* together.

Schedule and chore division Like Meana (2010), we find that assisting couples with structural problems is often beneficial in positively affecting their sexual connection. As examples, suggesting ways for couples to coordinate their schedules (e.g., email, shared electronic calendars, weekly meetings) or to divide up the sometimes overwhelming tasks of daily living (e.g., who will pick up children; who will get groceries and dry-cleaning) is useful.

Affectionate, sexual, and non-demand couple touching Low-passion couples have often ceased touching and end up in bed, exhausted and disconnected, sometimes with one initiating sex and the other turning down the invitation. Another related, common complaint is that the higher desire partner "gropes" the low-desire partner or, conversely, that the low-desire partner is rejecting of touch that was once considered fun and playful. It is therefore useful to help couples reintegrate affectionate, playful, and sexual touch into their daily lives. In our PLISSIT for Passion model, clients are instructed to initiate affectionate touch at least five times a day and erotic touch at least three times a day, at times specifically when "going all the way" is not an option.

In providing this latter suggestion, clients are reminded that, in the earlier days of their relationship, not all erotic touching led to "going all the way." They are asked to recall the excitement of events such as making out in their parents' driveways fully clothed. Importantly, although therapists can suggest purposeful affectionate and erotic touch in couples counseling, we also find that, when an individual client begins to touch his or her partner in affectionate, sexual, and playful ways, the partner often reciprocates without instructions.

A more specific exercise that falls into the domain of non-goal-oriented touching is sensate focus, often considered a mainstay of sex therapy. Weiner and Avery-Clark (2014) provide an

outstanding summary of the history, common misconceptions, and best practices associated with sensate focus (see also Avery-Clark & Weiner, this volume). Particularly important for low-passion couples is these authors' emphasis on mindfulness and focus on one's own pleasure as key in exercise implementation. Also, sensate focus exercises help to underscore the important notion that not all encounters need to end in orgasm, and not all need to be mutually satisfactory for both partners.

Masturbation Often, the low-desire partner has ceased to masturbate. Suggesting a masturbation practice is helpful on a number of levels. First, especially for women, masturbation can increase desire. Second, individuals can experiment with different types of touch during masturbation (e.g., different lubricants or vibrators for women; different types of strokes or pressure for men), which they can then translate into partnered sexual activities.

Sexual experimentation If low passion is due to boredom, sexual experimentation is a key intervention. Suggestions for novelty include, but are not limited to, the use of sex toys, role-plays, experimentation with different lotions and lubricants, blindfolds, and different positions and techniques, to name just a few. Additionally, couples can try reading erotic fiction or watching sexually explicit entertainment or educational videos or movies with sexual scenes; some couples like to do this together as part of their foreplay, and some individuals prefer to do this alone to enhance desire before a scheduled "tryst" (a suggestion explained below). Readers are encouraged to see Mintz (2009) for a more comprehensive listing of novel suggestions. It is also critical that therapists are knowledgeable about reputable sites for sexual media and toys; three excellent sites include sexsmartfilms.com, bettersex.com, and www.sexualityresources.com. Practitioners need to be able to present and discuss options to clients and effectively address concerns clients may have, and in fact, both Permission-giving and Limited Information are important to pair with Specific Suggestions to add sexual novelty. As an example, to address concerns that male partners may have about vibrators rendering them useless, it is useful to have knowledge of research on the commonality of vibrator use among couples and research showing that women who use vibrators report greater sexual desire, arousal, and satisfaction with partners (Herbenick *et al.*, 2009). Finally, practitioners need to help clients to differentiate between stretching their boundaries and doing something aversive; the former is encouraged, the latter prohibited.

Communication skills training In guiding clients to experiment sexually, as well as in implementing and processing the other Specific Suggestions contained here, helping clients to enhance their general and sexual communication is paramount. In fact, as noted earlier and akin to Permission-giving, attention to communication cuts across all specific strategies (Menahem, n.d.). We find the work of John Gottman (e.g., Gottman & Silver, 1999) and Harville Hendrix (2008) particularly useful in teaching communication and conflict resolution skills to clients. Mintz (2009) also included a full chapter on general and sexual communication skills in her empirically-supported (Balzer & Mintz, 2015; Mintz *et al.*, 2012) self-help book for women with low desire. Two suggestions included in this chapter, which are also emphasized by Phillips (2013), are encouraging couples to purposefully make daily complimentary and appreciative statements, as well as to laugh together both in and out of the bedroom. Finally, Phillips (2013), Mintz (2009), Menahem (n.d.), and Perel (2010) all suggested using letters, email, or text messages to exchange sexually-charged messages or information on sexual preferences; Perel (2010) went so far as to suggest setting up separate email accounts just for this.

When teaching communication skills, it is important to address unresolved conflicts. We tell clients that we all walk around with an invisible backpack on our backs for each significant relationship we are in. When things bother or upset us, we often don't tell each other. We may

think it isn't worth it or we won't be able to solve the problem anyway. Each upset that we don't discuss is akin to a pebble. We walk along picking up pebble after pebble and putting them in our backpacks. Eventually the pebbles add up, and the backpack is so heavy that it hurts to carry it. We dump it out, in an attempt to lighten our load. We start throwing the stones at each other. After sharing this metaphor, we help couples decide whether they need to process any prior resentment or if they simply prefer to go forward, using their newfound communication skills to avoid building up new resentments (Treadway, 2010).

Trysts A key suggestion for low-passion couples is what some experts call scheduled sexual encounters or what we call "trysts." In fact, with some clients, this is the only suggestion needed, whereas with other clients, trysts will only be successfully implemented after following many of the preceding Specific Suggestions. For example, for couples who enter therapy early in the low-passion cycle, with their only concern being a lack of spontaneous physical desire in one of the partners, but who nevertheless engage in mutually satisfying sex, the Specific Suggestion of trysts may be all that is needed. Indeed, if during assessment, an individual tells you that she/he rarely if ever feels horny but that she/he enjoys sex once it is underway, the first step of treatment entails providing information on the normality of this and giving permission to keep doing what she/he is already doing. We tell such clients that, rather than berating themselves for having sex when they are not horny, they ought to congratulate themselves on engaging in a sound sex therapy technique without even knowing it. We encourage clients to continue to have sex without feeling horny and to allow the sex to lead to desire and passion. We inform them that "if it's fun, it's not 'duty sex'"—as they often have been mistakenly labelling it. We also explain how having scheduled trysts does wonders to end the tension in a relationship over when sex is going to occur. We encourage couples to "focus on a desire for one's partner and desire during [trysts] … rather than a desire for sex" (Schnarch, 2010, p. 46).

Of course, treatment is rarely this straightforward. When prescribing trysts and educating clients about what Weiner-Davis (2003) called the "Just Do It" approach to sex, much guidance and reassurance is often needed, relying on previously outlined information and suggestions. For example, it may be necessary to help clients communicate about their ideal frequency for sex (i.e., how often to "just do it") and about what "doing it" means to them (i.e., helping them to not view sex as completely goal-oriented or intercourse-oriented). It may also be helpful to make suggestions about how to get one's mind, relationship, and body ready for such trysts (e.g., fantasizing prior to the tryst; practicing mindfulness during the tryst; spicing up trysts with novelty and experimentation). Also, it is useful to help clients figure out when it is best to have such trysts, encouraging clients not to schedule trysts at times (e.g., nighttime) when exhaustion is at its peak (Basson, 2010), and also explaining that there is evidence that, at night, testosterone is at its lowest (Crawford, Barqawi, O'Donnell, & Morgentaler, 2007). Some couples prefer a pre-determined time (e.g., when their children are out of the house at a weekly activity), some prefer to commit to engaging in sex at the first opportunity during a period of time (e.g., the first opportunity over the course of a weekend), and still others like to plan more extensive trysts (e.g., a weekend getaway; hiring a babysitter and going to a hotel rather than out to eat). Additionally, some couples need help in differentiating circumstances under which a planned tryst is legitimately abandoned (e.g., illness of one partner) as opposed to circumstances under which abandonment should not occur (e.g., one partner is simply not in the mood). Finally, there are some couples in which one partner refuses to let go of the myth of spontaneous sex while the other partner wholeheartedly embraces the notion that anticipating and planning a tryst will enhance passion. If this impasse cannot be resolved, sometimes individual sessions are needed during which the partner convinced that he or she would benefit from trysts decides that he or she will plan these and seduce his or her partner, while allowing the partner to continue to hold the illusion of spontaneous sex.

Intensive Therapy

The aforementioned Limited Information and Specific Suggestions, provided by an open, non-judgmental, and Permission-giving therapist, are often sufficient to enhance passion and, as noted earlier, comprise the mainstay of the PLISSIT for Passion model. However, when it is evident that the low passion is resulting from, has resulted in, or is being maintained by some more serious contextual factors (e.g., a sexual trauma in one of the partner's history, a sexual secret of one of the partners) or challenging stressors (e.g., an affair, lack of attraction, deep-seated anger in the relationship), Intensive Therapy is needed. As noted earlier, we find that it is most beneficial if such Intensive Therapy can co-occur with the specific sexual exercises and suggestions (McCarthy & Metz, 2008). In providing Intensive Therapy, techniques from emotion-focused sex therapy (Johnson & Zuccarini, 2011), from the authors in Leiblum's (2010b) volume, or from those in this volume can be effectively utilized. Although in some cases this Intensive Therapy can be provided by the couples therapist, either in couples or individual sessions, at other times a referral to another therapist or an intensive couples treatment program such as that provided by Schnarch (2010) is appropriate.

Relapse prevention

Relapse prevention comprises the final step in the PLISSIT for Passion model. One aspect is to help couples decide how long is too long to go without a tryst and to tell them that, if a break of this predetermined length occurs, it is a signal to reintegrate some of the previously helpful suggestions back into their routine and/or to seek help again. Central to relapse prevention is educating clients that enhancing passion is not a one-time event, but rather an ongoing process of integrating sexuality into ever-evolving lives and relationships.

Closing

In closing, we refer back to the song quoted at the beginning of this chapter. It is hoped that if that song was a couple's presenting concern (i.e., "We miss the way it felt back when we couldn't control ourselves"), readers would not proceed to help the couple do as requested (i.e., help them "feel that way again"). Instead, we hope readers would educate clients about the false myths entailed in the quest to feel the way one did in one's youth, before aging bodies, maturing relationships, and the ongoing stressors of adult life. We hope practitioners would use the strategies provided here to help clients create a sexual style that works for their current life-stage and life-stressors and to provide the tools to continually reinvent this style through the inevitable ups and downs of life and long-term relationships.

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Section II

Theoretical Approaches to Sex Therapy

11

A Traditional Masters and Johnson Behavioral Approach to Sex Therapy

Constance Avery-Clark and Linda Weiner

Introduction

William Masters and Virginia Johnson's (1966, 1970) contributions to the field of sexology and the birth of short-term sex therapy are based on the first laboratory research into the physiology of human sexual response (Althof, 2010; Atwood & Klucinec, 2007). Although they were not opposed to the use of additional data sources, they emphasized that *sex is a natural physiological function*. Their contention was that the physiology of sexuality must be understood and appreciated before attention can be paid to additional layers of social, psychological, relational, cultural, and other influences on human sexuality.

After laboratory procedures identified the physiological patterns of sexual arousal, and after interviews with laboratory subjects revealed the critical factors associated with sexual response (such as arousal and orgasm), Masters and Johnson applied this knowledge to the treatment of sexual dysfunction. Their approach, detailed in *Human Sexual Inadequacy*, was based "on a combination of 15 years of laboratory experimentation and 11 years of clinical trial and error" (Masters & Johnson, 1970, p. 1). It was qualitatively different from what, at the time, had been the customary psychoanalytical process of treating sexual concerns through long-term psychotherapy in which clients were assumed to have deeply rooted psychic conflicts that interfered with healthy sexual expression. Masters and Johnson concluded that effective treatment of non-medical sexual dysfunctions might be accomplished using a short-term, intensive psycho-educational approach coupled with behavioral assignments. This was publicized as an "astonishing triumph … emerging from the Masters and Johnson clinic—a new psychosexual treatment to rival Freud, with far better results.… *Time* placed Masters and Johnson into a gallery of other sexual pioneers, including Sigmund Freud, Alfred Kinsey, and Havelock Ellis" (Maier, 2009, pp. 184, 212). This triumph was so influential that the Masters and Johnson short-term, intensive approach became synonymous with the term "sex therapy" for the majority of sex therapists who followed in the subsequent decades.

Purpose

Despite their innovations, difficulties arose almost immediately after the publication of *Human Sexual Inadequacy* (1970). This was particularly the case with regard to the understanding of the initial aspects of Masters and Johnson's concepts and procedures:

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> *Human Sexual Inadequacy* lacks a formal presentation of the model and offers no comparisons with other approaches. Much of the presentation is limited to the assignments, but even the rationale for the assignments is given only the most limited coverage and the way the results are actually used in the therapy is entirely left to the reader's imagination.
>
> (Apfelbaum, 1984, p. 6)

Interpretative and practical application difficulties were due to a number of factors, most notably the lack of publications clarifying the details of Masters and Johnson's treatment approach and the evolution of their treatment model over their more than 25 years of experience. This is perhaps not surprising because "The actual clinical and conceptual processes of [Masters and Johnson] have been available only to the small group of clinicians who interact directly with them on an ongoing basis" (Schnarch, 1991, p. 145). The purpose of this chapter is to provide accurate and detailed information about Masters and Johnson's sex therapy concepts and procedures.

Masters and Johnson's Conceptualization of Sexual Problems

The theory underlying Masters and Johnson's perspective has been described previously (Weiner & Avery-Clark, 2014) and rests on the deceptively simple but elegant idea that "Sexual functioning is a natural physiological process … [like] respiratory, bladder, or bowel function" (Masters & Johnson, 1970, p. 9). All natural functions have three characteristics in common. They are processes: (1) *with which one is born*; (2) that *cannot be taught*; and (3) that *are not under immediate voluntary control.* However, all natural functions can be influenced to some degree by any negative emotional state (such as anxiety), and by distractions (such as observing and negatively evaluating oneself). Although in Western culture we expect that apprehensions and ruminations might keep us from falling asleep (which is also a natural physiological function), we have difficulty accepting that these similar preoccupations can affect the natural function of sex. One of the most common distractions affecting sexual functioning is *fear of performance* (Masters & Johnson, 1970, p. 10). This expresses itself as trying to make sexual desire, arousal, and/or orgasm happen. The harder one tries to achieve a sexual response, the more difficult it becomes. This is an example of the more general, paradoxical principle characterizing all natural functions: The more one tries to make them happen directly and at a particular moment in time, the less likely they are to happen. A nonsexual version of this would be trying to urinate on command when a doctor asks for a sample. In the case of sexual responsiveness, Masters and Johnson wrote:

> *… fear of [sexual] inadequacy is the greatest known deterrent to effective sexual functioning, simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner.*
>
> (Masters & Johnson, 1970, pp. 10–12, italics in original)

If fear-based distraction interfering with sexual function is a primary contributor to nonmedically based sexual concerns, it would seem logical that treatment for these concerns would emphasize teaching skills for identifying and managing these fears and distractions. Masters and Johnson developed their therapeutic approach based on this logic.

Masters and Johnson's Treatment Premises

Short-term intensive therapy

Although the importance of understanding the full individual and relational history of the couple was underscored in their work, the focus of Masters and Johnson's signature short-term therapeutic approach was not on the remediation of historical contributors to the sexual difficulties, unless addressing those was absolutely necessary to achieve results. Instead, the focus was on the alleviation of immediate causes (anxiety, cognitive distractions) that disrupt natural sexual expression, and any relational concerns that impact sexual interest or functioning. Masters and Johnson's goal was to do as much but no more than was required to resolve the difficulty. Masters and Johnson also believed that an intensive format—seeing couples daily or several times a day for a 14-day period—and meeting at a location away from the home environment could foster rapid progress for two reasons. First, social isolation for the couple facilitates focusing on their relationship and minimizing other obligations and distractions. Second, there is opportunity for a high frequency of sensory-oriented interactions. One of the ways to overcome fears of performance is to develop such a build-up of physiological tension that it is difficult for sexual desire or arousal to be waylaid by disruptive anxieties. According to Masters and Johnson (1970), "with the subject [and experience] of sex exposed to daily consideration, sexual stimulation usually elevates rapidly and accrues to the total relationship" (p. 17).

The Masters and Johnson 14-day intensive model includes laboratory testing, medical exams, and history-taking. Following this there is a feedback session (*the roundtable session*) and then the regular processing of therapeutic suggestions. Two-year follow-up telephone contact is offered to assist with re-entry into everyday lives as well as to facilitate the integration of the couple's new knowledge and skills into their routines.

Sensate Focus

If sexual functioning is negatively impacted by anxiety-provoking distractions, then a logical strategy is providing clients with an alternative neutral focus, similar to counting sheep when one cannot sleep. In order to provide an alternative to distracting thoughts (e.g., "Am I going to get aroused?" "Will my partner be upset?"), Masters and Johnson developed *Sensate Focus*, a series of structured touching opportunities that focus attention on tactile sensations of skin temperature, texture of hair and skin, and varying pressures of firmness and lightness. Johnson reportedly developed Sensate Focus in response to her memory of "facial tracing" by her mother during her childhood (Maier, 2009, p.182). Sensate Focus is the core feature of Masters and Johnson's sex therapy, and it serves two primary functions: allowing clients to focus on something over which they have voluntary control (attending to tactile sensations) instead of focusing on that over which they have no voluntary control (generating arousal); and providing an opportunity for generative intimate connection. Sensate Focus provides an attentional alternative that neutralizes unhelpful attempts to make natural sexual responses occur (or prevent them from occurring). By refocusing away from problematic distractions, Sensate Focus paradoxically allows the natural sexual responses to manifest on their own. The exercises also serve to systematically desensitize the client to anxieties interfering with sexual response. This neutralizing apprehensions by attending to sensory experiences in the moment is referred to today as *mindfulness,* a practice that has been formally used by some sex therapists (Brotto & Heiman, 2007; Weiner & Stiritz, 2014; see also Barker, this volume).

Sensate Focus exercises are both therapeutic and diagnostic. In addition to addressing anxiety and distraction, they also assist in identifying contributing factors to sexual problems. These include avoidance, *spectatoring* (watching arousal), and problematic couple dynamics.

Conjoint therapy

One of the most significant premises of Masters and Johnson's treatment approach is that, regardless of which client presents as the *identified patient*, both partners are affected by the sexual difficulty and each is critical to resolving it. Failure to include both partners is to ignore "half the problem" (Masters & Johnson, 1970, p. 3). As they put it:

> There is no such thing as an uninvolved partner in any [relationship] in which there is some form of sexual inadequacy… Isolating [either of the partners] in therapy from his or her partner not only denies the concept that both partners are involved in the sexual inadequacy with which their … relationship is contending, but also ignores the fundamental fact that sexual response represents (either symbolically or in reality) interaction between people.
>
> (Masters & Johnson, 1970, p. 2)

In short, the *relationship is the client.*

Conjoint therapy team The original Masters and Johnson model also includes a dual-sex therapist team. At the beginning, Masters and Johnson emphasized a male/female conjoint approach with heterosexual couples because "controlled laboratory experimentation in human sexual physiology has supported unequivocally the initial investigative premise that no man will ever fully understand woman's sexual function or dysfunction… The exact converse applies to any woman" (Masters & Johnson, 1970, p. 4).

A second rationale for their use of dual-sex therapy teams is related to the significance of transference; the dual team serves to enhance transference in one regard and minimize it in another. First, because the primary relationship in sex therapy is between the partners and not so much between the clients and therapists (as is usually the case in individual therapy), Masters and Johnson believed that a dual sex therapy team may reduce unproductive and distracting transference by de-emphasizing the therapist–client interaction. Additionally, because sex therapy can present ethical and even legal concerns, the dual-sex therapy team creates a therapeutic environment that provides protection and evokes a transference in which the therapists are viewed only in the limited roles of medical and psychological authorities. At Masters & Johnson Institute, therapists wore white lab coats, sat behind a desk, and all sessions were audio-recorded. There was no couch in the office and client privacy was assured with a series of enclosed waiting alcoves.

Education Masters and Johnson conducted their research and developed their treatment in an era when misconceptions and misinformation about sexuality abounded. Thus, they stressed the importance of disseminating detailed, sex-related anatomical and physiological information pertinent to the clients' needs.

Procedures

Assessment

Sex therapy begins with a thorough assessment of medical, psychological, cultural, relational, and lifestyle factors that might impact sexual functioning. Emphasizing that physiological causes should be considered prior to beginning sex therapy, Masters and Johnson (1970) wrote, "there is never any excuse for treating a physiological dysfunction as a psychological inadequacy" (p. 53). First, the couple is seen conjointly to review past and present therapy and current therapy goals, and to assess the relationship dynamics and motivation of both partners. Then follows individual psychosocial evaluations, or *history-taking*, of one to three sessions each. Each partner meets first and individually with one therapist, and subsequently

with the other therapist. The focus is on individual psychological makeup, attachment, family of origin, relationship and sexual history, as well as the partners' personal perceptions of one another and the presenting problem(s). The history-taking:

> … is structured to develop material within a chronologic framework of life-cycle influences, which reflects sexually oriented attitudes and feelings, expectations and experiences, environmental changes and practices. History-taking certainly must provide information sufficient to define the character (etiological background, symptom onset, severity and duration, psychosocial affect) of the presenting sexual dysfunctions. Equally important, history-taking contributes knowledge of the basic personalities of the … partners and develops a professional concept of their interpersonal relationship adequate to determining (1) changes that may be considered desirable, (2) personal resources and the depth and health of the psychosocial potential from which they can be drawn, and (3) [relationship]-unit motivation and goals (what the … partners actually expect from therapy).
>
> (Masters & Johnson, 1970, p. 24)

The history-taking is designed to rule out other medical as well as psychological issues such as clinically significant depression, psychosis, and substance abuse. These conditions make short-term therapy difficult and might suggest the need for medication or alternative treatment.

However, the most important goal of history-taking is understanding the sexual difficulty in its psychosocial context. It suggests treating "the individual as a whole person… when taken out of context of the total being and his environment, a 'sex' history *per se* would be as relatively meaningless as a 'heart' history or a 'stomach' history" (Masters & Johnson, 1970, p. 23). Out of the psychosocial sexual history emerges each client's *sexual value system*, "derived from sensory experiences individually invested with erotic meaning" and "reinforced by years of psychosocial adaptation" (Masters & Johnson, 1970, pp. 24–25). An understanding of this sexual value system is critical to ensuring that the treatment suggestions are sensitive to each client's core sexual identity.

Techniques and interventions

Following the history-taking, couples are invited to a *roundtable session* during which the therapists share their assessment of the sexual and/or relational difficulties and outline the treatment plan to address these concerns. Several crucial attitudes are introduced in this meeting, the first of which is a neutral, Gestalt-like, *here-and-now* approach, that focuses as little as possible on the past ("This never worked before!") or future ("Will this work?"). Second is an attitude of *radical self-responsibility*, in which each individual applies the skills while refraining from focusing on how effectively his or her partner is applying the skills. This diffuses projections of blame and circumvents unproductive interactions. Although not emphasized in this chapter, communication skills are a third critical component. Other self-management and relationship skills are offered as needed including, among others: identifying, accepting, and managing feelings; negotiating differences; creative problem-solving; and using the partner as a resource. These are necessary to create, revive, and/or sustain a secure relationship conducive to change.

For the purposes of this chapter, however, the most important feature of the roundtable session is the introduction of Sensate Focus. As previously indicated, this is the centerpiece and primary modality through which sexual difficulties are more fully understood and addressed in a Masters and Johnson approach. This also appears to be one of the aspects of the Masters and Johnson's approach that has most influenced the entire field of sex therapy. In a questionnaire study involving 80 sex therapists, 42% said that they "often" use Sensate Focus, and an additional 43% said that they use the technique "sometimes." Of those that used Sensate Focus in some fashion, 77% found it effective (Weiner & Stiritz, 2014).

The magic formula

When first presented, clients may experience Sensate Focus as alternately daunting and/or immensely awkward. In order to gain agreement and cooperation with engaging in it, it is vital to provide the rationale for the activities. Unfortunately, this rationale "is given only the most limited coverage" in the original Masters and Johnson publication (Apfelbaum, 1984, p. 6). Describing the rationale includes discussing how Masters and Johnson, through their laboratory and interview research, captured what might be considered a *magic formula* with regard to satisfactory and even optimal sexual functioning. This includes each client's practicing three skills: (1) While touching his or her partner, each client practices *touching for him- or herself* rather than focusing on the partner; (2) while touching or being touched, the client practices focusing on his/her own *interest*, which is defined as tactile sensations, rather than on pleasure or arousal; and (3) *redirecting attention* back to the touch sensations when distracted.

The first aspect, *mindfully touching for oneself*, represents an entirely new perspective. Many books are sold describing how to *turn on your partner*. Masters and Johnson were responsible for cultivating the radical notion that people's sexual responsiveness is essentially *self-generated and self-focused* and that people are actually aroused by taking in sensory information either by touching (or looking at or listening to) the partner or by having the partner touch (or look or listen). This amounts to absorbing the sensations provided by each other's bodies. The question, "When you are being orgasmic, of whom are you thinking?" highlights this attentional orientation. Most individuals are thinking of their own physical sensations immediately before and during orgasm. This suggests the importance of people being absorbed in their own experience, centering within themselves, and ultimately following their own sensations to higher levels of arousal. In a Masters and Johnson approach, clients are educated about the difference between this radical *self-focus* and unproductive *selfishness*: Selfishness is being so absorbed in one's own experience that one is unresponsive to partner requests, whereas self-focus is being absorbed in one's own sensory experience until and unless the partner makes a request, in which case one responds as best one can. This is because an aroused partner provides a critically erotic feedback loop that keeps the person who is doing the touching continuing to do so for him- or herself.

The second component involves *touching for interest* rather than for arousal or pleasure (i.e., focusing on sensations without goals or evaluation). *Interest* is defined as focusing on tactile sensations of temperature (cool or warm), pressure (hard or soft), and texture (smooth or rough). Trying to make a natural, emotional experience happen, like arousal or pleasure, is not under voluntary control, but attending to sensory experience is. This component honors the foundational belief that sex is a natural function that, like all natural functions, is not under direct influence but is, paradoxically, more likely to happen if the pressure to voluntarily control it (make it happen) is neutralized. Once the desire to control the response is neutralized, anxieties about touching correctly, having a sexual response, eliciting a sexual response in one's partner, and ensuring an enjoyable and pleasurable experience are nullified because these demands are no longer the goals.

It is unfortunate that the importance of touching for self without regard for self or partner responsiveness and pleasure has often been misinterpreted. As stated by Apfelbaum (2012), "Masters and Johnson's (1970) sensate focus assignments have been widely misunderstood as practice in focusing on the sensations that please one's partner… It actually refers to exactly the opposite: avoiding any effort to please one's partner" (p. 6), and, we would add, even avoiding any effort to please one's self.

The third element of the magic formula is *management of distractions*, especially those associated with demands for sexual and/or emotional responses. Clients are encouraged, whenever distracted by anything other than tactile sensations (including thoughts such as, "I am having such a wonderful time"), to redirect their attention onto that over which they do

have voluntary control, namely, the physical sensations. One cannot focus on any other thought, feeling, or behavior and simultaneously attend to tactile sensations at any one moment in time.

If clients practice the magic components of mindfully touching for their own interest, managing fears, and dealing with distractions by refocusing on tactile sensations, they cannot fail. The self-focused perspective allows them to let go of responsibility for the impossibility of making sexual response happen for themselves or their partner. The emphasis is on directing attention to sensory absorption, something they can do voluntarily.

Therapeutic Suggestions

Preliminaries

In the intensive model, clients are asked to schedule one to two touching opportunities daily. In a less intensive outpatient format, this is often modified to include one to three sessions a week. They can stop the touching or modify it according to their needs, but they are encouraged to do *no more* than what is suggested. This is critical and utilizes the paradoxical nature of sex as a natural function to their advantage; just as responsiveness is less likely to occur if there is a demand for it, it is also more likely to occur if it is not an expectation. Clients are also encouraged to spend unpressured time together beforehand, but they are discouraged from cultivating a *romantic* atmosphere, as intentionally generating romantic feelings represents yet another untenable demand. Couples are asked to conduct the session in a quiet, private setting, with some lighting, a comfortable temperature, as few clothes as possible, and as few external distractions as possible.

Sensate Focus Phase 1

Initially, *Sensate Focus Phase 1* begins with an explicit verbal invitation by the partner assigned to touch first (Weiner & Avery-Clark, 2014, p. 11). The person with the purported presenting difficulty is usually encouraged to be the initiator in an attempt to avoid partner pressure. The person initiating the touching, the Toucher, touches the partner all over his/her body using hands and fingers only. The Toucher: avoids breasts and genitals; focuses on his/her own experience of variable temperatures, textures, and pressures offered by the partner's skin and hair; and brings attention back to sensations when distracted. Talking, kissing, and full body contact are discouraged to minimize performance pressures. The person being touched, the Touchee, has two responsibilities: attending to the sensations wherever he/she is being touched; and moving the Toucher's hand away from any area that is physically or very psychologically uncomfortable and/or ticklish. This latter responsibility is particularly important in cases of low desire and sexual aversion where the Touchee must perceive that he/she has considerable control during the session. If the hand is moved, this is framed not as failure on the part of the Toucher to touch correctly, but as the Touchee's being self-responsible and courageously vulnerable by providing the Toucher with critical information. The Toucher is, therefore, able to touch with abandon, trusting that the partner will let them know if anything is physically or very emotionally distressing and allowing the Toucher to self-focus. These strategies tend to lower anxiety for both partners.

The Toucher is encouraged to touch long enough to get over any initial discomfort, but not so long as to get tired or bored. The initial sessions usually last between five and 15 minutes each, but clients are encouraged not to watch the clock. The partners switch, and the Toucher becomes the Touchee. The focus is on self-experience; practicing mindfulness; bringing attention back to temperature, texture and pressure; and allowing the partner to take responsibility for managing his/her discomfort. When the second Toucher has finished, he/she says

"Stop" or "Finished" or "Done," and the partners complete the session by lying together. They are asked not to engage in any sexual contact at this stage. As the therapists continue to increase the complexity of the Sensate Focus suggestions, and if one participant continues to feel aroused even after lying with the partner for awhile, this participant is invited to indicated this to the partner, and the partner can choose one of three alternatives for providing release. The partner can: (1) inform the participant asking for release that he/she prefers the participant provide his/her own release in private; (2) lie next to and hold the participant asking for release while that participant provides his/her own release; or (3) provide manual release for the participant seeking release. In intensive therapy, clients usually do not have difficulty delaying intentional release for a period of time. In less intensive out-patient settings, clients are invited to do whatever they wish as long as it is separate from Sensate Focus.

Sensate Focus Phase 2

As previously mentioned, the initial Sensate Focus instructions emphasize psycho-educational and behavioral techniques as well as needed relational and individual suggestions. Subsequently, *Sensate Focus Phase 2* suggestions begin to incorporate more between-partner sharing of information about what each prefers physically (Weiner & Avery-Clark, 2014, p. 12). Phase 2 Sensate Focus, the details of which will be the subject of future publications, includes practicing the technique of *positive handriding* during which the Touchee places his/her hand on top of or beneath the Toucher's hand and moves the Toucher's hand *towards areas that the Touchee might find of interest* (i.e., vivid in terms of tactile sensations). The Touchee continues to move the Toucher's hand away from anything that is uncomfortable (as described above). Additionally, verbal communication about more subtle preferences and experimentation is encouraged in this second phase.

Sensate Focus Hierarchy Sensate Focus was designed as a hierarchy of touching exercises. For the purposes of this chapter, this hierarchical approach will be associated primarily with Sensate Focus Phase 1. Usually clients in Phase 1 do not engage in subsequent stages prior to earlier ones, and they usually complete the entire Phase 1 hierarchy before initiating Phase 2. This is to desensitize them to experiencing what is usually the inevitable increase of anxiety-provoking distractions as they move up the hierarchy. However, the hierarchy is subject to modification based on the goals, progress, values, and sexual practices of the couples.

Sensate Focus begins with *breasts and genitals off limits*, as described above. In the first few sessions, the Toucher and Touchee can be in any comfortable position and can modify that position at any time. Couples can begin side to side without full body contact; the Toucher can change to kneeling next to the Touchee, or standing beside the bed. The Touchee can begin on his/her side/stomach or back and rotate as he/she feels inclined. When clients are able to touch for self-interest, focusing on sensations, and bringing themselves back from distractions, they begin Sensate Focus with breasts and genitals included. If they are not ready, they may be kept at the breasts and genitals off-limits stage with the addition of lotion to vary the sensations and to signify that progress is being made.

When *breasts and genitals are added*, the couple begins Sensate Focus as always, touching initially with breasts and genitals off limits until they are centered on tactile sensations. Then breasts and external genital touching mixed with full body touching for self-interest is suggested. Clients are encouraged to attend to changes in sensory experience, not to stay focused solely on the breasts or genitals once these are on limits, and to move away from breasts and genitals to experience a full body touching experience. For men with erectile insecurity, the partner is asked to move away from and then back to the genitals if there is engorgement in order to reduce spectatoring arousal and the elicitation of greater anxiety. Moving away from engorgement

and later returning to the genitals also allows for repeated experiences of gaining and losing engorgement, often a teaching opportunity for those with erectile insecurity. The same is true for women experiencing anxiety about their arousal once breast or genital touching is included. Initially, if they experience arousal, they are encouraged to direct their partner to move away from the breasts and/or genitals so that this does not become the focus. This is because it is very difficult at the beginning for clients to focus on breast and genital sensations associated with arousal without promoting anxiety or a goal orientation. However, as they become more proficient at focusing on sensations, they are encouraged to allow their attention to stay with the breast and genital sensations even when they experience arousal. This provides them with the opportunity to experience the return of arousal without having to try to make it happen.

The couple is offered two positions when breast and genital touching is added. The Toucher can sit up with the back against the headboard, pillows behind. For this position, the Touchee lies on his/her back with his/her face looking up at the ceiling and genitals close but not touching those of the Toucher. The Touchee places his/her knees and calves up and over the partner's thighs with feet on the outside of the partner's hips. Alternatively, if the Touchee feels too exposed in this first position, he/she can sit between the Toucher's legs, both facing forward, with his/her back up against the chest of the Toucher and his/her legs draped over the Toucher's. The Toucher can reach around the partner's body to include the breasts and external genitals.

When partners can touch for their own interest, focusing on sensations and bringing themselves back from distractions when breasts and genitals are added, they move to *mutual touching*. Partners lie next to each other and simultaneously touch for their own interest, mixing this with "my turn" and "your turn" experiences. At first they avoid breasts, chest, and genitals, and then they include them as they would any other part of the body. This is not as easy as it sounds because each partner focuses not only on sensations where he/she is touching the partner, but also on sensations where he/she is being touched, all the while managing distractions by returning the focus of attention to either one of these sources of sensations. Clients are confronted with a dynamic tension among different demands for their attention, and they must learn to endure the tension until they become adept at letting their focus move where it will. They are honoring the intersubjective space. Eventually, they practice these skills with other areas of the body, and in other positions as will be described below.

During initial Sensate Focus, clients are encouraged to communicate about their anxieties verbally before and after the sessions, and predominately nonverbally during the session using the techniques of moving the partner's hand away from any area where the touching is experienced as physically or very psychologically uncomfortable or ticklish. The exception to this nonverbal focus is when anxiety peaks in the touching. In such an instance, the use of a code word and a change in action are encouraged to help clients move beyond the anxiety. The code word should be chosen by the couple prior to the session and should be positive or neutral in nature, for example, "change."

The decisions about moving up the hierarchy are made in dialogue between the therapists and clients. Individual and couple dynamics are addressed *in vivo* as partner pressure, avoidance, couple conflicts, or pressuring for goal-oriented achievements arise.

Generally after the first experience of breast and genitals on limits, clients are asked to engage in a *clinical look* at each other's genitals. If one or both partners report being unfamiliar with his/her own genitals, the clinical look is conducted individually first. With some lighting on, clients are asked to alternate visually exploring their genitals with one another. This not only provides accurate information but also brings about a sense of intimate sharing, breaking down barriers of ignorance and discomfort. It promotes more disclosure in Sensate Focus Phase 1, where partners share what is of interest, and in Sensate Focus Phase 2, where partners share what is pleasing.

The next Sensate Focus experience is mutual touching with, in the case of heterosexual couples, the woman *going astride* her partner, sitting up on top, facing the partner, her knees on the bed, supporting herself with her knees and arm, in a tripod fashion. She is encouraged to use her partner's genitals much as she would use her own hand, playing with vulva, clitoral, and *mons* contact with her partner's genitals but without insertion. She maintains the attitude of touching for self-interest and redirects attention back to sensations. In the case of same-sex couples, genital-to-genital contact is modified according to the couple's sexual practices, goals, and values.

When genital-to-genital contact is paired with the preceding sensory experiences and the prohibition against doing anything intentional with the associated arousal, there is a harkening back to early, and often exciting, taboo-filled experiences of youthful, playful exploration. It is difficult for most people not to experience significant arousal by this point. However, in the case of arousal difficulties, the natural waxing and waning of responsivity may rekindle clients' fears of performance, especially given that expectations for excitement tend to be amplified when genital-to-genital contact is included in the astride position. These fears are addressed, which allows for the opportunity to discuss the fact that the lower anxiety partner is perfectly capable of being orgasmic even when the anxiety-wrought partner is experiencing little or no arousal. This is particularly important for men suffering from erectile insecurity: It assures them that the partners' absorption, arousal, and even orgasm does not depend on having significant penile engorgement. Therapists can offer a paradoxical injunction suggesting that clients intentionally observe the gaining, losing, and regaining of arousal. This preempts fears of losing arousal. It also facilitates both parties' experimenting with an attentional freedom that they most likely have never experienced before, and this may evoke a previously unbeknownst or forgotten sexual vitality.

Additional suggestions in the astride position may include insertion without movement, absorbing the genital sensations while resisting a goal-oriented agenda. Clients may subsequently explore movement and, slowly progressing into Sensate Focus Phase 2, begin to communicate increasingly about what each finds pleasurable. With clients for whom insertion is not a goal, obviously this step is omitted, clients are informed that, because of the regularity and intensity of physical contact, they may find themselves experiencing orgasm unintentionally in which case they are not to stop the touching. Touching for one's interest merges with what is stimulating for the client and the partner, and the partner's responsiveness contributes to an ongoing dynamic that elicits arousal for both. This becomes a positive sensual feedback loop.

Special considerations The specific sexual difficulty reported by the couple, the couple's goals, and their unique individual and couple dynamics, will dictate the structure, pacing, and processing of therapy. This is the art of sex therapy. Despite the recommended order of the hierarchy, the pace and process of the progression is not immutable. The therapist and client together adjust the pace and suggest changes in initiation and activity. While not exhaustive, some examples include individuals with low desire being encouraged to develop fantasy. Anorgasmic partners will be encouraged to learn about their responsivity themselves and communicate what they have learned to their partners. Men with rapid ejaculation will be given the coronal and then the basilar squeeze techniques with partner insertion and/or the Semans (1956) stop/start technique to increase their ability to tune into and moderate their arousal. Men with delayed ejaculation will be instructed in successive approximations wherein partner stimulation is mixed with the man's self stimulation, and insertion is encouraged at the point of ejaculatory inevitability. Women with vaginismus will be instructed in the progressive use of dilators, choosing partner involvement when they wish. Individuals with pain disorders are encouraged to maintain full control of position and movement if and when insertion is involved. Trauma survivors will be offered preliminary touching suggestions.

Common Problems Encountered with Behavioral Suggestions

Noncompliance with Sensate Focus touching

One of the most common difficulties with Sensate Focus is the clients' failure to do the touching exercises, or not doing them as suggested. This is processed in the therapeutic session to address confusion, avoidance, anxiety, expectations, discomfort, and problematic relational dynamics that are often the causes of noncompliance during the initial stages, especially when the partners have gone without physical contact for a long time. Specific management strategies are offered, including formally scheduling touching time; changing who initiates and who touches first; identifying, communicating, and managing the anxieties alone and/or with the partner's assistance; clarifying expectations; asking to be held prior to the session; or asking for immediate relief from anticipatory anxiety by proceeding ahead with the touching experience. The couple's anticipation of touching is often more anxiety-provoking than the touching itself which may be experienced as welcomingly non-pressured and emotionally connecting.

Ticklishness

Because ticklishness is a reflexive reaction, it is often experienced as a challenge during initial sessions. Protracted ticklishness across touching opportunities can also suggest myriad anxieties. Sometimes this can be severe and distressing and may be associated with a history of being relentlessly and even sadistically tickled as a child. The most frequent suggestion is to *handride* the partner, that is, to place the ticklish person's hand under or over the partner's hand in order to regain a sense of control. In some instances, such as feet ticklishness, the partner is asked to avoid that body area or be quickly responsive to the partner's nonverbal request to move away from the ticklish area for that moment, with the possibility of returning to it at a later time.

Ongoing evaluation, performance goals, and expectations

Sex therapists should never underestimate the understandable determination of some individuals to resist the paradox that sex is a natural function. Often clients have succeeded in many aspects of their lives by pouring conscious effort into whatever they have done. It is difficult for them to embrace the non-goal-oriented approach necessary for a natural function to express itself. Discussions of sex as a natural function may need to be reiterated, particularly the role that focusing on reliable sensations plays in managing demand expectations. The clients are reminded that, as soon as they remove themselves from immediate absorption in the moment by attending to goal-oriented cognitions and negative emotions, they are interfering with natural responsiveness. If their evaluation continues, it may call for a medication consult, as in the case of obsessive-compulsive disorder.

Feeling bored with, constrained by, or not liking Sensate Focus

It is not uncommon for clients to report feeling bored with or limited by the touching exercises and to yearn for spontaneity. Although clients come to sex therapists for direction, the highly structured therapy may chafe at first. Often when clients report boredom or lack of spontaneity they are still absorbed in demand expectations for enjoying, being excited by, or responding sexually to the touching exercises. It may be helpful to review the rationale for these exercises to build the foundation so that spontaneous experiences to later occur. For those who

continue to have difficulty following guidelines, it may be effective to suggest that they temporarily return to touching as they prefer, if only to re-experience the futility of that approach.

Feeling *nothing* during Sensate Focus

Frequently, clients will initially return from Sensate Focus reporting that they *felt nothing*. Just as with feeling bored with or constrained by Sensate Focus, this often means that they are still expecting to feel interested, aroused, and responsive despite therapists' statements to the contrary. This becomes diagnostic of a performance-oriented approach and serves as a teaching opportunity. Feeling nothing can also be an indication of possible sexual trauma and dissociation, or it can point to other concerns such as damaged nerve conduction from illness, medication, or treatment. Additionally, it can signify a client coming to therapy not actually to improve the sexual relationship, but rather with a motivation to prove the sexual relationship is toxic or irretrievably broken or because there is an ongoing affair or alternative sexual interest. Although every effort is made to identify these barriers during initial assessments and roundtable discussions, it is sometimes possible to do so only as problems surface in association with treatment suggestions.

Doing more than is suggested

It is expected that clients who have experienced the buildup of sexual tension from repeated Sensate Focus may be spontaneously orgasmic during the touching as part and parcel of natural, sexual functioning. However, there are some couples that repeatedly and intentionally seek orgasmic release as each successive touching opportunity is introduced, and/or who repeatedly move on to intercourse before this is suggested as part of the hierarchy. The usual intervention is to reiterate the concern about returning to goal-orientated expectations, and the importance of keeping Sensate Focus free of this pressure to increase opportunities for success. Sometimes the push for intercourse and orgasm is diagnostic of one partner's pressuring the other, of sexual compulsivity, of a personality disorder, or of a lack of sufficient education. All this is grist for the processing mill.

Sexual frustration

When Masters and Johnson were developing their sex therapy model from the 1960s to the 1980s, more men and women believed that masturbation should cease once they were in a committed relationship. A belief like this often inadvertently pressures the partner into a sexual service role that can have negative consequences for the couple, including resentment, loss of desire, and unwillingness to touch. The Masters and Johnson approach takes into account the value of self-stimulation if clients report they are becoming distractingly or uncomfortably aroused during the touching sessions. Self-stimulation or, as mentioned, partner choice in aiding and abetting the partner's release is suggested after breasts and genitals are added.

Another issue pertaining to distracting or uncomfortable arousal has to do with Masters and Johnson's original ban on sexual release outside of the touching sessions. The reason they encouraged this ban was due to the intensive format of their treatment and the greater accrual of sexual tension that could be cultivated by deferring release. However, it is difficult to gain client compliance with this suggestion when the treatment format is not intensive. Therefore, many therapists in more traditional settings suggest that if clients desire sexual release prior to its being incorporated into Sensate Focus, that they do so separate from the touching sessions themselves.

Strengths, Weaknesses, and Modifications of the Masters and Johnson's Model

Since the publication of *Human Sexual Inadequacy*, the field has grown richer. Talented clinicians have expanded Masters and Johnson's physiological-based, psycho-educational approach, highlighting its strengths and offered modifications to address problems of "theoretical paradigms, diagnostic nomenclature, treatment interventions, research methodology, assessment measures … effective medications, and leadership" (Althof, 2010, p. 390). However, confusions have arisen and further clarification is needed.

Conceptual issues

Complexity Masters and Johnson have been critiqued for overemphasizing the physiological aspects of sexuality (Foucault, 1990; Gagnon, 1990; Gagnon & Simon, 1973; Tiefer, 1991) and oversimplifying sexual responsivity by suggesting their famous linear model of arousal, plateau, orgasm, and resolution. They have been critiqued for what is regarded by some as prescriptive, "paint-by-numbers sex" (Kleinplatz & Krippner, 2005, p. 304), and even for being "technicians … [whose] work … lacks a philosophy of life and a theory of human behavior" (Abramson, 1994, p. 110).

Masters and Johnson would be the first to acknowledge that sexuality is more than biochemistry and physiology; that sexual responsivity is not a simple, sequential progression; and that the treatment of sexual difficulties requires more than just behavioral interventions. Their assertion that sex is a natural function and their advocacy for a short-term, operational approach to the initial treatment of sexual problems does not exclude a dynamic model that takes into consideration psychological and social aspects of sexuality, and it does not exclude deeper therapeutic and relational perspectives (Weiner & Avery-Clark, 2014). They stated:

> The cotherapists are fully aware that their most important role in reversal of sexual dysfunction is that of catalyst to communication. Along with the opportunity to educate concomitantly exists the opportunity to encourage discussion between the … partners wherein they can share and understand each other's needs.
>
> (Masters & Johnson, 1970, p. 13)

The fact that Emily Mudd, "pioneering marriage and family counselor … work[ed] closely with the Masters and Johnson clinic in St. Louis, to which she contributed thousands of case histories from her own practice" (Thomas, 1998), is a testament to Masters and Johnson's appreciation of dyadic dynamics. Although this current chapter focuses primarily on the natural underpinnings of Masters and Johnson's model of sex therapy and on the behavioral aspects of their treatment model, descriptions in this chapter of Masters and Johnson's approaches have been interlaced with references to the cognitive, affective, relational, and cultural variables that Masters and Johnson considered to be critical to the successful outcome of sex therapy.

Etiology Related to the critiques about complexity, the Masters and Johnson model has been characterized as dichotomous and, therefore, overly simplistic when it comes to etiological factors: Either the cause is regarded as medical or psychosocial (Althof, 2010). As the field of sex therapy has become more sophisticated, it is obvious that a simple *either/or* perspective is limited and inaccurate. Instead, a more complex *both/and* approach has become increasingly emphasized as necessary attention is paid to the interaction of physiological sources of sexual distress with psychological, interpersonal, social, and even spiritual contributions (Aanstoos, 2012; Levine, 1992; McCarthy & Fucito, 2005; Perelman, 2009).

This highlights the importance of the *meaning* or *frame* of the sexual concern for each individual (Atwood & Klucinec, 2007).

However, emphasis should not be confused with exclusion. Although the Masters and Johnson approach affirms previously unappreciated and unresearched physiological factors, it does not in any way preclude consideration of, and interaction with, other critical influences.

Sexual desire The original Masters and Johnson model does not focus on desire as a primary diagnosis but only as secondary to sexual dysfunction. Sexologists (Kaplan, 1977, 1979; Lief, 1977) considered this a significant shortcoming and added desire as a first, independent, and additional sexual concern. This has been further refined by researchers who advise that, not only is this progression not necessarily linear, but it may also differ for men and women. For example, sexual interest in women may be experienced subsequent to arousal rather than vice versa (Basson, 2001, 2006). This forms one of the bases for the change in the recent *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), which, in contrast to the prior edition, consolidated female interest (desire) and arousal (American Psychiatric Association, 2013).

Treatment issues

Efficacy of the Masters and Johnson model In *Human Sexual Inadequacy*, Masters and Johnson (1970) claimed a success rate of 80% for non-medically related sexual dysfunctions. This claim became controversial for two reasons. Zilbergeld and Evans (1980, p. 29) critiqued the research as "flawed by methodological errors and slipshod reporting and fails to meet customary standards" of evidence-based therapies. Other evaluators arrived at similar conclusions (Cole, 1985). Additionally, Masters and Johnson's published reports were appraised as deficient: "Our analysis forces us to conclude that Masters and Johnson have not provided the information necessary for either intelligent interpretation or replication" (Zilbergeld & Evans, 1980, p. 32). Kolodny, Masters and Johnson's colleague and third author on many of their books, has made an effort to address the first critique of methodological limitations by suggesting, "genuine attempts at research replication have been rare" (Kolodny, 1981, p. 316). They have often been conducted by single therapists in weekly sessions and/or by graduate students. The fact that Kolodny does not address the sufficient and necessary information concern suggests he is inferring that there is sufficient and necessary information for replication, but that there have simply been very few attempts at doing so. Nonetheless, there has been a failure to adequately and directly address both the replicability issue and the methodological concerns. Both of these limitations make it difficult to fully assess Masters and Johnson's results. Other researchers concur: "In general there has been relatively little congruence among the actual practice of sex therapy, development and investigation of underlying theory, and empirical research on both" (Wiederman, 1998, p. 95).

Despite the paucity of methodologically sound, comparative research into the efficacy of the Masters and Johnson treatment model, some substantive studies offer clear support. For example, although some have questioned the alleged superficiality of this treatment model and have also identified omissions in Masters and Johnson's published works, these same investigators confirm Masters and Johnson's originality and offer support for their methodology (Apfelbaum, 1984; Slowinski, 1984). Studies involving the use of Sensate Focus and a ban on intercourse have found a significant increase in the level of satisfaction for subsequent noncoital, sexual caressing as well as for intercourse (Fichten, Libman, & Brender, 1983). Randomized, placebo-controlled investigations (Fisher *et al.*, 2005) have "demonstrate[d] the negative effect of one partner's sexual dysfunction on the other's sexual dysfunction and the positive

effects of treating dysfunction in both the patient and partner" (Althof, 2010), thus offering support for Masters and Johnson's couple-based approach to treatment.

Population limitations Although the original research on male and female sexual response published in *Human Sexual Response* (1966) was carried out with both identified gay/lesbian and heterosexual individuals and couples, a complex and sophisticated understanding of sexual orientation and gender fluidity had barely been articulated at that time. Therefore, Masters and Johnson's therapeutic model was developed with able-bodied heterosexual couples in mind. One of the most fertile areas of expansion of their work has been the investigation of their techniques in many other populations (Linschoten, Weiner, & Avery-Clark, 2016). These include, among many others, people: with disabilities (Bell, Toplis, & Espie, 1999; Melby, 2011; Tepper, 2000); with medical conditions (Gallo-Silver, 2000; Jindal & Jindal, 2010; Sanders & Sprenkle, 1980); who have AIDS (George, 1990); who deal with substance abuse problems (Jensen, 1984); who have a history of sexual trauma (Maltz, 2012; Weiner, 1988); who are gay, lesbian, gender queer, or gender fluid (Hall, 1987; Iasenza, 2010; Leiblum & Rosen, 2007; Nichols, 1982); and who are from orthodox religious backgrounds (Ribner, 2003). These studies indicate that sex therapy and many of the Masters and Johnson techniques can be successfully utilized for treating sexual concerns across a wide variety of populations.

Dual sex team Although sexologists originally heralded the dual therapist team approach as "an extremely exciting research and clinical breakthrough in sexual knowledge," they also pointed out that "there are some evident problems in applying this model to 'typical' therapeutic practice," not the least of which is the "much greater time commitment on the part of two therapists" (McCarthy, 1973, p. 290). Most therapists do not have the luxury of dual sex teams, and this clinical model has been adapted to single therapist, out-patient settings. As McCarthy (1973, p. 293) noted:

> It would appear that as long as the therapist is aware of both male and female physical and psychological responses, as well as the power and communication aspects of the triadic therapeutic relationship, then he or she can function in a therapeutic way.

Nonetheless, the effect of a dual therapist team should not be underestimated. The perception of clients experiencing themselves as "each with a friend in court as well as an interpreter when participating in the [treatment] program" (Masters & Johnson, 1970, p. 4), potentially finesses a number of transference issues.

Intensive format If the accrual of sexual tension can be elicited and experienced in as contained a form as is possible in an intensive therapeutic format, sexual partners can progress expeditiously because they have Mother Nature on their side. For many couples for whom immediate results are critical, this approach continues to be ideal. For those who live in remote locations, and for those who find it impossible to shake off responsibilities while at home, sex therapy coupled with social isolation can fan a hot cauldron of change.

However, just as with the dual therapist approach, there are realistic limitations, as most sex therapy takes place once a week in 50-minute sessions with a single therapist (McCarthy, 1973, p. 290). Some therapists have modified the two-week, intensive format to this more common practice, with each session including (a) a review and discussion of the previous week's assignments, (b) processing the clients' feelings, and (c) offering the next set of suggestions. The advantage of this "elongated therapy period" is that it allows clients "to pace themselves in terms of acceptance of their sexual responses" (McCarthy, 1973, p. 293). It also finesses one difficulty with the intensive format, namely, that couples may have problems with

re-entry into their everyday lives. With the protracted format, partners can learn to balance job, family, self-care, responsibilities, and other interests while simultaneously maintaining their treatment progress. However, if a rapid, sequestered program is feasible, re-entry problems can be effectively managed with check-up appointments. This was done at the Institute with twice monthly telephone sessions for two years. This serves as a reminder to partners about setting aside quality time, scheduling touching on a regular basis, and practicing the individual and relationship skills.

Summary

Despite its limitations, Masters and Johnson's short-term behaviorally- and psychoeducationally-based approach to treating sexual difficulties has served as the touchstone for many sexologists for over 40 years. We cannot help but be enthusiastic supporters of its vitality and the remarkable and meaningful transformations that can take place through the seemingly simple suggestion of engaging in human touch without regard for result.

A Case Illustration

A number of the aforementioned points can best be illustrated through a case study. The Dorns (all identifiers have been eliminated or altered to assure anonymity) present for sex therapy with a pairing of two common complaints: low sexual desire on the part of the wife and erection difficulties on the part of the husband.

Initial conjoint consult

The initial conjoint session takes place as soon as it has been determined that there are no medical causes for the presenting sexual complaints. This session involves gathering information necessary to assess further the nature of the concern, the resources brought to bear, and the couple's therapeutic goals. The Dorns, a dual-career couple in their late 50s, have been married for 30 years. Having raised several children, they are at a time in life when couples often re-examine their relationship. The Dorns are steeped in anxiety and hostility as the sexual resentments have built up over the years. This has affected their sexual relationship, their ability to be physically affectionate, their communication, and the quality of the time they share. They desire not only to resolve their sexual concerns and to rekindle their original intimate connection, but also to cultivate greater meaningfulness in their sexual and relationship lives than they have previously experienced.

History-taking

This case example is intensive in format and involves a heterosexual couple. The initial consult with both partners takes place on the first day, and the individual history-taking sessions take place on the second day. The results suggest no depression, psychosis, substance abuse or other clinically significant psychological disorders in either partner. In her individual history-taking session, Mrs Dorn reveals that she was sexually active in her 20s prior to getting married. In his, Mr Dorn reports that he had few intimate encounters in his adolescence and early adulthood. Both indicate that their shared sexual relationship had been adequate for a number of years prior to having children. The frequency of sex had tapered off as the dual-career couple balanced professional pursuits and raising children to whom they were devoted. As the frequency of sexual encounters diminished, Mr Dorn began having difficulties maintaining his engorgement. On her part, Mrs Dorn began experiencing decreased sexual interest.

Mrs Dorn attributes her loss of interest in sex not just to career and children but also to the fact that Mr Dorn had become increasingly preoccupied with incorporating what she regarded as objectifying paraphernalia (garters, high heels) into their intimate encounters. Additionally, she experienced him as rushing to genital contact and attempts at insertion. Her goal is to feel interested again, and she expresses her desire to spend more time savoring the sensory experience of being together in a nonsexual fashion.

Although Mr Dorn is not unappreciative of the benefits of sensory mindfulness, he is more interested in exploring alternative sexual activities. He complains that his wife is unwilling to try variations in their sexual interactions, and he considers this the primary factor contributing to his arousal difficulties. He is a health-conscious man and does not want to use a phosphodiesterase type 5 (PDE-5) inhibitor, such as Viagra, preferring to address his erectile concerns through changes in his wife's willingness to dress for him and tease him.

Roundtable discussion

The roundtable begins with the therapist's mirroring an empathetic understanding of the same-sex partner's relevant history and concerns and, conjointly, introducing suggestions for resolving their identified issues.

Mrs Dorn's mirroring *It is reflected to Mrs Dorn that her desire for more unhurried, sensually connected time with her husband is not unusual and represents the erotic aspect of sexuality in the original sense of the word—having to do with relatedness, and especially relatedness to the immediate, concrete sensory experience. It is this giving herself to an overload of sensations that is at the core of Mrs Dorn's sexual value system. The mirroring reflects back to both spouses that Mrs Dorn became enamored of physical contact in her early adolescence the first time she was hugged and kissed by a boyfriend. She vividly recalls the overwhelming sense of comfort she experienced when he pulled her close and wrapped his arms around her. She described in detail the sensations of the moment: the smell of his musk-scented cologne; the sound of his leather jacket rustling; the salty taste of his lips; the heat of his skin where his hand caressed her face; and the black, chilly, and cloudless night that surrounded them as they walked. She recalls having experienced a sense of homecoming, mesmerized by the intense connection. When she is able to feel this type of connection with her husband, elicited by unpressured episodes of sensory absorption, she still feels desire for him, but these episodes have been increasingly infrequent. Mrs Dorn is concerned that every time she acquiesces to one of her husband's elaborate sexual scenarios, he will interpret it as meaning she is interested in it to the exclusion of more sensorial and affectionate relating. A tear runs down Mrs Dorn's face as she re-experiences the meaningfulness of this first encounter with sensuality, and Mr Dorn is unusually quiet.*

As part of mirroring Mrs Dorn's sexual values, the therapist also provide education to Mr Dorn about general female responsiveness. He is somewhat bewildered to learn that his frequent and self-professed approach of "a kiss on the lips, a touch of the breast, and a dive for the pelvis" (during which he stimulates his wife's clitoris with the same intensity he stimulates his penis) is often unsuccessful if only for a physiological reason: His wife's clitoris is so sensitive that intense stimulation in the absence of a more give-and-take interchange is overwhelming.

It is suggested to Mr. Dorn that his wife is not just being "difficult" (to use his word) when she encourages non-demand absorption before and during genital stimulation. In contrast to many men, women often need this to facilitate the arousal and lubrication necessary for subsequent intercourse and/or orgasm. He also learns that sexual desire for women may follow arousal rather than precede it, which is all the more reason for him to attend to what actually interests his wife. Mr Dorn is stunned. He takes his wife's hand and shows some awareness of one of the larger issues that burdens their sexual relationship: "You mean she's not just being difficult when she says she wants to go slowly?"

Mr Dorns' mirroring *Freud suggested, "When inspiration does not come to me, I go halfway to meet it" (cited in Zakia,* 2007*, p. 16). Mr Dorn has met inspiration halfway. What he lacks in an appreciation for emotionally connecting sensual immersion he has made up for in years of cultivating a rich, masturbatory fantasy life involving specific visual and tactile imagery. These include scripted scenarios such as his partner's dressing up in a red bustier, wearing black silk stockings with a garter belt, sporting stiletto heels, and engaging first in oral sex and then in female astride intercourse while speaking to him in a hushed voice.*

Mr Dorn's arousal patterns go back to an incident he had in middle school during which he caught a glimpse of black stockings and garters underneath a female classmate's skirt. He was able to recall vividly the feel of the soft, black and red skirt as she rose from her chair and brushed by his hand. He became extremely aroused during this encounter and spent countless hours stimulating himself to orgasm using this imagery. This early experience had transferred to his current interest in having his wife engage in his fantasy. Mr Dorn is concerned that not only will his wife never appreciate his sexual interests but also that, if he gives her the affectionate and sensory contact she desires, she will have all that she wants and will never want to experiment with what arouses him.

Additional educational points in Mr Dorn's mirroring include providing accurate information about: the negative effect of anger on sexual arousal; the effects of aging on erections; and the impact of his spectatoring, which began the first time he had erectile difficulties. Mr Dorn acknowledges that his concern about maintaining his engorgement causes him to rush to insertion, thereby increasing his anxiety and short-circuiting the stimulation he needs. This has led to a cycle of failure, resentment, and defensive loss of interest on the part of both partners.

*Mr Dorn's roundtable mirroring ends with an educational note for Mrs Dorn: Her husband is not necessarily being "insensitive" (to use her word) when he asks her to engage in scripted scenarios; rather, he is trying to achieve sufficient arousal to overcome the anxiety that interferes with his erections, and he has also cultivated these arousal patterns because he experiences them as genuinely pleasurable. Mrs Dorn is informed about the differences that appear to exist, on average, between patterns of adolescent masturbatory and fantasy activity for men and women (*Robbins et al.*,* 2011*). Masturbating to specific images is an effective and frequently employed way of conditioning arousal to stimuli, especially during the neurologically impressionable adolescent years. Thus, men have a higher probability than women of emerging from their teenage years with a finely honed awareness of the particular cues that assist their becoming sensorally and sexually absorbed.*

As Mrs Dorn listens to the information offered by the therapist, her countenance visibly softens. She looks at her husband, down at his hand holding hers, and back to the therapist. "You mean, he's not kidding? He's not just being insensitive? These scenarios really do mean something to him?"

In the mirroring sessions, both partners have the opportunity to learn about the importance of attending to and honoring their own and each other's sexual values. This forges a significant connection between them and reduces power struggles even before therapeutic interventions have commenced.

Therapeutic attitudes and skills *Following the roundtable mirroring, the therapist introduces the attitude of being focused on the present; the concept of self-responsibility rather than partner blaming; the importance of structuring quality time together; and communication, negotiation, and feelings management skills.*

Sensate Focus

Breasts and genitals off limits *Once the Dorns understand and commit to practicing the attitudes presented in the roundtable, Sensate Focus suggestions are offered. They are encouraged to schedule between two and three touching sessions between the roundtable and the next therapy*

session. In an intensive format, this would be two Sensate Focus sessions prior to the next day's therapy session; if treatment is in a less intensive, once-a-week format, this would entail one touching session no less often than an average of every 48–72 hours prior to the next week's therapy meeting. Because Mrs Dorn presents with a history of feeling more pressured by her husband, she is encouraged to initiate the first session—and the third session if the opportunity presents itself—by formally announcing, "I would like to do the touching session." This formality finesses subtleties and indirect ways of approaching the session that can easily be misinterpreted and that also may represent avoidant strategies. Mr Dorn is told he can always say, "No, I don't want to right now," but then it becomes his responsibility to reinitiate the session, and this still counts as Mrs Dorn's initiation. He is asked to be responsible for initiating the second Sensate Focus opportunity.

The Sensate Focus instructions are given for the first session with the emphasis on: touching for one's interest; focusing on temperature, pressure, and texture; and redirecting attention back to the sensations should focus drift to anything else. The words of the therapeutic suggestions are chosen carefully to eliminate even subtle implications of demands for particular affective responses; references to relaxation, enjoyment, and pleasure are assiduously avoided. The Dorns are asked to do no more than has been suggested and, in fact, to do less if major problems arise. The therapists are not interested in either an objective skin measurement (e.g., what the BTUs are), or an evaluation of whether the sensations felt nice, fine, or good. Rather, they are interested in whether the Dorns experience the sensations descriptively, "taking it precisely as it presents itself" (Aanstoos, 2012*, p. 56) in the moment. They are encouraged to make notes following Sensate Focus exercises of their experiences of the sensations, distractions, and ability to refocus for detailed discussion during subsequent therapy sessions.*

Although neither has particular difficulty with focusing on sensations, especially once they understand the premise of sex as a natural function, they both have concerns about focusing on these sensations each for his/her own interest and without the goal of arousal. Mrs Dorn resists: "This sounds so selfish!" Much discussion and support is necessary to help her understand that tuning in to her own sensory experience, although most certainly self-focused, is different than being selfish (defined by failing to respond to the partner's input). She is reminded of the freedom Mr Dorn has to direct her hand away if anything she does is uncomfortable. Even Mr Dorn bemoans this self-focusing and loss of goal orientation: "But I need her to do things to make me aroused!" He is reminded that since sex is a natural function, his wife cannot make him aroused, that arousal is not the goal of Sensate Focus, and that he will be given more skills for communicating his needs as therapy progresses.

Mr Dorn is much less enthusiastic about the touching experiences: "I didn't feel much." It is evident that his expectations are to feel sexually aroused mentally and physically. The goals of the touching are reviewed, and the couple is asked to repeat touching with breasts and genitals off limits but to add lotion to experience another set of sensations as the lotion first coats and then is absorbed by the partner's skin. Processing this second set of instructions, Mr Dorn is agreeable and appreciates the need for putting aside his goal-directedness toward arousal.

The impact of the shift to honoring sexual responsiveness as natural functioning by redirecting attention to the subjective, momentary tactile experience cannot be overstated. Mrs Dorn returns from the first Sensate Focus exercises sporting a notebook full of specific sensations on which she was able to focus. "I began by touching him on his shoulder, and I noticed that it was hard and smooth and warm." Mrs Dorn also reports being moved by the emotional closeness she has experienced with her husband. She has never had the opportunity to engage in such sensory exploration, and she easily becomes lost in the experience. It was as if she had revisited some long-lost force within her. Her loss of sexual desire already shows signs of abating.

Breasts and genitals on limits *After several sessions, Mr and Mrs Dorn have progressed sufficiently such that they are able to focus on sensations for their own involvement more often than not, and they are more frequently recognizing distractions and returning the focus of their attention back to the sensations. Touching with breasts and genitals on limits is introduced, encouraging the*

application of touching for their own interest on these areas of the body just as they have done before. Mrs Dorn continues to be assigned the initiation of the first in every set of touching opportunities, as this gives her a therapeutic sense of control. She is instructed to touch her husband first as she has done previously, avoiding the chest and genitals and, once focused, to assume the position of sitting with her back up against the headboard, her legs spread out in front of her in a "V" shape, and her husband lying on his back with his genitals close but not touching hers. She is eventually able to incorporate his chest and genitals into the contact, continuing to focus on temperature, pressure, and texture. She is asked to move to touching the genitals, and if there is any engorgement, to move away quickly, back to his whole body, then back to the genitals, and if engorgement is present, to move away again. This is designed to foster a whole body experience, to minimize spectatoring of the penis, and to reduce anxiety regarding the natural waxing and waning of engorgement. Once finished, they are to switch positions with her husband repeating what she has done with him. A clinical look is assigned whereby both partners explore the structure of one another's genitals apart from a touching opportunity.

Mr Dorn begins to understand that, although his aims of having stimulating sex and orgasm with his wife are valid, the manner in which he has been promoting them has been counterproductive not only with regard to his wife's arousal, but also with regard to his own. He stops trying to do so much for Mrs Dorn, and he increasingly allows himself to become more sensorally involved. Most surprising to him, Mr Dorn begins having less difficulty experiencing erections. Even more unforeseen to him, he becomes less focused on his erection status altogether. His verbal reports in the therapy sessions include fewer references to his state of engorgement, and more reports of the meaningfulness of the Sensate Focus sessions to him in general.

Mrs Dorn is also reassured. She has found it particularly helpful to learn that not only are sexual responses natural functions but also, like all natural functions, they wax and wane regardless of what either she or he does in terms of activity. She has been socialized that it is her responsibility to arouse her husband. Her mental set has been to please him, and this has interfered with her own sexual involvement. This understanding helps relieve her of her sense of responsibility for her husband's erection difficulties.

Mutual touching *Next the Dorns are given instructions for mutual touching. This involves lying next to each other and touching for their own interest at the same time that their spouse touches for his or her own interest, at first avoiding the breasts, chest, and genitals. This reinforces the interpersonal and nonverbally communicative nature of the physical exchange, and it multiplies the experience of sensations. The therapist explains, "We have had you touching essentially with one hand tied behind your back; one of you has been touching while the other one hasn't. Now we are going to have you touch simultaneously." Mr Dorn's interest noticeably picks up: "Now this is more like it!" Whereas only a few sessions before, Mrs Dorn might have fired back with a sarcastic comment suggestive of her husband's aforementioned insensitivity, she appears intrigued. Both the Dorns' burgeoning interest and ability to respond is reflected in their increasingly talking about their own individual experiences rather than the deficiencies of the partner.*

Although experiencing regular engorgement during most of the breast and genital touching and mutual touching, Mr Dorn had lost engorgement on one occasion when the touching occurred late at night and he was tired. He is paradoxically invited to actually practice gaining and losing his erection in order to develop the skills for redirecting his attention from his penis to something absorbing about his wife and, thereby, regain his engorgement. This builds confidence and lowers anxiety because increasingly, even when Mr Dorn loses his engorgement, he will have an understanding of the reasons why this occurred ("I was trying to make myself aroused"). Additionally, he will have a new skill set for dealing with this ("I need to refocus on sensations"). Encouraged to manage anxiety outside of the bedroom, if anxiety occurs during the touching session, the couple is instructed in the use of a positive code word. This signifies their need to change the activity and refocus on different sensations. Both feel empowered to move through the anxiety by changing positions and focus, and continuing on, usually with positive results.

Female astride, and optional insertion *Having acquired information and confidence about, and management skills for, gaining and losing engorgement, the female-astride position is introduced. Mrs Dorn is encouraged to straddle her husband and use her husband's penis against her vulva, focusing on her own tactile sensations in her genitals. The first time they try this, Mr Dorn promptly loses his engorgement, which is common with erectile insecurity at this stage. However, Mrs Dorn is orgasmic anyway as she adeptly uses her husband's flaccid penis against her clitoris. The fact that female orgasm is possible in the absence of an erection is a revelation for most men suffering from erectile insecurity. Several more sessions of female astride with his gaining and losing engorgement, and using the code word to alter the action, results in Mr Dorn's experiencing greater security.*

In the female-astride sessions, the Dorns are initially advised to avoid any insertion and are encouraged to think of their genitals as they did their hands in the early Sensate Focus sessions. Their focus is to attend to the touch sensations taken in by their own genital skin, and then focus on the tactile sensations they are experiencing when making contact with their partner's genitals using their own. They have never done this before in a non-demand, touching-for-their-own-interest fashion.

When they are able to apply Sensate Focus skills to genital-to-genital contact, they are encouraged to explore insertion in the same way if this is of value for both of them. When Mrs Dorn feels ready, she inserts her husband's penis and is asked to remain motionless, resisting any physiological impulse to engage in thrusting motion. This insertion without motion allows both to focus on the sensations of warmth and pressure and allows Mr Dorn to experience his worst fear, namely, the loss of his engorgement, this time in a purposeful way. In subsequent Sensate Focus exercises, insertion with movement is included. Even later, in Sensate Focus Phase 2, the Dorns are further encouraged to play with insertion and move from a variety of other sexual activities back to insertion with movement. This is all in an effort to cultivate an exploratory mindset and increase their nonverbal communication.

As the sessions involving female-astride progress, Mrs Dorn in particular reports experiencing an energy surge. She becomes increasingly willing to explore sexual options to ascertain her reactions to them. Although she has self-stimulated to a limited degree since she was a late adolescent, she is now willing to try this in the presence of her husband, paying particularly close attention to whether she can become absorbed in the arousal independent of her husband's (very positive) response to her doing so. She also reports that she is now willing to go shopping with Mr Dorn to purchase the high heels he so desires her wearing, and she is even considering trying on some cleavage-revealing dresses and lingerie. However, she reports that she is willing to engage in these extra-bedroom activities primarily as exercises to explore her own feelings about these activities regardless of her husband's (very positive) reception.

Following the tenth session of female-astride, and the second involving insertion, Mrs Dorn returns to therapy sporting a pair of high heels and a provocative dress. She can hardly contain her excitement. She describes how amazed she is that, contrary to the opinions of most of her friends and the negative beliefs instilled in her about high heels during her days as a hippie teenager, she has moments where she experiences the sexiness of wearing the heels for herself. Mrs Dorn reports being most pleased with the spillover effect that her sexual exploration is having on her overall mood.

Kissing *Often, one of the most emotionally charged activity for clients is kissing. For many couples, kissing is one of the first ways the sensorially explore one another. However, it may be one of the last activities attended to in sex therapy. It is discouraged prior to this point in the Masters and Johnson's approach because it often represents such a complex and intimate integration of sensory absorption, limit setting, and the ebb and flow of "yes" and "no" in communication between partners. It is often difficult for partners to kiss without evoking pressure to feel romantic and aroused. All of the physical contact up to this point in therapy is through touching with the hands. However, as Sensate Focus progresses, couples are able to experience and incorporate more intersubjectively responsive interactions while maintaining an exploratory mindset. Non-demand kissing-for-one's-own-interest becomes possible.*

The power of the non-demand, sensorial, and self-focused attitude on the Dorns' intimate interactions, even while engaging in intercourse and kissing, is significant. Mrs Dorn is able to surrender to the tactile immersion for which she so yearns. Her complaints of lack of sexual interest diminished significantly. She confesses she has deviated from the suggestions to such a degree that she is not only more easily aroused during some of the Sensate Focus sessions, but is even initiating physical contact beyond that which has been suggested by the therapists. Mr Dorn professes increasing confidence in his ability to be present to the sensory experience. He also feels he is effectively expressing his interests and receiving willing attention and responsiveness from his wife. He finds remarkable the sense of calmness, pleasure, and meaningful connection he feels to his wife even when orgasm or dramatic scenarios are not part of their activity. Mr Dorn is extremely pleased that he experiences less frequent difficulties arriving at full engorgement; however, he is most pleased by the fact that when he is having arousal concerns, he knows how to manage them. Both Mr and Mrs Dorn report that, despite a quarter century of marriage, they are having genuinely imaginative intimacy for the first time. They are very pleased with their progress but know that they must work hard to maintain it.

Conclusions

Masters and Johnson's approach to sex therapy is not exclusively physiologically or behaviorally oriented. Nonetheless, this article has focused on the concept of sex as a natural function that underlies their therapeutic model, and the behavioral and attentional techniques of Sensate Focus that represent the core of their treatment program. These techniques are used by many sex therapists. Sensate Focus in its initial phase is a set of touching exercises intended to cultivate a non-demand attitude of touching for one's own interest, and teach what clinicians would now call mindfulness practice. Sensate Focus serves as a valuable diagnostic and therapeutic tool, and it functions as an educational tool in that it teaches clients to experience sexual responsiveness by tuning into sensations and refocusing away from evaluative expectations that disrupt their natural responsiveness. This facilitates the conscious mind's getting out of the way of this natural responsiveness.

Sensate Focus in its initial phases is *not* an attitude of demand pleasuring for the partner or for one's self (Weiner & Avery-Clark, 2013). Sensate Focus is *not* touching for the other person or to sexually arouse one's self or one's partner. It is *not* intended to foster relaxation, enjoyment, pleasure, or eroticism. It is *not*, as it is so often portrayed, "caressing and sensual massage during noncoital loveplay" (Albaugh & Kellogg-Spadt, 2002, p. 402). It *is* "intended to be an experience in itself, not a prelude to 'sex' or a form of foreplay" (De Villers & Turgeon, 2005, p. i). As Weiner and Avery-Clark (2014) noted, "It is the paradox of pleasure and sexual responsiveness that being present to conscious sensory experience, rather than trying to make these natural emotions happen, is what promotes them" (p. 12).

If the behavioral involvement and attentional redirection that are the components of initial Sensate Focus are practiced regularly, they may serve as powerful portals into the subsequent Phase 2 components. These are associated with the very emotions clients are long to experience when they first come into therapy but cannot make happen, just as the practice of mindfulness can serve as an impressive inroad into cultivating calmness. The experience of Phase 2 includes not just desire, arousal, and orgasm, but also the deep connection to one's partner to which Kleinplatz refers as "optimal sexual experience" (Kleinplatz & Ménard, 2007, p. 74) and which Avery-Clark (2012) described as "numinous." If couples engage in Sensate Focus in the non-demand touching approach that Masters and Johnson suggest, they increase the probability of experiencing the way in which intimate connection and sexual enjoyment can arise meaningfully and naturally so as to increase the likelihood of the emotional closeness for which they yearn.

In summary, the Masters and Johnson approach involves not only behavioral intervention through Sensate Focus exercises but also educational, attitudinal, cognitive, and affective components inside and outside the bedroom. Its focus is on appropriate assessment of the sexual problem, with individual, family of origin, cultural, relationship, and lifestyle factors influencing the pace and approach taken with the couple. The emphasis on doing no more than is required to address the sexual difficulty offers the opportunity for short-term treatment in consideration of the clients' values and interests.

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12

A Psychobiosocial Approach to Sex Therapy

Barry McCarthy and Lana M. Wald

Introduction

Sex educators, therapists, and researchers view the formal beginning of modern sex therapy as the seminal work of Masters and Johnson (1970). As a gynecologist, Masters emphasized a rigorous medical evaluation while encouraging the assessment of psychological and interpersonal components for the treatment of sexual dysfunction, thus providing a major contribution to the sex therapy field. Specifically, the Masters and Johnson approach emphasized couples, rather than individual, sex therapy. Although many of the prime components of the Masters and Johnson model are no longer used (e.g., a male–female co-therapy team and a two-week intensive program), the lasting legacy of their model is the comprehensive approach to assessment and treatment of sexual dysfunction (e.g., see Avery-Clark & Weiner, this volume). Their work set the stage for the psychobiosocial approach to treating sexual problems.

In contrast, the introduction of Viagra (Goldstein *et al.*, 1998) heralded a dramatic shift from the couples sex therapy approach to the biomedical model of sexual dysfunction, especially erectile dysfunction. Because pharmaceutical companies contribute the majority of funding for sex research in the US and many other Western countries, biomedical factors have dominated in the areas of assessment and treatment of sexual dysfunction for the past 15 years. As a result, psychological, relational, and social issues in sexuality and sex therapy have been largely overlooked, and Rowland (2007) raised the concern that psychological and relational approaches to research and treatment were in danger of being completely ignored. Consistent with this, the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5; American Psychiatric Association, 2013) describes sexual dysfunction using the common medical approach of individual symptoms and assessment.

This chapter will describe and contrast these two very different models of sexual function and dysfunction—the psychobiosocial model and the biomedical model—and will argue that, despite the dominance of the biomedical model, the psychobiosocial model is the superior approach to treating clients' sexual concerns.

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Comparison of the Biomedical and Psychobiosocial Models

The biomedical model focuses on individual sexual performance (e.g., erection for males and orgasm for females) rather than on issues of sexual pleasure and satisfaction for the couple. The biomedical model assumes a heteronormative focus on intercourse as the sole "natural sex." The predominant course of treatment is a stand-alone medical intervention that uses medications, hormones, or injections, without active partner involvement. The biomedical model focuses on individual sexual performance in the context of heterosexual intercourse rather than on the couple sharing pleasure and utilizing a range of sensual, playful, and erotic scenarios, as well as intercourse. With a focus on the individual and not the couple, the biomedical model does not provide a comprehensive, multidimensional assessment or intervention.

In contrast, the psychobiosocial model attempts to promote a comprehensive, integrative approach to male and female sexual function and dysfunction by integrating medical interventions into the couple's sexual style of intimacy, pleasure, and eroticism. Each individual is responsible for his or her own desire and arousal. However, the core of sexuality is being an intimate sexual team. This is true whether dealing with married or unmarried people, straight or gay couples.

Notably, the psychobiosocial model reprioritizes the elements of the more commonly termed *biopsychosocial* model. The biopsychosocial model is often acknowledged as superior to the biomedical model in the sex therapy field despite the predominance of research (and research funding) using the biomedical approach. The biopsychosocial model emphasizes the importance of biological and medical issues, while attempting to understand and treat medical problems in the context of psychological and social factors. The biopsychosocial model has been applied to the treatment of diabetes, cancer, heart disease, and chronic fatigue, among other conditions. Although it is primarily a medical model, the biopsychosocial approach also emphasizes psychological factors in coping and recognizes the importance of social factors such as race, poverty, gender, and social support systems. However, the problem with the biopsychosocial model is that, in practice, it merely gives "lip service" to psychological and relational factors. The reality is that most physicians view individual consultation and use of medications as the first line of treatment and consider psychological and couple factors only if the medical intervention is not successful (Berry, 2013). In contrast, the psychobiosocial model, discussed here, forefronts the importance of psychological and relational factors, while continuing to acknowledge the importance of biomedical factors.

According to the psychobiosocial approach, the mantra for healthy couple sexuality is desire, pleasure, eroticism, and satisfaction (Foley, Kope, & Sugrue, 2012). For example, the most common sexual problem that brings couples to therapy is a lack of sexual desire or conflicts over sexual desire and intercourse frequency (Leiblum, 2010). Although potentially affected by biological components (e.g., illness, side-effects of medications, sleep disorders, hormone deficits, alcohol and drug abuse, and poor behavioral health patterns such as lack of exercise and weight issues), desire problems are most likely to arise due to psychological or social/relational factors (e.g., anger towards the partner, poor sexual self-esteem, rigid male–female roles, antisexual family or religious beliefs, conflict between spouse and parenting roles, negative body image, resentment about money, and lack of trust as a reaction to an extramarital affair). Desire problems illustrate the importance of a comprehensive psychobiosocial approach to understanding, assessing, treating, and preventing relapse of sexual dysfunction; however, the psychobiosocial approach is applicable to the treatment of a range of sexual concerns. We discuss the specific differences between the biomedical and psychobiosocial approaches to treating sexual concerns in more depth below, using several different sexual concerns as illustrations.

Differences in who heads the treatment team

A core difference between the two models is whether a physician or a psychotherapist is the first professional to be consulted, and whether that first step in the process is an individual or couples consultation. The physician acts as the head of the team in the biomedical model, administering the individual consultation as the first step to assess medical pathology.

On the other hand, the psychobiosocial model, in most cases, initially begins with a couples consultation facilitated by a psychotherapist. From the onset, psychological, biological, and social/relational issues are explored, and when needed, detailed assessment is pursued by professionals in a number of different fields (e.g., psychiatrists, internists, gynecologists, urologists, endocrinologists, physical therapists, addiction specialists, or individual therapists). In addition, current and former clinicians of either one partner or the couple (e.g., a couples therapist, pastoral counselor, sex addiction program therapist, psychiatrist, sexual medicine specialist, individual therapist) are contacted to gather input on past treatment and therapeutic suggestions. In the psychobiosocial model, these additional assessments proceed concurrently with the couple's psychological/relational/sexual histories. In this model, clinicians function as well-respected colleagues with unique contributions to the assessment and treatment processes.

Differences in the identified patient

The biomedical model emphasizes *individual* sexual dysfunction with the focus on curing the individual and promoting predictable sexual function. The traditional focus with males is overcoming erectile dysfunction and premature ejaculation. The goal is that the male regain erectile function with intercourse that lasts at least one minute (Waldinger, 2005). For women, the focus is on orgasm and pain-free intercourse. Professionals, especially physicians, are accustomed to seeing individuals rather than couples and emphasizing an acute problem, a specific diagnosis, and a specific medical intervention that leads to a cure.

Although these are worthwhile goals, the psychobiosocial model emphasizes sexuality as a *couple's* process, and treats desire and satisfaction as more important than arousal and orgasm (McCarthy & Wald, 2012). The psychobiosocial model is comprehensive, but also more flexible than the biomedical model in terms of desire, function, and satisfaction. The couple setting personally relevant sexual goals with the focus on reducing distress and promoting desire and satisfaction is key. The clinician is likely to obtain a clearer, more honest picture of desire, pleasure, and satisfaction from couple reports rather than the individual reporting to the physician that, "sex is okay" or "everything is back to normal." By its nature, couple sexuality is variable, complex, and multidimensional. This is even truer for subjective feelings and sexual satisfaction than objective sexual function (e.g., erections and orgasms). It is crucial to recognize that sex is more than intercourse and that sexuality involves desire, pleasure, eroticism, and satisfaction. The research of Heiman *et al.* (2011) demonstrated the complexity of roles and meanings of sexuality for the man, woman, and couple.

Differences in the conceptualization of sexual function and dysfunction

The biomedical model is based on an individual approach to sex dysfunction with the prime focus on making the right diagnosis, using the best medical intervention, and curing the sexual dysfunction. Perfect individual sex performance is the outcome goal inherent in the biomedical model. According to this model, *sex* is narrowly defined as intercourse with orgasm, and a great deal of emphasis is placed on both terms. There is a clear image of "normal" sexual function in which each partner is expected to be functional in terms of arousal and orgasm. Predictable erection often is the focus for males, and for females the focus often is predictable orgasm.

The biomedical model focuses on objective sexual function and dysfunction. Thus, the biomedical model works best with a specific etiology, an acute illness, and a specific medical intervention.

Alternatively, the psychobiosocial model emphasizes sexual dysfunction as a multicausal, multidimensional couple issue, and approaches assessment, treatment, and relapse prevention by respecting individual, couple, cultural, and value differences. Change requires using all psychological, biological, and relational resources, with a focus on enhanced desire and satisfaction. According to this model, *sexual* refers to a range of attitudes, feelings, and scenarios. Although this approach may certainly attend to intercourse and orgasm, it also allows for many other sexual dimensions. In the psychobiosocial model, the goal of perfect individual sexual performance is replaced by the goal of positive, realistic, "Good Enough Sex" couple expectations (Metz & McCarthy, 2007b). The Good Enough Sex approach to sexual expectations and satisfaction emphasizes variable, flexible sexual outcomes rather than a "cure" focusing on perfect performance.

Even among relationally and sexually functional couples, it is the norm that 5–15% of sexual encounters will be mediocre, dissatisfying, or dysfunctional (Frank, Anderson, & Rubinstein, 1978). A prime focus of the psychobiosocial approach and the Good Enough Sex model is to accept the normal variability and complexity of individual and couple sexuality. Although the ideal scenario is a mutual synchronous experience, where both partners experience desire, arousal, orgasm, and are sexually satisfied, this is not a realistic expectation of "normal" sexuality in every single encounter.

Differences in the types of interventions

To illustrate the differences in interventions between the biomedical and psychobiosocial approaches, we describe examples of the biomedical and psychobiosocial treatment approaches to erectile dysfunction and female genital pain.

Comparisons of the treatment of erectile dysfunction The biomedical model places prime importance on the medical intervention. Perhaps the most salient example is treatment of erectile dysfunction (ED). The biomedical model's treatment of ED focuses only on the man, and erectile performance is measured by intercourse success. From the biomedical perspective, the more intrusive the medical intervention, the more effective the treatment will be (as measured by predictable erections). The most effective medical intervention is penile prosthesis, followed by penile injections, the medicated urethral system for erections (MUSE), and the external pump. The least powerful intervention is the use of pro-erection medications such as Viagra, Cialis, and Levitra. In the biomedical model, the woman's role in the treatment of ED is limited to urging her partner to consult his physician.

The psychobiosocial model for assessment and treatment of ED incorporates medical, psychological, and relational interventions and treats the problem as a couple issue. The woman is not blamed for the ED but does have an integral role in assessment, treatment, and relapse prevention. Thus, with the psychobiosocial model, any medical intervention needs to be assessed in terms of acceptability to the man and the couple. Using that as a criterion, pro-erection medications are perceived much more positively than surgery, injections, MUSE, or external pumps, which are less typically acceptable to the man and couple. In the psychobiosocial model, the woman has an active, involved role throughout assessment and treatment. Biologically, both partners have access to vascular, neurological, and hormonal assessments. When medical interventions are recommended (e.g., pro-erection medications, testosterone supplements, and/or penile injections), both partners are involved. They adopt a specific plan for how to integrate the medical intervention(s) into their couple style of intimacy, pleasuring, and eroticism.

In terms of the psychological component of the psychobiosocial approach, the challenge to the man and couple is to rebuild sexual anticipation and regain comfort and confidence in variable, flexible erectile function. In terms of relational/social factors, the man approaches the woman as his intimate and erotic ally. In our treatment approach to ED, we encourage partners to embrace the Good Enough Sex model rather than clinging to the traditional male performance approach of perfect erections and intercourse performance. As part of a psychobiosocial approach, the Good Enough Sex model emphasizes couple sexuality as inherently variable and flexible with a range of roles and meanings, whereas the biomedical model uses a binary function/dysfunction approach. The psychobiosocial approach, using a Good Enough Sex model, sets the expectation that perhaps 85% of sexual encounters will flow from comfort, to pleasure, to erotic flow (i.e., objective and subjective arousal), and then to intercourse, rather than expecting that *every* encounter will involve erection and intercourse.

In terms of psychosexual skills, a very important lesson for couples dealing with ED is to transition to intercourse at high levels of erotic flow (rather than as soon as the man obtains an erection) and to utilize multiple sources of stimulation during intercourse. Examples of multiple sources of stimulation include combining intercourse with receiving testicular or buttock stimulation, touching the partner's breasts or clitoris, or using erotic fantasies to enhance erotic flow. A crucial psychosexual strategy is to utilize a sensual, cuddly scenario and/or an erotic, non-intercourse scenario (e.g., oral sex) as an alternative when the sexual encounter does not flow to intercourse. It is crucial to reinforce that the essence of sexuality is sharing pleasure rather than the "sex = intercourse" approach. We believe that the multidimensional respect for sexual complexity and the variable, flexible, Good Enough Sex model is a better fit for dealing with ED than the biomedical model (McCarthy & Fucito, 2005).

Comparisons of the treatments of female sexual pain Next, let us contrast the biomedical and psychobiosocial models for understanding and dealing with female sexual dysfunction. A specific example is the issue of sexual pain (traditionally categorized as dyspareunia or vaginismus; American Psychiatric Association, 2000). Primarily utilized by gynecologists, the biomedical intervention focuses on diagnosing a medical cause, medications for infections, and surgical interventions, with the goal of pain-free intercourse resulting in orgasm. Typically, the male partner has no, or minimal, role.

In the past ten years, there has been a revolution in understanding, assessing, and treating female sexual pain (Binik, Bergeron, & Khalife, 2007; see also Meana, Fertel, & Maykut, this volume). Recent literature strongly supports use of the psychobiosocial approach. Although DSM-5 lists pain as a sexual disorder (American Psychiatric Association, 2013), most sex therapists have understood this as a pain disorder rather than a sexual dysfunction. Ideally there are three professionals involved in assessment and treatment of chronic sexual pain problems: a couples sex therapist, a gynecologist or nurse practitioner with a specialty in sexual pain, and a female physical therapist with a specialty in female pelvic musculature. Consistent with a psychobiosocial approach, each member of the team has a valuable role in assessment and treatment. They function in a synergistic manner to help the woman and couple to reduce and manage pain, while promoting healthy female and couple sexuality.

A major difference between the psychobiosocial and the biomedical approach is the psychobiosocial focus on engaging in valued sexual activities in contrast to the biomedical focus on pain-free intercourse (although if this occurs during psychobiosocial treatment, it certainly is celebrated). In other words, for most women the goal is enjoyable couple sexuality (including but not limited to intercourse) without significant interference of pain. Ideally, painful sensations are substantially reduced and coped with, rather than the woman feeling that pain subverts her sexual desire and function. Sexual pain is recognized as multicausal and multidimensional, with large individual, couple, and cultural differences. As in any good sex

therapy, "one size does not fit all." Interventions are individualized for the woman and couple. A particularly valuable intervention includes mindfulness strategies with a focus on relaxation, breathing, awareness, and acceptance (Brotto & Woo, 2010; see also Barker, this volume).

In both ED and female sexual pain, as well as in a variety of other sexual problems, the complex, multidimensional, individualized psychobiosocial model is more likely to be of value to the individual and couple than the biomedical model.

Differences in relapse prevention

A meaningful difference between the biomedical and psychobiosocial approaches involves issues of relapse prevention and long-term sexual expectations. The stance of the biomedical model is clear-cut. Once the person returns to "normal" sexual function there is no need for a relapse prevention plan or discussion of sexual expectations. If a dysfunction were to reoccur, the patient would contact the physician and reinstate the medical intervention.

In the psychobiosocial model, a specific, individualized relapse prevention plan is an integral component of comprehensive couples sex therapy. Healthy sexuality needs time, mindful awareness, and energy. In the relapse prevention program, the most important dimensions are desire and satisfaction. Although arousal, intercourse, and orgasm are highly valued, "normal" sexual function is not the key factor or even a particularly meaningful concept.

Both "booster" sessions and six-month "check-in" sessions over a two-year period following treatment are highly recommended. These sessions keep the couple accountable and motivated. The function of a booster session—scheduled within days to two weeks after a negative sexual encounter—is to assess whether this is a normal setback or whether the dysfunctional experience is a sign of a larger problem requiring additional treatment. The function of the check-in session is to reinforce sexual gains and set a new goal for the next six months. Sexual problems can easily reoccur and reestablish the negative cycle of anticipatory anxiety, tense intercourse, and frustration leading to avoidance. Thus, additional treatment may be necessary.

Comprehensive treatment sets the stage for a thorough, individualized relapse prevention program. Sexual problems do have a high risk of relapse, especially desire problems and erectile dysfunction (Althof *et al.*, 2005). In the psychobiosocial model, the core prevention strategy is the acceptance of the Good Enough Sex model by the man, woman, and couple (Metz & McCarthy, 2012). In terms of sexual expectations, the Good Enough Sex model is based on the inherent variability and flexibility of couple sexuality. Of course, mutual, functional sexual experiences are most highly valued. However, when the sexual encounter does not flow to intercourse, the couple can comfortably transition (without panic or apology) to either a sensuous, cuddly scenario, or an erotic, non-intercourse scenario. Similarly, mutual erotic scenarios where both partners are orgasmic are highly valued. However, asynchronous erotic scenarios where one partner is orgasmic while the other partner may be willingly and cheerfully "going along for the ride" are accepted and normalized. Asynchronous pleasuring, erotic, and intercourse scenarios are all part of a broad-based couple sexual repertoire. Asynchronous sexual expression is healthy for the couple as long as there is a clear agreement that it is not at the expense of the partner or the relationship.

The psychobiosocial model emphasizes a strong, resilient approach to psychological, biological, and social/relational factors in reinforcing sexual function and satisfaction. Psychologically, maintaining healthy sexual attitudes, behavior, and feelings is vital, as is embracing the variable, flexible, Good Enough Sex model. Biologically, maintaining good health and behavioral habits (e.g., sleeping, exercising, eating well, moderate or no alcohol, no smoking) promotes sexual health and function. With illness, aging, and medication side-effects, it is important to use the physician and medication resources in a positive manner.

The psychobiosocial model emphasizes integrating pro-sexual medications (e.g., Viagra, Cialis, and testosterone) into the couple sexual style of intimacy, pleasuring, and eroticism rather than using them as a stand-alone intervention (McCarthy & Metz, 2008). As physiological sexual response becomes more vulnerable (due to age, illness, or other factors), emphasis on psychological, relational, and especially psychosexual skill resources is necessary to compensate for less efficient physiological systems and less predictable sexual response.

Socially, it is very important for relapse prevention and long-term sexual satisfaction to confront the cultural and media stereotypes that the best sex is new, dramatic, romantic, passionate, erotic, and ideal. Although sex may approach this ideal at the beginning of the relationship, this romantic love/passionate sex/idealization phase of a relationship is powerful but very fragile, typically lasting only six months to two years. The challenge for married or partnered couples is to develop a couple sexual style focused on strong, resilient sexual desire. Valuing variable, flexible couple sexuality and embracing the Good Enough Sex model would be a major cultural breakthrough. Unfortunately, this is a much more difficult challenge for men than women because the traditional approach to "first class" male sexuality emphasizes total predictability and control. From a social/cultural perspective, the concept of adopting a mutually acceptable couple sexual style and playing to the strengths of the chosen sexual style while monitoring potential vulnerabilities is an empowering strategy (McCarthy & McCarthy, 2009).

Relationally, the couple needs to reinforce being both intimate and erotic allies. The essence of the couple approach is that sexuality is a "team sport." Reinforcing healthy couple sexuality and preventing relapse entails increasing comfort with use of psychosexual skills. The best example is transitioning to intercourse at high levels of erotic flow and using multiple sources of stimulation during intercourse.

The psychobiosocial model emphasizes complexity in assessment and treatment, as well as relapse prevention. An active, comprehensive, individualized program is crucial to grow the sexual relationship and to guard against relapse.

Different implications for working with diverse clients

Kelly and Shelton (2013) noted that sex therapy has a strong bias toward heterosexual, young, well educated, Caucasian, middle-class, and physically healthy people. A challenge for clinicians is to be culturally aware and competent and to consider racial, ethnic, religious, class, and cultural components in assessment and treatment. This means not falling into negative stereotypes. Even more important is being aware of ethnic, cultural, religious, racial, and class sexual strengths. For example, Hispanic couples have traditionally valued marriage and family, and African-American couples have traditionally valued sexual vitality. In studies of different cultures, both Western and non-Western, as well as in studies of minorities in the US (especially gay men, Latinos, and African-Americans), it is clear that there are marked differences in sexual attitudes, behavior, emotions, and values (Hall & Graham, 2013).

Because the biomedical approach is primarily interested in physiological functioning, and because it assumes that all healthy bodies function in the same way, issues of diversity are typically ignored in the biomedical approach. Additionally, the biomedical model is strongly biased toward treatment of male sex dysfunction, while largely ignoring female sexual dysfunction, especially the role of female sexual pleasure and sexual equity. The biomedical model is often more acceptable to men than women because of its focus on individual sexual performance and intercourse as the measure of success. This is a special problem for cultures with traditional power differences between men and women.

Regarding diversity issues, the social dimension of the psychobiosocial model plays a major role that is largely ignored in the biomedical model. There are a myriad of possible

cultural/social/value issues that impact upon sexual satisfaction, including sexual orientation, gender roles, sex for fertility vs. pleasure, the sexual double standard regarding affairs, and shame about sexual trauma. All of these factors deserve to be considered not just in assessment and treatment, but also in terms of therapeutic outcomes and sexual satisfaction.

Diversity adds an important and complex set of issues to sexual function and dysfunction models. This complexity is best understood and dealt with by utilizing the psychobiosocial model. Additionally, it is important to be aware of potential dangers of the biomedical model, especially regarding issues of gender and power inequality.

Case Example of Treatment Using the Psychobiosocial Approach: Elizabeth and Porter

Now that we have made the case that the psychobiosocial approach is superior to the biomedical approach in treating a variety of sexual concerns, we will describe the case of Elizabeth and Porter to illustrate the application of this approach. When Elizabeth and Porter arrived for their first session, it was clear they were a drained and demoralized couple. This was a second marriage for 33 year-old Elizabeth. Although 29 year-old Porter had been in a six-year cohabitation relationship that ended destructively, this was his first marriage. Before their marriage of 28 months, Porter and Elizabeth had agreed they wanted a satisfying, stable marriage and two children.

Like most couples, Elizabeth and Porter had never had a discussion about individual and couple sexual strengths and vulnerabilities. These became clear to the therapist through individual meetings with each member of the couple. Porter acted as a "sexual pleaser" as a way to compensate for his lifelong sexual dysfunction—ejaculatory inhibition (a condition also labeled delayed ejaculation). As a college student, women and male peers had been impressed by Porter's "staying power." He would almost never ejaculate in the first three intercourse encounters with a new partner. Subsequently, he would ejaculate approximately 50% of the time after 20–30 minutes of thrusting. After six months in a relationship, Porter usually experienced both a decrease in desire and a major worsening of ejaculatory inhibition. Porter developed a pattern in which intercourse was for the woman and masturbation for him; he masturbated three to four times a week and had no difficulty reaching orgasm during masturbation. His long-term cohabitating relationship ended with the woman labeling Porter a "sexual weirdo," saying that she felt sexually used and humiliated because of his ejaculatory inhibition. As a result, Porter was extremely avoidant of discussing sexuality with Elizabeth because he feared that she would blame and shame him. Porter genuinely loved his wife and wanted this to be a successful marriage with children. However, at this point he was feeling helpless and hopeless.

Elizabeth presented with a completely different set of psychological/relational/sexual strengths and vulnerabilities. She had an unplanned pregnancy at 16 and another at 23. Both times she chose an abortion due to her commitment to educational and career goals, but she had every intention of having children once married. Elizabeth was a psychologically-minded person who was pro-relationship and pro-sexual. Her first marriage (at age 26) ended after 11 months when she discovered her husband was having an affair with an old girlfriend. She was shocked to find that he did not value a traditional marriage bond with a commitment to monogamy. Although hurt and disappointed by the divorce, Elizabeth was resilient and highly motivated to establish a satisfying, stable, sexual marriage and a four-person family.

When Elizabeth met Porter, she saw him as a perfect potential spouse with his commitment to traditional monogamy and marital stability. This was Elizabeth's first experience with ejaculatory inhibition, but Porter was very solicitous about her emotional and sexual feelings. Thus, Elizabeth

convinced herself that, with greater love, communication, and commitment, they would be intimate sexual soul mates.

As illustrated here, the advantage of individual psychological/relational/sexual histories is that it gives the therapist a clearer, less defensive, truer understanding of each person's strengths and vulnerabilities. Elizabeth and Porter illustrate the importance of the four-session assessment process (McCarthy & Thestrup, 2008*). This process involves an initial couples session, the individual psychological/relational/sexual history session with each partner, and then a 90-minute couple feedback session. If the psychological/relational/sexual session history is done with the partner present, it is likely the clinician will hear a "sanitized" version. Individual sessions elicit a clearer picture of psychological/relational/sexual strengths and vulnerabilities. In addition, health factors, medications, and health habits can be evaluated during the individual assessment.*

In Elizabeth and Porter's case, the first couples session was painful for everyone, as this was the fourth couple therapist they had consulted, and they had been in infertility treatment for over 18 months. More than any other sexual issue—including a non-sexual relationship and extra-marital affairs—infertility drains emotional and sexual energy (Schmidt, 2006*). With every passing month, the stress, financial costs, and hopelessness increased. Elizabeth was unsure whether to blame herself, Porter, or their relationship for the inhibited sexual desire. The core issues for Elizabeth were guilt and shame about the past and panic that she would not have the life, marriage, sexuality, and family that she very much wanted. The core issues for Porter were his fear of Elizabeth's judgment and abandonment, coupled with a powerful need to hide the reality of his ejaculatory inhibition and inhibited desire with couple sex.*

The 90-minute couples feedback session is a crucial component that bridges the assessment and therapy phases. The feedback session allows the couple to explore individual and couple strengths and vulnerabilities. They assess how these issues have contributed to the sexual problem, adopt a comprehensive treatment plan, and receive their first psychosexual skill homework exercise to be done in the privacy of their home. There are three foci: (1) a new individual and couple narrative that is genuine and motivating, (2) an agreement on a therapeutic plan and goals, and (3) assignment of the first psychosexual skill exercise to reinforce the therapeutic strategy that half of the therapy occurs in the office and the other half in the privacy of the couple's home (McCarthy & McCarthy, 2012).

The major psychological issue in this case was to motivate Elizabeth and Porter to view sexual desire as a couple challenge. They needed to rebuild positive anticipation, and they deserved for desire, pleasure, eroticism, and satisfaction to be part of their marriage. Rekindling desire is both an individual and couple challenge. Your partner cannot give you desire or force desire on you. Desire is a prime example of the personal responsibility/intimate sexual team model of change. Healthy relationships are based on a positive influence process, which is especially true of couple sexuality. Power struggles and shame poison sexual desire. Accepting the partner's "sexual voice" (i.e., autonomy) and viewing each other as both intimate and erotic friends who are open to pleasure and erotic scenarios will promote desire.

Elizabeth and Porter found the focus on sexual desire as a couple challenge refreshing and motivating. They realized that this was much-needed input. They needed to rebuild intimacy/pleasure/eroticism so they could bring a new, energized focus to the infertility issue.

Elizabeth was urged by the therapist and by Porter to ask the infertility doctor important fertility and sexual function questions. When the responses from the doctor were unsatisfactory, Porter and Elizabeth decided to seek a new infertility team who were open to a comprehensive medical/sexological assessment and treatment approach. Porter needed to take an affirmative role rather than be controlled by shame about ejaculatory inhibition—an issue that had been ignored by the previous infertility specialist. Porter and Elizabeth interviewed two specialists before choosing a gynecologist with whom they felt comfortable and who utilized an integrative team approach. From the beginning with this new physician, Porter was involved in the infertility process and

forthcoming about his ejaculatory inhibition. The infertility team encouraged Porter to continue couples sex therapy, but in terms of the fertility program, strongly advised using insemination with his sperm. Porter and Elizabeth were reassured to learn that technically insemination was a more effective way to achieve pregnancy than intercourse. In fact, they became pregnant at the third insemination, although sadly it resulted in a miscarriage. Four months later they had a successful insemination, ultimately resulting in a healthy baby.

From a relational perspective, Elizabeth and Porter were learning to be an intimate sexual team in dealing with desire, (in)fertility, and ejaculatory inhibition. With reduced anxiety and defensiveness, Porter (with Elizabeth's active involvement) was able to implement the core strategies to overcome ejaculatory inhibition: (1) transition to intercourse at high levels of erotic flow, (2) utilize multiple sources of stimulation during intercourse, and (3) use "orgasm triggers" (movements, thoughts, sensations to transition from high erotic flow to orgasm; Metz & McCarthy, 2007a*). Porter gave himself permission to be "sexually selfish" by using self-stimulation as part of the pleasuring/eroticism process; by requesting a more rhythmic, focused technique of fellatio; by using erotic fantasies both before and during intercourse; by receiving multiple sources of stimulation during intercourse, especially testicular stimulation; by changing thrusting rhythm and intercourse positions; and by internally verbalizing wanting to come, which was his orgasm trigger. Porter had been afraid Elizabeth would be turned off by his erotic techniques, but in fact, his being an involved erotic partner was a turn-on for her (an example of partner interaction arousal).*

In situations where Porter could not reach an erotic flow with intercourse, rather than continuing to thrust, he said to Elizabeth (without panicking or apologizing), "Let me pleasure myself to orgasm." In this situation, she would hold him and provide testicular stimulation to enhance erotic flow and orgasm.

At the termination of the sex therapy sessions, Porter and Elizabeth discussed a relapse prevention plan. Their plan included six-month follow-up sessions over two years. If either desire or ejaculatory inhibition again became problematic, they would schedule a "booster session." They realized that maintaining desire, pleasure, eroticism, and satisfaction required continued communication and energy. Sexuality cannot "rest on its laurels." Elizabeth and Porter had come too far to allow a sexual relapse. They were committed to maintaining a satisfying, stable, and sexual marriage as well as enjoy parenting.

Summary

This chapter explored two models for understanding, assessing, and treating sexual problems: the biomedical model and the psychobiosocial model. The primary strength of the biomedical model is its specificity and recognition of the crucial role of biological/medical factors in sexuality, especially vascular, neurological, and hormonal factors. Many of the recent advances in understanding and changing sexual dysfunction have occurred as a result of sexual medicine research, including studies funded by pharmaceutical companies. However, we believe the more comprehensive psychobiosocial model provides a better approach to understanding and treating sexual function and dysfunction, especially a couple approach focusing on desire, pleasure, eroticism, and positive, realistic sexual expectations that lead to sexual satisfaction.

The problem with the biomedical model, which focuses on individual sexual performance and "normal" sexual function, is that it sets unrealistic and intimidating norms for real-life couples. Alternatively, a psychobiosocial approach that promotes the Good Enough Sex model is both positive and realistic, and encourages individual and couple acceptance and satisfaction.

An important factor for sex researchers and clinicians to acknowledge is that human sexuality is multicausal, multidimensional, with large individual, couple, cultural, and value differences. This is crucial in assessing and treating male, female, and couple sexual dysfunction. Whether a physician, psychologist, or couples therapist, the professional needs to assess carefully the psychological, biological, and social/relational factors, and then provide comprehensive treatment to promote desire, pleasure, eroticism, and satisfaction.

Our advocacy for the psychobiosocial model, concepts, and terminology is to emphasize sexual dysfunction issues as primarily a couple/interpersonal concern rather than an individual issue of sexual performance for intercourse and orgasm. A couples comprehensive, integrative approach to assessment and treatment, as well as a focus on relapse prevention and generalizing sexual gains to enhance relationship satisfaction, is the better fit to help individuals and couples to experience sexual desire and satisfaction.

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13

A Systemic Approach to Sex Therapy

Katherine M. Hertlein and Matthew Nelson

Introduction

A young couple came to counseling seeking help with sexual problems. The couple had been married for approximately six years and had two children, aged 4 and 1. The husband complained that his wife didn't seem interested in him anymore and that he was feeling neglected. The wife complained that she didn't feel appreciated or attractive to her husband anymore. Each of them was placing the blame for the situation squarely on the shoulders of the other; neither wanted to admit that they were part of the problem. For example, when he was asked for potential solutions, the husband stated that she "just needed to pick herself up and move forward." Each of them was looking at the other as the source of the problem and therefore the solution was to fix the other person. What they were missing was the systemic nature of the problem.

Fragmentation in MFT and Sex Therapy Fields

As clearly systemic as sexual problems are, there are few contexts in which systems theory and principles of sex therapy are integrated (Hertlein & Weeks, 2008). From a professional lens, there are several different organizations devoted to promoting couples therapy (e.g., the American Association for Marriage and Family Therapy, AAMFT), separate organizations related to sex therapy (e.g., the American Association of Sexuality Educators, Counselors, and Therapists, AASECT; and Society for Sex Therapy and Research, SSTAR), but little overlap between the members of these organizations. In addition, training around areas of sexuality within accredited couples and family therapy graduate programs is left largely up to the program, as programs are responsible for developing their own educational objectives, outcomes, and assessment procedures. In short, couples and family therapy programs are permitted to establish their own standards for the inclusion (or exclusion) of the treatment of sexual problems as part of their training program. Given the many other demands of the training programs paired with the complexity of treating sexual problems, training related to systemic sex therapy must be minimal—at best—within marriage and family therapy (MFT) training programs.

In addition to fragmentation at the level of training, academic journals also reflect a lack of integration between couples work and sex therapy. Few articles published in top sexuality journals such as *Archives of Sexual Behavior*, the *Journal of Sex and Marital Therapy*, and the *Journal of Sex Research* attend to the interactional, dynamic, or relational theories that serve as

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the foundation of a systemic sex therapy perspective (Hertlein & Weeks, 2008). In addition, a practicing couples therapy clinician outside of an academic setting will probably not have access to these sexuality journals without membership of specific sexuality-related professional organizations (Lambert-Shute, Hertlein, & Piercy, 2009). Given that these organizations, as discussed earlier, are notably separate from couples therapy organizations, this provides another barrier to integration. Despite the fragmentation, systemic sex therapy is uniquely suited to treating the interrelated individual and systemic causes of a couple's sexual problems.

Overview of Systemic Sex Therapy

In order to discuss systemic sex therapy, it is necessary to give a definition to the term "systems". De Shazer (1991) wrote that the "'system' is an abstraction involving the perception that the whole is different from the sum of the system's parts" (p. 19). A family, for example, is a system because, when a change is made to one area of the system, the rest of the system will also make changes. Consider the changes to the system if the husband described above were to pay the wife a sincere compliment regarding her attractiveness to him. Perhaps this small change would spark in her a desire to put greater effort into her appearance around him, which, in turn, would prompt more compliments from him. Thus, her self-esteem would increase and allow her to feel comfortable being intimate with him again.

There are three key features that apply to all systems, which can help to elucidate the role of systems when working in sex therapy:

1 Systems rely on the concept of *wholeness*, such that a change in one area of the system will necessarily affect the system as a whole (de Shazer, 1991). The non-summative nature of systems dictates that the parts are not independent of each other, but rather have a coherence that is unique to that system (Becvar & Becvar, 1999). For example, a partner learns that she will be losing her source of employment soon. Consistent with the concept of wholeness, this information affects not just that individual, but also her partner and any children in the relationship, as money becomes an issue. The way in which the family handles the difficulty is an experience that is unique to this system because they are the only ones experiencing that exact set of circumstances.
2 The next feature of systems is *equifinality*, which refers to the fact that different starting points and paths will lead to the same results. This allows the therapist to enter the here-and-now and view the present interactions as examples of the end result of many other prior interactions. An example of this would be a therapist highlighting unhealthy communication patterns that lead to conflict. The therapist would use specific examples to showcase the larger patterns in the couple dynamic.
3 The final feature is *circular causality,* which helps to move away from blame or guilt by promoting the understanding that each person gets 50% of the responsibility for each action within the system (Becvar & Becvar, 1999). This concept can be difficult as many people are accustomed to thinking in a linear fashion (i.e., A causes B which results in C). In the linear model, one event caused the subsequent actions. Couples fall into this type of thinking when blaming occurs, not realizing that they had a part in the final result. A fight about the frequency in which a couple engages in sexual relations can demonstrate the circular causality. The husband may be thinking that the wife is not interested in his advances, while the wife is thinking that the husband is not as romantic as he once used to be, and so she experiences a diminished interest. Meanwhile, the repeated denials from the wife cause the husband to wonder if it is because he experienced difficulty in maintaining an erection previously. Circular causality means that blame cannot be isolated to just one incident or person, rather it is part of a larger system of events and feelings.

Systemic sex therapy relies on this view of individuals, couples, and families. Systemic sex therapists evaluate the quality of a couple's relationship as well as the broader context surrounding the sexual problem. Systemic sex therapy is an integrative paradigm, which addresses the cognitions, emotions, and behaviors surrounding the sexual behavior rather than prescribing interventions rooted in only one of those areas. In so doing, it attends to the complex context in which the sexual difficulty is embedded and increases the likelihood of effective treatment. To achieve these goals, a systemic approach to sex therapy is informed by two key theoretical constructs: the Intersystem approach (Weeks & Hof, 1987) and the interactional components perspective, both of which will be discussed in the remainder of this chapter.

The Intersystem Approach: Five Dimensions of Assessment and Intervention

The Intersystem approach has previously been applied to the treatment of a number of clinical sexual concerns such as erectile dysfunction, hypoactive sexual desire disorder, and infidelity (Weeks & Gambescia, 2000, 2002; Weeks, Gambescia, & Jenkins, 2003). This approach to therapy encompasses five different areas, which each contribute to the overall scope of treatment: individual biology, individual psychology, dyadic issues, family-of-origin issues, and sociocultural issues. The therapist's response to each of these factors is discussed in each section below.

The Intersystem theory has not been empirically tested as a whole, but many studies have acknowledged the interplay of multiple factors contributing to the development and maintenance of sexual problems (Jha & Thakar, 2010; Palacios, Castaño, & Grazziotin, 2009). The following section will examine some of the studies for each component of the Intersystem approach.

Individual biology

Biological functioning for each individual is an important first step in the assessment and treatment of sexual problems in any couple. An abundance of literature is available examining the physical contributions to sexual dysfunction (Hughes, Hertlein, & Hagey, 2011), such as the well-documented evidence that erectile dysfunction can be caused by diabetes (Malavige & Levy, 2009; Thorve *et al.*, 2011). A study looking at patients with diabetes found a high prevalence of sexual dysfunctions for both genders (Ziaei-Rad, Vahdaninia, & Montazeri, 2010). In women, for example, the result can be lubrication problems, orgasm problems, and decreased libido (Meeking, Fosbury, & Cummings, 2013). Other physical conditions associated with increases in sexual dysfunction include cardiovascular problems (Bispo, Lima Lopes, & Barros, 2013; Jackson, 2009; Morrison, Aitchison, Connelly, & Mair, 2011; Nascimento *et al.*, 2013; Steinke, 2010), multiple sclerosis (Khan, Pallant, Ng, & Whishaw, 2011), renal conditions (Moriyama, 2011), neurological disorders (Matthews, 2009), Parkinson's disease (Hand, Gray, Chandler, & Walker, 2010), endocrine disorders (Bhasin, Enzlin, Coviello, & Basson, 2007), and prostate disease (Kim, 2011; Kuehn, 2012).

In addition, health behaviors can impact sexual functioning. For example, smoking—and even passive exposure to smoking—can almost double the likelihood of moderate or severe erectile dysfunction in men (Feldman *et al.*, 2000). Obesity and/or being overweight has also been shown to contribute to sexual dysfunction in women (Erenel & Kilinc, 2013; Yaylali, Tekekoglu, & Akin, 2010).

Medications can cause disruption in one's sexual functioning (Kaufman & Struck, 2011). Evans, Buck, and Conner (2005) reported that patients receiving antihypertensive medications were more likely to report erectile dysfunction than those patients not receiving medications

for hypertension. Those findings were corroborated by Bailie *et al.* (2007). Antidepressants—specifically the selective serotonin reuptake inhibitors (SSRIs)—have also been known to impact sexual functioning, specifically with regard to enjoyment and arousal (Segraves & Balon, 2003; Taylor *et al.*, 2013). Antipsychotic medications have a notable impact on sexual functioning, resulting in erectile dysfunction and retrograde ejaculation for men, and vaginal lubrication and arousal problems for women (Castaño *et al.*, 2008; Smith, O'Keane, & Murray, 2002; Uçok, Incesu, Aker, & Erkoç, 2007). In addition to screening for prescription drug use, it is important to review with the clients any over-the-counter medications, as well as any herbal or vitamin supplements being taken. Research suggests that, for men, the more medications that are being taken, the more likely it is that erectile dysfunction will be a problem (Kotz, 2011). In addition, medications may have effects that persist after one stops taking the medication (Bahrick, 2008), so recently discontinued medications should be reviewed as well. Sending clients to visit their primary care physician for a physical may be warranted to help identify whether there are any biological factors present that may be causing sexual dysfunction.

Awareness of any sexual limitations caused by medical conditions or treatments may help to open conversations between partners about what is possible sexually and what is beyond the capabilities of each partner. This communication becomes even more important when working with a client who has cancer or other long-term illness, as these situations can cause a decrease in sexual desire and other problems (see also Zhou & Bober, this volume).

In order to uncover and address biological issues that are contributing to the problem, the therapist should conduct an assessment that will reveal any conditions which may be contributing to the sexual problem. In many cases, the therapist's response should also include collaboration with any medical professionals to coordinate treatment. In addition, therapists can respond by gaining more education about the impact of various conditions on sexuality through training, reading published journal articles, or other means.

Individual psychology

Individual psychology comprises factors such as: personality, psychopathology, intelligence, temperament, developmental stage, attitudes, and defense mechanisms (Hertlein, Weeks, & Sendak, 2009). This list is not all-inclusive, but rather an example of factors to be considered. Included in this category are potential mental health issues that may negatively impact sexuality. Among such issues, depression is generally considered to be one of the most common. The Centers for Disease Control and Prevention (2014) estimated that 7.6% of adults experienced symptoms of a depressive disorder during the two weeks preceding their national survey. In Portugal, prevalence estimates are as high as 20% of the population (Lourenço, Azevedo, & Gouveia, 2011). In a study by Lourenço *et al.* (2011), more severe depression was associated with lower sexual desire. Along with depression, other internalizing disorders, specifically anxiety disorders, have been found to be related to sexual dysfunction (Laurent & Simons, 2009).

Within the context of individual psychology, studies have shown that the immediate emotional state of each individual in a sexual relationship is important, as the emotional states have been linked to the level of sexual arousal experienced by the individual. For example, Laan, Everaerd, Velde, and Geer (1995) found that women who reported higher in-the-moment joy levels felt more aroused after viewing erotic films than women with lower joy levels. In men, it was shown that there was an initial delay in sexual arousal when the men were experiencing depressed affect, showing men's arousal is also influenced by their immediate mood states (Meisler & Carey, 1991).

Another relevant area of individual psychology is the sexual knowledge of the individual. What exactly does he or she understand about various sexual activities? Is there a lack of

information that could be preventing enjoyment of sexual activities? Does the individual hold any beliefs that sex is sinful or shameful? Nobre and Pinto-Gouveia (2008) observed that sexual conservatism seemed to be closely related to hypoactive sexual desire. Further, they found negative cognitive beliefs about physical appearance also seemed to contribute to orgasmic difficulties. These negative beliefs included such low self-body image thoughts as "an ugly woman is not capable of sexually satisfying her partner" (Nobre & Pinto-Gouveia, 2008, p. 339). The beliefs one holds about sex play an important role in sexual functioning and satisfaction.

The therapist can respond to individual psychological barriers in ways that are consistent with the psychological issue contributing to the problem. For example, if a feeling such as guilt is affecting the sexual relationship, this feeling may be worked on alone or in an individually-focused session with the other partner present. Evidence-based therapies such as cognitive-behavioral therapy may be effective in reducing the power behind negative cognitions and their impact on the individual and, consequently, the couples system.

Dyadic issues

Although each partner brings his or her individual beliefs, assumptions, and behaviors into the relationship, the couple consists of a blending of the two individuals, which can cause incongruences and dysfunction. In addition to conflicting beliefs and understandings related to sexuality within the relationship, there exist a host of stressors that can arise both within the relationship and from outside sources. Couples experiencing high levels of stress within the dyad have been reported as having lower levels of marital and sexual satisfaction, coupled with lower levels of sexual activity in general (Bodenmann, Ledermann, & Bradbury, 2007). In addition, couples with ineffective conflict-management strategies have also been shown to be at risk for the development of sexual dysfunction (Metz & Epstein, 2002). Another issue potentially related to sexual dysfunction in couples is power and control. In a sample of Chinese participants, wives who reported less power and less gender equality in their relationship were more likely to experience sexual dysfunctions than wives with greater power and equality (Lau *et al.*, 2006). Finally, sexual incompatibility with one's partner (e.g., disagreements about the desired amount of foreplay) has been shown to contribute to desire and orgasm disorders in women (Witting *et al.*, 2008).

Other examples of issues that couples experience include physical and/or emotional abuse within the relationship, negative cognitions about the relationship, differing perceptions of intimacy, and attachment injuries. One potential problem may be the existence of differing expectations for the relationship. Women's sense of having to be perfect has been shown to have a negative impact on not only their own level of marital satisfaction, but also their husbands' levels of satisfaction (DiBartolo & Barlow, 1996).

The appropriate therapeutic response to the dyadic issues is to work on strengthening the relationship in several key areas: communication, expectations, and relational confidence. In our experience, communication is key because the sexual issues generally existed within the couple for quite some time before they decided to seek therapy for them. In such cases, sexual problems have likely become a topic that has become associated with shame, guilt, and past arguments. Therapists can assist couples through the use of couples therapy sessions and exercises that are not focused specifically on the sexual issue. For example, they might employ a sofa session (i.e., homework assignments in which couples schedule time to sit together on the sofa and discuss increasingly challenging or intimate content) or other similar strategies to increase the quantity of safe communication. In cases in which poor communication has led the couple to experience attachment injuries, the therapist can work using theoretical approaches such as emotionally focused therapy (see Johnson, this volume) to improve the quality of the communication.

Couple expectations sometimes require a therapeutic response. In many cases, the expectations regarding the frequency and definition of intimacy in the couple's relationship will undergo a period of redefinition through the sex therapy process. The therapist can assist the couple with this redefinition by educating the couple about the processes and normalize the couple's feelings around it. Therapists can also respond by confidence-building with the couple. Again, as the couple has experienced problems over time, they enter the therapy room with a diminished faith in their ability to solve problems or even have a sexual relationship with one another. Therapists can acknowledge this loss of confidence and assist the couple in gaining it over time.

Working on strengthening the relationship can contribute to better sexual functioning, but it can also be difficult because couples who are eager to address their immediate sexual problems may not understand the shift in therapeutic focus from the sexual issue to the couple dynamics. The therapist should be prepared at the start of therapy to discuss the planned course of treatment and to highlight the impact that the problems outside of sex are having on the couple's sexual functioning.

Family-of-origin

Family-of-origin can be one place where messages about sex are first communicated. For example, the fact that some families do not discuss sexuality sends a message to the children in those families about the shame and secrecy associated with sex. The messages are sent covertly (e.g., by avoiding the topic of sex) or overtly (e.g., by reprimanding a child who speaks of sex), and the messages can be internalized by the child to a degree that the child may not be conscious of the messages. Smith and Cook (2008), for example, examined the impact of parents' sexual behaviors and attitudes on their adult daughters' help-seeking following a sexual assault. Their findings showed that women whose parents were inhibited about talking about sex were less likely to seek support from their parents following a sexual assault; the parents' inhibition likely contributed to the women's inhibition. In contrast, the majority of women "who received promoting messages about sexuality disclosed their assault to at least one parent or caregiver" (Smith & Cook, 2008, p. 1343). In another study, parents' open non-verbal communication about sex was associated with earlier onset of sexual activity, fewer sexual partners, and lower levels of sex guilt (Joffe & Franca-Koh, 2001). In particular, openness regarding nudity was associated with earlier onset of sexual activity, and greater levels of affection between parents was associated with fewer overall partners.

An inhibited type of sexual communication from an individual's family-of-origin is likely to carry over to adult relationships as well. If sex-negative communication is what an individual is used to, it may be difficult to discuss sexual problems, concerns, and conflicts with their partner and their therapist. Kinzl, Traweger, and Biebl (1995) found that women with any kind of sexual disorder tended to classify their relationship with their parents more negatively than women without a sexual disorder. They also had a more negative view of sexual education than women without sexual disorders.

A focused genogram detailing the family-of-origin experiences with sexuality and the messages that were sent about sexuality may be effective to assess these trends. The therapist can reference a book about focused genograms (e.g., DeMaria, Weeks, & Hof, 1999) or a book on how families influence sexuality (e.g., Zoldbrod, 2009). In many cases, the education around sexual behavior in families can provide insight and allow the client to remove self-blame as to how they are contributing to the problem. Another way that messages can be challenged is through participation in the Empty Chair Technique from Gestalt family therapy, in which clients can role-play, responding to and sharing their feelings with family members who are not present. Once the familial trends and messages are identified, the therapist and client can begin to challenge negative views and maladaptive patterns, and work to replace those messages with more positive ones.

Sociocultural issues

Much like the family-of-origin, there are traditions and values about sex that are derived from culture, the society around us, and religious influences. The increasingly diverse population of the US will likely result in more therapists treating clients from outside their own ethnic groups. It is no surprise that there are differences in the sexual attitudes across different ethnic groups. These cultural—and individual—differences include attitudes towards homosexuality, opinions about premarital and extramarital sex, and beliefs about appropriate and inappropriate gender roles (Ahrold & Meston, 2010). Knowing that attitudes about these concepts vary across cultures increases the need for awareness and sensitivity on the part of therapist when assessing and treating sexual problems. For example, masturbation is not accepted in some communities (Ahmed & Bhugra, 2007); this has implications for sex therapists who want to implement masturbatory training exercises with these populations.

It is also worth noting that variability within any ethnic group is as great as the variability between groups (Ramirez, 1984). Acculturation is the process whereby members of a minority group incorporate aspects of the mainstream culture within their heritage culture, and degree of acculturation is one factor that can lead to within-ethnic group variability in sexual attitudes and values. This can create an even greater challenge, as the therapist cannot make any assumptions about a client's beliefs based purely on their ethnicity or nationality-of-origin. Rather, the therapist and couple must work together to understand the impact that culture and society have had on the couple's sexual decision-making, values, and behaviors (Hertlein *et al.*, 2009).

The therapist's role in response to sociocultural issues is essentially to combat the messages in society that are not helpful or adaptive and that are contributing to the couple's problem, particularly if those messages are sociocultural myths. Masters and Johnson (1970) stated—quite simply—that lack of sexual information contributed to sexual problems. An absence of information can lead to a perpetuation of sexual myths that complicate couples' sexual problems. Although society's interest in sexuality may appear widespread, media and literature commonly portray myths about sex. Therapists need to address misinformation with couples and consider pairing the strategies for correcting misinformation with anxiety-reducing strategies. Ask each partner to list the maladaptive beliefs they have about their sexuality, and then help them to change those beliefs by (1) pointing out distortions in their cognitive processes, and (2) correcting inaccurate information about sexuality.

The Role of Interactional Components

Human systems are composed of at least two interacting people, with each person's behaviors and responses to the other person's behavior defining the nature of that relationship. This corresponds to the concept of *homeostasis* or system equilibrium, in which changes or responses in one person are responded to by the other in a way to maintain the system's original state. In many cases, the interactional information brought into a system occurs within the context of positive and negative feedback loops. Thus, as one person communicates fears or discomfort or stops a behavior, another person may respond to that with their own thoughts or with distancing. The interactional perspective suggests that maladaptive behavior is self-fulfilling (Claiborn & Lichtenberg, 1989). Maladaptive behavior occurs when one person uses the same strategies to respond to their partner no matter what the circumstances, thus impairing one's ability to gain feedback about their own behavior. For example, Landon and Patricia argued because Patricia felt unsafe in the relationship due to Landon's repetitive response to any issue Patricia raised—that is, he also blamed it on Patricia. In addition, because the structure in such relationships is usually set up with complementary roles, where one person has greater power than the other, the feedback loops and communication patterns are often defined by the individual with greater power (Claiborn & Lichtenberg, 1989).

With regard to systemic sex therapy, there are several ways in which the interactional perspective applies. First, because the non-sexual communication aspects of a couple's relationship affect their sexual relationship, understanding the quality of the clients' relationship and how it manifests in the sexual encounters is critical. For example, Sally and Marcus had been struggling with their sexual relationship since Sally was diagnosed with bipolar disorder. As a result of her interpretation of the diagnosis as indicating that she is "damaged," she began to act like she was damaged, in both emotional and sexual ways. Marcus reinforced this idea by agreeing that she was the one with whom the power in the relationship resided, and stated "once Sally gets better, we won't have any problems."

Second, a couple's sex life is where many of their interactional exchanges emerge. Both partners are participants in the sexual encounter and make meaning of their partner's behavior in the sexual context. For example, if Francine's advances are rebuffed by Martin, this may result in Francine interpreting this as a sign that she is unwanted, and she may not feel safe to initiate future sexual interactions.

The Intersystems approach is informed by the interactional perspective (Strong & Claiborn, 1982). The interactional perspective is rooted in the fact that one's interactions are shaped by others, the environment, and the context (i.e., the dyadic, family-of-origin, and sociocultural dimensions of the Intersystems approach). Four main principles (Claiborn & Lichtenberg, 1989) guide this perspective: (1) One's behaviors are the result of a continuous influence of other people and the environment; (2) the individual is an active participant in these interactions, such that the influence is bidirectional (known as reciprocal causality); (3) cognitive factors are key; and (4) the psychological meaning one makes of the interaction is essential to understanding her or his behavior. In other words, both people in the interaction have responsibility for choosing their responses, and together they shape their interaction. Behaviors and emotions become messages sent between the actors (Claiborn & Lichtenberg, 1989) and, in many cases, then become punctuated with other behaviors. For example, Josie stated her partner's orgasms were not strong enough and believed that the reason was her inability to pleasure her partner. Her perception of her partner's lack of pleasure and her subsequent ownership of it created distress in her. Although her partner did not indicate any such feeling, Josie's decision that she was not pleasing him contributed to her decision to avoid sexual situations. Therefore, the message (fear) was punctuated with a particular behavior (avoidance). In turn, Josie's partner began to feel undesired and, consequently, began to avoid her. In applying the four principles mentioned above, the environment and context contributed to Josie's cognitive interpretation that her performance was not stimulating enough for her partner, thus affecting her behavior. Her behavior of withdrawing affected her partner's behavior and contributed to more withdrawal by both parties.

Case Example

Ainslie and Derrick sought couples therapy to address their constant bickering. They stated that they fought every couple of weeks and that their fights were not productive and did not lead to resolution. Specifically, Ainslie stated that, when she got upset, she ran to the bedroom. Derrick pursued her, which created even more fear in her, and the fights escalated. Ainslie indicated that her fear and anger were triggered by the fact that her husband called her names and banged at the door when she locked herself in the bedroom. Derrick agreed that the cycle was not working and that the couple needed another way to communicate about differences, and he minimized his behavior when Ainslie characterized it as "violent." However, Derrick had, on a few occasions, drunk to the point of blacking out. It was during these times that he became physically threatening to Ainslie (e.g., chasing her as she ran out to her car), screamed obscenities at her, and yelled at her from outdoors if she was inside the house. These instances, though far and few between, weighed heavily on

Ainslie and contributed significantly to her hypervigilance when Derrick was angry. During the initial couples sessions, Ainslie claimed that she only married Derrick because he was a "problem to be fixed." Derrick responded by telling her that, if she wasn't happy in the marriage, she should move home with her parents and stop acting like a child, and he ended the conversation abruptly.

Ainslie was a student in a graduate program, while Derrick owned his own business and was in sales. The couple dated for two years prior to getting married and had been married for two years. Neither of their families lived close to them, although Ainslie reported that she was in constant contact with her family and spoke to her mother at least three times a day. The couple noted that they had been having problems since approximately eight months prior to their wedding day—nearly three years total. In therapy, Ainslie was the more vocal of the two in discussing the deterioration of their relationship, particularly the sexual aspect of the relationship. She maintained detailed records of the couple's sex life and noted a significant decline in sexual activity after they had become engaged. She stated that, by the time the wedding day arrived, she and Derrick had not had sex in two months. Over the past two years of marriage, Ainslie indicated the couple had had sex 11 times.

The therapist asked about the couple's sexual interactions and tried to understand how the couple usually initiated and maintained sexual interactions. Ainslie stated that she was "always" the initiator of the interactions. She stated that one of her favorite things was trading touch and holding hands with Derrick but that, very frequently, things would not progress beyond that level. Derrick stated that he sometimes tried to begin sexual interaction with foreplay (e.g., stroking, fondling, etc.) but that Ainslie was always interested in getting to the "main event" (i.e., intercourse). Ainslie agreed that she rebuffed his attempts at foreplay and just wanted to get to having sex. Her lack of appreciation for foreplay, dismissal of his desires, and sole interest in wanting penetration immediately was a turn-off to Derrick, thus compromising his experience of their sex life. Ainslie stated that she generally started their sexual activity by touching him and "grinding" on him until she was able to orgasm. Afterward, she would go to sleep before he would orgasm.

Derrick also discussed the context of their sexual activity. He stated that Ainslie was in control of many of their interactions—sexual and otherwise. For example, Ainslie had a history of ordering off the menu for both Derrick and herself at restaurants, and of controlling the finances in the relationship, berating Derrick if he spent money while she was able to spend the money freely. Similar themes also were observed in session, with Ainslie frequently interrupting Derrick and making corrections to his comments when he tried to speak. With regard to their intimate relationship, Derrick stated that, during sexual touching, he was not allowed to wear what he wore to work, and Ainslie demanded he take a shower every day after work before she would touch him. Ainslie indicated that this was due to her fear of germs. In addition, Ainslie slept covered in layers of clothes, from head to toe, as a way to hide herself. Ainslie reported that this was because her body image was so bad that she didn't want to be seen. She only removed her clothes if she was interested in some physical activity; then she bundled back up and went to sleep.

When asked what their goals were, Derrick indicated he wanted to want sex with Ainslie, but that he wanted her to decrease her demands of him and improve her poor self-esteem, as both were impairing his desire to have sex with her. He stated that everything had to be Ainslie's way all of the time and that he lost interest in sex as a result. Ainslie's response was that she wanted to have sex more frequently with Derrick and that she wanted their arguments to stop.

Intersystem assessment

In the assessment phase of treatment, the therapist reviewed several key dimensions. First, the therapist evaluated the individual biological issues that each member of the couple could be contributing to the problem. Derrick reported that he was taking antidepressants and that these had a noticeable impact on his sexual arousal. In addition, both members of the couple noted that they had poor eating habits, which might have been contributing to their low levels of energy to devote to each other at the end of the day.

Second, individual psychological issues were assessed. Derrick indicated that he had been suffering with depression for the last two years for which he was taking an antidepressant. This antidepressant as well as the depression might have been contributing to his lack of desire. Ainslie acknowledged that she experienced a great deal of anxiety, and it had grown worse over the course of her marriage. She noted that her anxiety manifested in several ways, such as some of the obsessive-compulsive behaviors mentioned earlier, as well as in tears and "being mean" when she was highly anxious as a way to "protect" herself. Ainslie also indicated she previously suffered from eating disorders, as well as other significant body image issues (i.e., body dysmorphia). Such issues contributed to her decision to stay bundled up in clothes while in bed with Derrick. In addition, Ainslie had been traumatized by a prior abusive relationship, which launched her into a near-panic attack whenever the two of them argued.

Next, the therapist reviewed the relevant couple issues at play. Most obvious was the issue of power and control present in the couple's relationship. Derrick admitted that his lack of interest in sex was a way to regain control of their sex lives. He stated that, until he was able to have some control in their relationship, he wasn't interested in having sex with Ainslie.

Family-of-origin issues also came into play. First, the couple's conflict was influenced by lessons learned from both of their parents. Ainslie stated that her father told her that she should never back down or be in situations in which she felt taken advantage of, or in which she wasn't getting what she wanted. In addition, Ainslie reported that her mother, when in conflict with her father, would run from the situation and never go back to deal with issues. Thus, Ainslie was living the relationship pattern she had learned. These strategies did not work in Ainslie's family, as her parents were in the process of divorcing at the time she was receiving treatment. As a result of the divorce, Ainslie spent much time and energy being triangulated by her parents in their divorce. Derrick observed that his father raised his voice and chased after people in the house as a strategy to deal with conflict, and Derrick, therefore, learned that behavior from him.

Sociocultural issues were also a factor for this couple. As the couple began to experience sexual difficulties, they often compared themselves to other couples with similar demographics. For example, Derrick stated that Ainslie would pressure him to have sex by sending him links and articles about the number of times the average couple has sex in a week.

Interactional components

This couple was also significantly impacted by the interactional components within the relationship (Strong & Claiborn, 1982*). For example, with regard to the couple's sexual interactions, Ainslie insisted that Derrick have sex with her, but he objected, creating a context in which she continued to feel unwanted. The meaning she made of this event was that she was not desired by Derrick. Once she had inferred this meaning, it fueled her behavior of keeping herself wrapped up in clothes at night in order to provide distance between her and her husband—and thus protect herself from the perception of his rejection. Ironically, though, the nighttime clothes contributed to Derrick's lack of interest in sex with Ainslie.*

Factors complicating treatment

The therapist also assessed additional factors complicating treatment (Hertlein et al., 2009*). One of the factors relevant for this couple was the fear of intimacy. For example, Ainslie's bedtime dress was a clear message to Derrick to stay away from her. Although she indicated that this was out of a need to hide her body, it ultimately served to increase the emotional distance between her and Derrick. Another factor complicating treatment for the couple was fear of loss of control, particularly for Ainslie. The fear of loss of control extended from the bedroom to other areas of the relationship. Derrick shared that Ainslie tried to control everything in their relationship—from the dates on which they would have children, to the manner in which the house would be cleaned, to what they*

would eat at restaurants. In addition, Ainslie was in control of the sexual interactions, thus preventing Derrick from experiencing sex in a way that was exciting to him. Derrick, in turn, attempted to take back control by refusing sex.

Systemic treatment

The treatment plan for Ainslie and Derrick was organized around reducing the vulnerabilities identified in the assessment phase, as illustrated in Table 13.1. Use of this table as a way to organize treatment was described in the text on systemic sex therapy (Hertlein, Weeks, & Gambescia, 2008*; Hertlein et al.,* 2009*). This table allows for the development of a treatment plan specific to all five Intersystem dimensions. The therapist's understanding of the goals and treatment plan are shared with the clients in an effort to (1) assess the accuracy of what the therapist has heard and understood with regard to the clients' concerns, and (2) invite the clients into and obtain their investment in the process of treatment.*

Individual biological *To address the individual biological level, both Ainslie and Derrick had to make a commitment to take better care of themselves physically. The couple discussed a plan to eat better and to manage stress more adaptively.*

Individual psychological *The individual psychology component was composed of two different aspects. First, the couple's therapist advised that Ainslie seek individual treatment for her poor body image and her anxiety. Second, the therapist requested that Ainslie address in individual therapy her need to be in control; Ainslie was to identify ways in which she can be in the relationship without feeling as if she is giving up control and self-protection. Derrick, on the other hand, was instructed to do some work on his interactions with Ainslie when he was drinking. Derrick attended two treatment sessions before deciding to limit his alcohol intake to avoid future problems.*

Dyadic *Dyadic issues were addressed in two different ways. In the dyadic part of the treatment plan, Derrick was advised to write a love letter to Ainslie, as he had done in the past, and Ainslie was advised to communicate to Derrick how much she enjoys him. Ainslie indicated she had difficulty understanding the point of the assignment. The therapist and Ainslie discussed the importance of her giving up some control over the therapy process as well as the relationship.*

In another part of the treatment plan, the couple was instructed not to engage in sexual activity, as the topic was still surrounded by conflict. Until the couple could manage a sexual interaction without making negative attributions about the other's intentions, participating in sexual activity could lead to more instances of negative conditioning. For example, when Ainslie initiated sexual activity, if she noticed that Derrick did not respond, she felt rejected and became critical and argumentative. This, in turn, fueled Derrick's tendency to stay distant from her. Over time, Derrick had become conditioned to experience anxiety at the onset of a sexual encounter because of the expected response from Ainslie, and Ainslie had become conditioned to believe that Derrick would reject her. Eventually, as a way to condition the couple to respond positively to one another and to help the couple manage their anxiety about sexual interactions, the couple was advised to embark on a series of modified sensate-focus exercises. Specifically, Ainslie was asked to progressively remove one layer of clothing per day as she crawled into bed, paired with relaxation skills, as a way to get her more comfortable with her own body.

Another part of the dyadic treatment was to have Ainslie reduce the amount of criticism she expressed toward Derrick, and for Derrick to take ownership of the way he created fear through being violent toward Ainslie. Part of this involved providing education about the damaging effects that critical comments can have on the relationship, both inside and outside of the bedroom. Derrick was provided with education about the impact of his violence on Ainslie's hypervigilance. The couple worked to move toward a forgiveness session in which Derrick expressed genuine apologies for his actions.

Table 13.1 Intersystem assessment and treatment plan for Derrick and Ainslie.

	Vulnerability	*Goal*	*Plan*
Individual biology			
AINSLIE	Poor self-care	Manage self-care	Maintain management of self-care (e.g., improve diet)
DERRICK	Use of antidepressants	Manage self-care	Maintain management of self-care (e.g., improve diet); regular physician visits to monitor medication
Individual psychology			
AINSLIE	Fear of loss of control; anxiety; body image issues; history of abusive relationship	Minimize fear of losing control; reduce impact of previous abusive relationship on current relationship	Emotionally-focused couples therapy: individual treatment to address negative body image, anxiety, and need for control
DERRICK	Fear of loss of control; depression; alcohol problems; anger management problems	Minimize fear of losing control	Individual treatment to address alcohol abuse and anger management problems
Dyadic			
AINSLIE AND DERRICK	Poor communication and problem-solving skills; power struggles	Improve structure and process of communication; improve sex life; create a better balance of power in relationship	Identify patterns of communication; explain the reasons why couples struggle (Sanford, 2010); reclassify interactions as being related to power
Family-of-origin			
AINSLIE	Learned problematic patterns of communication; triangulation by Ainslie's parents	Learn different ways to be loyal to the family	Explore family patterns in greater depth (e.g., identify how her response in an argument was based on how she saw her parents operate)
DERRICK	Learned problematic patterns of communication	Learn different ways to be loyal to the family	Explore family patterns in greater depth (e.g., identify how his response in an argument was based on how he saw his parents operate)
Sociocultural			
AINSLIE AND DERRICK	Pressure to be sexual; "shoulds" in language	Develop a clear contract of life together	Discussion using new communication skills; develop social support

Family-of-origin *Family-of-origin issues were treated in two ways. First, the couple had to identify ways in which they could stay loyal to their family-of-origin without repeating the ineffective conflict patterns that they observed in their parents' interactions. Second, the couple had to put a boundary around their relationship—more specifically, to exclude Ainslie's parents from their interactions—as a way to focus on themselves. To accomplish this, Ainslie and Derrick discussed the times in which it would be best for Ainslie to communicate with her parents. He was also able to provide increased support to her during the times in which her parents tried to triangulate her more intensely.*

Sociocultural *Derrick and Ainslie were embedded in a sociocultural context that influenced their sexual behavior and their interpretations of their behavior. Being a young couple, both acknowledged that they felt a certain pressure to be sexually active with one another. In addition, neither member of the couple reported that they felt safe talking with their friends about their sexual problems, because the fact that they weren't having sex would not be accepted well in their social context. From this lens, the therapist worked with the couple to eliminate the "shoulds" in their language and instead develop a timeline for treatment that would work better for them specifically.*

Conclusions

During the course of therapy, the couple made significant improvements. Ainslie attended individual treatment to confront and better manage her issues related to control in the relationship, which stemmed from a previous relationship in which she was abused. Ainslie and Derrick developed boundaries around their relationship with regard to her parents, and her parents understood and responded well to the boundaries. In addition, the couple began spending more date time together and taking structured time-outs to avoid escalating their cycle. At last check-in, Ainslie and Derrick reported continued positive communication and greater degrees of flexibility in their sexual relationship. Ainslie stated that she was sleeping in appropriate pajamas, and they enjoyed their nights together.

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14

An Existential-Experiential Approach to Sex Therapy

Peggy J. Kleinplatz

Introduction

Sex therapy and existential-experiential approaches to psychotherapy do not generally appear together in the same sentence. Sex therapy was created to fill a clinical niche—to understand sexual functioning and to help people who reported sexual difficulties. It was developed in the 1960s by Masters and Johnson (1966) and refined by them and Helen Singer Kaplan in the 1970s (Kaplan, 1974, 1987; Masters & Johnson, 1970). These pioneers and their early followers created a brief, intensive, behaviorally-oriented treatment model for the sexual dysfunctions. It often worked quite effectively and quickly to ameliorate the symptoms of sexual problems. It became so popular as a treatment modality that it took on brand name proportions: Sex therapy became the Kleenex of psychotherapies (Kleinplatz, 1996). It was so efficient that it took some time for therapists to begin to realize the costs of doing what works without considering the consequences for the individual and relationship when we fix only the symptom and ignore the context in which it came to be problematic.

Existentialism starts with a whole other set of foundations, including its roots (European philosophy); its epistemology (mostly phenomenological); and its emphases on the subjective, on meaning, on freedom, and on responsibility. It provides a way to think about human distress and suffering, the farther reaches of human nature, the mind-body problem, and other big questions for therapists, who generally self-define as existential, humanistic, or experiential psychotherapists (Bugental, 1965, 1987; Frankl, 1955; Laing, 1967; May, 1969; Yalom, 1991, 2001). There are over 50 different approaches to "experiential" therapies alone, and they have very little in common (e.g., Lowen's [1967] Bioenergetics; Perls' [1971] Gestalt; Gendlin's [1978, 1996] Focusing; Greenberg and Johnson's [1988] Emotion-Focused Therapy), save for an emphasis on affect as a dimension of change (Mahrer, 2007; Mahrer & Fairweather, 1993).

Sex therapists do not generally know much about or show much interest in existential philosophy or psychotherapy. Correspondingly, existential and experiential psychotherapists have traditionally shown minimal interest in dealing with sexuality. This strikes me as a pity because the two have always seemed to me a natural fit. I find it enormously helpful when dealing with sexual problems in individual and couples therapy to use an approach focused (1) not only on the symptom, but also on its meaning, purpose, and possibly adaptive value; (2) not only on the objective, physical dysfunction, but also on the subjective experience for the man, woman, or couple; (3) not on whether the problem is organic or psychological, but rather on how it is inevitably both—and also relational and psychosocial and socioeconomic; and (4) not only how

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to fix the problem, but also on how to use it as an entry point for personal and interpersonal growth and, beyond that, how to aim for optimal erotic intimacy.

For my objectives as a therapist who focuses on sexual problems and concerns in individual and couples therapy, Mahrer's Experiential Psychotherapy (1978, 1996/2004, 2002, 2011) seems the ideal choice. This approach was developed over a 40-year period using extensive psychotherapy-process research on the world's largest psychotherapy tape library, representing master clinicians of every orientation. The objective in developing Experiential Psychotherapy was to establish methods intended to bring about substantive personality change rather than aiming for treatment of specific *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2000, 2013) defined disorders (Mahrer, 1994/2006, 2002, 2004, 2011). However, in helping the client become whatever he or she was meant to be, the presenting problem disappears.

Although Experiential Psychotherapy was never designed to treat the sexual dysfunctions and disorders, it brings about changes so fundamental to personality that it eventuates in better intrapsychic and interpersonal relations, increased embodiment, improved sexual functioning, and an increased capacity for intimacy. It has proven very effective at dealing quickly (i.e., fewer than 10 sessions) with a broad array of problems, sexual and otherwise, such as phobias (Mahrer, 1996/2004), dysthymia (Mahrer, Boulet, & Robson, 1998), and depression (Mahrer, 2006). When the client/couple in which the problems are manifest change substantively, the erectile dysfunction (Kleinplatz, 2004, 2012b), vaginismus (Kleinplatz, 1998), low desire (Kleinplatz, 1999, 2006, 2007, 2010a; Mahrer & Boulet, 2001), paraphilias (Kleinplatz, 2014; Kleinplatz & Krippner, 2005; Mahrer, 2012), sexual symptoms following trauma (e.g., sexual abuse and assault; Kleinplatz, 1998, 1999, 2001, 2006, 2007), and so on are similarly eradicated. The objective is not to target the sexual disorder, but rather, to change the person/couple in which sexuality has become problematic. Thus, although I do not "treat" sexual dysfunctions/disorders, I "cure" them nonetheless. Beyond eliminating symptoms and problems, this work also allows the couple to fulfill their inner potentials and thus to lay the foundations for optimal erotic intimacy (Kleinplatz, 2010, 2016).

Critiques of the Predominant Sex Therapy Paradigms

Various objections to conventional sex therapy paradigms have been emerging over the last 20 years or so. For example, these approaches have been accused of being goal-oriented (e.g., focusing on erections and penetration) rather than pleasure-oriented (Kleinplatz, 2001, 2004, 2012b; Ogden, 1999; Shaw, 2012); of conforming to a troubled norm (e.g., performance-oriented) rather than promoting social change (Irvine, 2005; Reiss, 2006); and of creating a situation in which the clinician acts as an agent of social control (e.g., by "treating" harmless but atypical sexual interests and behaviors; Moser, 2001). Conventional sex therapy paradigms emphasize objective, behavioral, and physiological indices in assessment and outcome criteria, over subjective, contextual, and systemic meaning (Aanstoos, 2012; Alperstein *et al.*, 2001; Hertlein, Weeks, & Gambescia, 2009; Kleinplatz, 2007; Loe, 2004; Schnarch, 1991, 1997); performance over embodiment, connection, and integration (Barker, 2011; Kleinplatz, 1996, 1998, 2004, 2012b; Ogden, 2012); and adequate functioning over optimal sexual potential (Kleinplatz, 2010, 2016; Schnarch, 1997; Shaw, 2012).

These critiques have become all the more relevant as sex therapy has become far more medicalized than Masters and Johnson (1966) could have imagined in the 1960s. Masters and Johnson (1970) had conceived of brief, behaviorally-oriented treatment for what they had perceived to be primarily psychogenic and relational problems generated by sex-negative cultures and repressive upbringings. Their primary interventions—psychoeducational sex counseling combined with sensate focus exercises and specialized exercises for each of the

sexual dysfunctions—were intended to free couples from a performance-driven view of sex (see Avery-Clark & Weiner, this volume). Most of their techniques remain popular among sex therapists but have been supplemented—or sometimes replaced—by medical interventions such as erectogenic drugs (i.e., Viagra, Levitra, Cialis) for erectile dysfunction; Botox injected into the female genitalia with dilator-based treatment of vaginismus (Pacik, 2010); vacuum suction devices applied to the clitoris (i.e., the Eros CTD) for treatment of female arousal disorder; selective serotonin reuptake inhibitors (SSRIs) for rapid ("premature") ejaculation; Flibanserin for low desire in women and so on. This seems ironic because none of the conventional paradigms has articulated a theoretical foundation for the relationship between mind and body, let alone in the context of sexual intimacy. Thus, medical interventions allow practitioners to focus on eliminating the symptom rather than on the symptom's meaning, purpose, or value (Kleinplatz, 1998, 2004, 2006, 2007).

The parts are all working but the persons within are disconnected

The methods and goals of conventional sex therapy are usually oriented towards enabling patients to engage in heterosexual intercourse. Problems are defined precisely in terms of the extent to which they impede penetrative sex. Vaginismus, erectile dysfunction, and rapid ejaculation occurring prior to intromission are excellent examples of sexual dysfunctions that prevent intercourse but not necessarily other forms of sexual expression. The treatments for them, however, may fix the "parts in disrepair" (Soble, 1987, cited in Tiefer, 1991, p.13) while leaving the persons within untouched. As such, it is not surprising that the frequency of sexual activity often fails to increase despite improved sexual "functioning" (Hanash, 1997). That is, the focus of conventional treatment paradigms is on ameliorating the mechanics of sex rather than enhancing the pleasure of lovers.

Conventional treatment models may be very effective at fixing the symptoms of sexual difficulties without distinguishing between the symptoms versus the problems of the individuals or couples who continue to suffer. If anything, the act of enabling two people who feel emotionally disconnected or alienated from one another to engage in sexual intercourse may create more problems than it solves. The message implicit in such treatment methods or goals is that genital functioning (e.g., vaginal lubrication, erections) is more important than subjective arousal, embodiment, or relational intimacy.

The mind-body position

The mind-body position in the conventional paradigm is implicitly dualistic: Either the problem is organic or psychogenic. This has been the stance from the outset. In 1970, Masters and Johnson identified 90% of sexual problems as psychogenic and 10% as organic. Interestingly, by the mid-80s, they had revised their original estimate, stating that 20% of sexual dysfunctions were of organic etiology. The change was due to an increased prevalence of pharmacological treatments for other health problems, which had led to a higher incidence of iatrogenic sexual disorders (Masters & Johnson, 1986). By the mid- to late 1990s, during the run-up to the 1998 introduction of Viagra, the first of the phosphodiesterase type 5 (PDE-5) inhibitors or oral erectogenic drugs, Pfizer touted their own new estimate that 90% of erectile dysfunction was organic and 10% psychogenic (cited in Loe, 2004). Although the numbers were reversed from those of Masters and Johnson's, the basic dualistic paradigm had become further entrenched.

In contrast, from an existential-experiential perspective, the "symptom" of the sexual dysfunction can be viewed instead as the bodily expression of the underlying experiencing (Mahrer, 1996/2004). From this vantage point, appropriate interventions would hardly involve using physical manipulations to circumvent sexual reluctance; for example, the existential-experiential perspective would reject the use of vaginal dilators to teach women diagnosed with vaginismus to open and close their pelvic floor muscles on command and the

use of "mental bypassing" (cf., Kaplan, 1974) to circumvent the reality that the man with the soft penis feels belittled by his partner's criticism. Instead, from this perspective, the symptom is viewed as a message from within calling for attention, to be heeded rather than "successfully" ignored; indeed, from this perspective there is quite a price to be paid for such "success" (i.e., alienation, objectification, dehumanization, reductionism). Or to go a step further, sometimes the vagina closed tightly or the flaccid phallus are demonstrating evidence of good judgment (e.g., when there has been relational conflict). Alternative goals in such cases may involve helping the client give voice to his/her inner experiencing or to change the nature of the relationships within or with others so that the sexual symptom is no longer necessary and thus ceases to exist. In other words, the focus here is not on the somatic or psychogenic cause(s) of sexual dysfunctions but rather their purpose, function, and value. "Symptoms" are not automatically deemed problematic or in need of elimination. Rather they are to be respected as pointing towards the entry point for profound change. This is not a change in degree but in kind. Outcome is no longer to be assessed by the angle, firmness, or duration of a man's erection but rather by whether he feels integrated, centered, and satisfied when—and if—he chooses to relate sexually and in his life in general. When the whole person changes, that is, when the person with the sexual symptom becomes integrated, the underlying problem is eradicated, and thus the sexual symptom evaporates in its entirety.

Alienation from within versus embodiment

In conventional sex therapy as described by Kaplan (1974), the technique of *bypassing* entails ignoring one's subjective experience, whether feelings, thoughts, or both. Bypassing is prescribed in order to allow automatic functioning to occur (e.g., ignoring anxiety about pain on penetration in order to "tolerate a phallus size object"; Kaplan, 1987, p. 99). In this model, put forward by Masters and Johnson (1970) and adopted by Kaplan (1974), the underlying assumption is that sexual functioning is a normal physiological process, comparable to urination, defecation, and respiration (Masters & Johnson, 1986). The goal of therapy is to restore normal physiological functioning, which has been impeded by the dysfunction. What is curious here is that the very notion of bypassing implies aiming for disconnection from within in order to perform "normally." An interesting illustration of a "home remedy" which uses the same assumption is rather common among men who present with rapid ejaculation. When asked what they have tried to alleviate the problem prior to seeking therapy, many will acknowledge having attempted do-it-yourself bypassing by thinking about something neutral (e.g., baseball scores) or something revolting (e.g., a particularly gruesome episode of a crime drama). Not only is this approach unsuccessful, but its goals involve increasing performance by reducing pleasure. More recently, third-generation cognitive-behavioral therapy techniques emphasize Buddhist-inspired mindfulness in dealing with sexual problems, encouraging clients to notice distracting thoughts or feelings and then let them go. Although these approaches show promise, they risk training clients to ignore important messages from within (Barker, 2013).

Bypassing stands in marked contrast with the high levels of embodiment that mark Gendlin's (1978, 1996) focusing, Lowen's (1967) bioenergetics, and Mahrer's (1996/2004) experiencing. The Gestalt slogan, "Lose your mind and come to your senses" (Perls, 1971) seems especially fitting for the world of existentially-oriented approaches to sex therapy. In the realm of existential-experiential therapies, the capacity to listen to messages from within is to be honed and cultivated. Rather than teaching "anorgasmic" women to override their fears of "letting go" with partners they do not trust, the solution will arise by paying attention to the feelings of distrust. Instead of instructing the man with the penis shriveling up upon penetration to go for the chemical bypass (e.g., Viagra), perhaps he ought to be listening to the penis, which is quietly exclaiming—in effect—"Get me out of here!"

More recently, research demonstrates that *high* levels of embodiment are both a component of and a contributing factor to optimal sexual experiences (Kleinplatz, 2016; Kleinplatz,

Ménard, Paquet *et al.*, 2009; Ménard *et al.*, 2015). Whereas trying to ignore intrapsychic or relational elements may—or may not—eventuate in tolerably functional sex, the most fulfilling erotic intimacy requires that the participants be fully present and engaged, acutely aware of themselves and one another in the moment (Kleinplatz, 2010; Kleinplatz & Ménard, 2007).

Interpersonal/relationship context

The idea that a pill can enhance sex reveals a great deal about the nature of the sex aspired towards. Viagra may produce rigid erections while creating new difficulties for the forgotten man who is attached to those erections, for the partner who wants to be desired, or for the couple attempting to achieve greater emotional connection. New pharmacological interventions, aiming to achieve traditional sex therapy objectives, produce the same old effects and side-effects: reductionism, alienation, fragmentation, mechanization, objectification, and dehumanization. Improving sexual functioning outside the context of interpersonal relationships in which it is safe to be authentic and vulnerable hardly helps patients to fulfill their fondest dreams. On the contrary, research on optimal sexual relations has demonstrated that it is possible to experience intimate erotic connection even without genital functioning in the elderly, chronically ill, and disabled when the lovers are free to explore the range of sexual possibilities (Kleinplatz, 2016; Kleinplatz, Ménard, Paradis *et al.*, 2009; Ménard *et al.*, 2015). In other words, the good news is that sexual functioning is not required for optimal erotic intimacy; conversely, the bad news is that sexual functioning is not sufficient to create optimal erotic intimacy (Kleinplatz, Ménard, Paradis *et al.*, 2009). Individual maturity, growth, and self-knowledge help to create an atmosphere of trust and trustworthiness. Correspondingly, mutual interest, knowledge, and especially empathy can create just enough safety to access and reveal deep vulnerabilities, which in turn enabled intense, erotic exploration.

What about outcome?

The current psychotherapy research literature suggests that traditional outcome models, focused on randomized controlled trials (RCTs) and empirically validated treatments (EVTs), are inappropriate for measuring complex outcomes in psychotherapy practice. The field of psychotherapy has spent the last decade moving beyond the crude EVT and Health Maintenance Organization (HMO) fights of the 1990s, which defined "effective" outcomes in narrow and often clinically empty ways (cf., Bohart & House, 2008; Duncan, Miller, Wampold, & Hubble, 2009; Greenberg, 2008; Norcross, Beutler, & Levant, 2005; Wampold, 2005, 2007). The realization that multifactorial, multidetermined problems require commensurately complex clinical strategies—not simple treatment algorithms—and therefore demand more sensitive research paradigms was well established in the world of psychotherapy outcome research more than ten years ago. Sex therapy, however, has been blinded to the broader field's progress. The field of sex therapy seems oblivious to the factors that research has proven lead to patient improvement in the broader field of psychotherapy. The isolation of the field of sex therapy from mainstream psychotherapy (Kleinplatz, 2012a) has led us to narrow our vision of available or even possible research/treatment options, even as we claim the need for comprehensive treatment models. Astonishingly, we ignore the salient literature (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Bohart, 2005; Bohart, Elliott, Greenberg, & Watson, 2002; Burum & Goldfried, 2007; Castonguay & Beutler, 2005; Duncan *et al.*, 2009; Elliott, Bohart, Watson, & Greenberg, 2011; Greenberg, 2008; Norcross *et al.*, 2005; Wampold, 2005, 2007) that shifts the focus from EVTs to empirically validated *principles of practice*. This body of outcome data demonstrates that the factors that lead to change in psychotherapy comprise, for example, heightened empathy (Bohart *et al.*, 2002) and intense affect and emotional expression in therapy sessions (Burum & Goldfried, 2007; Greenberg, 2008). These factors account for effecting positive change in psychotherapy, as

well as the majority of the variance in outcomes (Elliott *et al.*, 2011), across different clinical modalities. These factors are among the crucial, active ingredients in Experiential Psychotherapy (Mahrer, 1999; Mahrer, Boulet, & Fairweather, 1994).

What is Experiential Psychotherapy?

Experiential Psychotherapy was slowly and carefully assembled by psychotherapy researcher Alvin R. Mahrer over a 40-year period by gathering together the world's largest psychotherapy tape library in cooperation with the Association for the Advancement of Psychotherapy. Mahrer and his research team carefully and methodically studied and analysed master psychotherapists at work in search of the active ingredients of substantive personality change as effected in therapy. The resulting series of clinical steps and substeps designed for transformation came to be known as Experiential Psychotherapy. It is, thus, an empirically derived approach with a goal of nothing less than transformation (Mahrer, 2011, 2012).

Role of the therapist and epistemological stance

How are we to know what is going on inside the client? In the conventional paradigms, we listen with the intent to formulate an understanding of the problem—a case history and history of the sexual problem—and begin to think about the goals of sex therapy based on the nature of the presenting problem. We assess until we have arrived at a case conceptualization and a diagnosis. When these are complete, we proceed to provide treatment, which is focused specifically on the symptoms of the presenting problem.

In the Experiential paradigm, we learn what is happening in the client moment-by-moment throughout the duration of therapy, rather than by applying prior knowledge to understanding this particular client during the assessment phase. The process is continuous rather than a feature of the first phase of therapy. The ongoing attempt to live in the client's world occurs via Experiential listening, which is the fundamental method of Experiential Psychotherapy and is a prerequisite for any other work of the session.

Experiential listening is the primary vehicle for living in the client's phenomenal world. During the course of an Experiential session, the therapist is to position, situate, or align him/herself metaphorically in order to open him/herself to the client's lived experience. What does this mean, and how is it to be accomplished? This entails relinquishing the role of the observer, the assessor, the one who knows about how sex and relationships ought to be, and the authority on diagnostic and treatment models—in short, the role of expert—and instead beginning each session poised to enter fully into the client's world. In essence, this means listening as though the client's words are coming through you. This is beyond ordinary levels of empathy (Mahrer, 1996/2004; Mahrer *et al.*, 1994) in which the therapist understands, appreciates, and can relate to the client's experience while still retaining his or her own separate points of view; rather, here the therapist virtually enters the client's world for the duration of the session. The therapist is to listen, allowing the client's words to evoke images, bodily sensations, and emotions as lived by the client. When the client is describing his mother, you see his mother and not your own. When he describes his wife, you are picturing her just as he does, as a big threatening ogre, and feeling your heart pounding—notwithstanding the fact that she is actually in this room at that moment and that you would normally describe her as a gentle and petite woman with a welcoming smile. When the client is describing his feelings of failure and inadequacy when his penis became limp last night, you are feeling that same penis—your penis—in your body shriveling up and withdrawing, even though, ordinarily, you are a woman. How do therapists do this? They learn with a lot of training and practice (Mahrer, 1996/2004, 2005). How do therapists know if they are listening experientially accurately? The test is empirical

rather than theoretical. If the levels of emotion, intensity of bodily sensation, and vividness of imagery in the client increase and are enhanced, the therapist is on track and listening experientially well. If the client suddenly seems disengaged and the feeling level drops, the therapist is on the wrong track and is not listening accurately. Fortunately, clients usually correct the errant therapist quickly, thus getting the session back on track without delay.

The goals of Experiential Psychotherapy

There are two goals in Experiential Psychotherapy, referred to as actualization and integration (Mahrer, 1996/2004). What these goals entail is allowing whatever is deepest within the client to become alive within his/her personality (i.e., integration) and as part of his or her ways of being in the world (i.e., actualization). Individuals often ward off and lose access to parts of their inner world in the course of personality development. (This may be especially true when it comes to one's sexuality, where cultural norms regulate sexual expression.) The Experiential Psychotherapist uses the presenting problem as the entry point to the client's deeper personality processes so that those processes can be reintegrated into the client's lived experience. The outcome is that the client is freed of whatever painful feelings were present at the outset of therapy. In other words, given that Experiential Psychotherapy involves substantive personality change, the individual who entered therapy with a particular complaint is enabled to change profoundly enough that the initial symptom seems to disappear. In the case of sexual problems and concerns, what this involves is change, not only within the individual (i.e., integration), but also in his/her relationship to his/her body and with others, including sexual partners and significant others (i.e., actualization).

These Experiential Psychotherapy goals clearly differ from the goals of traditional sex therapy. As described by Mahrer (2012), "The aims and goals of the Experiential therapist-guide and the sex therapist are very likely to have almost nothing in common, with those of an Experiential session probably being deeper and more comprehensive, and those of the sex therapist probably more superficial and truncated" (p. 234).

The methods of Experiential Psychotherapy

Each session uses moments of strong feeling as an avenue to enter the client's inner world. There are four steps in Experiential Psychotherapy. The first step involves finding a scene of strong feeling and using intense images, emotions, and bodily sensations to search for the moment of peak experiencing. By entering into and dilating the peak moment, something new from deep within the individual begins to emerge (Mahrer, 1999). Its presence is ascertained via a felt shift within the client (and correspondingly, within the therapist who is listening experientially), such that painful feelings and sensations seem to yield and the unexpected becomes palpable (Mahrer, 2002). Part of the excitement for the therapist is the sense of discovery of the unknown and unpredictable during this process. During the second step, the newly-discovered inner experiencing or way of being is welcomed, for example, by naming it, identifying it, and attending to any accompanying shifts in bodily sensations. During the third step, the client returns to past times when this newly-accessed way of being had emerged or had begun to emerge. By re-entering such moments and allowing this new/old way of being full expression with strong, good feelings, it becomes possible to integrate this inner experiencing into one's current life. In the fourth and final step, the client considers, envisions, and rehearses the possibility of living as this newly-integrated person beyond the therapy room after the session ends.

Experiential Psychotherapy was designed by Mahrer for individual psychotherapy. However, I have used it for the last 30 years or so with couples with sexual-relational issues and concerns and, occasionally, in group therapy (e.g., for individuals with histories of incest and for couples with sexual desire discrepancies). Experiential Psychotherapy with couples involves the same four stages as with individuals; however, it necessitates a few variations at the outset and at the conclusion. First, in the initial stage, the moment of strong feelings may occur in the context of

the interaction of the couple. The compelling feelings emerging in *either* person during the couple's interactions in session become our access and entry point to the inner experiencing of one, the other, or—over a series of sessions—both. The therapist is attuned to pronounced feelings and begins to work intensively with whichever individual is beginning to show them. Secondly, it is a truism in couples therapy that changes in one can be threatening to the other. For that reason, there is something very special and risky about entering, exploring, and expressing one's own depths while knowing that one's partner bears witness. The partner watching the profound changes in the other during Experiential Psychotherapy tends to be inspired by and in awe of the courage required to open up one's inner world while being observed. This tends to reduce the feelings of threat that might otherwise occur in the observing partner; instead, the act of witnessing the change tends to open up the possibility of greater intimacy. Third, whereas in individual sessions, in the final stage of the process, the client imagines a whole new way of being after the session, when the spouse is present, the individual need not wait until later. Rather, the client has the opportunity to include the partner and to experiment with or play out this new way of being with him/her, right then and there. The immediacy of being able to share so deeply in the moment makes it all the more likely that the changes will be enduring and that the couple can create space for new ways of being to occur in the relationship. Partners are typically receptive to these initiatives and tend to be eager to participate in the other's growth.

Clinical Vignette: Vaginismus

A woman presented for individual sex therapy because she was struggling with, what in the DSM-IV-TR (American Psychiatric Association, 2000*), would have been labeled vaginismus (i.e., pain and contraction of the vaginal walls during attempts at sexual intercourse). Although she had no history of pain or difficulty with sexual intercourse in prior relationships, she was unable to contain her husband's penis without considerable discomfort. Her gynecologist had performed a pelvic examination, and there were no remarkable findings. She was referred, nonetheless, to a pelvic floor physiotherapist and prescribed dilator treatment. Notwithstanding her "success" in accommodating the largest dilator, she continued to find sexual intercourse with her husband intolerable. She was then referred to me for sex therapy for vaginismus, and a brief history suggested that couples sex therapy was required.*

Meeting the couple in the initial session of couples sex therapy was illuminating. Although she was the identified patient, he focused the session on his rejection and suffering. He felt wounded and betrayed by the fact that she was able to insert the dilators yet she still grimaced and cried during sexual penetration with him. He felt hurt and manipulated, but they continued engaging in sexual intercourse, regularly and often.

In Experiential Psychotherapy, the therapist aims to heighten the immediacy of the experiencing by working in the first person, present tense, and having clients speak accordingly, even—or especially—when reliving past events. For that reason, the rest of the therapy process will be described as it occurred, in present tense.

I encourage him to stay with these feelings and let them grow so that we might enter into the heart of them. I ask him to take me to moments where these feelings of hurt and betrayal are especially intense so that I might know them—see and feel them—right alongside him, as if I were virtually in his skin. He takes me through a series of memories, going progressively further backward in time. These events could objectively be characterized as a longstanding pattern of abusive behavior on his part in occupational, social, and sexual relationships. Subjectively, though, his experience is of a victim rather than a perpetrator. In each memory he feels hurt, rejected, and unloved, despite his good intentions; in each instance, when the pain becomes overwhelming, he shuts down, saying he feels dead. As I ask him to describe the deadness, it emerges as more of a steely armor, being made of stone, impervious—"you can't get to me." I ask him to take me further back in time, to a time before the hurt could be escaped by numbness, to a time when the pain was so awful and unending as to be beyond endurance. Before I can even finish my instructions, he is back as a little boy.

There he is, in his bedroom, five years old, watching his father, big and menacing, threatening his little sister, and all he can do is watch, his eyes fixed on her. He is desperate to help her but is frozen. I ask him to keep looking at her and say aloud the words he could not afford to speak at the time. He speaks with kindliness and a wisdom beyond his years, "Don't give up, I love you … You know that, right? Just hold onto that thought and you'll get through it. This will pass, but you'll still be alive…" He sighs deeply, lapsing back into helplessness and pain as his gaze shifts towards his father. I ask him, now, to speak directly to his father. He responds:

> *Not then … It was useless, then, but by the time I was 14, I'd figured it out. I didn't want to kill him—I just wanted to neutralize him. [His voice has shifted from the prior feelings of being hurt, betrayed, and manipulated, and he is now back to the steely deadness. He is impervious but clever.] I'd figured out that all it would take would be one phone call to the police and he'd be put away along with the other child molesters, and after all, you know what they do with child molesters in prison.*

He chuckles softly. And as I let that little chuckle reverberate within me, something new is beginning to emerge, but I cannot quite name it yet. I asked him to keep going, to make it more vivid. He continues:

> *It would have been cheap and easy to have him put in prison but then where would we be? Wards of the court? Homeless? So I just warned him—and he knew I meant it—that either he "pretended" to be our father, to hold down a job and send us to college, never touching my sister again, or I'd call the cops. And that was it! That was the last time!*

He chuckles again and a third time, becoming more vociferous. As I let these beginnings of laughter rumble through me, I am beginning to grasp his inner experiencing and give voice to this newly-emerging potential: "I'm free!" "That's it! I'm liberated! No one's ever gonna hurt her again. And I don't have to be on guard, vigilant always, or hurt and unloved. I can just be free!" As we continue, we are beginning to speak over one another, completing one another's sentences and thoughts: "And I can feel it in my body, not so armored but strong and alive…" As he adds, "Yeah, blood pulsating from head to toe … It's lighter now, more energized…".

As the feelings and sensations grow ever more saturated with intensity, he says, "If only I could feel that way all the time … I've been cold and miserable for too long…" the images of the man that he was intended to become all along begin to spring forward. "What would that be like?" I ask. "Who would this man be … the one who never had a chance to grow up in your world?" "Well for one thing, he wouldn't be so hulking. I'd be running and swimming, the way I used to as a kid. I'd be slimmer but gentler. I'd be kinder … more loving and softer with my wife …". He turns to her, taking her hand. As his words come through me, I feel giddy and am beginning to tremble with sheer aliveness and new possibilities. In place of the steely deadness or the hurt and betrayal, he is open, energized, kind, and caring. He is crying as he reaches over to hold his wife. He begins to sob as he says, "And I would really love you… I'd take care of you and never hurt you…". He is stroking her back as she, too, softens in their embrace. "I adore you and touching you, and I… I… want to be tender and protective from now on. No one should ever hurt you, let alone me!" She takes his hand and smiles with wonder as they leave my office.

In the next session two weeks later, they report that, after the previous session, they had gone straight home to make love. Indeed, he was loving and gentle. She had opened to him effortlessly, in fact, without even thinking about her "vaginismus."

Although the identified patient was the wife, the changes that occurred at the deepest levels in her husband enabled her "problem" to disappear. Along the way, he had resumed his interest in swimming, and they had gone to the lake, diving playfully and "making out" in the water. Sex since then had been slow and mutually nourishing, with plenty of time to connect and play. In addition, he mentioned that his problems with his junior managers at work dissipated once he became less vigilant over them and offered to help them instead.

Conclusion

This case illustrates some of the advantages of Experiential Psychotherapy when dealing with sexual problems. Although the vaginismus was never targeted, the problem was eliminated. The sexual symptom may have appeared in the wife, but it was by dealing with the intrapsychic and interpersonal context—notably *his* and theirs, respectively—in which her vagina became problematic that *her* bodily symptom was resolved. The husband's longstanding dilemma of alternating between being either armored, steely, and impervious, or hurt, rejected, manipulated, and betrayed, was transcended by entering into a deeper way of being, long inaccessible to him. When he was freed to become the person who was within all along, what emerged was a man who was lighter, kinder, gentler, softer, and more caring. His relationship to himself, his wife, and his colleagues at work all changed simultaneously. As a result, she opened to him, and their lovemaking was not merely free of obstructions, it was tender and mutually nurturing.

This outcome could never have been foreseen if judging only by the presenting complaint. More importantly, the act of "treating" the "vaginismus"—which had already undergone the standard physiotherapy/dilator treatment unsuccessfully—would have prevented the possibility of profound personal and, subsequently, interpersonal growth that ensued from Experiential Psychotherapy.

For me, as a therapist, there is something wondrous about the process of discovery that occurs when I enable clients to search within and encounter their own inner worlds. The possibilities for transformative change when we work respectfully with whole people—not just their parts—makes me feel excited and blessed to be a witness to such intimate developments. I hope that other sex therapists in search of brief, effective, powerful approaches to effecting fundamental and multilayered change in individuals and couples will consider trying Experiential Psychotherapy.

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15

A Narrative Therapy Approach to Sex Therapy

Ron Findlay

Positioning this Chapter

I would like to acknowledge that there are many respected schools of narrative therapy. The particular narrative therapy (NT) approach I write about is the one founded by Michael White of Australia (see www.dulwichcentre.com.au for readings) and David Epston of New Zealand (see www.narrativeapproaches.com for readings).

This NT has drawn on the works of many diverse theorists. A full description is beyond the scope of this chapter. However, there is a common thread to these sources; they all look at how stories and lives and identities are constructed in language and culture. Some notable influences include:

- Michel Foucault's (1978, 2000, 2003) post-structuralist ideas;
- Jerome Bruner's (1990) narrative theories;
- the French philosophy of Jacques Derrida (1972/1981) on the construction of texts and language (see White, 2005a, p. 15);
- anthropological work, especially the work of Barbara Myerhoff (1986) on identity ceremonies (see White, 2007, pp. 180–184);
- Clifford Geertz's (1973) ideas on interpreting stories and culture (see White 2001, p. 31);
- Victor Turner's (1969) work on social and cultural rituals marking changes in identity, especially "rites-of-passage" (see White, 2002b); and
- Lev Vygostky's (1962) education theories (see White, 2007, pp. 263–290).

Feminist and social justice ideas also have contributed greatly.

Before describing NT as it applies to the treatment of sexual problems, I would like to responsibly acknowledge that the use of NT in sex therapy is still in its infancy. None of the founders of NT have published articles or books on its use for sexual problems. Few practitioners in this model work in sex therapy; those that do have written only a handful of published articles on its use for problems in sex, and none are based on empirical research.

So why then do some sex therapy practitioners use it? Perhaps, like myself, they agree with its theory and practice, with its non-pathologizing ethics, and with its focus on recognizing and encouraging people's own skills. Perhaps they also appreciate its "user-friendly" feel for both therapists and clients.

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

Assumptions of the NT Approach

NT rests on some underlying sets of assumptions about how our "selves"—or at least our "stories" of ourselves—are "made" (Bruner, 1990; White, 2007). Understanding these assumptions is important to understanding the approach.

First set of assumptions: narrative and story

(1) Humans are meaning-making creatures We make sense of ourselves and our lives in stories. As White (2007) said, "… people link the events of their lives in sequences that unfold through time according to a theme or a plot" (p. 61).

(2) The events of our lives can be woven into more than one story Does our dominant story make us out to be a hero or a villain, a success or a failure? The events of our lives can't be changed, but which events we choose to weave into our story and how we weave them together can be changed. There are always other ways the many events of our lives can be linked together to create other stories of ourselves—alternative, more preferred versions of our lives and identities. There is always more than one story of each of us that can be told (White, 2007, pp. 61–125, pp. 219–262).

(3) Stories are to be lived and performed For preferred stories to become more meaningful and influential, they need to be put into life—"enacted" or "performed." Stories with new knowledge can give rise to trying new actions and new deeds. What is learned from these new actions and activities in life may lead to more new discoveries and more new knowledge, which can inspire more new actions. A positive cycle continues, extending, thickening, and enriching the story as it goes.

(4) Stories of the self are socially negotiated; they are "peopled" Although an individual may lay claim to a new and different story, sympathetic witnesses may also be required (White, 2007, pp. 165–218; see also Gergen & Gergen, 1984). Witnesses can be "recruited" to be an audience to the new story and to validate, thicken, reinforce, and add their positive contributions to the new story—all to ensure the new story's richness and viability.

Second set of assumptions: narrative and identity

In many psychotherapies, "identity" and "the self" (and in popular and self-help literature, terms like "core self" and "true self") are seen as objective structures with measurable characteristics and qualities. In NT, we can see identity in alternative ways (White, 2001, 2002a, 2007).

(1) Identity can be viewed as moral or ethical "claims" or "conclusions" people make about themselves and each other These claims flow from the moral and ethical stance or position the individuals hold on events in their lives and in the world—in other words, "I am what I stand for." Epston (2008) suggested a similar concept; that is, "identity as reputation," meaning reputation in our own eyes and in the eyes of others (p. 128).

(2) Identity can be viewed as a story We can understand ourselves as a composition of the stories we hold, recall, tell, and exchange about ourselves; that is, our identity is made up of stories we and others tell (a) about events in which we have been a part and (b) about events

in which we were not a part, but which inspire or influence us. These stories may come to us from people we know, like friends and family, but also from media like books, the internet, songs, films, and movies. Stories shape who we are. White (2007) said, "… it is in the trafficking of stories about our own and each other's lives that identity is constructed" (p. 80).

(3) Identity can be viewed as an "association of life" From this perspective, identity is a composition of the people and their voices in our lives—people past and present, fictional and real (White, 2007, p. 129, p. 138). Beyond just their stories, their associations in our lives can also include a sense of their ongoing presence with us, like a "club of life" of significant people that we carry with us. This is an understanding that White (2001) postulated is well known to some indigenous peoples, who might say their way of understanding themselves includes, "… our ancestors, who are walking beside us and holding our hands …" (p. 38).

In addition to these three views of identity, White (2007) offered two other related concepts of identity and self. He described autobiographical memory as a source of self, saying, "… autobiographical memory … provides the foundation for a sense of personal identity … (p. 67). He also identified stream of consciousness as source of sense of self, saying that one's stream of consciousness provides "… a familiar sense of who one is in the flow of one's inner experiences of life" (p. 67).

Third set of assumptions: bias towards conscious purposes and principles

Why do we do things? For conscious or unconscious reasons? Different therapies take a variety of different stands as to conscious versus unconscious motivations and determinants of human behaviour. NT clearly leans to the conscious end of the spectrum.

NT also often describes a similar but slightly different spectrum, *intentional states* versus *internal states.* Internal state understandings refer to seeing people as having inner drives, qualities, and traits, such as bravery and courage or fear and doubt, which influence their actions. Intentional state understandings refer to seeing people as full of conscious purposes, hopes, intentions, beliefs, and principles that guide their actions. Examples of questions that address internal states include, "How did you use courage to stand up against the fear and to talk with your partner about the sexual problem?" and "Was it hope or fear or desire or all three that drove you to do something about it?" Examples of questions that address intentional states include, "What is so important to you that it motivates you to bring up the sexual problem with your partner even though it is scary to do so?" and "What type of a relationship do you believe in and hope for that contributed to your decision?"

In NT, people are seen as principles in actions rather than as collections of internal traits; thus, intentional states are emphasized over internal states. This positioning makes eliciting and honoring conscious beliefs, principles, hopes, purposes, commitments, and intentions a central necessity in NT. These intentions will guide therapy, just as they guide people in their own lives (White, 2007, pp. 100–106).

The Double Focus of NT

NT has a double focus, which might be called in non-narrative language: (1) focus on the problem; and (2) focus on the solution—including finding and then strengthening the solution. In narrative therapy language, the double focus can be called: (1) externalizing the problem; and (2) re-authoring. The re-authoring focus includes both initially finding the new story and then thickening or enriching the new story.

The double focus of NT implies the need for a narrative therapist skill that I consider central to this work, a skill to take to each and every session: *double listening* (or to use White's [2004]

original term, "doubly listening," pp. 47–48). In double listening, we always keep an ear out for two messages in what people are telling us: *effects* and *responses*. In other words, we are listening for their accounts of the problem and its effects, and simultaneously we are listening for accounts of their responses that are opposed to the problem (or at least not subservient to it). NT believes every sentence uttered by a client will hint at both. For example, "We have come to therapy because we are unhappy that we are not having sex." The effect of the problem is unhappiness, and the response (i.e., the action taken to oppose the problem) is to come to therapy to seek help.

Sex, Classification and Failure Identities: The Influence of Foucault

A discussion of the principles of NT as applied to sexual problems is not complete without a discussion of the influence of Michel Foucault. Foucault (1978, 2000, 2003), as a historian, wrote much about the problematic ideas and practices of "the self" and identity; about the problematic classification and management of "abnormal" human behaviour; and about the theories, ideologies, and institutions that support and uphold each type of classification. I simplify Foucault's social classifications of so-called abnormality as "bad" (i.e., criminal), "mad" (i.e., psychologically disordered), and "perverse" (i.e., sexually deviant). In relation to sex, Foucault can be understood as warning that classifying human sexual acts and actors as bad, mad, or perverse can lead to people being medically or psychologically treated by others or by themselves to ensure that they fit the sexual "norm," whether or not that norm is the best for them as individuals (Foucault, 1978, 2000, 2003). This is a common outcome in relation to problems with sex.

Inspired by Foucault, White (2001, 2002a, 2007) wrote extensively on the problem of "normalizing judgement" (White, 2002a, p. 57) and identity. White also wrote on the prevalence of pressures and processes in the modern world to set up a norm, and if one fails to live up to the norm, to see one's self—one's identity—as "spoiled," "negative," or a "failure." White (2002a, 2007) contended that narrative practices can break from participating with that process.

In my words, "classification is the new repression." If you do not match or fit the perceived norm in any aspect of sex, you risk being seen as one of the many negative identities available to us: perverse, weird, faulty, inadequate, damaged, abnormal, a failure, a loser, a freak. (Note that this critique of normalizing judgement is not meant to condone non-consensual sexual acts perpetrated against others.)

Components of a Narrative Therapy Session

Starting the session with friendly and polite inquiry

A narrative session, as in many other therapy models, will start with a "meet and greet" and a general interested polite inquiry about the people, their lives, and their activities. There will be an inquiry about what the problem is, which may include asking how they understand it, what they think may have caused it, and what they have tried so far to fix it. It will also include inquiry about their preferred directions and principles for life, to help guide the therapist in the work.

How do we then proceed? Sometimes we may follow by discussing the problems. Other times, we may proceed by discussing the solution (i.e., identifying positives and an alternative story). There is always, too, the option of a mix of both.

Externalizing conversations

To discuss problems in NT, the preferred approach is not a general venting or airing of problems, but to talk about them in a specific way. This involves using language that separates problems from the person and is called "externalizing" or, more accurately, "externalizing conversations" (White, 2007, p. 9–59). In NT conversation and dialogue, problems are grammatically phrased and worded as separate from the person's identity or personhood, creating a (reflexive) sense of distance between the person and the problem. (Not as separate from their body, though; many sexual problems are obviously located in the body, but NT would say that does not mean they are part of the individual's personhood.) For example, "a premature ejaculator" could become "a person struggling with premature ejaculation." "I am undersexed" could become "I am a person dealing with 'undersexed' issues." "I am a sexual weirdo" could become "I am a person with some weird thoughts about sex." Clients may arrive thinking they are the problem, only to find instead that they are people with problems. This type of conversation serves to open an (experiential) space for a person to "stand back" from problems.

The therapeutic aim of this type of conversing is twofold. The first aim is to lighten the sense of the weight and burden of problems, to reduce the "problem-saturated feeling," and to be less overshadowed by the problem. The second aim is to use this distance from the problem to better consider potential or real action to reduce the problem. Externalizing conversations were the original hallmark of NT, and they give rise to the narrative maxim, "the problem is the problem, not the person" (source unknown). Externalizing conversations can be a diverse and rich practice. I divide them into three broad and overlapping categories.

Externalizing 1: characterizing the problem Externalizing involves talking about the problem as a character with motives, intentions, and techniques of its own (e.g. with "malicious intent"). This technique is widely known for its use with kids (e.g., White, 2007, pp. 14–18, pp. 41–43); for example, bedwetting is characterized as "Sneaky Wee" (White, 2007, pp. 26–27). However, in NT, it is also used extensively with adults in an age- and culture-appropriate way. An NT sex therapist might ask the following types of externalizing questions: "What is the 'pain-with-sex' inviting you to think about the future of sex with your partner?"; "What pressures is it putting upon you?"; "Are guilt and shame working with you or against you?"; "These 'articles-in-the-popular-media' about what other couples do sexually, are they trying to persuade you that your relationship is a success or a failure?"; "Are they your friend or are they the opposite?"; "Ok, you say they are a bit of both. Thanks. Can you elaborate?"

Part of characterizing is to talk about ways and areas of the person's life that the problem has influenced, but also ways and areas it has not been successful in its influence (White, 2005b). For example, "Are there some aspects of your relationship where you have been able to prevent the 'arguing-about-sex' from hurting?"

Externalizing 2: deconstructing problems The concept of deconstruction is often credited to the work of Derrida (1972/1981), who wrote on philosophy and textual analysis. Therapists have widely applied and adapted deconstruction in therapy work in many different ways. I see deconstructing problems as dismantling problems into their component parts. This may lead to more awareness of how problems work and, hopefully, by breaking them into smaller parts, inspire ideas about how to minimize them. In other words, "divide and conquer"—but problems, not people.

There are two types of deconstructions common in narrative practice. The first type of deconstruction involves dismantling the problem into component knowledges (ideas/concepts) and actions (White, 2001, pp. 47–54). This involves questions such as the following: "When you have trouble with erections, what does that cause you to end up *thinking* [idea]? What does it cause you to end up *doing* [action]?" "Feeding back what you said, 'not wanting

sex' often causes you to believe that you are a failure as a partner [idea] and leads you to actively find ways to avoid sex [action]. Is that right?"

The second type of deconstruction involves dismantling the problem into component sociocultural ideas and pressures This can be done by identifying and making visible *current* social-cultural components of problems (in contrast to the psychological components of the problems). For example:

> So you are feeling like you are "an inadequate person" because you need a vibrator to orgasm. How much is that coming from you, and how much is that coming from ideas around in society, like the popular media portrayals of women in sex? Perhaps I could put it this way: how many movies show women happily coming from vibrators as compared to the movies showing women coming from vaginal sex with penetration? And how does that compare with research on what women actually do to orgasm?

Alternatively, this can be done by exploring and making visible the *history* of any current cultural component identified, as a way of exposing it as an "idea" and not a "truth" (Findlay, 2012, pp. 22–24; see also Foucault, 1978, 2000, 2003). For example:

> You feel you are under pressure to think about and try different types of sexual acts. Whether that is good or bad by your standards is a very important consideration. We have identified this as a big current cultural pressure. To help with this, can I ask first, when and how in our history do you think the current profusion of people talking about different sex acts arose? To what degree do you think it arose from altruistic people wanting to spread ideas about making sex life more pleasurable, acceptable, and diverse, and to what extent do you think it arose from industry discovering it could be a good way to make a profit selling articles and books on sex? What types of sex practices were being sold to people 10, 50, or a 100 years ago? Can you guess what will be marketed in 10 years time? If you consider this history, does it help you sort out a little bit what you want for yourself?

Externalizing 3: statement of position map 1 To help therapists learn NT, White (2005b, 2007) described the various distinctive techniques of his approach as different "maps," outlining the steps to each. There is one map on aspects of externalizing the problem that he called, "statement of position map 1" (White, 2007, pp. 38–59). It gets its name because, at its completion, the person has defined their position with regard to the problem. It has four lines of inquiry. I have a simplified and trimmed version of these questions, which is slightly different from White's original richer version:

1 Naming questions (e.g., "What do you call the problem?"; "What is your name for it?")
2 Effects questions (e.g., "How is it affecting your life/your confidence/health/sleep/relationship?"; "How are you experiencing it?"; "What is its impact?"; "What is it putting you through?")
3 Evaluation questions (e.g., "Is this good or bad or mixed in your opinion?"; "Is that OK by you or not?"; "Is it working for you or doing the opposite?")
4 Principles questions (e.g., "What principles do you hold to in deciding it is not what you want?"; "What hopes and dreams do you hold for sex, and your sex life, and the part it should play in your relationship?")

Sometimes these types of questions are done sequentially, but more often we jump around and mix and match the types of questions. I will often start with principles questions first, as I find they also help me to get to know the person and what they value in life. Effects questions are one of my favourites; using them encourages me to "sit" with a person and allow them to talk about their problems in an externalizing way and to slow down and not rush to "fix" the problem, especially before the person is ready.

Re-authoring conversations

Working on the problem and the story that the problem has created is one focus; the other is building the new preferred story. As White (2007) said, "… I believe [the therapeutic task] to be principally about the redevelopment of personal narratives and the reconstruction of identity" (p. 80). This preferred story can't be a fantasy, and it can't be composed independent of action in the real world. It must be inspired by the peoples' beliefs, woven from real discoveries they make, and performed and negotiated with important people in their life.

Re-authoring step 1: finding unique outcomes The first step is often finding and spotting building blocks for the new story—what NT calls unique outcomes (UOs) (White, 2007, p. 61–128, p. 219–261). UOs are welcome and positive events that fly in the face of the problem. They include helpful discoveries the individuals report they made, behaviors that they do to help themselves, or parts of their life that they treasure and that the problem has not touched. They can also be the hopes and dreams that they hold onto in the face of the problem, that they have not let the problem shake from them.

Re-authoring step 2: linking the unique outcomes into the preferred story These UOs could easily be lost, dismissed, or overshadowed. To prevent this, they need to be connected and woven together for any new preferred story of the person to arise and take a firm hold. From the field of UOs, some will be selected and linked to build the new preferred story (also sometimes called the alternative, subordinate, or counter-story). This story will be themed according to the person's preferred principles and directions in life, as well as by the person's movement against presenting problems. Sample themes include "Rob's struggle to enjoy sex again and establish a happy life," and "Jane's endeavors to overcome anxiety and be happy with her body."

A new account, which includes their UOs (especially those of their own making, called "*initiatives*"; see White, 2005a, p. 17), will develop over time and be fed back to them using as many of their own words as possible. This will be followed by asking whether this new account fits. In NT, feeding back what people say is often called an *edit* or *editorial* (White, 2007, p. 45). For example, in the therapist's statement below, the client's own words appear in quotes:

> You said that you believe sex is "a healthy part" of any relationship, including your own. You said you became "puzzled" about why, in recent times, you "have gone off sex," so you made a decision to "do something about it." You have been "having a good think about why" it could be and what to do about it. Instead of saying nothing, you made times to "talk about it" with your partner, you made the effort to come here, and you plan to keep all this going. Is that right?

If the editorial is accepted by the client, more UOs need to be found and threaded in, to build the fledgling new account into a new robust story. One way to do this is to inquire about UOs occurring at various times of their life—past, present, and possible future. White's (2007) "re-authoring conversations map" describes a way to do this (pp. 61–128). It explores discoveries over four different times of the person's life, using two types of questions:

1. *Landscape of identity questions* (also known as landscape of knowledge or consciousness questions) are questions about discoveries of useful and helpful knowledge, concepts, and ideas, and questions about new positive discoveries the person is making about their identity.
2. *Landscape of action questions* (also known as landscape of performance questions) are questions about new useful and helpful skills, practices, and activities (i.e., actions that the person puts into practice to help them go forward).

By recruiting the answers to these questions, another editorial can be provided. For example:

> In our session today, you reported that, over the weekend [time in life number 1], you decided to resist "thinking of yourself as a failure" because you are having "orgasm problems." We then discussed other times in your life you resisted pressures to think of yourself as a failure. At school [time in life number 2], when being bullied, you said to yourself, "It is not me that is wrong; bullying is wrong!" Later in life, at university [time in life number 3], you changed your course of study. At that time, you reminded yourself, "It is not that I'm useless at study; it is that these subjects don't suit me." You call this "seeing myself with self-respect." We then finished by discussing how you can hold onto this "self-respect" image of yourself in the near future [time in life number 4] to keep "I-am-a-failure-thinking" away while you sort out your sexual responses. Is that right?

Re-authoring step 3: thickening (or enriching) the preferred story The new preferred story (or preferred identity claim) now has many UOs woven in over a spread of time. However, even this story of the self could be lost in the face of the problems and their impacts. NT attempts to strengthen the preferred alternative story until it becomes the new dominant story, supplanting the old dominant story (i.e., the version written by the problems).

Narrative approaches to thickening or enriching the new story's claim to the throne are creative and many. Although an in-depth discussion is beyond the scope of this chapter, these approaches include:

1 *Therapeutic documents.* For example, the therapist might write letters or emails to a client outlining the problems externalized and the positives identified in the session. Additionally, in conjunction with clients, therapists might create "certificates" marking points of achievement, or they might help clients to draft "declarations of independence" from problems, in which clients state their principles and notify problems that the struggle to win back their lives from them has now begun (Fox, 2003).
2 *Re-membering practices.* This involves recalling and listing the people—real or fictional—in the clients' life, past or present, who have contributed to and/or acknowledged the positive understandings, skills, and attributes of the person, putting these people in favored positions in the person's symbolic "club of life" and demoting or expelling those who are harmful. White (2007) has a specific map to aid this process, the "re-membering conversations map" (pp. 129–163). It includes a real or imagined discussion with an honored person from the client's life. The conversation involves asking about what the honored person contributed to the clients' life, and what the client contributed to the honored person's life (i.e., the "double contribution").
3 *(Identity) definitional ceremonies.* NT encourages recruiting sympathetic audiences and conducting ceremonies and rituals to hear, confirm, add to, and celebrate the achievements of the client's new story and positive identity. The audience can be enlisted from other people who have solved the problem, understanding friends, partners, family, or sympathetic therapists and mental health workers.

One very specific definitional ceremony practice (White, 2007, pp. 65–118) involves inviting selected sympathetic audiences to respond as "outsider witnesses" in a very particular way to the client's story. "Outsider" in this case means that they first listen to the person's story and then respond (White, 2007, p. 169). The witnesses are asked for their responses to address four types of questions: (1) expression questions (e.g., "What positive things did John say that particularly caught your attention or impressed you?"); (2) image questions (e.g., "What image of John did that evoke in your imagination?"); (3) resonance questions (e.g., "Why, from your own experience, do you think that that is meaningful and important and relevant?"); and (4) transport questions (e.g., "How have you been moved or changed by hearing John tell of his struggle?").

My variant of "transport" questions are the following two questions: first, "What positive things did you learn [knowledge]?"; and second, "What things might you now try to do in your own life after hearing John tell of his struggle [actions]?"

It is rare to do the full ceremony with an audience of witnesses in sex therapy, as it is difficult practically to organize, and people understandably may not want others present or involved in sexual conversations that they prefer to keep private. However, these types of questions and responses can be used in daily practice without bringing in others (Findlay, 2012). For example, with couples, the narrative therapist can use each partner as an audience to the other partner by asking questions such as, "Jack, when you were listening to Jill talk about trying to deal with her fears about sex, what positive things did you hear Jill say that caught your attention?"; or "Jill, from listening to Jack talk about trying to manage anxieties about sex, what new helpful ideas and activities might have occurred to you to try and explore in your own struggle?"

The therapist may also provide the witness report: "Can I tell you what things you said today that caught my attention, why I think they are important, and how I shall use them in my work to help others?"

With witnessing, a counter-practice is in operation. Instead of the witness (even a therapist) saying how the client should change, the witness says how she or he will change as a result of hearing the client's story.

Narrative Therapy Ethics for Practice

There are several principles and ethical guidelines that guide the narrative therapist's choices and actions—a NT ethics of practice. Drawn from widespread sources, they include the following:

- Try to use the client's actual words, as opposed to replacing them with your own. Similarly, try to promote the use of the client's own "vernacular" and minimize (not ignore or disown) the use of pathologizing, diagnostic, and professional nomenclature in therapeutic conversations.
- Promote the client's own discoveries about what helps, in preference to promoting and providing the client with professional and "expert" solutions. This can include collecting, collating, and distributing examples of "local knowledge" for solving problems, such as compiling accounts of other similar people's discoveries on how they reduced problems to give to clients (Epston, 1999).
- Try to expose and critique the presence and imposition of negative or failure or spoiled identities on people (White, 2007, pp. 26–27; see also White, 2001, 2002a). For example, point out and critique statements such as, "I am a failure," "I am a loser," "I am a freak," and "I must be abnormal." This concept is expanded on below.
- Try to expose and critique social and cultural ideas, pressures, and social norms for what they are, and invite a critical analysis of their activities and influence. Especially, but not only, try to expose and critique the presence of gender and race assumptions and biases and how they operate and affect the client's wellbeing.
- Elicit and use the client's principles, hopes, dreams, and beliefs as a guide to your work with them. Work *with* people, not *on* them.
- If a client's beliefs are in significant conflict with your own, consider making this transparent and discuss with them how best to proceed.
- With regard to trauma and loss, acknowledge that people may suffer for what they believe in and care about, not because they are "flawed" or "damaged" individuals (White, 2004, 2005a).

- Attempt to be transparent and explain the direction you take in the therapy sessions and your techniques and questions.
- If a client has "touched" or "moved" you or taught you something, if possible acknowledge it to them.
- Use humor in your work with people, but use it respectfully.

Three Stories from Practice

Working with a narrative approach to problems with sex can be done with an individual, a couple, a family, a group, or a community (e.g., using a narrative approach to assist the running of a sex education program). My own practice is mainly with couples. My client group is mainly white and heterosexual; thus, the stories may reflect that perspective. The dialogue in all three clients' stories is reconstructed from memory and session notes, so it is part truth and part fiction.

Story 1: Co-research

Judy and Jack are talking to me about different interests in sex. Jack wants more; Judy is happy with less. A NT post-structural understanding of this common type of sex problem expresses discomfort with the use of what we call "hydraulic" (liquid) or "steam" (gas) theories of sexual drive (i.e., that sex drive is an energy or force that builds up and needs release). From the hydraulic and steam perspectives, disparity in interest in sex is seen as resulting from a deficiency/depletion, an excess/buildup, or both, of this "fluid," "substance" or "force." Professionals and clients often debate the appropriate or "normal" pressure range on the sexual energy measuring gauge (Findlay, 2012, pp. 18–19; Kelly, 2001, p. 95; White, 2005a, p. 15; White, 2007, p. 101).

Sexual interest does have strong biological (e.g., hormonal) contributions that wax and wane, and medical problems should always be considered when addressing sexual interest concerns, but sexual interest is not identical to the more archetypal biological drives of hunger and thirst. When it comes to interest in sex, any biology is in tightly intertwined companionship with morals and attitudes, with the presence and effects of beliefs about right and wrong, and with struggles of power and control over principles and fairness. In practice, seeing "sex interest" as "sex energy" leads people into a fruitless discussion: "You have too much," "No, you have too little." As White (2007) said, this is a "conversational cul-de-sac" (p. 143).

In my clinical experience, different interests in sex (related to frequency or preferred activity) are almost universal among couples and often persisting—similar to almost any issue that people argue about when they have different interests, beliefs, and opinions. I have no great NT magic-bullet answer. People often find ways to manage the difference and, less often, to solve it (Findlay, 2012). I usually discuss how each person's interest in sex—whatever that is—is constructed by, affected by, and related to, not just personal history and experience, but also (1) personal, familial, peer, and cultural attitudes about sex; (2) the couple's attitude and ability to talk about sex, including about giving and taking what they want; and (3) any struggles for power and control in the relationship, including and especially the presence of criticism, contempt, and abuse.

With Judy and Jack I discussed these and many others issues of life in a mix of individual and joint sessions. At about two months into the work, Judy reported a potential problem in an individual session: She realized that, at times, by waiting until Jack asked for sex, then deciding to say "yes" or "no," she used sex to get other things she wanted in the relationship. She rhetorically asked me if this was good or bad. I could have answered (and would have given my opinion if she pushed for one, as I believe that would have been her right), but the opinion would have come from my male, professional position. I feared that by expressing my opinion, I could risk "colonizing" her with my gendered, professional, and class-specific view, no matter how much I tried not to do so.

Instead, with her agreement, I used a type of NT co-research (Epston, 1999; Findlay, 2012). I asked her to write down her question in her own words, and I showed the question (anonymously) to other women (consenting and keen to help) and asked for their own personal answers to her question. Jill wrote her question as: "If he is not nice to me, I show no interest in sex (refuse sex) until he is. Is that right or wrong?" The other women's replies, which I gathered, were as follows:

- "*You're just being honest; it is what we all do.*"
- "*It's normal.*"
- "*On the one hand, I think it is bad. On the other hand, I have to admire you. It reminds me of the story of the wife who said to her husband, 'if you want to have sex, the bathroom needs to be clean.' Well, that bathroom was always spotless!*"
- "*I'd do it in a (sex) role play. I'd act it out; I'd be the boss queen, and he has to be my bowing subject.*"

I fed the replies back to Jill, and asked what she got from them. She replied that they were helpful, not because she got any specifically useful ideas, but rather, she got a most welcome sense of not being alone and a sense of encouragement to keep trying to find her own answers. This is the usual feedback I get from clients after they read the co-researched replies to their questions. The collective replies gathered and documented are all different—and can even be contradictory—but they are all "local" knowledge, that is, in this case, knowledge used and owned by the women in the community. This approach is different from dispensing "expert knowledge," such that the therapist would make a diagnosis and then suggest a treatment appropriate for that diagnosis (Epston, 1999; Findlay, 2012).

Story 2: The PDE-5 inhibitor diaries

Alan (late 60s) and Anne (early 70s), a retired couple, came to therapy every three months to talk about coping and caring for each other as they live with the problems of ill health and aging. I saw them together. Despite their age and physical disabilities, they enjoyed sex once a week, usually on a Friday evening, or if not, then Saturday or Sunday evening. One day, Alan took the first half of the session without Anne present to discuss a problem with sex. He wished to discuss phosphodiesterase type 5 (PDE-5) inhibitors to help with having an erection. I requested he see his regular family doctor for a medical check-up, to seek a prescription, and to ensure monitoring of any side-effects and drug interactions.

At this point, Alan hesitated. He reported he did not want to discuss it with his family doctor, whom he had known for years. As with his wife, he was embarrassed to discuss it. He found it hard to talk about with people he knew well. (Retrospectively, I can see that his statement also implied a possible solution; that is, he could talk to people he knew less well. In NT, this is called an "absent but implicit" solution.) I responded with externalizing questions. Sometimes (but not always) the skill required is to ask externalizing questions so they sound like ordinary conversation—"gentle externalizing." Here is the recreated conversation. Note the NT use of the client's own words quoted in my questions and responses:

ALAN:	*It's embarrassing. Men my age, we just don't discuss these things.*
THERAPIST:	*[Naming question] "Embarrassment" is the problem then?*
ALAN:	*Yes. He is a great doctor, and I have seen him for years. He is like a friend, and I just could not discuss it with him.*

I next widen the externalizing from an individual, internal factor, to an interactive factor, then to a sociocultural factor, using as many of his own words as possible.

THERAPIST: *I understand better now. "Embarrassment" [individual factor] goes with "not discussing it with friends" [interactive factor]?*
ALAN: *Yes.*
THERAPIST: *And you said "embarrassment" and "not discussing it with friends" is not just you. It is also about what "men your age" generally see as proper to discuss with people you know well?*
ALAN: *Yes.*
THERAPIST: *[Naming question] Do you have a name for this social propriety of "men of your age" [sociocultural factor]?*
ALAN: *Not sure. It's something about being discrete. I shall have to think about it.*

I was worried the first externalized problem, "embarrassment," if left alone, still risked leaving Alan with an impression of having a personal flaw, a pathology, or a moral weakness. Adding the extra interactive and sociocultural externalizations (i.e., the social propriety of the "discretion" of "men of your age") could help counter-portray Alan as a decent person with a problem in daily life that is shared with other similar people—a de-individualizing of the problem (Findlay, 2012, pp. 23–24).

THERAPIST: *[Editorial] The big effect of "embarrassment" and "not discussing it with friends" and "the discretion of men of your age" is that it has you in a position where you want a prescription but can't get one?*
ALAN: *Yes, unfortunately.*
THERAPIST: *[Evaluation question] It seems obvious, but I have to check: Are these problems and their effects good or bad in your opinion?*
ALAN: *Obviously bad, but more to the point, how to solve it? If I told my regular doctor, I would be too embarrassed to see him again, and I would lose a good doctor. The problem is how to keep my family doctor and still get the pills.*
THERAPIST: *[Principles question] Two things are important to you, to keep your competent family doctor and to maintain your sex life with Anne. How to respect both?*
ALAN: *Yes indeed. That's where I am at.*

Problems can be seen as a tussle between competing principles rather than competing drives. As the therapist, I was in a similar position of competing principles: I believed in recommending honesty and trust (i.e., that he discuss it with his doctor and wife), and I believed in acknowledging his solutions and decision about what is best for him (i.e., not telling him what to do). In the end, I did both.

THERAPIST: *Ok, Alan. I want to say, as you can probably guess, that for a host of reasons, I am in favor of you telling Anne and your GP, but I also believe, within limits of course, that the best solution may be one that you find yourself and that fits for you.*

When externalizing problems, narrative therapists try to (at least temporarily) tame "lecturing," "pointing out positives," and "jumping to provide suggestions." (Notice my externalizing language for my own therapeutic process.)

Once a person has defined the externalized problem and their principles and position, they often move into solution thinking on their own accord. The next appointment was, as usual, three months later. Alan again took the first half alone.

THERAPIST: *How is it going with your dilemma?*
ALAN: *I got my prescription [for a PDE-5 inhibitor].*

Given that Alan started with a solution, common NT sense would say to start this session with a focus on discussing the solution, not the problem—in narrative language, a re-authoring discussion.

THERAPIST: *Ok, don't keep me in suspense. How did you do it?*
ALAN: *My doctor went on his annual holiday. I booked in to see the temp doctor that he hired to cover for him. He had all my medical reports, checked me over, and gave me the script.*

I thought to myself, "What a relief, his regular doctor will have it all on file."

ALAN: *It was easy with the temp because I don't know him.*
THERAPIST: *[Unique outcomes or landscape of knowledge question] Can I ask what you have learnt so far from trying the tablets?*
ALAN: *I have learnt to get the long-acting one, which will cover the possibility of it happening on either Friday, Saturday, or Saturday night. I get the script for the double-strength pill, as I can cut it into smaller doses. It costs less than two scripts of the regular strength.*
THERAPIST: *[Landscape of identity question] Sounds like you have made yourself a bit of an expert on them now?*
ALAN: *Yes, and I found it can give me a headache and indigestion, so I take two paracetamol beforehand and one of my tablets to turn off stomach acid a few hours later. They help a lot. I also found the cheapest pharmacy—10 dollars less for four tablets than all the others.*
THERAPIST: *[Co-research question] Can I pass that pharmacy name on to some other people that I am seeing? They all say how much it costs.*
ALAN: *Sure.*
THERAPIST: *And I am still not comfortable about you not telling Anne that you are on it. I know that you two have a good relationship, so wouldn't it be …*
ALAN: *She knows.*
THERAPIST: *[Landscape of action question] You ended up discussing it with her?*
ALAN: *Not really. I paid for the tablets on my credit card, and I forgot she manages the monthly account. Anyway, she is fine with it now. Shall we invite her in?*

This account highlights again how NT prefers therapists to (somewhat) discipline and restrain themselves from making helpful suggestions and from providing expert interventions and instructions. Instead, the therapist is to externalize the problem and ask questions to help uncover, develop, and promote the client's own discoveries, steps, and solutions. Initially UOs may seem thin and far between, but the NT belief is that they are always there.

This client story also highlights another frequent observation: that problems in sex from the client's side may be different from what most concerns us from our professional side of proper diagnosis and management. What clients see as problems may partly be the same as us and partly different—more "ordinary." In Alan's case, the therapist understandably might be concerned with asking diagnostic questions about the frequency, context, and duration of Alan's erections or lack thereof. To Alan, his problems with PDE-5 inhibitors are problems of daily life, including whether or not to tell his partner or his doctor, where and how to get a prescription, practical ways to manage side-effects, how to plan and coordinate sex and taking the tablet with his weekly routine, cost of medications, and so on. Acknowledging and discussing these types of concerns takes the therapist more into the world of the client.

Story 3: Pleasure, pain, and recovery from past hurts and disappointments

Tom, aged 46, and Yolande, aged 41, initially came to see me to discuss what to do about "text-and-email-wars" with Tom's ex-partner Mary over Tom and Mary's son Shane, age 4. For four sessions, we discussed ways to minimize or avoid them, including reviewing and evaluating peacemaking tips that I had compiled from previous veterans of such troubles.

Toward the end of the fourth session, I incidentally asked how things were going between them. They both reported that Yolande, emboldened by a recent flurry of popular culture books and TV shows on what is often called BDSM, had recently disclosed to Tom that she liked a bit of spanking.

Tom had given it a try, but in Yolande's words, "He's not good at it! Can you help him learn how to do it?" Running short of time, we agreed to discuss Yolande's request at the next appointment. Yolande explained she would try to come to that session, too, but if she was too busy at work, to proceed without her. One week later, Tom came alone; Yolande, as foreshadowed, couldn't make it. (Narrative therapists are more likely to see whoever turns up for a session than practitioners trained in some other models, partly because we assume good will in our clients' decisions about whether or not to come to session. A complete discussion of the pros and cons of this are beyond the scope of this paper.)

A full psychosexual history has an important place in sex therapy; however, in private practice, my clients usually don't have the time or funds to spend on lengthy or multiple sessions to gather this complete information. I do the best I can in the time we have. As I gathered information in this session, Tom reported he and Yolande enjoyed sex. They usually kissed and cuddled, proceeded to mutual genital touching and play, and then to penis-vaginal penetration—usually face to face but also with Tom from behind. Intercourse led to Tom's orgasm. Then with the help of a vibrator and four hands between them, they would play with Yolande's genitals until she came.

The (reconstructed) conversation went something like this. Again, note the use of client's own words:

THERAPIST: *So if you would like and are comfortable, tell me: How did trying the spanking go?*
TOM: *Well I tried it—spanking her bum. I wanted to please her, but I couldn't hit her as hard as she wanted. It hurt my hand, and I would stop, as I wanted to go back to fucking. And I was worried I was hurting her. I care about her. I know she wants it, but I find it hard to give her pain when I care about her.*
THERAPIST: *[Principles question] So you believe in caring for her; therefore, it is important to you to please her, and it also is important to you to not hurt her?*
TOM: *Yes.*
THERAPIST: *[Effects question] And you find it hard to tell if the pain is pleasurable or not for her?*
TOM: *Yes. How do I tell? I can't see her face when I spank her, so it's hard to tell. If I do see her face it looks like she is in so much pain that I want to stop.*
THERAPIST: *I have to ask, can you not just ask her if she is liking it?*
TOM: *I have. She is not good at telling me. She told me that she is not into talking about sex; it is not her style.*
THERAPIST: *[Naming questions] So you have two problems born of caring for her: one is how to tell her pleasurable pain from non-pleasurable pain, and two is how to get better at your technique of spanking so it is better for her and so it does not hurt your hand?*
TOM: *Yes and yes.*

Despite an NT wariness about providing (i.e., colonizing with) "expert advice," I do occasionally give it. I believe hiding a potentially helpful treatment from a client is also questionable. However, as is the situation here, clients usually then remind me that they prefer and better accept their own useful discoveries.

THERAPIST: *I just do talking therapy, but I have known some reputable colleagues who are happy to go over spanking technique.*
TOM: *(looking horrified, as if this is too far out of left field) Not sure I want to do that. It is just good to talk about it with you.*
THERAPIST: *And there are internet sites that show …*
TOM: *I checked out the porn sites. I did not like them; they were full of hugely-built actors. They are just acting.*

As expert advice-giving did not seem helpful, I returned, with my tail between my legs, to basic narrative questions.

THERAPIST: *[Narrative edit and landscape of identity question] Can I ask then, what does it tell me about you that you have done all this? First, you tried spanking to make Yolande happy. You did not give up when it did not go right. You checked out the internet (even if it did not help). You also came along today.*

TOM: *That she means something to me, I guess. It shows that I care about her.*

THERAPIST: *Yes, caring is something you are certainly describing doing, but I am asking a narrative therapy identity question, what do your caring acts also say about the type of person you are?*

TOM: *A caring person. I always make an effort for someone I care about.*

THERAPIST: *It would be hard to argue with that conclusion, and I know I don't want to. [Outsider witness variation question] So in hearing yourself talk today, what are you learning that is positive?*

TOM: *Well it has me realizing that I have just been focused on how I have been stuffing up, not how much I have been trying.*

For a new story of the person to prevail, it needs to expand from a single account at a single time, to embrace other positive events and times over the person's life. The re-authoring conversations map (see above) identifies positive discoveries in knowledge, action, and identity over different times and places in a person's life and links them together with present discoveries (White, 2007, pp. 75–128).

THERAPIST: *Was coming along to work out better ways to stop "email-and-text-wars" from affecting everybody another example of your "making an effort for people you care about" [using his phrase from a previous answer]?*

TOM: *Yes, it wasn't the only reason that I did that, but it was an important part.*

THERAPIST: *[Re-authoring question] Can you tell me other times in your life you have gone through sacrifice, or hard times, or a demanding effort to do what you believe in?*

TOM: *Let me think … Yes, retraining in IT work. It was hard, and we were financially stretched, but I had to do it to earn enough to be able to care for the family in the long run.*

The story of this endeavour was first expanded, then other efforts in other times of his life were inquired about, added in and expanded similarly.

In the next session, two months later, both Tom and Yolande turned up. The conversation continued.

THERAPIST: *How is he doing?*

YOLANDE: *He is not a grand master, but he is a lot better at it. It's working for me. I won't get rid of him, yet [said jokingly].*

THERAPIST: *[Unique outcomes question] What worked, Tom?*

TOM: *I started watching TV documentaries about sex. Some included interviews with women who really liked spanking. I could see from their faces they really looked forward to it. One of the women had made some videos, so I looked them up on the internet. I could see in the videos that she had that same look on her face—as far as I could tell anyway!*

THERAPIST: *[Unique outcome question] Did you then see that look in Yolande's face?*

TOM: *A little, but more it helped me to know for sure she must like it. I began to feel that she liked it. I could spank a bit harder and know that she liked it. And the videos showed so many different ways to do spanking, so I got some ideas on what to try with Yolande. I tried a cane, and she liked it.*

THERAPIST: *[Unique outcome question] Ah, no more sore hand?*

TOM: *Exactly.*

THERAPIST: *[A non-narrative question] Yolande, I have to ask, can't you just tell him what you like and don't like?*

YOLANDE: *It is not my style. I am not used to that, but I will think about it. He is being so considerate for me; I want to pay him back in kind.*

THERAPIST: *[Landscape of identity question] Are you a considerate person yourself?*

YOLANDE: *Yes. I have got a bit away from that in recent years, but that is how—deep down—I really am.*

The next couple session was one month later.

THERAPIST: *[Non-narrative question] How did you do with my request to think about telling him more what you like?*

YOLANDE: *[Graciously] I am talking more about sex, but it takes time.*

TOM: *She found her own way to do it.*

THERAPIST: *[Unique outcome question] Tom, what did Yolande do that worked?*

TOM: *She loaned me a book of hers on women's erotica. Two chapters were her favorites. They were pretty well thumbed, too. Now I know what she likes*

THERAPIST: *[Unique outcome question] So she likes written stuff, not so much talking about it in person?*

TOM: *Yes, that's what I thought, so instead of asking her so much what she liked, I sent her an email of a little fantasy I made up about us and spanking, and I invited her to send me one she made up in return. She did so a week later. Now it's my turn to email her one.*

THERAPIST: *[Landscape of action question] You both put into practice ways to show "care" [his word from above] and "consideration" [her word from above]?*

YOLANDE: *Yes. My upbringing was that girls shouldn't enjoy sex. I discovered years ago that I really enjoyed it. It is great to do it with someone who is considerate about my pleasure too.*

THERAPIST: *[Principles question] Tom, are you a person who believes in enjoyment in sex, too, as well as caring for people?*

TOM: *Yes, always. Although I am not sure my ex sees me as a caring person. I am glad Yolande does.*

THERAPIST: *[Landscape of identity question] Yolande sees you as a caring and considerate person?*

TOM: *I think she does, yes.*

YOLANDE: *He is.*

Tom added that, recently, he realized he had been asking Yolande what she liked but not telling her what he liked, so he had disclosed to her he liked oral sex—giving and receiving. Oral sex had not been part of their repertoire. Yolande told him she had tried it in the past with previous partners with little or no enjoyment. However, she was not opposed to it, and fitting with their spirit of mutual caring and consideration, she had agreed to try it again with Tom. They discovered they both enjoyed it with each other. They reported she initially had her own technique problems but was working on it. Then the mood turned pensive.

YOLANDE: *You know, with my ex, we enjoyed sex, but he was so selfish. We did what he liked. He brushed me off if I wanted something. I stopped asking for or expecting to get what I wanted. My girlfriends said he was not good for me. Tom is actually genuinely interested in what I like. I am coming out of myself slowly. I say I want something, and we try something new. It's amazing, but I get really scared the next few days, but then I am OK.*

TOM: *If I asked for anything with my ex, we ended up having a fight like we did with most things. I stopped asking. I didn't realize, Yolande, that you get scared after trying something new in sex. I do too. Sometimes it lasts a week, but then I am OK, too.*

THERAPIST: *[Co-research question] Hmm, that got me thinking: Perhaps I could—I should—be asking other clients if that happens to them, too. If so, any tips for others about how to get through that? But first, I have to ask, in showing care and consideration to each other, to help each other enjoy and explore sex, are you also recovering from some of the unwanted effects of past relationships on yourself and your sex life?*

TOM: *Say that again. I'm not sure I understood that? Is that one of your narrative therapy questions?*

THERAPIST: *Sorry. In being considerate and caring for each other when you explore and enjoy sex with each other, are you also healing each other and yourselves from past hurts about sex and relating?*

TOM AND YOLANDE: *Yes.*

THERAPIST: *And returning or restoring yourselves to the person you each want to be?*

TOM: *Another of your narrative questions, Ron? Anyway, yes I agree.*

This story includes responding to the presenting problem, both by externalizing it and by identifying unique outcomes against it. It includes establishing people's principles for life, sex, and relating and, with that, identifying an idea or theme about where they want to go in life. These are all used to build a preferred story and identity for each. The chosen story and identity is then thickened with other actions and discoveries in other times of life that fit with it.

As other problems emerge (e.g., past relationship hurts), the preferred story is recruited to help to heal and move on (White, 2004, 2005a). Then those extra forward steps are also used, in turn, to enrich the favored story.

Discussion of the practice stories

Absent but implicit An important approach in NT for identifying a UO is to look for the "absent but implicit" (White, 2005a, p. 15). When Alan said it's hard to talk about it with people he knows well, he may have been implying it is easier to talk about it with people he does not know well (i.e., an implied solution). In NT, we would not assume that it is definitely the case that this is a solution, but we would inquire: "Alan, does that mean it is easier for you to talk about sex with people who aren't friends, who you don't know so well?"

The position of the therapist: decentered but influential As the therapist, I took the responsibility for and did a lot of work in determining the direction of the conversation, but I kept my ideas of any solutions more to the periphery and the clients' solutions more to the center. This is an example of what is seen as an important NT therapist task when running a session, being *de-centered* off the expert's knowledge (and centered on the clients' knowledge) but *influential* in the running of the session. The hard work of the narrative therapist is not to provide solutions but to run the conversations so that the clients find them (White, 2005b). "Scaffolding conversations" is one NT way of doing this (White, 2007, pp. 263–290).

Professional versus personal names for problems Although there were many opportunities to do so, I declined to introduce professional nomenclature such as medical and psychological terminology. Even street or popular culture classifications, such as "BDSM," were downplayed, and the clients' own words were spotlighted (i.e., "spanking"). Similarly, the term "past hurt" was preferred over terms like "trauma." One reason for this is the well-known concern about "labelling"; that is, that diagnostic language might alienate and de-skill clients, leaving them dependent on an expert for salvation. The second reason is the concern about implying "flawed," "failure" and "abnormal" identities, which professional and pop classifications and names for sexual problems can imply (see above about Foucault & White on identity). Using people's own words—particularly those that simply *describe acts* like "spanking" in preference to professional or pop culture terms that *describe classifications*—can help to minimize this risk (Findlay, 2012).

This bias against professional language is not an absolute rule. If a client found a diagnosis freeing and unburdening, that would be respected. Also respected is the position where a therapist needs to make a diagnosis to better treat a client or to qualify with external requirements necessary to secure funding to enable working with a client.

Conclusions

Externalizing the problem in conversation, re-authoring conversations (i.e., finding unique outcomes), and composing preferred stories of the person are the backbones of narrative practices. Other practices to thicken the preferred story, such as therapeutic documents, remembering, and outsider witnessing, help these processes and can also be used wonderfully on

their own. Throughout, there is the influence of narrative politics, ethics, and morality, and positive assumptions about life, people's stories, and therapy, without which NT becomes sterile and mechanical.

Without substantial published articles and solid research, I cannot yet professionally recommend narrative therapy use by practitioners for any specific sexual problems—especially when clinicians are aware of an approach with more solid evidence for a particular problem. I will say, though, that NT serves a great function in assisting people who succumb to the idea they are a failure as a whole person because they have been "failing" at sex in some way.

Practitioners who use this brand of the narrative approach do so because it makes sense to them, theoretically, practically, and ethically. NT practitioners work from a narrative position a little or a lot. (My own approach is mostly narrative with some solution-focused and applied communication theory thrown in.) Many use NT as a therapeutic tool in conjunction with other therapeutic modalities. I have seen it used successfully with CBT, solution-focused approaches, and mindfulness approaches, in particular. Many narrative techniques and ethics are similar to those used in other approaches, so for these, NT cannot claim exclusivity.

If you plan to give NT a try, you might consider recruiting clients to assist your evaluation of any new skill and employ what can be called "evaluation of the session" questions:

> I am trying some narrative therapy techniques and I shall explain them as I go. Is that OK with you? Would you let me know what you think of them, what helps, and what does not? How did they affect you? And would you have me do more or less of them?

NT believes—similar to several other models—that we learn not just from professional texts and teaching, but from our clients too.

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16

An Emotionally Focused Approach to Sex Therapy

Sue Johnson

Sex is a Bonding Behavior: The Emotionally Focused Approach to Healing Sexual Issues

A strange thing has happened to sex and sexuality. It is increasingly portrayed, as psychologist Leonore Tiefer (2010) suggested and critiqued, as purely a physical process similar to *digestion*. As such, sexual problems are "medicalized" (Leiblum & Rosen, 2000), much as problems in digestion are. For the clinician who sees partners together, however, it is clear that sexuality is best viewed as a reciprocal *dance* that occurs in a particular interactional context (Tiefer, 2010). In fact, I would argue that, even in solo sex acts, such as masturbation, sex occurs in the context of our primary relationships because such relationships shape our perceptions of our body; our orientation to our needs; and our ability to engage fully with and integrate our emotional experience of self, as well as others. We are social animals who live, even when we are physically alone, lives that are saturated with constant images of, models of, and inner conversations with others. As an attachment-oriented researcher and clinician, taking sexuality out of a relational context is clearly, in my view, a major mistake in terms of understanding how sex works, what healthy sex is, and how to treat sexual problems. This attachment perspective involves more than recognizing that "sex therapy is … inextricably tied to relationship issues and psychological functioning" (Leiblum & Rosen, 2000, p. 11). It implies that relational issues are primary; they are the defining context for sexual functioning. The quality of our attachments—our emotional connection with key others—is seen as irrevocably shaping the other elements of a relationship, namely care-taking and sexuality (Johnson & Zuccarini, 2010).

This chapter will examine the emotionally focused approach to dealing with sexual problems and the implications of this attachment-oriented perspective for our understanding of sexuality, sexual health, sexual dysfunction, and the treatment of sexual issues. It will present an overview of "emotionally focused couples therapy" (EFT), a well-validated approach to relationship distress (Johnson, 2004; Lebow, Chambers, Christensen, & Johnson, 2012). EFT is the only couple intervention that is systematically grounded in a consistently validated, developmental, relational theory of personality and human functioning—namely, attachment theory (Bowlby, 1988; Mikulincer & Shaver, 2007). As part of this overview, the attachment orientation to sexual health and dysfunction will be outlined. EFT interventions that address sexual functioning will be described and examples given. Conclusions will be drawn from attachment theory and research and EFT practice as to the nature of sexuality and the best path to the remediation of sexual difficulties.

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The Attachment Perspective on Adult Love and Sexuality

As stated above, EFT is based on an understanding of romantic love as an emotional bond. The nature of this bond is outlined by the last 15 years of adult attachment theory and research (Mikulincer & Shaver, 2007). The attachment framework not only offers a procedural template for understanding relationship distress and remediating it, but also offers a particular view of sexuality (Johnson & Zuccarini, 2010, 2011).

An attachment bond is characterized by the seeking of physical and emotional proximity, particularly at times of uncertainty or stress; the creation of a safe haven connection that regulates emotion, especially fear; the shaping of a secure base with a loved one that supports exploration and autonomy; and separation distress responses when emotional contact with an attachment figure is lost. These distress responses—the intensity and nature of which will vary depending on the level of felt security or connection in the relationship—include protest, clinging, and despair, finally culminating, if no renewal of connection occurs, in numbing and detachment. Attachment bonds prime the release of oxytocin, which increases the ability to tune into others, down-regulate fear, and stimulates the production of reward hormones such as dopamine (Johnson, 2008, 2013).

In adults, these bonds are more reciprocal than between parent and child, and they can be accessed through mental representations when the other person is absent; adults think of loved ones when under stress and so find comfort and strength. Physical proximity and comfort also expand into a sexual bond in adulthood. Bowlby (1969), the father of attachment theory, considered that, of the three behavioral systems active in close relationships (attachment, caregiving, and sexuality), it is the attachment bond—with its core associations with safety and survival—that is primary. Attachment then structures the other two behavioral systems: caregiving and sexuality.

A secure emotional bond, characterized by accessibility and responsiveness, optimizes healthy sexuality in that, by its nature, such a bond fosters the ability to play, to put aside defenses and trust bodily responses, to tune into another person, to express sexual desires and needs, and to deal with sexual differences and problems. Safety allows for all of one's attention and mental and physical resources to be directed to and used in the service of sexuality. In a reciprocal feedback loop, secure attachment, with its accessibility and responsiveness, potentiates adult sexuality, and secure sexuality, in turn, promotes emotional connection and bonding. Conversely, insecure attachment, in which partners are anxious and vigilant for cues of rejection or abandonment, or in which they shut down attachment needs and actively avoid contact with others when vulnerable, constrains the experience and expression of sexuality.

Secure attachment and optimal couple sexuality

As stated above, secure attachment offers a secure base from which individuals can explore their universe and adaptively and flexibly respond to internal and external cues. It allows partners to be attuned to each other, sensing each other's inner state and intention and responding to each other's shifting states of arousal in the same way that an empathic mother is attuned to her baby (Stern, 2004). Non-verbal cues—sighs, gaze, and touch—carry exquisitely coordinated signals. The resulting sense of deep rapport creates a "synchrony" in which emotional, physical, and sexual cues can be integrated into the dance with a lover. In a secure relationship—marked by emotional accessibility and responsiveness—attachment, caregiving, and sexuality are integrated in such a manner that emotional and physiological responsiveness, tender touch, and erotic playfulness can all come together. With the integration of attachment, caregiving, and sexuality, lust and passion can flow into affection and intimacy. Eastwick and Finkel (2008) persuasively defined passion as the uniting of attachment longing with erotic connection.

As Heiman (2007) suggested, sexuality is an affect-oriented interaction. Ways of regulating and expressing emotion constitute our ways of engaging others. Thus, emotional safety shapes physical synchrony, and physical synchrony embodies emotional safety (Johnson, 2009). One of the most basic elements of sexuality—touch—integrates the language of sexuality and of attachment. Touch arouses, and it also soothes and comforts. Sexual thrill and eroticism in a secure attachment arise from the partners' openness to moment-to-moment connection and fully-engaged presence. Sexual exploration is also more possible with an engaged partner, who is able to surrender to sensation without reserve or caution. It is also the case that, with secure attachment, partners can tolerate shifts in sexual focus between one's own and the other's attachment and sexual pleasure goals without experiencing fears of abandonment or rejection, as one person risks sharing their sexual needs and longings with the other. Secure partners can then flexibly tolerate variations in a partner's needs, including the passionate, emotional, and physical aspects of sexuality. As a result of this attunement, securely attached partners can achieve a sense of connection and closeness in the sexual realm, which is a primary reason for engaging in sex (Davis, Shaver, & Vernon, 2004; Schachner & Shaver, 2004).

There is, however, much confusion in the couples therapy field as to what healthy sexuality looks like. This tends to hinder any effective integration of sex therapy and couples therapy, and it confuses clinicians. Some commentators suggest that the most functional sex arises when partners do not depend upon each other, but maintain clear personal boundaries and a sense of individuation or differentiation from each other. This conceptualization arises from Bowen's (1978) theory of family therapy, developed many years ago to address schizophrenia in a family context. The concept is that, to be arousing, one must be emotionally separate and different (Schnarch, 1997). This is tied to the idea that what is thrilling inevitably arises out of constant novelty and foreignness. It follows from this perspective that security diminishes desire and sexual boredom is the key problem in long-term relationships. Couples then have to spice up their sexuality, for example, by playing the role of the stranger, prostitute, or adulterous lover (Perel, 2007). The leap is then sometimes made into the argument that monogamy is essentially unnatural, and that it, in fact, kills eroticism. There is little research to support any of these views. The best survey research in the US (Laumann & Michael, 2001) suggested that happy long-term couples have more and better sex than those in uncommitted or short-term relationships. Even as adolescents, those with an orientation toward secure attachment—who feel confident that they can reach for and rely on others—report fewer erotophobic responses (i.e., fewer negative affective-evaluative responses to sexual cues and more positive and passionate emotions during sex) compared with those with a less secure attachment orientation. Expressing love and affection is also one of their main motivations for having sex, and those with a secure orientation prefer sex in committed relationships rather than casual relationships (Brennan & Shaver, 1995; Tracy, Shaver, Albino, & Cooper, 2003). In adulthood, they also have more positive sexual self-schemas than those with a less secure orientation (Cyranowski & Anderson, 1998). Attachment research supports the idea that secure connection fosters sexual satisfaction.

From an attachment viewpoint, the focus on sensation and performance that saturates the alternative novelty- and thrill-orientated approach to sex, as described above (Perel, 2007; Schnarch, 1997), sounds much like the operation of avoidant attachment (discussed later in the chapter). Avoidantly attached lovers, who are uncomfortable with closeness, are more likely to state that their motivation for sex is oriented to sensation, stress control, and self-image aggrandisement or prestige with peers. They also report less frequent sex and less satisfaction in their sexual relationships (Bogaert & Sadava, 2002; Davis *et al.*, 2006; Schnachner & Shaver, 2004). Compared with securely attached individuals, avoidant individuals endorse more positive attitudes toward emotion-free and recreational sex and more dislike of the bonding aspects of sex such as cuddling (Gillath & Schnachner, 2006). This constricted view of sexuality does not lend itself to foreplay or afterplay and generally seems foreign to the

process of secure bonding or a rich sex life. If emotion is viewed as the music of the dance, sex without emotional engagement might be compared to dancing without music.

An attachment-oriented perspective suggests that, in fact, it is emotional safety rather than novelty and unfamiliarity that offers the best platform for passion and ongoing arousal in a long-term couple relationship. Paradoxically, a felt sense of safety allows sex to be an adventure, in which risk and exploration can occur. As deep emotional engagement occurs, the awareness of the innate "otherness" and the ultimate unknowable-ness of another person become clear, so the capacity for exploration is infinite. Sex and bonding are also natural bedfellows; they share the same chemistry in that they are both associated with dopamine and oxytocin. Interestingly, oxytocin also interacts with dopamine to block habituation to reward effects in drug studies. It is possible that it may have a similar effect in bonding interactions. Attachment researchers such as Gillath, Mikulincer, Birnbaum, and Shaver (2008) found that, if men and women are subconsciously primed with erotic stimuli, then they also respond more positively to questions about bonding responses, for example, about their willingness to make sacrifices for a relationship, their desire for closeness, and their ability to find caring ways to resolve conflict.

There is evidence that, especially for women, emotional and physical safety and security are key ingredients in the experience of sexual arousal. Given the extent of the attunement and coordination necessary for good sex and the constricting nature of anxiety, it certainly makes sense that this would be true for sexual satisfaction as well. In one study, the prefrontal cortex and other areas involved in making judgments became activated in women's brains when they were exposed to subliminal and explicit sexual primes (Gillath & Canterbury, 2012). This response was not found for men. The researchers suggested that women naturally pair safety concerns with lust, and indeed, this seems functional given how vulnerable women are during sex. In couples therapy, men also typically talk of how criticism and anger from their partner turn on anxiety and turn off their sexual response. In clinical situations, both men and women typically identify a lack of safe emotional connection with their primary partner, rather than lust for another partner, as the trigger for extramarital sexual involvement.

The impact of attachment insecurity on sexuality

Sexuality is experienced, expressed, and enacted differently by those in relationships characterized by secure versus insecure attachment (Diamond & Blatt, 2007; Mikulincer & Shaver, 2007). A couple's sexual connection may be a source of insecurity or a resource that builds and maintains greater attachment security.

Insecure forms of attachment with their unique forms of affect regulation and relationship strategies have been classified in over 50 years of research into three styles—namely, *preoccupied anxious*, *dismissing avoidant*, and *fearful avoidant or disorganized* attachment. Anxious attachment, which arises in the context of inconsistent caregiving where a child has to intensify attachment signals to get a caregiver's attention, shows up in adult relationships in terms of unremitting attempts to elicit responsiveness from a partner and to find proof of love. For example, Bruce tells his wife:

> So what if we have been married for 25 years. How do I know you really love me? If you made love to me twice a day and showed that I pleased you by having multiple orgasms then maybe I would believe it. And I don't want you to look at other guys at parties.

Abandonment and rejection sensitivities complicate all aspects of sexuality for an anxiously attached individual such as Bruce. The anxiously attached person's sexual interactions could be termed "solace sex" because sex is mostly about relieving fears of rejection rather than eroticism or pleasure (Johnson, 2008).

Dismissing avoidant attachment occurs when loved ones have been unresponsive or even dangerous and so needs for connection have been shut off and any form of dependency is shunned. This shows up in adult relationships in the form of mechanical and emotionally dissociated sex. For example, Andrew tells his wife,

> So what if I watch porn all the time. It's just to get off. It's easier than doing all that talking and cuddling that you want to do if we make out. And I want more intense sex than you do—more charge.

Andrew's conversation about sex is filled with references to sensation and specific performance concerns about needing sex to be "hot" and wanting his wife to dress in "hot" clothes to turn him on. This could be labeled "sealed-off" sex, in that the longing for love and connection are removed from the sexual act.

The partner caught in a fearful avoidant style has usually been abused by attachment figures, and this often includes sexual abuse. For such people, sexuality is then a paradoxical mix of desire, longing for comfort in a dangerous and chaotic world, and fear of connection that may lead to violation and betrayal. These individuals often flip between anxious, desperate clinging and dissociated, defensive distancing in bed and out of it. EFT is the only couples therapy in which an outcome research study has been conducted specifically with this population (Macintosh & Johnson, 2008), and case studies can be found in the couples therapy for trauma survivors literature (Johnson, 2002).

In general, in insecure attachment, the sexual dance is inevitably impacted by one's own or a partner's self-protection strategies, such as anxious pursuit or reactive numbing, employed to manage attachment distress. With attachment insecurity, partners struggle to manage frustrations, failures, and differences in each partner's desire and arousal. All couples face the inevitable waxing and waning of desire, arousal, and orgasm capacities throughout their history together. How these changes and possible frustrations are dealt with and how they impact the relationship as a whole will be influenced by a couple's attachment security. Desire, arousal, orgasm, and satisfaction will be impacted by each partner's level of security and associated attachment strategies (Birnbaum, 2007; Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006).

Perhaps the greatest strength of an intervention based on attachment is that this perspective offers an integrated model of relational and sexual health in terms of optimal development, as well as dysfunction. This gives both couples therapists and sex therapists—two roles that are becoming more and more intertwined (Leiblum, 2007)—a clear direction for intervention that goes beyond simply the reduction of general relationship distress or the alleviation of sexual symptomatology.

For many couples, sexual problems arise as a result of relationship breakdown and wane when the relationship is restored, although both positive and negative sexual experiences tend to have more impact on relationship interactions for insecurely attached partners than for securely attached ones. For example, anxiously attached partners use such sexual interactions as a barometer for the viability of the relationship as a whole and as a sign of how much or how little they are valued by their partner (Birnbaum *et al.*, 2006). For some partners, however, sexuality and sexual issues are front and center and have to be addressed in a relationship therapy in a more systematic and deliberate manner, rather than simply as a side-bar in the general process of relationship repair (Johnson & Zuccarini, 2011). The remainder of this chapter will consider the EFT model of couples intervention and the addressing of sexual issues in the context of EFT.

The EFT Model of Couple Therapy

Theoretically, EFT draws on a synthesis of humanistic/experiential and systemic assumptions (e.g. Minuchin & Fishman, 1981; Rogers, 1951), both of which are evident in EFT's dynamic use of reprocessed and "new" emotional experiences to engage partners in the enactment of

more adaptive relational patterns. Shortly after Johnson and Greenberg's (1985) promising initial outcome study on EFT and the sudden growth of the literature on adult attachment (e.g. Hazan & Shaver, 1987), EFT began to contribute to the integration of attachment concepts into couples therapy (Johnson, 1986). The approach became more and more explicitly focused on strengthening a couple's bond through increased mutual emotional accessibility and responsiveness.

The primary treatment manual for EFT (Johnson, 2004) described this brief, systematic approach (8–20 sessions). EFT combines a shared focus on interpersonal interaction patterns and intrapsychic processes, which are understood in terms of adult attachment theory (Mikulincer & Shaver, 2007). The therapist serves as a process consultant, focused on facilitating in-session experiences of interactive and inner experiential emotional cycles. To facilitate access to the underlying aspects of a client's emotional experience, the therapist builds a safe and collaborative therapeutic alliance. This alliance enables couples to engage and explore their habitual emotional responses, and provides a felt sense of security as each partner takes steps to restructure their negative patterns and to address unmet needs for secure connection. The approach assumes that couples have mutual goals and a workable commitment to changing their relationship. EFT is not meant for use with violent partners or with couples demonstrating incompatible relationship goals (Johnson, 2004).

In this model, a distressed couple's problem is not seen as a lack of communication skill, an inability to negotiate differences, or a propensity for conflict. Disagreements and conflict occur in every relationship. Distress instead is seen as the result of chronic emotional disconnection without reliable repair. Partners continually trigger each other's fears of rejection and abandonment and then protest or try to "fix" their lack of safe haven connection. The usual pattern is that one partner blames and demands, while the other shuts down to try to regulate their emotions and prevent escalation. This dance of disconnection takes over the relationship and leaves both partners hurt, and in what emotion researcher Jaak Panksepp (1998) described as *attachment panic*. This panic is viewed as a specific form of fear that is wired into the mammalian brain, reflecting the fact that mammals are born helpless and require connection with others to survive. Emotional isolation is encoded as a danger cue or a threat to survival in much the same way as extreme thirst or hunger. In a secure relationship, partners are able to reach for each other and repair rifts; this process helps each to find emotional balance. In terms of sexuality, the experience of fear and the task of regulating survival-oriented emotions interferes with processes necessary for satisfying sex—such as engaged sexual arousal and attunement to and coordination with the other's physiological and emotional state. In couples who do not present with specific sexual problems, the EFT therapist assumes that, once this relational block or insecurity is addressed and safe emotional connection restored, then the door opens to positive sexuality. A recent study showing that EFT increased relationship satisfaction and the security of the emotional bond between distressed partners also found that sexual satisfaction increased in these partners' relationships (Elliott, Wiebe, Johnson & Tasca, 2016).

In EFT, the therapist attempts to create safety in the session and then constantly cycles through five key interventions. These interventions are intrapsychic/experiential and interpersonal/systemic. The description of these interventions offers an overview of the EFT model.

First, the therapist reflects the process that occurs in the present moment in the session, *between* members of the couple or *within* the emotional experience of the partners. For example, the therapist might comment:

> I notice that you talk about many issues where you disagree. But, Ann, when the fact that you seem to have lost the closeness and sexuality in your relationship comes up, you get very agitated, and you try to get Jerry to see how you experience him as "difficult and cold." You sound angry. Jerry, you turn your chair away and sigh. You say, "Not this again. There is no point in talking to you," and go silent. This dance of "I-push-you-to-open-up-and-look-at-how-distant-we-still-are"

> followed by "I-step-back-and-close-down-because-we-will-just-get-into-a-'pointless'-struggle-with-no-good-outcome" seems like it leaves you both so discouraged. And the more you, Anne, demand to be heard, the more you, Jerry, step back because it seems kind of hopeless to talk?

Anne and Jerry agree and help the therapist to refine this description, which offers a meta-perspective of their self-perpetuating interactional dance. They also each learn how the dance impacts the other emotionally.

Second, the therapist focuses on the inner emotional experience of each partner and how this emotion is constructed and regulated, using empathic reflection and evocative questions. The therapist might say, "Anne, right now, as you use the word 'cold', your voice goes soft and your face changes. What is happening for you?" Anne tunes in and finds that she suddenly feels sad rather than angry, and with the therapist's help, she formulates this feeling in terms of "desperate-aloneness". The therapist has deepened Anne's engagement with her emotions and helped her to order and articulate them in a clear and specific way.

Third, the therapist invites each person to coherently shape this newly-formulated emotion into a new message to his or her partner. She distills Anne's experience and asks, "So can you turn to Jerry right now and share with him these feelings of desperation and loneliness that hit just before you get mad? These feelings of having lost him?" The therapist supports Anne to do this, perhaps by helping her, first, to talk about how hard this is to do and how worried she is about Jerry's response. New emotions are shaped into new signals that are crafted to engage the other partner emotionally and evoke empathic responsiveness. Anne shares her desperateness and admits that, although showing anger is easier than showing her desperation, it still leaves her feeling all alone.

Fourth, the therapist processes these new steps in the dance—this new enactment—with both partners, asking Anne what it was like to share (she says it was scary but good) and asking Jerry what it was like to hear this message. Jerry confides that he feels confused, and he says that he is so focused on monitoring his wife's anger that he never considers she might feel scared or worried about losing him. He turns his chair more towards her. She begins to cry, and he puts his hand on her knee. She then shares that the most painful part of this is that she worries he no longer desires her because she has put on weight. Jerry seems to uncoil from his cool reserve, and he leans forward and tells her that he feels lots of desire but loses it when she becomes "dangerous."

Fifth, the therapist takes this new experience and new interaction and contrasts it with the couple's regular pattern of responding. In doing so, the therapist encapsulates and reviews the new interaction to build confidence and hope and to help each partner to integrate it into their model of self and other. The therapist notes, "Look what you just did here. [She recaps the moves each made.] That is amazing." Helping partners change how they engage emotionally and see the impact of this change creates a sense of competence that motivates them to continue to explore and learn.

In order to deepen clients' exploration of their emotions, the EFT therapist continuously uses focused empathic reflection, evocative process questions (e.g., "How does your body feel as you talk about this?"; "What do you say to yourself as this happens?"), small interpretations at the leading edge of a client's experience where that experience is unformulated or vague, and validation that emotions and habitual interactional moves make legitimate sense. All of this occurs while the therapist's ordering of the process helps the couple stay in emotional balance. Therapy then becomes a safe adventure. The therapist also creates enactments that slowly move partners towards the safe, congruent emotional connection that characterizes a secure emotional bond. The map of relatedness provided by attachment theory also allows the therapist to create therapeutic reframes; for example, the problem in the relationship can be reframed as the dance of disconnection that has captured the couple and holds them in its thrall, rather than as a personal inadequacy on the part of the partners. Another reframe is that withdrawn partners shut down, not out of indifference, but because they are so overwhelmed by and care so much

about the messages coming from their lover. All of the above five moves and interventions are well articulated and demonstrated in the many chapters and training DVDs on EFT (available from www.iceeft.com).

These moves and interventions span the whole of course of therapy, but they may differ in intensity and directiveness across the three stages of EFT.

1 In the *de-escalation stage*, the negative cycle of disconnection is outlined and contained so that the partner is no longer viewed as a danger cue but as a fellow victim of the negative relational pattern. Primary emotions that have gone unacknowledged, such as deep loneliness and fears of inadequacy and rejection, are now explicated. The couple now has, in attachment terms, a secure base upon which to stand. This enables them to risk engaging at a deeper level. In a couple in which this distress has undermined sexual connection, this sexual connection usually begins to return at the end of this de-escalation stage, when the couple feels safer and has more hope that positive change can occur.
2 In the *restructuring attachment stage*, the therapist guides each person into owning their attachment needs and fears and expressing these in a manner that primes empathy and responsiveness in the other. This stage ends with powerful bonding conversations that have been found in nine studies to be associated with success in therapy, relationship recovery, and long-term relationship satisfaction (Greenman & Johnson, 2013).
3 In the *consolidation stage*, the changes the couple has made are reviewed and integrated into the models of self, other, and relationship, and visions of the future are shared.

EFT has been extensively empirically validated. The most rigorous older studies find that 70–73% of couples move out of distress by the end of therapy, and 86–90% report significant improvement in distress levels (Johnson, Hunsley, Greenberg, & Schindler 1999). Factors such as the pre-treatment level of distress or traditionality (i.e., the couple's level of adherence to traditional gendered marriage roles) do not seem to significantly impact outcome; the level of engagement in the tasks of therapy and the perceived relevance of the tasks set up by the therapist seem to be more important (Johnson & Talitman, 1996). EFT has been implemented with depressed and traumatized couples with good success; it has also been found to lead to improvement in both individual depression and trauma symptoms (Dalton, Greenman, Classen & Johnson, 2013; Denton, Burelson, Clark, Rodriguez, & Hobbs, 2000), both of which are known to impact sexuality. One older study, which looked at the impact of 12 sessions of EFT specifically on distressed couples' sexuality, found only weak evidence of any positive results (McPhee, Johnson, & van der Veer, 1995). However, as mentioned previously, a more recent study (Elliott *et al.*, 2016), in which 20 sessions by more experienced therapists were offered to couples facing relationship distress and insecurity, did find that EFT was associated with an increase in sexual satisfaction.

EFT researchers have concluded that the large effect sizes and the stability of these effects arise from the active utilization of the most powerful unconditioned human drive: the longing for a secure bond with another human being. In any short-term intervention, focus is key, and as an intervention, EFT is on target from the point of view of attachment theory and research. It is also consonant with the psychotherapy literature that suggests that emotional engagement is the core active ingredient in successful psychotherapy, and collaborative rather than coaching models attain this kind of engagement most effectively (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Coombs, Coleman, & Jones, 2002).

The 10 principles for addressing sexual problems from an EFT perspective

Principle 1 Sexuality is never addressed as purely an individual problem; the partner's responses are always viewed as part of any sexual issue. Sexual disconnection is placed in the context of a couple's negative cycles of interaction that undermine safety and intimacy.

Depressed, emotionally withdrawn partners, for example, may actually occasionally seek positive engagement in the area of sexuality, but their already-alienated partners cannot respond to these overtures. Even if a partner comes into a relationship with a serious sexual problem—for example, a lack of desire and emotional numbing as a result of previous sexual abuse—interactions with the partner will potentiate or block healing (Johnson, 2002). Therapy always begins, then, with an assessment of a couple's patterns of emotional engagement and disengagement, and the patterns of sexual interaction are viewed in this context.

Principle 2 When specific sexual complaints are central to relationship distress, the therapist will, in the individual sessions that are part of the assessment process in EFT, conduct a sexual functioning assessment, including querying cultural and family scripts about sexuality; physiological functioning; childhood trauma; current medical treatments; and mental health issues, such as anxiety and depression, that undermine positive sexuality. Consultation with an expert professional specializing in sexual dysfunction also may be sought. A relational perspective is still maintained, however, with a focus on the details of present sexual interactions. Couples' problems are often mutually sustaining; for example, a woman's arousal difficulties may prime her husband's premature ejaculation and vice versa.

Principle 3 In general, partners are guided to de-escalate conflict and distancing strategies (the main focus of the first stage of EFT) and to slowly shape safe touch and emotional connection before addressing sexual issues. If attempts at sexual relations prime escalating negative interactional cycles, then the therapist encourages the couple to set aside attempts at intercourse for a period of time until they can create a secure base to explore the blocks to positive sexuality and until they are capable of wooing and supporting each other. The attachment narrative around disappointments in sex is explored; such disappointments are often experienced as shaming and trigger catastrophic expectations of rejection and abandonment. EFT is a collaborative therapy so the above process is all conducted with the active participation of both partners. EFT therapists talk about how they are conducting therapy as they do it, so at the end of Stage 1 of EFT, both general interactional cycles that impact sexuality and specific cycles of sexual disconnection are clear. At that point, the couple has a meta-perspective on how both types of cycles trap them in a state of emotional and sexual starvation. Partners also begin to see how they can collaborate to name these cycles as they occur, understand how the cycles trigger each other's pain, and help each other to curtail the power of such cycles to take over the relationship and demoralize them both.

Principle 4 Sexual responses are placed in an attachment frame. For example, Terry's inability to keep an erection since his wedding is placed in the context of his sudden sense of risk and vulnerability related to his awareness that Amanda now has the power to "devastate" him because he committed to her as a partner and now "depends" on her so much. Similarly, Claire's rage at her husband's apparent lack of desire is linked to her silent terror that, since her mastectomy, he inevitably finds her to be "ugly and deformed."

Principle 5 Once a couple can begin to create a secure base in the session and at home, the active shaping of more engaged emotional accessibility and responsiveness—the key ingredients of a secure bond—begins. Each partner is supported to engage with, actively explore, distill, and express attachment fears and specific needs in powerful re-engagement and softening conversations. These conversations, in which soft emotions, such as sadness, shame, and fear, are owned and shared and longings then articulated, are also called Hold Me Tight conversations. In couples with specific sexual issues, these conversations, and the deeper exploratory processes leading up to them, often focus on the sexual issue, or if not, these are repeated

later with the sexual issue as the focus. For example, Mary and Ryan begin their Stage 2 conversations with Ryan re-engaging fully from a withdrawn position and sharing his sense of inadequacy around sharing emotions and his terror of being found wanting by Mary. He is able to own this terror and ask for Mary's reassurance and forgiveness concerning his detachment from her. This process is then repeated with reference to his numbed-out sexuality and apparent desire problem, which are perpetuated by Mary's frantic and increasingly angry attempts to get him to respond to her.

Principle 6 Positive links between sexuality and moments of security and bonding are explored so that partners understand them. For example, the therapist focuses on how David's new tender holding of his wife after lovemaking, which he dismisses as incidental, impacts her sense of him as a partner, her continuing desire, and her felt sense of secure connection in the relationship.

Principle 7 As part of the sexually-oriented bonding conversations, sexual experience is tracked and made explicit. The couple is then encouraged to risk sharing erotic cues and sexual longings and desires. Once the couple is tuned in and coordinated on an emotional level, the goal is to create a similar synchrony in the bedroom.

Principle 8 If in the processes described above, sexual cues spark past traumatic cues that block physical connection, the safe alliance with the therapist offers a safe haven to explore such cues and reprocess them on an emotional level. For example, Danielle is able to tell her husband, Jim, for the first time, that the way he kisses her neck spirals her back to a rape she experienced earlier in her life and makes her feel "crazy." The therapist can help Jim hear this and support his wife rather than moving into his own fears of personal rejection. They can then share ways to prevent this triggering and ways that Jim can comfort Danielle and help her calm down when she is triggered. They decide she can tell him, "The shadow has come for me again," and he can then support her by remaining silent but holding her in a certain way and just breathing with her in a synchronized fashion. When she is able to do this, she takes control of her trauma flashbacks, and he feels both unique to and needed by his partner.

Principle 9 In the consolation stage of EFT, emotional, physical, and sexual connection are reviewed, and the couple's achievements are celebrated. The process of how exactly they helped each other move into these new levels of engagement is outlined, offering them a prototype of relationship recovery that they can use in the future. Partners are encouraged to take a meta-perspective and view themselves in the continuous dance of emotional and sexual synchrony, mis-attunement, loss of connection, re-attunement, and recovered connection. In other words, they view themselves as able to make and remake their emotional and sexual bond. As McCarthy and McCarthy (2003) concluded, "Sex works best when each spouse is open and receptive" (p. 32). Partners are helped to articulate explicitly how they can each help each other step into and maintain this state.

Principle 10 Last, but not least, in all of the above, the EFT therapist offers education concerning sex and normalizes each partner's response—for example, by telling Elizabeth that her sexual functioning is normal and that most women cannot reach orgasm simply from penetration, and by actively countering her shame about her masturbation. The therapist also offers an alternative point of view to the compartmentalization and objectification of sex that is found in our culture, offering a more whole and integrated view of sexuality and adult love.

A Case Example: The Lover Who Got Married

James and Carol were referred to our clinic by Carol's doctor, who felt that Carol's marriage was bringing her to the edge of a breakdown. Carol was a 48-year-old stay-at-home mother. Her son had just gone off to high school, and she was studying for business school entrance exams. Her husband, James, 54, was a consummately successful businessman.

This couple presented with an extremely volatile interactional cycle of loud, angry attacks on Carol's part followed by urbane justification, evasion, and withdrawal on the part of her husband. He came to therapy after she had told him that she was moving out of the family home because she believed he was gay. Carol came from a home where her father was alcoholic and her mother was permanently depressed and unavailable, and she had been involved with several very unhappy love relationships before meeting James. James, who was handsome and charming and who described himself as being an "expert at compartmentalization," did not want to discuss his past. However, he did mention that, before he met his wife, he had, for many years, successfully courted and bedded a large number of "beautiful" women, with whom he would stay until they "fell in love" with him, at which point he would immediately end the relationship. Shortly after their wedding, Carol had been diagnosed with Crohn's disease and had also become pregnant. Her son was born with severe health issues. After this child's birth and her own lengthy medical treatment, James had withdrawn from her physically to the point of not touching her at all, stating that he had no sexual desire. He then completely immersed himself in his work. Their child's and Carol's own health problems had consumed much of the next decade, but as these issues stabilized, her belief that her husband was simply stressed and would eventually return to making love with her changed to a conviction that he had deceived her all these years and was, in fact, gay. He completely denied this, stating that he loved his wife, and attempted to minimize their emotional and sexual problems.

EFT begins with two couples sessions in which the members of the couple meet together with the therapist and are asked to talk about their relationship strengths and problems and give a relationship history. The therapist also observes and sets up interactions between partners to begin to grasp the couple's habitual interactional patterns, styles of communication, and ways of regulating emotion. This couple presented with an extremely escalated cycle of outraged accusation and blaming by Carol, followed by defensive justifications and withdrawal by James. He stated that he deeply loved his wife and, in fact, that she was the only woman with which he had ever fallen in love. She seethed in response. He was very supportive in many ways, offering to support his wife in her studies and future dreams and stating that he did not want her to leave him.

In the two individual assessment sessions (one per partner) that followed the joint sessions (this is typical procedure in EFT), Carol painted a picture of very volatile and unsupportive family-of-origin relationships and early romantic connections in which her needs were dismissed and denied. Her anxious attachment and pain at her partner's lack of desire and physical affection were palpable. The only way she could understand this was as a wholesale deception regarding his sexual orientation.

James, in his individual session, painted a picture of his lonely childhood in a Hungarian village dominated by his randomly abusive and fanatically religious mother and his always drunken father. He also described his childhood love of books and desire to escape to North America. He reported that he thought of his wife in sexual fantasies and occasionally looked at sexy magazines and masturbated to them. He had not made advances to her or to any other woman in the last 12 years. When asked about his physical distance from his wife, he became very silent. The therapist asked him what happened to him when his wife ran her hand along his back in bed, as she described she used to do. He winced and replied that he could not breathe and wanted to run away. This reaction began after his marriage and at the same time that his wife became physically ill and then preoccupied with a sick child. When asked very pointedly about sexual abuse as a child, he began to speak with great difficulty about being abused continually in the church school where he had been educated from ages 4 to 18. He had tried once to confide this to his mother, who then berated him

as being sinful and evil. He also noted that he had succeeded in putting "this all aside" when he moved to Canada and became a lady's man, having very brief affairs with many women whom he expertly seduced but with whom he never became emotionally involved. He was filled with deep shame about his abuse, and the therapist referred him for additional individual therapy that ran concurrently with the couples sessions. Both therapists—his individual therapist and the couples therapist—conferred together. The link between his traumatic past and his avoidant attachment to his wife was clear.

I will now replay some key moments in the change process, as they occurred in Stage 1 (de-escalation) and Stage 2 (restructuring attachment) of EFT with this couple. In Session 3, the therapist actively intervened, with empathic reflection, soothing validation, interpretation, and reframing to calm Carol and help both partners see the negative cycle of abandonment followed by angry blaming. It was explained that this cycle triggered evasion and distancing in James and maintained emotional and physical disconnection.

CAROL: *I don't believe anything you say. The only thing that makes sense is that you have been gay all along and you lied to me.*

THERAPIST: *This is the only way you have been able to make sense of James's "sudden shut down" of his sexuality. It has caused such pain for you. It has left you so alone and feeling so undesired. So it's hard to let it in when he says that he loves you and desires you but that he blocks out these feelings and stays at a safe distance. This is so disorienting that you get angry. Then you look even more dangerous to him, and he withdraws further; it confirms his fears that emotional and physical connections are not safe.*

JAMES: *Yes. It doesn't feel safe, so I kind of numb out. Somehow, before you, those other women never got to me. I never needed them. It was such a risk to love you, and then you kind of disappeared into the kid and into all the medical stuff, and my brain just freaked out. I kept thinking this would all just go away, but …*

THERAPIST: *Connection was scary just because you DID love her—because you let yourself need her. And that was the first time you let yourself need or be vulnerable. But when the fear came out, it was overwhelming? [He nods.] So you tried to hold onto her and keep the fear at bay, too—you held onto her and shut her out at the same time? What is happening as I say this, James?*

JAMES: *I don't feel well. [The therapist leans forward with a questioning look on her face.] I have a pain here. [He touches his chest.] It does feel like fear. That is ridiculous. But I freeze up. Feels like I am a kid at home with my crazy mother ranting at me or all alone in that church… [He tears up.]*

CAROL: *What does this have to do with you never making love to me? Tell me that! [She smacks her hand on her other hand.]*

THERAPIST: *I am going to stop you, Carol. Can you hear him say that it is fear that has him shut down and shut you out? And what comes up are images of his mother—with whom needing or longing for closeness was totally dangerous and filled with pain—and images of being vulnerable and being abused.*

JAMES: *I could make love to women who never touched me here [touches his heart], but … suddenly it's like I knew I needed you but … you were sick, and you were miles away, it seemed. And all this got all caught up in the abuse stuff that I had never taken out of the closet—even with you.*

THERAPIST: *Can you feel the fear now? [He nods.] Can you tell her what it feels like in your chest and when it comes up at home? Then we will look at the terrible thoughts that come with it.*

JAMES: *Yes. [To Carol:] It hurts—like I can't breathe. Frozen up. I am six-years-old and back in that dark church. You put your hand on my back when we are in bed, and I just freeze up. And I know it hurts you. Some part of me wants to run; it seems like, if I stay, I will shatter. No control. I can't breathe and then … [The therapist comments on the sadness in his face.] Yes, if I stay, I will fall apart, weep forever … and if I don't stay… It's black no matter what I do.*

THERAPIST: *Right. So can you tell her, "It's desperate aloneness and blackness to lose you, but also to let you in feels like terror and brings back the hurt of the past?" You stay but keep her at a distance. You can't lose her and can't be this vulnerable. Is that it?*

JAMES: *Like she says. [He laughs.] … It's like anything I do feels bad so that I just freeze; then I don't feel. Anything. No desire or anything. [Carol looks sad but confused.]*

THERAPIST: *What is this like to hear, Carol? Confusing? It is new? Your man isn't indifferent or deceiving you, he is afraid and dodging the ghosts of the past.*

CAROL: *[To James:] This is about that past stuff—the abuse stuff? You made it seem like no big deal when you spoke about it. This is really fear? [He nods.] But then you go and leave me all alone—untouched.*

JAMES: *I know. I am ashamed that I let you down. I didn't know what else to do. I don't want to lose you.*

The therapist summarized the negative cycle of Carol's anger and James's numbing and how each now triggers the other. The therapist also outlined again how James's trauma shaped needing and loving into a threat. She also linked James's shame and fear to his total sidelining and numbing out of his sexuality. As moments like this occur, the partners saw their negative coping cycle and the "dragons" of James's past hurts as the problem. This cycle was normalized and framed as an "enemy" they could stand together and face. The therapist, of course, also worked in a similar fashion with Carol's sense of rejection and her fears that she "disgusted" her husband because she was in ill health or simply not attractive enough. During this time, the therapist framed safe connection as a necessary prerequisite for any kind of sexual advance and encouraged sharing soft emotions but not expecting physical touch. As a result of these actions, Carol calmed down and stopped exploding and threatening to leave if her husband didn't come on to her sexually. After 16 sessions, this couple had a secure base to explore their emotional bond on a deeper level and begin to explore how to renew their physical connection.

Later in therapy, James was able to explicate and share the link between closeness, needing, and his traumatic responses, and he was also able to ask Carol's forgiveness for leaving her so alone. He was able to offer her touch and physical comfort when she expressed her hurt and her fears around her apparent inability to spark desire in him. She became much more open and less volatile. The therapist encouraged James to initiate safe touch and comforting moves, and James began to share his positive images of their early sexual life, which he kept in his mind and "held on to." Each partner was able to move into their deeper vulnerabilities and ask the other for comfort and care. James could tell Carol, for example:

> *I feel safer with you, and I want you to give me the chance to walk back through my fears and find you—find us—again. It really helps when I can tell you that "the shame shadow has come for me" and you are there for me. I am less numbed out. I want us to be sexual with each other, but I have to do it in small steps. So I want you to give me the chance to do that.*

Once Carol was able to see James as a trauma survivor for whom love and vulnerability were tied to old, but still raw, wounds of shame and fear, she was able to frame his physical withdrawal from her in a more acceptable way and to begin to empathize with him. The therapist framed James as a virgin when they married, in that the relationship with Carol was the first time he had tried to meld his sexuality with an open heart. The therapist also helped Carol to explore how her anger at her "abandonment" by James had created ever more hostile interactions that continued to trigger James's fear. The therapist helped Carol move to sharing her own fears, namely that she was deeply flawed, unlovable, and at fault for her own illness.

The interactions that occurred at this point constituted a "softening event," in which a previously hostile and blaming partner can share core fears and ask for contact and comfort in a manner that pulls their partner towards them. Key statements made by Carol in this softening event included:

- *I guess I have been so angry for so long. I just never understood why you stayed so distant. It felt deliberate. So I got into threatening and berating you. I didn't know what else to do. I was so hurt and lonely.*

- *It was like we suddenly became roommates, and even after my illness and the baby was well, it didn't change. I was trying to change you. It has hurt so much to feel rejected. I just died inside. Never mind sex, I just needed you to hold me. It's been so long. [She weeps and James reaches and holds her hand.] I need physical closeness. I want to feel desired. It helped when you said you always fantasized about holding and making love to me … felt like I still mattered then—like I was still your wife.*
- *The worst was when I decided that all of this was because I was disgusting—flawed. That was like falling down a deep hole. The anger kept me from staying there. I am afraid that you don't desire me—that you don't want me as a partner in bed.*

With the therapist's help, James was able to help Carol with this latter fear and reassure her that, to him, she was beautiful and perfect and that he wanted to learn to risk coming close. He told her:

> *I need lots of reassurance here. I know we need to make what is called a "safe haven" and take things slow. But I need to know that you want lovemaking too, and I need you to touch me and be there if I get lonely and scared.*

All through these kinds of events, the therapist reflected and ordered the clients' experience, validated their struggle, asked simple questions to keep them on track, and gently helped them move out of blocks to openness and connection. The therapist also structured the sharing of fears in a simple distilled form; facilitated clear requests for connection; and encouraged supporting the other spouse to respond.

Once this couple had a secure base of emotional confiding, increased faith in their relationship, and the ability to soothe each other with physical affection, then they directly addressed how to change their sexual relationship, and how to "woo" and "court" each other into lovemaking. Carol admitted that, after more than a decade, it was scary for her, as it was for James, to begin to be openly sexual. The therapist encouraged them to share their images of what small sexually-tinged encounters would look like and how they would feel, as well as how to invite each other into them. Gradually this couple moved from holding and affection to foreplay to intercourse. As James said in the last session, " I didn't need help to be sexual; I needed help to clear my fears and old emotions out of the way so I could love and make love at the same time." As this couple made love more often, this also strengthened their emotional bond.

Leiblum (2007) noted that there has been increasing recognition of the need for an integrated approach to the treatment of sexual disorders and complaints. A focus on relationship context is essential. The success of more traditional, graduated sexual stimulation techniques, such as sensate focus exercises, seems to be largely determined by a couple's ratings of communication prior to treatment (Hawton, Catalan, & Fagg, 1992); in other words, poor relationship attachment decreases the effectiveness of traditional sex therapy interventions. Thus, a secure bond is the perfect context for the development and maintenance of rich, satisfying, and functional sexuality. It is also the most relevant context for sexual healing.

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Section III

Sex Therapy with Specific Populations

17

Treating Sexual Problems in Lesbian, Gay, and Bisexual Clients

Kenneth M. Cohen and Ritch C. Savin-Williams

Introduction

Effective therapy with lesbian and bisexual women and gay and bisexual men is best realized when clinicians are aware of the unique developmental challenges that lesbian, gay, and bisexual (LGB) individuals experience. This chapter considers these elements and highlights their potential impact on the psychotherapy process. The limited literature on LGB sexual dysfunction is also reviewed. Given the recent upsurge in acceptance of LGB sexualities that renders earlier research of questionable generalizability, this chapter focuses on studies published within the past decade. Although understanding the unique challenges that bisexuals face is undeniably important, the scant scientific literature on bisexual sexual dysfunction offers little to enlighten the reader. For a broader examination of psychotherapy issues with bisexual clients, therapists are referred to Bradford (2006) and Goetstouwers (2006). A discussion of LGB affirmative psychotherapy as it relates to sex therapy concludes the chapter.

Who's Gay? Does It Matter?

Sexuality comprises various domains, including sexual orientation (erotic attraction or fantasy), sexual behavior (genital contact), and sexual identity (label). There is no consensus about whether emotional attraction (infatuation, romance) is an expression of sexual orientation or is a separate domain (Savin-Williams, 2014). Clinicians usually become aware of clients' sexual orientation after a sexual identity label is volunteered. Although often an accurate representation of sexual and romantic desires, a sexual identity label is only one sexual domain and can be misaligned with sexual orientation or behavior. Because identity labels are chosen and subject to societal pressure towards heterosexuality, sexual orientation is better determined by erotic and romantic attractions. Sexual and dating behavior are similarly limiting because they, too, are a matter of choice and often do not correspond with true sexual desires.

To illustrate possible inconsistencies, consider the woman who is bisexual by orientation (attracted to men and women), heterosexual by behavior (in a longstanding relationship with a man), and lesbian by identity (because she lacks a bisexual community or fears rejection by disbelieving lesbians). Or, consider the man who is gay by orientation (attracted to men), bisexual by behavior (engaging in overt sex with women and covert sex with men), and heterosexual by identity (because he fears societal homophobia). Depending on the questions asked by the clinician, very different conclusions will be drawn about these clients' sexual orientation.

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

To be sure, many more people have some degree of same-sex romantic and sexual attraction than the minority who embrace a LGB identity label (Bostwick, Boyd, Hughes, & McCabe, 2010). Moreover, as today's youth increasingly gravitate toward a post-gay sensibility in which sexual identity labels are considered restrictive, inexact, or unnecessary, the classifiers they use are ever-more personally meaningful but objectively nebulous. For example, what exactly did the high school girl mean when she described her sexual identity as "squiggly" during a recent workshop led by the second author? And what did her peers mean when they enthusiastically agreed with her and asserted that they too were squiggly? To successfully treat sexual-minority clients (those with any degree of same-sex attraction), it is incumbent upon clinicians to carefully assess sexual/romantic attractions, sexual behavior, and sexual identity so as to avoid approaching client concerns with erroneous assumptions and misguided recommendations.

Developmental Challenges

The experience of growing up with a sexuality that society deems unacceptable, even repugnant, can result in a unique developmental trajectory that departs from that of other marginalized groups. Most notably, sexual-minority youth are often left to navigate unaided—at least during their influential early years—the intricacies of a marginalized identity. Afraid of scolding, if not outright rejection or disbelief, they may initially conceal their perceived differences from self and others. Believing their sexuality is wrong and to be resisted, they may spend their early years suppressing burgeoning sexual longings while striving to conceal their erotic and romantic attractions from themselves and others. The psychological acrobatics necessary for achieving this can be exhausting and costly, resulting in truncated emotional and social development that infiltrates their daily experiences far beyond their sexuality.

At some point in their development, it is not uncommon for LGBs to believe that sexual minorities are a sad bunch who are roundly disliked, if not loathed. Depending on their exposure to conservative politics, fundamentalist religion, and narrow gender-role expectations, they may learn that LGBs are promiscuous, lonely, pedophilic, damned to burn in hell, mentally ill, and/or desiring to be the other sex. The media's focus on the ubiquity of gay youth depression and suicidality leads some to expect that this, too, is their fate (Savin-Williams, 2005). Perhaps the greatest sources of apprehension are the feared losses of family, friends, religious community, God, identity, and an anticipated (heterosexual) future.

These concerns thwart some from recognizing ("I'm not a lesbian, I like wearing makeup!"), accepting ("Maybe if I prayed harder…"), or disclosing ("What if they reject me?") their sexuality. Because of external and internalized homophobia, LGBs may strive to avoid stigma by concealing their attractions and attempting to behave outwardly in ways that are forced and unnatural (e.g., rigid gender conformity, dating and having sex with the gender to whom they are not attracted). Regrettably, some individuals escape feared scrutiny and rejection by abandoning their religion and relocating far from family and friends.

To maintain a forestalled sexual identity, LGBs may forsake development in related arenas lest their homoeroticism be uncovered. For example, they may avoid socializing (e.g., at parties) when it will likely lead to dating pressure, or they may withhold from friends and family personal details about their lives because sharing would engender intimacy and the expectation of further divulging. Besides failing to develop social and emotional skills at the same pace as heterosexual peers, LGBs may feel inauthentic for disguising their attractions, and sad that they may never achieve the desired (heterosexual) life that they had envisioned.

A common, although not universal, feature of growing up with same-sex attractions is a history of ridicule and resulting shame about being insufficiently masculine (for boys) or feminine

(for girls). Although one may wish to reject such an obvious gay stereotype, there is considerable evidence (Cohen, 2002) that while growing up gays are more feminine and lesbians (to a lesser degree) are more masculine than heterosexual peers; bisexuals are intermediary. Although gender nonconforming behavior decreases after puberty—likely as a result of social ridicule, learning to suppress some behaviors and express others, and the sexualizing effects of puberty-related sex hormones—it persists to a lesser degree in adulthood and can sometimes be detected by those unaware of the subject's sexual orientation (Rieger, Linsenmeier, Gygax, & Bailey, 2008). The repercussions of past (and possibly ongoing) gender nonconformity cannot be overstated.

Judgmental peers are often unforgiving of gender transgressions—especially during the middle school years—and relentlessly ridicule or bully violators, inflicting emotional scars that may never fully heal. This shaming behavior may or may not be attached to explicit accusations of homosexuality, but for many sexual minorities the accusations are implied and leave them feeling exposed and believing that people around them are able to divine a sexuality that they are desperate to conceal or may not even fully recognize. Research on depression and suicidality has consistently found that being bullied for gender nonconformity contributes to mental health problems *among both heterosexuals and nonheterosexuals.* That is, regardless of actual sexual orientation, peers bully peers because of gender transgressions, and it is this bullying, and not the sexual orientation *per se*, that is enduringly harmful (Rieger & Savin-Williams, 2012).

Valuing, but failing to achieve, masculine ideals is exceptionally disconcerting to some gay and bisexual men. Sánchez, Westefeld, Liu, and Vilain (2010) found that most gay men wished to be more masculine than they perceived themselves to be, and that the more they valued and feared violating masculine ideals, the worse they felt about being gay. These findings underscore the therapeutic import of understanding a gay client's investment in masculinity attainment. Speculating that gay men who overly value stereotypical masculine ideals may be high self-monitors who are quick to feel badly when they believe they have failed to meet these ideals, Sánchez *et al.* (2010) warned that the desire to avoid feminine traits may lead to fear of intimacy and relationship dissatisfaction. Bepko and Johnson (2000) similarly observed that relationship dysfunction may result when a history of childhood gender nonconformity renders boys and men exceedingly insecure about their gender-role proficiency, causing them to reflexively respond to perceived challenges to their masculinity and to express relationship role inflexibility. For example, when confronted with issues of dependency and attenuated self-sufficiency, they may react defensively by emotionally withdrawing or responding with anger and counter-attacking. Tunnell (2006) suggested that some gay men have so consistently downplayed their desire for male emotional intimacy that they enter romantic relationships unable to relate emotionally with their partners.

The strict policing of gender, which some gay men have internalized and rigidly adhere to, can lead them to pursue exclusively hyper-masculine partners—perhaps in the hope that the masculinity will transfer onto them. Sanchez *et al.* (2010) cautioned, "Although stereotypically masculine traits are not necessarily problematic, rigidly ascribing to certain traits (e.g., ignoring fear and pain) can undermine psychological well-being" (p. 109).

LGBs usually present for psychotherapy years after they were ridiculed, and they seldom appear as gender nonconforming as they did when they were growing up. Despite the centrality of those early painful experiences, they are often reluctant to suffer the humiliation of exposing what was perhaps the most shameful period of their lives. Anticipating that clients likely will not volunteer this aspect of their history, it is incumbent on therapists to assume its possible existence and delicately inquire, while normalizing its prevalence and noting the enduring impact it has on a sense of masculinity/femininity, self-concept, and worthiness.

Identity Confusion as a Presenting Problem

In some cases, a mismatch between different domains of sexuality—attraction, behavior, and identity—or confusion about the role of gender nonconformity in sexual orientation may be what drives a client into therapy. Below are several examples of failures to align that can result in sexual confusion and dysfunction.

Discrepancy between sexual and emotional attractions

Some homoerotic people, especially men, are sexually attracted to the same sex but *emotionally* attracted (e.g., crushes) to the opposite sex, convincing them of their heterosexuality and resulting in unsuccessful or unfulfilling heterosexual sexual encounters. For example, gender nonconforming men with same-sex attractions, who directly suffered male-perpetrated hostility and rejection or who witnessed the torment of other gay or gender nonconforming males, are likely to have established emotionally intimate—even romantic—friendships with accepting females with whom they often share much in common. Other men, who they see as dangerous, shaming, and socially unobtainable, may frighten these men. Much to their chagrin, however, these other men usually remain erotically stimulating, although emotionally uninspiring.

Homoerotic men may also suppress same-sex emotions to downplay their homosexuality, believing "lots of straight guys 'get off' with dudes, but only a homosexual falls in love!"

Josh, a 19-year-old student who identified as heterosexual, presented to a medical center requesting treatment for his inability to maintain an erection and achieve orgasm during sexual encounters with women. He was offered Viagra and referred to a urologist who failed to identify physical causes for his problems. He eventually sought treatment at the university counseling center and was assigned to the first author. Josh presented as controlled, self-assured, and highly masculine. He viewed himself as reasonably attractive and said he had no difficulty finding women to date and sharing sexual intimacies. He reported that, typically, after several minutes of initial sexual contact he lost his erection and that he found it nearly impossible to orgasm with women. He denied excessive use of alcohol or other substances as well as any performance-related anxiety. During our second session, I collected his sexual history, and it was immediately apparent that, although he dated women and identified as straight, he was primarily sexually attracted to men and successfully masturbated to male images. Ensconced in a heterosexist culture in which everyone is assumed to be heterosexual unless proven otherwise (and Josh certainly behaved outwardly in a stereotypically masculine way), none of Josh's previous treatment providers had asked about his specific sexual attractions, accepting at face value his stated heterosexuality. This insight about his sexual attractions was not surprising to Josh, and he quickly forsook pursuing women in favor of discussing his same-sex attractions in therapy. After six months of treatment, he had his first sexual encounter with a man and was pleased that he maintained full sexual functioning. Had the referring physician inquired about Josh's sexual functioning (successful masturbation when alone, waking with erections), medical causes could have been ruled out and an unnecessary visit to the urologist avoided.

Whereas Josh was quick to recognize his underlying sexual orientation—he had suspected that something was amiss because "straight guys don't usually jerk off thinking about guys"—others continue to attempt unarousing heterosexual behaviors, which frequently produce erectile difficulties, in an attempt to avoid acknowledging same-sex attractions.

"I'm not like them"

Some people do not recognize their sexual orientation because they fail to manifest stereotypical LGB behaviors and interests.

Anna was a 21-year-old student who appeared hyper-feminine and professed an interest in "all things girly": makeup, beautiful clothes, manicured nails, fashionable hairstyle, and feminine behavior. Similar to Dan, a 19-year-old college junior who believed himself to be straight because he enjoyed football and hanging out "talking trash" with his fraternity brothers, Anna was certain she could not be a lesbian because, in her words, she had no interest in "driving a pickup and fixing things around the house."

These examples of the ways in which gay stereotypes can deceive and lead to erroneous conclusions about sexual orientation reinforce the importance of clinicians focusing on sexual and romantic attractions rather than identity labels when elucidating a client's sexual orientation.

Misinterpreting human sexual response: "Am I like them?"

Some clients are uninformed about human sexual responding and misattribute their ability to derive sexual gratification from particular sexual activities to specific sexual orientations. For example, heterosexual men who delight in receptive anal stimulation may fear that this implies that they are gay. While being cautious not to rule out a homosexual orientation too quickly, detailed exploration of sexual longings and masturbatory fantasies allows therapists to provide sexual education (e.g., discuss the inherent pleasure from stimulation of anal nerve endings and the prostate) and usually offer confirmation of the client's heterosexuality. Cohen (2006) described a case example of this phenomenon:

> *Chad, a tall, burly college athlete who was vice president of his fraternity, sought counseling for panic attacks, growing depression, and passive suicidal ideation that began three weeks earlier and for which he could not identity a precursor. During the second session he discussed a new relationship with a sexually adventurous woman whom he both lusted after and feared. He shamefully admitted that during an initial sexual encounter she had inserted her finger into his anus, giving him a powerful orgasm and longing to repeat the experience. After he explained that this meant he must be "homosexual," we explored same-sex attractions (negligible), discussed his fears of peer rejection and need to maintain a hypermasculine persona, and clarified male physiology while normalizing his sexual response. By the following week, his symptoms had abated and his heterosexual identity was reaffirmed. He was able to discuss sexual needs with his girlfriend, who confirmed his heterosexuality and agreed to further integrate anal stimulation into their future lovemaking.* (Cohen, 2006, pp. 222–223)

Psychopathology and identity confusion

Clients may be uncertain or anxious about homoerotic thoughts that are unrelated to their sexual orientation. For example, those with borderline personality disorder sometimes experience sexual identity confusion or instability. A more likely cause of acute sexual identity concern, which does not respond to psychodynamic exploration, is obsessive-compulsive disorder (OCD). In contrast to LGB clients, those with OCD fail to develop sexual clarity or relief through traditional psychotherapy. As Cohen (2006) described:

> *Jennifer, a successful freshman with a history of untreated mild childhood obsessions and compulsions, presented for counseling reporting apprehension that she was lesbian—despite previously identifying as heterosexual, exclusively dating males, and observing no appreciable attraction toward females. Shortly before our consultation, she began noticing females around campus and ruminating about whether she was aroused and, therefore, lesbian. So upsetting was this unlikely possibility (her frequent checks for vaginal lubrication suggested no genital arousal) that she developed a depressive disorder. Though she insisted she and her liberal parents were "fine" with homosexuality, she declared she would kill herself if she were lesbian. Initial psychodynamic exploration proved fruitless in clarifying her sexuality or diminishing her sadness. Only psychotropic medication was successful in remitting her symptoms.* (Cohen, 2006, p. 230)

In contrast to LGBs who are ambivalent about their sexual attractions but usually nonetheless enjoy homoerotic fantasies, at least in the moment, clients with OCD are often frightened or disgusted by uncontrollable sexual thoughts that they have no desire to enact yet embrace as evidence they are lesbian or gay (Gordon, 2002). These ruminations are frequent, intrusive, and may be perceived as immoral, perverted, or a sign of weakness. The thoughts, which are not part of their usual sexual repertoire and are rarely sexually arousing, can lead to depressed mood, attenuated self-esteem, diminished concentration, and sexual behavior inhibitions. Gordon (2002) noted that, despite the absent desire to act out the obsession and therapist reassurances that they are not LGB, intrusive ruminations do not abate. Rather than interpreting

their presentation as latent homosexuality with the goal of self-acceptance, Gordon emphasized that it is essential for therapists to address this condition as they would other OCD-related obsessions.

Sexual Dysfunction in LGB Populations

In addition to presenting with identity concerns or confusion, LGB clients, like straight clients, may seek sex therapy to address sexual dysfunctions. Little is known about the prevalence of sexual dysfunction (SD) among gay men and even less among lesbians and bisexuals. The literature on sexual orientation differences is scant, often contradictory, and of questionable generalizability. Until recently, most research had been conducted on men who are HIV positive. Other studies sampled clinical populations or solicited sexual minorities who visited websites that cater to sexually active (and partner-seeking) individuals. Many studies are decades old and fail to represent the current zeitgeist of accepted gender and sexual diversity. Definitions of SD (e.g., severity, frequency, and duration of SD symptoms) vary across studies, and measures of SD use heteronormative and heterosexist language and have usually been developed to assess functioning in heterosexuals in which a phallocentric perspective is assumed (Campbell & Whiteley, 2006; McDonagh, Bishop, Brockman, & Morrison, 2014).

In addition to contextualizing gay men's sexuality and SD from a heterocentric perspective, studies have failed to ask gay men what *they* consider problematic. A recent review of SD measures (McDonagh *et al.*, 2014) concluded that the very context in which sexual identity and behavior develops is strikingly different between gay and heterosexual men. While heterosexual men are indoctrinated into and subsequently internalize what society considers to be appropriate heterosexual male thoughts, feelings, and behaviors (Sandfort & de Keizer, 2001), gay men develop sexual values and identity following a uniquely protracted process of growing up gay and navigating a coming-out process during which sexual expectations and scripts are questioned and sometimes dismissed. Devoid of culturally sanctioned sexual scripts, gay development is unencumbered to evolve in unique ways that are perhaps better suited for some men. Although less discussed, this likely applies to lesbians as well. For example, unlike sex between a man and a woman in which (male) power and domination and (female) submission are often expected, sex between same-sex individuals is more egalitarian and reciprocal and does not necessarily include penetration, the successful completion of which is usually equated with heterosexual functioning. It is noteworthy, however, that because women who have sex with women (WSW) and men who have sex with men (MSM) are removed from pressure to achieve penetration, sexual problems such as erectile dysfunction, vaginal pain, or anorgasmia may be easier to conceal or may remain unnoticed when gay men or lesbians perform, rather than receive, oral sex or when gay men adopt the receptive position during anal sex. Underreporting of SD may also be a consequence of gay men and lesbians forestalling expected homonegativity from clinicians by deferring medical treatment altogether.

Several studies group various sexual concerns under the nebulous umbrella "sexual dysfunction." In some such cases (King & Nazareth, 2006), LGBs are not found to be at significantly higher risk than heterosexuals, although reported rates of SD are substantial for all groups: straight, bisexual, and gay men (46%, 61%, and 55%, respectively), straight, bisexual, and lesbian women (61%, 60%, and 54%, respectively). Kuyper and Vanwesenbeeck (2011) similarly found no differences between heterosexuals and LGBs in rates of sexual dysfunction or satisfaction, although they did find that, within LGB populations, internalized homonegativity predicted sexual dissatisfaction and dysfunction. This relationship, however, has not been consistently reported, especially in later studies and among women (Armstrong & Reissing, 2013; Szymanski, Kashubeck-West, & Meyer, 2008). Review of the scant, often deficient, findings related to sexual dysfunction in MSM and WSW are discussed separately below.

Sexual dysfunction in MSM

Soliciting MSM from "gay-oriented sexual networking, chat and news websites," a clearly unrepresentative and ungeneralizable sample of homoerotic men, Hirshfield *et al.* (2010) found that 79% of their sample had experienced at least one symptom (e.g., erection problem, pain during sex, premature ejaculation) of sexual dysfunction over the past year; the most prevalent sexual concerns were low sexual desire, erection problems, and performance anxiety (see also Bancroft, Carnes, Janssen, Goodrich, & Long, 2005). However, these findings are difficult to interpret because each of the seven sexual concerns they investigated was assessed by a single question without regard to symptom frequency, duration (participants were asked whether they had experienced any of the symptoms over "a period of time"), severity, or the onset and context of their occurrence. Further undermining their findings, the authors suggested that it may be inappropriate to measure SD in gay men in the same way as straight men because gay men have different gendered partners, cultural norms, sexual expectations, and interpretations of the questions asked. It is noteworthy, though, that SD was affected by age, HIV status, and possibly HIV medication side-effects, as well as other untreated sexually transmitted infections (STIs). This study illustrates the challenges of investigating sexual dysfunctions in MSM and is a reminder for clinicians to focus less on expected group differences and more on individual client assessment, especially given that individual differences may be more predictive of SD than sexual identity *per se*.

For example, exploring within-sexual orientation differences, Zamboni and Crawford (2007) reported that sexual functioning difficulties among gay and bisexual African-American men were associated with male gender role stress, racial discrimination, and gay bashing—although causality could not be determined. The authors encouraged sex therapists to recognize and address stressors inherent in being a stigmatized double-minority that undermine sexual functioning. It is important to keep these individual difference factors in mind as we review the literature on specific sexual dysfunctions experienced by MSM.

Erectile dysfunction An early review of the empirical literature (Sandfort & de Keizer, 2001) found that, compared with heterosexual men, gay men were more likely to report erectile dysfunction (ED) but much less likely to report rapid or delayed ejaculation or low sexual desire (except when HIV seropositive). However, many of these early studies suffered from methodological flaws that probably inflated gay–straight differences; these disparities often disappeared or were found to be more nuanced in later studies that incorporated better controls. For example, a recent study of medical students initially found increased prevalence of ED among gay men compared with straight men, but this difference disappeared once the researchers controlled for marital/domestic partnership status and other variables (Breyer *et al.*, 2010). Bancroft *et al.* (2005) reported that gay and straight men were equally likely to report experiencing frequent erectile difficulties (i.e., erection problems "most of the time"), but gay men were more likely than straight men to endorse less frequent (i.e., "occasional") difficulties with erections.

Similar to non-MSM, risk factors for ED among MSM include older age, lack of a stable sexual partner, lower urinary tract symptoms (LUTS), and HIV seropositivity (Shindel, Vittinghoff, & Breyer, 2012). HIV positive individuals are generally at greater risk for developing erectile dysfunction, and when HIV-associated dysphoria is treated with selective serotonin reuptake inhibitor (SSRI) antidepressants, the risk is exacerbated (Purcell *et al.*, 2005).

Alcohol and recreational drugs are potential organic causes of ED and should be carefully assessed. Numerous studies have documented the elevated prevalence of substance use among gay men (and lesbians), a population that might therefore be at increased risk for substance-induced sexual dysfunction. For example, ecstasy, which is consumed by some gay men at gay bars and dance clubs, generates feelings of sensuality and closeness that can be

mistaken for sexual arousal, but which ultimately diminishes sexual desire and produces erectile and ejaculatory difficulties (Passie, Hartmann, Schneider, Emrich, & Kruger, 2005). Chronic substance misuse also can lead to occult vascular or endocrine disease, an early symptom of which is sexual dysfunction (Bhugra & Wright, 2007). Further, given the relationship between substance use and unsafe sex practices, MSM may contract STIs that generate distress and sexual dysfunction that remains long after the (usually treatable) STI is resolved (Bhugra & Wright, 2007). Thus, careful screening of substance use and current and past STIs—as well as psychological reactions to the STIs—should be regularly practiced. However, because consumption of substances may be reinforced in gay communities, clients may be unwilling to curtail their use (Bhugra & Wright, 2007), and clinicians who attempt to strong-arm them into reducing intake may create a therapeutic schism that can undermine the working alliance.

Premature and delayed ejaculation The literature is inconsistent and inconclusive regarding whether gay men are at lower risk than straight men for premature and delayed ejaculation (PE/DE). Whereas Bancroft *et al.* (2005) found that heterosexuals experienced more PE than gay men, especially if they were in an exclusive relationship, Breyer *et al.* (2010) reported no differences based on sexual identity. Among MSM, Shindel, Vittinghoff, *et al.* (2012) reported that PE was associated with younger age, fewer lifetime sexual partners, and LUTS.

DE can result from anxiety, medications, recreational substances, and neurological and other medical conditions, so organic and substance-related causes should be ruled out (Joannides, 2012). Although men with DE may be able to sexually function while masturbating in isolation, the distraction of a partner may result in diminished stimulation that inhibits sexual functioning. In such cases, the additional stimulation provided by a vibrating butt plug, a vibrating cock ring, or other sex toy may help them override distracting thoughts and feelings (Joannides, 2012). More gay and bisexual than heterosexual men report using sex toys during masturbation and partnered encounters (Reece *et al.*, 2010). Thus, they may be receptive to clinical recommendations for incorporating sex toys into their treatment for DE. (Therapists can also encourage clients to embrace toys, either alone or with partners, as safe alternatives to risky sexual behavior; Rosenberger, Schick, Herbenick, Novak, & Reece, 2012).

Heterosexual men with conservative religious beliefs appear to be at increased risk for DE. Thus, religious prohibitions may be especially oppressive for MSM who are, or have been, devout. Clinicians should remain cognizant of the importance that religion plays, or once played, in the lives of many sexual minorities. These sexual minorities may nurture unresolved feelings of guilt or shame for having left their faith or for embracing a life that their religion deems unacceptable, if not abominable. Collecting a careful religious history and avoiding assumptions that religion is not relevant helps clients to reconcile, or mourn, religious conflicts that can undermine sexual functioning.

Low sexual desire There is a paucity of data on sexual orientation differences in sexual desire. When depressed or anxious, most men, regardless of sexual orientation, experience decreased desire, although a minority undergoes an increase in desire and the remainder reports no change. Gay men, however, are more likely than straight men to experience changes at the poles: They report both greater increases and greater decreases in desire in response to depressed or anxious mood (Bancroft, Janssen, Strong, & Vukadinovic, 2003; Bancroft, Janssen, Strong, Vukadinovic, & Long, 2003). Clinicians should also be cognizant of the tendency for some gay men to engage in risky sexual behavior when anxious or depressed.

Many gay men are part of an open relationship in which they agree to have sex with other partners (see below for further discussion). Spitalnick and McNair (2005) suggested sexual problems, such as low desire for a longstanding partner, can arise when one or both members of an open relationship rely on sex with outsiders for sexual fulfillment—although which

came first, the agreement to engage in an open relationship or the lack of desire within the relationship, is difficult to ascertain.

When same-sex-oriented but heterosexually identified men (or women) repress what they believe are wrong or forbidden homoerotic desires, they may be left with negligible sexual attractions and erroneously conclude that they are asexual. Although unlikely, the possibility that a client is asexual should nonetheless be explored, as recent evidence suggests that this orientation is more prevalent than previously thought (Bogaert, 2012).

Anal pain The 2012 National Survey of Sexual Health and Behavior (NSSHB), using a nationally representative sample of adults, found a considerable lifetime prevalence of insertive and receptive anal intercourse among heterosexual men (33% and 3%, respectively), bisexual men (75% and 66%), and gay men (83% and 90%) (D. Herbenick, personal communication, April 20, 2015).

Despite the pervasiveness of anal intercourse, there is little research regarding the experience of painful anal sex (Hollows, 2007). Damon and Rosser (2005) found that 14% of MSM experienced—usually lifelong—"frequent and severe pain during receptive anal sex" (p. 129), which the authors termed "anodyspareunia." Documenting the mostly psychological and treatable causes (e.g., anxiety, partner penis size, lack of lubrication, or lack of finger-anus foreplay) and occasional medical precursors (e.g., hemorrhoids), the authors argued that pain during anal sex is neither inevitable nor necessary. Yet, those who reported anodyspareunia suffered distress and sometimes avoided receptive anal sex altogether; in fact, half of those who experienced it limited themselves to insertive anal sex. Almost a third of the sample said it had negatively impacted a relationship, and 15% reported it interfered with establishing new relationships. Noting similarities to dyspareunia in women regarding prevalence (10–15%), emotional consequences, and etiology, the authors argued for its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) under the category of painful sexual disorders.

To treat this proposed condition, Damon and Rosser (2005) advised adequate anal sphincter preparation, achieved through anal foreplay and massage as well as penetration with fingers and dildos to dilate the anus. By extending foreplay, feelings of safety are enhanced, fear of anticipated pain reduced, and sphincter relaxation achieved. Clients should also be taught to practice relaxing the anus while maintaining deep breathing during solitary anal masturbation and partnered anal foreplay and receptive sex.

Although cautious about imposing a diagnostic label on a group of symptoms of unknown etiology, Hollows (2007) advocated thorough clinical assessment of anal pain and treatment via sexual education and relaxation training. Therapists should also explore reasons why clients continue to engage in painful receptive anal sex, such as masochistic enjoyment, belief that this is expected gay behavior, underlying erectile dysfunction and inability to assume the insertive role, need to overcome personal fears or pain, and fear of losing a relationship.

Sexual dysfunction in WSW

Notwithstanding the lack of consensus regarding the definition and assessment of sexual dysfunction (SD) among lesbian and bisexual women, a recent comprehensive review of the literature concluded that, although SD was common among women in general (between 22% and 68%), *overall* there were no SD sexual orientation differences (Armstrong & Reissing, 2013), especially among recent cohorts. Indeed, coupled lesbians experienced sexual satisfaction that was equal to or greater than that reported by heterosexual women in relationships (Meana, Rakipi, Weeks, & Lykins, 2006), including greater arousal and more orgasms (Beaber & Werner, 2009). Breyer *et al.* (2010) reported that lesbian medical students experienced less sexual dysfunction than either bisexual and heterosexual female medical students. Recent findings of lesbians matching or outperforming heterosexual

women may be the consequence of younger generations of WSW experiencing sexual comfort and sexual ownership uncharacteristic of previous cohorts.

In one study (Spitalnick & McNair, 2005), in comparison to gay and heterosexual couples, lesbians engaged in more hugging, kissing, and cuddling. They highly valued emotional intimacy, and similar to heterosexual women, they were less interested than both gay and heterosexual men in casual sex and cared less about the physical characteristics of their partner. Compared with women in heterosexual relationships, women in lesbian relationships had fewer sexual encounters and, unsurprisingly, less vaginal penetrative sex, although they had an equal amount of oral sex and reported greater sexual satisfaction (Sanchez, Moss-Racusin, Phelan, & Crocker, 2011). Furthermore, discrete sexual episodes were longer-lasting, placed greater emphasis on foreplay, were more likely to incorporate sex toys, and resulted in more orgasms. In contrast to partnerships between men and women, two women shared more consensual encounters in which there was focus on the sexual behaviors that women find most desirable (Nichols, 2004, 2014).

In her review of the literature, Nichols (2014) found that lesbians were less likely than straight women to complain of pain disorders, specifically, and sexual dysfunction generally. For example, Nichols (2004) reported that lesbians had fewer sexual problems such as difficulty lubricating, difficulty achieving orgasm, and experiencing painful vaginal entry. Shindel, Rowen, *et al.* (2012) speculated that WSW reported less sex-related pain than women in straight relationships because they focused less on vaginal penetration and thus inadequate lubrication and resulting painful penetration were avoided. With the exception of findings such as these, most of the literature addressing specific sexual dysfunctions in women has focused on low desire.

Low desire Similar to heterosexual women, the most frequently reported sexual problem among WSW is low sexual desire and sexual frequency; in fact, for lesbians, this is the *only* consistently reported sexual problem (Nichols, 2014). Both heterosexual and lesbian couples tend to experience a gradual decline in sexual frequency over the course of long-term relationships (Cohen & Byers, 2014).

The allegedly inevitable diminution of lesbian sexual behavior over the course of a relationship—termed "lesbian bed death"—has been widely reported in both the clinical and popular literature. Although based on only a few empirical studies, this phenomenon has achieved the status of urban legend. Yet this sexual outcome is not as ubiquitous as claimed (especially among younger cohorts), and partly derives from inadequate male- and heterocentric conceptualizations of female sexuality that fail to account for differences in the way women experience and express their sexuality (Diamond, 2008; Savin-Williams, 2005).

It is generally believed that lesbians' supposedly attenuated sexual desire is the consequence of inhibition secondary to internalized homophobia or to gender-based differences in intimacy and desire (such that women desire intimacy more than men, and men desire sex more than women). The latter explanation refers to the documented tendency for women to experience lower libido, sexual assertiveness, and sexual activity relative to men, probably as a result of both biology and socialization. In the case of lesbian bed death, it was reasoned that without the presence of a male catalyst to invite (or demand) sexual intimacy, a relationship composed of two women would naturally drift toward celibacy (Nichols, 2004). An alternate gender-based hypothesis involved a belief in women's greater desire for relationship intimacy, which can lead to an emotionally enmeshed partnership, referred to as "merging" or "fusion," in which sexual intimacy feels less erotic and more similar to incest.

Various writers have pointed out that the above reasoning reflects underlying heterosexism and that the very definitions of sexual behavior typically used are limiting and fail to capture the depth of female–female sexual intimacy (Nichols, 2004). For example, traditional measures of sexual activity omit behaviors such as mutual masturbation, nongenital contact, and sexual

pleasure without orgasm, and they prize sexual frequency over encounter duration and quality. Nichols (2004) contested the derisive and pathologizing terms "merging" and "fusion" and proposed: "One person's 'fusion' can be seen as another's intimacy, and judgments about what is 'too much' or 'not enough' closeness are fraught with personal bias" (p. 365).

The concepts of lesbian fusion and merger (as well as gay men's "disengagement," which is proposed to explain their non-monogamy; see below) were conceived by psychotherapists treating distressed couples and have not been observed among nonclinical samples of lesbians and gay men (Green, Bettinger, & Zacks, 1996). In fact, same-sex couples tend to be more cohesive than heterosexual couples. Furthermore, some argue that lesbian bed death was based on too little data and the implications of the findings exaggerated. For example, although Nichols (2004) found slightly less sexual behavior among lesbians than heterosexual women, both were sexually active approximately once a week.

Cohen and Byers (2014) warned that the majority of research documenting lesbian bed death is more than 20 years old; sampled women who identified as lesbian rather than the broader spectrum of WSW; usually measured sexual frequency with a single question (e.g., "How often do you have sex?"); and given the phallocentric nature of the question, probably failed to elicit from respondents behaviors such as genital touching, oral–genital contact, and nongenital activity. In their study of almost 600 women in long-term (from 1 to 36 years) same-sex relationships, Cohen and Byers (2014) found three-quarters had engaged in one or more genitally-based sexual interaction at least once a week during the past month. Most (88%) reported at least daily nongenital sexual activity, such as kissing, hugging, and whole body contact. Not unlike heterosexuals, frequency of genital contact, though not nongenital contact, had decreased over the years. Nevertheless, on average, the women in same-sex relationships reported being sexually satisfied.

For cases in which lesbian couples want to rekindle diminished sexual behavior, Nichols (2014) advocated helping them transition from a model of "lust"-inspired coupling to "sexual willingness," in which planned sexual actions supplant spontaneous encounters. Couples are encouraged to schedule dates, reintroduce seduction and flirtation, and foster arousal by eliciting sexual thoughts hours or days in advance. Sexual exploration (e.g., toys, role playing) is prescribed to counteract routineness, and the importance of orgasm as a goal that must be achieved by partner stimulation is downplayed.

In conclusion, whereas some lesbian couples, like their heterosexual counterparts, experience a decline in sexual behavior over the course of their relationship, contemporary WSW are likely to maintain gratifying genital and non-genital sexual activities, suggesting they are anything but celibate. Therapists should recognize the variability of sexual behavior between women, appreciate that fulfillment may be achieved through activities more suited to women's sexuality, and accept that quality of sexual interactions may be more important for sexual satisfaction than frequency. Couples who present for treatment complaining of diminished sexual behavior may be sexually content but nonetheless responding to the myth of ubiquitous lesbian bed death that leads them to assume their sexuality is somehow deficient and in need of repair. These clients should be distinguished from those whose sexual decline is ego-dystonic or pathogenic and is not substituted by other pleasurable non-genital behaviors. Before clinicians treat purported low sexual desire, they should offer psycho-education about the nature of female sexual responding and determine whether change is required or simply believed necessary.

Sexual Relationships and Monogamy

As illustrated by the concept of lesbian bed death, gay and lesbian relationships have long been subject to distorted myths and stereotypes. For example, LGBs have been characterized as infantile and hedonistic, and thus their relationships have been perceived as uncommitted and

transient (Campbell & Whiteley, 2006). From this perspective, it is unimaginable that same-sex couples could maintain lasting, mature relationships personified by empathy and skilled communication.

By directly observing same-sex couple interactions, researcher John Gottman came to a very different conclusion: "Gay and lesbian couples are a lot more mature, more considerate in trying to improve a relationship and have a greater awareness of equality in a relationship than straight couples" (as cited in Schwarz, 2003). He noted that, in contrast to heterosexual couples, gay couples begin conversations about their relationship with greater "humor and affection, are less domineering and show considerably more positive emotions." Because they come across as "warmer, friendlier and less belligerent," their romantic partners are more likely to allow themselves to be swayed by their partners' perspective. Other researchers (e.g., Green & Mitchell, 2008) also have found that same-sex couples navigate their relationships with equal or superior proficiency to heterosexual couples.

Society's general unwillingness to support same-sex relationships diminishes their perceived importance and leads some sexual minorities to conclude that their partnerships are inferior and unsustainable. Believing that they are doomed to fail may precipitate a self-fulfilling prophecy, as LGBs underinvest in these relationships or abandon them prematurely. Green and Mitchell (2008) reported that "ambiguous commitment" is common among LGB couples seeking counseling because their relationship was not preceded by "an extended courtship or engagement phase, demarcated by a commitment ceremony, governed by statutes for legal marriage, approved by the partners' respective families of origin, or (in most cases) solidified by becoming coparents to children" (p. 667). Couples who move into sexual intimacy before a sound emotional and relational connection is established risk being ill-equipped to address sexual problems. In such instances, Rutter (2012) suggested that the therapist focus on promoting other areas of attraction (e.g., intellect) while addressing sexual issues.

In some respects, gay and lesbian relationships function differently from straight relationships, and this is partly a consequence of being unfettered by heteronormative rules and traditions. Because heterosexual scripts are of little utility in same-sex relationships, couples are free to invent and negotiate, and then reinvent and re-negotiate, the rubric of their relationship. Indeed, the extended period of coming out to self and others affords opportunities to reevaluate the self and one's identity, resulting in some LGB people rejecting dominant cultural paradigms and scripts (Campbell & Whiteley, 2006). Freed from gender-based expectations or from having to adapt their behavior to address the needs of an other-gendered (i.e., heterosexual) partner, lesbian and gay couples can shape their relationships to better match individual desires, including sexual needs. As others have observed (Shernoff, 2006), many gay men practice sexual behaviors that are desired by most men (i.e., in terms of sexual frequency, variety, and kind) but are usually prohibited or constrained by female sexual partners or dominant heterosexual relationship scripts. Thus, sex therapists should expect that sexual behavior plays an important role in the lives of gay men.

These factors contribute to the stereotype that gay men are non-monogamous, which, according to data, is often true. Compared with women and heterosexual men, gay men have sex more frequently and with more partners (Nichols, 2014); however, the percentage of non-monogamous gay men has decreased from 83% in 1975 to 59% in 2000 (Gotta *et al.*, 2011). Recent data indicate that these numbers continue to fall, with current estimates suggesting that 42% of gay men are in non-monogamous relationships (Parsons, Starks, DuBois, Grov, & Golub, 2013). This diminution parallels developments among contemporary gays and lesbians, especially younger cohorts, who increasingly desire long-term, committed, monogamous, and legal relationships. Thus, non-monogamy remains common but far from universal among gay men.

Nevertheless, unlike heterosexual partnerships in which mutually agreed-upon sex outside the relationship is uncommon, gay couples are far more likely to openly discuss extradyadic sexual desires and negotiate terms around extra-relationship liaisons (Hoff & Beougher, 2010).

Parsons *et al.* (2013) found that, among non-monogamous gay relationships, half were "open," whereby each member agreed to allow for sex, with or without preset rules, outside of the relationship. The other half were "monogamish," whereby sex with others occurred only when both partners were present, usually during threesomes or group sex. In contrast to open relationships, monogamish ones were associated with numerous positive mental and sexual health indicators.

Tunnell (2006) reported that nearly all gay couples with open relationships have established rules, "even if it is 'don't ask, don't tell'," and emphasized that therapists should avoid negatively judging these relationships, such as by attributing current relationship problems to non-monogamy. To illustrate, Tunnell recalled a man he saw in therapy who declared, "I really don't care where he puts his penis as long as his heart belongs to me" (p. 142).

When treating gay and bisexual men who are in same-sex relationships, it is essential to inquire without judgment about relationship non-monogamy, how it is defined, and how it was decided (Hoff & Beougher, 2010; Nichols, 2014; Rutter, 2012). Besides normalizing and destigmatizing, which encourages client disclosure and deepens the clinical relationship, these questions can illuminate the nature of the relationship, which would otherwise be unclear. For example, to preserve the primacy of the couple's relationship, members may agree to various conditions: no sex with close friends or past lovers, no (or only) bringing someone home for sex, no second or third hookups, no dating or romance, no French kissing or sleeping overnight, no exchanging contact information, no unsafe sex, no engaging in specific sexual activities such as anal or oral sex, or only engaging in specific activities such as mutual masturbation. Couples also vary regarding whether they wish to be informed about extra-relationship encounters; some welcome storytelling as an aphrodisiac to stimulate their lovemaking, and others prefer to hear nothing about the liaisons. Shernoff (2006) offered useful clinical guidelines for helping couples negotiate non-monogamy, including a warning to therapists not to blindly support or encourage opening the relationship until the meaning of doing so is understood and possible partner ambivalence or coercion is explored. Shernoff cautioned that extra-relationship sex should not be used to avoid couple problems, and that opening up failing relationships usually does not save them. Bhugra and Wright (2007) suggested that it may be beneficial to temporarily suspend open relationships while working on couples issues in therapy; preventing members of the couple from meeting needs outside the relationship can facilitate their emersion in the therapeutic work and stimulate honesty and therapy commitment.

LGB Affirmative Psychotherapy

Effectual and ethical psychotherapy with LGB clients begins with understanding the context from which the problems evolved. Thus, it is essential that therapists be cognizant of LGB developmental issues (for reviews, see Cohen & Savin-Williams, 2012; Savin-Williams, 2005; Savin-Williams & Cohen, 2015) and recognize that sexual orientation *per se* is not the cause of psychological problems; rather, the problem lies in society's reaction to the sexual orientation or LGBs' internalized beliefs that their attractions are inherently problematic. Understanding the omnipresence of heterosexism and homonegativity engenders empathy and helps therapists to appreciate the apprehensions of same-sex attracted persons. The American Psychological Association (2012) provided helpful guidelines for working with sexual minorities in which, among other recommendations, they underscored the importance of understanding the following: the effects of stigma (i.e., prejudice, discrimination, and violence); HIV/AIDS; the influences of religion and spirituality; the challenge of racial and ethnic minorities negotiating multiple and often conflicting norms, values, and beliefs; the role of nonbiologically-related persons who constitute a "family-of-creation"; and therapist biases and deficits for which

consultation or referral may be appropriate. They also recommended skill development through continuing education, training, supervision, and consultation.

It is especially inspiring to envision therapy with LGBs as unfolding within a zone in which anything is possible and the unexpected is anticipated. Iasenza (2010) cleverly observed: "Sex is a queer experience for everyone at one time or another. It can be unruly, ecstatic, routine, mysterious, transgressive, confusing, unpredictable, and changeable over the lifespan. It defies easy generalization, categorization, and explanation" (p. 291). Society, with its deep-seated prejudices and taboos, imposes constraints on our understanding of a phenomenon that is inherently broad, sometimes fluid, certainly multidimensional, and often multidetermined. Iasenza proposed that human sexuality is "queer" insofar as sex and gender transgressions occur frequently and cause misunderstanding and distress. By thus conceptualizing sexuality, we encourage clients to embrace the inherent contradictions and paradoxes among gender and sexual domains (masculinities/femininities, attractions, fantasies, identities, behaviors) and "(re)imagine themselves in whatever inclusive or expansive ways they need" (Iasenza, 2010, p. 292). By acknowledging the queerness of sexuality, we likewise give ourselves permission to flounder, reexamine preconceived notions, and tolerate "'queer moments' in therapy when we feel perplexed, off balance, or uncomfortable with the impasses, intensities, and surprises that often develop within expansive erotic space" (Iasenza, 2010, p. 292).

This perspective is invaluable when confronting judgment-laden issues, such as nonmonogamy, polyamory, BDSM, gender rejection and nonconformity, risky sexual practices (e.g., barebacking), and definitions of successful and healthy sexual behavior. Bhugra and Wright (2007) warned, however, that although it is essential that therapists avoid pathologizing LGB relationships and sexual behaviors, they must be equally cautious about normalizing sexual dysfunction out of fear of being perceived as prejudiced.

Rutter (2012) insisted that such gay affirmative therapy "deconstructs dominant paradigms, confronts gender stereotypes and patriarchy and broadens the lens of potential socioeconomic status and ethnic/cultural groups who may benefit" (p. 35). A feminist approach that explores internalized patriarchal messages and gender stereotypes may be especially helpful in addressing feelings of shame and inadequacy resulting from negative societal reactions to a client's gender nonconformity (Rutter, 2012). This approach also encourages adaptation and role fluidity when responding to life challenges, such as an HIV positive gay man transitioning from insertive to receptive anal sex to mitigate HIV transmission. Some important considerations when practicing gay affirmative therapy are discussed below.

Racial and ethnic minorities

Same-sex attracted individuals from diverse racial and ethnic groups are double, or triple (or more), minorities who likely suffer the burdens of additional stereotypes and homosexuality prohibitions. Depending on the degree of acculturation, they may have to negotiate their multiple identities—such as a lesbian who is reconciling being Cuban, Catholic, and her parents' caregiver—and determine to whom their allegiance belongs. Often they must navigate their sexuality alone and within the context of a mostly white, urban gay subculture in which racism and classism predominate (Dubé & Savin-Williams, 1999). As double minorities, they typically face homophobia from their racial/ethnic communities and racism from LGB communities (Ro, Ayala, Paul, & Choi, 2013). For many, to embrace a gay community is to betray their culture; the task of integrating personal and group identities often necessitates choosing one over the other. For example, the broader African-American community may view coming out as a gay man as a betrayal because there is a shortage of black men to partner with black women due to the many black men who leave the family or are incarcerated (Savin-Williams, 1996).

Ethnic and racial groups vary in their conceptualization of homosexuality, but it is common across groups for it to be interpreted as a sign of rebellion, against God's will and therefore immoral, and a Western or white disease. Many groups believe there are no gay people amongst them or equate homosexuality with the observed behavior of gays in the country from which they or their parents immigrated. For example, homosexuality may have occurred underground or been associated with prostitution and cross-dressing, and thus encapsulated in secrecy, shame, and stigma (Savin-Williams, 1996).

Latinas from traditional families who come out as lesbian may be perceived as rejecting the traditional female role of "etiqueta" in which women are to be passive, subservient, and showpieces to be adorned. From this perspective, lesbians are man-haters who are acting selfishly and trying to overthrow men. Because male homosexuality is equated with effeminacy and passivity, gay Latinos may be seen as eschewing "machismo"—the role of the defiantly masculine and heterosexual male—especially if they assume the receptive role in anal intercourse (Savin-Williams, 1996). Sexual tops (the inserter) may not be viewed by themselves or others in the Latino community as gay, thereby increasing their risk of contracting STIs such as HIV (and spreading them to the women with whom they are sexual) because they ignore educational messages directed at self-identified gay and bisexual men (Jeffries, 2009). Latino men who are on the down-low—identifying as heterosexual but having covert homosexual encounters—may not define themselves as gay or bisexual and therefore their attractions to men may remain undiscovered until clinicians ask specific questions about sexual behavior.

During sexual encounters with non-Latino men, Ro *et al.* (2013) found that gay Latinos may encounter depersonalizing, sexualizing stereotypes in which they are assumed to be fiery and passionate lovers devoid of education (see also Newcomb, Ryan, Garofalo, & Mustanski, 2015; Wilson *et al.*, 2009). One interviewee emphasized that gay Latinos are expected to be unskilled (if not undocumented) laborers: "So I think that the way some of the White men look at some of these Latino immigrants is like, maybe like slave labour or like a slave lover" (Ro *et al.*, 2013, p. 844).

Amidst pervasive cultural racism and racial community homophobia, African-American homoerotic men are left to establish personal identities that "can be simultaneously contradictory, paradoxical and boldly self-authoring" (Husbands *et al.*, 2013, p. 435). The outcome of this undertaking is nearly impossible to appreciate without a comprehensive understanding of the historical forces shaping our understanding of black male gender and sexuality over centuries. One legacy is that African-American homoerotic men are saddled with clashing stereotypes that render them both desired and feared. It is common for them to be fetishized by gay partners for their supposedly large phalluses; they are also expected to embody hypermasculinity and to assume the inserter role during sex (Calabrese, Rosenberger, Schick, & Novak, 2015; Newcomb *et al.*, 2015; Wilson *et al.*, 2009). In contrast to Asian gay men, who may be regarded as feminine and submissive, African-American men often report that they are expected to play the role of the "physically powerful Black man [who] sexually dominates his White partner" (Ro *et al.*, 2013, p. 843). This stereotype of primal sexuality, however, can clash with the stereotype that African-American men are intimidating and physically threatening—resulting in being at once feared and lusted after. Despite the appearance of African-American sexual empowerment, Ro *et al.* emphasized "the definition of roles is ultimately one where their White partners are sexually serviced" (2013, p. 843). Of course, not all black gay men want to assume sexual dominance, and to the extent that their sexual needs are sacrificed, mental health and sexual functioning may be undermined.

Among some traditional Asian communities, in which community and family priorities supersede individual needs, coming out as gay or lesbian may be seen as selfish and disrespectful to parents and the extended family (living and deceased) and is sometimes viewed as

tarnishing the standing of current and past generations. Although it is generally undesirable to be different or conspicuous, this is especially the case when it pertains to sexuality, a topic seldom openly discussed in many traditional Asian families. Importantly, declaring or acting on same-sex attractions is sometimes interpreted as failed parenting, and thus parents may blame themselves for their child's "unacceptable" behavior (Savin-Williams, 1996). It is not uncommon for LGB Asians to feel that they are bad children and to worry about failing to comply with the assumed duty to marry and take care of aging parents. Thus, they may find themselves caught in a dilemma of choosing between personal happiness and fulfilling family and cultural expectations. This may be especially acute among Asian women, some of whom choose to forfeit family ties in exchange for a lesbian community.

Both the empirical literature and clinical observations document the challenges of same-sex dating among Asian gay men, who report that they are considered less desirable than white gays, perhaps because of stereotypes related to small penises, or that they are viewed as exotic or fetishistic objects who are expected to be subservient bottoms willing to please (Ro *et al.*, 2013; Savin-Williams, 1996; Wilson *et al.*, 2009).

Therapist issues

Therapist microaggressions Most caring therapists would not intentionally express prejudicial or homophobic assumptions. However, we are raised in the dominant culture that supports—indeed, institutionalizes—these values; thus, it is inevitable that we internalize some biases and that they inevitably escape, although not necessarily in blatant or overt ways. In contrast to the flagrant expressions of revulsion and antipathy characteristic of overt discrimination, Shelton and Delgado-Romero (2013) pointed out that disapproving messages can be communicated as microaggressions, defined as "communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics. They may be delivered in the form of snubs, dismissive looks, gestures, and tones" and often are perpetrated "by well-meaning and kindhearted individuals, and can be easily explained away through nonbiased and valid reasons" (p. 59). Microaggressions are typically subtle and difficult to address, but they serve to undermine sexual-minority development, self-concept, and mental health.

Examples of microaggressions by compassionate therapists illustrate the potentially harmful consequences of stereotypical assumptions or beliefs that homoeroticism is undesirable and alterable. One clinician ignored blatant cross-gender behavior in a man who came to sessions wearing painted nails and women's blouses. Underlying transgender issues were not addressed until the client met with a newly-requested therapist because the first therapist had assumed that cross-dressing was common among gay men. (See Spencer, Iantaffi, & Bockting, this volume, for a discussion of treating transgender clients.)

Microaggressions are especially insidious when they occur within a psychotherapy context by caring but uninformed or biased clinicians. Shelton and Delgado-Romero (2013) identified seven key sexual orientation microaggression themes that occur in psychotherapy and that should be avoided: (1) assuming that sexual orientation is the cause of all presenting issues; (2) avoiding and minimizing sexual orientation; (3) attempting to overidentify with LGB clients; (4) making stereotypical assumptions about LGB clients; (5) expressing heteronormative bias (e.g., assuming that a partner is of the other sex); (6) assuming LGB individuals need psychotherapeutic treatment; and (7) warning about the dangers of identifying as LGB. The violation of at least one microaggression theme was evident when one of us witnessed a particularly caring clinician concede to a client's request for "reorientation" therapy by teaching her to snap an elastic band on her wrist when sexual or romantic thoughts of women entered her mind. By assuming that same-sex attractions should (and can) be changed, this clinician had committed a therapeutic microaggression without awareness or intended malevolence.

Coming out to clients Gay affirmative psychotherapy may incorporate a feminist perspective (Rutter, 2012) in which traditional, hierarchical client–therapist roles are questioned and therapist openness and equality are encouraged. This has implications for whether a LGB therapist comes out to his or her LGB clients. This issue should be carefully considered. On the one hand, many clients desire and benefit from appropriate LGB role models. They may believe (not always correctly) that LGB therapists specialize in sexual minorities or at least know enough to allow for greater understanding and more succinct communication. On the other hand, therapists should guard against overidentification and excessive sharing; using the therapy interactions for personal gratification or as their own therapy; indulging inclinations to rescue or quickly advance client sexual orientation self-acceptance; and participating in seduction or gratuitous, sexually stimulating banter, or, conversely, avoiding sexual exploration for fear of appearing unnecessarily curious or titillated. Further, a therapist coming out as LGB, even unintentionally, can frighten clients who may assume their clinician is no longer impartial and will coerce them toward accepting a homosexual identity. If this occurs and the working alliance is irreparably ruptured, transfer to another clinician may be indicated.

Heterosexual therapists who come out as straight should also consider their reasons and the possible consequences. For example, is it to avoid the awkwardness of clients assuming, or hoping, that they are gay; to maintain distance and prevent feared (or desired) seduction; to feel superior; or to remind clients that they, the therapists, are safely "normal?" Some LGBs actually prefer working with a heterosexual therapist from whom recognition and acceptance would be more meaningful than if it came from another sexual minority. Alternatively, LGB clients may wish to avoid possibly developing attractions toward a gay therapist.

Psychodynamically trained clinicians may believe that coming out to clients is counterindicated because it obstructs transference development. Although this assertion is not without merit, therapists may be presumed to have disclosed their sexual orientation by virtue of not disclosing it; that is, the pervasive assumption of heterosexism is that everyone is heterosexual until proven otherwise. Thus, therapists can elect to intentionally disclose their true sexuality or unintentionally disclose what may be a false (hetero)sexuality. Other inadvertent ways in which (usually heterosexual) therapists broadcast their sexual orientation are by displaying family photos and sporting a wedding band (the latter only recently becoming a viable option for LGBs).

Establishing safety: physical environment, assessment, and language

Although LGBs utilize therapy more frequently than heterosexuals (Cochran, Sullivan, & Mays, 2003), past discrimination may incline them toward caution, even suspicion, when interacting with treatment providers and the institutions they represent (Bhugra & Wright, 2007). Having encountered negativity from previous providers through heterocentric or homophobic assumptions, ignorance, stereotyping, or minimization of LGB concerns, they await proof that therapists are informed and supportive. Thus, it is incumbent on therapists to actively demonstrate engagement and respect because the absence of that demonstration will likely be interpreted, perhaps erroneously, as the therapist being judgmental, adversarial, uncaring, uncomfortable, uninformed, or biased. Bhugra and Wright (2007) suggested that this may be curtailed when and if therapists express their own and the institution's appreciation of sexual diversity and openly invite clients to share concerns or discomforts that may arise. For clients who experience high internalized homophobia, are not yet out to self or others, or are unprepared to adopt a sexual-minority identity label, the therapist can convey appreciation for various sexualities without directly implicating the client's sexual orientation.

Physical environment LGBs and their supporters are highly attuned to whether an environment is welcoming, and feel grateful and safe when they observe signs of recognized sexual orientation diversity. Usually, their first encounter with a clinician is in the waiting room, and

thus to instill trust and comfort, LGB-oriented posters, magazines, information pamphlets, and a non-discrimination policy statement should be displayed. It is also meaningful to have gender-neutral bathrooms for trans-identified clients. The next stop is the therapist office, which should exhibit LGB books and other positive symbols such as "Safe Space" stickers, rainbow flags, and indications of LGB pride. Clients who visit the first author's office sit adjacent to a visually unavoidable bookcase displaying numerous LGB books and other representations of gay culture. Several times this has been a catalyst for disclosure, such as when a heterosexually identified woman hastily declared before running out of the door: "I see you have a lot of gay books. I'm helping a lesbian friend deal with that. I'm lesbian. Just joking."

Intake questionnaire, clinical interview, and language Whether eliciting information from an intake questionnaire or during the clinical interview and subsequent meetings, therapists should use non-oppressive, non-discriminatory language that is supportive and validating. They can avoid heterosexism and heterocentric assumptions by using gender-neutral and bi-gendered language. For example, rather than posing vague questions about ambiguous "significant others" or "partners," they can ask whether clients are or have been romantic or sexual with "men, women, or both." Questions about sexual behavior should be specific; rather than inquiring about "intercourse," queries should distinguish between penile-vaginal, vaginal-object, and anal intercourse. Questionnaire assessment of sexual orientation should include the options "questioning," "uncertain," and "other" (with a space provided for elaboration) in addition to "heterosexual," "lesbian," "gay," and "bisexual." The clinical interview should further clarify sexual orientation (including sexual/romantic attractions and masturbatory fantasies), identity, *and* behavior.

Conclusions

In recent years, the social pendulum has swung from viewing non-heterosexuality as near-tragic to incidental. Sometimes accompanying this evolution is an uninformed sexual liberalism in which people of all sexual orientations are assumed to be similar, and therefore, focus on the unique experiences of sexual minorities is assumed to be unnecessary, or even prejudicial. And yet, some LGBs challenge cultural assumptions about gender expression and sexual desire, attraction, and behavior. To appreciate their needs, it is helpful to understand the ways in which biology and environment coalesce to shape and then continually influence their lives (LeVay, 2016). In fact, research suggests that many LGBs grow up experiencing unique life events, which result in developmental experiences that are both similar to and dissimilar from heterosexual peers (Savin-Williams, 2005). For example, the lifelong task of finding similar others, coming out, and negotiating real or imagined disapproval is impactful and can undermine sexual functioning. Sexual dysfunction also can ebb and flow over the life course, especially during times of stressful transition, such as when coming out to self and others, starting or ending a romantic relationship, or changing a job or geographically relocating at which time coming out is once again experienced as a risk-laden undertaking (Bhugra & Wright, 2007). To provide effective and ethical therapy to sexual minorities, therapists should educate themselves about the unique developmental trajectories traversed by many LGBs.

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18

Treating Sexual Problems in Transgender Clients

Katherine G. Spencer, Alex Iantaffi and Walter Bockting

Introduction

The past decade has seen a profound progression in transgender healthcare. Professional organizations such as the American Psychological Association (Anton, 2009) and others have published statements about providing competent care for transgender clients. The American Counseling Association recently published a set of competencies for providers working with transgender clients in therapy (Burnes *et al.*, 2010). Included in these competencies is the important framing of transgender identities and experiences through the lens of intersecting oppressions—acknowledging the impact of sexism, transphobia, and racism on transgender people's experiences. The competencies briefly and indirectly acknowledge sexuality as a topic to be addressed in assessment and psychotherapy with transgender clients, which is consistent with the prevailing literature on transgender issues in psychotherapy. There continues to be very little specific clinical guidance regarding sex and sexuality issues in working with transgender clients.

Before we review existing knowledge in the area of sex therapy with transgender clients, we would like to define some terms used throughout this chapter. We will use the terms *transgender* and *trans* interchangeably to indicate those people whose sex assigned at birth is not aligned with their gender identities, and we will use the terms *cisgender* or *cis* to indicate those people whose sex assigned at birth does align with their gender identities (Richards & Barker, 2013). The term *sex therapy* is used here as an umbrella term to cover psychotherapeutic interventions focusing on the assessment and treatment of issues related to sexual functioning, sexuality, and sexual relationships.

Another term that we will use when discussing some of the identities and experiences of transfeminine people is *transmisogyny*. Transmisogyny is a term referring to the intersection of transnegativity and misogyny (Serano, 2007). Transfeminine-identified persons are at greater risk of violence than the general population, often motivated by cultural taboos, fear of feminine expression, and fear of trans bodies. Serano (2007) identified several layers of transmisogyny, including the hypersexualization of transfeminine bodies; the idea of "trans panic" (used as a defense for violence against trans women who "deceive" others into believing that they are cisgender women); and the double bind of pressure to conform to and reject femininity norms, which can serve to affirm female gender identity but which are also punished due to the devaluing of femininity in a patriarchal culture. Often transmasculine and transfeminine

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experiences are included into a monolithic "trans experience." Transmisogyny highlights the unique impact of sexism and the privileging of masculinity and devaluation of femininity on the experiences of transfeminine people.

Gender identity, expression, and roles—identified with labels such as masculine, feminine, genderqueer, fluid, or androgynous to name but a few—are not the only constructs that impact the diverse experiences of trans people. It is worth noting, before delving into an overview of the chapter, that sexual orientation and gender dysphoria also impact individuals' experiences in ways that are vital to consider when conducting sex therapy with trans clients. Sexual orientation has historically been conflated with gender identity in mainstream culture. This conflating of sexual orientation and gender identity is evident in the historical inclusion of sexual orientation as an important consideration when diagnosing what was called "gender identity disorder" until the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5; American Psychiatric Association, 2013). The shift is indeed so recent that often it is brought up as a topic for therapeutic discussion by trans individuals or their family members.

In a recent study, we found that trans people seem to follow a similar pattern to cis people with regards to the distribution of sexual orientation (Iantaffi & Bockting, 2011). This means that, when working therapeutically with trans people, therapists will come across bisexual-, pansexual-, asexual-, lesbian-, gay-, and queer-identified trans folks in a range of relationship configurations. The intersection of gender identity and sexual orientation does, however, often create distinct experiences and challenges for clients and therapists alike.

Discussing those experiences and challenges can also bring up the issue of gender dysphoria. Gender dysphoria can be defined as a discomfort and distress between one's gender identity and sex assigned at birth (Richards & Barker, 2013). This construct is often treated as monolithic, whereas trans people's experiences in this regard may vary greatly. For example, some trans people may have a high degree of dysphoria around their genitals and might experience different types of sexual contact as triggering that dysphoria. Others might have minimal discomfort with their genitals.

These complex relationships with the body are crucial to explore therapeutically when addressing sex and sexuality with trans clients. Individuals' level of comfort, not only with their body in general, but also with specific components of their body, may be influencing their level of dysphoria at particular points in time; understanding these issues can greatly influence, not only the clients' goals, but also the therapeutic interventions that may be more or less suitable when undertaking sex therapy with trans clients. Level of bodily comfort and degree of gender dysphoria are further influenced by issues such as access to desired transition-related medical interventions, including hormone treatments and/or surgical options. In contrast, the availability of those interventions might have minimal relevance for clients who do not desire to medically transition but only to socially transition.

In some countries, like the US, access to transition-related medical interventions is heavily influenced by other issues such as economic status, insurance coverage, and citizenship. Even in countries where health services for transition are provided free of cost at point of delivery, access is often influenced by factors such as geographical location and meeting the criteria set by the specific providers to whom the client is assigned through a national health system.

In this chapter, we strive to discuss sex therapy with trans clients from an inclusive perspective and to acknowledge the range of bodies and experiences that therapists will come across when working with this population. This means that, at times, we will discuss the impact of transition-related medical interventions and post-surgical concerns. We will not provide here a complete overview of what those medical interventions might be, as this has already been provided elsewhere in the literature (e.g., Gooren & Asscheman, 2014; Monstrey, Buncamper, Bouman, & Hoebeke, 2014).

Overall, existing literature on sex therapy with trans people is limited. Therefore, as well as reviewing and synthesizing current scholarly work, in this chapter we also offer insights and knowledge based on the authors' extensive clinical experience working with trans people, their partners, and their families. We will provide an overview of issues to consider in sex therapy with trans clients. We will address assessment and treatment considerations (including the role of medical transition, masturbation, safe sex, and dating) with trans clients before providing a clinical illustration of these issues through two composite case studies. Considerations specifically for providers (including discussion of the provider role, the impact of gender roles and stereotypes, and generational differences between younger and older clients) will be discussed before offering some conclusions to this chapter. Wherever possible, we endeavor to address those issues from an intersectional lens.

Intersectionality as a concept was first introduced by legal scholar Kimberlé Crenshaw (1989) and has been increasingly used since then as part of third wave feminism and a move towards inclusivity. This concept posits that the ways in which complex bodies and communities experience oppression are deeply interconnected and therefore cannot be disassembled and their parts analysed separately. Even though using an intersectional lens might at times complicate traditional knowledge construction, we believe this to be essential to honor the range of bodies, identities, and experiences of trans individuals and communities, as well as to address the complexities of sex and sexuality.

Existing Scholarship on Sex Therapy with Transgender Clients

In the last few years, there have been two book chapters explicitly devoted to sex therapy with transgender clients, both by the same authors, in two separate volumes (Lev & Sennott, 2012a, 2012b). Despite the encouraging emergence of interest in this area, literature searches for sex therapy-specific articles with transgender clients yield few, if any, results. A recent review of literature focused on relationships and couples issues with transgender clients and published in the *Journal of Marriage and Family Therapy* found that, since 1997, there have been 30 articles devoted to transgender issues, of which nine actually were focused on transgender experiences, and of those, none of them were focused on sex therapy concerns (Blumer, Green, Knowles, & Williams, 2012).

Historically, research in the area of trans sexuality has been devoted to understanding the intersections of gender identity and sexual orientation (e.g., Bockting, Benner, & Coleman, 2009). Psychologists were interested in the sexual orientation of transgender people as they transitioned. This focus seemed to come from the historical heteronormative assumption that, if a trans person undertakes social, legal, and/or medical transitions, they will be (or should be) heterosexual post-transition. This assumption was reflected in the inclusion of sexual orientation as a source of diagnostic subtyping for what used to be called gender identity disorder (GID) in the DSM-IV (American Psychiatric Association, 1994). Subtyping by sexual orientation was only recently removed in DSM-5 when GID was also reclassified as "gender dysphoria" (American Psychiatric Association, 2013). The research focus on trans people's sexual orientation was not invested in improving the sexual functioning or positive sexuality of the person who was transitioning, but rather on the social imperative of maintaining heteronormative order in adherence with sociocultural norms. This imperative is evident in historical and current laws on a global level that demanded for trans people to divorce their spouses and even undergo sterilization procedures in order to access legal and medical transition options (Carrera, Lameiras, DePalma, & Casas, 2013; Nixon, 2013). In recent years, however, there have been increasing conversations within clinical practice circles about sexual functioning among trans individuals, specifically by surgeons at the request of their patients, who are invested in sensation and functioning after surgery (Costantino *et al.*, 2013; Garcia, Christopher, De Luca, Spilotros, & Ralph, 2014; Wierckx *et al.*, 2014).

The primary focus of sexual health research over the last ten years for trans and gender nonconforming clients has been on STI and HIV infection and prevention. Although this is an important topic, given that black trans women are among the groups with the highest rates of new HIV infections (Baral *et al.*, 2013), there has been a dearth of empirical and applied literature supporting the development of positive sexuality and sex therapy with transgender and gender nonconforming clients. Specifically, the challenges of developing an embodied, empowered sexual self when confronting, not only internal experiences of gender dysphoria and lack of affirmation in gender identity, but also external experiences of trans negativity, cisgenderism, misogyny, sexism, and racism, are themes missing from the canon of literature on transgender health and wellbeing.

Assessment of Sexual Functioning and Sexuality Concerns

Competent sex therapy with transgender clients begins with a thorough assessment of sexual functioning in addition to assessment of gender dysphoria. As practitioners often conflate gender and sexuality, assessment of how gender concerns impact sexual functioning and sexuality is often not fully addressed at intake. For example, although practitioners may assess for level of anatomical dysphoria, the client may not be queried as to how their anatomical dysphoria impacts their sexual functioning with themselves or with partners, and practitioners may shy away from asking specific questions about how clients are sexual with the bodies they have (Burnes *et al.*, 2010). Asking whether a client masturbates, how often they masturbate, whether they are able to have an orgasm when doing so, and how long this takes, provides important information to establish a baseline of the client's relationship to self-pleasuring. Additionally, asking questions about whether there were changes in their masturbation practices and functioning after any transition-related medical interventions, such as hormone treatment or surgery, would be relevant to their sexual health. This is important information to gather in order to support clients in developing a healthy, embodied sexuality. Through this process in therapy, clients begin to develop language to describe their experiences of their bodies, are validated in their experiences of dysphoria, and receive the message that their sexuality is valuable.

Sexual dysfunction has increasingly become medicalized in mainstream sex therapy (Wincze & Carey, 2012). A thorough sex therapy assessment should be conducted using a biopsychosocial approach, incorporating not only biological barriers to sexual health, but also social and psychological factors that may be present (Wincze & Carey, 2012). Sexual dysfunction is organized around the sexual response model (Masters & Johnson, 1966) and includes assessment of desire, arousal, orgasm, and pain. For many trans clients, reports of decreased desire and arousal may be connected to experiences of gender dysphoria (De Cuypere *et al.*, 2005). Desire can also be impacted by hormone therapy, as can experiences of arousal (e.g., decreased tumescence with estrogen therapy; decreased lubrication and vaginal tissue atrophy with testosterone therapy; Murad *et al.*, 2010).

Given the lack of literature to guide the incorporation of a thorough sexual health assessment in working with transgender clients, sexual functioning can easily be overlooked. We have found in practice that including questions assessing several areas of functioning in the intake can open the dialogue to addressing sexual health in psychotherapy. For example, in addition to a mental health and psychosocial assessment, practitioners can ask about current sexual behaviors with self and partners; ability to experience desire, arousal, and orgasm; and feelings about sex and sexuality. We have found it is important to ask about how trans clients feel their dysphoria does or does not impact their sexual functioning and whether there have been any shifts in sexual functioning over time, either with different partners, with age, or with medical interventions.

Timing of the sexual assessment depends on context, and the provider should be mindful of the client's presenting concerns and whether sexuality is identified as an area of concern in a holistic assessment. Psychoeducation about the common messages that trans people receive about their bodies and their sexuality—either hypersexualization or desexualization—can be an effective early intervention to open up future sex therapy work.

We also have found that many trans clients minimize their sexual needs and tend to focus on their partner's sexual needs instead. This can be related to discomfort with receiving sexual stimulation in the case of anatomical dysphoria, and can represent a coping strategy developed in order to still be able to engage in sexual activity and feel desired, while managing dysphoria and internalized transnegativity. For example, a client might be focused on a partner's sexual needs because they fear expressing their own needs might alienate their partner and lead to rejection. Assessing the client's sexual self and resultant behaviors is an important, yet often underexplored, aspect of sex therapy with trans clients.

Important Themes in the Treatment of Sexual Functioning

Medical interventions and post-surgical concerns

Medical interventions for transgender clients may include hormone therapy and a multitude of surgical interventions. Current statistics vary in relation to how many transgender clients seek out medical interventions, and these numbers are complicated by issues in the US around access and insurance coverage. Access issues can affect how clients pursue medical interventions. For example, rates of transgender clients who have had surgical interventions are much higher in European countries, where medical interventions are fully paid for in a single payer system, than in the US, where many insurance plans do not cover surgery. The *Injustice at Every Turn Survey* reported 75% of feminine spectrum respondents and 90% of masculine spectrum respondents reported they would like to or have had medical interventions (either hormones or surgery or both; Grant *et al.*, 2011), but access issues often prevent transgender people from pursuing the interventions they may want and/or need. For trans clients, sexual functioning potentially can be impacted either by medical transitions or by the inability to access desired medical transitions.

In a review of the findings of sexual functioning after hormone therapy and genital surgery, reports of increased desire, arousal, and orgasmic functioning were found across male-to-female (MTF) and female-to-male (FTM) populations (Klein & Gorzalka, 2009). Similarly, in a study of Dutch transgender clients who had undergone gender-confirming surgery, 80% reported improvement of their sexual satisfaction post-surgical intervention (De Cuypere *et al.*, 2005). Trans women reported more frequent masturbation than trans men, although overall, trans men in the study reported more easily achieving sexual excitement and orgasm than trans women.

In qualitative reports, trans women described a range of sexual behaviors and functioning pre- and post-medical interventions (Murad *et al.*, 2010). Some women reported pain with erections post-estrogen therapy, which impacted desire. Partner choice and partner acceptance also may play a role in sexual functioning and desire to be sexual (Murad *et al.*, 2010). In our practice, it appears that trans clients with non-accepting or ambivalent partners experience less desire and arousal and more barriers to being sexual than trans clients with accepting partners.

Masturbation

Masturbation is a core area of exploration in sex therapy and a starting point for many sex therapy interventions (Coleman, 2003). Masturbation has long been a foundational therapeutic tool for addressing difficulties with orgasm, sexual arousal, and sexual desire. Many trans clients have discomfort with touching their genitalia and may avoid self-pleasuring (Erickson-Schroth,

2014). Masturbation may increase or complicate trans clients' dysphoria, and broaching this topic can be sensitive in the clinical context. Additionally, as noted above, some medical interventions may trigger sexual dysfunctions by lowering libido, inhibiting orgasm, or impacting arousal (De Cuypere *et al.*, 2005; Klein & Gorzalka, 2009). As masturbation can be a core component of sex therapy and a possible space for exploring and accessing sexual self-knowledge and pleasure, it is important that providers assess, introduce, and encourage masturbation when appropriate to the clinical goals.

Research on the impact of gender dysphoria on masturbation has been sparse and mainly focused on post-surgical outcomes. A 2009 review of post-hormonal and post-surgical sexual functioning outcomes found mixed results across studies, with various studies showing increased, decreased, and no change in masturbation frequency from pre- to post-intervention (Klein & Gorzalka, 2009).

In our clinical work with clients, we have found that introducing masturbation as a positive practice for exploring fantasy and increasing congruence between genital sexuality and sexual experience can help decrease dysphoria. Clients can be encouraged to find ways to touch their genitals that feel more congruent to their affirmed gender—for example, imagining that a clitoris is a penis, or learning the technique of "muffing" where a person with a penis and scrotum can press inward in the scrotal area analogous to vaginal penetration (Erickson-Schroth, 2014).

Masturbation can also can be a needed outlet for transmasculine people who may have increased libido post-testosterone therapy. Many transmasculine people report an increase in libido after starting testosterone (Costantino *et al.*, 2013; Erickson-Schroth, 2014) and may not have access to or interest in partnered sex. Masturbation can be an excellent outlet for coping with increased desire in these cases. It is worth noting that, as well as increases in libido, some clients report a change in desired stimuli following hormonal treatment. For example, some transmasculine clients might find that they now enjoy penetration but that this also triggers their dysphoria or that they need more pressure to be applied and that reaching orgasm might take longer or feel different than it did previous to taking testosterone. Masturbation can be a safe and useful outlet for exploring these new sexual needs and desires.

Masturbation post-genital surgery can be an important aspect of sexual exploration and redefining sexual functioning. Post-genital surgery, many trans women report requiring a period of adjustment to their new clitoris and needing to practice in order to learn to have an orgasm through clitoral stimulation. Estrogen therapy may also impact how transfeminine people access orgasm. Learning new methods for masturbation and new ways of experiencing sexual pleasure can allow for exploration of their feelings about their feminine spectrum identity and sexuality. A host of literature exists within traditional sex therapy aimed at helping women explore their sexuality and achieve orgasm (e.g., Barbach, 1976, 1980; Heiman & LoPiccolo, 1976). We have found in clinical practice that some of the same sex therapy exercises can be adapted to work with transfeminine clients. For example, the use of a sex history, exploring social norms around female sexuality, masturbation homework, and naming and developing a positive relationship with genitals are some exercises that can be adapted to work on increasing orgasmic functioning with transfeminine clients.

The provider must balance communicating the value and importance of a healthy embodied sexuality with the validation and acknowledgement of the experience of dysphoria, if present. The goal is to collaborate with the client to develop a pathway to accessing their sexuality in the body they have, and possibly as they choose medical interventions to increase congruence with their physical bodies.

Safer sex

Sex with others is also something that might change as clients go through transition. For example, one of our studies has shown that some transmasculine people who are attracted to men might engage in more sex with gay and bisexual cis men post-transition as compared

with pre-transition; yet they may not be equipped to negotiate boundaries in new communities and situations (Feldman, Swinburne Romine, & Bockting, 2014). In fact, for some transmasculine people in those situations, barebacking, that is, intentional sex without a condom, might be affirming of their sexual orientation and masculinity (Feldman *et al.*, 2014; Iantaffi & Bockting, 2011). Similarly for transfeminine people, attraction and sexual encounters might change as they become more comfortable with their identity and gender expression. This might lead to negotiating sex with cis straight men (or with trans men or other trans women) for the first time.

Regardless of sex partner, safer sex information specifically aimed at trans people is limited. However, rates of STIs and HIV seem to be higher for trans people—especially for trans people who have sex with cis men—due to a range of factors. It is not within the scope of this chapter to address those issues, but it is important, when conducting sex therapy with trans people, to address matters of safer sex. This means, for example, asking specific questions about who clients are having sex with, where they are meeting their sexual partners, and whether there is fluid exchange during sexual encounters. It is also important to assess clients' capacity to advocate for their own needs and boundaries and to evaluate whether clients need access to information; competent healthcare providers; or even safer sex supplies such as condoms, lube, and dental dams.

Although it is important not to stereotype trans clients by assuming that all trans people will be at higher risk of STIs and HIV than cis people, it is important to be aware of risk behaviors and to discuss those with clients. Introducing clients to the idea of risk-aware, consensual sex encounters can be a way of addressing safer sex in a non-judgmental or stereotyping manner. For example, what is the client's understanding of consent in sexual scenarios? Does she/he/they feel able to give and obtain consent in a range of sexual situations? A trans client might have happily negotiated condom use within the context of relationships prior to transition, but might find herself at a loss in a new relationship or in her "new" gender role. Actively discussing scenarios, educating clients about consent, highlighting potential risk behaviors, and identifying strategies for addressing those can be important aspects of sex therapy with some clients, especially those who are experiencing significant changes in their desire and relationships or who might finally feel able to express their sexual desire and attractions.

A therapist might also be the only source of information for resources, including trans-friendly HIV testing sites, competent providers to pursue pap-smears or seek pre-exposure prophylaxis treatment, and community-based groups that may be active in the client's areas of interest (e.g., queer dating, sex on premises venues, BDSM organizations, etc.). Therapy also might be the place where trans clients who are living with HIV are able to explore negotiating sex as an HIV-positive trans person or process feelings about their status. Sometimes discussion of those issues reveals histories of substance use and trauma that might also relate to gender identity issues, as well as having a significant impact on sex and sexuality. Therefore, it is vital not to underestimate the importance of assessing the level of knowledge, information, and access to sexuality education a trans client has, and to be able to point clients in the direction of appropriate resources so that they can pursue a fully embodied sexuality in the healthiest way possible.

Dating

The literature on trans dating concerns has focused on sexual orientation exploration (Bockting *et al.*, 2009), sexual behavior practices and safer sex (Bockting, Robinson, & Rosser, 1998; Feldman *et al.*, 2014; Operario, Nemoto, Iwamoto, & Moore, 2011), experiences of dating violence (Ard & Makadon, 2011), and fetishization and hypersexualization of the trans body (Mauk, Perry, & Muñoz-Laboy, 2013).

Several authors have explored how the shifting of sexuality over the course of transition and gender exploration then impacts dating and perceptions of sexual orientation (Wierckx *et al.*, 2014).

As discussed above, sexual orientation may be fluid or shift through gender exploration. This impacts dating experiences, as well as how people are perceived in their gender presentation over the course of their transition (Dozier, 2005). From clinical experience, many clients report a reticence to begin dating until they have completed some aspect of their medical transition, stating that they do not feel comfortable with their bodies as they are or that it feels difficult to find potential dates when they are perceived as trans, especially for trans women. In group therapy sessions, when discussing dating, the topic of whether to disclose or not to disclose trans status is frequently debated. This issue is complicated by the fact that some trans people can "pass" (be perceived as cisgender in their affirmed gender) and others cannot (meaning they are perceived as transgender).

Mauk *et al.* (2013) described a study in which they interviewed cisgender men who pursue sexual relationships with trans women. Their informants described a network of sex-focused "parties" in which cisgender men can meet trans women for sex, paid and unpaid. This points to another complication with trans dating, specifically for feminine-spectrum trans clients, who may experience people who want to date them or have sexual relationships with them *because of* their transgender status, leading to a fear of being fetishized. Julia Serano (2013), in her book *Excluded: Making Feminist and Queer Movements More Inclusive*, also spoke to the experiences of lesbian and bisexual trans women who feel excluded from queer women's spaces and not valued as potential partners.

Transmen encounter challenges in dating, as well, in multiple contexts. For transmasculine people who partner with heterosexually identified cisgender women, at times there is difficulty in navigating their partners' lack of knowledge about transgender experience and bodies, as well as in dealing with transphobia in family and peer networks (Wierckx *et al.*, 2014). For gay, bi, and queer trans men, cisgender gay men are not always open to trans male bodies, or may negate their masculine identity by hyperfocusing on genitalia (Bockting *et al.*, 2009; Erickson-Schroth, 2014). Trans men who elect to pursue hormone therapy, and who may have an easier time "passing" due to the effects of testosterone, are often in a position of choosing when and how to "out" themselves as transgender and dealing with the emotional impact of potential rejection as dating and relationships progress (Erickson-Schroth, 2014).

There have been multiple studies published, particularly with young people, on dating violence in LGBT communities. Earlier studies tended not to separate trans and gender nonconforming youths' experiences from the overall sexual minority sample. However, a recent report by the National Coalition of Anti-Violence Programs (2014) found that transgender participants were twice as likely as cisgender participants to experience intimate partner violence. Black trans women and transfeminine persons who were engaged in underground economies were also more likely than white, middle- or upper-class, trans men to be victims of violence (Brennan *et al.*, 2012). This finding illustrates the problem of lumping all trans experiences into one, since important differences exist within this diverse population.

Case Example 1

Sarah was a 46-year-old white, middle-class trans woman, who had been on hormones for six months, had socially transitioned in her life everywhere except her work, and was currently married to her cisgender, heterosexually identified wife of 20 years. Sarah reported that, since beginning her transition, she had lost sexual desire, had been masturbating less frequently, and had experienced less enjoyment with masturbation. She reported she masturbated "just for a release" and felt increasing levels of dysphoria when being sexual. Sarah reported that she used to masturbate about two to three times per week and was sexual with her wife one to two times per week. Her masturbation had decreased to once a month, and she and her wife had discontinued sexual interactions due

to conflict and strain around the impact of her transition on their marriage and due to her wife's identification as heterosexual and discomfort being sexual with Sarah in a lesbian relationship. At first, Sarah had difficulty talking about her sexual functioning and masturbation habits and reported high levels of shame and feelings of disgust about her genitals when she thought of them as male. Sarah identified as a heterosexual cross-dresser for several years prior to coming out as transgender, and she questioned whether masturbation was healthy for her given her history of seeking out anonymous encounters with men in which she could present as female and be validated for her femininity. In beginning to work with Sarah on her sexuality, the therapist began by assisting Sarah with contextualizing her past sexual behaviors as a coping and survival strategy for dealing with her gender dysphoria and her inability to live in her affirmed gender. The therapist encouraged Sarah to allow herself to grieve the loss of her sexual development as a girl and encouraged her to celebrate the milestones of her "second puberty" as she began her journey on feminizing hormones. The physical changes that began to occur, such as breast tissue growth, became access points to explore how Sarah could develop a more embodied and congruent sexuality through masturbation. The therapist shared with Sarah several resources on sexuality (e.g., Trans Bodies, Trans Selves*; Erickson-Schroth, 2014), and Sarah worked on developing language for her genitals that felt more congruent for her (calling her penis her "clit" and her anus her "pussy") and explored different masturbation techniques, including stimulating her inguinal canal and anus. The therapist also encouraged Sarah to explore trans-positive sexually explicit media to assist in developing sexual role models and to see bodies like hers enjoying sexual pleasure. As Sarah developed a stronger sense of her sexual self, she and her wife began to reconcile the changes in their relationship as they shifted from a heterosexually identified couple to a lesbian relationship. Sarah and her wife engaged in multiple couples therapy sessions aimed at working through the shift in identity and exploring whether they could reconcile their sexual desires. The therapist worked with Sarah to advocate for her sexual needs and to assert the importance of being treated and perceived as female in her sexual relationships. The therapist supported Sarah and her wife as they came to recognize their sexual needs were incompatible, and helped them to identify a solution for this given their relationship with each other.*

Case Example 2

Javier was a 26-year-old, working-class, Latino trans man, who had been on hormones for two years and had chest surgery one year ago. He had socially transitioned fully and was perceived in his affirmed gender in all aspects of his life. He had recently been exploring his sexual orientation and his attraction to men. Before transition, he had identified as a butch lesbian, and since transitioning, he had identified as queer. In therapy, he had identified his newly-felt attraction to men and the desire to explore his attractions with gay men. Javier expressed fear of rejection for not having had bottom surgery and feelings of increased dysphoria about his genitalia associated with the thought of being sexual with cisgender gay men. The therapist and Javier explored his indecision about vaginal penetration and worked on conceptualizing how he could enjoy vaginal penetration (as he had in the past and with masturbation) and identifying more neutral terms that did not trigger his dysphoria ("front hole" rather than vagina). Javier and the therapist worked on boosting his assertiveness skills in negotiating safer sex with potential partners, as this was a topic he had avoided with previous partners out of shame and discomfort in sexual situations. The therapist provided Javier with online resources and encouraged him to attend a trans men's support group at the local LGBT Community Center where there was a monthly sexuality topic discussion. Javier joined an online discussion forum for gay and bisexual trans men and joined several dating websites that cater to gay men. He explored in therapy how and when to disclose his transgender history and was able to gain encouragement in his support group around dating experiences.

Considerations for Providers

Provider role

The provider in sex therapy tends to take a more active, directive, psychoeducational, and advocate role than the provider in general psychotherapy (Burnes *et al.*, 2010; Lev, 2004). This remains true for sex therapy with trans clients. Although there has been sparse empirical literature on the role of the provider in sex therapy with trans clients, the intersection of advocacy and transgender health work has been well documented (Bockting, 2014; Lev, 2004; Lev & Sennott, 2012a, 2012b).

In dealing with the impact of transmisogyny on trans people's development of a sexual self, the provider must take an active role in countering messages of devaluation of trans sexuality. As when working with other oppressed/marginalized groups, therapists working with trans clients may find themselves being active in their advocacy and accountable for countering the trans negative messages pervasive in our culture. By countering these messages, the provider serves a deeply therapeutic function of helping clients to internalize trans-affirmative messages about themselves and about their sexuality. This includes helping to expose the client to alternative trans-affirmative media and support groups and engaging in community advocacy work as a provider. The provider cannot remain an impartial observer given the impact of minority stress in trans clients' lives (Burnes *et al.*, 2010).

Gender roles/stereotypes

The field of transgender sexuality is heavily influenced by the cultural context in which we live (Lev, 2004). From the days of Christine Jorgensen and the arguments about whether she was a "real woman" and thus able to marry—discussions that rested on the assumption of her heterosexuality and desire to marry and that reflected the belief that a woman's worth is defined through her marriage and reproductive capacities—to the current fascination with trans men and pregnancy, culturally couched assumptions about "natural" gender roles and sexuality inform the lens through which we understand transgender issues. Therapists' values can impact therapeutic outcomes (Vasquez, 2007), and this is especially salient in work with transgender clients in sex therapy, given the deeply ingrained cultural values around gender, gender nonconformity, and sexuality (Heck, Flentje, & Cochran, 2013).

As gender is a binary in dominant Western culture, femininity is necessarily defined in opposition to masculinity (Serano, 2007). As sexual beings, the feminine is defined as the object and the receiver of sexual attention, as evidenced through countless examples of how women are expected to dress, act, and present themselves; are judged for their appearance; and are expected to be submissive, interested in men's approval, and so on. As such, many feminine-identified people internalize the idea that their sexual worth comes from being desired by the other, and because we live in a patriarchal culture that values masculinity and masculine sexual dominance, this is often defined as value through the male gaze (Serano, 2007). As noted above, this can contribute to risky sexual behaviors in the search for male affirmation and love.

Pressure to conform to masculinity norms can also impact sexual behavior and functioning. Patriarchal masculinity norms include values of power and dominance, being sexually promiscuous, increased risk-taking behaviors, and anti-gay attitudes (Mahalik *et al.*, 2003). Therapists working with trans clients have a responsibility to observe and challenge these problematic gender stereotypes in themselves and in their trans clients.

Couples therapy

Trans people may seek couples therapy in the context of sex therapy for a range of reasons. Sometimes trans people might bring partners into sessions as part of their transition process as they negotiate their gender identity, expression, and roles with existing partner(s). At other times,

trans people might seek couples therapy to address issues that are not related to their identities or transitions. It is important to note that trans people are likely to be in a broad range of relational configurations, as are cis people (Iantaffi & Bockting, 2011). This means that, although it is important to take into account the trans identity and history of a client, it is vital to reflect on whether this is central to the client's presenting issue and goals for couples therapy.

In some of the historical literature, much attention has been placed on the cis partner's experience of being in a relationship with a person in transition. Although it is important to address any feelings that a cis partner might have about someone's transition, one aspect that has not yet been researched—but that we have experienced in a clinical context—is the impact of cisgenderism on couples therapy. For example, often a trans client in a relationship might feel "guilty" about a relationship breakup, even when their partner has been completely unwilling to engage in or even attend therapy. Those feelings of guilt might drive trans people to tolerate behaviors from their partners that might otherwise be considered inexcusable or even abusive, such as being blamed for all relationship issues or for children's misbehaviors and acting out. In those cases, using narrative techniques (see also Findlay, this volume), such as externalizing cisgenderism and guilt, exploring the impact they have on all parties, and addressing them explicitly, can be important ways of challenging internalized trans negativity and systemic oppression, including microaggressions, occurring within a relationship system.

Addressing those issues directly might also support couples in discerning between sex and sexuality issues that are directly related to gender identity and transition, and those that might be impacted and connected to gender, but are not directly stemming from it. Being able to discern those issues can be helpful in restoring some balance within systems in which trans identities and experiences have become the main focus of "blame" or have been pathologized. Maintaining and modeling therapeutic neutrality and curiosity while being aware of how the therapy room can become a mirror of dominant discourses, which potentially marginalize the voices and experiences of a trans member of a couple, are vital challenges for sex therapists engaging in couples work with trans clients. However, resources on how to work therapeutically with couples where one or more parties are trans are sorely lacking. More research is needed to inform the work with couples in this area.

Generational differences

Over the past ten years there has been a shift in the age range of transgender clients seeking services, with more and more youth accessing gender services (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Olson, Forbes, & Belzer, 2011). With increased trans visibility and the emergence of a sizable trans community on YouTube and other social media outlets, trans youth are beginning their social and medical transitions and gender exploration at earlier ages, with some youth transitioning in childhood (Brill & Pepper, 2013). The age at which someone transitions impacts their experiences in the world and their sexual development. Although not well documented in the literature, there are clear themes in these generational differences that are emerging through our increased clinical work with transgender youth. These themes include generational shifts in understandings of sexual orientation identity, understandings of gender identity, and ideas about coming out. Additionally, the fact that many trans youth are living in their affirmed gender from an earlier age than older trans adults has a positive impact on their self-esteem, sense of self, and relationships. There has been an increase in diverse sexual orientation identities over the past ten years, including asexual, demisexual, pansexual, panromantic, aromantic, and so on (Kuper, Nussbaum, & Mustanski, 2012). As these new sexual orientation terms have become more visible, more people have claimed them as their own. Anecdotally, it appears that trans youth (aged 13–26) claim these terms more often than older trans clients. The intersections of sexual orientation identity and gender identity can be highly salient in sex therapy work with a trans client, regardless of whether the individual is in a sexual relationship with another person or not.

Generational differences also exist in understandings of gender identity. Many transgender people who transition when they are older may have had vastly different experiences than their younger counterparts. Narratives about transgender identity are shifting through the expansion of social media networks and increased visibility (Kuper *et al.*, 2012). In the past, transgender content was sparse and difficult to access, leading to singular narratives about the transgender experience. In contrast, currently there are increasingly complex and varied narratives and pathways to trans identity, inclusive of genderqueer identities, and diverse discourses in trans communities around gender identity, dysphoria, and transition. These generational differences in gender identity and contextual community understandings about sex and sexuality can differentially shape individuals' relationships to their bodies and sexualities. For example, some middle-aged and older trans women may identify with their dysphoria in such a way that they are only "real women" after genital surgery, whereas a person from a younger generation may have been exposed to different media about genitals and dysphoria and have a narrative that their womanhood is not reliant on surgical intervention. In these examples, the level of dysphoria may be the same, but how they conceptualize themselves in their identity is the difference.

These identity factors can shift as a result of culture, as well as generationally; a 23-year-old transmale-identified person from a white, middle-class, college-educated background is going to have a different understanding and context for what identity markers mean compared with a 64-year-old trans woman, who is Latina and working-class. These different experiences in the world shape understandings of identity in profound ways, which also shape sexual behaviors and relationships. A provider must be sensitive to how these intersections of identity and context shape an individual's self-concept and view of their own sexual behaviors and relationships.

Conclusions

The existing literature specifically aimed at sex therapy issues with transgender clients is sparse and limited in scope. We have attempted in this chapter to review and synthesize the broader literature in this area and to add to this knowledge base with our combined decades of clinical experience. As noted in multiple locations across disciplines when discussing transgender health topics, there is a dire need for increased research and writing on transgender health concerns in sex therapy. With increasing attention on trans health issues arising in multiple disciplines, the clinical and research canon will hopefully continue to grow and more adeptly address trans health, and importantly, sexual health and sexuality.

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Treating Sexual Problems in Children and Adolescents

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Introduction

Celeste is a 13-year-old girl who referred herself for therapy to talk about "drama" she was having with her boyfriend. Within the first 10 minutes of meeting Celeste, she boasted about being sexually active, not only with her boyfriend, but with "tons of hot guys" who gave her attention. As our relationship developed, it was clear that Celeste's sense of self-worth was rooted in her ability to be sexually desired by boys. Celeste would brag about having multiple partners at a time and spoke with self-congratulatory excitement about cheating on her boyfriend, sending provocative sexts, and putting racy photos on Facebook to make all of her "boy toys" jealous and angry. Celeste used her sexual escapades as a weapon to hurt boys—perhaps before they had a chance to hurt her—and to wound her boyfriend worst of all.

Later in the therapy, Celeste disclosed that her first sexual experience had been when she was 10 years old with an 18-year-old member of her father's gang. Celeste expressed that this was the only boyfriend with whom she had ever been in love, and she shared her devastation when he was murdered in a gang-related shooting. Celeste's own father had been in and out of jail for most of her life, and she described herself as her "father's keeper," always being the one—even when she was as young as 5 years old—to remind him to stay out of trouble. "I'm my daddy's whole life, and he's my best friend," Celeste would say. "I don't give a fuck about any of these other boys. I just like to play with them!"

Celeste has a trauma history, and many therapists are probably comfortable working with sexual material that comes up in therapy when they see the child as traumatized, even in the case of sexual behaviors that are as prolific and unusual as Celeste reported, because the sexual behavior can be viewed as a symptom of the trauma. But therapists are often more perplexed when childhood sexual play, talk, and behavior occur in absence of sexual trauma. For example, Mark, aged 12, came into the office with a fantasy of holding a gun to his teacher's head and making her undress. He had no trauma history. And Paul, only 8 years old, had the Barbie dolls in the therapy office humping and kissing, making broad slurping and moaning noises when he played. Renee, 7, presented herself sexually to her therapist by doing a bump and grind. And Kaylin, 14, argued that getting drunk to have sex with random boys at parties was what everyone was doing. Ronald was 16 and worried that he engaged in excessive masturbation. Ellen, 6, asked her therapist, "What does 'fuck' mean?"

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

When there is trauma present, we therapists often understand the sexual material presented by children and adolescents as post-traumatic. When sexual material is presented by children, we look for trauma and are confused when we don't find it. But in both cases—when a child or adolescent has experienced sexual trauma and when he or she has not—sexual material will enter the therapy room. Even in cases of children and adolescents who have not been traumatized, sexual material should be considered not special, but rather, similar to all material that comes up in therapy. Sexual thoughts, feelings, and behaviors are a part of life, from birth to death, and become integrated into other issues that children and adolescents bring into the therapy room. Sometimes the sexual thoughts, feelings, and behavior are the core issue, but more often than not they are integrated with other problems like attachment issues, tendencies towards compulsive behavior, anger at a parent, and more. Before considering the range of normative to more problematic childhood sexual behavior in more depth, it is important to understand the theoretical foundations upon which child and adolescent sexuality are built.

Theories of Sexual Interest in Childhood and Adolescence

Psychodynamic theories

Freud, of course, is credited with bringing to the field of psychology and psychiatry the idea that sexual feelings are part of the life force and that, from infancy on, individuals are sexual beings (Freud & Strachey, 1905/1975). In his early work, Freud drew correlations between childhood sexuality and early experiences of childhood sexual abuse. He later proposed that unconscious, rather than conscious, experiences underlie childhood sexuality (Masson, 1984). For example, Freud asserted that boys harbor repressed, unconscious sexual feelings for their mothers, and that girls possess parallel feelings for their fathers. He termed these phenomena the *Oedipus Complex* and *Electra Complex*, respectively. Freud also identified six sexual stages though which children develop these unconscious sexual feelings: (a) oral, (b) anal, (c) phallic, (d) oedipal, (e) latency, and (f) genital (Freud & Strachey, 1905/1975). According to Freud, in the first three of these stages, children derive pleasure and achieve release from different body parts. In these various *psychosexual stages*, individuals invest libido or sexual desire in—or *cathect*—different body parts as they develop. According to Freud, failure to successfully complete any of these stages results in unhealthy aspects of one's personality in adulthood.

Following Freud, object relations theorists such as Klein, Winnicott, and Fairbairn, as well as ego psychologists like Erik Erikson, minimized the sexual nature of these childhood developmental stages to such an extent that the child began to be viewed as negotiating attachment relationships rather than unconscious sexual drives. While object relations theorists emphasized early attachment as the foundation for later development, Erikson (1966), an ego psychologist, emphasized the integration of the world around the child, changing Freud's psychosexual stages into psychosocial ones. Much more recently, psychoanalytical theorists have taken a second look at the sexual nature of the child. Fonagy and Target (1996, 1997), for example, revisited Freud's assertions about childhood sexuality to integrate them with their idea that children develop their self-concepts by inferring states of mind in themselves and others. These theorists noted that the manner in which children develop internal representations of sexual experiences or arousal depends on how their primary caregiver mirrors these experiences. If children do not find their early sexual experiences reflected by their caregivers (e.g., "You like to touch your penis. It feels good to do so"), their arousal will intensify. Rather than being able to take ownership of and manage these feelings, they may interpret the state of arousal as incongruent or foreign.

Post-modern/constructivist theories

Another set of theories that contribute to thinking about early sexuality comes from social theorist and philosopher Foucault (1978), who explored the discourse around sexuality in societies as it works to represent the status quo and powerful institutions, and to repress and shape sexuality. He held that the experience of pleasure transcends repressive practices and labels. He described public discourse about children as shaping them and their experience in the following ways: (1) supporting the idea that children are innocents; (2) positioning psychiatrists as the ones who have the power to define "harm" and "trauma" as well as "normality"; and (3) picturing many kinds of adults and adult/child interactions as dangerous for children. Foucault wrote that pleasure in and of itself—the powerful experience that it is—helps children and adults overcome the regulation of sexuality through ideologies embedded in society. Postmodernist theories emerged not only from Foucault but out of feminism, queer studies, and theories of gender. These theories maintain that sexuality discourses control who can and cannot be sexual, and thereby marginalize certain kinds of sexuality, including childhood sexuality.

Sexual script theory, a theory that buys into the idea that how we think about sex and perform sexual acts is constructed by society, comes from the field of sociology and argues that individuals follow social scripts for all behavior, including sexual behavior (Gagnon & Simon, 1973). What is normal, then, becomes a socially-agreed-upon version of what is expected and follows a script that has been influenced by a number of social institutions, including the media. For example, scripts for childhood sexual play might be "I'll show you mine if you show me yours" or "playing doctor," which are heavily influenced by social understandings of what childhood sexuality is about (e.g., exploration and binary understandings of sexuality).

Biological theories

The biological theory of childhood sexuality asserts that children only become sexual around the age of 12 when they are flooded with hormones and that up until that point are asexual (Bailey, Dunne, & Martin, 2000; Buchanan, Eccles, & Becker, 1992; Byne, 2007; Weisfeld, 1999). Although hormones certainly contribute to sexual changes that occur in childhood and in the transition from childhood to adolescence, they are not the only factor.

Anthropological theories

Anthropologists have long been interested in other cultures' treatment of sexuality in order to highlight the culturally determined nature of what we in the US and other industrialized, Western countries call normal. For example, in her study of adolescent girls in Samoa, where sexual experimentation among girls is culturally condoned, Margaret Mead (1961) found that girls possessed positive attitudes about their bodies and sex and did not experience the same sexual turbulence as adolescents do in industrialized nations. This and other research, particularly Herdt's (1987) longitudinal study of the homosexuality of boys in New Guinea, supported the cultural boundedness of normative sexuality. In his study, Herdt found that the practice of fellatio between men and young boys was a ritual associated with masculinity and a boy's entrance into manhood. Anthropologists often hold the view that sexuality and normality is deeply culturally specific, and that, when studying another culture, it is very hard to understand the nuances of any sexual act because the researcher cannot fully understand the cultural context in which the act is embedded.

Much of the *research* on children, however, does not come from any of these theoretical perspectives. The research we describe below, on children's sexuality, often presents findings from an atheoretical perspective. It is important to remember, while reading the findings, that all research takes place in a cultural context and suggests some theoretical perspective, even if that perspective is not named.

Research on Children and Sexuality

Much of the research on the sexual interest of children has focused on the ages at which children begin to show sexual interest, rather than on what makes them sexual (Lamb, 2002). This research often has privileged a biological perspective. Such research was fueled by an interest in learning what, if any, patterns of behaviors in childhood led to adult sexual preferences, and much of this research occurred in a context in which rights for non-heterosexual individuals were questioned. It may be that this research on early sexual feelings was undertaken in order to support a perspective that argued against the conservative idea that LGBTQ individuals had control over whom they were attracted to and thus that sexual preference for same-sex partners was, to them, a choice. The assumption of this research seems to have been that, the earlier the attraction, the more likely it was to be biological and innate.

Money (1986) noted that *love maps*, which he defined as schemas that children develop for preferred sexual objects and behaviors, begin as early as 8 years old. Herdt and McClintock (2000) asserted that *adrenal puberty*, which occurs between ages 6 and 10, marks the beginning of adolescents' subjectivity, which includes feelings of attraction and awareness of their own sexuality and the sexuality of others. This stage is different from *gonadal puberty*, which commences around age 11 and is accompanied by a greater and different influx of hormones. These authors also asserted that middle childhood, which begins around 10 years of age, represents the time period during which psychophysiological arousal creates stable and memorable sexual attractions.

Another area of child sexuality research has addressed the presence and prevalence of specific sexual behaviors. It seems to us that this kind of documenting of the commonality of sexual behaviors was undertaken in an era when sexual abuse concerns were prominent. Thus, the documentation of normative behavior also helped the mental health profession to document non-normative behavior as evidence of harm from abuse.

In their study of 1114 children who were rated by their caregivers, Friedrich, Fisher, Broughton, Houston, and Shafran (1998) found that sexual behaviors tended to peak by the age of 5 before tapering off. These researchers found that the most common behaviors reported by caregivers were children touching their own body parts at home or trying to look at others undressing. Friedrich, Grambsch, Broughton, Kuiper, and Beilke (1991) also found that "latency-aged" children (ages 7–11) express their sexuality through their use of language, looking at nude pictures, trying to see people undress, and kissing nonfamily adults. It is critical to mention, however, that relying on self-reports of observed behavior may not reveal the extent of these behaviors because many sexual behaviors may not be observed by parents.

Little research has been done on masturbation in childhood. This could be due to parental discomfort with discussions of childhood sexuality (De Graaf & Rademakers, 2006). It also could be because, after a certain age, it is difficult to observe children masturbating, as this is an activity that they are taught to do in private. On the other hand, from a perspective that views research as influenced by cultural discourse around sexuality, it is quite possible that little research has been done on childhood masturbation because, although experts will say it is "totally normal" (e.g., Leung & Robson, 1993), at various times and within various disciplines in the US and some other industrialized countries, there is still widespread discomfort with children masturbating. For example, even when it is acknowledged as normal, it is rarely included in any sex education course or books for children about bodies and how they work. The limited research that is available reveals that children of both genders normally touch their genitals between the ages of 2 and 9 (Friedrich *et al.*, 1991, 1998).

Sexual play among children is common. Sexual play can be defined as any play containing sexual elements, from preschoolers playing "doctor" to older children simulating intercourse

by "dry humping" or comparing their genitals in the locker room (Gil, 1993). There are a few studies documenting such, although rarely do mainstream studies exploring play among children integrate the study of sexual themes in play as a topic to investigate. The study of sexuality in play seems to be treated as a topic separated out and of a different category than play in general. In one study of 233 parents in Ireland, 36% reported that their children engaged in sexual play (Fitzpatrick, Deehan, & Jennings, 1995). Sexual interest has been documented among 5- to 7-year-olds, through a sample of teachers who observed students making verbal comments about sex and attempting to touch their peers' butts, breasts, or genitals (Kaeser, DiSalvo, & Moglia, 2000). In one study of 377 urban children who were questioned themselves (Pluhar & Kuriloff, 2004), of the 11- and 12-year-olds, 6% reported having touched a boy's penis, 5% reported having touched a girl's vagina, and 10% had "made out" with someone. Seventeen percent of 6–12 year olds reported playing games involving hugging and kissing. Haugaard (1996) surveyed over 600 undergraduates about their sexual experiences in childhood. He found that 38% reported a sexual experience (which included "undressing together") between the ages of 7 and 10, and 35% between the ages of 11 and 12. In their retrospective study of child sexual interpersonal behaviors. Lamb and Coakley (1993) found that, of 128 undergraduate women surveyed, 85% reported having played a sexual game in childhood (e.g., "I'll show you mine if you show me yours"), 15% had touched another child's genitals while clothed, and 17% had touched another child's genitals while unclothed. In these studies, same-sex childhood sexual play is common; the majority of the 128 undergraduate women that Lamb and Coakley (1993) surveyed about childhood sexual experiences reported that their play involved members of the same sex. In terms of the impact that childhood sexual play has on adulthood, Okami, Olmstead, and Abramson (1997) found no relationship between having a sexual experience with another child between the ages of 3 and 6 and long-term adjustment.

Research on Adolescents and Sexuality

Compared with understanding childhood sexuality, understanding normative sexual behavior for adolescents is more ambiguous and variable depending on context, culture, religion, and region of the country. Adolescence represents a period in which there is a great deal of diversity with respect to sexual behavior, despite the common misconception that preteens and teens are all driven by rampant hormones (Lamb, 2006). In addition, research on this topic has tended to focus on teens' likelihood of engaging in sexual activity based on race, gender, religion, and socioeconomic class. For example, some research reported that at least a third of girls and half of boys masturbate (Baldwin & Baldwin, 1997); however, this gender difference is likely to change over time as society gives more permission for girls to be sexual in adolescence and as masturbation for girls becomes more of a topic of conversation among adolescents in the media and in their own interactions. On average, adolescents tend to have sexual intercourse for the first time at age 17. And a recent study showed that, in the US, only 16% have had sex by age 15, about 48% by age 17, and 71% by age 19 (Finer & Philbin, 2013).

With regard to sexual identity, we know that confusion and fluidity are common during this time, as adolescents explore their sexual identity and preferences for members of the same and/or different sex (Diamond, 2009; Savin-Williams, 2006). Data have shown that 5–13% of adolescents in grades 7 to 12 have had same-sex romantic feelings (Savin-Williams & Ream, 2007). Diamond (2009) has shown that female sexual identity is much more fluid than male sexual identity, not strictly homosexual or heterosexual, and something that changes according to an individual's life stage and social group.

What is Normative?

The first step in working with children and adolescents with sexual problems is to learn how to distinguish between what can be considered "normal" sexual behavior and what is indicative of sexual problems stemming from abuse. If a therapist understands the perspective that sexual "problems" usually don't exist in isolation but are integrated with other psychological issues, the question of normal or not is undone. In fact, all material that is brought into the therapy session is material to work on, and jumping too soon, or at all, to tell a child or adolescent that what they are experiencing is normal or pathological can cut off important work.

In earlier work, the first author (Lamb, 2002, 2006; Lamb & Coakley, 1993) explored childhood sexuality from a perspective of health and resiliency, noting that sexual play in children of all ages is a part of healthy development and a way in which they can express their interest in sex and sexual development. For example, very young children often play games that include elements such as, "I'll show you mine if you show me yours." They also exhibit curiosity and pleasure in looking at and touching their own genitals. Sexual excitement in the form of orgasms has been documented in children as young as 7 months (Kinsey *et al.*, 1953) and self-touch and masturbation throughout the childhood years (Friedrich *et al.*, 1991, 1998). As they get older, children's play becomes more imaginative and sexual elements become incorporated in solitary play as well as play with others. Children's sexual play reflects the society in which they live and the messages they absorb about sex from older siblings, parents, TV shows, and the internet, among other sources of information. In this way, play can take a range of forms, from acting out "sexual scenarios" they have witnessed or inferred to be occurring at home (e.g., parents going to bed and "humping"), or to acting out scenes of prostitution (Lamb, 2002).

Sometimes these games create feelings of sexual excitement and sometimes simply excitement about getting caught or violating norms, such as when children dare others to get naked in front of the rest of the group. Researchers consider this play normative because it occurs among children of the same age and is mutual. There are often feelings of guilt and anxiety associated with sexual play, as children understand the taboo and secret nature of engaging in sexual activities (Bromfield, 1993; Lamb, 2006), but feelings of guilt and secrecy are normative too and not necessarily indicative of a problem.

Sexual Problems in Childhood and Adolescence

Just as it is hard to define normal sexual behavior, it is very difficult to define what constitutes a sexual problem. This is because sex and sexuality are such taboo topics—except in the media, in which sexual issues are omnipresent and sensationalized—and because our society is constantly changing with regard to what is acceptable sexuality.

Often, parents of our young clients—and even our young clients themselves—are concerned about their sexual thoughts, feelings, or behaviors. When we can, we sometimes normalize these feelings and behaviors to reassure a client or caregiver. Other times, however, these behaviors and feelings cause our young clients or their caregivers distress, and one or both of these parties seek therapy in order to put an end to the behaviors or the feelings of distress that remain after sexual play. Some children may act in an overtly sexual manner (e.g., show their genitals to a classmate on the playground or grab a peer's backside). These children may have general problems with social awareness, acting out, and impulsivity that get acted upon in a sexual way because of the overstimulating sexualized environment of today's child or because of some overstimulating sexual material in the child's own life. Although professionals may jump to see this as a sexual problem, it ought to be seen in the context of other developmental issues regarding self-regulation (Lamb, 2006).

Adolescents' exhibitions of sexually acting out may take the form of girls assuming the role of sex objects (i.e., acting sexy overtly to get attention and create desire in others). However, because adolescent female self-sexualizing is normalized in our culture (American Psychological Association, 2007), such behavior might not be identified as problematic, when in fact it is; it might reflect poor self-esteem or confused feelings about her value as a whole person. Girls who are exploring freeing sexual personae and experiences in adolescence can also put themselves at risk of exploitation. The feminist therapist who wants to encourage an adolescent girl's exploration of her body and her sexuality is placed in a bind regarding how to help this girl to live in a society that is dangerous to her. For example, drinking might lead to date rapes, and sexual exploration might lead to bullying the next day in school. Many feminist therapists would argue that most discussions about sex in society include unfair restrictions on girls' sexuality and sexual double standards, which allow boys more freedom to explore their sexuality than girls (Lamb & Peterson, 2012; Peterson & Lamb, 2012). Thus, normative sexual exploration for girls may still lead to exploitation or other problematic experiences. Therapists are wise to distinguish between the normative sexual behavior itself and the negative consequences of the normative behaviors that are due to an unhealthy environment for girls' exploration of sexuality.

Lamb (2006) also noted that boys, compared with girls, can act out sexually in a number of ways that are viewed as more healthy or acceptable in US society. For example, it might be seen as normative for a boy to pressure his girlfriend into sex when, in fact, it is evidence of a problem, or it might be seen as normative for a boy to call girls offensive names whereas it is seen as less normative for girls to do so. When a boy is targeted as having a problem behavior such as sexual aggression, although sex is involved, the problem might not necessarily be considered a sexual one. For example, a boy with a nonverbal learning disability may be more apt to be impulsive, have poor boundaries, and confuse sex with aggression when he becomes angry with a girl. This isn't a sexual problem *per se*, but a problem of impulsivity or aggression, a problem that took a sexual form because our media showcases acting in sexually aggressive ways towards women in numerous games, movies, and TV shows. Thus, an unhealthy but normative environment regarding sex and gender can influence behaviors in ways that are problematic for adolescents.

Although discerning what constitutes a sexual problem in children and adolescents is complicated given the normalization of potentially harmful sexual behaviors, Lamb (2006) offered five guidelines by which to identify sexual behavior as problematic: (1) sexual play is not mutual, either because one child is coercive or because one child is misusing the power of being older; (2) sexual behavior violates an individual's boundaries, meaning that someone feels uncomfortable about participating in the sexual play or act; (3) the behavior is adult-like, such as if two young children are attempting to have anal sex, or unusual in another way, such as if the child is experimenting sexually with an animal; (4) the behavior is harmful to the individual in a social, physical, or psychological way; or (5) the behavior is repetitive, persistent, or compulsive. For example, we would worry about a child who was repetitively rubbing his or her genitals to the point of physical discomfort (Lamb, 2006). It is important to keep in mind that we would also view any behavior, not just sexual behavior, as problematic if it involved compulsive acts, abuses of power, violated boundaries, or was harmful.

We would similarly worry about a teenage girl, in a relationship with a powerful boyfriend, who may not recognize or exercise her agency. That is, even if a relationship is felt to be mutual, it might not be. For example, we would worry about Celeste, whom we met in the beginning of this chapter, because she exhibits a pattern of sexual behavior in which she intentionally inflicts psychological harm on her partners, and we would worry for her because of her relationship with an 18-year-old at the age of 10.

There are also adolescents who are not sexually acting out in ways that victimize others, but who evoke our concern because of the way they present themselves as sexual objects.

For example, some gay adolescent boys cannot find appropriate same-age partners without outing themselves and trying to make contacts on apps, online, and in bars that are for older gay men, which puts them at risk. There are teen girls who have learned that their sexuality can get them the kind of easy rewards that hard work and developing their talents cannot yet do. These girls put themselves at risk for being "hit on" by men who have the money to treat them well and make them feel grown up. Yet these kinds of relationships can be disastrous in the long run when girls lose out on other opportunities for identity development (Phillips, 1998, 2000).

Causes of Sexual Problems in Children and Adolescents

Although identifying the sources of sexual problems in children and adolescents is not always black and white, we offer four general categories of causes of such problems: (1) overstimulation and/or cultural stimulation; (2) sexual abuse; (3) problems with attachment; and (4) unconscious conflicts.

Overstimulation

Sexual issues that therapists encounter in therapy come from a variety of places. Some sex play and questions are derived from what children see in the world around them. The world today is charged with sexual content. Children are bombarded with messages about sex and acting sexy at younger and younger ages, from shows like *Toddlers & Tiaras* (Rogan, 2013) to Miley Cyrus' pole dance at the 2009 Teen Choice Awards (Lamb, Graling, & Wheeler, 2013; McKay, 2009) and her "twerking" at the televised 2013 Video Music Awards ceremony. Magazines and internet searches are littered with pornographic images (i.e., nude or nearly nude simulations of sexual behaviors including oral and anal sex as well as more unusual practices). These pornographic images are no longer isolated to *Playboy* centerfolds (Dines, 2010). Lamb (2006) highlighted an example from *Shrek 2*, an animated movie targeted at children, in which a cartoon character performs an erotic dance on a chair.

These images are so embedded in our culture today that, in many ways, adults have become immune to them. Children, on the other hand, are stimulated—and often overstimulated—by these messages, which in some cases is what precipitates sex-related play. Part of distinguishing between what may be problematic behavior from what appears to be normative behavior is being able to know whether exposure to sexual material comes from one of these media sources, from victimization, or from some other source. That is not to say that some children who have experienced victimization cannot also engage in normative play enacting some of the media material they view. Also, some stimulation can come from intentional or unintentional overexposure in their lives, either from older siblings, parents, or abusive children, adolescents, or adults. Friedrich (2007), who asked that clinicians always assess family sexuality, pointed out that sexualized parents (e.g., parents who openly talk and/or act in a sexualized manner in front of their children) not only influence children but also are rarely fully aware of the sexualized content of their comments or interactions with their children or how stimulating these interactions can be.

Sexual abuse

Sexual abuse is also a form of overstimulation that promotes acting out or unusual sexual play in children. A history of sexual abuse in a parent can sometimes influence problems in parenting that might lead to acting out sexually in children (Friedrich, 2007). With children, a proper assessment is also important and should be undertaken with someone who will not become the child's therapist. When sexual material comes up in the therapy session, it can alert

the therapist that the child has been sexually abused, but one shouldn't immediately launch into a full-fledged sexual abuse interview. It could be the case that sexual interest and worry is being expressed in play completely unrelated to any abuse (Lamb, 2006).

What sets sexually abused children apart from other children acting out sexual material in therapy is the presence in the play of components related to the trauma. While sexual material can come out in the play of children who have been sexually abused, their play often does *not* have sexual elements to it and instead primarily reflects the trauma. Gil (2006) discussed the treatment of one of her child clients, Jessica, who was taken into the woods and molested by a male neighbor while she was playing outside. Rather than reflecting the sexual aspects of this incident, Jessica's play repeatedly centered around her mother, who was supposed to be watching her from the kitchen window as she played. For Jessica, as is the case for many children, the focus of treatment was her need to feel safe again, and this—rather than the sexual content—was reflected by her play.

Problems with attachment

Friedrich (2007), a proponent of family-based treatment, argued that attachment insecurity and family sexuality issues underlie a great deal of problematic sexual behavior in children and adolescents. He wrote that when there is problematic sexual behavior in a child, the clinician often sees disturbed sexual behavior in the child's primary socializing environment. Boundary problems of parents, avoidance of affection from mothers who had been sexually abused, role reversals, poor parental modeling and monitoring, and even rejection can be at the heart of sexual problem behaviors in children and adolescents.

Unconscious conflicts

If Freud's theories can still be given weight—and we believe they can—unconscious material can affect a child's play or an adolescent's acting out. For example, are there unconscious feelings of shame about one's genitals that arose during early childhood that are enacted in play? Are there competitive, Oedipal feelings aroused in early adolescence that affect someone's sexual acting out with older people? Modern psychoanalytic theorists, such as Fonagy and Target (1996, 1997), continue to integrate Freud's assertions about children's unconscious sexual feelings with their ideas about children's development of self-concepts. These theorists maintain that if caregivers are unable to reflect their children's early sexual experiences, children's arousal will intensify, feel foreign or incongruent to them, and may lead them to act out sexually.

Strategies for Working with Children around Sexual Problems

There are some general considerations for working with children and adolescents around sexual problems that cut across therapy models. For instance, no matter what the orientation, it will be important to understand whether the child or adolescent thinks the sexual problem is indeed a problem (Gil, 1993). All therapists need to establish a therapeutic alliance and will have to judge whether too much talk about the sexual issue at the beginning of therapy interferes with that alliance and makes a child or adolescent feel judged or ashamed. When working with children, all therapists should also be aware that children might use a different language for sexual acts and parts, as well as a simpler language to discuss all their concerns.

Different children work best with different therapeutic strategies, so it is difficult to match therapy to problem rather than to child. For example, if one isolates a problem like excessive masturbation and works only with that identified problem, a therapist might turn to cognitive-behavioral therapy (CBT) strategies to help a young adolescent find the control that he wishes he has. However, to use only a CBT strategy, which might indeed be evidence-based and might end

that problem, could ignore how a particular young man's perspective is influenced by the world around him and the family from which he comes. An integrated model of treatment would not only look at a problem behavior, but also consider how this problem behavior fits into the context in which the child is developing.

Even when using an integrated treatment approach, it might be good to begin treatment by addressing any compulsive sexual behavior, simply because there are evidence-based strategies to deal with compulsions. As with many compulsions and obsessions, CBT strategies work well with sexual compulsions. The strategies tend to involve the following: First, one externalizes the problem and makes it something that can be referred to with the child in a non-shaming way, but also in a way that suggests it is outside of oneself and can be controlled (e.g., one adolescent called it "that image" and another decided to simply call it "George"). Typically a child is asked to give it a name and to practice recognizing as soon as an obsessive thought enters his or her mind (Huebner, 2007). Older children and adolescents can be given the explanations for obsessive or compulsive behavior that are biological, as biological explanations can sometimes reduce feelings of guilt and self-blame. A sexual fantasy that keeps coming back can be likened to a brain tic. The turning to masturbation for comfort can be likened to a deep groove in the brain. A fantasy can be talked back to: "Go away you!" or "You are just my brain tic and not what I really want to do!" These intrusive thoughts can be explained as trash or junk that get stuck in the brain and that need to be thrown out in order to make room for more useful thoughts (Huebner, 2007). A habit can be pushed away by doing the opposite or by introducing other substitute behaviors and then rewarding those behaviors. Instead of rubbing her vulva compulsively, a preschooler can be given a stuffed animal to rub, and the comfort of a mother's hug is paired with the rubbing of the stuffed animal (Lamb, 2006). She is redirected when she rubs at her vulva.

Sometimes it is a good idea to discover from where the preoccupation might come, be it family disturbances around sexuality, overstimulation based on peer contact or media, fears about one's own sexuality, or trauma, before setting about to eliminate the preoccupation. Lisa, 14, came to therapy with an obsessive thought—really a picture in her mind that she couldn't get rid of and that frightened her. Too inhibited and shy to share with her therapist what that picture was and even what the obsessive fear was, the therapist guessed, "Is it about a rape scene perhaps rather than consensual sex?" "Yes." "Is the picture of something kind of graphic?" "Yes". "And when you try to not think of it, it comes to mind anyway and scares you?" "Yes." What the therapist did was talk to her client about how imagining something doesn't mean one wants that to happen, and that sometimes things that scare us come to mind unbidden as an opportunity to understand what exactly we are afraid of. One may think that the best way to work on this obsessive thought would be through the CBT methods described above. However, this therapist did not work directly with it but over time checked in about the thought. This therapist worked instead on issues of adolescent sexuality, bringing other thoughts, expectations, and wishes out into the open. Simply talking to the client about sexual behaviors and sex she might have in the future (because she was not yet sexually active), helped her to integrate the idea that she is a sexual person into her identity. The thoughts of aggressive sexuality diminished over time, and when she did picture that one scene, she reported that it had lost its impact. This illustrates the value of utilizing multiple treatment approaches to tailor therapy to the child. Below we outline five treatment approaches that are frequently used to treat sexual concerns in children and adolescents.

Individual play therapy

Play therapy can address the preoccupations of a younger child. Through dramatic scenes enacted with the therapist and with puppets, dolls, or figures in the sandbox, the therapist can watch and listen for feelings and concerns that the child may be having. Play therapists do not necessarily discover and address those feelings in the way that a CBT therapist might, but instead, reflect on

the feelings and concerns that evolve in the play, making comments about the figures and the solutions they are finding and why. For example, when a child has all the dolls running around naked in a chaotic household, the therapist might comment, "These children don't have clothes on" and "It seems in this house, people see each other naked. I wonder if they mind that at all." The talk then about sex and nudity emerges displaced onto the story and dolls.

Trauma-focused play therapy is a version of this approach that can be used with children whose sexual concerns seem to be a response to trauma. Post-traumatic play is identified by the following qualities: It is repetitive, literal, rigid, and lacks the joy and spontaneity of typical child play (Gil, 2006). In this form of play therapy, the therapist deliberately chooses toys that represent the child's trauma and then addresses the child's feelings, providing a verbal narrative in the same way as is done in regular play therapy. For example, a child who was sexually abused in the hospital might be given a small hospital set and dolls with which to play. As the child continues to play, the therapist encourages and reinforces instances in which the child demonstrates mastery or adaptive behavior. In this way, the therapist helps the child gain a sense of control over traumatic experiences through the natural activity of play. In one example of individual play therapy, Gil (2006) used play to help a sexually abused child, Scotty, who had developed selective mutism. Scotty eventually engaged in repetitive play in the sand that closely mirrored his experience of sexual abuse, by pushing objects in a sandbox into the holes of mounds he built out of wet sand. Having gained some control over this experience, Scotty's play became less repetitive—and therefore less post-traumatic—and he began to introduce new elements into his play.

Play represents a means of self-expression that, for children, is natural and self-soothing, and therefore it is a safe modality through which children can explore difficult feelings and/or process traumatic material. Although the therapist may at times be directive, inherent in play therapy is the fact that the child always remains in control of the process of his or her play.

Individual trauma-focused cognitive-behavioral therapy

When sexual concerns and preoccupations arise from sexual abuse, the therapist can also choose a CBT approach. In trauma-focused cognitive-behavior therapy (TF-CBT Web, 2005), fears are addressed through relaxation, cognitive reframing, and exposure (Gil, 2006). Children are taught relaxation and mindfulness methods to address feelings and thoughts about the abuse through cognitive reframing, and are exposed over and over to aspects of their own abuse through invitations to retell their story while using the relaxation methods. Therapists are warm but directive, always monitoring the level of anxiety the therapy is provoking. In contrast to trauma-focused play therapy in which children are invited to engage with traumatic material indirectly through the natural process of play and to interact with it at their own pace, therapists utilizing TF-CBT introduce difficult content directly and verbally to the child. For this reason, TF-CBT can be particularly effective for reducing symptoms and for sexually abused children whose play and talk stay on very superficial and unrelated themes. Gil (2006) suggested that children who have been victims of rape and/or those who are very sexually aggressive may benefit from immediate TF-CBT interventions as opposed to play therapy in which themes take longer to develop and resolve. We have found that TF-CBT is not useful when a child has not conceptualized what has happened to him or her as abuse and when the abuse was ongoing or chronic. It is also less appropriate for very young children who will have trouble creating a "trauma narrative," which is an important step in TF-CBT.

Family therapy

Family therapy is another treatment approach that may be used with children with sexual problems (e.g., Friedrich, 2007; Gil, 1993). Because a child's behavior originally develops within the family context, many therapists who treat children and adolescents with sexual problems

believe that it is critical to include the family in the treatment of sexual issues (Gil, 1993). The inclusion of the family in therapy is also important because family dynamics and family sexuality contribute to development of sexual behavioral problems in children (Friedrich, 2007). Structural considerations within the family, such as boundary- and limit-setting when children act out, parental conflict, and the presence of violence or substance use, are crucial to address in understanding and treating sexual problems in children (Gil, 1993). Gil (2006) found that, with children who have been sexually abused, treatment in which parents are involved has had greater positive effects on behavior than treatment in which parents are not involved.

It is important to consider the emotions that are likely to arise in family members as a result of the child's sexual concerns. These can be alarm, guilt, embarrassment, anger, or other challenging feelings. In cases of intra- or extra-familial abuse, legal and social service authorities may also have been brought into the picture, which could result in new tensions within the family (Gil, 2006). As such, Gil (1993) recommends that early family sessions focus on building rapport with the family, addressing the issue under consideration, and assessing the family's strengths and communication style. Family therapists recommend considering all family members as part of the "problem," rather than focusing only on the child. Each family member's concerns should be addressed, and all family members should be held accountable for their actions. However, by initially joining with the family, the therapist can gain the support of family members working together rather than treating therapy merely as a means of changing the "problem child."

Family play therapy is a modality that is gaining popularity in treating children and adolescents with sexual problems (Gil, 2006; Madanes, 1990, 2000). Family play therapy can best be described as the combination of family and play therapies, and it utilizes a variety of play and expressive therapy approaches with the purpose of engaging all of the family members in the process of therapy. By involving the whole family, family play therapy is also a means through which problematic family dynamics that might be underlying the child's sexual concerns can be identified and resolved. Puppets are one tool in family play therapy that can be useful during both assessment and treatment. Puppets allow members of the family to communicate symbolically, thereby decreasing defenses and helping family members to interact in a fun and positive way. Family art evaluation and family sand therapy (Gil, 1993, 2006) are other expressive family therapy techniques that may be used in family work around child sexual problems. Family art evaluation involves leading members of the family in the completion of individual and collective drawings, thereby elucidating family dynamics through the experience of creating art together. In family sand therapy, the family is encouraged to use miniatures to create a world together in the sand. This is another way for family members to use symbolism to reveal the feelings of family members and other family dynamics.

Parent–child interaction therapy

Friedrich's (2007) model of treating children who sexually act out relies on attachment theory. He works primarily with sexually acting out children who have also been abused, so repairing and even initiating important attachments for his child clients is key to their recovery and to helping to modify problematic behavior. A central component of Friedrich's approach is parent–child interaction therapy (PCIT; Hembree-Kigin & McNeil, 1995). This approach is rooted in the belief that strengthening the parent–child relationship is essential for treating children who have been abused. Prior to therapy, the therapist reaches out to establish a connection with the parent(s). The first two sessions are dedicated to gathering information about the parent(s) and child and building a therapeutic alliance. The next eight to ten sessions focus on child-directed interaction (CDI). Through CDI, parents learn the skills of playing and establishing a warm connection with their child. These competencies are referred to as the

PRIDE skills: (1) praise, (2) reflect, (3) imitate, (4) describe, and (5) enthusiasm. In the case of a child with sexually acting out behaviors, this phase also includes engaging the parent(s) and child in a discussion around sexual safety rules and troubleshooting alternative outlets and/or arrangements for the child's sexual behavior (e.g., dedicating a special private space for the child's masturbatory behavior). Once the goals of the CDI stage have been reached and the parent(s) and child exhibit a positive and collaborative relationship, the therapeutic process focuses on parent-directed interaction (PDI). During this stage, parents are taught how to effectively set limits, give their child commands, and utilize discipline strategies. For a more detailed outline of an assessment and treatment manual grounded in the PCIT model, see Friedrich (2007).

Group therapy

Children who act out sexually and who have a history of sexual abuse are often placed in groups that have a psychoeducational component. Some of these groups also have simultaneous groups for non-offending parents to attend to work on their own traumas as well as the trauma of having a child who has been sexually abused. The parents in these groups learn how their own traumatic experiences may have contributed to the choices of partners they have made, their lack of awareness when their child was being abused, and their reaction to the abuse. They learn how they can best handle the sexual material that may be emerging in their children as a result of the abuse. Parents learn simple parenting skills as well as the importance of limit-setting and boundaries, so that they can help their children with self-regulation and setting boundaries with others.

For the children's groups, the lessons are pre-planned and manualized, and children are encouraged to speak openly about their abuse. The belief is that this destigmatizes abuse and that coping skills used by some can be passed on to others. Scott (1992) noted that participation in group therapy can reduce a child's sense of isolation, provide clients with a safe place to explore different kinds of behaviors, and bring awareness about the experience of abuse. It provides children with a place outside of their family where others know about their abuse and in which they can have some emotional needs met. It encourages sexually abused children, who may have been treated by their abuser as too old for their years, to interact as peers with other children (Trepper & Barrett, 1989). Self-regulation and mindfulness skills training also tend to be a part of this kind of treatment. Most important, lessons on sexual development and normativity are often included because many children who act out sexually know very little about sex and have not had proper sex education. The Duluth Institute (2013) has designed group therapy that aims to help children to: (1) recognize unhealthy boundaries and sexual behavior; (2) understand victimization or exposure to sexual material that may have shaped their acting out; (3) recognize the thought/feeling/behavior connection; (4) recognize how their own feelings impact their behavior; (5) learn problem-solving and decision-making skills; (6) learn relationship skills; (7) reduce anger and aggression; (8) gain self-esteem; and (9) communicate better. In his group treatment for boys, Scott (1992) also discussed "internalized parts" of themselves so that boys in his group do not feel as if they are only victims or only perpetrators; instead, other non-sexualized parts of them can be brought to bear upon feelings and behaviors.

Conclusions

There is some fear among therapists regarding work with children who act out sexually. In our culture, where fear and anger about pedophilia runs high, sometimes these children are seen as budding sex offenders (Jones, 2007). Indeed, frequently young sex offenders are very much like the other children with preoccupations and sexual concerns, but the offenders have lower

levels of self-restraint and higher impulsivity. Key to working with these children around their sexual acting out behaviors is helping them to avoid the shame that prevents them from talking about it, as shame and secrecy may lead to greater difficulties with impulsivity and restraint (see also Berg, Munns, & Miner, this volume).

Working with children around sexual issues requires a higher level of attention to transference and counter-transference issues than working with adults. As a child or adolescent brings up sexual issues in therapy, he or she will be keenly aware of the therapist's reaction and may project his or her own internalized judgment and shame onto the therapist, perceiving the therapist's reactions as judgmental or critical. Because of this, the therapist may want to engage in some occasional conversations about what it is like for the client to share and what they imagine the therapist is thinking. One usually would not want to make this the focus of the session, but when necessary, these kinds of conversations are fruitful. With younger children, the therapist's level of engagement, stimulation, and boundary keeping will be noted by the child and will contribute to his or her feeling of safety in the therapy space. Transferential reactions might make small children want to sit on the therapist's lap, stroke his or her leg, or lunge for a kiss, especially in more exploited and sexually reactive children; the therapist who is aware of such will be on guard to set up boundaries gently and warmly.

Counter-transferential feelings will abound as therapists will react in various ways to sexual material. Most simply, a therapist may be uncomfortable talking about sex or seeing it acted out in play and will want to put a stop to it. This often comes from a worry that they are permitting overly stimulating material to occur when, in fact, the therapists themselves are the ones who might be getting overstimulated. Some therapists might be overly interested in the sexual material and this interest can signal to a child a lack of safety or a collusion in their troubling reactivity. Therapists also might want to act out in parental ways, wanting to be the good and non-abusive or non-neglectful parent that a child needs. However, as usual, these counter-transferential feelings need to be monitored, discussed in supervision, and not brought into action.

Ethical issues arise in working with children and teens around sexual issues. Some therapists in their initial contract with parents indicate that they may be talking about sex with the children or teens should it come up in conversation or play, and they may explicitly ask for permission to do so. It is awkward and betrays the child to ask a parent in the middle of ongoing therapy if one can bring in some sex education material, so it is best to ask upfront. When working with the family, the therapist may want to have some sex education materials to give to the parents and follow through in asking and helping parents to speak themselves to their children.

Other ethical issues come up when discussing sex with teens and what is reportable or must be shared with parents. Some teens do things that are victimizing to other people. Some do things that put themselves at risk of victimization. Being clear about the limits of confidentiality from the beginning is very important, and getting signed permission to maintain confidentiality from parents is always essential in working with adolescents. When a teen is taking risks that make a therapist uncomfortable, the therapist will need to work with the teen to discuss these with her or his parent. When a teen is victimizing others, depending on the severity and legality, the therapist will want to discuss this with a supervisor and/or an ethics consultant from their licensing board or insurance agency.

With all of this in mind, we return to Celeste, the teen girl who seems to be victimizing boys (although it may be hard for therapists to see her behavior in that way given her own neglect and trauma). Celeste benefited from one author's psychodynamic approach to treatment in which the roots of her "playing" boys were explored. Her therapist attempted, over the course of a year, to build up Celeste's self-esteem in other areas and to value her gifts and talents that were unrelated to her sexual self. The therapist encouraged and acknowledged Celeste's desire to feel and be powerful while at the same time, through the therapeutic relationship, teaching her that she was

valuable to the therapist for being who she was. The treatment of Celeste stands as an example of how good therapy is good therapy, no matter the content, and sexual material can be treated as representative of a host of other problems that therapists treat, rather than something separate and strange.

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20

Treating Sexual Problems in Aging Adults

Jennifer Hillman

Introduction

In prior decades, the topic of sexuality and aging was viewed as having no real importance, as a waste of professionals' time, or at worst, as an oxymoron. Only in recent years have sexuality and aging been addressed seriously and responsibly from a clinical perspective. Empathic, attentive work from clinicians and researchers has allowed the field to gain increased respect as well as a substantial body of empirical knowledge. With the change in US demographics and attitudes associated with the baby boom generation, including a dramatic increase in the sheer number of older adults and an increased tolerance for open discussion of sexuality, the need for clinical expertise in sexuality and aging has become readily apparent.

Findings from large-scale empirical studies conducted in a variety of countries and cultures indicate that most adults sustain moderate to high levels of interest in sexual activity throughout the life span (Kontula & Haavio-Mannila, 2009). Findings from one of the largest US national studies of the sexual behavior of adults (Lindau *et al.*, 2007) suggested that many older women and men are sexually active well into their 80s. Factors that diminish participation in sexual activity among older men and women include the absence of a willing or able partner and impaired health status (DeLamater & Sill, 2005). Additional findings have shown that, both men and women who are unable to engage in desired sexual activities, including penetrative sex, can experience guilt, anger, a decline in self-esteem, and even clinical depression (Cogen & Steinman, 1990). Relationships with partners may also suffer negative consequences.

Clearly, there is a need for effective sex therapy among middle-aged (45–64 years) and older adults (65 years and older). The practice of sex therapy, particularly evidence-based sex therapy, with middle-aged and older adults is quite similar to sex therapy with younger adults. However, it is essential that practitioners maintain awareness of the various factors and contexts that shape the experience and expression of sexuality among older adults. These influential factors include normal physiological changes that occur with age (e.g., menopause and adrenopause); common forms of sexual dysfunction associated with advanced age (e.g., vaginal dryness and erectile dysfunction [ED]); the sexual side-effects of commonly-used prescription and over-the-counter (OTC) medications; the impact of the medicalization of sexuality; unique, age-related risk factors for sexually transmitted infections (STIs) such as HIV/AIDS; and special considerations related to LGBT elders. This chapter is designed to introduce these multidimensional influences, discuss general considerations for treatment of sexual dysfunction among aging adults, and provide additional recommendations for health education, research, and advocacy.

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Normal Age-Related Physiological Changes

Menopause

The primary, normal change experienced by women during midlife is menopause. American women experience menopause at an average age of 51, although it can take place at any time between age 40 and 59. During menopause, the production of the hormones estrogen and progesterone decreases, while the production of follicle-stimulating (FSH) and luteinizing hormones (LH) increases as the body attempts to restore estrogen production. What this increase in FSH and LH actually tends to produce, however, is an increase in testosterone. Some estrogen is also produced in the body through the conversion of remaining adrenal androgens. During this alteration in hormone production, the size of the uterus, cervix, and ovaries is reduced in response to the body's shifting of resources away from needs for reproduction. Pregnancy is no longer biologically possible. The uterus itself may become reduced in size by up to 50% via changes in collagen and elastic content. A decrease in estrogen levels typically results in a thinning of the vaginal lining, a loss of vaginal elasticity, and a significant decrease in natural vaginal lubrication (Mayo Clinic, 2011).

Some middle-aged and older women have complained that, even though they have positive feelings about aging and their bodies and feel excited about no longer needing to worry about the prevention of pregnancy during sex, they feel like failures because they have allowed themselves to "fall victim" to menopausal symptoms of one type or another. They assume that a positive mental attitude will prevent them from experiencing any biological changes or physical symptoms. Although some symptoms of menopause appear to be mediated by individual, societal, and cultural expectations (e.g., Nappi & Kokot-Kierepa, 2010), a number of physical changes do occur during this developmental milestone. Given this, every woman's unique experience should be validated and explored. Accordingly, it is vital for both clients and practitioners to recognize that, even if a postmenopausal woman has positive feelings about sexuality and high levels of emotional readiness and arousal, without appropriate interventions, sexual intercourse may be experienced as painful and unpleasant due to lack of lubrication and thin vaginal walls. Understanding the typical changes that take place in the sexual response cycle can help aging women and their partners adapt and enjoy sexual activity in spite of these changes.

The sexual response cycle can be categorized in four stages: (1) excitement, (2) plateau, (3) orgasm, and (4) resolution (Masters & Johnson, 1966). A variety of estrogen and non-estrogen related changes can impact a postmenopausal woman's response—refer to Table 20.1 for an overview. One of the most obvious changes in sexual response with advanced age is the reduction in quantity of vaginal lubrication as a result of decreased estrogen production. The majority of post-menopausal women find that it takes significantly longer for them to become lubricated. Although it once took only 10 to 15 seconds to become aroused or "wet" in response to her partner, it may now take the woman up to five minutes, and she may still produce less than adequate levels of lubrication. In addition to experiencing painful intercourse as a result, an older woman may mistakenly assume that she is no longer feminine or may misinterpret her lack of lubrication as an emotional cue that she is somehow no longer interested in her partner.

In a parallel fashion, her partner may feel inadequate because more time is required for the woman to become "ready" for sex, and her partner may feel upset, annoyed, or even angry that she requires more foreplay. A postmenopausal woman's partner also may feel that he or she is no longer sexy or appealing to the woman, particularly if the partner feels anxious or ambivalent about his or her own advanced age. In addition, increased skin sensitivity sometimes makes breast, nipple, and clitoral stimulation irritating instead of arousing for the postmenopausal woman (Galindo & Kaiser, 1995), so techniques that used to arouse the woman are sometimes experienced as unpleasant by the woman, potentially leading to greater frustration on the part of her partner.

Table 20.1 The postmenopausal female sexual response cycle.

Stage	*Action*	*Age-related changes*
Excitement	Vaginal lubrication	Delayed; may take up to 5 minutes compared to 10–15 seconds among young adults; reduction in quantity
	Genital vasocongestion (blood flow to genitals)	Reduced
Plateau	Uterine elevation	Reduced
	Labia majora and breast changes associated with blood flow	Reduced elevation and swelling due to less vasocongestion; diminished nipple erection
	Clitoral stimulation	Maintained or heightened sensitivity; direct stimulation may produce irritation
Orgasm	Vaginal contractions	2–3 contractions versus 5–10 contractions among young adults
	Uterine contractions	Weaker; shorter in duration
	Subjective experience	Pleasurable sensations maintained
Resolution	Capacity for orgasm	Potential maintained for multiple orgasms
	Genital vasocongestion	Slower return to pre-arousal state

In a worst-case scenario, an older woman does not inform her partner that she simply needs more time and additional lubrication in order to enjoy sexual relations. Resultant painful intercourse (i.e., dyspareunia) may be accompanied by vaginal bleeding, itching, and burning sensations; increased urinary frequency or urgency; and swelling and soreness both during and after sex (Mayo Clinic, 2011). Some women may suffer in silence out of shame and misunderstanding, as well as out of a poor sense of entitlement to enjoyable sex.

An older woman and her partner also may be pleased to learn that her subjective experience of arousal may be just as strong and pleasurable as that experienced by her younger female counterparts. Pleasure from stimulation of the breasts remains intact, despite a lesser likelihood of vasocongestion and nipple erection (Kaiser, 1996). Despite changes in the objective experience of orgasm (e.g., an older woman is likely to experience more shallow, less frequent vaginal and uterine contractions; Zeiss, Delmonico, Zeiss, & Dornbrand, 1991), the overall subjective experience of orgasm as pleasurable remains virtually unaffected by age. Postmenopausal women also remain capable of experiencing multiple orgasms within the context of one sexual encounter (Leiblum & Rosen, 1989). In sum, once a postmenopausal woman becomes adequately aroused and lubricated, either naturally or with assistance, she can expect to experience subjective sexual pleasure and satisfaction similar to that experienced by premenopausal women.

Adrenopause

Although many men and women have some familiarity with the concept of menopause, far fewer appear aware of normal age-related changes in male sexual functioning. Adrenopause refers to the fact that, around age 50, men tend to produce less testosterone and experience an overall decrease in vascularization (resulting in diminished blood flow) throughout the body with age (Hillman, 2012; Lunenfeld, 2003). These two changes that come with increased age are associated with a number of normal changes in the male sexual response. With increased age, men typically experience a longer response time between sexual arousal and the development of an erection, a decline in the number of both spontaneous and morning erections, an increased need for tactile stimulation to produce an erection, erections that are less firm than those produced in early adulthood, reduced tension in the scrotal sac both before

and during intercourse, a longer time period required to reach orgasm, less intense orgasms and less forceful ejaculation, and a longer refractory period between erections (Kuzmarov & Bain, 2009). For example, the typical young adult man experiences an ejaculation of approximately 17 seconds, ranging from as short as several seconds to as long as a minute, with about 10 to 15 contractions during this time (Guha, 1975). As men age, however, they generally experience a decline in their ability to ejaculate. There are no pharmaceutical remedies currently available to enhance the duration, volume, or frequency of a male's ejaculation; the only treatments available are to change the quality of an erection, which may or may not lead to increased likelihood or duration of ejaculation (Johnson, 2010).

It is important to note that not all age-related changes in the male sexual response cycle are inherently negative. For many middle-aged and older men who previously experienced difficulties with premature ejaculation, an increased need for physical stimulation and a slower buildup to orgasm can prolong the sexual act, which can be associated with greater enjoyment for both partners. Some men have described feeling free to enjoy themselves and their sexual partners now that they no longer have to worry about "controlling themselves" (i.e., delaying orgasm) during intercourse. Others have reported that they enjoy the slower pace of sex now that they can "take their time" instead of rushing ahead to climax.

Prevalence of Sexual Problems in Older Adults

Rates of sexual problems among women

Findings from large-scale epidemiological studies provide insight into the numbers of postmenopausal women and older men who experience sexual problems and dysfunctions. The most commonly reported types of sexual problems among middle-aged and older women include dyspareunia (i.e., pain or discomfort during intercourse), vaginal dryness (which typically leads or contributes to dyspareunia), and low sexual desire. Estimates indicate that at least a third and up to half of middle-aged and older women report some degree of vaginal dryness or discomfort during sexual activity (Santoro & Komi, 2009; Waite, Laumann, Das, & Schumm, 2009). Population-based data suggest that approximately 18% of both middle-aged and older women report more substantial pain during intercourse (Waite *et al.*, 2009).

In terms of low sexual desire, population-based studies indicate that significant numbers of middle-aged and older women, including those with available partners, report having a sustained lack of interest in sex. For example, approximately 35% of middle-aged and 50% of older women in US population-representative samples reported that they have low sexual desire (Waite *et al.*, 2009; West *et al.*, 2008). Interestingly, these rates are virtually identical to the proportion of women who report vaginal dryness; it remains unclear whether there is a causal link between the two factors. What is also interesting to note is that the proportion of postmenopausal women who report that their low level of sexual desire is actually *distressing* to them is much smaller. Approximately 8–10% of women in large US samples (Simon, 2010; West *et al.*, 2008) report symptoms that would be consistent with the criteria for the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) diagnosis of Female Sexual Interest/Arousal Disorder, in which "the absent/reduced interest in sexual activity … [causes] clinically significant distress in the individual" (American Psychiatric Association, 2013, p. 433).

Rates of sexual problems among men

The most common type of sexual dysfunction reported by older men is erectile disorder (ED). Previously referred to as impotence, the currently used, and presumably less pejorative, term is ED. As defined in the DSM-5 (American Psychiatric Association, 2013), ED is a recurrent

inability to achieve or maintain an adequate erection during partnered sexual activities. To meet criteria for ED, the erectile dysfunction must occur for a minimum of six months, must be present 75–100% of the time, must cause significant personal distress, and cannot be accounted for by substance use. It is also essential to note that, by the time men reach age 40, more than 90% experience at least one episode of erectile failure; such a transient inability to attain or sustain an erection represents a normal part of aging, and is not a sign of ED (McCarthy, 2001). Findings from a large national survey indicated that there is a noted increase in the prevalence of ED as men age; 2% of men aged 40–49, 6% of men aged 50–59, 17% of men aged 60–69, and 39% of men aged 70 and older suffer from ED (Inman *et al.*, 2009). More liberal estimates suggest that, by midlife, 40% of all men will experience ED (Sand, Fisher, Rosen, Heiman, & Eardley, 2008), and by age 70 up to 67% will experience ED (Laumann, Paik, & Rosen, 1999). Research has suggested that the vast majority of men with true diagnosable ED (not merely normal, transient episodes of difficulty maintaining an erection) never seek treatment or receive a formal diagnosis (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994).

A variety of factors can lead to or exacerbate ED, including prostate enlargement or cancer; depression; anxiety; substance abuse; diabetes and other endocrine disorders; heart disease (e.g., high blood pressure, hardening of the arteries, stroke); Parkinson's disease; spinal cord or other physical injuries; and the side-effects of prescription and over-the-counter drugs (Chun & Carson, 2001). This list of health-related contributors is certainly not meant to be exhaustive, as increased levels of overall stress, fatigue, and distraction also can play a significant role. It is important to note the complicated etiology of ED in many cases. For example, a man might be clinically depressed and, as a result, develop ED. Yet, when his depression is resolved successfully with a prescribed selective serotonin reuptake inhibitor (SSRI) antidepressant such as Prozac, he might find that an unwanted side-effect of his medication is ED. To complicate matters further, few men or their healthcare providers broach the topic of ED on a regular basis; thus, the complicated—and often multifaceted—causes of ED are frequently never explored (Hillman, 2012).

Enlargement of the prostate gland, or benign prostatic hyperplasia (BPH), and prostate cancer can be linked to ED (see also Zhou & Bober, this volume). BPH is often prompted by age-related changes in the production of testosterone, and the majority of men can expect to experience BPH at some point in their lifetime. Autopsy studies of men over the age of 80 have suggested that nearly 90% of all men from this age group have an enlarged prostate. Findings from epidemiological studies have also suggested that one in six American men will develop prostate cancer at some point in his lifetime, and the risk increases significantly with age (National Cancer Institute, 2015). Additional risk factors for prostate cancer include a family history of the disease, obesity, and black race (Mayo Clinic, 2010), although black Caribbean men have higher rates than US-born black men (Bunker *et al.*, 2002). Also related to potential sexual dysfunction, the risk of complications in response to prostate biopsies, including incontinence and ED, increases significantly for men over the age of 75 (Begg *et al.*, 2002).

A digital rectal exam and antigen blood test are typically used to help diagnose prostate cancer (National Cancer Institute, 2015). However, some men decline to see their physician or other healthcare professionals due to significant anxiety and fear about the digital rectal examination. Some men fear that consenting to the rectal exam suggests that they may be gay; other men have fears that they will somehow "like it" and become aroused and embarrass themselves in front of their physician. A significant concern among many Latino men, who have some of the lowest rates of screening among various ethnic groups (American Cancer Society, 2009), is that they will lose their manliness (i.e., machismo) and become gay if they accept penetration of their rectum. For men without access to healthcare and accurate information about prostate screening, additional fears may stem from inaccurate beliefs that a rectal exam will cause ED and incontinence. The importance of educating older men about prostate screening cannot be overstated.

Sexual Side-Effects of Commonly Used Drugs

As noted, many drugs, including commonly used prescriptions, OTC medications, herbal supplements, and recreational substances, can cause significant sexual side-effects. These sexual side-effects can affect men and women of all ages, but because older adults often experience a decline in their liver function (reducing their ability to "clear" drugs and other toxic substances from their body), they may experience more frequent or severe side-effects. Older adults also may be taking more medications than younger adults due to age-related health issues. Examples of commonly used drugs and their associated sexual side-effects are presented in Table 20.2. As illustrated in this table, many of the most commonly prescribed drugs for older adults, as well as many popular OTC cold and allergy preparations, can cause significant sexual side-effects.

The Medicalization of Sexuality

An important factor that must be a part of any discussion of sexuality and aging is that of the medicalization of sexuality. In medicalization, a normal physiological change with age (e.g., slower sexual response; occasional difficulty obtaining or sustaining an erection) becomes viewed and treated as a form of pathology or illness (Conrad & Leiter, 2004). The medicalization of sexuality has particularly impacted men. For example, an overarching, potential problem with the widespread use of Viagra and other phosphodiesterase type 5 (PDE-5) inhibitors (along with their mass advertising) is the promotion of the implicit—or sometimes explicit—expectation that penetrative sex or intercourse is the only valid type of sexual activity that is shared among partners. In other words, if a man cannot have an erection firm enough for penetration, his ability or right to engage in sexual activity becomes null and void, or is at least considered substandard; thus, any difficulty with erection must be immediately treated with medication. Within the context of such rigid, unrealistic expectations for automatic arousal and associated penetrative sex, a man's sense of masculinity—and even self-worth—may be at risk. In some instances, men may feign that they have no knowledge of ED or options for its treatment (e.g., Viagra) because even admitting to possessing such knowledge would damage their sense of masculinity (Rubin, 2004).

Cultural messages about men's sexuality have identified the penis and its optimal functioning as one of the most vital parts of manhood. In the US, ejaculation is seen as a rite of passage to manhood; adolescent males who have achieved the physiological ability to have an erection that results in ejaculation are viewed as having "become men," and those who have not are considered less masculine and thus inferior (Diamond, 2002). It is important to note that some men in study samples (e.g., Rubin, 2004) have expressed sadness, anger, and frustration in relation to what they perceive as society's medicalization of sex, coupled with the typically unrealistic expectation that penetrative intercourse must be achieved "at any cost—at any age" (Potts, Grace, Vares, & Gavey, 2006, pp. 306). Similarly, other reports have indicated that some men feel as though they have been robbed of the opportunity or choice to age naturally (Hillman, 2012) and fully enjoy other types of non-penetrative sexual activity (Potts *et al.*, 2006). Pharmaceutical companies have created Viagra and other PDE-5 inhibitor drugs as a pharmaceutical remedy for a socially constructed problem (Johnson, 2010). Because there has been no female version of Viagra on the market, normal changes in women's sexuality with aging have not been subjected to the same degree of medicalization as men's. However, with the US Food and Drug Administration approving flibanserin for the treatment of female sexual dysfunction in summer 2015, older woman may increasingly experience similar pressure to men to medicate away normal age-related changes in their sexual functioning

Table 20.2 Sexual side effects of commonly used drugs.

Medication class	*Name*	*Common or trade name*	*Most common sexual side-effect(s)*
Prescription medications			
Antidepressants	Clomipramine	Anafranil	Anorgasmia (no orgasm); dysorgasmia (delayed orgasm)
	Fluoxetine	Prozac	Dysorgasmia
	Paroxetine[a]	Paxil	Anorgasmia; dysorgasmia
	Sertraline[a]	Zoloft	Anorgasmia; dysorgasmia
	Venlafaxine	Effexor	Anorgasmia; dysorgasmia
Antimania medications	Lithium		ED
	Topamarite	Topomax	ED
Anti-anxiety medications	Alpraolam[a]	Xanax	Decreased libido; vaginal dryness
	Lorazepam[a]	Ativan	Decreased libido; vaginal dryness
	Temazepam[a]		Decreased libido
Antipsychotics	Haloperidol	Haldol	Dysorgasmia; ED
	Mesoridazine	Serentil	Decreased libido; dysorgasmia
	Trifluoperazine	Stelazine, Suprazine	Decreased libido; ED
Antihypertensives	Atenolol[a]		ED; vaginal dryness
	Clonidine	Catapress	Decreased libido; ED
	Digoxin[a]	Lanoxin, Digibind	ED
	Hydrochlorothiazide[a]	Lopressor	Decreased libido; ED; vaginal dryness
	Rauwolfia alkaloids	Rauwolfemms, Resa, Serpalan	ED
Antiparkinsonian medication	Levodopa	Sinemet	ED
Antiseizure medication	Phenytoin[a]	Dilantin	ED
Chemotherapeutic medication	Tamoxifin	Nolvadex	Vaginal dryness, ED
Arthritis medication	Celecoxib	Celebrex	ED
Dementia medication	Donepezil[a]	Aricept	ED
Sleep medication	Zolpidem	Ambien	ED
Over-the-counter medications and herbs			
Antihistamines	Diphenhydramine	Benadryl	ED; vaginal dryness
	Drixoril	Tavist-D	ED; vaginal dryness
Heartburn medications	Cimetidine	Tagamet	Decreased libido; ED; vaginal dryness
	Ranitidine	Zantac	ED; vaginal dryness
Herbs	Hypericum	St. John's Wort	Dysorgasmia
Recreational and frequently abused drugs			
Analgesics	Opiates	Heroin, methadone	Dysorgasmia; ED; vaginal dryness
Depressants	Alcohol	Liquor, beer, wine	Decreased libido; ED, vaginal dryness
	Barbiturates	Amytal, downers	Decreased libido, ED
Stimulants	Amphetamines	Speed, crystal meth	Dysorgasmia, ED
	Cocaine	Coke, crack, blow	Dysorgasmia, ED
	Nicotine	Cigarettes, cigars, pipes, chew	Dysorgasmia, ED

Note: This list of drugs is meant to be illustrative rather than comprehensive. It remains essential to ask older adults about any side-effects with any medication, including atypical side-effects.

[a] Identified as one of the 50 most frequently prescribed oral medications among older adult patients (Steinmetz, Coley, & Pollock, 2005).

Unique Risk Factors for HIV and other STIs

Current reports indicate that more than 15% of all new HIV/AIDS cases are among adults over the age of 50, and that by the end of the decade more than half of all people living with HIV or AIDS will be over the age of 50 (Centers for Disease Control and Prevention, 2008). Rates of HIV/AIDS infection are increasing nearly four times faster among older adults than among younger adults, and the primary means of infection among adults over the age of 50 is through sexual contact—most commonly men having sex with men (Chiao, Ries, & Sande, 1999; Centers for Disease Control and Prevention, 2008). Significant racial disparities also exist; older black men are 12 times more likely than their older white counterparts to be diagnosed with HIV, and older Hispanic men are five times more likely to receive a diagnosis of HIV than older white men (Centers for Disease Control and Prevention, 2008). The significant increase in HIV infection among older adults is often referred to as "the graying" of the AIDS epidemic, and it has significant implications for not just the US, but global health (Emlet, 2006). Many older adults are likely to engage in unprotected sex due to inaccurate beliefs that they are somehow immune from STIs and a general lack of experience with condoms (Hillman, 2012). Recent findings suggest that two out of three sexually active adults over the age of 50 do not use condoms (Schick *et al.*, 2010).

More than half of all individuals infected with HIV in the US will be over the age of 50 by 2020, and ageism and heterosexism serve as significant barriers to treatment, particularly among sexual minority elders (Emlet, 2006). Because older adults are less likely to be tested for HIV than younger adults, many receive a diagnosis of HIV infection only within the context of treatment for other medical conditions or in an emergency room setting. These lower rates of testing, as well as delays in receiving an appropriate diagnosis, increase the likelihood that older adults will receive a concurrent HIV and AIDS diagnosis (Centers for Disease Control and Prevention, 2013). Specifically, more than half of all adults over the age of 50 who are diagnosed with HIV receive a concurrent diagnosis of HIV and AIDS, compared with less than one in three younger adults diagnosed with HIV.

Unfortunately, for middle-aged and older women, the thinning of the vaginal lining typically associated with menopause can be linked with an increased risk of contracting HIV and other STIs. When engaging in penetrative intercourse, a postmenopausal woman is more likely to experience both micro and macroscopic tearing of the vaginal wall than a premenopausal woman, putting the postmenopausal woman at greater risk of contracting the HIV virus (and any other sexually transmitted agents) into the bloodstream (Centers for Disease Control and Prevention, 2008). Additional age-based risk factors for STIs are the typical decline in immune function experienced with increased age, coupled with a decreased likelihood of condom use by postmenopausal women compared with younger women, perhaps because older women no longer fear becoming pregnant, have difficulty negotiating condom use with a partner, or simply assume that they are no longer at risk for contracting STIs (Schick *et al.*, 2010).

Significant increases in the diagnoses of chlamydia, syphilis, and gonorrhea have also been noted among older adults. Rates of infection have nearly doubled in the past 10 years in this population (Jena, Goldman, Kamdar, Lakdawalla, & Lu, 2010). Approximately 25% of all new cases of cervical cancer occur among women over the age of 65, with the majority caused by the sexually transmitted HPV virus (Cornelison *et al.*, 2002). It is unclear whether these older women contracted HPV when they were younger and the virus remained dormant, or if they were more recently infected.

Regrettably, no national, federally funded HIV primary prevention programs exist specifically for older adults (c.f., Orel, Stelle, Watson, & Bunner, 2010). In particular, such programs could inform women about their increased risk of infection during and after menopause and could inform both women and men about the ease with which they can protect themselves against infection from HIV and other STIs by using latex condoms.

LGBT Elders

It is difficult to gather accurate population estimates of lesbian, gay, bisexual, and transgender (LGBT) adults due to a lack of standardized LGBT self-identifiers in national surveys and general methodological problems in sampling; however, up to three million older adults in the US may identify themselves as LGBT. By the next decade, the number of self-identified older LGBT adults is expected to swell to more than seven million (National Gay and Lesbian Task Force, 2006). Additional estimates suggest that by the year 2050, 1 of every 13 older adults will identify themselves as LGBT (Grant, Koskovich, Frazer, & Bjerk, 2010). With such a large subpopulation, it is vital that care providers and policymakers do not make assumptions that all older adults are heterosexual.

Recent national surveys also demonstrated that fewer than 25% of older LGBT baby-boomers reported that they were willing to disclose their sexual orientation or gender identity to their healthcare providers, and approximately 20% indicated that they had "little or no confidence that medical personnel will treat them with dignity and respect" (Metlife Mature Market Institute & the Lesbian and Gay Aging Issues Network of the American Society of Aging, 2010, p. 52). Unfortunately, concealing one's sexual identity from healthcare providers can lead to ineffective or absent healthcare screening and treatment for STIs, including HIV/AIDS, for example (Fassinger & Arseneau, 2007.)

Older lesbians and their healthcare providers also appear to subscribe to the pervasive myth that lesbians are simply immune to the transmission of HIV and other sexually transmitted infections. However, nearly 50% of older lesbians report that they engaged in heterosexual vaginal or anal intercourse at least once in their lives, indicating potential risk for male to female viral transmission of STIs. In addition, up to 20% of all women who report that they never had heterosexual intercourse are infected with the HPV virus, the primary cause of cervical cancer. Accordingly, older lesbians and bisexual women should receive both routine screenings and appropriate preventative care messages (Addis, Mavies, Greene, MacBride-Stewart, & Shepherd, 2009).

Unique risks for HIV infection are also present for transgender elders. Significant health disparities exist because many transgender adults have experienced discrimination relative to their gender identity, live in poverty, and do not have health insurance; less than half have a primary healthcare physician. Studies have also suggested that many transgender adults do not engage consistently in safe sex (Cook-Daniels & Munson, 2010), and few transgender adults know that a surgically created vagina is at greater risk for micro- and macroscopic tears during intercourse than other vaginas. It also remains unclear what deleterious effects may be associated with aging among HIV-positive transgender elders who take both antiviral and hormone treatment therapies (Grant *et al.*, 2010).

Evidence-Based Treatments

Sexual dysfunction among aging women and men typically stems from a combination of psychological, relational, psychosocial, and physical or biological causes (van Lankveld *et al.*, 2010). Fortunately, a variety of interventions are available to assist aging men, postmenopausal women, and their partners. Before such treatments even begin, however, it is important to assess what factors underlie a middle-aged or older individual's sexual dysfunction. It is vital to understand whether a client has religious prohibitions; concerns about contracting HIV or another STI; a history of trauma or abuse; or depression or anxiety, or if their partner is insensitive or no longer interested in sexual activity (e.g., Knoepp *et al.*, 2010). Taking a thorough medical, sexual, and psychosocial history remains essential (van Lankveld *et al.*, 2010).

Treatments for sexual pain and vaginal dryness in women

Cognitive-behavioral therapy Among women, empirically-based treatments for sexual pain and vaginal contractions include cognitive-behavioral therapy; couples therapy; and biofeedback—a form of physical therapy to help restore pelvic floor function (e.g., Bergeron, Morin, & Lord, 2010; see also Meana, Fertel, & Maykut, this volume). Cognitive-behavioral treatments involve interventions to minimize cognitive catastrophizing; sensate focus exercises; and relaxation protocols, including guided imagery. It is important to note that treatment for sexual pain appears more effective when professionals are involved; attempts to self-administer cognitive or behavioral treatments often meet with only limited success (Donaldson & Meana, 2011). An integrated treatment including psychotherapy and physical therapy appears to promote the best outcomes (Bergeron *et al.*, 2010). Unfortunately, a number of these interventions have limited empirical support via large-scale, randomized clinical trials. The lack of large-scale trials likely speaks more to the previous lack of interest in (and funding for) evidence-based approaches to treatment of sexual dysfunction among older women (e.g., van Lankveld *et al.*, 2010), rather than an actual lack of utility of the interventions themselves.

Prescription lubricants For postmenopausal women who may experience vaginal dryness and pain during intercourse, many treatments are designed specifically to combat the loss of estrogen and have been employed successfully with community-based samples. One of the most easily employed interventions to combat vaginal dryness is through supplemental lubrication. One method is to introduce additional estrogen to vaginal tissues via topically applied prescriptions. Although a physician must prescribe these treatments, their effectiveness has been well documented and only limited amounts of estrogen are reported to enter the body's bloodstream (Krychman, 2011); thus, side-effects are relatively minimal. Vaginal estrogen can be delivered via topical creams (e.g., Premarin, Estrace). Vaginal estrogen can also be applied via a small, flexible, plastic vaginal ring (e.g., Estring) that is put into place near the cervix by either the patient or her healthcare provider once every three months. The third approach is to use a small, disposable applicator to insert an estrogen tablet into the vagina (i.e., a vaginal suppository). The tablet dissolves in the vagina and its use is painless. As noted, all topical medications that introduce estrogen can be obtained only by prescription and may carry the risk of various side-effects.

Non-prescription or OTC lubricants Estrogen-free topical lubricants are also viable treatment options for postmenopausal women who experience vaginal dryness. These lubricants are accessible over the counter, without a prescription. Many women have at least heard of KY Jelly or Astroglide, which are topical, water-based lubricants available at most drug and grocery stores. These types of products are easily obtained and do not pose any risk of hormonal side-effects. See Table 20.3 for information regarding the five different types of non-prescription lubricants available, along with their unique set of pros and cons (Andelloux, 2010).

Based upon the relative merits of the five different types of nonprescription topical lubricants available, it becomes apparent that different types of sexual activities, as well as personal sensitivities and preferences, will help to determine the appropriate selection. For example, clinical experience indicates that many older women and their partners assume that Vaseline petroleum jelly or a moisturizing hand or skin cream will serve as an effective, inexpensive, and readily available vaginal lubricant. However, such petroleum-based lubricants can cause vaginal irritation and infection and are not safe for use with latex condoms. The petroleum in these lubricants actually dissolves the latex in condoms, causing microscopic holes that are large enough for HIV and other viruses to pass through. Even though post-menopausal women or their partners may not be concerned about becoming pregnant, they should be aware that sexually

transmitted infections are not reserved for the young. Similarly, natural oil-based products like vegetable oil and butter can irritate the vagina and are unsafe with latex condoms.

Although KY Jelly, Astroglide, and other water-based lubricants are the most commonly recommended type of topical lubricant for women, they may not be the ideal choice because some women may develop vaginal yeast infections due to the relatively high glycerin or sugar content of the lubricant, and because they can dry out quickly and need to be reapplied frequently. However, in contrast to oil-based lubricants, water-based lubricants, both with and without glycerin, are safe for use with latex condoms.

Clinicians can help postmenopausal women become aware of these different types of lubricants and inform them that they have additional choices beyond what is offered at the local grocery or drug store. For example, if a woman wants to avoid yeast infections, needs longer-lasting lubrication, and does not want to compromise on the safe use of a latex condom, a silicone-based lubricant may be the best choice. The lack of taste and odor with silicone lubricants also benefits women who are interested in using them with oral sex. Unfortunately, silicone-based lubricants are typically the most expensive on the market.

It is also vital that clinicians normalize the discussion and purchase of such lubricants. It is essential to foster a frank discussion about the merits of the different kinds of lubricants, as well as the inter- and intrapersonal challenges that may arise with their selection or use (e.g., What if my partner thinks I'm a "slut" or "hussy" because I got some kind of fancy lubricant instead of just using Vaseline? Am I worth the $20 that this costs? How can I ever bring this up with my gynecologist?), particularly for women who may be feeling anxious, ambivalent, or ashamed about their sexuality. Information about lubricants could also be provided as a handout and given to clients for their review. Because an older woman may be too embarrassed to buy water-based non-glycerin and silicone-based lubricants at her local adult store, she may be relieved to learn that she or her partner can order them discretely online.

It is also important to recognize the psychological implications of using a sexual aid. Although topical lubricants appear to represent a simple and elegant solution to address vaginal dryness, some women may be uncomfortable applying them in front of their partner, or they may feel embarrassed or inadequate because of their need to use them at all. Effective communication between a woman and her partner becomes essential in order for both parties to feel comfortable. The use of lubricants can sometimes be incorporated as foreplay. For women who opt not to use lubricants immediately before intercourse, other non-prescription alternatives can be offered. These additional options, which should be discussed with one's healthcare provider, include OTC products such as Replens, a water-based vaginal suppository that can be used in advance of intercourse (Barbach, 1996).

Masturbation Self-stimulation is another effective, nonhormonal treatment for vaginal dryness and atrophy that may come as a surprise to both aging women and their practitioners. Women who remain sexually active—either through sexual intercourse with a partner or through mutual or solo masturbation—have shown lesser declines in vaginal lubrication with age than women who are not sexually active (Roughan, Kaiser, & Morley, 1993). Although the exact underlying mechanism is unknown, it is posited that masturbation increases blood flow to the surrounding vaginal tissue, which promotes increased lubrication on a daily basis (Galindo & Kaiser, 1995). Because of numerous religious and societal prohibitions against masturbation, however, suggestions to engage in self-stimulation must be discussed sensitively, particularly with older patients. Respect for a woman's religious prohibitions against masturbation must be acknowledged and may potentially circumvent any further discussion of the issue.

In contrast, other aging women who have previously ascribed to social taboos about masturbation may feel liberated when the practice is "prescribed" by their psychologist or other healthcare provider (Galindo & Kaiser, 1995). Anecdotal evidence suggests that a number of female patients have been cured of insomnia, vaginal dryness, and symptoms of anxiety after

Table 20.3 Characteristics of non-prescription vaginal lubricants.

Type	*Generic names*	*Sample brand names*	*Advantages*	*Disadvantages*
Petroleum-based lubricants	Mineral oil, hand moisturizers, most skin creams	Vaseline Petroleum Jelly, Stroke 29, Jack Off	Inexpensive, easily accessible	Irritating to vagina, not safe with latex condoms, stains fabrics, bad taste and odor
Natural oil-based lubricants	Vegetable, corn, olive, and peanut oil; butter	–	Inexpensive, easily accessible, does not irritate vagina	Not safe with latex condoms, stains fabrics, some taste and odor
Water-based with glycerin	–	KY Jelly/Liquid, Astroglide, Wet, Embrace, Good Head, KY Warming Jelly, Astroglide Warming Liquid, Replens (suppository)	Safe with latex condoms, inexpensive, easily accessible, does not stain fabrics, may taste sweet	Dries out quickly, can become sticky, can foster yeast infections, some odor
Water-based without glycerin	–	Liquid Silk, Maximus, Saliva, Slippery Stuff, Oh My, Probe, Sensual Organics	Safe with latex condoms, relatively inexpensive, does not stain fabrics, lasts longer and is thicker than water-based lubricants with glycerin	Found primarily online or in adult stores, bitter taste
Silicone-based	–	Eros, Wet Platinum, Id, Millennium, Pink, Gun Oil	Safe with latex condoms, lasts three times longer than water-based lubricants, does not irritate vagina, odorless, tasteless	Expensive, found only online or in adult stores, may need to be removed with soap and water, cannot be used with silicone sex toys

being instructed by their clinicians to experiment with masturbation before bedtime. Older women also may be encouraged to learn that masturbation does not have to involve penetration into the vagina with a finger, dildo, or other foreign object. Manual stimulation of the clitoris and labia is often enough (and for some women may be the best way) to induce sensations of pleasure and orgasm as well as the desired increase in blood flow.

Prescription hormone therapy Within the last decade, a number of controversial findings have emerged in relation to hormone replacement therapy. Previously, physicians often prescribed estrogen replacement therapy to assist postmenopausal women in dealing with the physiological changes induced by a lack of estrogen. Estrogen replacement therapy was touted as effective in combating hot flushes and vaginal atrophy and dryness and in reducing the risk of cardiovascular disease and osteoporosis. However, findings from the Women's Health Initiative's National Institutes of Health-funded, large-scale, randomized, double-blind clinical study of hormone replacement therapy compared to placebo revealed that use of such estrogen-rich medications actually increased a woman's risk for cardiovascular events (e.g., heart attacks,

strokes, and blood clots; Toh, Hernandez-Diaz, Logan, Rossouw, & Hernan, 2010), invasive breast cancer (Rossouw *et al.*, 2002), and even dementia (Coker *et al.*, 2010).

Alternative treatments currently under investigation include supplements such as soy-based isoflavoids, vitamin D, black cohash, and DHEA (Mayo Clinic, 2011). What remains central for most sex therapists, however, is not what type of medication or supplement postmenopausal female clients are prescribed or taking, but rather, our ability to help our clients communicate openly and effectively with their healthcare providers in order to make the best choice about their medications or supplements.

Treatments for ED in men

For middle-aged and older men coping with diagnosable ED (not age-related normal transient episodes of erectile dysfunction), a number of prescription and non-prescription treatments are available (see also Nobre, this volume). Before reviewing these, though, it is important to note that any treatment of ED should include dispelling the myth that sexual enjoyment and satisfaction can only be achieved if a man has a penis firm enough for penetration.

In terms of medical treatments, Viagra and Cialis both work by inhibiting the body's PDE-5 enzyme. A primary function of the PDE-5 enzyme is to metabolize or break down the neurotransmitter cyclic guanosine monophosphate (cyclic GMP), which helps relax smooth muscle tissue. When PDE-5 is inhibited, more cyclic GMP remains available in the body, which causes the walls of smooth muscle tissue, including arterial blood vessels, to relax and expand. With PDE-5 located primarily in the nose, skin, and penis, blockage of PDE-5 leads to an increase in cyclic GMP and related blood flow to those areas, leading to an increased likelihood of erection. With Viagra, men are typically instructed to take the "little blue pill" approximately one hour before intending to engage in sexual activity with the expectation that an erection can be obtained within the next four hours (Pfizer, Inc., 2009).

Levitra was introduced next by Bayer in 2003 as a more selective PDE-5 enzyme inhibitor requiring a smaller dose of medication when compared to Viagra. Erections can sometimes be obtained within 30 minutes (Levitra, 2009), and users typically do not have dietary restrictions as cautioned with Viagra. (Fatty foods and alcohol can slow the absorption of Viagra into the bloodstream; Pfizer, Inc., 2009.) Cialis was brought to the market shortly after in 2003, and this PDE-5 inhibitor from Lilly offers an extended half-life compared with its competitors. Specifically, a man who ingests Cialis has a 36-hour window in which to obtain an erection. Thus, Cialis is sometimes referred to as the "weekend [sex] pill" (Berner, Kriston, & Harms, 2006). Identified side-effects among the PDE-5 inhibitors are similar, including headache, stuffy or runny nose, flushing, nausea, muscle aches, photosensitivity, vertigo, and visual disturbances (e.g., blue or green tinted vision; Carson, 2006). In some men, the incidence of such side-effects may diminish with use over time (Pfizer, Inc., 2009).

So, which PDE-5 inhibitor is best? Although this question is complex and truly answered in concert with a trained healthcare professional, some facts are available for general consideration. Viagra has been on the market for more than a decade, with long-term data available regarding its efficacy and overall safety, whereas Cialis is the newest to market and does not offer the same wealth of empirical data. Levitra requires a lower dose than Viagra, and can be effective for men who have achieved only limited success with Viagra. Although Cialis offers the longest window of action for obtaining an erection, allowing for greater spontaneity in the initiation of sexual activity, the lengthier terminal half-life of this PDE-5 inhibitor also means that any side-effects are likely to last longer (Carson, 2006). Similarly, side-effects from Levitra may persist longer than those experienced with Viagra.

Men taking PDE-5 inhibitors are advised to seek medical help immediately if they experience a sudden loss of vision or hearing, a painful erection or one that lasts for more than four hours (i.e., priapism), heart palpitations, chest pain, or breathing difficulties. Various reports exist of

men suffering heart attacks while using Viagra and other PDE-5 inhibitors, but researchers caution that statistically similar numbers of men suffer heart attacks during sexual activity without the use of the medications. Although rare, such adverse effects, and even fear of them, can be disconcerting. Contraindications for use of this class of drugs include the presence of heart disease, recent stroke or heart attack, and high or low blood pressure. Men taking nitroglycerine or other nitrate-based medications are also advised to avoid PDE-5 inhibitors (Porst *et al.*, 2003).

A recent meta-analysis of clinical trials among the three available PDE-5 inhibitors taken at their maximum recommended dosages revealed that Viagra, Levitra, and Cialis all demonstrated significant clinical efficacy in improving erectile function when compared with placebo (Berner *et al.*, 2006). However, not all men in all trials were able to achieve an erection; the PDE-5 inhibitors were highly effective *on average*. Similarly, findings from large-scale clinical trials (e.g., Berner *et al.*, 2006) have suggested that Viagra may improve erections by 70–95%. It has also been shown that, on average, the duration of erection is extended by approximately 12 minutes with the use of Viagra (Rosenberg, Adams, McBride, Roberts, & McCallum, 2008). Closer examination of the results, however, revealed that men with minimal ED, who could occasionally have erections firm enough for penetration even without medication, had a significantly better response to the drug than men with more moderate or severe ED, who had only partial or no erections without the drug. In addition, men who had their prostates surgically removed did not respond as well to PDE-5 inhibitors as men whose prostates were intact. However, some men who had the prostate surgery in conjunction with a nerve-sparing procedure had greater success achieving an erection with treatment than men who had the surgery without the nerve-sparing procedure (Marks, Duda, Dorey, Macairan, & Santos, 1999).

Overall, the greater the severity of ED, irrespective of its underlying etiology, the less likely the desired response to treatment with the drug. Thus, not surprisingly, in prior research, the more severe the ED, the less likely the patient was to continue treatment with Viagra (Marks *et al.*, 1999). Additional factors that may account for the fact that less than half of all men refill their prescription for PDE-5 inhibitors include feelings that treatment is "unnatural," lack of success due to attempting to achieve an erection too soon after ingestion, lack of success due to insufficient arousal or physical stimulation to allow for erection, and the experience or fear of side-effects (Porst *et al.*, 2003).

It is essential that clinicians attempt to correct any myths and misconceptions that clients have regarding the use of PDE-5 inhibitors. Such misconceptions for male performance appear common (Rubin, 2004) and can lead to lower clinical efficacy, frustration or discomfort, and even potentially dangerous or fatal outcomes. For example, many men and women are unaware that Viagra, Levitra, and Cialis have no impact whatsoever on sexual desire. In other words, these PDE-5 inhibitors are not aphrodisiacs in and of themselves. A man must first become sexually aroused, which causes his brain to release nitric oxide from specialized cells. In turn, this nitric oxide causes the formation of cyclic GMP. Only after the man's sexual arousal is great enough to initiate the cascade of nitric oxide to the formation of sufficient amounts of cGMP, will the PDE-5 inhibitors help the blood vessels in the penis to relax and become filled with blood, causing an erection. Thus, if a man has low sexual desire or interest, Viagra and the other PDE-5 inhibitors are essentially rendered ineffective.

Even when a man who takes Viagra or other PDE-5 drugs becomes sexually aroused, additional physical stimulation—and for a relatively long period of time compared with sexual encounters before the experience of ED—may be required for the production of an erection. When healthcare providers fail to relay this vital information about the drug's method of action, consumers may become frustrated or disillusioned (McCarthy, 2001). Pfizer itself recommends that men try Viagra at least four different times before deciding to abandon use of the drug (Pfizer, Inc., 2009).

The quality of an erection associated with these drugs often differs from that produced prior to the time a man experienced ED. Erections produced with PDE-5 inhibitors are generally not as firm as the erections men experienced in young adulthood. In other words, the erections produced with the assistance of Viagra and other PDE-5 inhibitors are typically firm enough to engage in intercourse, but they are not the "rock hard" erections that many men (or their partners) might expect when taking the drugs.

Another misconception with dangerous and even fatal consequences is that Viagra and other PDE-5 inhibitor drugs provide protection against sexually transmitted diseases including HIV/AIDS. Understanding that PDE-5 inhibitors provide no protection whatsoever against STIs is particularly important for men and women over the age of 50, who typically do not see themselves as susceptible to infection. Because older adults are often less familiar with HIV, less likely to have their healthcare providers talk to them about HIV, less likely to use condoms due to decreased fears of pregnancy, and more susceptible to HIV per exposure due to age-related declines in their immune systems, some researchers suspect that increased numbers of HIV infection among older adults can be linked, to some extent, with the use of PDE-5 inhibitors (Hillman, 2012).

Another typically overlooked aspect of PDE-5 use is that of male users' partners (see Conaglen & Conaglen, this volume, for further discussion). Efficacy studies have typically involved heterosexual couples and have suggested that female partners generally concur with their male partners' and physicians' ratings of the drugs' effectiveness (Goldstein *et al.*, 1998). However, little is known regarding female and male partners' perceptions of the drug and its effects within the context of their own sexual experience or relationships. Many older women interviewed about their partners' Viagra use mentioned that, if the drug was not obtained in consultation with them as the primary partner, they felt angry or obliged to engage in sexual intercourse when it was no longer that important to them or to their sense of the relationship (Conaglen & Conaglen, 2009). Still other women expressed frustration when their male partner expected them to provide additional physical stimulation of the penis to achieve an erection, particularly when they had become accustomed to greater cuddling and non-genital foreplay during the untreated periods of ED (Conaglen & Conaglen, 2009). These comments are consistent with general advisories for older women to communicate openly with their male partners about their feelings when Viagra or other PDE-5 inhibitors are introduced into the relationship and for men and women to employ additional foreplay, lubricants, and a slower pace if sexual intercourse has not been a typical part of their sexual relationship in order to avoid discomfort (Hillman, 2012). However, other women interviewed about their husbands' Viagra use were thrilled with the resultant changes in their partners' ability to engage in intercourse, as well as their sense that their male partners felt more positively about themselves (Conaglen & Conaglen, 2009). In sum, it appears that female partners have both positive and negative responses to Viagra as a treatment for ED, and that communicating clear expectations for both emotional and physical responses and expectations between male and female partners is essential for a more positive outcome. In essence, sexual intercourse or activity with or without Viagra does not occur in a vacuum; it occurs within the context of a relationship.

A man's partner can also influence the extent to which he seeks treatment for ED. For example, one study demonstrated that men seem more likely to consult a doctor concerning ED if their female partners believe that the ED is permanent, severe, or linked to another medical condition, rather than being temporary or related to stress. Furthermore, the woman's perception of the impact that the ED was having on her life was strongly associated with the man's likelihood of seeking treatment. Finally, men were more likely to pursue treatment of ED if their female partners were supportive of the decision and believed that it was the right thing to do. Female partners who had a high degree of sexual satisfaction before the onset of ED were also more likely to have partners who sought treatment (Fisher, Eardley, McCabe, & Sand, 2009).

Advertisements for PDE-5 inhibitors virtually always fail to mention that optimal treatment outcomes are more likely to occur when men with ED receive *both* pharmaceutical agents and couples-based sex therapy (Brooks & Levant, 2006). Specifically, treatment of ED with both Viagra and sex therapy has been shown to provide increased erectile function and marital satisfaction, compared with treatment with Viagra alone (Aubin, Heiman, Berger, Murallo, & Yung-Wen, 2009; Qaseem, 2009). Relapse prevention also appears to be enhanced when treatment with a PDE-5 inhibitor is coupled with sex therapy. With the help of a trained therapist, men and their partners can become educated about positive, realistic expectations regarding the sexual response cycle of each partner, both with and without the use of drug enhancement. Therapists also can employ cognitive-behavioral techniques to help both partners to view sexual activity as occurring within the context of a relationship, rather than an isolated physical event revolving entirely around the ability to produce and sustain an erect penis. Dispelling many of the myths related to the medicalization of sexuality can be quite helpful.

Within the context of sex therapy, men and their partners can be helped to learn that periodic erectile failure, experienced both with and without the use of Viagra and other PDE-5 medications, is natural and to be expected. Once both partners have realistic expectations and view occasional disruptions and changes in the sexual response cycle as merely variations rather than causes for anxiety or alarm, they can be helped to plan for flexible and variable options in an expanded repertoire of sexual activity including intimacy, eroticism, and mutual and self-stimulation. Men with ED can also use Viagra and other PDE-5 inhibitors as an aid to masturbation. Experimenting with self-stimulation both with and without these drugs can help men regain a sense of confidence that can then transfer to sexual expression with a partner. Viewing a partner as a source of enjoyment and focusing on various forms of pleasure rather than a simple demand for an erection is also advised. Such an expanded perception of realistic and enjoyable sexual activity lends itself to enhanced relapse prevention of ED (McCarthy, 2001).

Even if men with ED do not seek out formal sex therapy in conjunction with PDE-5 treatment, general education provided with the prescription about the sexual response cycle in relation to increasing age—delivered through formal workshops or simple written materials—appears to significantly increase the likelihood of help-seeking behavior, communication among partners, and increased sexual satisfaction (Berner *et al.*, 2006; Goldman & Carroll, 1990). Certainly, a primary goal is to encourage physicians and other healthcare providers to garner some level of comfort in discussing sexual activity regularly with their male and female patients (Hillman, 2012). For healthcare providers who feel they do not have sufficient time or the personal inclination to discuss such matters at length, offering written materials to their patients would provide at least some benefit.

Case Example

Mary, a 71-year-old woman, and John, a 73-year-old man, presented to an out-patient clinic for couples' counseling. The couple had been married for 30 years; it was a second marriage for both of them. Mary complained that John didn't pay attention to her anymore because he was "so interested in that gross porn on his computer." John complained that he didn't want their marriage to end but that he needed something to help "spice things up" because Mary wasn't really interested in sex anymore.

After taking a detailed sexual history, it was revealed that John wanted Mary to perform oral sex on him and that she refused. Mary responded, "That's just nasty. I'm not some hussy who is going to do that." With further questioning and after the therapist helped the couple realize that their sexual activity was just a portion of their otherwise well-functioning relationship, Mary admitted, "It's like … I'm just not good enough anymore, just the way I am … I mean, everything sags and hangs a bit, but what am I supposed to do about it? I try to look nice for John, and it's like he doesn't

even notice." John responded, "It's just … Mary … I need a little more going on down there [pointing at his groin.]" With further, gentle questioning, John admitted that he could no longer attain an erection by "just looking" at her because he needed additional stimulation. He admitted that the novelty of viewing pornography helped a little but that he wished he could get that additional stimulation from his wife.

When the couple was educated about normative, age-related changes in the sexual response cycle, Mary said to John, "So it's not that you like those young girls on the computer better than me? It's that you need something to actually touch you down there to get an erection?" John sheepishly admitted, "Yeah, it's not like I think I need one of those blue pills to get going with you, but I guess I'm like an old car that needs a jump start." After lengthy discussion, Mary still maintained that she did not want to give John oral sex, but she said that she would agree to manually stimulate him using a silicon lubricant. (The couple found that water-based lubricants seemed to dry out much too quickly.) John was disappointed that Mary wouldn't give him oral sex, but he reported that he did enjoy the similar "feeling of wetness." Mary also indicated that she wanted to spend more time with John dancing, going to dinner, and getting couples' massages so that she felt more desired by him, too. In a few months, Mary and John settled into a much happier routine, and John reported that he rarely used the computer to become more aroused. With time, knowledge, and trust, both Mary and John reported that, on the whole, they felt emotionally and sexually satisfied.

A Call for Research, Health Education, and Advocacy

Although research on sexuality within the context of aging is becoming more available, there are some specific topics and special populations that need additional attention and investigation. For example, limited knowledge exists regarding the sexual function and dysfunction experienced among older minority group populations including Native American, Alaskan Indian, Asian American, and LGBT elders. Tending to the general health disparities among disenfranchised groups of minority group elders also is essential, as sexual health falls under that umbrella of care. Additional knowledge is needed regarding predictors of high-risk sexual behavior among older adults, particularly as they relate to exposure to HIV, hepatitis C, and other STIs. Significant work also remains to be done regarding the factors that predispose healthcare providers to routinely assess sexual health among their older patients and clients. In other words, what allows some clinicians to challenge the stigma and embarrassment that prevents many healthcare providers from offering complete clinical care? Additional research can also be used to identify the factors that lead some older adults to seek sex therapy in the first place, and how the availability of services, level of education of the clinician, cost of services, and other factors may influence their decisions to attend therapy and their adherence to treatment.

Sexual health education remains essential for both older adults and the healthcare providers who treat them. Most healthcare providers are unlikely to discuss issues related to sexual health with their older patients in general. Physicians are less likely to ask their older patients, compared with their younger patients, about sexual activity—including numbers of sexual partners, use of protection, and risk for HIV/AIDS—due to discomfort, as well as due to a common but mistaken belief that older adults are not sexually active (Hillman, 2012). Studies also suggest that less than one in five adults over the age 50 have ever discussed HIV/AIDS with their medical providers (c.f., Hillman, 2012). Sex therapists should work towards providing accurate and timely sexual knowledge to their older adult clients, and forging collaborative relationships with clinicians in primary care in order to encourage them to assess their older patients for sexual dysfunction or related concerns and make appropriate referrals. As shown in Table 20.4, a number of resources are available to engage both clients and healthcare professionals in appropriate sex education.

Table 20.4 Resources related to sexuality among aging adults.

American Association of Retired Persons (AARP)
www.aarp.org/home-family/sex-intimacy
LGBT-specific website: www.aarp.org/pride
American Association of Sexuality Educators Counselors & Therapists (AASECT)
www.aasect.org
1444 I Street, NW, Suite 700, Washington, DC 20005
Phone 202.449.1099, Fax 202.21.9646, Email: info@aasect.org
American Psychological Association (APA)
Aging and Human Sexuality Resource Guide: www.apa.org/pi/aging/resources/guides/sexuality.aspx
750 First Street, NE, Washington, DC 20002-4242
Phone 800.374.2721
National Institute on Aging (NIA)
HIV, AIDS, and Older People website:
www.nia.nih.gov/health/publication/hiv-aids-and-older-people
P.O. Box 8057, Gaithersburg, MD 20898-8057
Phone 800.222.2225
The North American Menopause Society (NAMS)
www.menopause.org
5900 Landerbrook Drive, Suite 390, Mayfield Heights, OH 44124
Phone 440.442.7550, Fax 440.442.2660, Email: info@menopause.org
Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE)
www.sageusa.org
305 Seventh Ave, 15th Floor, New York, NY 10001
Phone 212.741.2247, Fax 212.366.1947, Email: info@safeusa.org
Sexuality Information and Education Counsel of the United States (SIECUS)
Sex in Middle and Later Life Bibliography: http://www.siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=634&parentID=477
90 John Street, Suite 402, New York, NY 10038
Phone 212.819.9770, Fax: 212.81.9776

Advocacy for appropriate national healthcare policies is also essential for our growing aging population. Despite the increasing proportion of older adults becoming infected with and living with HIV, the Centers for Disease Control's (CDC; 2006) current recommendations only call for routine HIV testing for patients up to 64 years of age. In response, clear recommendations can be offered that the CDC change its routine HIV testing guidelines to include older adults; that federal funds be devoted to the development of national STI prevention programs including HIV/AIDS, hepatitis C, and others among older adults; and that healthcare providers obtain mandatory continuing education in relation to sexuality among older adults. Ignorance of sexuality and aging can no longer be accepted as a barrier to effective prevention, assessment, or treatment. Tending to the sexual health of older adults is essential, as all individuals can expect to one day belong to this growing population.

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21

Treating Sexual Problems in Clients with Cognitive and Intellectual Disabilities

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Introduction

Intellectual disability (ID) is demonstrated in everyday social and work activities by significant difficulties in both intellectual functioning and adaptive behavior starting before the age of 18. Intellectual functioning limitation involves deficits in cognitive abilities such as reasoning, problem-solving, and learning. One example of a standardized test measure used to identify cognitive limitation is the Intellectual Quotient (IQ) score. Standardized tests and assessments can also measure adaptive behavior problems through the applied performance of learned social, practical, and conceptual skills in everyday life.

Cognitive disability (CD) is a broad term that covers medical and mental conditions that interfere with the cognitive processes. Cognitive disability can be classified in terms of clinical diagnoses such as traumatic brain injury, autism, and dementia. Cognitive disability can also be classified by functional deficits in problem-solving, memory, attention, math, and reading.

The understanding of ID and CD—and the attitudes towards people with ID and CD—has changed dramatically over the course of history (DiGiulio, 2003). Ancient Romans and Greeks believed that ID was the result of an angered god, and children born with ID were left to die without support or assistance (Harbour & Maulik, 2010). Over the centuries, societies utilized a range of approaches to deal with ID, including reliance on religious "cures" or protective care in monasteries (Beirne-Smith, Patton, & Kim, 2006). Isolation and ostracization were not uncommon practices. Individuals with ID or CD who had sexuality concerns found most professionals ill-equipped or unwilling to address such needs, lacking the ability to provide realistic meaningful support or to serve as an educational resource. In fact, healthcare and research of ID and CD neglectfully avoided the issue of sexuality.

Perspectives on Intellectual Disability (ID)

In the 1800s, many rehabilitation programs for individuals with ID began appearing, including the first residential facility in Switzerland in 1841 and a private institution in America in 1848 (Beirne-Smith *et al.*, 2006). Despite a wave of program development, a troubling societal shift

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occurred in the mid- to late-19th century with the popularization of genetics and eugenics. Many manuscripts were published describing the hereditary nature of ID. There was particular attention paid to the rate of ID in immigrant populations and to the relationship between ID and criminality. Consequently, the discussion of reproductive rights (or lack thereof) of people with ID came to the forefront of public attention, and "selective breeding" emerged as a widely utilized practice.

The concept of selective breeding was not novel, with early mention dating back as far as Plato (Haavik & Menninger, 1981). There were likely three main reasons that the idea of selective breeding for individuals with ID emerged as common practice in the late 19th and early 20th centuries (Paul, 1973): (1) the development of less dangerous sterilization methods, such as the vasectomy and tubal ligation; (2) the beginning of the eugenics movement; and (3) the incorporation of Mendel's laws of heredity into an understanding of how traits or conditions such as epilepsy, criminality, and mental retardation could have the potential to be passed on to offspring. When selective breeding practices were enacted, sterilization generally occurred without the person's—and without a legal guardian's—consent. Many times individuals were told they were getting a more innocuous or medically necessary procedure done, such as removal of the appendix, when instead they were being sterilized.

In the 1930s and 1940s, evidence began to surface that, in addition to being passed on genetically, ID could also be caused by a host of environmental factors, metabolic disturbances, and *de novo* genetic mutations (i.e., non-hereditary mutations). At this time, the development of legal and social services for individuals with ID and their families began picking up speed. This change in attitude was also reflected in the study of individuals with ID. In 1954, the *British Medical Journal* published a small study of individuals with ID using the common terms of the era—"feeble-minded" and "mentally deficient" (O'Connor & Tizard, 1954). The questions asked of participants (all 12 of whom were in an institution for ID) were designed to provide a comprehensive overview of the life of these patients. However, only three questions were at all related to sexual activity (i.e., asking about any history of "homosexual behavior, indecent assault, and sexually transmitted diseases or pregnancy"). Still, with the passing of a 1974 law prohibiting the use of federal funds for the sterilization of "incompetent" adults, the movement to learn more about and support the sexuality of people with ID continued to grow.

Measuring the attitudes of families and caregivers toward the sexuality of people with ID is one way to assess how sexuality in this population is perceived (Swango-Wilson, 2008). In 1974, for example, Sol Gordon described a talk on sex education he gave to staff at an institution for people with ID. The main question that was posed to him was, "How do we stop masturbation?" (Gordon, 1974). He also cited examples of staff members who held less conservative views on the sexuality of people with ID and who were fired from their employment because of those views (de la Cruz & LaVeck, 1973).

Toward the end of the 20th century, the movement to provide more typical lifestyles to individuals with ID was gaining strength. However, this movement did not always include acknowledgement of sexuality as part of a typical lifestyle. For example, although in Sweden sex education has been mandatory in public schools since 1955, sex education remains insufficient in Swedish schools with special education programs (Löfgren-Mårtenson, 2012). In Poland, despite the recognition of the sexual rights of individuals with ID almost 20 years ago, there is still no syllabus for sex education with individuals with ID, as this particular topic has been turned into a taboo and pushed into the background (Kijak, 2011). In the US, the sexual revolution of the 1960s and 1970s began to extend to some individuals with ID as other prosocial movements, such as deinstitutionalization, began to take hold. Still at that time, there were many laws prohibiting people with ID to marry (Wade, 2002), highlighting a failure to recognize the importance of intimacy and sexuality in the lives of individuals with ID.

In an ethnographic study of 14 woman with ID from four agencies in the Midwest of the US (Bernert & Ogletree, 2013), most of the women had very limited and solely heterosexual sexual experiences, with the majority practicing abstinence from intercourse. Noteworthy is that most had negative views of sex related to fear of the first intercourse act, fear of experiencing undesirable consequences, physical concerns about the act, and expected or actual nonexistence of pleasure. These findings clearly highlight sex education as one necessary factor in pushing forward the rights of people with ID to realizing and expressing their own sexuality. Clearly, the topic of sexuality education can generate feelings ranging from avoidance, to discomfort, to sadness and disappointment or frustration (Hough, Warren & Crehan, 2016); these common negative reactions may have contributed to the absence of formalized sexual education for individuals with ID.

The idea of sex education for people with ID became more mainstream during the 1980s, when the high prevalence of sexual abuse of individuals with ID was recognized (O'Callaghan & Murphy, 2007). Given that the prevalence of sexual abuse of people with ID may be higher than in the general population, many programs outlining positive sexuality or safe touching were developed and implemented, with the hope that increasing education would decrease the incidence of abuse (American Academy of Pediatrics Committee on Children with Disabilities, 1996). As recently as 2004, a study comparing young adults with and without ID found that, compared with those without ID, those with ID had significantly less knowledge about a range of issues relating to sexuality, including masturbation, contraception, and pregnancy (Murphy & O'Callaghan, 2004). Thus, education is an area for growth both in the prevention of sexual abuse, but also in the ability for people with ID to fully experience the sexual components of living.

Public opinion on sexuality and ID also appears to be changing over time, trending towards the less conservative in more recent years. In 1971, John Money reflected on "sexual taboos and … rights," saying that, "Teaching sex education … may require teaching the actual positions in coitus through the use of pictures in books and films.… However, most of us are extremely inhibited with regard to pictures of sex" (de la Cruz & LaVeck, 1973). Since the 1970s, there has been progress in this area; one can now find instructional graphic videos available, and the comfort level for clinical utilization of these resources has increased in the US.

Although enacted individually, sexuality is culturally and socially developed through sexual socialization (Löfgren-Mårtenson, 2009). Sexual socialization generates schemas and scripts that become the foundation for establishing societal sexual values and rules (Brodwin & Frederick, 2010). However, for some individuals with ID, values and rules may not include the freedom of association, autonomy, and privacy that establishes most people's adult identity (Bernert, 2011). Thus individuals with ID may confront barriers to accessing helpful sexual socialization, determining the selection of partners, and engaging in sexual expression because others may judge them as incapable of handling sexual information or of making sexual decisions (Abbott & Howarth, 2007; Bernert, 2011; Blanchett & Wolfe, 2002; Cuskelly & Bryde, 2004; Evans, McGuire, Healy, & Carley, 2009; Stinson, Christian, & Dotson, 2002). Moreover, family members, professionals, caregivers, and significant others can negate or hamper the positive sexual experiences and expectations of individuals with ID, causing conflict that may impede healthy, enjoyable activities and meaningful relationships.

Societal attitudes toward sexuality have a major impact on how sexuality-related information is conveyed to individuals with ID. Professionals and staff members at hospitals, residential settings, and other healthcare environments may reflect societal values and thus have limited knowledge and comfort levels with sexual information, which, in turn, impacts access to information for individuals with ID (Bazzo, Nota, Soresi, Ferran, & Minnes, 2007). In a recent study of 181 health workers, attitudes towards relationships among people with ID

were measured. Domains such as friendship and love were rated positively by the health workers, but domains such as the acceptability of sexual intercourse between two people with intellectual disabilities, the relevance of sexual drive for people with ID, and the value of masturbation for people with ID were rated negatively (Parchomiuk, 2013). This illustrates that attitudes toward sexual rights for individuals with ID have grown in some areas, but there is still a need for education and resources to support people with ID in fulfilling their basic human right of sexual relationships (Higgins, 2010; World Health Organization, 1975).

The avoidance of addressing sexuality in a more transparent, formal, and consistent manner results in blocked access to correct, respectful information. Even in the absence of formal sexuality or relationship-based education, individuals without disabilities generally learn about sexuality from their families, their peers, and media such as television and the internet (Gougeon, 2009; Somers & Surmann, 2004). Given that individuals with ID may have less access to these types of informal discussions and given that sexuality information from media sources may be inaccurate or misleading, it is imperative that families and schools of individuals with ID are supplied with the means to convey correct, consistent information in an appropriate manner to enhance comprehension about sexuality and healthy relationships (Grieveo, McLaren, & Lindsay, 2006; Swango-Wilson, 2009).

Perspectives on Cognitive Disability (CD)

Injury to the brain can result in significant changes in one's cognitive abilities, which can lead to loss of function in the performance of daily routines, school demands, work responsibilities, and effective interaction within relationships. Trauma or injury to the brain can be caused by external forces such as damage sustained in motor vehicle collisions, falls, or concussions from sports or violent assaults. Trauma or injury to the brain also can be caused by internal forces that impede blood supply to the brain, such as stroke or cerebrovascular accident, in which there is internal bleeding or internal hemorrhage, or ischemia, which is caused by a restriction in blood supply. Damage to the brain can cause inability to move certain parts of the body and can impair speech and language, vision, memory, attention/concentration, reasoning, motor coordination, and interpersonal and organizational skills. Sexuality relies heavily on one's cognitive abilities in order to process complex human interactions. Knowing when to initiate and when to say "No"; utilizing communication filters and paying attention to cues that direct successful social behavior; and remembering special dates, anniversaries, and a person's likes or dislikes all play a critical role in our sexual interactions.

Similarly to ID, integrating sexuality into rehabilitation medical healthcare for individuals with CD has been a slow process. Interdisciplinary staff have varied amounts of knowledge, awareness, and acceptance of sexuality as a part of rehabilitation healthcare, as well as varied comfort levels in active listening related to sexuality and participation in addressing sexuality needs (Healy, McGuire, Evans, & Carley 2009; Hough, 1989).

Awareness regarding traumatic brain injury (TBI) has grown tremendously through the development of standardized clinical identification criteria with severity measures, and through the interdisciplinary rehabilitation treatment of military service members and veterans, as well as civilians surviving motor vehicle collisions, falls, violence, and accidents where brain function has been compromised to various degrees of impairment. More recently, due to increased awareness of the significance of concussion injury sustained by many adults, teenagers, and children during sport activities, there has been a movement to improve the identification of brain injury and further improve rehabilitation treatment (Institute of Medicine and National Research Council, 2014). Furthermore, there are continued efforts to change cultural responses to CD, moving from a model emphasizing crisis response and management to a

more proactive model emphasizing education and avoidance of conditions that increase the risk or severity of impairment.

More specific to sexuality, organizations such as the Commission on Accreditation of Rehabilitation Facilities (CARF, n.d.) have established formal survey accreditation criteria to review whether the needs, including the sexual needs, of the person receiving rehabilitation treatment are being met.

The term "walking wounded" illustrates that some individuals can have a TBI, but the severity of their impairment may go undetected without rigorous examination and observation, possibly occurring over an extended time. Such individuals may not receive assessment or intervention related to cognitive impairment, much less intervention related to disruptions in their sexuality.

Psychological Components of ID and CD that Impact Sexual Intimacy

Sexual intimacy is a complex experience influenced by cognitions, emotions, and social expression. Impairment or lack of development in any of these areas may impact the ability of an individual with ID or CD to understand and express emotional intimacy. For example, the potential difficulty in communication and expression of personal needs for some individuals with ID or CD can generate frustration and emotional disconnection from others, making sexual intimacy quite difficult. Additional sexual issues for individuals with cognitive impairment or intellectual disability may include lack of access to private masturbation, limited awareness of and ability to protect themselves from sexual abuse, sexual offending or boundary violations related to difficulty in understanding or monitoring social situations, need for guardianship consent to have sexual activity, lack of or limited information and comprehension regarding contraception and the risk of sexually transmitted infections, lack of access to protection such as condoms, limited access to what is needed for consistent safe menstrual management, and limited information about the rights and responsibilities involved in pregnancy and childrearing (Eastgate, 2008). Despite these many challenges, with appropriate access to education, information, and social support, individuals with ID and CD can initiate, maintain, and enjoy productive, healthy sexual relationships.

Neuropsychological Components of ID and CD that Impact Sexual Intimacy

Clinical neuropsychology, an established subfield of clinical psychology, focuses on the diagnostic assessment and treatment of people with brain injury (acquired or congenital), degenerative disorders, learning disorders, and other neurocognitive impairments. Although neuropsychologists have conducted some research into specific neuropsychological correlates of sexuality, there has not been a great deal of research focused on neurocognitive components that would aid or impede sexual intimacy.

Recent literature has just begun to explore the connections among clinical neuropsychology, sexuality, and disability (DenBoer & Hough, 2010), but this work is still in its infancy. This empirical interest has often taken the form of articles and books examining gender differences in neurocognitive abilities. Although some consistent neuropsychological differences have been found across gender and sexual orientation categories, the majority of these differences appear to be due to an interaction of biological predisposition and social factors. Additionally, research has focused on the neurobiological development,

psychosocial-environmental contributions, and neuropsychological correlates of sexual offending behavior (e.g., Talbot & Langdon, 2006).

Although neuropsychology has only been peripherally involved in research concerning human sexuality, clinical neuropsychologists are especially trained to provide unique assistance in the form of diagnosis and treatment of problematic behavior, and can assist in examining sexual dysfunction/impairment related to cognitive difficulties. Therefore, the task of identifying neuropsychological components that may assist in or impede sexual intimacy and relationships appears perfectly suited for collaboration between the clinical neuropsychology specialty and the field of sexology. Such neuropsychological findings and recommendations are an important part of an interdisciplinary team's rehabilitation efforts and can also be utilized by experienced professionals (e.g., psychologists, social workers, marriage counselors) in their work by incorporating that information into the treatment plan.

Neuropsychological barriers to sexual intimacy

Neurocognitive deficit and sexual dysfunction have been shown to overlap in individuals with TBI (Hibbard, Gordon, Flanagan, Haddad, & Labinsky, 2000) and spinal cord injury (SCI) (Ducharme, 2000), as well as in individuals with concomitant TBI/SCI (DenBoer & Hough, 2007). Some individuals with moderate to severe TBI and/or SCI have significant difficulty engaging in sexual intimacy due to the physical nature of their injury.

In addition to the primary effects of their injury, patients can have secondary effects, including decreased sexual desire, decreased arousal, difficulty reaching orgasm, lack of satisfaction after climax, and reproductive challenges. Regarding the latter point, for men this may take the form of decreased sperm production, whereas for women this may take the form of irregular menstrual cycles or periods (Sander & Maestas, 2014).

Changes in sexual functioning after TBI can be due to a variety of causes, including but not limited to: damage to the brain, hormonal changes, medication side-effects, fatigue/tiredness, problems with movement, self-esteem problems, changes in thinking abilities, emotional changes, and changes in relationships and social activities (Sander & Maestas, 2014). Damage to the brain can lead to a variety of cognitive impairments, including deficits in memory, impulsivity, disinhibition, and poor decision-making. These cognitive challenges can create relationship stress for the individual and his or her partner. For example, memory and initiation problems may lead to ineffective attempts to express spontaneous loving emotion; thus, the patient's partner may misinterpret the patient as being emotionally distant.

Also in relation to memory, individuals with CD may forget the people that they meet and forget to keep appointments, impacting their ability to form close relationships. Furthermore, an individual may forget to plan for safe sex, making sexual intimacy a potentially dangerous endeavor. These deficits may be somewhat ameliorated by use of a written planner, smartphones with apps to assist in recall of information and planning, alarm watches to remember birth control medication, and reaching out to trusted and knowledgeable professionals and peers for support and guidance.

Impulsivity can also represent a huge barrier to sexual intimacy. Impulsivity is typically related to damage to the frontal lobes of the brain. This may cause the individual to engage in unsafe sexual advances with others, to display decreased filtering of content during interactions, to have difficulty maintaining acceptable sexual boundaries and finding appropriate outlets for feelings, or to engage in other impulsive behavior. A combination of behavioral re-training, behavioral management, and psychotherapy may prove helpful to assist individuals in this area following brain injury (Zencius, Wesolowski, Burke, & Hough, 1990).

Many individuals can have, in addition to neurocognitive impairment, significant mental health issues. These include, but are not limited to, depression and anxiety. Depression and anxiety can have a significantly detrimental effect upon sexual intimacy, with problems ranging

from erectile dysfunction and difficulties with orgasm to emotional distancing and isolating behaviors. Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), can also have significant sexual side-effects.

Neuropsychological assists to sexual intimacy

Fortunately, certain interventions are available to assist with the problems abridged above. These forms of treatment, which are designed to assist the individual in forming more intimate sexual bonds, range from medication to individual or group therapy. Sex therapy, with an experienced sex therapist who has a clinical understanding of the individual's cognitive and psychosocial strengths and weaknesses, may be of benefit.

In addition to sex therapy, interdisciplinary neurorehabilitation may be indirectly beneficial in assisting with sexual intimacy for individuals with CD, as this approach addresses holistic life functioning abilities. Neurorehabilitation includes an interdisciplinary team of experts, such as speech and language therapists, neuropsychologists, occupational therapists, physical therapists, physicians, nurses, psychologists, social workers, psychiatrists, nutritionists, recreation therapists, and kinesiotherapists. As the brain recovers following injury and shows improvement through a combination of therapy, intervention, and time, improvement in the ability to feel, express, and enjoy one's sexuality may be expected. However, specific intervention such as compensatory strategies may be helpful for some individuals who continue to experience difficulty in sexuality and relationship expression.

For individuals that have a TBI, Sander and Maestas (2014) proposed many helpful suggestions to improve sexual functioning. These include the following: obtaining a comprehensive medical evaluation and interdisciplinary team assessment as clinically indicated; arranging for a non-distracting environment during sexual activity; and minimizing fatigue/tiredness. The authors also propose a variety of compensatory techniques and thoughts. These include compensations for a decreased ability to imagine or fantasize about having sex, memory problems such as not being able to remember dates, and male erectile dysfunction and female sexual functioning difficulties. Additional interventions that would assist with sexual intimacy include increasing opportunities for social interaction in a non-threatening, comfortable fashion such as through behavioral rehearsal or practice. Relationship skill rebuilding can help patients to utilize environmental cues to identify potentially unsafe situations and to take precautionary measures—such as politely not accepting an alcoholic drink from a stranger. The authors proposed the following social skills guidelines: smile and greet, listen before talking, focus on the other person, don't wait for others to call, participate in recreational activities, invite others over, and join a club or organization. A therapy group devoted to dating and relationships (Hough, Stone, & Buse, 2013) might be helpful to address the components of social skills enhancement and rebuilding, to improve the patient's social confidence, and to identify social networking opportunities specific to the individual's needs. An important ingredient of social and life functioning is the balance between work and play. Individuals with cognitive impairment can benefit from social skills training, as well as specific vocational or avocational skill development and skill rebuilding to address lost or decreased vocational or avocational performance (Hayashi, Arakida, & Ohashi, 2011; Hough & Brady, 1988). Improving these skills often leads to increased social confidence, as well.

In addition to some of the helpful recommendations mentioned above, in order to maximize the capability for sexual intimacy and social relationships, Sander and Maestas (2014) listed a few other sex-specific helpful hints, including trying changes of positioning during sexual intimacy, masturbation or self-pleasuring, gratification through erotic media, and cyber relationships. Such instructional discussion can be especially helpful for individuals who have difficulties with cognitive initiation and idea generation. Regarding the last suggestion, though, cyber activity should be used cautiously by all and especially for those individuals with severe

cognitive difficulties such as impairments in memory and reasoning, who should consider having their interactions monitored by a trusted friend or colleague, due to the potential for experiencing manipulation or coercion by online "partners."

Addressing sexuality among those with cognitive and intellectual disability is a multifarious and intriguing direction for sex therapy, and it represents an important challenge for the neurorehabilitation movement. Interdisciplinary and multidisciplinary teams across various healthcare and residential settings are increasingly required to specifically address the merging of the physical, cognitive, and emotional aspects of sexuality, which is a part of daily functioning. The experienced and knowledgeable sex therapist, sex educator, or mental health provider, along with the rehabilitation team, is now asked to address and not avoid the issue of sexuality following injury.

Case Study

Jared was a 30-year-old man who suffered a traumatic brain injury when he was hit by a car while riding his motorcycle. He and his wife, Karen, had three young children at home. He had difficulties with his memory and attention, making it challenging for him to keep an erection. Due to his memory deficits, he also did not remember how frequently he and his wife had had sex, and he would initiate sex more often than Karen wanted. Even prior to his injury, they argued regularly about their desire discrepancy.

Assessment

As part of a thorough assessment, a medical evaluation should be completed in addition to a cognitive evaluation. For Jared, the medical evaluation indicated a diagnosis of erectile dysfunction. Jared was able to achieve erections but had difficulty sustaining them for long periods of time. The therapist worked on reframing what sex was, focusing on other types of pleasurable activities outside of penile-vaginal intercourse. The couple also began to use a tension ring during intercourse to extend the time that Jared was able to sustain an erection. He worked with his physical therapist on sustaining attention during exercise, with the hope that this would translate to increased attention during sexual activity.

Notes from speech therapy or neuropsychology can also be helpful in understanding any cognitive deficits the person may be displaying. In particular, the therapist should take note of deficits in executive function, attention, memory, and communication. It is also important to assess for any pre-injury issues that the couple was having and how this may have changed after the injury, and to assess how relationship roles may have changed secondary to any medical diagnoses. For example, has the partner become a primary caregiver to the patient? For Jared and Karen, they had begun to experience emotional disconnection due to their new challenges with sexual function and changes in communication patterns. Jared would become frustrated with his erectile dysfunction and would get upset with his wife. Karen, in turn, would become frustrated with being blamed for Jared's erectile dysfunction and was stressed from being his primary caregiver. During sessions, she also revealed that Jared was initiating sex frequently, often at inappropriate times, such as in front of their children. She indicated that he would get upset with her when she declined, and she felt that this put her in an awkward situation and decreased her desire to be intimate with Jared.

Intervention

Interventions for couples where one partner—or both partners—has ID and/or CD should be structured. Comprehensive education was provided to Jared and his wife about the possible sexual side-effects, both direct and indirect, of his traumatic brain injury. This included specific

information about common changes in desire and arousal, erectile function, ejaculation, orgasm, cognitive abilities, communication, emotional reactions, and relationship roles.

To address Jared's difficulty with sustained attention, the therapist recommended that they declutter their bedroom—or wherever they were going to be having sex—to decrease distractions. They were advised to turn off the television and any other background noises that could be distracting. They also changed the time of day that they had sex from late evening to early morning, when Jared was better able to focus and was not cognitively fatigued.

In addition to couples therapy, the therapist incorporated cognitive-based interventions into Jared's treatment. Jared began to track his and his wife's sexual activity in a log, to help with his memory.

Due to insurance restrictions, Jared was only able to stay in rehabilitation for several weeks after his injury. The hospital staff were able to begin the process of providing education and addressing Jared and his wife's concerns about sexuality, but due to the limited amount of time, Jared and his wife were referred to a sex therapist upon discharge for ongoing intervention. Jared continues to follow up with his rehab physician for any medical concerns.

An Approach for Sex Therapy

Specific relevant educational materials and personalized information are fundamental when addressing sexuality concerns for individuals with ID and CD (see Appendix A for a list of helpful resources). Beyond counseling associated with relationship issues and pragmatic instruction related to sexual positioning in the case of co-occurring physical limitations, there may be a need to address the situational complexity of sexuality and to promote understanding, expression, access, joining with others, and choices related to sexual expression. Emotionally focused therapy presented in isolation may be difficult for some individuals with ID or CD who have decreased insight and social interaction difficulties. However, a more systemic approach can be helpful in identifying and targeting for intervention any contributing or exacerbating factors within individual, couples, or family therapy or within educational settings.

The healthcare professional with advanced sex therapy training—and perhaps certification (e.g., from the American Association of Sexuality Educators, Counselors and Therapists; AASECT, n.d.)—and with clinical understanding of the individual with ID or CD, may be able to provide a key perspective to maximize goal attainment and to achieve a successful outcome. However, a consistent and transparent approach to dealing with issues of sexuality must be established.

Here are some suggestions. First, understand the referral question and the reason for the referral. Second, understand the environment in which the referral was made and the reality of the person's life situation. The mental health provider is not an instructor in the school classroom. Rather, the mental health provider has entered the person's classroom, so there is a need for the mental health provider to learn from the individual. Incorporate the identified patient, as well as significant others when clinically indicated, to understand the problem and address the individual's goals. Significant others may include spouses, partners, family members; friends, coworkers, classmates, neighbors, guardians, and members of the interdisciplinary rehabilitation or healthcare team such as nurses, physicians, case managers, counselors, psychiatrists, psychologists, clergy members, social workers, occupational therapists, physical therapists, speech and language pathologists, and other rehabilitation specialists. For individuals who are under-age or have a legal guardian, adherence to legal mandates—along with personal respect for the therapeutic relationship—will require awareness and due diligence in navigating the complexity of relationships and boundaries. Consent to treat will need to be obtained and documented. Clarification of who has legal access to records and the limits of confidentiality will need to be understood and followed. The complex question of whether guardianship implies control over sexual consent will need to be elucidated.

One approach to providing sexual services to individuals with ID or CD is to employ a process that embraces the EX-PLISSIT model of sex therapy (Annon, 1976; Davis & Taylor, 2006; Taylor & Davis, 2007). The four primary levels of the original PLISSIT model (Annon, 1976) include Permission-giving, providing Limited Information, offering Specific Suggestions, and Intensive Therapy. Within this model, the therapist starts with the least invasive intervention (i.e., permission-giving) and moves up the hierarchy as needed to address the sexual concern. The EX-PLISSIT revision (Davis & Taylor, 2006; Taylor & Davis, 2007) extends the explicit permission step to each level so that the person feels comfortable acting on the information provided in each step. A necessary element for this model to be effective with individuals with ID or CD is to monitor for comprehension through supportive check-ins and then to ensure functional understanding through further discussion, visual aids, or rewording until it is clear that the person is able to grasp the concept.

The assessment of the client's comprehension and retention of information is required throughout therapy. Of critical importance is to offer repetition of information as needed, to provide clear, straightforward information and feedback, and to avoid overloading with too much information. The pragmatic nature—providing the "how to do it" and evaluating the "realistic ability to do it"—of the intervention is critical. It is necessary to address issues of sexuality through information and application (Hess & Hough, 2012), to incorporate sexuality education (Schaafsma, Kok, Stoffelen, & Curfs, 2015), and to ensure consistent access to therapeutic support in the healthcare environment (Gill & Hough, 2007a).

Conclusion

The respect for individual differences and appreciation for the diversity of sexuality is a paramount ethical standard for implementation of educational and clinical practice. Policies and guidelines to protect the rights of the individual with ID or CD in terms of sexuality need to be established and enforced in relevant settings. These guidelines should ensure the provision of education, awareness, and structure for consistent objective adherence (Gomez, 2012). The fabric of one's individuality and identity include one's ethnicity, race, culture, religious views, as well as sexual orientation, sexual lifestyle, and sexual expression (Gill & Hough, 2007b). A personal therapeutic relationship—to build trust and comprehension along with practical information and support—will be the primary element in providing effective sex education and sex therapy for individuals dealing with sexual challenges from intellectual and cognitive conditions.

Appendix A Resources on Disability and Sexuality

All of Us Talking Together: Sex Education for People with Developmental Disabilities **(video, 1999)**
Available from Program Development Associates: www.disabilitytraining.com

Brain Injury Survivor's Guide: Welcome to Our World **(book)**
Jameson, L., & Jameson, B. (2007). Denver, CO: Outskirts Press.

Facing Disability **(website)**
www.facingdisability.com

Center for Parent Information and Resources **(website)**
www.parentcenterhub.org

Feeling your Way: Relationships and Sexuality after Spinal Cord Injury **(video, 2013)**
Available from Mayo Clinic: http://store.mayoclinic.com/products/bookDetails.cfm?mpid=138

Healthy Relationships, Sexuality and Disability **(resource guide, 2013)**
Available at http://www.mass.gov/eohhs/docs/dph/com-health/prevention/hrhs-sexuality-and-disability-resource-guide.pdf

National Association of Special Education Teachers **(website)**
https://www.naset.org/

Program Development Associates: The Professional's Choice for Disability and Diversity Resources **(website with resource list)**
http://www.disabilitytraining.com/product-list.php?Sexuality_and_Relationships-pg1-cid51.html

Sexuality Education for Youth with Disability or Chronic Illness: A Resource List **(website)**
www.med.umich.edu/yourchild/topics/disabsex.htm

Sexuality Information and Education Council of the United States (SIECUS) **(website)**
www.siecus.org

The American Association of Sexuality Educators, Counselors, and Therapists (AASECT) **(website)**
www.aasect.org

The Society for the Scientific Study of Sexuality (SSSS) **(website)**
www.sexscience.org

Note: A good place to start when hunting for resources is the national and local organization identified with the condition or conditions of interest. This can readily be identified with a quick online search of the name of the condition combined with the term "sexuality".

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22

Treating Sexual Problems in Clients with Mental Illness

Stephanie Buehler

Mental Illness, Sexuality, and Relationships

To date, a single book (Buehler, 2011) has been published on the topic of sexuality and mental illness. Although that book was released several years ago, there have been few additions to the literature on this topic since its publication. Why the dearth of research on the relationship between mental illness and sexual function? First, psychiatrists and psychotherapists receive little formal training on sexuality, and few seek out postgraduate training opportunities on the subject. Second, mental illness is terribly stigmatized, even among mental health professionals. Indeed, mental health professionals often eschew diagnostic labels, perhaps believing that a mental illness label causes shame and perhaps missing the point that labeling is sometimes exactly what is needed to ensure appropriate treatment. Third, it is often difficult, or thought to be difficult, for a study on sexual attitudes and behaviors to pass an internal review board—perhaps especially if that study involves potentially vulnerable mentally ill participants.

Nevertheless, despite often being ignored, the intersections between mental illness and sexuality are real. About 26% of adults in the US are affected by mental illness each year (National Institute of Mental Health, n.d.), and about 66% of adults are married or in a committed relationship (Wang & Parker, 2014); these facts bolster the supposition that a large number of married or committed adults suffer from mental illness. What isn't known is how many adults divorce because of relationship or sexual problems attributable to mental illness. These are important questions to be addressed in future research, as numbers may highlight the need for appropriate individual and couples interventions.

What follows are suggestions for how psychotherapists might go about assessing the intersection of mental illness and sexual problems; a brief overview of several major categories of mental illness and their impact on sexual functioning and relationships; and some broad treatment recommendations to help couples struggling with co-occurring mental illness and sexual problems.

Assessment

Couples who come to therapy for help with sexual problems may not always realize that there are mental illnesses that may be driving or contributing forces. Members of the couple also may collude in not discussing potential psychological problems with each other and/or with

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

the therapist. Additionally, it is sometimes easier to focus on sexual problems, with their distinct symptoms and behavioral treatments, than on other—more complicated—mental health problems that are affecting the relationship.

Confronting problems such as attention-deficit/hyperactivity disorder or substance abuse too early in sex therapy treatment may disrupt rapport, unless such problems are openly reported on the intake form or immediately brought up by a frustrated spouse. In my practice, clients complete a checklist on the electronic medical record system, which is especially helpful for couples ostensibly coming in for sexual problems, as it allows me to quickly discern symptom constellations and make hypotheses regarding diagnoses that I can then check through intake questions when face-to-face with the clients. Therapists could employ a measure such as the Symptom Checklist-90 (Derogatis, 1994), which is available online. In the absence of a checklist, the therapist may observe and make a mental note of symptoms such as "difficulty focusing," "feeling wound up," "insomnia," "acting robotic," "smoking pot all the time," and so forth, forming a fuller clinical picture of the couple before explicitly addressing possible mental illness diagnoses.

Once rapport has been developed and the therapist has gathered enough information to warrant frank exploration, the therapist may ask questions such as the following:

- Has anyone ever diagnosed you with _____?
- Has either of you wondered if _____ is part of the problem?
- I wonder if _____ is contributing to your sexual problem. What are your thoughts?
- In the past few weeks, I have noted that you have mentioned the following symptoms [list symptoms]. Are you aware that these are symptoms of _____? What are your thoughts about this?

Sometimes the therapist will get agreement from both partners that a certain diagnosis is indeed a problem. However, sometimes a partner will proclaim relief that his or her suspicion is finally confirmed, while the afflicted individual will become defensive or remain in denial. If this occurs, the therapist may choose to deal with this in several possible ways: (1) treat sexual symptoms with a proviso to the couple that they may not be resolved without appropriately addressing the mental disorder; (2) treat only the sexual symptoms initially but reserve the "right to revisit" the mental illness if progress isn't made; (3) provide additional educational resources to bolster the clinical observation; or (4) refer to another therapist or psychiatrist for a second opinion.

One more word about diagnosis: Many psychotherapists object to labeling a client because mental illness labels can be stigmatizing. This thinking misses the point of diagnosing, which is to develop an accurate understanding of the problem so that a targeted intervention can be used to help the client treat or manage symptoms and improve quality of life. When working with a couple, though, care must be taken to carefully educate both partners regarding the diagnosis, its causes, and its treatment. Couples may benefit from hearing how common the problem is in order to destigmatize it. Treatment decisions (e.g., whether to try medication, when and if to seek individual therapy, and whether or not other family members should be told) must ultimately rest with the individual receiving the diagnosis. Most importantly, a diagnosis should be used neither as a weapon nor an excuse. When this occurs, it creates grist for the couples therapy mill.

Mental Disorders and Sexual Symptoms

Here I focus on some of the mental illness diagnoses that I see most often in my psychotherapy practice and that often contribute to sexual problems.

Mood disorders

The National Institute of Mental Health (n.d.) reported that mood disorders are the most commonly diagnosed mental health disturbances, with an estimated 9.5% of Americans over the age of 18 experiencing major depression, dysthymia, or bipolar disorder in any given year. Mood disorders can negatively affect sexual health and intimacy, but sexual symptoms can also be a harbinger of all three diagnoses (Cohen *et al.*, 2007). For example, many men who complain of low sexual desire or erectile dysfunction misidentify or ignore feelings of anhedonia, pessimism, or other signals of depression. For both men and women, depression can make it difficult to become aroused or experience orgasm. A bleak outlook and tendency to isolate also make it unlikely that a depressed person will seek out a sexual partner (Baldwin, 2001) and may lead the depressed person to distance themselves from established relationships.

Sexual symptoms associated with bipolar disorder vary, of course, according to the phase of the illness. When hypomanic or manic, interest in sex may increase dramatically (McCandless & Sladen, 2003). Sexual behaviors with inherently negative consequences may ensue, including sexual activity with anonymous or multiple partners and other sexual behavior that puts one at risk for sexually transmitted infections (STIs) or unwanted pregnancy. People with bipolar disorder have a higher than average rate of divorce, which may, in part, be attributable to an inability to control sexual behaviors (Hirschfield & Weissman, 2002).

Depression case example: Seymour *Seymour complained to his urologist that "my orgasms aren't the same" after a vasectomy, which was performed at the request of his wife after she gave birth to their third child. Such post-surgical complaints occur in only about 0.01% of men, and because the urologist could find none of the other issues that may co-occur with poor surgical outcomes, he referred Seymour to a sex therapist for an evaluation. To the therapist, Seymour seemed depressed, but he denied it and remained singularly focused on his weak orgasms.*

The therapist, however, did discover that Seymour also wasn't enjoying golf or having a beer with his buddies. At that point, the client recognized that, yes, perhaps he did feel down. Several sessions later, an emotional Seymour cried about a close friend who had tragically died during high school. Confusing though it may seem to an outsider, Seymour connected his depression and unsatisfying orgasms to multiple losses, including the loss of his high school friend and the loss of his ability to procreate. After this cathartic session, Seymour called the therapist to report that he had had sex with his wife and had regained his capacity for satisfying orgasm. His mood immediately improved, and he terminated treatment.

Anxiety disorders

Performance anxiety is a commonly recognized factor that contributes to sexual problems. But anxiety disorders of any kind may interfere with sexual response (Elliott & O'Donohue, 1997; Fontanelle, Wanderson, de Menezes, & Menlowicz, 2007; Kendurkar & Brinder, 2008; Van Minnen & Kampman, 2000). For example, having social phobia may make it difficult to function in such a way as to meet an appropriate sexual partner. Health anxiety also can prevent an adult from engaging in sex when there are overblown concerns about contracting an STI or other disease from intimate contact.

Obsessive-compulsive disorder is another anxiety disorder that can create problems in the bedroom (Abbey, Clopton & Humphreys, 2007; Aksaray, Berkant, Kaptanoglue, Oflu & Ozaltin, 2001). Problems include difficulties with orgasm for women, and with erectile dysfunction and delayed ejaculation for men, primarily because distracting or irrational thoughts interfere with arousal (e.g., "If he touches my genitals, then the pillow, there will be germs on the pillow").

Obsessive compulsive disorder case example: Gerald and Mariam *Gerald and Mariam reportedly had a good relationship, as they shared the same faith, parented their children well, and enjoyed one another's company when they had an opportunity to be alone. Their sex life, however, suffered because Gerald had delayed ejaculation, taking up to 30 minutes to complete intercourse. This left Mariam feeling, not only tired and sore, but also unattractive. She also felt that there was an emotional disconnection during intercourse, as Gerald kept his eyes closed while he mechanically thrust into Mariam's vagina.*

Suggestions to help Gerald become more aroused prior to intercourse did not help. Increasing a sense of emotional connection by keeping eyes open while sensually stroking and verbally expressing love also did little to improve the problem. An exploration of Gerald's masturbation patterns ensued, which is when Gerald admitted that, in order to climax, he had a singular sexual fantasy that he needed to complete from beginning to end. If a dog barked or a car alarm went off, he had to replay his fantasy all over again from the beginning. This description enlightened us to the fact that Gerald perhaps had obsessive-compulsive disorder. Mariam then reported that Gerald needed to check all the locks on doors and windows at least three times before they went anywhere for a significant period of time. These revelations then guided the treatment, which focused on decreasing Gerald's obsessive-compulsive symptomatology and helping him to develop a more satisfying approach to life, love, and sex.

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) attributable to childhood sexual abuse (CSA) or adult sexual assault may lead to sexual difficulties in some, although not all, survivors (Buehler, 2008; see also Hall, this volume). One of the most common experiences is "triggering," when a stimulus that occurs during an intimate encounter causes a flashback or unwanted memory of the traumatic event, which may bring sexual activity to a halt. The stimulus may be obvious, such as the smell of beer on a partner's breath reminding someone of their abuser's breath, or more subtle, such as a certain type of light stroke on the inner thigh. The fear associated with flashbacks or unwanted memories can be mild or severe.

Other sources of trauma, such as serving in combat, also can interfere with sexual function. Combat veterans, for example, may lose interest in sex, and male veterans may struggle with erectile dysfunction (Buehler, 2011; Tran, Dunckel & Teng, 2015). Individuals suffering from PTSD also may attempt to avoid thoughts about the trauma by engaging in risky or impulsive sexual acts.

PTSD case example: Petra *Petra rarely enjoyed sex with her husband, who had a high level of desire. Petra reported that she did love her husband, with whom she felt very compatible in nonsexual ways. Her husband's support and patience in the bedroom were wearing thin, however, which led Petra to seek help.*

During the course of therapy, Petra recognized that, overall, she was fine being intimate with her husband until he touched her breasts in a certain manner. Petra had a sudden insight during therapy that this is the way her abusive stepfather, a nurse, would manipulate her breasts during "examinations" when she was just 11 or 12. This made Petra angry enough to finally confront her stepfather. Although he denied any wrongdoing, Petra held strong in her conviction that her stepfather had, in fact, molested her. Petra now felt she could claim her sexual enjoyment for herself, although she did request that her husband not touch her breasts in the way that triggered bad memories. She continued treatment to improve other symptoms that concerned her, such as problems with knowing whom she could trust and feelings of low self-worth.

Eating disorders

Researchers have concluded, based on a review of the empirical literature, that people with eating disorders have more sexual problems than the general population (Beerens, Vermassen, Vrieze & Pieters, 2014). Such problems include low levels of sexual drive and activity, as well

as high levels of sexual dissatisfaction. The authors also found that those with anorexia nervosa have more sexual problems than those with bulimia, the latter of whom may be more willing to experiment sexually than the former. Women with bulimia also may have a stronger sex drive than women in general (Quadflieg & Manfred, 2003; Wiederman & Pryor, 1997). With less impulse control, women with bulimia may begin sexual activity at a younger age than women in general and have more sexual partners. This may lead to feelings of regret or shame, which can impact negatively on self-concept and intimate pleasure.

Anorexia nervosa often begins in adolescence. At a time when many teens are enjoying their changing bodies and awakened sexuality, some anorexic teens may diet to diminish or prevent the appearance of secondary sexual characteristics such as increased breast size (Weiderman, 1996). By making themselves overly thin, they may attempt to send a signal to possible suitors that they are disinterested in sex, both for recreation and procreation. Other anorexic teens may be trying to achieve what they believe to be an ideal weight based on media images and cultural pressures, sexualizing an unhealthy female form (Ackard, Kearney-Cooke & Peterson, 2000). In either case, the focus on body and body image can have a direct impact on the sufferer's ability to experience their sexuality in a healthy way, as it can distract from feelings of pleasure.

Alcohol use disorder

Clients, their spouses, and their treatment providers frequently overlook alcohol misuse as a factor that can contribute to sexual problems. In the short term, alcohol can increase social confidence as well as sexual confidence and initiative (Fahrner, 1987; Johnson, Phelps, & Cottler, 2004; Le Pera *et al.*, 2008; Turner & Dudek, 1982). Add to that the ability of alcohol to disinhibit sexual expression, and many people—teens and adults alike—discover that sex while inebriated can be quite pleasurable, although this may be more related to alcohol expectancies than actual pharmacological effects (George & Stoner, 2000). Additionally, for some who suffered childhood sexual abuse, alcohol allows them to quell both flashbacks and shame, allowing them to participate in sex. However, in a large number of instances, men especially, may have negative effects from excessive alcohol consumption, including low desire, erectile dysfunction, delayed ejaculation, or rapid ejaculation (Arackal & Benegal, 2007).

Additional problems arise when drinking alcohol leads to a full-blown addiction. For some people, alcohol abuse prevents them from being intimate, driving a wedge in a couple's relationship that can be difficult to overcome. Additionally, if alcohol-dependent individuals stop drinking, they may have difficulty engaging in "sober sex." If both partners abuse alcohol or other substances to overcome sexual shame, once sober they may realize that their sex life has been based on a merry-go-round of drinking–sex–shame–drinking–sex–shame.

Alcohol use disorder case study: Frankie *From the time she was in her late 20s until her late 40s, Frankie drank alcohol to stave off depression from the trauma of incest. When drunk, Frankie engaged in varied sexual practices with her husband, including finding women on the internet to join them for threesomes, which her husband very much enjoyed.*

Frankie's decision to become sober occurred when her ex-husband learned about the threesomes from their teenage son, who was nearly seduced by one of the women who had been in their home. Worried that she might lose custody of their three children, Frankie entered AA. With the support of the group, a sponsor, and a therapist, Frankie proudly achieved a year of sobriety.

Her husband James, meanwhile, became increasingly resentful of Frankie's sobriety. He complained of "boring sex." At first Frankie felt defensive, but then she saw James' point: She was stiff and unresponsive in the bedroom without having anything to drink. Frankie knew then that alcohol had allowed her to at least function sexually. She knew she had to seek treatment to address the effect the incest had on her sexuality.

Neurodevelopmental disorders

Attention-deficit/hyperactivity disorder (ADHD; Betchen, 2003), autism spectrum disorder (Attwood, 2007), and learning disorders can all affect a person's ability to sustain an intimate emotional and sexual relationship. All three disorders may have a negative impact on an individual's self-concept and self-esteem, as well as his or her ability to understand a partner's frustration with thoughts and behaviors that—for the diagnosed individual—are ego syntonic.

There is very little research on ADHD and sexuality beyond some research on increased sexual risk, likely associated with lack of impulse control, in adolescents with the disorder (e.g., Brown *et al.*, 2010). Clinically, however, I have heard men and women with ADHD describe a lack of focus, which can make it difficult to become aroused, leading to delayed ejaculation and anorgasmia, respectively. Boredom and problems with impulse control can lead to issues such as infidelity or overuse of pornography. Outside the bedroom, typical behaviors associated with ADHD, such as forgetfulness or inability to complete a task, can lead to a partner becoming frustrated. The partner may not understand that such behaviors are unintentional and are not designed as passive-aggressive expressions of anger; thus, it is the therapist's task to help generate understanding and empathy.

Partners of individuals with autism spectrum disorder often have complained to me that their partner is "mechanical" in the bedroom, "behaving like a robot," emotionally disengaged during sex, or lacking in sexual interest. Partners of individuals with autism spectrum disorder, like partners of those with ADHD, also may complain of difficulties in daily life that interfere with intimacy, including the diagnosed individual's intense devotion to work or odd interests (e.g., finding and climbing long staircases); rigid adherence to routine; or inability to understand a partner's request (Attwood, 2007). For example, the diagnosed individual might refuse to brush his or her teeth at the partner's request because the diagnosed individual cannot smell his or her own bad breath, and thus cannot understand the source of the partner's frustration.

The impact of learning disorders on intimacy is perhaps least understood of all, and because learning disorders are diverse, their impacts on sexuality are likely to be diverse as well. People with learning disabilities can sometimes have sensory deficits, making sex awkward or uncomfortable (e.g., a husband complained that his wife with sensory processing problems "grabs my penis like it's fish and she's an octopus"), or they may miss social cues that signal that their partner is interested in romance or sex. Learning disorders also can lead to general relationship discord. For example, one female partner of a man with dyslexia sneered at her partner's difficulty in reading a menu, leading to the man feeling humiliated and, therefore, uncooperative.

ADHD case example: Leanne *Leanne's initial complaint was a lack of interest in sex with her husband of five years, which she attributed to being molested by a physician she visited as a pre-teen. However, her early sexual relationship with her husband had been very satisfying, and she had had several shorter but satisfying sexual relationships prior to meeting him.*

Leanne also was trying to establish a new business creating baskets for corporate clients to send as gifts. She complained of having difficulty with keeping track of dates and details and had nearly lost a client because she forgot to include certain items in a basket.

The therapist made further inquiry into Leanne's childhood. Leanne admitted that she was known as the class "chatterbox," that she spent her time daydreaming, and that her grades were just average even though she read books intended for students well beyond her grade level.

The therapist diagnosed Leanne with ADHD and explained why. Leanne agreed, as she had often wondered if that diagnosis fit. Relieved, Leanne began to read about and learn strategies for managing adult ADHD. However, these did not lead to any changes in the bedroom. Extrapolating from the fact that Leanne had mentioned boredom, a common problem in ADHD,

the therapist asked Leanne's husband to join a session so that the couple could learn ways to add variety to their sex life. Within a few weeks' time Leanne reported that her orgasms had returned—and her business was booming, too.

Autism spectrum case study: Lawrence and Hua *Hua, an immigrant from mainland China, sought the help of a sex therapist because her partner Lawrence liked latex. Hua had no problem wearing latex during sex, and she thought of it as an exchange for the fact that Lawrence, an engineer, paid her expensive tuition and travel expenses home whenever she wished. Hua balked, however, when Lawrence began to insist that Hua wear the latex cat suit around-the-clock. Lawrence told her it was because he couldn't stand to see or feel any irregularities on her skin. When the therapist met with Lawrence alone, Lawrence stated, unprovoked and in a deadpan manner, that he loved their cats more than Hua—the reason being that he understood cats. When the therapist shared with Hua and Lawrence the diagnosis she had given Lawrence, Hua recognized autism spectrum syndrome as an innate problem that wasn't going to change unless Lawrence made great effort. For his part, Lawrence refused to stop insisting that Hua wear a latex suit. Hua felt her decision now was whether or not to wear the latex cat suit or exit the marriage.*

Treatment

Treatment of sexual problems co-occurring with mental illness varies, of course, depending on the presenting sexual problem; the comorbid diagnosis; the individual's and partner's response to the comorbid diagnosis; and the severity of the problems. Before addressing the sexual problem directly, the therapist will need to help the couple to understand the comorbid diagnosis to ensure that they understand that there is another potential contributing factor. The couple will need to know how the diagnosis might contribute to the sexual problem and impact the treatment options.

When considering treatment options, another question may arise, which is whether the couples therapist will treat the comorbid problem as well as the sexual problem. Problems like mild depression or anxiety often can be treated with short-term cognitive-behavioral therapy or even self-help resources, but other problems, like PTSD, generally require intensive individual treatment. If the couples sex therapist determines that individual therapy must precede couples therapy, then she or he needs to make appropriate referrals. Before initiating a long delay in couples therapy, the couple may benefit from a few joint sessions, during which they can get support and process their feelings about the diagnosis. Couples sex therapy can then recommence once the comorbid problem has been treated.

There are several common sex therapy interventions for couples in which one (or perhaps both) partners are struggling with a comorbid mental disorder.

Education

Couples need good information to be able to separate what is a relationship problem and what is an individual problem. For example, when a partner is depressed and not feeling like having sex, it can be helpful to remember that not enjoying sex is a *symptom* and not a way of withdrawing love from the partner. Couples can learn other ways of being physically intimate when intercourse requires too much mental or emotional energy.

Roles

Couples need to be made aware that taking on patient-caregiver roles is generally not a sexy arrangement. To that end, couples need to be in agreement regarding who is in charge of managing symptoms. Whenever possible, the individual with the diagnosis should take primary

responsibility for his or her own care (with support as needed from the partner) to avoid the partner taking on the primary role as caregiver. For example, if one partner has ADHD, the couple may agree that the diagnosed individual is in charge of making decisions regarding which prescribing doctor he or she will see and what medication he or she will take, but the other partner will support those efforts by ensuring that the medications are ordered and available, as these are details that are particularly difficult for the individual with ADHD to manage.

Communication

Couples may determine that scheduling a weekly check-in regarding the mental illness diagnosis, especially in the initial stages of treatment, may help them both learn more about the problem and how they can each make things better. Couples also may wish to develop "shorthand" phrases to use, for example, to remind a spouse that they need to exercise or meditate more or even to remind a spouse to back off or stop intruding. They also may need to consciously check in about how sex is going and be willing to make adjustments to keep their sex life satisfying.

Stress

Stress is a sexual desire killer, and it also may exacerbate the symptoms of mental illness. Couples can mitigate the effects of many mental health problems by diminishing stress and its effects. A couple may decide to develop streamlined routines, get additional family or other support, or cut down on outside activities. The non-diagnosed partner also may need to develop separate individual activities or support for when the diagnosed partner is feeling less well or is in a difficult phase of his or her individual treatment.

Realistic expectations and acceptance

Couples need to understand that some difficulties may never completely disappear. In those specific cases, they need to know that the goal is management and not cure. They then can get some emotional distance on the problem, cherish what works well, and continue to support one another.

Broader sexual repertoire

Like many couples, those who have sexual difficulties related to a mental health problem need to broaden their ideas about what constitutes "sex." Rigid patterns—sexual or otherwise—often do not work well for those with mental illness, and they also can make sex one-dimensional. Couples can benefit from learning sensate focus exercises to diminish performance anxiety and increase sensuality (see Avery-Clark & Weiner, this volume); mindfulness to stay engaged during sexual and affectionate activity (see Barker, this volume); and "outercourse" activities such as frottage (rubbing one's genitals against the partner) or mutual masturbation. Outercourse can be used when the partner with a mental illness, such as depression, feels too tired or has low energy, as sometimes occurs during struggles related to healing or changes in medication.

Conclusion

Although there is little research on the topic of sexuality and mental illness, their interaction is likely to be a significant contributing factor to many instances of marital or relationship dissatisfaction. Therapists need to conduct a thorough mental health assessment, even when the

presenting problem is a sexual complaint. In cases in which the comorbid mental illness diagnosis is moderate to severe, appropriate referrals to an individual therapist or a psychiatrist may need to be made. Otherwise, the therapist must ensure that mild to moderate symptoms are appropriately addressed before commencing with couples therapy; that couples are united in understanding and supporting the affected partner; and that modifications are made to the couples' expectations and outcomes regarding their sex life going forward.

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23

Treating Sexual Problems in Cancer Patients and Survivors

Eric S. Zhou and Sharon L. Bober

Cancer Patients and Survivors

Over 14 million new cases of cancer are diagnosed annually across the world (Cancer Research UK, 2012). There are over 100 different types of cancer, all of which share the commonality of abnormal cells within the body dividing without control. Cancerous cells can begin in the skin or tissues (carcinoma); bone, cartilage, fat, muscle, blood vessels or other connective/supportive tissue (sarcoma); blood-forming tissue such as the bone marrow (leukemia); immune system (lymphoma and myeloma); or tissues of the brain and spinal cord (central nervous system cancers). Given this significant variation in cancer types, there is a broad array of treatment options for oncologists to consider, including surgery, chemotherapy, radiation therapy, hormonal therapy, immunotherapy, and stem cell or bone marrow transplant.

As a result of remarkable advances in the efficacy of these medical treatments, as well as increased awareness of early screening and preventive health practices, the majority of patients who are diagnosed with cancer will survive their disease (American Cancer Society, 2014). Therefore, there is a large and growing population of individuals who are faced with the prospect of adjusting to life post-treatment. Of particular concern for a sex therapist is that many of these survivors will continue to experience long-term physical and psychological side-effects of their cancer treatment that can impact their sexual functioning (Basson & Schultz, 2007). A thorough, though not exhaustive, list of possible side-effects of cancer treatment that a patient may report to their therapist as having an impact on their sexual health is presented in Table 23.1.

Impact of Specific Cancers on Sexual Functioning

Sex therapists must be cautious not to make the assumption that one cancer patient will present with the same sexual dysfunction as another cancer patient. In fact, it is prudent for the therapist to remember that two patients who have the same cancer diagnoses and received the same treatment (even at the same hospital) may report dramatically different side-effects of treatment and impact of treatment on their sexual health. It is critical to note that there is not a single cancer "type," and therefore, a sex therapist who intends to work with cancer patients should be prepared for the tremendous variation in the case presentations that they may see when treating cancer patients. To assist therapists who may be unfamiliar with the nuances of how cancer-directed treatments may differentially impact a patient's health, we will briefly outline

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Table 23.1 Cancer-directed treatment side-effects that can impact sexual health.

Male	*Female*	*Male and female*
Erectile dysfunction	Dyspareunia	Reduced libido
Dry/painful orgasm	Vaginal atrophy	Pain
Ejaculatory dysfunction	Loss of nipple sensation	Chronic fatigue
		Nausea/vomiting
		Lymphedema
		Urinary incontinence
		Bowel incontinence
		Scars
		Amputations
		Ostomies
		Problems with arousal
		Reduced sexual motivation
		Decreased body image
		Loss of sexual self-esteem

the most common health consequences of cancer-directed treatments for the most prevalent cancer diagnoses, thus reflecting the presentations of the patients you are most likely to encounter. Given the substantial efforts made by researchers in advancing medical treatments for cancer patients, it is possible that some of the information that is current as of this publication may become quickly outdated. Therefore, we strongly encourage ongoing consultation with the oncology professionals who have treated your patients and review of information from the National Cancer Institute (http://www.cancer.gov), the American Cancer Society (http://www.cancer.org), and the International Agency for Research on Cancer (http://www.iarc.fr).

Breast cancer

Around the world, more than 1.6 million cases of breast cancer will be diagnosed this year (Cancer Research UK, 2012). Treatment for breast cancer can involve a combination of surgery, chemotherapy, radiation therapy, and/or hormone therapy, including the use of adjuvant therapy given after primary treatment has ended as a means of increasing long-term survival. Regardless of the choice the medical team and the patient make, it should be expected that treatment for breast cancer will impact the individual's sexual health afterwards (Bredart *et al.*, 2011; Katz, 2011). In particular, therapists working with breast cancer survivors should be aware that these treatments often result in a negative impact on libido, vaginal health (e.g., dryness and discomfort secondary to treatment-induced menopausal symptoms), orgasm, body image, sense of intimacy, and partner function (Dizon, 2009; Elmir, Jackson, Beale, & Schmied, 2010; Emilee, Ussher, & Perz, 2010; Katz, 2011).

Gynecological cancer

A therapist who encounters a gynecological cancer patient should immediately anticipate that her treatment has caused sexual dysfunction (Abbott-Anderson & Kwekkeboom, 2012). These women report more sexual problems than women in the general population (Lindau, Gavrilova, & Anderson, 2007), regardless of specific site of their gynecological cancer (e.g., endometrial, vulvar, cervical), treatment type, time from diagnosis, or age (Golbasi & Erenel, 2012; Wilmoth, Hatmaker-Flanigan, LaLoggia, & Nixon, 2011). Furthermore, sexual dysfunction secondary to gynecological cancer treatments often worsens over time (Rodrigues *et al.*, 2012), so a therapist working with a gynecological cancer survivor should discuss time since treatment.

Surgery (e.g., hysterectomy, salpingo-oophorectomy, etc.) is a common component of treatment for gynecologic cancers and can result in long-term sexual health issues including pain, loss of sensation, changes in body image, vaginal dryness, and difficulty reaching orgasm (Carter, Stabile, Gunn, & Sonoda, 2013), and can trigger premature menopause symptoms including dyspareunia and low libido (Parker, Jacoby, Shoupe, & Rocca, 2009). Many gynecological cancer patients also receive pelvic radiation, which additionally can have a significant negative impact on vaginal health, including long-term damage to vaginal tissue (Jensen *et al.*, 2003). Therapists should also be aware that gynecological cancer patients may present with difficulty related to negative changes in their feelings of femininity, mood, self-esteem, and relationship function that can be connected to their cancer treatment (Afiyanti & Milanti, 2012; Akyuz, Guvenc, Ustunsoz, & Kaya, 2008; Burns, Costello, Ryan-Woolley, & Davidson, 2007; Cleary & Hegarty, 2011; Gilbert, Ussher, & Perz, 2011; Greenwald & McCorkle, 2008). Many gynecological cancer survivors, like breast cancer survivors, feel a sense of being "damaged," and these changes can be hard to talk about.

Prostate cancer

Typically, prostate cancer patients undergo treatments that can include surgery, radiation, and/or hormonal therapy, all of which generally impair sexual function (Helgason *et al.*, 1996; Litwin *et al.*, 1995; Stanford *et al.*, 2000). Following their treatment, survivors commonly report symptoms such as erectile dysfunction, dry orgasms (i.e., orgasms without ejaculation), urinary incontinence during orgasm, decreased satisfaction with orgasm, decreased penile length, and avoidance of sexual activities (Choi, Nelson, Stasi, & Mulhall, 2007; Dubbelman, Dohle, & Schroder, 2006; Elliott *et al.*, 2010; Fraiman, Lepor, & McCullough, 1999; Gacci *et al.*, 2009; Gontero *et al.*, 2007; Guay & Seftel, 2008; Koeman, Van Driel, Weijmar Schultz, & Mensink, 1996; Lips, Van Gils, Van Der Heide, Boeken Kruger, & Van Vulpen, 2009; Mitchell, Jain, Laze, & Lepor, 2011; Munding, Wessells, & Dalkin, 2001; Nilsson *et al.*, 2011; Penson *et al.*, 2005; Potosky *et al.*, 2002; Sanda *et al.*, 2008; Savoie, Kim, & Soloway, 2003; Schover *et al.*, 2002; Tal *et al.*, 2009). In particular, for men who are placed on a hormonal regimen that blocks testosterone, known as androgen deprivation therapy (ADT), sexual changes are very severe. These men are essentially chemically castrated in order to manage aggressive prostate disease, and the sexual side-effects are pronounced. These include body feminization, profound loss of libido, hot flushes, and emotional lability, in addition to erectile dysfunction (Alibhai, Gogov, & Allibhai, 2006; Holzbeierlein, McLaughlin, & Thrasher, 2004). A sex therapist should be aware that sexual recovery for prostate cancer survivors is often a lengthy process and can take 18 to 24 months after cancer treatment ends (Bianco, Scardino, & Eastham, 2005; Penson *et al.*, 2005; Schover, 1993). Unfortunately, for some prostate cancer survivors, sexual function never completely returns to pre-cancer baseline (Litwin *et al.*, 1999). It has also been shown that, even for men who do experience some recovery of sexual function, they can continue to endorse sexual bother, indicating that their perception of sexual health may not be entirely tied to performance (Benedict *et al.*, 2014; Parker, Wang, He, & Wood, 2011) and that other perceived changes continue to be distressing longer-term.

Testicular cancer

Testicular cancer is the most common cancer among young adult men (Jemal *et al.*, 2011) and is typically treated with surgery (orchiectomy) first, possibly followed with radiation therapy or chemotherapy (Albers *et al.*, 2011, 2015; Laguna *et al.*, 2001). Sexual problems commonly reported by testicular cancer survivors include difficulties with sexual desire, ejaculatory difficulties, and erectile dysfunction (Brodsky, 1995; Dahl *et al.*, 2007; Jonker-Pool *et al.*, 2001;

Kuczyk, Machtens, Bokemeyer, Schultheiss, & Jonas, 2000). As a result, these men often report reductions in sexual activity levels and general sexual dissatisfaction following treatment (Nazareth, Lewin, & King, 2001; Rossen, Pedersen, Zachariae, & von der Maase, 2012). Testicular cancer survivors also may be self-conscious about changes in testicular appearance and perceived loss of masculinity.

Bladder cancer

Treatment for bladder cancer is most commonly surgery, with alternative options including radiation therapy, immunotherapy, and chemotherapy. For men, standard radical cystectomy (i.e., removal of the bladder and surrounding tissue and organs) is often associated with the loss of sexual function, most notably erectile dysfunction (Zippe, Raina, Massanyi, *et al.*, 2004). For women, radical cystectomy is also likely to create prominent sexual dysfunction, including reduced libido, dyspareunia, decreased lubrication, and diminished ability or inability to achieve orgasm (El-Bahnasawy *et al.*, 2011; Zippe, Raina, Shah, *et al.*, 2004). Therapists should also consider that surgical treatments for bladder cancer can result in urinary diversion, which is associated with body image concerns for both men and women (Bjerre, Johansen, & Steven, 1997; Hart *et al.*, 1999; Rosen, Taylor, Leiblum, & Bachmann, 1993; Weijmar Schultz, Van De Wiel, Hanh, & Bouma, 1992).

Head and neck cancer

Treatment for head and neck cancers (including surgery and radiation therapy) can cause significant disruption in sexual function and intimate interactions. Facial disfigurement, as well as persistent changes to saliva quality and/or quantity, breathing and speech (Bjordal *et al.*, 2000) can have an enormous impact on experiences such as kissing and oral sex, which need to be addressed (Breitbart & Holland, 1988). Therapists must consider not only the implications that these changes may be having on the social relationships of their patients, but also on body image and sexual self-esteem (Gamba *et al.*, 1992; Gritz *et al.*, 1999; Meyers, Aarons, Suzuki, & Pilcher, 1980; Moreno *et al.*, 2012).

Hematological malignancies

For those diagnosed with hematological malignancies (leukemias and lymphomas), chemotherapy, total body irradiation, stem cell transplantation, and even the placement of a central venous catheter can impact body image, intimacy, and sexuality (Chatterjee, Kottaridis, McGarrigle, & Linch, 2002; Milroy & Jones, 2010; Moller & Adamsen, 2010; Yi & Syrjala, 2009). Male survivors may report erectile dysfunction, female survivors may report vaginal dryness, and both males and females may report pain and difficulty with orgasm (Humphreys, Tallman, Altmaier, & Barnette, 2007; Liptrott, Shash, & Martinelli, 2011; Milroy & Jones, 2010; Slovacek *et al.*, 2010).

Childhood cancer

Adult survivors of childhood cancer are a small but growing population thanks to significant advances in cancer care. Those diagnosed with cancer at a young age are exposed to treatments that can have a significant and lasting impact on psychosexual development. Physically, treatment during critical developmental periods can impair hormonal, vascular, genito-urinary, and neurological function, placing these survivors at risk for both sexual dysfunction (Bober *et al.*, 2013; Green *et al.*, 2009a, 2009b; Jacobs & Pucci, 2013; Schover, 2005; Tromp *et al.*, 2011) and infertility (Kenney *et al.*, 2012; Zebrack, Casillas, Nohr, Adams, & Zeltzer, 2004).

These physical complications may also be accompanied by a sense of social isolation, and childhood cancer survivors can have marked challenges with sexual behavior development due to delays in dating and social experimentation (Gurney *et al.*, 2009; Hall *et al.*, 2012; Noll, Bukowksi, Rogosch, LeRoy, & Kulkami, 1990; Puukko *et al.*, 1997; Ropponen, Siimes, Rautonen, & Aalberg, 1992; Sundberg, Lampic, Arvidson, Helstrom, & Wettergren, 2011; van Dijk *et al.*, 2008). For adult survivors of childhood cancer, it is important for the sex therapist to be attuned to previous developmental experiences, or lack thereof, and to address these potential issues. Therapists may need to consider current sexual problems in the context of a survivor's earlier developmental challenges.

Treatment Model for Cancer Patients and Survivors

There are a number of models that can guide a therapist through the assessment and treatment process with cancer survivors (Annon, 1976; Hordern, 2008). One that offers a direct model for communication about sexuality, and that can be readily employed within a therapeutic setting, is the Five A's Framework (Park, Norris, & Bober, 2009). This counseling model emphasizes five key components during the treatment process: Ask, Advise, Assess, Assist, and Arrange.

First, the therapist must ensure that all of the cancer survivors they treat are *Asked* about sexual health. It is important that the therapist takes a non-judgmental approach and uses open-ended questions that avoid medical jargon. For example, a question such as, "Sexual problems after cancer are very common, how has treatment affected your sex life?" validates the problem and gives the patient permission to address this topic. Second, the therapist needs to signal a willingness to *Advise* the patient. It is crucial to let patients know that these problems are not only normal but also that help is available. Next, the therapist must adequately *Assess* the problem by conducting a thorough review of the patient's medical history, as well as a standardized assessment that identifies symptoms, in order to initiate further discussion and treatment recommendations. Patients can then be *Assisted* through therapeutic efforts, which can include offering ongoing psychotherapy; delivering resources such as information sheets, educational books, and websites; and referring to medical professionals that can support the therapeutic efforts. Finally, therapists need to *Arrange* follow-up. It is critical that patients receive routine follow-up so that the progress that is made is not lost over time. In addition, this will support the efforts that the therapist makes towards ensuring that patients follow through with their treatment recommendations.

Ask and Assess: conducting a thorough patient assessment

It goes without saying that any effective interventions for sexual dysfunction should follow a thorough assessment of the patient's concerns as they relate to sexual health. However, we believe that this step is of particular importance in the cancer population and is deserving of further attention than the therapist may normally provide. This is because a therapist who is working with a cancer survivor should not be surprised if the patient has not had the opportunity to disclose their sexual health concerns with their medical team previously. The literature has consistently demonstrated that cancer patients will rarely discuss issues of sexual function with medical providers (Park, Bober, *et al.*, 2009), meaning that this may be the first opportunity that the patient/survivor has had to truly explore the impact of treatment on their sexual health.

This unfortunate state of affairs is generally not due to a lack of attention or care on the part of medical providers during cancer treatment. Understandably, the treatment team is initially concerned with survival, and therefore the short- and long-term sexual health consequences of their treatments are simply not always at the forefront of the physician's thought processes (Cox, Jenkins, Catt, Langridge, & Fallowfield, 2006; Stead, Fallowfield, Brown, & Selby, 2001).

Once this initial opportunity for conversation has passed, it can continue to be a challenge for medical providers to bring up sexual concerns. Medical professionals concede that they do not often initiate discussions of sexual health with their patients. Providers describe various barriers including lack of time, lack of preparation and training to discuss sexual health, and concern about making their patients uncomfortable (Bober *et al.*, 2009; Park, Bober, *et al.*, 2009). For example, the overwhelming majority of providers treating women with ovarian cancer indicated that they did not discuss sexual issues, despite acknowledging that these patients were likely to experience some form of sexual dysfunction following treatment (Stead, Brown, Fallowfield, & Selby, 2003). Like their colleagues in oncology settings, medical providers within the primary care environment are also unlikely to discuss sexual health. In a survey of primary healthcare physicians, more than half said that they were unlikely to initiate a conversation about sexual dysfunction with their patients, and consequently, over 60% of providers reported that they "never" or "rarely" addressed sexual dysfunction issues during patient appointments (Bober *et al.*, 2009). Even when discussions do occur, they are often limited to the discussion of functional status, and rarely do issues related to the impact of sexual dysfunction on mood, quality of life, relationship functioning, and so on, get discussed (Hordern & Street, 2007a, 2007b). Given that your patient is unlikely to have had a thorough discussion of sexuality with his or her medical team, it is vital that you, as the therapist working with a cancer survivor, first collect as much information as possible regarding the sexual health status of your patient.

Paper and pencil tools It is often helpful to collect self-report questionnaire data from the patient to provide a brief assessment of sexual function, and to help to start the conversation about which areas may require further evaluation and targeted assessment. Therapists can utilize the patient's responses as a starting point for a more thorough conversation about endorsed dysfunction. In addition, screening tools can serve as a more objective measure of progress throughout the course of therapy. Completing measures at regular intervals of time can help to track whether therapy has been effective.

Therapists can consider several easily accessible and widely utilized instruments for the evaluation of sexual dysfunction. For female patients, the Female Sexual Function Index (FSFI) (Rosen *et al.*, 2000) is a widely used, well-validated, 19-item self-report measure originally developed to assess female sexual function in women of any age, including pre- and postmenopause, in the general population. It takes approximately 15 minutes to complete. The scale assesses function over the past month in several domains—desire, arousal, lubrication, orgasm, satisfaction, and pain (Corona, Jannini, & Maggi, 2006)—and has been utilized and validated in cancer patients and survivors (Baser, Li, & Carter, 2012; Jeffery *et al.*, 2009). Those seeking further information about this scale can find additional resources at www.FSFIquestionnaire.com (Rosen *et al.*, 2000). In male patients, providers can consider the International Index of Erectile Function (IIEF; Rosen *et al.*, 1997). The scale is a 15-item self-report measure developed to assess erectile function in men in the general population and has been utilized in studies with cancer patients and survivors, particularly with prostate cancer populations (Jeffery *et al.*, 2009). The IIEF measures function over the past month in the following domains: erectile function, orgasm, desire, intercourse satisfaction, and overall satisfaction. Therapists should be aware that there are a large number of other sexual function measures available. When making a decision as to which measure to utilize, the validity and reliability of the measure, as well as the time it takes to complete and the breadth of the assessment, are crucial factors for the therapist to consider.

Clinical evaluation You may work with some patients whose stated presenting problems are sexual dysfunctions secondary to cancer treatment. It is also likely that you will encounter patients who present with relationship or sexual dysfunction, and you may have to connect the dots to relate their current sexual experiences to previous cancer treatment, which may have

occurred years before. Rest assured that, if this is the case, most patients want to understand how changes in sexual function and intimate relationships may be related to previous cancer treatment, and are generally relieved to discuss this issue with clinicians (Bruner & Boyd, 1999; Hordern & Street, 2007a; Stead *et al.*, 2001).

As part of the initial steps in the five A's framework discussed earlier (*Ask, Assess*), a brief but focused medical history can help to flesh out the patient's specific sexual concerns. The following questions can help to initiate a conversation that will provide valuable details about sexual dysfunction:

- It is common that cancer treatment can affect sexual health in many ways. Have you experienced sexual changes or sexual problems since undergoing cancer treatment?
- Have you experienced changes in your sexual desire, arousal, or orgasm?
- Are you experiencing pain with sexual activity or do you avoid sexual activity because of pain?

These queries are purposefully broad to invite further discussion. In addition, it can be important to consider additional consultation with your patient's oncology team. There may be details of your patient's cancer-related recovery that can either facilitate or impede your efforts during treatment, which can only be understood within the context of a biopsychosocial model of treatment. For example, it may be helpful for therapists to consult with the oncology team around an expected course of hormone therapy or to obtain a more detailed understanding of the impact of pelvic radiation. Unlike other sex therapy patients, who may present with a primarily psychosocial difficulty that impairs sexual health, many cancer survivors are very much physically limited by their previous treatments, and it is valuable to acknowledge the full extent of this impairment as you strategize your treatment approach.

Advise and Assist: treatment strategies

Men Addressing the sexual health symptoms that are commonly reported by male cancer survivors often involves collaboration with medical professionals (e.g., urologists) due to the physical side-effects of cancer treatment. Their sexual dysfunction presents as a biopsychosocial challenge (Bober & Varela, 2012) that requires multidisciplinary management from physicians, nurses, physical therapists, and therapists who can work together in treating both the physical and psychological consequences of cancer treatment (Peltier, van Velthoven, & Roumeguere, 2009; Walker & Robinson, 2012; Wittmann, Foley, & Balon, 2011). Thus, a key role that the sex therapist can play during their treatment is the facilitation of improved communication about sex between the patients and their medical providers, with whom the men have probably had minimal interaction regarding medical options for sexual dysfunction.

First and foremost, a sex therapist is likely to encounter erectile dysfunction in their male cancer survivor population. To treat erectile dysfunction, oral phosphodiesterase type 5 (PDE-5) inhibitors are commonly used as the first-line treatment, as they are effective and less invasive than other medical interventions (Yuan *et al.*, 2013). Unfortunately, there are a number of men who discontinue PDE-5 inhibitor use for a variety of reasons, including physical side-effects (e.g., headache, muscle pain, dyspepsia, facial flushing, etc.) and psychological concerns (e.g., anxiety about medication use; Carvalheira, Pereira, Maroco, & Forjaz, 2012; Gresser & Gleiter, 2002). For men who have psychological concerns, a sex therapist can play an active role, in conjunction with the medical team, in facilitating medication adherence. Common psychological barriers that arise include concerns about medication dependence, difficulty with having to plan or schedule romantic encounters, and a fear that use of medication represents a loss of masculinity or virility. It is important for the therapist to evaluate whether these, or other psychological concerns, are impacting the willingness of the patient to continue PDE-5 inhibitor use and to address these concerns accordingly.

If oral PDE-5 inhibitors fail for physiological reasons, intracavernous injection therapy, transurethral alprostadil, and vacuum erection devices are alternative treatment modalities, which the patient can consider. Intracavernous injection therapy is effective in up to 85% of individuals who report erectile dysfunction (Baniel, Israilov, Segenreich, & Levine, 2001; Dennis & McDougal, 1988; Raina *et al.*, 2003), and those who are adherent to treatment report increases in sexual activity (Virag, Shoukry, Floresco, Nollet, & Grecco, 1991) and improvements in sexual satisfaction (Sidi, Reddy, & Chen, 1988; Virag *et al.*, 1991). Unfortunately, intracavernous injection therapy is often anxiety-provoking for patients, and up to half of patients who are offered this treatment either refuse or stop treatment over the first six months (Mulhall *et al.*, 1999; Polito, d'Anzeo, Conti, & Muzzonigro, 2012). Often, the prescribing medical team has trained staff who can provide psycho-education to address some of this anxiety. In addition, your role as a sex therapist could be to conduct desensitization therapy focused around the continued use of injection therapy to address erectile dysfunction.

In addition to erectile dysfunction, men who undergo hormonal therapy, specifically androgen deprivation therapy (ADT) for treatment of prostate cancer, typically experience a marked decrement in libido. This is a particularly difficult side-effect of treatment to address, as medical options, such as increasing testosterone levels, would be counter to the cancer-control purposes of hormone therapy. There has been recent interest in investigating the role of estrogen in restoring libido among men undergoing hormone therapy (Wibowo, Schellhammer, & Wassersug, 2011). However, until medical advances become available to address this problem, the sex therapist can play a vital role in the recovery of libido. To date, behavioral and psychological interventions designed to improve a couple's communication, reduce relationship distress, broaden the definition of sexual activity beyond just intercourse, and improve coping skills are the best available resources to support the patient and their partner (Badr & Krebs, 2013; Beck, Robinson, & Carlson; Chambers, Pinnock, Lepore, Hughes, & O'Connell, 2011; Chambers *et al.*, 2013; Chisholm, McCabe, Wootten, & Abbot, 2012; Siddons, Wootten, & Costello, 2013).

Ultimately, as these men are not likely to recover sexual function to their pre-cancer baseline, it is the work of the sex therapist to help them understand and accept that cancer has forced them to write a new chapter in their sexual history. Although there are a number of medical options that can help to facilitate some recovery of function, the distress associated with changes in function—and the possible relationship dynamics that result—are often more problematic than the dysfunction itself, and these issues represent the core of the work for the sex therapist.

Women Similar to male survivors, the first avenue for female patients is to ensure that they have explored all medical avenues possible to help improve function. As discussed previously, cancer survivors do not generally have these conversations with their medical providers, so it is important for sex therapists to ensure that their patients have done their due diligence to maximize their physical recovery from cancer treatment.

One of the most commonly reported post-cancer treatment symptoms for women is vaginal dryness. Vaginal dryness, and ultimately vaginal atrophy, are not only debilitating for women because of physical consequences such as pain, chafing, and bleeding, but are also directly implicated in loss of sexual desire. More specifically, the therapist can explain that alleviation of vaginal dryness and, in turn, dyspareunia, with vaginal lubricants and/or moisturizers, can have a positive impact on the sexual response, such as increased desire, subjective arousal, and ability to reach orgasm, which may, in turn, lead to improved sexual satisfaction and well-being (Madalinska *et al.*, 2005; Robson *et al.*, 2003; Zhou, Falk, & Bober, 2015). First-line treatment for dryness includes vaginal lubricants and moisturizers. Many patients are not familiar with the difference between these two types of products; however, there are distinct rationales for use of each. Vaginal lubricants are used to provide topical lubrication and promote comfort during

sexual activity. In the majority of instances, we recommend the use of water- or silicone-based vaginal lubricants. If the patient uses these lubricants properly, it can help to prevent irritation and potentially avoid mucosal tears. We caution against the use of petroleum-based lubricants as they can damage latex condoms, making them ineffective in preventing pregnancy or protecting against sexually transmitted infections (European Working Group on HIV Infection in Female Prostitutes, 1993). Unlike lubricants, vaginal moisturizers are intended to be used consistently for overall vaginal comfort and are not used on an as-needed basis for sexual comfort. Moisturizers hydrate the vaginal mucosa and improve the balance of intracellular fluids in the vaginal epithelium. For female cancer survivors who experience regular vaginal dryness, vaginal moisturizers should be used as a regular part of their self-care regimen to promote vaginal health. There are many different vaginal moisturizers that are commercially available. Evidence indicates that that the benefit of a vaginal moisturizer depends upon regular usage, rather than on a specific formula. It should be noted that some female cancer survivors may need to administer vaginal moisturizers up to five times per week due to the severe nature of estrogen deprivation experienced with cancer treatments, and the moisturizers should be applied at bedtime for optimal absorption. Sex therapists may play a key role in ensuring adherence to the routine, especially given that some women complain that the regular use of vaginal moisturizers is messy. In addition, therapists should consider helping their female patients explore the use of vaginal suppositories containing hyaluronic acid (Costantino & Guaraldi, 2008; Ekin *et al.*, 2011; Rosenbaum, 2007), or vaginal moisturizer suppositories containing hyaluronic acid with vitamins A and E (Costantino & Guaraldi, 2008), as hyaluronic acid is effective at retaining moisture. Further investigation in cancer patients is necessary at this time for these approaches.

Therapists working with sexual dysfunction in female cancer survivors should also consider discussion of improving pelvic muscle floor strength and tone and vaginal elasticity, which have been associated with reductions in vaginal pain (Goldfinger, Pukall, Gentilcore-Saulnier, McLean & Chamberlain, 2009; Tu, Holt, Gonzales, & Fitzgerald, 2008) and better sexual functioning (Schroder *et al.*, 2005). Many women can learn to tense and relax the muscles around the vaginal introitus by modifying standard Kegel exercises to be more challenging by increasing the length or number of repetitions of the muscle contractions. If a woman is noted to have difficulty with pelvic floor muscle contractions, physical therapy can be helpful in determining if a pelvic floor dysfunction exists and providing treatment. Women may be taught by a knowledgeable sex therapist to do pelvic floor muscle exercises on their own or may be referred to a pelvic physical therapist if the patient struggles to do the exercise on their own.

In addition, therapists of female survivors can consider the use of vaginal dilator therapy, particularly following pelvic radiation. The goal is to maintain vaginal length and caliber after radiation therapy by preventing agglutination (i.e., adherence) of the vaginal walls. Long-term dilator use after pelvic radiation therapy may be important to prevent fibrosis and ensure overall vaginal health (Denton & Maher, 2003; Miles & Johnson, 2010). Sex therapists versed in the use of vaginal dilator therapy can help to instruct women on the process of controlling tension and relaxation in the pelvic floor muscles and decreasing friction, which can contribute to pain and tissue inflammation (Denton & Maher, 2003). Encouraging women as they progress through dilator therapy is a component of the work that a therapist will do; through this therapy, a survivor can develop confidence, understanding, and a sense of control over the insertion of objects into her vagina without pain—an important step for tolerating sexual activity.

Couples Often sex therapists are presented with relatively straightforward sexual problems, as previously discussed. However, at times, therapists may instead find themselves confronting relationship distress (Badr & Taylor, 2009; Zhou *et al.*, 2011) or poor communication

(Garos, Kluck, & Aronoff, 2007) rather than a sexual problem as the primary presenting issue. In such a situation, it may be particularly helpful to consider the incorporation of the "cancer dyad" into any discussion that involves sexual functioning (Soloway, Soloway, Kim, & Kava, 2005). That is, inclusion of both the patient and their partner in the clinical assessment can be very important in revealing how the cancer experience has impacted intimacy for the couple as a dyad, not just for the cancer survivor. For example, couples may struggle with the transition from patient and caregiver to partners or lovers. Alternatively, couples may find that they have progressively grown apart emotionally and physically because they were initially trying to protect each other by keeping their cancer-related fears and sadness to themselves. Next steps can then take the form of structured couples and/or sex therapy interventions, or a more loosely organized intervention that incorporates themes of relationship functioning into the therapeutic process as needed. Evidence indicates that the presence of both partners in any treatment program is beneficial for both individuals during the cancer recovery process (Manne, Ostroff, Winkel, Fox, & Grana, 2005; Scott, Halford, & Ward, 2004), and it will be important to consider and address how relationship dysfunction (e.g., disagreements over sexual expectations) may be impacting the course of therapy.

Arrange: working in collaboration with other providers to provide follow-up

As noted above, sexual dysfunction within cancer populations occurs in a broader context in which medical, psychological, and interpersonal factors are often all relevant. As sexual problems after cancer are often multidimensional (e.g., vaginal dryness leading to pain and loss of desire, which in turn impacts relationship dynamics), we again emphasize the role that a sex therapist plays in helping the patient to navigate and integrate ongoing care related to these challenges. Thus, it is important that the sex therapist creates a multidisciplinary referral list of specialists that can assist during the course of their sex therapy and in the follow-up after therapy. Collaborative relationships developed across disciplines and within the community are crucial so that, when a problem is identified, established resources are available. A list of non-mental health professionals that may provide key elements an integrative treatment plan includes:

- urologists and uro-gynecologists who specialize in sexual medicine
- gynecologists
- pelvic floor physical therapists
- primary care physicians
- endocrinologists
- cardiologists to address potential cardiac side-effects of PDE-5 inhibitor use in the treatment of male erectile dysfunction.

Case Example

Donna (51 years old) and her husband, Chuck (56 years old), explained on their first visit that they are interested in some couples consultation in light of growing tensions in their marriage. Donna had recently found a ticket stub from a "gentlemen's club" in another city that Chuck must have attended when he was away on a recent business trip. She was very distressed to make this discovery. She also explained that she and Chuck had been in a "sexless marriage" for many years and that, besides feeling angry, she was also feeling guilty that perhaps their lack of intimacy "drove him to do this."

You agreed to see them and started by scheduling an individual appointment with each partner. At Donna's initial individual visit, you took a thorough sexual history. You learned that she and Chuck

had a relatively active sex life from the time that they were married until they had their second child. At that point, regular intimate activity slowed down and never returned to quite the same level of frequency or satisfaction as it had been before kids. Twenty years into their marriage, Donna was diagnosed with breast cancer at age 45. She explained that she was successfully treated with surgery, chemotherapy, and radiation and had bilateral breast reconstruction with implants. Donna also recently completed five years of hormone therapy (Tamoxifen) to lower her risk of recurrence. She noted that, since her treatment, she had really lost interest in sex. In her words, "I'd rather read a book; I just don't think about it anymore." Upon further inquiry, she explained that, although she and Chuck did attempt to have intercourse two or three times after treatment ended, it was very "difficult." She experienced vaginal bleeding, and it was "just too painful." Chuck understandably did not want to hurt her, so within a short time, they essentially gave up trying. She also noted that, since that time, she had also had difficulty getting a gynecological exam because it was "excruciating," and she occasionally had some itching and chafing, which she found irritating.

From the point of view of a sex therapist completing an initial evaluation and consultation, it should be observed that Donna is, in part, describing the consequences of undergoing treatment-induced menopause at the age of 45. Treatment-induced menopause can be abrupt, with a dramatic and steep loss of estrogen. Although the depletion of estrogen is important to lower the risk of cancer recurrence, vaginal tissue also thrives on estrogen. When vaginal tissue is estrogen-deprived, there is marked loss of natural moisture, elasticity, and blood flow to the vaginal walls, and these changes ultimately result in vaginal atrophy. When there is atrophy, the vaginal walls become thinner, dryer, and often inflamed, and penetration can become prohibitively painful. Unless women actively replace moisture and restore elasticity and blood flow to the vaginal tissue, this atrophic state only worsens over time. Although there are likely many factors at play with Donna and Chuck, it is unfortunate that it seems Donna did not receive enough information about treatment-induced menopause from her oncology team. In particular, it appears that Donna was not educated about how to address vaginal health after breast cancer. Unfortunately, she has likely been struggling with untreated vaginal atrophy for years. From the perspective of a biopsychosocial approach, it is important for Donna to get the information she needs about restoring vaginal health so she can increase function, reduce pain, and begin to regain a sense of confidence in her body. More specifically, it is essential that Donna learns about how to restore moisture, elasticity, and increased blood flow to vaginal tissue because these symptoms do not improve independently and, in fact, typically worsen over time. It would be helpful to give Donna a resource such as the American Cancer Society's booklet *Sexuality and cancer: For the woman who has cancer and her partner* (Schover, 2001), which has detailed information about sexual renewal after cancer. She may also benefit from seeing a pelvic floor physical therapist who can help to manage atrophy by employing a range of strategies, such as manual manipulation and biofeedback to help increase awareness of the pelvic musculature. Moreover, it may be helpful to encourage Donna to communicate with her oncology team so that they are aware of the work she is doing to manage her sexual dysfunction. This potentially could be vital in the future if Donna has other medical challenges that arise; if that occurs, a cohesive team focused on addressing her sexual dysfunction will be needed.

As the sex therapist moves ahead with counseling the couple, it will also be imperative to query Chuck about his experience of changing roles from caregiver back to partner, as well as what it was like for him to be in a situation in which he felt that, by initiating sexual contact, he was potentially "hurting" Donna. Partners themselves often receive little, if any, guidance about how to help participate in sexual recovery. When couples have gone through a range of stressors pre-cancer and find that libido is already on the wane, often the symptoms of cancer-related sexual dysfunction feel overwhelming. In this context, couples feel defeated and retreat from intimacy altogether. In sum, although there may well be a range of other issues to work through, it is essential to bring awareness of this aspect of cancer survivorship care into the sex therapy.

Conclusion

Cancer survivors are at significantly elevated risk for the development of sexual dysfunction following treatment. These issues are often complex in nature, weaving together physiological, psychological, and social components that interact with one another. The clinical responsibilities of a sex therapist mirror this complexity, as the therapist may play various roles including traditional therapist, patient navigator, health information psycho-educational expert, and relationship counselor. Therefore, any treatment approach must include a thoughtful and thorough evaluation of dysfunction and subsequent collaboration with other professionals who will help your patient to resolve their sexual health issues using a multifaceted approach (Sanchez Varela, Zhou, & Bober, 2013). For so many cancer survivors, you are the first professional with whom they have had an opportunity to discuss, in detail, their sexual dysfunction that was either caused by cancer treatment or that cancer treatment worsened. Even modest interventions can have enormous potential benefit for, not only the targeted symptoms, but also overall quality of life for the patient and their partner. Given the multiple challenges that many cancer survivors face following treatment, it is unfortunate that so many suffer from sexual dysfunction, which can be improved. You have an exceptional opportunity to reshape the cancer recovery process for a patient who stands to benefit so greatly from your efforts.

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24

Treating Sexual Problems in Survivors of Sexual Trauma

Kathryn S. K. Hall

Treating the Sexual Consequences of Childhood Sexual Abuse: A Not So New Frontier for Sex Therapy

Joe and Brenda sat nervously together during our first meeting. The presenting problem was Brenda's lack of desire, and she had recently told Joe that she was not going to have sex with him (or anyone else) ever again. This declaration provoked a crisis in a marriage that had been sputtering along for years. Joe, an athletic man in his mid-40s, was devastated. He loved Brenda and wanted to stay married to her. Joe was convinced that Brenda's absent desire was the result of the incest she had suffered 30 years previously. When I asked Brenda if she thought the incest affected her current sexuality, she haltingly replied, "I don't think so."

Who is right? Is Brenda's history of incest interfering with her sexual desire and enjoyment as Joe believes? Or perhaps there are other, more immediate factors contributing to this 42-year-old woman's rather startling declaration that she no longer wants to be sexual.

As a high school freshman, Frank was sexually abused by his basketball coach. Frank grew up terrified that he too would become a child molester. After all, wasn't this the pattern? Don't men who are sexually abused become abusers? Convinced that this was his destiny unless he took drastic measures, Frank abstained from all sexual activity as an adolescent, except for occasionally masturbating. After graduating from college, he married Catherine, who had been impressed with Frank's willingness to refrain from sex before marriage, which had been her wish as well. However, even once married, Frank continued to put restrictions on sex, making sure that his sexual behavior was always in check. Catherine complained that she did not feel desired and that sex was too infrequent. Frank felt that this was for the best.

Was he right to be fearful of his tainted sexuality? Or could he, as Catherine hoped, loosen the restrictions?

These two cases mirror some of the therapeutic dilemmas faced by clinicians treating men and women with a background that includes childhood sexual abuse (CSA). The questions arise: Is a history of sexual abuse always or irrevocably responsible for sexual problems? If not, when and how does sexual abuse in childhood affect adult sexuality? And regardless of whether CSA affects adult sexuality, does CSA affect the treatment process and prognosis for sexual problems in adulthood? It is these questions that this chapter will address.

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

Defining CSA: Legal, Clinical and Research Conundrums

CSA may be broadly defined as any act or acts in which an adult, older child or adolescent, or person in authority, uses a child for his or her own sexual gratification. Children may be defined as under the age of 18, 16, 14, or 12 years depending on the context in which sexual abuse is examined. CSA is a term used in various arenas—legal, clinical, and research. Although the terminology may be the same, the definitions often differ; thus, what is legally defined as sexual abuse may not match clinical criteria and vice versa. There is, for example, the highly publicized case of Genarlow Wilson in Georgia, who was sentenced to 10 years for aggravated sexual assault. At age 17, Genarlow was videotaped at a New Year's Eve party having consensual oral sex with a 15-year-old girl (Goodman, 2007). He served over two years in prison. Even though the girl acknowledged that the act was consensual, she was legally under the age of consent. Although legally the girl was a victim, clinically she was not. As a result of this and similar cases, many states have passed what is known as a Romeo and Juliet clause, such that an age difference of at least four years is required for the legal definition of sexual assault. Clinical and research definitions of CSA also often stipulate an arbitrarily defined age difference of four or five years to differentiate between childhood sex play, consensual sex between teens, and sexual abuse. However, there is no empirical evidence that age differences predict whether the experience is *perceived* as abusive (Rind & Welter, 2014). In therapy, sex between two teens or two children of similar ages may still be considered abusive by a clinical definition if one person was tricked, felt coerced, or was intoxicated or under the influence of drugs at the time. In the mental health field (including clinical settings and clinically relevant research), the legal definition of CSA does not need to be met for a history of abuse to be determined.

Peters, Wyatt, and Finkelhor (1986) differentiated activity-specific and relationship-specific definitions of abuse. Activity-specific definitions are based on behavioral parameters such as age or age disparity, sexual acts (penetrative vs. non-penetrative), and use of force. These definitions are often used in research, posed as questions such as, "Did you experience any of the following before age X?" It is sometimes important for research purposes to try to gauge the severity of abuse by determining whether there was penetration (vaginal, anal, or oral), use of force, young age, and/or close or familial relationship between the victim and perpetrator. However, relationship-specific definitions of abuse are more often used and useful in the context of psychotherapy (Rellini, 2014). These definitions essentially rest with the judgment and self-report of the patient—"I was sexually abused when I was a child"—and the severity of the abuse is likewise gauged by the patient's reactions and self-report.

Definitional problems may still exist even when using the self-report criterion. For example, a notorious case in the US involved a 34-year-old female teacher, Mary Kay LeTourneau, and her 13-year-old student, who were subsequently married after the teacher satisfied her jail sentence for statutory rape (Zernike, 2005). Although the young boy did not identify as a victim, it is hard not to think that his experience was abusive and to wonder if he might not have made different life decisions had he identified the relationship as such.

False memories represent yet another clinical conundrum. The term arose in the 1990s in response to allegations of sexual abuse that were "recovered" years or decades later during psychotherapy (Loftus, 1993). Although it is generally agreed that abuse may be forgotten, the notion of repression is highly problematic. In truth, it is difficult, if not impossible, for a clinician to determine the accuracy of a strongly held memory. Happily, this is not the task for a therapist. Instead, what is essential is that a therapist not diagnose CSA in the absence of patient report ("You behave like someone who was abused, perhaps you were and have repressed this memory?") and not engage in unethical practices that that have been shown to produce false memories, such as attempting to recover lost memories of sexual abuse using suggestive practices such as hypnosis or guided imagery (Garry, Manning, Loftus, & Sherman, 1996; Lindsay, Hagen, Read, Wade, & Garry, 2004). Likewise, it is equally problematic

to tell a patient that he or she was not abused when the patient identifies as an abuse survivor. If a patient believes he or she was abused, the clinical task is to help the person move forward in his or her life. CSA is not a diagnosis; it may be a relevant factor in the history of patients presenting with mood disorders, post-traumatic stress disorder (PTSD), or sexual problems, and it is these issues that are the focus of therapy. It is almost certainly more often the case that patients fail to disclose abuse that they remember (Goodman *et al.*, 2003; Hébert, Tourigny, Cyr, McDuff, & Joly, 2009) than that they misreport abuse that never occurred. Frequently it requires time, the building of a trusting therapeutic alliance, and the patient's understanding of the relevance of their abuse before they choose to mention it in therapy (Hall, 2006; Rellini, 2014).

Prevalence of CSA

It is generally agreed in the scientific community that CSA is a widespread and global concern. Two meta-analyses of studies on sexual abuse of children found a global prevalence rate of 18–19% for girls and slightly more than 7% for boys (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). In the US, approximately 28% of women and 10% of men report a history of sexual abuse prior to age 14 (Leonard & Follette, 2002). When abuse is broken down into penetrative and non-penetrative (i.e., fondling) experiences, 13% of women and 4% of men in the US report the former and 23% of women and 12% of men report the latter (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). Self-report surveys indicate that the risk for CSA extends into late adolescence,with lifetime prevalence rates of 27% for girls by the age of 17 years and 5% for boys by the same age (Finkelhor, Shattuck, Turner, & Hamby, 2014). The sexual abuse of gender dysphoric and sexual minority children is likely to be vastly underreported, and CSA may be more prevalent among those groups than in the general population, given their vulnerability to sexual assault in the context of (transgender and sexual orientation) bias crimes (Gehring & Knudson, 2005; Shipherd, Maguen, Skidmore, & Abramovitz, 2011). Children with disabilities and children in residential treatment facilities are also at increased risk of abuse, given their social isolation and difficulties communicating (Glaser, 2015).

Cultural differences in CSA prevalence

It has historically been assumed that there are no cultural or ethnic differences in the prevalence of sexual abuse; however, more recent epidemiological research challenges this assumption. Pereda *et al.* (2009) reviewed 65 articles covering 22 countries, and found the highest incidence of CSA in Africa and the lowest incidence in Europe. In reviewing CSA publications from six continents (excluding only Antarctica), Stoltenborgh *et al.* (2011) noted the highest prevalence for girls in Australia/New Zealand and for boys in Africa. The lowest prevalence for both genders was found in Asia. These results were essentially replicated when the meta-analysis was broadened to include more recent data (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2015). For girls, the prevalence rates of CSA in Australia and North America continued to be higher than those in Asia and Europe. For boys, the reported prevalence rates were again higher in Africa than in Asia, Europe, and North America. When looking at ethnicity as a moderator in North American studies on CSA (currently the only continent in which there are sufficient studies for comparison), Asians had the lowest rates of CSA, whites were intermediate, and black and Latino/Latina children had the highest rates (Kenny & McEachern, 2000; Stoltenborgh *et al.*, 2011).

It is unclear whether the difference in reported prevalence rates across nationalities and ethnic groups reflects a difference in rates of CSA or in rates of disclosure. Stoltenborgh *et al.*

(2011) noted that, across countries, the highest prevalence rates came from self-report data, whereas the lower rates came from data collected by child protective services. The difference in reported prevalence may reflect a difference in cultural attitudes towards reporting sexual abuse. In collectivist cultures in Asia, individuals may be reluctant to report abuse due to the impact a report would have on the family. The higher rates of reported CSA in Australia and New Zealand could conceivably be due to the individualistic nature of those societies, which emphasize individual wellbeing over concern for the group (Hofstede, 2001; Stoltenborgh *et al.*, 2011).

Cultural differences in reporting may also reflect cultural differences in the definition and repercussions of abuse. Societies in which consent is essential may define abuse more broadly than societies that tolerate unwanted touching (e.g., the fondling of girls in crowded subways and trains), or in which an individual's consent is not important (e.g., forced marriage of girls in some nations). A girl, and perhaps also her family, is unlikely to report abuse if the consequences of such a report would bring shame and dishonor to the girl and reduce the likelihood of her making a satisfactory marriage.

However, there may also be cultural differences related to sex and sexual restraint that may influence the actual prevalence of CSA. The higher rates of CSA reported in Africa, for instance, may reflect belief in the cultural myths regarding HIV cure and avoidance strategies (e.g., having sex with virgins protects from or cures HIV) that are held in some African communities (Kenny & McEachern, 2000; Stoltenborgh *et al.*, 2011).

Poverty is another risk factor for CSA. In some of the poorest countries in the world, there are reports of families selling children into servitude (sexual and forced labor). In North America, a lack of adequate childcare among poor families often puts children at risk of victimization (Bolen & Gergely, 2014).

Prevalence of CSA in sex therapy patients

Until recently, there was little indication that individuals or couples presenting for sex therapy were more likely to have experienced CSA than those not presenting for sex therapy. Sarwer and Durlak (1996) found a prevalence of CSA in sex therapy patients (20%) that was similar to that found in the general population. Some 18 years later, Berthelot, Godbout, Hébert, Goulet, and Bergeron (2014) found a rather startlingly high rate of sexual abuse in sex therapy patients. In their study, 56% of women and 37% of men reported a history of CSA, and these sex therapy patients were also more likely to report psychological problems (e.g., depression and anxiety) and relationship difficulties than other sex therapy patients, although the relationship difficulties were only found for patients who had experienced penetrative sexual abuse. The increased prevalence rates of CSA among sex therapy patients in this study as compared with that of the earlier Sarwer and Durlak (1996) study may reflect differences in sampling across the two studies, or an increased likelihood of patients reporting CSA over time. It is also possible, however, that the results reflect an actual increase in the number of men and women with CSA that are presenting for sex therapy treatment over the last 20 years. Men and women who have experienced CSA may now feel entitled to have a better sex life, and they may feel more confident that sex therapy can provide that.

CSA and Sexual Problems

It makes intuitive sense that traumatic sexual abuse in childhood or adolescence will negatively affect sexuality in adulthood. However, studies in this area have failed to reach consistent or conclusive results. Large-scale surveys have found an increased risk of experiencing sexual dysfunction for women who were sexually abused in childhood compared with women who

were not sexually abused (Laumann, Paik & Rosen, 1999; Lutfey, Link, Litman, Rosen, & McKinlay, 2008). However, the effect sizes were modest, and other studies have failed to find such a link (e.g., Staples, Rellini, & Roberts, 2012). Leonard, Iverson, and Follette (2008) found that difficulty experiencing orgasm was the most common sexual dysfunction suffered by women with histories of CSA, but others have found sexual desire disorders to be most prevalent (Rellini, 2014). What seems clear is that sexual abuse *can* impact adult sexuality by increasing the risk that a woman will experience prolonged difficulty in the desire–arousal–orgasm spectrum of sexual functioning. When there is a history of CSA in women complaining of painful sex, it tends to involve both physical and sexual abuse prior to age 12, as well as abuse being committed by a parent, parental figure, or sibling (Rellini, 2014).

There is a general consensus in the literature that CSA is more strongly linked to level of sexual satisfaction than it is to sexual function (Leonard *et al.*, 2008; Rellini & Meston, 2007). Hall (2006) commented that sexual abuse impacts the ability to enjoy sex but not always the ability to function sexually; CSA survivors can often *engage in* sex even in the absence of pleasure. The source of the dissatisfaction may be sexual problems other than the dysfunctions listed in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5; American Psychiatric Association, 2013). Sexual problems frequently experienced by CSA survivors include sexual revictimization in the form of adult sexual assault, engaging in sexually risky behaviors, having unwanted sexual thoughts and fantasies that may feature abuse, problems with sexual boundaries, difficulty trusting one's sexual partner, and confusion regarding sexual orientation (DiLillo *et al.*, 2009; Hall, 2006, 2008; Maltz, 1992, 2002; Rellini, 2014; Wilson & Wilson, 2008).

Westerlund (1992) proposed that women with a history of CSA experience a disconnect between sexual functioning and sexual distress. CSA survivors have been found to experience higher levels of sexual distress in the context of good sexual functioning compared with women without a history of CSA (Stephenson, Hughan, & Meston, 2012). So although CSA survivors may indeed be at higher risk for sexual dysfunction, they may also experience distress even in the context of "normal" sexual function.

Further, an association between CSA and risky sexual behavior has been found for women across a variety of populations (general, clinical, and at-risk populations). The sexual risk behaviors that have been most consistently found to be associated with CSA history include younger age at first intercourse, a greater number of sex partners, and a greater likelihood of having been diagnosed with an STI (Senn, Carey, & Vanable, 2008). There are many fewer studies examining the impact of CSA on sexual risk in men. Some of the studies on the impact of CSA in men involve men who have sex with women and some involve men who have sex with men, but the findings are similar. Compared with men without a CSA history, men with a CSA history report an increased likelihood of sex trading, a higher number of sex partners, more frequent unprotected sex, and higher rates of diagnosis with an STI or HIV infection (Senn *et al.*, 2008).

The evidence also suggests that the majority of boys who were sexually abused as children will not become abusers themselves. Rather, it is a subset of the most vulnerable male victims who are at increased risk of committing acts of abuse in adulthood. The boys with a CSA history who are most at risk for engaging in abuse in adulthood have also witnessed serious domestic violence and have suffered from physical and emotional abuse and neglect in addition to sexual abuse (Salter *et al.*, 2003).

How does CSA affect sexuality?

The fact that not all women and men with a history of CSA go on to develop sexual dissatisfaction or dysfunction has led researchers to speculate that a history of CSA may work in conjunction with other factors to increase risk for sexual dysfunction in adulthood

(Staples *et al.*, 2012). Given that CSA is correlated with a higher frequency of psychopathology including PTSD, depression, and anxiety, it may be that the effects of CSA on sexuality are mediated by psychiatric conditions. However, there is little evidence supporting this contention. The fact that sexual dysfunction exists even in the absence of other psychopathology, and persists even when PTSD and mood disorders are successfully treated, points to other pathways by which CSA affects adult sexuality (Meston, Lorenz, & Stephenson, 2013). Indeed, Zollman, Rellini, and Desrocher (2013) found that a greater susceptibility to daily stressors was more predictive of detrimental effects on sexual arousal functioning in CSA survivors than were symptoms of PTSD.

In addition to psychopathology, a variety of other psychological factors have been examined as possible mediators in the relationship between CSA and sexual dysfunction or sexual distress. Sexual self-schemas (the way one thinks and feels about oneself as a sexual being) have been found to be related to CSA status and sexual enjoyment. CSA survivors have been found to have sexual schemas that are less romantic/passionate than those without a CSA history, and this less positive mental representation is associated with negative affect during sexual activity (Meston, Rellini & Heiman, 2006).

Many survivors of CSA retrospectively report dissociating during abuse as a way of coping (Maltz, 1992). Dissociation is a splitting-off of mental processes in times of high stress; intuitively, one might expect that dissociation might be one mechanism by which CSA impacts adult sexuality. Surprisingly, dissociation has not been found to have an impact on sexual arousal in women with CSA. In fact, women with CSA in long-term relationships do not appear to dissociate during sex more often than do non-abused women (Bird, Seehuus, Clifton, & Rellini, 2014). However, in a sample of HIV-positive men with a history of CSA, most of whom were homosexual in orientation, the men reported a high incidence of dissociation during sexual activity. This effect was strongest in participants who had a diagnosis of PTSD or dissociative disorder and whose sexual abuse was of a longer duration and involved multiple perpetrators (including intimate partner violence in adulthood; Hansen, Brown, Tsatkin, Zelgowski, & Nightingale, 2012). Dissociation may be present in more distressed samples (e.g., men with a concomitant diagnosis of HIV) than the community sample of Bird *et al.* (2014). It may also be a more common occurrence in people who are having sex outside a committed relationship, unlike the participants in the Bird *et al.* study. Gender differences, of course, cannot be ruled out, and the impact of dissociation on the sexual experiences of men and women with CSA histories merits further attention.

Having a primary sexual experience that is non-consensual, often occurring even before one is physiologically capable of sexual responding or emotionally able to process the experience, may disrupt the connection between cognition, mood, physiological arousal, and sexual enjoyment that would otherwise develop over time. Several studies have found that women with no history of sexual abuse (NSA) make connections between affect, physiological responses, and sexual responding that CSA survivors do not. Seeking and experiencing an intimate connection with one's partner during sex is associated with increased sexual responding in NSA women but not women with CSA histories (Staples *et al.*, 2012). The experience of depersonalization (a feeling of disconnection from one's body, the sense of watching oneself as an observer) during sex interfered with sexual arousal for women who had never experienced sexual abuse, but had no effect on the sexual arousal of CSA women (Bird *et al.*, 2014). Pre-existing negative affect negatively impacted the genital responding of NSA women, but had no impact on the genital responding of CSA women (Rellini, Elinson, Janssen, & Meston, 2012). In other words, it appears that connections that would otherwise exist are not present and do not influence the sexual responses of women with CSA. More research is needed to understand exactly how these poorly-established connections impact the sexuality of individuals with a history of CSA.

Several recent studies have examined the body's physiological response to stress as a mediating factor in the relationship between CSA and sexual outcomes. In sexually healthy women,

there appears to be an optimal level of sympathetic nervous system (SNS) activity that facilitates genital arousal. This appears to take the form of a curvilinear relationship, such that too little or too much SNS activation is detrimental to optimal sexual arousal (Lorenz, Harte, Hamilton, & Meston, 2012). Examining this association in women with and without CSA, Rellini and Meston (2006) found that exercise-induced activation of the SNS improved genital arousal for NSA women, but not for women with histories of CSA. They speculated that women with CSA may have higher baseline SNS activity, such that increasing this level inhibits genital responding. In keeping with these results, Meston and Lorenz (2013) also found that SNS activation had different effects on sexual responses based on history of trauma. SNS activation was associated with higher sexual functioning and satisfaction in NSA women with low exposure to trauma. However, the reverse was true for women with CSA; better sexual functioning was associated with decreases in SNS activity. This effect was more pronounced for CSA women who had experienced a single traumatic episode than for CSA women with multiple traumas. These findings led Meston and Lorenz to conjecture that a single traumatic episode of CSA may result in a stress response to sexual stimuli, such that SNS activity needs to be decreased for good sexual functioning. This stress response to sexual stimuli is blunted with repeated exposure to CSA, such that the effect of reducing SNS activation is not as strong in this group of multiply-traumatized women. Meston and Lorenz used heart rate variability (HRV) as the measure of SNS activity, and they proposed that incorporating measurement of HRV into clinical practice (as in biofeedback) may be beneficial.

Meston and Lorenz (2013) also measured cortisol levels in response to sexual stimuli. Cortisol is a hormone that mediates the body's long-term stress response. For women never sexually abused, decreased levels of cortisol in response to sexual stimuli (indicative of reduced stress) was associated with higher sexual function, and increased cortisol levels (indicative of high stress) were related to diminished sexual functioning. There was no effect of cortisol levels on the sexual functioning of CSA women. These results led Meston and Lorenz to propose the possibility that CSA results in hormonal disruptions that disconnect the body's stress response from the sexual response. Indeed, Hamilton, Rellini, and Meston (2008) found that CSA survivors inaccurately perceived greater physiological sexual responding when cortisol levels were high; in other words, they believed that they were experiencing greater genital sexual response than they were actually experiencing. Misattribution is another form of disconnection, and women with CSA may misinterpret their stress response as arousal to a sexual stimulus.

In addition to looking at predictors of sexual dysfunction, much of the research on mediating factors between CSA and sexual outcomes has addressed the often-noted association between CSA and risky sexual behavior (high number of partners, having unprotected sex, engaging in sex with drug-involved partners). Negative thoughts and feelings about sex, including sex guilt, have been linked to risky sexual behavior (Senn, Carey, & Coury-Doniger, 2012), as has low self-esteem and a diminished sense of self-efficacy (Lamoureux, Palmieri, Jackson, & Hobfoll, 2012), negative sexual self-schema (Niehaus, Jackson, & Davies, 2010), and the use of self-destructive coping strategies (Merrill, Guimond, Thomsen, & Milner, 2003). These factors may form a pathway between CSA experiences and risky sexual behavior.

It is evident from reviewing the studies above that a variety of mechanisms contribute to the association between CSA and sexual difficulties in adulthood. One of the reasons for the different effects found is that the studies reviewed above often used different criteria for assessing CSA (Rellini, 2014), combined CSA survivors with multiple versus single incidences of abuse, employed different samples (clinical vs. community), and relied on different outcome measures (laboratory assessment of sexual arousal versus questionnaire data). Nevertheless, it is likely that the effects of CSA on adult sexuality are, indeed, mediated by a number of variables that differ across survivors and relationships. Sexual abuse is not a discrete event. It occurs in a particular context to a child who has preexisting personality characteristics, vulnerabilities, and strengths. It occurs to children who grow up in environments where the sexual nature of the

abuse has different meanings and consequences. The sexual effects of abuse are experienced differently by men and women of varying sexual orientations and interests, relationship statuses, and levels of physical and emotional wellbeing. It is, therefore, almost inevitable that the effects of CSA will be wide-ranging, as will the factors that mediate those effects.

Treatment Outcome Studies

There has been little empirical attention paid to the impact of CSA on the process and outcome of sex therapy. Meston, Lorenz, and Stephenson (2013, pp. 2177–2178) commented:

> … there are few treatments for sexual dysfunction that have been empirically validated for adult survivors. Treatments for sexual problems that were developed in women *without* abuse histories have shown inconsistent results in women *with* abuse histories. For example, traditional sex therapy techniques such as sensate focus are overwhelming for many women with CSA histories.

Although a few studies have shown that general psychotherapy can be effective in alleviating the sexual anxiety and sexual avoidance behavior of CSA survivors (Hazzard, Rogers, & Angert, 1993; Hébert & Bergeron, 2007), other studies have shown that sexual problems often persist even after successful treatment of other psychopathology (Classen *et al.*, 2011; Rieckert & Möller, 2000). It is safe to assume that the sexual problems of CSA survivors will be best served by a separate and specific clinical focus. The belief that other psychopathology related to CSA (e.g., mood disorders, PTSD, self-destructive behavior) needs to be resolved before attention is given to sexual problems (Maltz, 2002) has not been empirically validated. It does make clinical sense, however, to prioritize those symptoms that may interfere with sex therapy for CSA survivors (e.g., flashbacks).

Mindfulness and cognitive-behavioral therapy

The addition of mindfulness approaches to cognitive-behavioral therapy (CBT) has been called the third wave of CBT. Mindfulness is based on the pioneering work of Jon Kabat-Zinn (1982) in bringing Buddhist meditation practices into psychological therapy. Mindfulness has been shown to be a useful therapeutic adjunct to traditional cognitive-behavioral approaches for a variety of psychological problems, most notably depression and anxiety. Mindfulness has also been shown to be a useful therapeutic addition to current sex therapy practice in treating female sexual dysfunction (FSD), especially low desire and arousal problems in women (Brotto & Basson, 2014; see also Barker, this volume).

Brotto, Basson, and Luria (2008) adapted a mindfulness-based psychoeducation module (three 90-minute group sessions) for use with women with sexual arousal difficulties. The mindfulness component was found to be the most effective element of the treatment, and a *post hoc* analysis revealed that the protocol was most effective for women with a history of CSA.

Brotto, Seal, and Rellini (2012) compared CBT and mindfulness-based therapy (MBT) in the group treatment of women with CSA and sexual distress. Although both treatment groups experienced a decrease in their sexual distress, the women in the MBT group showed a greater connection between their physiological and subjective sexual arousal post-treatment than did women in the CBT group. In other words, at post-treatment, women in the MBT group experienced greater levels of subjective sexual arousal than women in the CBT group in response to the same level of genital arousal. The authors noted that mindfulness may be particularly helpful for CSA survivors because, while CBT strives to change thoughts, MBT aims to change the reactions to the thoughts. For example, CBT might target the maladaptive cognition, "Sex is something my partner likes; I have to do it to please him," hoping that at treatment's

end the thought is healthier, for example, "I don't have to have sex to please my partner; sex is a way of connecting with him." In contrast, with MBT the focus is on noticing, in a non-judgmental way, the thought, "I have to have sex to please my partner." The goal, then, is not to become attached to the thought—"Oh, there is that thought; I'm not going to get focused on that"—and instead a woman might redirect her focus to the sexual stimulation she is receiving and giving.

Sexual self-schema therapy

In addressing the negative self-schemas of CSA survivors, Meston *et al.* (2013) explored the efficacy of a five-session protocol involving expressive writing tasks, either focused on understanding the general traumatic effect of the abuse or on understanding the specific effect of the abuse on thoughts, feelings, and beliefs about sexuality. Women in both writing interventions experienced improvement in symptoms of depression and PTSD. However, the women who wrote specifically about the impact of the abuse on their sexual schema were significantly more likely to experience improvement in sexual functioning. Although writing exercises have often been a part of therapeutic interventions for trauma (Pennebaker, 1997), these results support the addition of sex-specific writing assignments in sex therapy for CSA survivors.

Psychopharmacology

Flibanserin is currently the only medication for FSD that is approved for use by the Food and Drug Administration in the US. Others are likely to follow. In pharmacological research for FSD, women with a history of sexual abuse are almost invariably excluded, making even preliminary efficacy data of limited utility for this population. However, the Flibanserin studies excluded only those women who reported that they were currently experiencing problems that they attributed to a history of CSA (Katz *et al.*, 2013). Unfortunately there are no published data comparing the effectiveness of Flibanserin in women with and without a history of CSA. It should be noted that Flibanserin targets only a small percentage of women with sexual desire disorders (premenopausal women without other psychopathology or relationship distress).

To date there is only one published study comparing women with and without a history of CSA in their response to sexual medication. The study in question focused on sildenafil and found a marked difference between groups. Only a minority of women with CSA histories experienced a positive response to the medication, whereas the majority of women without CSA noted positive changes in genital responding (Berman, Berman, Bruck, Pawar & Goldstein, 2001). Trials for sildenafil for all women were later discontinued due to the lack of positive benefit for women's sexual experience. Although there are a number of medications for male sexual dysfunction, especially erectile dysfunction and premature ejaculation, there are no published outcome studies evaluating their efficacy specifically for men who have experienced sexual abuse.

Clinical Treatment of the Sexual Difficulties of Patients with CSA Histories

Although the variation in experiences of CSA makes it difficult for researchers to decipher the impact of sexual abuse on adult sexual functioning, for clinicians, solving such puzzles on an individual/couples level is par for the course. The question in therapy is: For this particular person, is the history of sexual abuse relevant to their presenting problem? The empirical literature can provide some guidance to clinicians, especially regarding the assessment and treatment of heterosexual women who were sexually abused as children. The impact of CSA on the sexuality

of boys and men, as well as on sexual and gender minorities, remains woefully understudied. What follows below are recommendations for the assessment and treatment of the sexual concerns of CSA survivors, based on empirical literature and clinical practice.

Assessment of the individual

A thorough sexual history should always include inquiry into childhood sexual experiences. It is important not to label patients' experiences for them. Rellini (2014) suggested that clinicians attend to both activity-specific and relationship-specific parameters for identifying clinical issues. A relationship-specific definition allows for a client-centered approach to diagnosis and treatment. An activity-specific focus helps determine elements of childhood experiences that may have contributed to current sexual problems. Looking at the difference between self-reported (relationship-specific) and behavioral (activity-specific) definitions may also allow the clinician to explore whether shame or fear of being stigmatized by the label of "victim" is important clinically. Although there is no one correct way to conduct an interview, it makes sense to ask about activity-specifics first, followed by a clarification of relationship-specifics. For example, a therapist may ask about childhood sexual experiences and may inquire if any of these experiences were forced or coerced or if they involved contact with an adult. If the answer to any of these queries is yes, the therapist's next questions would seek to determine how the patient viewed the activity. This sequence avoids asking a patient if he or she was sexually abused and then continuing to inquire about childhood sexual events even after a "no" response.

Some patients may feel that their experience does not warrant the label of abuse if, for example, the activity did not involve penetration. Women with more severe types of sexual abuse (penetrative abuse and abuse by a family member) have been found to be more likely to self-identify as sexual abuse survivors than those who experienced less severe abuse (Rellini and Meston, 2007). Gender differences in identifying as a victim of abuse also exist. Boys are less likely to disclose abuse than girls, and men are more likely than women to retrospectively report that a childhood sexual experience was consensual (Holmes & Slap, 1998). Men and women may not report CSA if they do not believe it is relevant to their presenting complaint. It is also important to note that an acknowledgement of a history of abuse may come once therapy is under way and the patient has come to trust the therapist.

During the interview, the key questions the therapist is looking to answer are: Is there a history of sexual abuse? Is it relevant to the presenting problem, and if so, how? What obstacles, if any, will the history of CSA present in treatment?

Questions directed to the patient will center on the details of the abuse. When did it begin and end? How and why did it end? What sexual acts were involved? How was the patient made to comply with the abusive acts and to keep silent, if he or she did? If the patient told someone about the abuse, it is important to know who and to know what the person's response was (e.g., dismissive, supportive, blaming). If the patient is currently in a relationship, it is important to know whether the current partner knows about the abuse and, if the partner knows, what his or her response was to learning about the abuse.

Questionnaires, such as the Childhood Trauma Questionnaire (CTQ; Bernstein *et al.*, 1994), may supplement the information gained in the clinical interview. This particular questionnaire provides measures of the following abuse experiences: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect. Given that sexual abuse often co-occurs with multiple other types of abuse, this questionnaire can help the clinician be aware of and inquire further into experiences of other forms of abuse and neglect. However, even when questionnaires are used in a clinical assessment, an in-depth interview is still essential to capture the emotional nuances of the patient's unique experience. The process of telling the story and having someone listen without judgment is therapeutic. As treatment progresses it is important for the patient to know that he or she is allowed to talk about the CSA. Sometimes, in an effort

to help the patient avoid discomfort, therapists fail to ask questions about abuse history and thus inadvertently send the message that they don't want to hear about it. Talking openly about the abuse in very specific terms lets the patient know that the therapist really understands his or her history of CSA. This understanding can be conveyed in a clinical interview in a way that reading a questionnaire cannot.

Sexual function questionnaires may also supplement a clinical interview. Commonly used assessment instruments include the International Index of Erectile Function (IIEF; Rosen, Cappelleri, & Gendrano, 2002) and the Female Sexual Function Index (FSFI; Rosen *et al.*, 2000). The IIEF is a validated measure that assesses erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall sexual satisfaction in men. The FSFI assesses desire, arousal, lubrication, orgasm, satisfaction, and sexual pain in women. Another often-used measure of sexual wellbeing in women is the Sexual Satisfaction Scale for Women (SSS-W; Meston & Trapnell, 2005), which measures sexual contentment, communication, compatibility, personal concerns, and relational concerns. The FSFI and the SSS-W have been validated for use with women who have been sexually abused (Stephenson, Pulverman & Meston, 2014); other sexuality questionnaires have not yet been specifically validated for populations with abuse histories. Although the FSFI, the SSS-W, and other sexuality questionnaires may provide supplemental information regarding sexual function and satisfaction, they should not replace a sexual history that occurs in the context of a clinical interview.

Listening to stories of sexual abuse and assault can be difficult for a therapist, just as telling the story can be difficult for the patient. It is important to respond compassionately, taking care not to label the experience for the patient. This warning about labeling extends to labeling the emotional valence of the experience; for example, it is important to avoid saying things such as, "That must have been terrible for you" or "How horrible!" The therapist may mirror the patient's emotional reactions, or may even challenge a seemingly inappropriate reaction (especially the "it's no big deal" reaction), but the therapist should not assume to know the patient's emotional response to the abuse. Some stories of abuse are more difficult to hear than others. Burnout is a possibility, especially for therapists who hear many stories of abuse. Self-care for the therapist may begin with peer or other supervision to process the emotional reactions inherent in bearing witness to painful experiences.

The assessment should provide the therapist with at least a rudimentary understanding of how the sexual abuse has impacted the patient's sexuality. Some of the hypotheses to examine are provided by the empirical literature. To summarize, possible sexual outcomes associated with CSA include: dissociation during sex; avoidance of intimacy, sex, and/or sexual feelings; physiological stress responses induced by sexual stimuli; sexual aversion; negative sexual self-schemas; personal sexual resiliency (e.g., increased sexual self-esteem and self-efficacy); the presence of other psychopathology associated with the abuse that contributes to sexual problems; and an increased susceptibility to daily stressors that interfere with sexual functioning or pleasure. It is important to be aware of the possibility that a history of CSA (especially a single episode, non-familial, non-penetrative experience) may not be related to a presenting sexual complaint.

Assessment of the couple

One of the mainstays of couples sex therapy is the four-session assessment in which the couple is seen for one session, then each partner is seen individually, and then the couple is seen together again. This protocol can be applied to couples in which at least one partner has a history of CSA.

Session 1 In this first session, the therapist can get a sense of how the partners interact and get a perspective on the couple. Meeting the couple first minimizes the possibility of alliances (perceived or real) being formed with one person. In this session, the couple is the patient,

so the presenting problem is viewed from the couples' perspective, and the history and background are the history and the background of the couple. Although a history of CSA may be introduced as a topic in this initial session (by the patient, not the therapist), an in-depth exploration of the topic should wait for the individual session.

Sessions 2 and 3 In these sessions, individual sexual histories—including CSA histories—are obtained, as well as individual perspectives on the current sexual problem. It is important to establish clear boundaries; that is, whatever is shared in this session may be discussed in future couples sessions, and any secrets that are disclosed (e.g., an extramarital affair or even CSA) may need to be resolved in individual sessions with the therapist before couples therapy can begin. An insistence by one member of the couple that a relevant secret cannot be shared in couples therapy may preclude couples therapy.

Session 4 In this session, in which both members of the couple are again present, the assessment involves a dynamic exchange between the participants, with the therapist offering preliminary observations and hypotheses about the presenting problem and the couple reacting to these ideas. This session lays the groundwork for sex therapy, especially for initial assignments.

In this fourth session it is important to move the dynamic of the couple away from blaming their problems on the history of CSA because doing so, in essence, blames the survivor of the abuse. Survivors often already feel like "damaged goods" (Maltz, 1992), and introducing a therapeutic dynamic wherein they must be taught how to behave or feel sexually by an older or more experienced person—in this case, the therapist—may replay the sexual abuse dynamic (Hall, 2008). Often there is some initial resistance to sharing responsibility for the sexual problem. The survivor, often accustomed to feeling blamed, may want to view her or his partner as healthy or even idealized. The partner who was not abused (the NSA partner) may not want to view him or herself as having sexual issues and may even be accustomed to being in the healthy or helper role. However, it is enormously beneficial to rebalance this dynamic during the assessment phase. As treatment continues, the therapist should be aware that the NSA partner may want to move back into a position of helping—perhaps to avoid addressing his or her own issues or because it is a familiar position in the relationship. The NSA partner should never become the co-therapist.

In this fourth session, it is also important to assess how both partners are dealing with the history of sexual abuse, if the abuse is shared knowledge. *In the opening vignette, for example, the husband, Joe, appeared sympathetic to his wife's history of abuse, but he attributed Brenda's low desire to the abuse and took no responsibility for his part in the sexual problems of the couple. Once Joe, a successful businessman and competitive athlete, realized that he never altered his aggressive style when moving from business and sports to interpersonal or intimate encounters, couples therapy could begin in earnest. Brenda was more willing to address her sexual avoidance given that Joe was motivated to develop more intimate ways of relating to her.*

A similar process occurred with Catherine and Frank (the couple from the second vignette). *Frank's reluctance to address his sexual avoidance was mitigated by Catherine's understanding and acceptance of her own need to be more communicative about when she did (and did not) want sex. Frank was relieved of the burden of trying to overcome his reluctance to initiate sex by knowing that Catherine was working on her own sexual issues. If Catherine could communicate her sexual interest to him, Frank felt more comfortable with his own sexual desire.*

Treatment

The sexual concerns of CSA survivors need to be addressed directly in treatment. However, the dearth of published treatment outcome studies requires clinicians to be creative, while at the same time remaining grounded in the empirical literature, by understanding the dynamics

of sexual abuse, being well versed in the practice of sex therapy, and—over and above all else—having excellent boundaries.

Hall (2006, 2008) proposed that typical sex therapy treatments can be successful with this population as long as some modifications are made, such as slowing down the treatment process and tweaking the sensate focus exercises. Likewise, Maltz's (1992, 2002) practices are also grounded in traditional sex therapy and CBT approaches, with modifications in timing, expectations, and exercises. For example, instead of sensate focus beginning with an exploration of the entire body (excluding breasts and genitals), Maltz (1992, 2002) suggested that partners begin by holding and caressing hands.

The nascent treatment literature has provided important guidelines for clinicians. Unfortunately, this literature is focused entirely on the treatment of female survivors of CSA and may or may not pertain to men. Nevertheless, the following recommendations for therapy are offered with this caveat in mind. Improving how survivors see themselves as sexual beings, including increasing their sense of self-worth and self-efficacy, can be addressed using the expressive writing exercise adapted from Pennebaker (1997) and described by Meston and Lorenz (2013), or using a cognitive-behavioral approach in psychotherapy sessions. Dissociation, emotional avoidance, and aversion that disrupt sexual experience, pleasure, and function can be addressed by modified sex therapy approaches that may include mindfulness or biofeedback to reduce acute stress reactions.

There are no empirical studies on couples therapy with survivors of CSA. However, related sources can provide guidance. The sexual pain literature is relevant in that it describes treatment aimed at helping partners to be encouraging and supportive of wives or girlfriends that are fearful of sex (Rosen, Bergeron, Lambert, & Steben, 2013). Somewhat surprisingly, the clinical literature regarding BDSM practices also can provide some practical guidance on building trust and establishing boundaries (Weiss, 2011; see also Nichols & Fedor, this volume). A brief summary of the therapy of the two couples previously discussed will illustrate these points.

No more portobello mushrooms: Brenda and Joe *Brenda did not think that her CSA history affected her loss of desire. However, she agreed to come to therapy for the sake of her marriage. Initial sessions focused on how the couple handled daily stresses and leisure time. Joe was encouraged to work on changing his style of communicating with Brenda from a business model to an intimate one. Brenda was helpful and encouraging in this process, and their relationship improved. Although they did not have sex, the couple did cuddle briefly at night, and both were comfortable with this. Thus, this was the first exercise assigned: to cuddle for five minutes, with Joe being the one to stop the cuddling. Putting Joe in charge of setting—rather than pushing—the boundaries built Brenda's trust that he could keep limits, and also lessened the hurt Joe invariably felt when Brenda pulled away from him.*

After several months of progress, when therapy progressed to sensate focus, Brenda experienced a recurrence of PTSD symptoms and had flashbacks of the abuse in the therapy session. This brought home to her that her CSA was indeed interfering with her sexuality. Joe was loving and supportive as treatment returned to a slower pace. Individual sessions with Brenda focused on helping her to come to terms with the impact of the sexual abuse on her sexuality (e.g., her sexual self-schema).

Couples sex therapy resumed with Brenda's new understanding of the role of her CSA history and her increased motivation to learn a new way of being sexual that involved being more present in her body and more aware of her sexual feelings. Mindfulness was added to the couple's treatment, which included a very slowly paced modification of sensate focus, beginning with foot massages and progressing from there.

"Stop" can be a loaded word for CSA survivors—it may be a word that was ignored in the past, that reminds them of the abuse, or that they are reluctant to use repeatedly to a partner they love. So Brenda and Joe picked a "safe phrase" for ending a sexual activity (a technique borrowed from practices in the BDSM community). They chose "portobello mushrooms" because Joe loved them and, although he could not understand why Brenda disliked them, he had never "forced her to eat one." In the beginning stages of touching with mindfulness, Brenda often invoked the phrase, and Joe always respected it. Slowly, the body parts that were available for touch expanded, and the level of arousal Brenda could enjoy without

anxiety increased. However, we all knew that treatment was successful when Joe proudly exclaimed one session that, over the past six weeks, there had been no portobello mushrooms in the bedroom.

Wanting sugar: Frank and Catherine *Frank was aware of his sexual avoidance. It was a strategy that he consciously employed to keep his stress low. After several weeks with no sex, however, Catherine would get angry and complain. Frank would initiate sex a day or two later. Catherine would think that he was not initiating out of his own desire but rather in response to her pressure, and she would refuse sex until Frank tried to initiate several more times. This pattern repeated itself, such that the couple had had only sporadic sex over the two years of their marriage.*

After the assessment, Catherine recognized that she had a sexual problem as well. It was difficult for her to signal sexual interest or initiate sex. She had been raised by strict Catholic parents, who admonished her throughout her adolescence: "Don't behave like a slut." Catherine agreed to try to express her sexual interest to Frank when he did approach her on pre-assigned "date" nights (i.e., nights designated for having sex if they wanted to). The pre-arranged date nights also alleviated the burden on Frank to be sexually "aggressive" (the very state he strove to avoid). This worked well for the couple, but they recognized a need to improve the pleasure they gave and received. They also wanted sex to be more spontaneous.

In one session, Catherine complained to Frank, "You haven't come after me in a long time." It turned out that this was the language they each used to refer to sexual initiation. I suggested that they change their language to something less aggressive sounding. They finally settled on "asking for sugar." This small change in language resulted in a vast improvement in how they thought about sex. Frank began to initiate by asking Catherine if she "wanted some sugar." He found that, by asking in this way, he was more comfortable initiating sex, and so he initiated more often. Catherine began to leave sugar packets on his pillow when she was interested in sex. Overcoming his initial reluctance to experience his own desire freed Frank up to be more creative and spontaneous in his lovemaking. Catherine continued to struggle with her own openness to sex, and she continued to rely on Frank's initiation (both for the start of sex and for initiating activities during sex). Catherine was, however, more demonstrably responsive and receptive to Frank's advances.

Future Directions

Existing research on sexuality and CSA is focused primarily on North American and European populations and on heterosexual women. Future research should expand to include men, sexual minorities, transgender individuals, and people from other countries and cultures. The growing recognition that not all sexual abuse is the same in terms of its impact also needs to inform future research. The recent research regarding the apparent disruption in the physiological–affective–sexual connection as a result of CSA also warrants further research; understanding these disrupted connections might help to inform interventions with this population. The promising results from interventions that are designed to help CSA women decrease their SNS activity and focus on the feelings of sexual arousal (e.g., MBT) are clearly related to these findings and also merit more study. Clinicians should continue to be grounded in good psychological practices and should continue to stay current with the dynamic empirical literature on this subject. The skilled clinician will be able to modify and adjust proven therapy techniques as needed with CSA survivors. Sharing clinical information regarding treatment successes and failures will also help developing clinicians as well as inform future research.

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25

Treating Sexual Problems in Clients from Conservative Protestant and Catholic Backgrounds

Tommy E. Turner

Sex Therapy and Religion

Therapeutic fields such as psychology and counseling once largely neglected the spiritual background of clients as a formative part of their belief systems (Jones, 1994). Not only has religion often been neglected, it has sometimes even been viewed as detrimental, reflecting illusory or neurotic maladjustments (Plante, 1999, 2007). This chasm that has existed between spirituality/religion and therapy has increasingly been bridged during the latter part of the 20th century and the beginning years of the 21st century. A few notable examples of this reversal of separation include the following: The American Psychiatric Association has made efforts to train residents in religious issues (Fallot, 1998); the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5; American Psychiatric Association, 2013) has included a category (V62.89) for religious or spiritual problems; and many training programs have begun offering courses in spirituality or spiritual development. Notably, although the inclusion of a DSM-5 category addressing religious or spiritual problems could be viewed as placing religious or spiritual concerns under an umbrella of pathology, it is also the case that identifying religious or spiritual pathology involves acknowledging that this is a deviation from a much broader "normal" continuum of religious and spiritual health. Thus, by recognizing the potential of problematic religious or spiritual experiences, the DSM-5 acknowledges that there is a larger experience of normal and helpful spiritual and religious experiences (Basu-Zharku, 2011; Miller & Thoresen, 2003). These are only a few examples of contemporary thinking among mental health professionals that recognize the important value that should be placed on the client's religious and spiritual background. To ignore or avoid the rich spiritual or religious background of clients could omit one of the greatest potential sources of support and meaning for the client.

The historical chasm between counseling/therapy and spirituality/religion is even more evident in the divide between sex therapy and spirituality/religion. Influential thinkers in Western thought, such as Augustine and Thomas Aquinas, taught a traditional Greek tripartite makeup of man; man is made up of body, soul, and spirit. However, they also relegated the body to an inferior status. The historical result in much of Western thought has been the divorce of body and spirit and, therefore, sexuality and spirituality (Turner, Center, & Kiser, 2004). Consistent with this, until more recently, sex therapy has generally been directed exclusively toward physical mechanics, with little emphasis given to clients' beliefs and values (Kaplan, 1974a, 1974b; Masters & Johnson, 1970).

The Wiley Handbook of Sex Therapy, First Edition. Edited by Zoë D. Peterson.

Cultural Competency

The ethical imperative that therapists show unconditional positive regard for the worth and dignity of every client obliges the mental health professional to become familiar with various belief systems (Frame, 1996; Turner *et al.*, 2004). As an example of a holistic therapeutic approach that respects the religious/spiritual culture of clients, Sue and Sue (2013) proposed three basic multicultural competencies that must be achieved by therapists in order to assist clients most effectively. First, the therapist must make a concerted effort to understand the basic worldview of the client. Certainly, the worldview resulting from the spiritual and religious background of the client is an essential part of the client's culture. Second, the therapist must become aware of his or her own biases and prejudices related to other cultures and individuals within those cultures. With the recognition of such biases comes the ethical responsibility to educate oneself more fully in order to become more culturally competent (American Counseling Association, 2005). Third, Sue and Sue proposed that therapists must develop and employ assessment and intervention strategies that are appropriate for the client's cultural background.

Although this therapeutic equation does not dictate that therapists share or agree with their client's customs, preferences, or practices, it remains that clients typically feel more comfortable with—and indeed, experience a greater trust in—therapists who exhibit knowledge and awareness of the client's culture; this trust is further strengthened if the therapist exhibits an understanding and appreciation of the client's worldview (Sue & Sue, 2013). In the particular case of sex therapy, it is imperative that clients are understood in the context of their basic belief systems, with particular recognition of the fact that the religious background in which a client was raised often remains a very powerful influence in the client's life, whether or not the client has continued to identify with that specific belief system or religious institution.

Thus, knowledge—even rudimentary knowledge—of differing religious worldviews may be the basis for developing strong rapport with clients from diverse religious backgrounds. Frame (1996) asserted that it is essential for therapists to become familiar with the basic tenets of a variety of religious belief systems. This is essential because values, particularly sexual values, vary widely across cultures. To that end, the following section examines pertinent Roman Catholic and conservative Protestant beliefs regarding sex that might influence the progression of sex therapy.

Roman Catholic and Conservative Protestant Beliefs about Sex

Clients from Roman Catholic and conservative Protestant backgrounds have some things in common. The importance of scriptural/biblical teachings to the Catholics, and the professed singularity of scriptural authority for conservative Protestants, are extremely influential in adherents' lives. Furthermore, the absolute authority of the Church—and her dogmas and decrees—are the final authority for practicing Catholics. Those clients from either a Catholic or conservative Protestant tradition who enter sex therapy for sexual dysfunctions, sexual identity issues, or challenges involving sex that arise in other arenas (e.g., marital infidelity, artificial contraception, abortion, etc.) have the undercurrent of scriptural and church teaching running throughout their life. At some point, this will likely enter into the therapeutic process.

Therefore, it is out of acknowledgement of the therapist's need for cultural understanding and worldview awareness that this subject is entertained. It is the purpose of this article to: (1) outline the basic, and fairly consistent, beliefs and teachings regarding sex of both Roman Catholic and conservative Protestant traditions; (2) suggest possible situations in which these teaching and beliefs about sex might intersect and influence the therapeutic process; and (3) highlight the paramount ethical concerns that arise with the merger of sexual therapy and spirituality/religion.

Roman Catholic beliefs regarding sex

Traditional Roman Catholic teachings regarding sexuality are based on two structures: the holy scriptures and the Church dogma. These teachings have been fairly consistent across the centuries.

Sex and procreation The scripture and the Church agree that sex is intended for both procreation and pleasure. The Church has further interpreted that sex cannot properly be separated from the possibility of procreation (O'Leary, 2006, p. 225). That is, even when entertained for pleasure, the consciousness of the potential for procreation is always to be present. To ignore the procreative purpose and possibility of sex perverts the sublime meaning and power of the sexual act, and leads to other undesirable outcomes. For example, masturbation has consistently been viewed as "an intrinsically and gravely disordered action" because it is separated from the ordained procreative possibility (Seper, 1975; Section IX, Line 1). Further, masturbation is viewed by the Church as essentially self-centered rather than self-giving. Masturbation is lumped with any use of the "sexual faculty" outside what would be considered the "normal conjugal relation" (Seper, 1975; Section IX, Lines 14–15). Thus, there is an indissoluble link between the sexual act and procreation. Children are to be considered as the "supreme gift of marriage and greatly contribute to the good of the parents themselves" (Flannery, 1975, p. 953). There are high and lofty purposes of marriage other than childbearing (Abbott, 1966), but those married couples who bring forth a "relatively" large number of children are deserving of "special mention" (Abbott, 1966, p. 255).

Artificial contraception and abortion The procreative purpose of the sexual act is the foundational premise undergirding the longstanding ban on artificial contraception and the church's opposition to abortion (O'Leary, 2006, p. 224). When couples deem that increasing family size is not prudent, at least temporarily, then faithfulness ("faithfulness" here would imply sexual fidelity to the partner but also fidelity to the overriding procreative purpose of sexual intercourse) and full intimacy is difficult to sustain. In other words, when the possibility (i.e., risk) of creating a pregnancy via non-contraceptive sex is seen as too great a possibility, then abstinence from full sexual intimacy often results. This breach of full intimacy is seen to imperil faithfulness and fruitfulness. Often "dishonorable solutions" (Abbott, 1966, p. 255), such as foregoing sexual relations with the partner in favor of masturbation or taking of life (via abortion), are entertained. The Church has maintained that there can be no separation of, nor contradiction between, God's intentions for procreation of life and genuine married love. Therefore, in order to preserve the purpose of marriage, avoidance of intercourse and artificial contraception, much less abortion, is inconceivable.

The position of the Church has been that, when the issues of married love, sex within the institution of marriage, and procreation are discussed and considered, final decisions and actions cannot be based on sincerity of intention or evaluation of motive. In other words, good intentions do not absolve individuals from bad behavior. Rather, there must be an objective standard that determines the proper course of action. That objective standard is the teaching of the Church (Abbott, 1966). For example, the objective standard regarding contraception was exemplified by the decree of Pope Pius XI in 1930, in the encyclical *Casti Connubi*, that artificial contraception is a "sin against nature … shameful and intrinsically vicious" (O'Rourke & Boyle, 1993, p. 81). So diaphragms, condoms, and other contraceptive devices were not permissible to any adherents who wanted to be true to Church teaching.

However, the development of the pill brought a different discussion. To many, the scientific knowledge necessary to create hormones in pill form to control a menstrual cycle was not really different than previous advances in knowledge, which allowed verification of infertile periods during the menstrual cycle. Thus, it was, to some, parallel to any other "natural" contraceptive

method. After commission studies starting in 1963, the majority decision from the Commission on Population, Family, and Birth, as reported to Pope Paul VI in July 1966, was that it is morally acceptable for married couples to use hormonal contraception (i.e., "the pill" or oral contraception). More than two years later, after what reportedly was an agonizing struggle (O'Leary, 2006, p. 185), Pope Paul ruled against the Commission, summarily stating that there could be no division between the unifying, intimate nature of sexual intercourse and the procreative possibility of sexual intercourse. Therefore, there could be no separation between the sexual and reproductive facets of the marital act (O'Leary, 2006, p. 186). The rulings of this encyclical brought protests from near and far. In the final analysis, surveys revealed that more than 80% of Catholic couples began to or continued to ignore the ban on artificial contraception. Pope Paul was apparently so distraught by the reaction against the interpretation that he never issued another encyclical (O'Leary, 2006, p. 187).

Similarly, Roman Catholic teaching has consistently been strongly opposed to abortion. Abortion at any stage, therefore, is the taking of a human life. A personal anecdote will be illustrative of the traditional Catholic position. In the late 1970s, only a few years after the United State Supreme Court legalized abortion via the Roe versus Wade decision, the author was a member of a panel of local clergy invited to receive questions from high school seniors on the topic of "good citizenship." The panel was fairly representative of the religious institutions of the time in this southeastern state—United Methodist, Episcopalian, Church of Christ, Baptist, Presbyterian, Pentecostal, Roman Catholic, and so on. One of the questions from the students was "What are your views on abortion?" To the person, the non-Catholics disdained abortion "except in the cases of rape or incest or to protect the life of the mother." Upon his turn, the local parish priest related that the consistent position of the Catholic Church has always been that abortion in any form, for any reason is murder, regardless of the means of conception, and as such, is "absolutely excluded as licit" (*Humanae Vitae*, 1968, p. 1192).

The inseparable union of the sexual act of intercourse and the possibility of procreation also eliminates the moral possibility of all forms of artificial insemination, within the marriage or via a third party (O'Leary, 2006, p. 227). This poses great difficulty for some couples who desire children and for whom in-vitro fertilization could provide help. There is often an objection to the disposal of embryos produced from in-vitro. From the point of view of the Catholic Church, however, the final disposition of any embryos from in-vitro is a moot point because fertilization did not occur by sexual intercourse; thus, the creation of the embryos was immoral and sinful. Further still, to dispose of extra or spare embryos produced in-vitro amounts to induced abortion (O'Leary, 2006, p. 226). The basic position of the Church has been that the intended noble end of producing offspring does not justify the means of achieving that end in an artificial way.

In most religious expressions, the dominant culture of a region seems to mitigate the actual practice of religious traditions and cultures. For example, this is the case with Muslims living in the Western world (Turner, Fox, & Kiser, 2007). This also seems to be the case for many Roman Catholics in the West, especially in North America. Many practicing Catholics recognize the Church's authority in prescribing appropriate sexual behaviors; yet, in the personal life of Catholics, use of artificial contraception is common. As noted above, surveys of American Catholic couples have indicated that more than 80% of Catholic couples have ignored the Church's pronouncements prohibiting artificial contraception (Catholics for Choice, 2008; O'Leary, 2006, p. 187). This is also the case with in-vitro fertilization. As O'Leary (2006) stated, "Some married Catholic couples who need medical assistance … take little cognizance of abstract theological principles … the Church's insistence makes little sense to them when infertility is a persistent problem" (p. 228). Although the number of professing and practicing Roman Catholics who have had an abortion is unknown, the assumption may be well placed, once again, that culture has mitigated the teaching of the Church. Indeed, a significant number of prominent theologians support the idea that a pre-embryo is not a person, and there is no

moral entitlement to the distinction as human life (O'Leary, 2006, p. 230). This assertion—that a pre-embryo is not a person—is completely contradictory to the traditional Catholic position that human life begins at the moment of conception.

This discussion highlights the fact that the therapist cannot presume to know a client's entire belief system simply by knowing that the client belongs to a particular religious group. The practice of belief by an individual client may be mitigated by culture, personal choice, or other influences. Therefore, it behooves the professional therapist, as much as is possible, to be aware of the basic belief system of various religious/spiritual systems, but also to listen closely and empathetically for variations within the individual client.

Premarital and extramarital sex The scriptures and the Church agree that sex is reserved for the married relationship (Seper, 1975, Section VII, Line 7; see also I Corinthians 5:1; 6:9; 7:2; 10:8 Ephesians 5:5; I Timothy 1:10; Hebrews 13:4.) Therefore, premarital and extramarital sex, including same-sex sexual activity, are forbidden, primarily on the basis of the exalted position and desirability of marriage. The conjugal bond of marriage, solemnized according to the Church as a Sacrament, is the only moral domain for sexual intimacy, due at least in part to the procreative function and potential of the sexual union. Notably, this procreative purpose would not be potential in a same-sex bond.

From the perspective of the Church, Jesus affirmed the importance of marriage in Matthew 19:4-7:

> Have ye not read, that he which made them at the beginning made them male and female, and said, For this cause shall a man leave his father and mother, and shall cleave to his wife, and they two shall be one flesh? Therefore, they are no more two, but one flesh. What therefore God has joined together, let not man put asunder.

Furthermore, Paul explained that if an unmarried person cannot live in a chaste manner, refraining from sexual intimacy/intercourse, then that person should marry: "I say to the unmarried and to the widows … it is better to marry than to burn (be aflame with passion)" (I Corinthians 7:8-9).

It is to be inferred from the first scripture ("male and female") that same-sex marriage is not possible. So, although Catholic teachings acknowledge that a homosexual tendency may come from two sources—inadequate or false education/abnormal development *or from some innate instinct*—a homosexual act or practice is never approved (Liebard, 1978, p. 435).

Pornography A growing number of persons are presenting for sex therapy because excessive pornography use is impacting upon sexual functioning. The *Catechism of the Catholic Church* (n.d.) states:

> Pornography consists in removing real or simulated sexual acts from the intimacy of the partners, in order to display them deliberately to third parties. It offends against chastity because it perverts the conjugal act, the intimate giving of spouses to each other. It does grave injury to the dignity of its participants (actors, vendors, the public), since each one becomes an object of base pleasure and illicit profit for others. It immerses all who are involved in the illusion of a fantasy world. It is a grave offense. Civil authorities should prevent the production and distribution of pornographic materials. (Section 2354)

Thus, Roman Catholic belief has resulted in a strong statement opposing pornography. It is opposed because it disrespects the sexual union in marriage, it challenges the privacy and intimacy reserved for two persons, it carries individuals from the real world of personal sexual intimacy to a realm of illusion, and it profiteers from a violation of sanctity and privacy.

This brief discussion of four controversial topics that could arise in sex therapy—artificial contraception, in-vitro fertilization, abortion, and pornography—and the mention of the forbidden nature of all extramarital and premarital sexual intercourse, including same-sex sexual activity, provides a window of understanding into the belief system of those who come from a background of Roman Catholicism. The scope of this article is not intended to be exhaustive, but to set forth representative issues from a client's religious/spiritual background that may arise during sex therapy, or give occasion for the need of therapy.

Conservative Protestant beliefs about sex

Protestants, especially conservative Protestants, have emphasized church dogma to a lesser degree than Roman Catholics and have underscored a belief in the priesthood of the (individual) believer or the priesthood of all believers (Plass, 1959, p. 1140). The basic tenets of this position, in contrast to Roman Catholic teachings, hold that neither grace nor infallible teaching is mediated through the institutionalized church, nor is either embodied in any person holding a church office, such as priest, pastor, or other clergy. Rather, the final and ultimate authority for the individual believer is God and His Word (i.e., the Bible). Although some might deny it, this belief implicitly gives a greater flexibility in practice to the individual because individuals have the authority to interpret God's Word, led by the Holy Spirit (see John 16:13; I John 2:20, 27), without the absolute need for further priestly or ecclesiastical intervention or assistance (Nessen, 2013). Thus, it could be concluded that the Catholic tradition and teaching is actually more "conservative" than the Protestant tradition, if by "conservative" one means uniform, rigid, authoritative, and dogmatic.

Premarital and extramarital sex Sex was scarcely mentioned in the conservative Protestant church until a few decades ago. The cultural openness created during the sexual revolution of the 1960s and 1970s not only created an acceptable forum to discuss sex, it also implicitly placed a demand upon the church to address sex directly. The public conversation following the onset of the sexual revolution eventually bled into the church, as organized religion has shown the propensity to slowly but surely mirror cultural changes. On a higher, more noble plane, perhaps the church felt it essential to respond to the quest of increasing numbers of persons to experiment with—and seek fulfillment in—sexual interactions. The church could make no practical argument that sex is not enjoyable, but it did argue that sex is to be enjoyed within the parameters of a marriage between a man and a woman. According to church teachings, violation of this safe arena of monogamy leads inevitably to personal and social problems, including but not limited to divorce, transmission of sexual diseases, unwanted pregnancies, and personal guilt and self-blame that often results from violation of one's own professed moral code (Ethics and Religious Liberty Commission, 2006). Thus, according to conservative Protestant teachings, sex is reserved for the marital union ("And Adam knew his wife …"; Genesis 4:1). Sex outside of marriage—premarital and extramarital sex—is prohibited. The basic scriptural teaching, consistently held over time by almost all conservative Protestants, is that sex outside of marriage is sinful and wrong, counterproductive and destructive (Exodus 20:14; see also Ethics and Religious Liberty Commission, 2006).

Nevertheless, conservative Protestants teach that sex is good. Sex is God's gift (Wheat & Wheat, 2010, p. 18). God created human beings as complex creatures, and a part of that complexity is that humans are sexual beings. Humans also have minds, emotions, and will as a part of that complexity. In all cases, these aspects of human personhood are to be in subjection to God's will and purpose. As the individual chooses or wills to submit the whole person to the will or purpose of God as revealed in the Bible, a transcendent state of life (John 10:10) results—one of abundance, joy, and spiritual, emotional, and physical fulfillment. In other words, God's gift of sex is not to be treated lightly or squandered in some manner that is

outside God's ultimate purpose for the gift: procreation and pleasure. It is God's gift to be supremely enjoyed, fully appreciated, and appropriated within the parameters God intended—that is, within a marriage between a man and a woman (Ethics and Religious Liberty Commission, 2006).

From this conservative Protestant perspective, sex is also explicitly between a male and a female (God created them "male and female"; Genesis 1:27). The obvious anatomical differences between the sexes are seen as providing a "complementary" role for each gender and are evidence that God intended sex for opposite sex partners. Males and females are essential to complete each other, and in the sexual union, the "two become one" (Genesis 2:24). This assumes an exclusive emphasis on the penile/vaginal anatomy and eliminates the possibility of anal intercourse between two males or oral sex between women.

Despite conservative Protestant teachings that sex is reserved for marriage, recent surveys indicate that as many as 35–60% of all married men and 17–50% of all married women have engaged in extramarital sex (Crosby, 2008). This very fact may result in clients seeking out a sex therapist, or other professional, to address resultant marital discord, sexually transmitted disease, unplanned pregnancy, divorce, discontent, or other changes in the sex life of the married couple.

Contraception and abortion It is worthy of note, and certainly different from the traditional Roman Catholic tradition discussed earlier, that the two-fold purpose of sex, procreation and pleasure, may be either separate and distinct or combined. That is, most conservative Protestants, unlike Catholics, hold that marital sex may be enjoined purely for pleasure, with no thought to or even possibility of procreation. In fact, it is often acknowledged that marital sex may involve less anxiety, and marital pleasure may be enhanced, when contraception—natural or artificial—lessens the likelihood of procreation.

Therefore, most Protestants would likely disagree with the Catholic prohibition on artificial contraception. As was stated above, in good conscience, most Protestants can separate the procreative function from the goal of pleasure in sex. In other words, Protestants generally would assert that sex may be experienced purely and solely for pleasure within the marital relationship, while protecting against an undesirable or untimely pregnancy. Further, some would argue that the practice of artificial contraception is wise stewardship. At the core, the Christian concept of stewardship comes from two Greek root words, *epitropos* and *oikonomos*, meaning something similar to legal representative or household manager. So, consideration of the ability and means to provide adequately for a child or children—prior to conception—would be considered good management or wise stewardship.

Most conservative Protestant denominations and groups have developed position statements regarding abortion. Most of them define a narrow scope of potential circumstances in which abortion may be considered a viable option (e.g., pregnancy due to rape or incest, or when the life of the mother is endangered by the pregnancy).

Pornography Many conservative Protestants believe pornography, including child pornography, may be the largest single sexual problem in the modern day (Ethics and Religious Liberty Commission, n.d.). Given this position, it is likely that the therapist will encounter individuals from conservative Protestant traditions who are troubled by their own use of pornography.

The Ethics and Religious Liberty Commission (n.d.) of the Southern Baptist Convention, a conservative Protestant denomination, stated:

> Pornography perverts and distorts all of the God-given purposes for sexual intimacy. It tells us it is permissible, if not obligatory, to disregard the sanctity of marriage and the "one flesh" concept and sells sex as a form of recreation with superficial self-gratification. It hawks the view that sex is a purely physiological response.

The Intersection of Belief and Sex Therapy

The most commonly reported client sexual issues can be grouped into two basic categories: problems that are not explicitly related to a client's religious values and beliefs, and problems that are more closely tied to religious and spiritual background.

The first category includes issues that are strictly functional in nature. For example, erectile dysfunction, premature ejaculation, vaginal dryness, and infrequent orgasm; these problems may have no obvious connection to religious or spiritual background. However, even in the treatment of sexual dysfunctions there is often considerable shame associated with discussion of sexuality in general, and of personal sexual problems in particular. One of the challenges of sex therapy with clients from a Roman Catholic or conservative Protestant tradition is overcoming the silencing that has often precluded any discussion of sex—and especially of one's personal sexual experiences. The empathetic therapist must first establish a trusting relationship with the client. Once this foundational therapeutic alliance has been forged, communication about sex that is clear, tactful, yet straightforward, kind and thoughtful, and free of judgment, may proceed.

What a client may do, or contemplate doing, in response to sexual functioning problems may have great spiritual/religious impact. *For example, a middle-aged female client, who has loved and been devoted to her husband, reaches a point of great frustration due to her spouse's erectile dysfunction and subsequent unwillingness to engage in sexual activity. He will not go to see a medical doctor, as is the case with the majority of persons experiencing sexual dysfunctions (Dunn, Croft, & Hackett,* 1998*), probably because of embarrassment and pride. She is faced with a complex dilemma: Should she continue to initiate intimacy with her spouse, knowing that it will lead to frustration for her and him? Should she just resign herself to celibacy within her marriage and forego sexual pleasure with her spouse? Should she entertain an extramarital affair for sex only, while remaining married to her spouse in all other ways? Because of her deep religious history and spiritual priority, the very consideration of these alternatives creates a great deal of stress and internal conflict for her.* Perhaps the therapist could explore additional alternatives with the client, especially since none of the alternatives mentioned by the client seem to provide a satisfactory response to the crisis. As a therapist, one would certainly consider the option of a joint session with the couple, with one goal being a consultation with a medical doctor; after all, success rates for improvement of sexual function are quite encouraging. Of course, the likelihood of a joint session to discuss sexual dysfunction may be contingent upon the level of communication previously existing between the partners.

The suggestion of masturbatory training, a common sex therapy technique, may cause recoil in the conservative Protestant or Catholic client, or it may not invoke that reaction. With this awareness, the therapist could proceed with the suggestion, seeking to keep the discussion functional in nature. However, it should be noted that, if the client mentions spiritual/religious concerns, the therapist should respectfully deal with those cardinal issues. Subsequent continuation with masturbatory training may need to be curtailed and other alternative directions sought. Thoughtful therapist-initiated exploration of values can be extremely helpful; imposition of values is not.

The second category of sexual issues that clients may bring to therapy are more directly related to and impacted by the clients' religious and spiritual backgrounds. These are not the categorized sexual "dysfunctions" but, rather, are complex issues intertwining religious/spiritual, sexual, social, and political beliefs and values. Personal guilt and shame associated with marital infidelity, homosexuality, abortion, and even sexual thoughts and fantasies, are impacted by deeply woven principles and traditions from both Roman Catholicism and conservative Protestantism. The complexity of these deep-seated issues, which include both overt behaviors (e.g., marital infidelity, abortion) and covert or internal issues (e.g., thoughts, fantasies,

sexual orientation) should not be taken lightly or dismissed by the therapist. Ethical responsibility demands that the therapist be well-versed and communicative in the religious tradition of the client, even if the client no longer necessarily adheres to religious practice. If the therapist is not proficient or comfortable in discussing innocence/guilt, absolution, or forgiveness from the perspective of conservative Protestant or Roman Catholic belief systems, it may be most beneficial to consult with clergy or other professionals from the religious tradition of the client. It has been the experience of the author that consultative alliances, with predetermined and clear boundaries, between the professional therapist and religion professionals have brought maximum benefit to the client.

How does the client's religious/spiritual background intersect with the counselor's background and with the underlying assumptions of sex therapy? One should expect that clients who come from this tradition of ecclesiastical authority and who have subscribed to the teachings and decrees of the Church would have considerable dissonance if they have chosen to deviate from those teachings and have practiced artificial contraception, for example. The internal turmoil, including guilt and the perceived need for forgiveness, which result from known violations of one's confessed values, is of no small consequence. Does one keep that violation a secret, or is it confessed? And if confessed, is that going to mean that the practice will be abandoned?

Still further, if a Catholic client adheres to the teachings of the church regarding artificial contraception, becomes pregnant unwillingly or unexpectedly and then submits to an abortion, the personal anguish and guilt that is resultant to such a violation of the decrees of one's chosen church may be a terrific burden. In this case or similar cases, the sex therapist surely would want to consult with, and likely refer to, an appropriate clergy/representative of the client's religious persuasion.

Naturally following is consideration of the place and importance of confession in the Roman Catholic religion. The practice of confession assists one in dealing with personal guilt and shame, as well as meeting the demands of scripture and the expectations of the Church. Confession is to be made to God ("If we confess our sins, He is faithful and just to forgive our sins…"; I John 1:9), as well as to others ("Confess your faults to one another…"; James 5:16). But should a guilt-ravaged client confess an affair to an unsuspecting spouse? Well-meaning sex therapists may have differing opinions about this; it is obvious that such confession could have a detrimental effect on the relationship, and failure to confess could be extremely stressful should the partner ever find out about the infidelity. Further, the failure to confess may leave the client with a deep, dark, and foreboding secret that in itself becomes an invisible barrier between partners. Personal confession is an area where beliefs and church expectations place constraints upon the guilt-laden client. Together with the therapist, the client can examine the potential for doing more harm than good to a spousal or other relationship to openly confess to a wronged party or in a public setting. It could be the case that such a confession could add insult to injury.

Ethical Considerations for the Sex Therapist

The therapist must avoid the imposition of personal values on the client or into the therapeutic relationship. To impose one's values would be a serious breach of professional ethics. Regardless of the theoretical framework of the therapist, issues of guilt, forgiveness, and reconciliation related to sexual beliefs and behaviors will need to be addressed. The wise therapist would do well to consult with a local priest or pastor (Sue & Sue, 2013, p. 283) to discern what actions the client might take to find restoration with the church, absolution of guilt, and personal forgiveness, and what avenues exist for the client's future.

Specific ethical concerns

Confidentiality and exceptions to confidentiality One of the cornerstones of the therapeutic relationship is trust. Clients must be able to trust the confidentiality of the relationship. Certainly, sexual concerns are among the most personal, private, and intimate concerns that clients may bring to the therapist. The client's right to privacy must be respected (American Counseling Association, 2005). Therapists do not share information that is confidential without client consent, or without solid legal or ethical justification (American Counseling Association, 2005).

The confidential posture of the priest/clergy and the therapist are closely related. The relationships between priest and parishioner and between therapist and client are both considered special relationships. The generally accepted position is that a priest must never reveal information gathered in a confession unless the confessor has given explicit consent to do so (Dyer, 1975, p. 270). The therapist/client relationship is viewed as being slightly less binding. In the therapeutic relationship, there are limits to confidentiality, such as the therapist's duty to warn appropriate persons if the intent to harm self or another is manifested or in the case of knowledge of HIV/AIDS or other serious contagious disease. Given the limits on confidentiality, such limits should be clearly communicated with the client from the outset of the therapeutic relationship, especially because clients from some religious backgrounds may assume that the therapist is bound to the same rules of confidentiality as the priest/clergy.

For example, the exception to confidentiality noted above—the case of client disclosure of HIV/AIDS—has been legally placed in the same category as a client who reveals the intent to kill, or otherwise harm, a third party. The duty of the professional to warn identifiable potential victims is well established. In the case of an HIV-positive client, client disclosure of past intimate behaviors or the intention of such intimacies in the future necessitates clarification of the limits of confidentiality and appropriate action on the part of the therapist. On the other hand, the priest would never reveal such information if it was gleaned during the confession (Dyer, 1975, p. 270).

Boundaries of competence Therapists are ethically bound to operate only within their competence, as determined by education, training, supervised experience, professional credentials, and professional experience. Although it is incumbent upon therapists to seek a growing competence in working with clients from diverse cultures, including those of diverse religious backgrounds, it should be recognized that complete knowledge regarding every potential cultural/religious/spiritual tradition from which clients may come is impossible. Sue and Sue (2013) stated that "… cultural competence … is aspirational rather than achieved" (p. 48). If the counselor is not competently acclimated and/or trained in the Roman Catholic or conservative Protestant traditions, for example, then consultation or referral is in order while new awareness and skills are being developed (American Counseling Association, 2005).

Personal values Therapists must be aware of their own beliefs and values, and avoid imposing such upon clients in any case. The majority of therapists are not religious, and even fewer receive any instruction in spiritual or religious issues in their training programs (Bergin & Jensen, 1990). Nevertheless, the ethical therapist respects the rich diversity of clients. Religious background is a part of that rich diversity, with 80% or more of people in the US stating that religion is important in their lives (Sue & Sue, 2013, p. 281). Thus, to ignore or challenge deeply held religious beliefs is, in many cases, unethical behavior. Further, it seems apparent that, in the event of personal discomfort, lack of knowledge, or disagreement with the client's religious persuasion, the ethical therapist will objectively seek to be informed regarding the religion of the client, perhaps consulting with or referring the client to a religious professional. Conflicting viewpoints regarding culture, worldview, and religion are likely quite common in

the therapist–client relationship; the therapist must be able to lay aside personal values—purposely avoiding imposition of such—and seek to empathetically enter the client's world.

The ethics of couples and family counseling Naturally, sexual therapy often involves more than one person. It may involve, directly or indirectly, the client's spouse, for example. It is incumbent that the therapist identifies exactly who the client is—and is not. Limits of confidentiality in such cases must be clarified. Negotiating couples and family therapy can be especially challenging in cases in which the religious backgrounds of the individuals differ. As one example, a husband coming from a Roman Catholic tradition, and his wife, who converted to Catholicism, disagree significantly over the use of contraceptives. As another example, a wife discovers her husband's affair. Being a devout Roman Catholic, she insists that he must go to confession and acknowledge his affair. He is unwilling to do so, stating that he does not want to "air his dirty laundry." In these cases, the couples' conflict is heightened by the difference in religious belief and practice. In such cases, the therapist must clearly identify who the client is, and work to facilitate a negotiation that honors the religious beliefs of the identified client or clients.

Case Example

Luis and Amanda married in 1980. Both had come from families whose religious orientation was very consistent and influential during childhood and adolescence. Luis was from a Roman Catholic family that had been faithful adherents for several generations across several decades. Amanda was reared in the Midwest in a small farming community. Most of the residents of the community, including Amanda's family, were active Protestants, including United Methodists, Lutherans, and Presbyterians.

During the initial period of their marriage, Luis and Amanda—aged 22 and 20, respectively—essentially dismissed any discussion of contraception because they were enjoying their sexual intimacy immensely and were also eager to "start a family." Amanda became pregnant in the tenth month of their marriage, and their first child was born after about a year and a half of marriage. Within three years, Amanda had given birth to two beautiful children and was pregnant with a third. In the months after the birth of the second child, Amanda began to experience some discomfort during intercourse, and subsequently, the frequency of sex diminished. During the third pregnancy, Amanda brought up the subject of contraception or having a tubal ligation. Luis was shocked and quite disturbed that Amanda was entertaining such thoughts. For the first time, they discussed Luis's religious background and the Roman Catholic prohibition of contraception. He was adamantly against any consideration of artificial contraception in any form. Amanda took a stance more in keeping with her traditional Protestant understanding, which did not seriously question the conscientious use of artificial contraception. They were both deeply committed to their marriage, but their intimate sexual episodes became fewer and fewer. Amanda continued to experience consistent and worsening vaginismus, and her sexual desire waned. Luis was increasingly frustrated and grew emotionally distant. Neither of them had any thought that the source of their sexual challenges lay in their deeply held religious differences. They were wise enough and sufficiently committed to their marriage, and to one another, to seek counsel. Amanda's gynecologist referred her to a professional therapist with expertise in sex therapy. Eventually Luis joined her. Not only did Amanda's pain diminish with a typical treatment regimen, but Luis and Amanda were able to build stronger communication skills, especially in their ability to talk about their expectations and potential solutions that would improve their waning sexual connection.

Summary

In summary, for many years, therapists in various areas of mental health generally avoided talking with clients about spiritual or religious backgrounds and issues. Reasons for such willful silence were—and are—many: feelings of incompetence, fear of accusations of proselytizing or being judgmental, feelings of personal inauthenticity in breaching religious or spiritual topics,

or displacing the role of clergy (Sue & Sue, 2013, p. 281). On the other hand, research findings have indicated that religion/spirituality is strongly correlated with one's cultural identity, and adherence to religious beliefs is significantly related to fewer mental health and physical problems (Sue & Sue, 2013, p. 281). Thus, an awareness of the spiritual/religious background of clients would seem to be a professional necessity for the sex therapist.

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26

Treating Sexual Problems in Clients who Practice "Kink"

Margaret Nichols and James P. Fedor

Introduction

Pepper Schwartz, the sociologist who has been studying American couples since 1980, and her colleagues completed an internet survey of over 90,000 people worldwide. They reported that 86% of all men and women said they were "intrigued by kinky sex" (Northrup, Schwartz, & Witte, 2012, p. 77). Further, their data were collected before the publication of *Fifty Shades of Grey* (James, 2011), the popularity of which likely increased people's fascination with kink. As recently as ten years ago, we would have written this chapter with the intent of convincing the reader that people with sexual interests in bondage and discipline, dominance and submission, sadism and masochism—often referred to collectively as BDSM—are not intrinsically mentally ill, and we would have appealed to the clinician's/reader's sense of justice to have compassion for this underserved and misunderstood population. But now we write, in part, so that sex therapists unfamiliar with kink and the people who practice it can see the strengths inherent in this kind of sexuality. Kinky people are models of sexual communication that we all would do well to emulate; the variety found in their sexual practices can keep sex edgy and hot even in long-term relationships; and BDSM is connected to spirituality and sexual healing, much like tantric sex practices.

Kink is a slang term meaning sex that is non-standard and may include any of the following: role play (e.g., teacher/student, army sergeant/army private), performances of power dynamics (e.g., dominant/submissive roles), and unusual forms of stimulation (e.g., flogging or spanking, bondage), as well as the use of specific objects or materials (e.g., leather) or a focus on specific non-genital body parts (e.g., feet) to achieve sexual satisfaction. Many, probably most, people "into" kink incorporate some aspects of BDSM sex into their sex lives privately, with a frequency ranging from occasionally to nearly always. A smaller number feel that being kinky is essential to their identity, and many of these people are members of a BDSM subculture, one that is partially intertwined with the LGBT or queer community, but which also includes many heterosexually-oriented people as well. For obvious recruitment reasons, virtually all research on kink is based on the small group of people who belong to BDSM organizations, and thus, most of the research is restricted to those for whom kink is a central part of their identity. We know next to nothing about the many people who just incorporate spanking or bondage or role playing into their private sex lives but who would not identity as kinky or go to a club

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or an organization. Pepper Schwartz's data and the popularity, not only of *Fifty Shades of Grey*, but also of the BDSM toys and paraphernalia related to the book, indicate that the number of those people may be far greater than we had imagined.

It is fitting that this topic be covered in a book on sex therapy. The field of sexology is considered to have been born with the 1865 publication of Kraft-Ebbing's *Psychopathologia Sexualis*, a book written to aid police in their pursuit of deviants and perverts, groups that included homosexuals and anyone interested in what we would now call BDSM (Nichols, 2014). From 1865 to the present day, kinky sexual practices have been viewed within sexology as inherently pathological (i.e.,"paraphilias") by some (e.g., Freud) and as simply interesting deviations from the norm by others (e.g., Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). From the time of the American Psychiatric Association's (1952) first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until the publication of the revised fourth edition in 2000 (DSM-IV-TR; American Psychiatric Association, 2000), all of the sexual behaviors entailed in consensual kink have been lumped with each other and with other nonconsensual acts, like pedophilia and sadistic rape, and considered mental illnesses.

The field of psychiatry has a long and ignominious history of aiding in the social oppression of certain groups, such as black people, women, gays, and anyone with unusual sexual tastes (Lev, 2005). For most of the 20th century, laws criminalizing homosexuality were justified on the grounds that gay people were mentally ill predators, and homosexuality was grounds for commitment to a mental institution. Many historians believe the remarkable gains in the social acceptance of gay people in recent decades would not have possible without the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973 (Bayer, 1981).

Social attitudes about kinky sex are evolving as the topic "comes out of the closet" and appear to be following the trajectory established by attitudes and laws about homosexuality. Until recently, the psychiatric label "paraphilic" has been invoked to justify discrimination in housing, employment, even healthcare, and it has been used to wrest custody and visitation rights away from parents (Klein & Moser, 2006). However the current volume of the DSM, DSM-5 (American Psychiatric Association, 2013), is a radical departure from the past. It distinguishes between people (1) who may be paraphilic but not mentally ill from (2) those for whom the paraphilic behavior has been nonconsensual or has caused significant distress and impairment to personal functioning. The category name has been changed from "paraphilias" to "paraphilic disorders" to highlight that not all paraphilias are considered disorders. These changes were made, in part, because of the educational efforts of civil rights advocates and, in part, because recent research on people who practice BDSM showed them to be overall mentally healthy and high functioning (Richters, de Visser, Risset, Grulich, & Smith, 2008; Sandnabba, Santtila, & Nordling, 2002; Wismeijer & van Assen, 2013). Within months of the release of the DSM-5, the National Coalition for Sexual Freedom, an advocacy group for people in the BDSM and polyamory communities, reported better legal outcomes for kinky people fighting custody or visitation battles (Wright, 2014).

The DSM changes were driven by advocates from within the kink community as well as by scientists and therapists, just as was the removal of homosexuality from the DSM decades before. In the 21st century, many mental health practitioners and sexologists have moved from arguing about whether BDSM represents a pathology to really exploring the interesting ways in which BDSM people differ from more "vanilla" individuals (i.e., the term kinky people use to describe those interested in only "standard" sex, such as fondling, intercourse, and oral sex), what sexual problems might be specific to kinksters (Ortmann & Sprott, 2013), and what kinky sex can teach us all about sexuality more broadly (Easton & Hardy, 2004; Kleinplatz, 2006; Langdridge & Barker, 2013; Nichols, 2006).

Myths and Misconceptions

Because BDSM practices have long been considered a taboo expression of sexuality and/or identity, the kink community has existed in the shadows, and many myths and misconceptions have developed. Here we discuss some of the most common of them. It is important to be mindful that these myths may have been internalized, not only by treating therapists, but also by the kinky client. Assessing for the client's sense of internalized "BDSM-phobia" must become a part of the therapeutic process in an effort to empower the client to explore and embrace their place along the BDSM spectrum.

Myth 1: BDSM is abuse

In any community, mainstream or kinky, there will be some individuals who use sex abusively or engage in violence. But BDSM is not abusive *per se*, and there are many differences between kinky sexual practices and abuse. The motto of the kink community is "safe, sane, and consensual." The National Coalition for Sexual Freedom (2015) defined safety as "being knowledgeable about the techniques and safety concerns involved in what you are doing, and acting in accordance with that knowledge." Sane was defined as "knowing the difference between fantasy and reality, and acting in accordance with that knowledge." And consensual was defined as "respecting the limits imposed by each participant at all times." For any type of BDSM encounter to occur, both parties must be consenting individuals, and limits to the interaction must be clearly discussed and agreed upon. Although some aspects of BDSM play might carry an element of risk (e.g., biting and "breathplay," in which partners temporarily cut off or limit the other person's oxygen supply), both parties must communicate how personal safety will be maximized. This sometimes entails the use of a "safety word" for one partner to indicate to the other that a limit is being reached. Although it might be assumed that this is done solely to protect the partner who is in a more submissive role, it can equally apply to concerns that the dominant partner may have. For example, a dominant might invoke the usage of a safety word if discomfort in exercising control over the submissive is being experienced. Setting limits is a crucial element of BDSM practice; unlike what happens in most vanilla—or nonkinky—sex, before having sex, BDSM partners typically communicate explicitly, verbally, and in great detail about what they like, what they are willing to try, and what is a hard "no." This also establishes safety.

In a statement from the Lesbian Sex Mafia (n.d.), seven distinctions were made between sadomasochism (SM) versus abuse: (1) An SM "scene" is a controlled situation whereas abuse is an out-of-control situation; (2) negotiation occurs before an SM scene to determine what will and will not happen in that scene, whereas, in abuse, one person determines what will happen; (3) SM involves knowledgeable consent to participate in the scene expressed by all parties, whereas abuse involves the absence of consent; (4) SM employs a safe word that will allow for a discontinuation of the scene at any time for physical or emotional reasons, whereas an abused person cannot stop what is happening; (5) everyone in the SM scene is concerned about the needs, desires, and limits of others, whereas abuse is the lack of concern for the needs, desires, and limits of the abused person; (6) the people involved in an SM scene are careful to be sure that they are not impaired by alcohol or drug use during the scene, whereas alcohol or drugs are often used before an episode of abuse; and (7) after an SM scene, the people involved are more likely to feel good, whereas after an episode of abuse, the person abused is more likely to feel bad.

Myth 2: People who like kink were abused as children

Many people believe that those who engage in BDSM must have a history of being abused when young, and that this abuse has shaped their "sick" sexual desires. In fact, there is no evidence of greater incidence of child abuse among the BDSM population in comparison with

those who engage in vanilla sexual behaviors (Moser, 2002). Additionally, there is no difference in childhood attachment styles between kink and nonkink individuals (Nordling, Sandabba, Santilla, & Alison, 2006). Some therapists assume that "bottoms"—also called "submissives"—must be self-destructive and that those who play the dominant role must be violent or angry, but there is no evidence for these assumptions either (Kolmes, Stock, & Moser, 2006). Indeed, people who have a history of being abused exist in all communities, and the therapist should not assume that a client's history of being abused caused a BDSM orientation.

Myth 3: BDSM is addictive

Observing the intense stimulation involved in BDSM practices like flogging, some people fear that those who try them will become "addicted." They believe that BDSM practitioners habituate to the stimuli and require increasing amounts of, for example, pain in order to reach the same "high." From this perspective, even experimenting with kink is viewed as dangerous, as experimentation can become a "slippery slope" that will result in people requiring more extreme or intense experiences. This belief is part of the pathologicalization of BDSM, and there is no evidence for this nor for the related beliefs that people who like kink *only* engage in kink, or that kinksters gradually spread their interests to nonconsensual paraphilias, like pedophilia or sadistic rape (Barker, Iantaffi, & Gupta, 2007). Unlike addiction, there is no proof that those who engage in BDSM continuously search for a new "high." In fact, most people experience a "levelling off" of their kink behaviors following their initial experiences (Nichols, 2006).

Although there is no evidence that kinky individuals escalate over time in terms of their need for intensity or in terms of the harmfulness of their behavior, it is the case that most kinky people have a wider repertoire of sexual acts than vanilla people and rarely confine their sexual interests to one activity (Sandnabba *et al.*, 2002). Thus, the therapist should expect her/his kinky clients to engage with various aspects of BDSM; the therapist could even encourage the client to explore the variety of BDSM expressions in a safe, sane, and consensual manner, as a way of learning more about their own sexual tastes.

Myth 4: BDSM is all about pain

Many people associate BDSM with pain. Although the exchange of pain may be an occasional part of BDSM practices, it is incorrect to assume that activities like flogging or spanking are practiced by all kinky people, or that pain is the only or primary sensation that is experienced during a BDSM interaction. Further, the experience elicited, for example, during a spanking, is not pain as most vanilla people think of it. BDSM is an exchange of heightened emotional or physical stimulation, and much of the stimulation takes place during periods of very high levels of sexual arousal when the body is less susceptible to feelings of pain. As Nichols (2006) explained, "Think pain as in biting your lover in a moment of sexual abandon—not pain as in root canal" (p. 284).

Power dynamics are often more significant in BDSM interactions than the giving or receiving or pain. For example, a person who enjoys being slapped by his partner may be receiving just as much, or even more, stimulation from the act of being submissive to the partner than from the slapping itself. There are many kink activities that involve a dominant/submissive dynamic but do not incorporate pain, such as bondage or role play. And the sources of pleasure in BDSM are complex. One client recently expressed, "My partner does not allow me to masturbate, sometimes for days or weeks. Of course it's hard for me to control that. But being obedient to him ultimately gives me a rush that no amount of masturbation could ever achieve."

Countertransference

Mental health practitioners across psychological, social work, and counseling professions are obliged to provide therapeutic services to their clients without bias or judgment (American Psychological Association, 2010; National Association of Social Workers, 2008). This is not always easy. Countertransference is widely understood to be the personal reactions experienced by the therapist in response to the client, and it can often be useful in the treatment itself—for example, when the therapist's reactions resemble those of people in the client's everyday life and thus provide important information about how the client impacts others. But a distinction must be made between diagnostically useful countertransference and potentially destructive countertransference. If the therapist is not educated about kink and self-aware (i.e., conscious of his/her feelings of countertransference), personal reactions may be projected onto the patient. Because kinky practices and identities are both misunderstood and stigmatized, elements of countertransference may arise within a therapist who is unfamiliar with BDSM. Indeed, "many psychotherapists appear to have limited or inaccurate information concerning persons who engage in BDSM, to be uncomfortable with such persons, to employ unhelpful or unethical practices with their BDSM clients, and to inappropriately pathologize BDSM activities" (Lawrence & Love-Crowell, 2008, p. 68).

Common countertransference feelings described by therapists who have little experience with BDSM include shock, fear, anxiety, disgust, and revulsion (Nichols, 2006). It is imperative for the therapist to be aware if such feelings arise and to work on resolving negative reactions and ingrained biases. Yet, as important as it is to acknowledge one's feelings of countertransference toward kink, this issue has received scant research attention. One qualitative study conducted by Lawrence and Love-Crowell (2008) examined the experiences of psychotherapists who had worked extensively with BDSM clients. The psychotherapists from this study believed, first, that knowledge of BDSM practices and values is a component of culturally competent practice, and it is the therapist's responsibility to remain educated and knowledgeable about this. Second, the psychotherapists in this study iterated that BDSM is typically a background issue for the client rather than a central issue in therapy. In other words, the unchecked countertransference of the therapist may cause the therapist to exaggerate the role of BDSM practices and values in the patient's treatment-seeking, when in fact the BDSM might not be the main concern for which the client is pursuing therapy. Third, working with BDSM clients may present challenges to the maintenance of the therapist's boundaries, specifically around the therapist's own unresolved or unexplored issues of sexuality. An unaware clinician may not recognize his or her own fear and anxiety projected onto the kinky client in the form of revulsion or negative judgment. One study conducted by Hoff and Sprott (2009) asked 32 BDSM-identified heterosexual couples to describe how their BDSM identities influenced the therapeutic relationship and process. Although some positive therapeutic experiences were reported, for the most part respondents indicated that they had not disclosed their sexuality to their therapists, or that when they did disclose, they were greeted with negative judgment and even termination of services.

By addressing her or his countertransference, the sex therapist is able to maintain the nonjudgmental attitude so necessary for clients to open up and disclose private sexual issues and to allow an honest therapeutic relationship to develop. Addressing a medical audience, Williams (2012) explained how a non-judgmental presence can allow the client to discuss erotic activities that may carry certain specific physical or psychological risks. Williams further reminded professionals that lack of knowledge or comfort regarding BDSM may lead to the oversexualization of kink practices. Understanding that, beyond the role of sex in BDSM, "for some, BDSM offers a safe space to enjoy creative, embodied experiences and to express important aspects of identity that are not often realised or performed" (Williams, 2012, p. 745)

can allow for a deeper rapport to be built with the client, which may result in an overall more enriching therapeutic experience.

For example, Sam was a 45-year-old man who was seeking therapy for increasing feelings of depression and anxiety. Heterosexually married for 10 years, Sam had been having an intimate relationship outside of his marriage with a woman named Kate for the last six years. During the initial assessment, Sam stated that he had seen countless therapists throughout his life, but that most of them were only for a few sessions. He felt he had never "clicked" with a therapist and had never been completely open with any of them. I probed this a bit further, asking Sam if there was a particular issue that he felt uncomfortable discussing in previous therapy. Sam stated that there were certain kinky elements to his relationship with Kate that previous therapists sought to "cure." As a kink-aware therapist, I asked if his relationship with Kate was safe, sane, and consensual. He confirmed that it was, and I began to normalize the range of kinky relationships, using certain terms, such as "master/slave" and "dominant/submissive," that are well known to people who engage in kink and that served to reveal my understanding and acceptance of the subculture. Sam's body language and facial expression immediately became more open, and he stated, "I've never had a therapist who spoke my language!" Sam explained that he was the "Dom" to Kate's "Sub," a relationship that only occasionally involved sexual intercourse. I validated this dynamic by addressing how kink relationships can sometimes be more about a particular mindset than about sexual expression. From there, Sam began speaking of his recent feelings of depression and anxiety. At the end of the session, Sam stated, "I have told you 90% more in one session than I have ever told a previous therapist. Thanks for not making me feel like a freak."

Knowledge and non-judgment of Sam's kink orientation made it possible to build a more authentic rapport, which in turn allowed Sam to more openly discuss his vanilla marriage, his increasing identification with closeted kink lifestyle, and other aspects of his life that were causing him distress.

Common Clinical Issues of Kinky Clients

Lawrence and Love-Crowell (2008) concluded that most people who engage in BDSM practices come to psychotherapy for reasons unrelated to their sexuality. A client entering treatment for, say, depression might well never disclose their interest in kink to a previously unknown therapist. Many practitioners have no idea they are treating clients with strong sexual interests in BDSM. However, there are two groups of kinky clients who might disclose their interests to their therapists—particularly sex therapists—and these groups seek out different types of therapists. When kinky clients who are comfortable with their kinky identity have sexual problems or some other issue that involves disclosing their sexuality, they are most likely to seek help from a therapist known within the kink community, who will be affirming of their identity. The average sex therapist, who does not specialize in kink, therefore, sees a very particular subsegment of those interested in BDSM, one that may trigger countertransferential judgments of pathology. For example, a sex therapist who is not a kink specialist often sees people just "coming out" as being into kink, including older people married to vanilla spouses; those who have been "discovered" as engaging in kinky behaviors by their disapproving partners; and those who want to be "cured" of their interest in kink. In other words, a therapist not specializing in work with sexual minorities may see the kinky people who are in the most distress about their sexuality, the most ignorant of the BDSM subculture, and the most likely to have internalized kink-phobic attitudes.

"Coming out" as kinky

Because BDSM has been pathologized and stigmatized, people with kinky sexual interests often go through a period during which they keep their interests secret from others and may even deny or repress them. They come out, much as LGBT people come out, because they are discovered by someone else or because they can no longer deny this important component of

their sexuality and even identity. They undergo a process that may be painful and scary, in which they explore their newly-emerging selves and determine where they fit along the BDSM spectrum. Some clients may not know that they are "allowed" to entertain kinky thoughts, and may be seeking "permission" from their therapist—and needing it—to even verbalize these thoughts. Often, a therapist is in a position to create a safe space for the client to first begin to express these desires.

> *For example, Chris was a 23-year-old bisexual man, who sought treatment for anger management. Chris was in a two-year-long relationship with his girlfriend Jade, age 25, who sometimes accompanied Chris to sessions. Chris and Jade agreed that Chris's anger often erupted immediately after sex. In individual sessions, Chris expressed his fear that he was impotent, as he found it difficult to maintain an erection during sex with Jade. After exploring this more, Chris finally admitted that he did not find sex to be satisfying with Jade, and this made him feel like a failure as a boyfriend. Taking a sexual history in session, Chris could only remember one previous sexual partner with whom he was able to feel sexually satisfied on a consistent basis. For some time, Chris maintained that there was nothing different about this previous sex partner, until he was asked about less typical sexual acts. When asked explicitly if there were any kinks or fetishes that he was able to explore with the previous partner that he was not able to do with Jade, Chris's first response was that he was not into pain or "master and slave stuff." After the therapist normalized kink by giving examples of how it might be expressed (e.g., "Some people enjoy role play, or foot worship, or being tied, and might think that they are the only ones who have these desires."), Chris then hesitantly admitted that he had enjoyed engaging in watersports (i.e., urination play) with this previous partner and felt that he couldn't tell Jade that he enjoyed this. He said that he was afraid that Jade might think he was "weird" for liking this, and he wasn't sure how to broach this topic with her. As Chris began to accept this fetish as a harmless aspect of his sexual behaviour, he developed more confidence in talking about it with Jade. Chris's eventual disclosure to Jade of his interest in watersports led to a dialog in which Jade also expressed some of her desires and fantasies that had never before been expressed. With Chris's disclosure, communication between him and Jade gradually improved overall, allowing a climate of safety to grow.*

People with BDSM interests often go through an identity evolution process similar to that described by Cass (1979) in her stage theory of coming out as gay or lesbian. It is not unusual for feelings of guilt or shame to exist during the time a person is coming out as kinky, even though, in general, BDSM practitioners experience no more guilt or shame than others. Kolmes *et al.* (2006) warned against therapists perpetuating clients' guilt and shame by urging their clients to stop their sexual practices. Although clients might be urged by the sex therapist to go through the process of self-exploration and disclosure slowly, eventually the process leads to self-acceptance and even identity pride. Clients just beginning to explore their kinky sexuality need their therapist to provide an affirming alternative to the negative attitudes of the mainstream culture. Clients in the coming-out process also may feel compelled to search for the reasons "why" they identify with some aspect of BDSM. A client who is asking "why me?" can be encouraged to explore what their beliefs are as to what "caused" their connection to BDSM; this can allow valuable insight into the client's sexual history and value system, which may be beneficial for the therapeutic process. The therapist can be of critical importance during the initial stage when the client is coming out to themselves, allowing a safe place for the client to express any concerns, beliefs, or opinions related to BDSM.

In these authors' experience, coming out as kinky appears to be easier for non-heterosexuals, in part because gay people have already gone through one coming-out process and in part because the queer and kink communities have considerable overlap. As a gay client stated:

> Once you come out as gay, the taboo has already been lifted. I came out to everyone as a gay man years ago, so I already declared to my friends and family who it was that I loved, and they now knew who I wanted to have sex with, basically. So I was forced to confront issues of sexuality, masculinity, and identity, and what it meant to me, at a pretty young age. I don't think most straights need to

> do that. So being into SM, well, it's no problem at all for me to talk about this with people. And I've learned to not be surprised by what people tell me. Someone wants a threesome? OK. A guy wants me to trample him? Sure, why not.

For example, Jon is a 32-year-old, gay, biracial man of African-American and European descent. Since the ending of a long-term relationship about a year before, Jon had been casually dating and having sex with a few different men, "nothing serious—just fun." Several months before coming to therapy, Jon had had a sexual encounter with a man who incorporated leather into their sexual play. He said:

> *I knew that there were guys who were into leather, but never really knew what it meant. But there was something about the scent, the feel of the leather, how it felt on him as we were having sex… it just did something to me, tapped into a different part of myself, and I loved it. It meant something to me—masculine, sexual, and real.*

After that experience, Jon began frequenting leather bars, met new people, and began to expand his network of friends, acquaintances, and lovers. As he said:

> *It's so freeing. These people I've met at parties, bars, whatever—nothing shocks them. Anything that I previously would have kept to myself in terms of my sexual desires, or of my need to dominate someone else, they understand. It's like there are other people who speak my language. And the more I meet with these people, the more I realize what I like and what I don't. It reminds me exactly of what I went through when I realized I was gay. As a kid I thought that being gay was this huge sin and that I was the only one, until I began opening up to people and then realizing that I could have actual relationships. With BDSM, it's the same thing.*

Because Jon had the support of a gay BDSM community, his coming out was relatively easy.

When the client coming out as kinky is heterosexual, the process may be more difficult, especially in more conservative, non-urban areas. BDSM organizations are more invisible outside of queer, urban communities, and the person first discovering or expressing their kinky sexuality may feel stigmatized and isolated. These individuals need referrals to resources—books, online informational sites, support organizations—because they need to know how to navigate safely within BDSM practices and, if they choose to frequent them, BDSM clubs and parties. One excellent resource for the beginner is Fetlife.com, a kind of Facebook or Match.com for kinksters. Fetlife has special interest groups for support and information exchange, and the largest special interest group is for novices. Other sites, like KinkAcademy.com, include thousands of videos demonstrating BDSM techniques.

BDSM sex, because of its psychological and physical intensity, carries certain risks, and the kink community is acutely attuned to issues of safety and consent. The "safe, sane, and consensual" motto of the kink community is heavily enforced at clubs, organizations, conferences, parties, and other public events. An unaccompanied woman, for example, is probably safer at a BDSM event than at the average vanilla bar. Therapists working with clients just coming out into kink would do well to direct them to the novice group of their local BDSM organization (most major cities have one).

Therapists should also be aware of the laws impacting BDSM (Klein & Moser, 2006). There are no legal protections against housing or employment discrimination for kinky people, so coming out must be done judiciously. A kinky lifestyle may be grounds to deny child visitation or custody, so disclosure to an unsupportive spouse is fraught with danger. Although the therapist may consider openness and authenticity psychologically healthy, it is not always possible for people who practice BDSM sex to risk such authenticity. Indeed, the legal risks are serious enough that, at the clinic where both authors practice, we avoid any documentation of BDSM activities in our clinical files.

Clients caught by spouses and clients who ask to be cured

As we have already mentioned, the average sex therapist is less likely to see clients who are comfortable with their BDSM sexuality and more likely to see people who have BDSM/fetish sexual preferences but who are closeted and isolated, especially if the clients are heterosexual and the area is not urban. Therapists are also likely to see those who have internalized negative social attitudes about kink and are horrified, ashamed, even repulsed by their own sexuality. Some of these people will ask you to cure them of their kinky interests.

There is no evidence that therapy can eliminate kinky sexual desire. Indeed, BDSM calls into question our concept of "sexual orientation." Although the term tends to be used only to describe same- versus other-sex sexual attractions, it has come to connote sexual preferences that seem "hard-wired"; unchangeable, at least through conscious will; and persistent. By this definition, BDSM is a sexual orientation that varies along a continuum just like same- or other-sex attraction, with many people having no interest in BDSM, many having small to moderate amounts of interest, and a few whose kinky tastes dominate their sexuality. At the Institute for Personal Growth, where both authors have a clinical practice, we explain to clients who wish to be cured that they can control their sexual behavior but not their desires. We explain that their sexuality is unusual but not pathological, and that there are many others with the same tastes. We validate and affirm them, and we give them resources—online informational sites, groups and organizations, and books. Most of all, we encourage self-acceptance. Clients who can achieve some degree of self-acceptance—and therefore lower their distress level—are paradoxically likely to experience a reduction in their obsession with the taboo sexual preference and may even become more able to enjoy vanilla sex acts. Their kinky sexual preferences are not eliminated, but the intensity abates and their sexuality may expand. Many clients who come in self-hating and asking to be cured eventually act on their preferences without shame or anxiety. Some choose to try not to act on them, with varying degrees of success.

This approach, reframing pathological sex as a less common but normal variation, is most effective with clients who are not in committed relationships with unsuspecting partners (i.e., clients whose lives will not be turned upside down if they acknowledge or express their sexuality). Those whose sexuality is hidden from spouses are often the most distressed, particularly if they believe the partner will be disapproving and if they want to preserve the relationship or marriage. These individuals are reluctant to tell their partners and, once they are convinced that they cannot be cured, are likely to either attempt to repress their behavior or to maintain a secret second life.

Case example *Tony was a 33-year-old construction worker, who came to therapy in desperation. He had strong BDSM desires, which he had fought for years, acting on them only intermittently with women he met online. He was engaged to be married, and his fiancée was pregnant with their first child. Tony had strong, traditional Catholic values. He could not imagine telling his fiancée of his sexual tastes and felt that acting on his BDSM desires would condemn him to a nontraditional life, outside of the mainstream, which he could not tolerate. Over time, he became convinced that his desires were not "sick," but he still rejected the idea of telling his fiancée. As he became more self-accepting, he was encouraged to at least allow himself to fantasize about kink while making love with his partner. This had the effect of making him enjoy intercourse and oral sex more, which in turn, reduced his anxiety and distress. After months of therapy, he broached the idea of light bondage to his partner, and to his surprise, she showed genuine interest. Once Tony realized that his ability to be faithful to his about-to-be wife would be strengthened by making sex with her more enjoyable to him, he incorporated a little kink into his sex life—without ever disclosing the extent of his BDSM interests. He felt satisfied with this outcome and left treatment.*

Case example *Steven came to sex therapy ostensibly to deal with erectile dysfunction (ED), but it quickly became apparent that his ED was driven by lack of arousal. He had intense interests in bondage and discipline, which he had always suppressed. His had not told his wife of seven years, Karen, about*

these interests. The sex they had—or attempted to have—was purely vanilla. Steven and Karen, however, were both already nontraditional; they were educated, technologically-minded people, who ran a social media business together, knew many gay people, and were liberal and open-minded. Steven eagerly embraced the idea that his sexual desires were normal after only a handful of sessions, and worked to reduce his shame and increase his self-acceptance. He wanted to tell Karen, and so eventually he brought her to sessions so he could come out to her in the safety of the therapist's office. Karen was surprised and distressed, but not because she thought Steven was sick. Steven was a bottom and wanted a partner who would dominate him, and Karen could not imagine herself in that role. She had been physically abused by her father as a child and equated dominance with cruelty. However, Karen and Steve had a solid, loving relationship, and Karen very much wanted to at least experiment with being in the dominant role. She realized that her reticence represented unresolved trauma from her childhood abuse and decided that working on this issue would be helpful no matter what the outcome. So Karen and I did some individual work involving trauma-related interventions and, as a result, her misgivings diminished. To her surprise, she found that being in a dominant sexual role was exhilarating and healing—it felt like a ritualized re-enacting of her childhood abuse in a way she experienced as corrective. This couple has remained in touch with me over the years, and they continue to be happy and contented in their relationship—sexually and in other ways.

Case example *Lou came to treatment asking to be cured of his desires to be in a dominant/submissive relationship. He had been married for over 20 years to a woman who never enjoyed sex and who over the years had gradually ceased to be sexual. During the early years of his marriage, Lou had managed his kinky interests through fantasy during masturbation and during sex with his wife, but as his wife became less sexual, Lou's drive to act out his kinky fantasies increased. He came to me asking for a cure, but readily accepted the concept that his desires were normal but less common than vanilla sexual interests. Still, Lou refused to tell his wife about his sexual interests or bring her into therapy, instead constructing a secret life for himself with outside partners, while attempting to maintain the image of a perfect suburban husband. After a couple of years, however, his wife discovered his activity and the marriage did, as he had predicted, dissolve. Despite a difficult and costly divorce, Lou feels he is better off now. He is able to pursue BDSM relationships, which he finds rewarding personally and sexually.*

It should be clear from these examples that the affirming approach we advocate here has some potentially momentous consequences. Some clients, when affirmed, decide to act upon their impulses and leave their committed relationships, a potential outcome that should be explained to the client at the outset of treatment. If clients decide to act on their desires in a secret way, the therapist faces the ethical dilemma of being in some ways complicit in adultery. Working with this population who is seeking a cure—almost entirely heterosexual men who are married—is very similar to working with married gay men who are struggling with a secret sexual attraction to men, and it raises some of the same ethical and countertransferential issues.

If the therapist is able to see the couple together, it is critical to validate the wife's point of view. Regardless of the final outcome, initially she usually feels betrayed, blindsided, frightened, confused, and angry. If she was really ignorant of her husband's sexual interests, her faith in her own judgment is often shattered. How could she have lived with this man and not known? If he acted on his feelings with outside partners, her pain is typically magnified exponentially, and the therapy often must focus on the betrayal of infidelity before the kink can be addressed. The kinky partner, the husband most likely, may have unreasonable expectations of understanding from his wife, driven by his own needs and desires, and he may be hurt or angry when he does not receive the compassion that he expected. The wife must be allowed time to process her grief, loss, and mistrust before therapy can deal with the issue of whether there is any way for the two to "match" their sexual scripts, and often the marriage will dissolve as a result of disclosure. Clients who consider disclosing must be made aware of this risk.

Learning from Kinky Clients

If one adopts the view that BDSM desires and practices are not inherently pathological, but are instead normal—if less common—sexual variations, one can learn things from the BDSM subculture that might be helpful to those who practice vanilla sex (Kleinplatz, 2006). Those familiar with the BDSM community are impressed by the level of sexual satisfaction attained by kinksters and the way in which sex has stayed hot for decades in many long-term kinky relationships. How has this been attained?

Communication and negotiation

For a BDSM encounter to be successful, the dominant person, the person in charge, must know a great deal about his or her submissive, and both partners must reach a mutual understanding about the general parameters of what will take place between them. Questionnaires listing the kind of information a Dom often obtains from the Sub can be found online as well as in SM manuals. In some of these, as many as 200 sexual activities are listed, and the submissive rates each with an 8-point system ranging from *Essential* to *Curious* to *Not Now, Maybe in the Future* to *Never*. The average vanilla person likely could not list 200 sex acts, much less readily identify his or her level of interest in each. BDSM forces people to know their own sexuality intimately and in great detail; to acknowledge their deepest sexual fears, desires, and fantasies; and to communicate those things to a partner. At the same time, participants in an SM scene agree upon rules and procedures, including safe words, and ways to communicate discomfort and lack of consent clearly during the sex act itself.

BDSM scenes also require sexual negotiation. Participants often must push their own boundaries, restrain their desires, or compromise a bit on what they want in order to create a joint pleasurable experience. Sexual giving and generosity is emphasized, and participants are forced to clarify their boundaries, within themselves and with their partner, in order to determine where they are and are not willing to compromise (Sophia, 2013).

Objectivity and non-judgmentalism about sex

After working with people in the kink community, who go out of their way to be non-judgmental of any consensual adult sexual practices, one is struck by the sexual judgmentalism of the mainstream culture and of many mainstream couples. Kinky people approach sex with what Buddhists call "Beginner's Mind," a mind free of preconceived expectations and opinions. This attitude engenders mutual trust and openness, whereas mainstream value-laden sexual attitudes encourage shame, guilt, and fear of sharing one's deepest sexual fantasies even with one's partner. In the vanilla world, sexual inhibitions are often related to fear of judgment, and sadly that fear is sometimes realistic. BDSM practitioners may not share one another's desires, but they do not condemn each other for these desires. There is even a word—getting "squicked"—that kinksters invented to say, "It's a turn off for me but, hey, whatever…".

Sexual variety

Surveys of people who identify as kinky invariably find that BDSM practitioners engage in a far greater variety of sex acts than their vanilla counterparts (Richters *et al.*, 2008). Sandnabba *et al.* (2002) found 40 different sex acts and six role plays that had been experienced by their participants, and the most common, oral sex, is not even kinky. Kinksters are sexual adventurers whose tastes range far and wide, rather than being narrowly focused. They actually achieve what Esther Perel (2007) and others recommend: No matter how mundane their everyday relationship may be, no matter how familiar they become with their partner, they can always

explore new, slightly risky, edgy sexual fantasies together. Over time, the variety results, not just in a breadth of activities, but in psychological and emotional depth in the form of trust and intimacy (Kleinplatz, 2006).

Planning vs. spontaneity

How many times as sex therapists do we struggle to get couples to accept that they must plan for sex? The myth of spontaneity is firmly ingrained as a sexual value—except in the kink community. By necessity, BDSM sex must be planned—equipment prepared, scenes negotiated, costumes assembled. Not only does this not detract from the enjoyment of the sexual encounter, it facilitates "simmering," or anticipation of pleasure, which heightens and extends the entire experience.

Technical skill

Too often sex therapists downplay the importance of sexual technique. BDSM practitioners pride themselves on being highly practiced and technically competent in, for example, the use of particular floggers or a type of bondage. Among kinky people, there is an expectation that sexual skill is learned through practice and that responsible players learn and perfect their skills before trying them out on a partner. Nonkinky people, however, often maintain the myth that sex should come "naturally" and that skills are irrelevant. For many people, it is insulting or shame-inducing simply to suggest that their sexual technique needs improvement because the assumption is that they are naturally unskilled. In reality, sexual skills, like all skills, are learned.

Sex as a form of healing

Barker, Gupta, and Iantaffi (2013) wrote, "One key narrative, which has emerged recently in accounts of BDSM experience, is that of BDSM play as a safe space to explore issues that might traditionally have been brought to contexts such as counseling and psychotherapy" (p. 203). Kleinplatz (2006) also movingly described therapy with a lesbian couple who used BDSM to explore, re-enact, and resolve trauma related to the childhood abuse suffered by one of the partners. Although people with BDSM desires are no more likely than others to have endured such childhood trauma, for those who have, kink can be a pathway to sexual healing. Easton (2013) called this "shadowplay," after the Jungian concept of the shadow side of one's personality, the part that holds darkness and negative emotions but also tremendous capacity for creativity. Shadowplay is not always about childhood issues or psychological problems. Easton described a woman who constructed a BDSM scene in which she was "abused" by four gay male friends, and while she was restrained in bondage, she could safely vent some of the rage she felt about living in a sexist society and dealing with patriarchal abuse every day. Easton and Hardy (2004) described scenes in which one of the participants used the scenes to come to terms with a feared part of herself, a part she named the "hostile horny nasty teenage boy."

Therapists working with kinky people need to acknowledge there are many ways to resolve trauma and negative feelings, and that incorporating this resolution into sexuality is not necessarily pathological. If one believes that intimate relationships can heal old wounds, BDSM is the ideal crucible in which to re-enact or resolve trauma and fears. Sagarin, Cutler, Cutler, Lawler-Sagarin, and Matuszewich (2009) researched the neuronal and chemical changes experienced during extended BDSM play and confirmed hormonal changes that enhance intimacy. Shadowplay is not recommended for beginners, but it can accomplish healing when done thoughtfully between experienced, trusted partners. It could be thought of as a form of erotic bodywork.

Sex as spirituality

BDSM play takes much longer than more standard sexual encounters, requires more planning, and is often much more emotionally and physically intense. In fact, people in the kink subculture have BDSM sex much less frequently than the average couple has heterosexual intercourse, often once a month or less (Sandnabba *et al.*, 2002). The BDSM scene itself involves an extended amount of time in what Masters and Johnson would label the plateau stage, the very heightened arousal state that precedes orgasm. Probably because of this, BDSM participants often experience altered states of consciousness referred to within the kink subculture as "Sub space" or "Dom space." Researchers have recorded changes in cortisol levels and blood flow during and after extended kink encounters of the sort that are capable of altering consciousness (Ambler *et al.*, 2015, as cited in Sagarin, Lee, & Klement, 2015). One part of the brain that seems to be affected during BDSM is responsible for one's sense of identity, leading researchers to speculate that the experience produces a sense of dissolution of self and union with the universe. BDSM practitioners have long known this (Beckman, 2013), and many are open about considering these sexual practices sacred—a path to spirituality. Just as those who practice tantric sex experience, not only more intense sexual experiences, but also a sense of spiritual connection, so do some kinksters. Easton and Hardy (2004, p. 57) described this:

> When I am dancing in the storm of a flogging, to the song of the whip; when I am writhing in the throes of orgasm; when Kundalini the great snake is awake all through my body and beyond and I am thrashing and bellowing on my meditation mat, I know that the divine is real.

Summary and Conclusions

Like same- or other-sex sexual attraction, the attraction to BDSM sexual practices varies along a continuum. At one extreme of the continuum are those who not only prefer kinky sex, but who identify as kinky and spend a good deal of their time with others who practice BDSM, within BDSM organizations, and in a BDSM lifestyle. Somewhere in the middle of the continuum are "kink curious" people who want to incorporate some BDSM practices into their mostly vanilla sex life. At the other extreme are those who have no interest in or willingness to try kink.

In the 21st century, BDSM has entered the culture at large. There is tremendous interest in kink as a sexual spice, and this may be slowly leading to increased acceptance of those whose sexual interests are mainly or exclusively kinky. The mental health field has also begun to depathologize BDSM; in contrast to all prior editions of the DSM, DSM-5 does not consider these practices to be evidence of mental illness unless they cause distress or functional impairment.

Sex therapists can help clients with kinky sexuality by affirming and validating them and helping with resources and psychoeducation. Moreover, sex therapists can learn lessons from their kinky clients, lessons about how to communicate, how to be non-judgmental about sex, how to negotiate sex, and how to use sex for psychological healing and spirituality. These lessons are important for all clients—kinky and vanilla alike.

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Section IV
Future Directions in Sex Therapy

27

Mindfulness in Sex Therapy

Meg-John Barker

Introduction

Mindfulness has been the fastest growing form of therapy to appear in recent decades, swiftly becoming extremely popular (Barker, 2010). It has been hailed as the "third wave" of cognitive-behavioral therapy, with the first wave being the behaviorist movement of the 1950s (focused on operant and classical conditioning), and the second wave being the shift to addressing cognitions as well as behaviors in the late 1960s (Williams & Kabat-Zinn, 2011).

In addition to counsellors and psychotherapists embracing mindfulness, mindful ideas and practices (such as meditation) have captured public attention, with many best-selling self-help books offering mindfulness approaches to common problems like depression, anxiety, and pain (e.g., Williams, Teasdale, Segal, & Kabat-Zinn, 2007; Orsillo & Roemer, 2011), and to aspects of everyday life such as work, relationships, and daily stress (e.g., Kabat-Zinn, 1996; Williams & Penman, 2011).

Although there are now extensive popular, therapeutic, and research literatures relating to mindfulness and wellbeing generally, there has not been a great deal of work so far addressing sex specifically from a mindful perspective. However, what has been done suggests that mindfulness is a very promising sex therapy approach. This chapter summarizes much of what has been written on mindful sex therapy (also see Brotto & Barker, 2014) and brings together the broader literatures around mindfulness and sexuality to point to potentially fruitful future directions in this area.

This chapter begins by introducing the concept of mindfulness for the unfamiliar reader. It then considers what mindfulness might have to offer to sex therapists by applying the theories and practices of mindfulness to sexual experience. Following this, there is a summary of the existing literature on mindfulness as a form of sex therapy, exploring the effectiveness of mindfulness in this area and the ways in which it has been incorporated so far.

Mindfulness has frequently been regarded as an "add-on" set of techniques and ideas, which can usefully be offered to clients alongside conventional therapy. However, this chapter argues that thorough engagement with mindfulness involves not simply tagging it on to therapy, but rather, allowing it to permeate the therapeutic work and potentially to alter therapeutic practice. This can occur through recognizing the challenges that it poses to some of the standard ways of understanding human beings and their struggles, particularly in the arena of sex. Towards the end of the chapter there is an exploration of how a fully mindful sex therapy might work with sexual difficulties, concluding with a possible blueprint for future sex therapy which places mindfulness at the heart of the work.

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What is Mindfulness?

It can be difficult to capture mindfulness in words, as evidenced by the variety of sometimes conflicting definitions that have been put forward over the years by Buddhist scholars, researchers studying mindfulness, and mindful therapists (see Williams & Kabat-Zinn, 2011). Mindfulness has its roots in Buddhism, and it is important to remember that there is not one Buddhism but rather multiple different Buddhisms, which have developed over the centuries in the cultural and historical contexts of various South and East Asian countries (Keown, 1996). There are also multiple ways in which Buddhism has been taken up by Western writers in the last century or so, as well as different ways in which popular Buddhist teachers such as Thich Nhat Hanh (1991) and the Dalai Lama (2012) have brought Buddhism to the West. Finally, there are multiple ways in which psychologists, psychiatrists, and psychotherapists engaging with these interpretations of Buddhism have developed mindfulness and other forms of therapy drawing upon these (see Barker, 2013b).

Perhaps the best way to get a sense of what mindfulness is all about is through experience. Below is a form of one of the most common mindfulness practices, which I invite you to try for yourself. Read the instructions through, and then have a go. It isn't complicated.

> Breathing meditation:
> *Find a comfortable place to sit where you will not be disturbed: perhaps cross-legged, or in a chair with your feet planted firmly on the ground and your back upright. Close your eyes, or allow them to rest, unfocused, a few feet in front of you. Check your body for any tension and relax it. You may want to set a timer, at this point, for five minutes, so that you will know when to finish.*
>
> *For the next five minutes sit there simply noticing your breath: What does it feel like going in? What does it feel like going out? Don't try to control or count the breaths, or to breathe in any particular way, but just let it happen naturally and notice how it feels in your nostrils, your mouth, your torso, and the rest of your body.*
>
> *You will almost certainly find that your attention drifts many times during the five minutes. You will continually notice that you have become so caught up in a thought process that you've lost track of your breathing. At such times don't give yourself a hard time; this is part of the process. Just observe what has happened and gently bring your attention back to the breath. You might find the metaphor of a boat on the water useful (Batchelor, 1997): The anchor is the breath, and any thoughts, feelings or sensations that you have are the choppy waves that toss the boat about here and there. You can always come back to the grounded tether of the anchor.*
>
> *When the five minutes are up, give yourself a little time to stretch. Consider how you might bring the same mindful approach into the next thing that you do with your day.*

Mindfulness is a word for the kind of attention that we cultivate during meditations like this. It refers to the capacity to be present to what is happening, curiously noticing all aspects of our experience without constantly evaluating them, and remembering to return to what is going on when we become caught up in our own stories, fears, and desires.

Importantly, although the emphasis is often placed on meditation, really the only point of practices such as this one are to become better able to be mindful in our lives as a whole. There is nothing particularly special about breathing, other than the fact that our breath is always easily accessible to us and is also a relatively simple thing to bring our attention back to. We could just as well cultivate mindfulness whilst drinking our morning coffee, washing the dishes, or—indeed—having sex (Sommers, 2013).

Although mindfulness has often been interpreted as a noun—a thing that one has or does not have—it is often better considered as an adjective: a way of being that we can try to cultivate in everything we do. That is why I generally refer to "mindful sex therapy," to explore ways in which we might conduct sex therapy mindfully, rather than simply adding this thing—mindfulness—onto existing sex therapy.

The practice of mindfulness makes sense when we have some understanding of the underlying theory behind it. It is one of the key ways through which Buddhism proposes that humans can understand and alleviate suffering. The central tenants of Buddhism are known as the "four noble truths". These suggest that: (1) Suffering is an inevitable part of being alive; (2) we need to attend to suffering in order to understand that it is rooted in craving: our habitual human tendency to try to grasp hold of all the things that we want (*attachment*) and to get rid of all of the things that we don't want (*aversion*); (3) if we can let go of these craving patterns of attachment and aversion through (4) cultivating wisdom, ethical conduct, and concentration, then we can alleviate suffering (see Batchelor, 1997).

Mindful Therapy

Some therapists who have drawn upon mindfulness have embraced this Buddhist theory as well as the practices for cultivating mindfulness. Such practitioners bring mindfulness into therapy because they see these patterns of attachment and aversion as underlying mental health problems such as depression, anxiety, and addiction, and they see mindful practices as one way of addressing these through offering an alternative way of being.

For example, when we are depressed, we often try desperately to get rid of our tough feelings (aversion), whilst attempting to do anything to feel better (attachment). Mindful therapies such as mindfulness-based cognitive therapy (MBCT) or acceptance and commitment therapy (ACT) suggest that such an approach is likely to sink us deeper into depression (Crane, 2009; Hayes, 2005). An alternative would be to be present to our here-and-now experience, noticing how our feelings ebb and flow without trying to fix them or eradicate them (see Barker, 2010). Similarly, mindful therapy for anxiety suggests approaching what we find fearful and noticing our experience rather than attempting to avoid anxiety or cling onto calm (Orsillo & Roemer, 2011).

However, other therapists have embraced mindfulness practices without necessarily taking on board Buddhist theories of suffering. Whether we refer to "conditions of worth," "defense mechanisms", or "core beliefs", it could be argued that all of the major Western therapies share a broad understanding of people's problems. That is, problems are rooted in patterns that are laid down in our pasts and become fixed through constant repetition in ways that adversely affect our present experiences and future possibilities (Barker, 2013b). Mindfulness practices under such an understanding could represent one way of noticing these habitual patterns (through slowing down and observing thoughts, feelings, and sensations) as well as having the potential to shift such patterns through loosening them, experimenting with other ways of thinking and behaving, and observing these new thoughts and behaviors.

There are three main ways in which therapists can engage with mindfulness. Perhaps the most obvious way, which I've focused on so far, is to teach mindfulness practices and/or theories to clients as a way of addressing their problems. However, many therapists have also written about the value of therapists themselves practicing mindfulness in order to cultivate therapeutic qualities such as attention, empathy, compassion, self-awareness, and the ability to sit with difficult material (Hick, 2008). Finally, there are those who suggest that we can best help clients by cultivating a mindful *relationship* with them wherein we are both present to one another, sitting with whatever comes with equanimity, and empathically accepting each other in all our difference (see Barker, 2013d). Of course, these three ways of engaging with clients mindfully need not be separate. We can cultivate mindfulness in ourselves in order to relate more mindfully in therapy, and mindful relating can be one way of modelling this approach for clients who wish to try it themselves.

One thing that is vital is that, when therapists offer mindfulness to clients—or practice it themselves—they should not do so assuming that it is easy or that it provides a quick fix to problems. As you will have found if you tried the breathing meditation earlier, sitting like this can be very challenging. We can experience all kinds of frightening thoughts and feelings that we'd rather not face; we can become frustrated at how hard it is to stay with the breath. Mindfulness can easily become yet another thing for which to criticize ourselves (not doing it right, not practicing enough, failing to stay mindful when things get tough; see Chödrön, 1994). Also, a key element of mindfulness is embracing difficult feelings and sitting with them, rather than trying to escape or avoid them. Although this can help immensely in preventing negative feelings from spiralling into something that is even harder to deal with, like all therapy, mindfulness does involve facing some very hard and personally challenging experiences, and we should not expect or suggest otherwise.

Mindfulness Theories and Sex

So what does mindfulness have to offer for the understanding and treatment of sexual difficulties? First I'll consider how mindful theories of suffering make sense of what is happening when people are struggling with sex, and then I will take a closer look at some mindful practices and what they have to offer for sex therapy.

As we've seen, the primary theory underlying mindfulness is the idea that suffering is rooted in craving: The pattern of attachment to the things we want and aversion to the things we don't want. Batchelor (2001) used the metaphor of holding a precious object. First, we grasp hold of it to keep it safe and to make sure that nobody else gets it, but if we do that, we cannot see it and our hand gets a cramp. So we hurl it away because it is causing us pain and no pleasure, but then we have lost it entirely. An alternative is to hold it lightly so that we are able to see it properly and to put it down and pick it up again as needed (Barker, 2013c). This is the way of being that we are cultivating in mindful practice: the capacity to hold everything gently, rather than labelling things as wholly good or wholly bad and grasping them or hurling them away accordingly. The metaphor works for so many things: thoughts, feelings, identities, relationships, memories, plans, and experiences.

You might find it useful to reflect on this metaphor in relation to sex. What aspects of sex do you grasp hold of? What aspects do you hurl away?

Considering our own experiences, and those of our clients, we can see that this craving pattern is fundamental to sexual difficulties. In relation to grasping, there are the times when sex itself, of whatever kind, becomes something that we crave because of the rush of excitement and pleasure, the escape from reality, the soothing effect, or whatever else it is that we get from it. We may find ourselves retreating into sexual fantasy in ways that stop us from being present to the rest of our lives, or we may become stuck in patterns of searching for a particular experience or stimulus that will quench our craving. As all sex therapists know, grasping is also common when it comes to specific sexual experiences. The strong goal of achieving an erection or an orgasm often, paradoxically, makes it very difficult indeed to do so.

So we grasp hold of the kinds of sex that we want, and we grasp particular kinds of sexual experience. However, we also engage in the pattern of hurling away with sex. Sex can become bound up with all kinds of difficult feelings—shame, embarrassment, fear—such that we become averse to it or try to avoid it entirely. Levels of sexual anxiety are generally very high, and mostly these relate to fears that we might be sexually "dysfunctional" or "abnormal" (Barker, 2011b). We attempt to avoid or to eradicate any sexual problems, as well as any sexual fantasies, desires, and activities that we find fearful or disturbing. Again, as with the craving for orgasm, there is a paradox here that such attempts to get rid of sexual feelings can make them more sticky and compelling, such that they continue to haunt us.

The implications of this for sex therapy are that it can be useful to introduce clients to the idea of patterns of grasping and hurling away, exploring how these relate to their experiences. How does the client label certain sexual experiences as good or bad? Where do these ideas come from? What does this mean for their sexual experience?

Along with the theory of craving, another thing that mindfulness has to offer for our understanding of sexual problems is a "non-dualistic" approach to human experience. This means that mindful approaches do not separate the mind and body, or the person and the world, in the ways in which we are used to doing in Western culture. It wouldn't make sense for a mindful therapist to ask, as therapists often do in sex therapy, whether a particular problem is physiological (and best treated with pharmaceuticals or medical interventions) *or* psychological (and best treated with psychotherapy). Rather, all aspects of human experience would be regarded as complexly biopsychosocial (Barker, 2013b), an idea which is also more consistent with more recent Western thinking on health and the body (Fox, 2012).

To give an example of this, consider the common experience of pain and muscle contractions during vaginal penetration (historically referred to as "vaginismus" in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision [DSM-IV-TR] and included within the diagnosis of Genito-Pelvic Pain/Penetration Disorder in DSM-5; American Psychiatric Association, 2000, 2013). Conventionally, when somebody presents with such vaginal tension, a therapist might first try to determine whether there is an underlying physiological cause amenable to medical treatment. If no physiological cause is apparent—as is often the case (Iantaffi, 2013)—the therapist might turn to a psychological explanation, such as sexual anxiety, and treat this with relaxation exercises during vaginal dilation and/or with therapeutic exploration of past sexual experience. However, if the therapist were taking a more mindful biopsychosocial approach, we would be alert to the bio, psycho, *and* social elements of the experience. Rather than seeing one or more of these as simply "causing" the "effect" of "vaginismus," we would expect these elements to be complexly interwoven.

In the case of a young woman with the symptoms of vaginismus, for example, we might consider the psychological meanings that she has around femininity and sex and how these are embedded within wider sociocultural understandings, as well as how they operate through her body during sex. For example, she may place great importance on being desirable to others, particularly to her boyfriend, in order to feel of value. Part of this might involve ensuring that her body always looks attractive. So she may try to adopt certain positions during sex to control how she appears, attempting to prevent her partner from looking too closely at her genitals, about whose appearance she is uncomfortable. Like many women, she might also control her bodily functions such that she waits to urinate and defecate when nobody is in earshot, she prevents herself from passing gas, and she finds menstruating stressful, fearing that others will be able to tell that she has her period. All of this contributes to tension, discomfort, and pain in her body, particularly in her genital region, which is further exacerbated by her anxieties about not being able to provide "proper" sex to her boyfriend and what that means about her as a woman (see Barker, 2011a; Mize & Iantaffi, 2013; Rosenbaum, 2013).

As illustrated in this example, in sex therapy it can be very useful to move away from simple cause–effect relationships and mind/body (psychological/biological) splits towards a sense of the complex ongoing interplay among our bodies and brains (bio), our thoughts and feelings (psycho), and the cultural messages around us (social). Such an approach maintains awareness that there can be a role of medical conditions in sexual problems, whilst also considering the psychosocial ways in which diabetes or genital cancers, for example, play out in each person's unique experience.

We will consider the implications of this for the kind of therapy that we might then offer to clients, such as the young woman described above, in the next section.

Mindfulness Practices and Sex

The theory and practice of mindfulness cannot really be separated because, as discussed above, mindful practices are a key way through which we experience our tendencies to engage in patterns of attachment and aversion or our tendencies to separate off the mind and the body. If, for example, we sit and meditate on our thoughts—observing them coming and going—we soon notice how we tend to grab hold of a pleasant thought and spin it into a fantasy, or how we attempt to avoid the difficult and painful thoughts, but how sticky they are (Batchelor, 2001). With a meditation on the body or on sounds, for example, we begin to see the problems with our dualistic mind/body, self/world splits as we realise how difficult it is to find any clear division between a physical sensation or a sound and our experience of it (Batchelor, 1997).

One practice which I have found extremely useful for helping people to think about mindfulness and sex is as follows. You may like to try it yourself before reading on.

> Fulfilling and non-fulfilling experiences:
> *Write two paragraphs briefly describing two recent experiences that you have had of the same type of sexual/erotic/sensual activity: one when it was fulfilling and one when it was not. These can be anything at all, from a fantasy to a kiss, to sex with a partner or masturbation, to a massage or steam bath. It is just important that you pick an experience that you can remember being fulfilling on one occasion and non-fulfilling on another. Make sure that you pick something that feels comfortable enough to remember (the non-fulfilling example shouldn't be anything traumatic, just a time when you didn't really enjoy it). Try to describe both experiences in rich detail, bringing in all of the different sensations, thoughts and feelings involved, considering how it began, developed and ended. Once you have the two descriptions written down, spend some time reflecting on what the key differences are between the two experiences.*
>
> *These differences can then be discussed with a therapist, or in groups if the activity is done as part of a group therapy session or workshop (with the differences written up on a board as they are discussed). Participants should be reassured that they don't have to share their individual descriptions, just the differences that they notice between them. If participants aren't comfortable with writing, they can draw, collage, or make modelling clay representations of the two experiences instead. Alternatively the activity can be done as a guided meditation, remembering each experience in detail.*

I have carried out this activity on a number of occasions now, and the kinds of differences that people come up with are remarkably consistent. They describe fulfilling experiences as being caught up in a kind of flow, whilst non-fulfilling experiences feel more disjointed, with the person often becoming detached from what is going on. People often have a sense of being in the present moment during fulfilling experiences, whilst the past and future intervene in non-fulfilling experiences (e.g., worrying about what to do next or becoming distracted by everyday concerns). People often monitor, evaluate, and criticize themselves in non-fulfilling experiences (I look bad in this position. Is my partner enjoying this? What does my partner think of me? I'm too embarrassed to say what I want. I'm being really clumsy. I can't get into this.).

In relation to the mind/body relationship, people describe fulfilling experiences as being "at one" with their body—or embodied—whereas during non-fulfilling experiences, they are often treating their body as more of an object: aware of how it might appear to others or judging it for not performing as they want it to. Regarding their relationship with the other person or people involved (if the experience is with others), fulfilling experiences often involve a sense of connectedness, intimacy, and even a lack of clear separation between self and other (whether the encounter is with a partner or a stranger). Non-fulfilling experiences are more likely to have a sense of disconnection, frustration with what another person is doing, or worrying about how they will be perceived by the other person (see McCreary & Alderson, 2013). This activity is useful on a number of levels: It helps us to begin to understand what mindfulness is all about, it enables us to comprehend how sex—like all experience—is biopsychosocial, and it points towards potential ways of addressing non-fulfilling sex through further mindfulness practices.

First, it is clear that people's fulfilling and non-fulfilling experiences map on rather well to more or less mindful ways of being. So we can use this activity to help people to understand what it means to be mindful: more present to experience, more aware of what is going on, less evaluating of experience (judging what is "good" or "bad" and grasping/avoiding accordingly), more embodied and tuned in to the body (rather than treating their body as an object), and more connected and empathic with anyone else who is present.

Second, the non-fulfilling experiences help us to see how sex (and other sensual/erotic experiences) is complexly biopsychosocial. What people often notice when reflecting on these experiences are the critical thoughts, which bubble up and make it difficult to stay present and in-tune. Rather than beating themselves up about this (and criticizing themselves for criticizing themselves), I encourage them to be curious about these thoughts. Such curiosity often reveals that—rather than being "silly" thoughts that the individual person is conjuring up—these thoughts represent wider social messages that operate through us all.

Most people in the West live in cultures that encourage us to constantly scrutinize what is "wrong" with us and to try to improve ourselves. This is the message of so much of the media around us (advertising, makeover television, magazines): You are not good enough as you are, and you need to hide this fact and try to make yourself better (Barker, 2013e). Nowhere is this more true that in the sexual arena (Loy, 2013), where a massive proliferation of sexualized media shows us a very narrow and restricted "perfect" type of sex to which we should be aspiring. At the same time, sex is regarded as taboo and is not really openly discussed, and we are warned against slipping into various forms of dangerous sex that are socially unacceptable or that put us at risk for disease or unwanted pregnancy (Attwood, Bale, & Barker, 2013). It is evident that we are socially saturated in messages that reinforce and perpetuate the patterns of attachment and aversion that we've explored, and these messages operate through our brains and bodies. This can help us to better understand why we fall into such patterns during sex and to treat ourselves more kindly when we find ourselves doing so, instead of allowing this to become one more thing for which to criticize ourselves (see Mize & Iantaffi, 2013; Rosenbaum, 2013).

We have seen how mindful practices can be helpful in terms of understanding sexual difficulties. Slowing down and noticing our experience can show us how social patterns of attachment and aversion play out during sex in ways that interrupt the flow of experience. Mindfulness practices can also demonstrate how treating our bodies as objects to perform and to invoke desire in others can be problematic. What can mindful practices offer for addressing non-fulfilling sex?

First, as we have seen, mindful practice can help people to cultivate a more non-grasping way of being. For example, they can help people to let go of intrusive thoughts and to stay with feelings as they are, rather than judging them. In addition to basic breathing practice, meditating on letting go of thoughts or noticing how we quickly evaluate feelings as good or bad can be helpful in order to then bring such approaches to sexual experience (see Barker, 2013b).

There are also many practices that help people to experience themselves as more embodied, rather than splitting the mind and body (Bazzano, 2013). This might be particularly helpful, for example, with people like the client with vaginismus symptoms above, who are focused on how their body appears, or with people (often men) who regard their bodies as machines, which need to perform (with erections and ejaculations on demand). Such clients can find it helpful to engage in body sweep/scan meditations (where you spend time attending to each part of the body from top to toe) or slow walking meditations (see Barker, 2013a). It can also be helpful simply to find out from clients when they feel most embodied (often alone during physical activities or pleasant experiences such as hot baths) and encourage them to engage in those things more in order to tune into their bodies (Barker, 2013e; see also Goldmeier, 2013; Mize & Iantaffi, 2013). We will return to some of these ideas once we have considered the existing literature on mindfulness and sex therapy in more detail.

Mindfulness and Sex Therapy

As previously mentioned, the literature on mindfulness and sex therapy is not yet extensive. In particular, much of it has focused on mindfulness-based CBT approaches rather than the full range of therapeutic approaches that have been integrated with mindfulness (see Barker, 2013a). Also, there have been relatively few quantitative evaluations of the effectiveness of mindfulness in the treatment of sexual problems, compared with the number existing for the treatment of pain, stress, depression, anxiety, or even relationship problems (see Barker, 2013b).

This section summarizes much of what has been written so far, before considering some potential criticisms of the forms of therapy that have been put forward to date. Much of this section draws on Brotto and Barker's (2013, 2014) collection of papers, which gives a good sense of the field. There are also a couple of useful review papers to be found (Brotto, Krychman, & Jacobson, 2008; Goldmeier & Mears, 2010).

Is mindfulness-based sex therapy effective?

Lori Brotto is perhaps the key figure in the application of mindfulness to sex therapy. Her laboratory in Vancouver is the main hub of empirical research on mindfulness for women's sexual difficulties. Reviewing the literature in 2011, Brotto reported that there are "a small smattering of uncontrolled empirical trials but a much larger collection of clinical experience integrating mindfulness in the treatment of a variety of sexual ailments" (p. 216).

Brotto's own work is perhaps the only research that compares a mindfulness intervention against a control group. In Brotto, Erskine, *et al.*'s (2012) study, cancer survivors who received individual mindfulness-based CBT reported improved sexual desire, arousal, lubrication, orgasm, and satisfaction, and decreased sexual distress, compared with those on a waiting list. However, subjective improvements were not mirrored by changes in genital arousal (a physiological measure of blood flow to the genitals), suggesting that mindfulness-based CBT led to cognitive and emotional, but not physiological, change (Brotto, Basson, & Luria, 2008; Seal & Meston, 2007). Similar findings have been elicited in studies on women without cancer who had sexual arousal and desire problems (e.g., Brotto, Basson, *et al.*, 2008), with mindfulness seemingly particularly helpful for women with histories of sexual trauma in terms of increasing desire and decreasing sexual distress (Brotto, Seal & Rellini, 2012). Brotto, Heiman, *et al.* (2008) found that women with sexual desire problems found mindfulness exercises more helpful than other interventions that they had experienced, and reported increased desire, decreased distress, better perception of their bodies and greater awareness of arousal, which helped them to become even more aroused. However, it can be difficult, depending on control groups used, to be sure which elements of improvement are due to mindfulness and which are due to other components of the psychoeducation and skills in the treatment programs (Brotto, Heiman, *et al.*, 2008), and there is therefore a need for further studies, as well as research on other genders and sexual problems.

There have also been a number of qualitative studies on the experiences of women with sexual problems who have taken part in mindfulness-based therapy. Brotto, Basson, Carlson, and Zhu (2013) found that women who experienced chronic pain when their genital region was touched reported greater self-efficacy and other general improvements in their lives following four sessions of mindfulness-based CBT. Mize and Iantaffi (2013) conducted mindfulness-informed group therapy with groups of women experiencing sexual problems. They reported that participants found mindfulness skills to be particularly useful and transferable to their daily lives. Participants also felt that mindfulness had had a positive impact on body awareness and connection.

Additional research has been undertaken with people who are not suffering from sexual problems. Lazaridou and Kalogianni (2013) quantitatively compared people who practiced

mindfulness to those who practiced sports. They found that the former demonstrated more novelty-seeking and theorized that this might be an important component in sexuality. Those who engaged in sports had less sexual depression and anxiety than those who practiced mindfulness, whilst mindfulness correlated positively with sexual motivation and sexual consciousness. Mayland (2005) qualitatively studied ten married women who had been engaging in mindfulness for an average of 19 years. These participants described a heightened awareness of emotions and sensations during sex, and also used mindfulness to manage sexual anxiety and to let go of expectations around sex. McCreary and Alderson (2013) conducted a phenomenological study of women engaged in meditation. The women felt that meditation had improved their sexual and relational lives, resulting in better emotional intimacy and connection, heightened experience of sexual pleasure, and enhanced spiritual or meditative aspects of sex.

How does mindfulness-based sex therapy work?

In relation to the question of how mindfulness helps with sexual problems, a number of possibilities have been put forward based on what is known about the impact of mindfulness, but none of these theories have been extensively tested in this particular domain to date.

Baker and Absenger (2013) proposed a model whereby the stress-reducing effects of mindfulness are the helpful component in mindfulness-based sex therapy, given that stress is known to contribute to loss of desire and sexual problems. This mechanism could involve both psychological processes and physiological ones via the nervous systems and the balance of circulating sex hormones (see also Sommers, 2013). If stress reduction increases sexual activity, Baker and Absenger (2013) suggested that this could set up a kind of virtuous cycle since sex can also have stress-reducing effects.

Sommers (2013) and others suggested that cultivating mindfulness enables people to be both more "present-centered" (rather than past/future focused) during sex, and more "process-absorbed" (rather than being goal-directed), both of which improve sexual experience. Goldmeier (2013) agreed that people with orgasm difficulties, in particular, often become very goal-focused, and that awareness of the body without a particular goal can be very helpful. Just as the breath is the anchor in traditional meditation, sexual/sensual feelings and sensations can become an anchor during sex. Thoughts can then be observed without attaching an emotional valence to them (Brotto, 2013), which enables people to become less catastrophizing if they do become distracted, less concerned with what they think they *should* be feeling, and able to reel in negative evaluations of themselves or partners (McCreary & Alderson, 2013). As Rosenbaum (2013) put it, "the client is encouraged to reframe sex as something to be experienced with meaning rather than an achievement … goal oriented language (e.g.,'we tried,' 'we succeeded,' 'we failed') is pointed out and discouraged" (p. 26).

Some authors have emphasized the impact of mindfulness on relationships as a whole (Carson, Carson, Gil, & Baucom, 2005) and have suggested that this may be responsible for improvements in sexual experience (e.g., McCarthy & Wald, 2013; McCreary & Alderson, 2013). However, all of these researchers found that it was important for both partners in a couple to be on the same page with mindfulness; otherwise it can increase distance rather than closeness, which can lead to further problems.

How is mindfulness incorporated into sex therapy to date?

Readers who are familiar with conventional sex therapy will likely already have made the connection between mindfulness and the standard "homework" of sensate focus (see also Avery-Clark & Weiner, this volume). Indeed, Goldmeier (2013) pointed out how sensate focus could be seen as a form of mindfulness of the body, given the focus on bodily sensations and letting go of distracting thoughts. He suggested that clients undertake a mindfulness body scan prior

to sensate focus and that therapists describe sensate focus in mindful ways, such as staying with anxiety rather than aiming at relaxation (Goldmeier & Mears, 2010). Mize and Iantaffi (2013) concurred with this, pointing out that an ability to be present and mindful is assumed in conventional sensate focus, and that most people would benefit from learning practices that cultivate this. They also suggested bringing mindfulness together with other body awareness practices.

A practice that Brotto, Krychman, and Jacobson (2008) described in order to introduce clients in groups to mindfulness is the penny exercise. Clients are all given a penny and encouraged to mindfully attend to it for five minutes or so (in a similar way to the way we attend to the breath or to eating a raisin in other mindful practices, see Barker, 2013b). The pennies are all collected and then each person is invited to find their penny again from the pile. Realising how easy it is to do this can help clients to feel more confident in their ability to focus their attention. After this point in the groups, clients are encouraged to try out mindfulness in their daily lives (body scans and mindful activities) and then to engage in individual practices in which they attend to their whole body, and then their genitals, in non-judgmental ways. This is followed by incorporating nonsexual touch. The prospect of incorporating mindfulness into sex is discussed in groups prior to bringing mindfulness into masturbation and/or sex with partners.

McCarthy and Wald (2013; see also McCarthy and Wald, this volume) described incorporating mindfulness into sex therapy with couples. The focus is on decoupling sex from performance and shifting views of sex as a pass/fail test. Clients are encouraged, between sessions, to mindfully stay with cuddling or other physical intimacy rather than focusing on sex. Later they are encouraged to mindfully remember, and then play out, their preferred erotic scenarios, with their partners mindfully being present to these (whilst being able to veto any specific activities with which they do not want to engage). Mindful acceptance of the arousal/erotic patterns of oneself and one's partner is encouraged, for example, accepting that sex might be asynchronous, rather than both people always experiencing arousal and/or orgasm. Awareness and acceptance are put forward as alternatives to trying to force a sexual response (attachment) or giving up and avoiding sex (aversion).

Criticisms of the existing literature on mindfulness and sex therapy

My key concern with the forms of mindfulness-based sex therapy that have been proposed so far is that they risk sneaking back into a goal-directed approach to sex, where "proper" sex is regarded as a particular and limited set of activities. Like sensate focus, whilst mindfulness-based sex therapies advocate being present-centered and process-absorbed (Sommers, 2013), many seem to have underlying assumptions that people should be sexual and that sex should involve erection, penetration, and orgasm, generally through heterosexual coupled penis-in-vagina (PIV) sex (see Barker, 2011b).

The danger of this is that it sets up a division between the type of sex people should be seeking (attachment) and avoiding (aversion), as well as retaining the kind of goal focus which—as I have discussed—often exacerbates sexual problems. In this section I provide evidence that assumptions about the goals of "normal," "functional," "proper" sex commonly sneak back into mindfulness-based sex therapy. I then argue that part of the reason that this occurs is that many mindfulness-based sex therapists do not engage fully enough with the *social* in biopsychosocial. There is not enough criticism of the cultural pressures towards a craving relationship to sex, which perpetuate these problematic approaches. Finally, I put forward a model for a more socially mindful form of sex therapy (see also Barker, 2013c, 2013d, 2014).

Although many of the papers discussed in the review of the literature do emphasize being present and letting go of thoughts about what people *should* be doing during sex, assumptions about what sex should involve do remain. For example, Goldmeier (2013) suggested that

cultivating mindfulness can help men with "rapid ejaculation" to identify the point just before ejaculation, and men with "delayed ejaculation" to know the point at which to penetrate a partner to ensure that they are excited enough to orgasm. Assumptions about the right amount of time prior to ejaculation and the necessity of PIV penetration seem to be present here.

Similarly in the literature on genital pain, there seems to be an assumption that people should engage in sexual intercourse in spite of the pain. This is a tricky area. Of course mindfulness has been found to be very effective for people with chronic pain in general (Veehof, Oskam, Schreurs, & Bohlmeijer, 2011) because it decouples actual pain from the subjective experience of pain, reduces negative appraisals of pain, and decreases stress (which exacerbates pain). However, chronic pain is something that people cannot help experiencing in their daily lives. Sexual pain, in contrast, often only occurs during certain types of sex (e.g., penetration). So the literature on mindfulness-based sex therapy for sexual pain seems to assume that such sex is a necessary part of daily life, rather than questioning the sociocultural assumptions that sex—and specifically certain kinds of sex—are necessary. It is often suggested that women continue to have painful sex but become less "hypervigilant" and "catastrophizing" about it, learning to "ride out" the sensation of pain and detaching it from emotions (Brotto, 2013, p. 216). Goldmeier (2013) encouraged the woman experiencing pain to become:

> emotionally willing to agree to intercourse, even though she is not desirous or aroused when she initiates physical interaction. In fact, sexual arousal, for instance breast stimulation at foreplay, can feel quite aversive until she responds. Mindfulness can be very useful in that she can learn to sit with these early aversive physical and emotional feelings until arousal and responsive desire take off. (p. 81)

Here we see an assumption that sex is necessary even if painful, and that it should take the form of intercourse (other forms of stimulation are just "foreplay").

This assumption of an imperative to be sexual is also present in other research which emphasizes the value of sex for wellbeing and relationships. For example, Baker and Absenger (2013) wrote about sex reducing stress, improving mood, and increasing the likelihood of further sexual activity. Brotto, Erskine *et al.* (2012) suggested that being unable to have sexual intercourse will negatively impact on women's emotional wellbeing and intimate relationships. McCarthy and Wald (2013) suggested that sexual avoidance can rob relationships of intimacy and security. These are presented as statements of fact rather than there being any recognition of the social constructions of sex, sexuality, femininity, and relationships that underlie these assumptions and that could be otherwise (and, indeed, are in other cultures and in some communities within Western culture; see Barker, 2011a). The social element of the biopsychosocial nature of sex is also missing in conceptualizations of the evaluating thoughts that people experience during sex. These are generally regarded as "cognitive distractions" or "intrusive thoughts" (e.g. McCreary & Alderson, 2013) rather than as social messages operating through people's brains and bodies (Barker, 2013c).

My concerns with this are that such forms of sex therapy exclude both asexual people (i.e., those that are not interested in sexual relationships), and the many people who enjoy forms of sex that are different from coupled PIV intercourse (see Richards & Barker, 2013). By ignoring these groups, traditional sex therapy unwittingly perpetuates a problematic hierarchy of acceptable sexuality (Barker, 2013e; Rubin, 1984). Also, such sex therapy explicitly seems to *discourage* people from addressing the mind/body split and tuning in to the messages that their bodies are telling them. As Kleinplatz (2012; see also Kleinplatz, this volume) wisely wrote, there are often good reasons that penises don't become erect or vaginas don't want to be penetrated, and it is vital that we explore these in sex therapy—through mindful awareness of what clients' bodies are telling them.

Brotto (2013) argued that sexual pain is rooted in "dysregulation of central pain circuitry" (p. 2), but surely it may often be rooted in the messages people have received about sex and

the pressures that they are putting on themselves (as in the client with "vaginismus" considered previously). Such messages seem particularly damaging given the culture of non-consent that pervades around sex (Barker, 2013e). Should we be telling people—particularly women—that they should be going ahead with sex that they really don't want to have, rather than, for example, being comfortably nonsexual and/or tuning into and communicating their own desires (Barker, 2013e)? Mayland (2005) reported that participants who engaged in mindfulness outside of sex therapy found that it helped them to release their expectations around sex, including being comfortable with periods of sexual abstinence. Rosenbaum (2013) stated that mindfulness should allow people to challenge "notions of intercourse as critical and primary to the integrity of the sexual relationship, resist self-judgment, and experience, rather than achieve, sexual joy and connectedness" (p. 23).

A mindful future for sex therapy?

Rather than tagging mindfulness on to conventional forms of sex therapy, a thorough engagement with mindfulness requires a critical evaluation of sex therapy as it stands and some radical shifts in both theory and practice. This presents a great challenge given that it involves letting go of some of the elements of sex therapy with which we are familiar, and which, perhaps, provide us with a sense of legitimacy and mastery as individuals and as a profession.

Like Peggy Kleinplatz's existential therapy (Kleinplatz, this volume) and many of the other approaches included in her *New Directions in Sex Therapy* collection (Kleinplatz, 2012), a mindful approach requires giving up our attachment to divisions between functional and dysfunctional, normal and abnormal sex (as enshrined in nosologies like the *Diagnostic and Statistical Manual of Mental Disorders* or the *International Classification of Diseases*). Such divisions risk reinforcing and perpetuating the patterns of sexual attachment and aversion that exacerbate the suffering of our clients (see Barker, 2013c, 2014).

Similarly, we need to let go of the idea of a specific form of "proper" sex as the goal of sex therapy if we are to enable clients to be truly present-centered and process-absorbed during sex, rather than sneaking that "proper" sex goal back in or colluding with assumptions about acceptable and unacceptable sex (see Berry & Barker, 2015). As Baker and Absenger (2013) argued, mindful approaches offer a valuable alternative to the current sexual health focus on pathologization and medicalization: diagnosing sexual problems and attempting to fix them with purely medical and behavioural approaches.

Of course, many clients are likely to be steeped in the very assumptions around sex that we, ourselves, struggle to be aware of and to let go of, so it behooves us to be mindful of this rather than expecting clients to be able to step outside of the culture in which they are immersed. It is useful, early on in therapy, to offer a number of possible aims of therapy rather than expecting either that clients will automatically want a "quick fix" *or* that they will want to engage in questioning of the social assumptions around sex (see Kleinplatz, 2012). Regarding diagnostic and other labels, it can be useful to bring in the metaphor of the precious object described earlier, helping the client to hold such categories gently, exploring what possibilities they open up and what they close down, rather than uncritically accepting a label such as "orgasmic disorder" or "sex addict," or dismissing it entirely (Barker, 2013b).

Additionally, it can be helpful to normalize the experience of sexual difficulties, for example by citing the statistic that almost half the population now report one or more sexual problems (Mitchell *et al.*, 2013). The starting position that sex is, at this point in time, something with which most people struggle, may well be preferable to one that suggests that this individual client has something wrong with them that requires fixing. Such a starting position also points the way to a more biopsychosocial, rather than individualistic, conceptualization of their issues.

Mindful practices can be presented to clients as one potential way of proceeding with therapy (see Cooper & McLeod, 2011, for details on pluralistic therapy; and Barker, 2013b, for more on introducing clients to mindfulness). For those clients who are keen to explore this approach, it may well be useful to start by introducing basic practices (breathing, body scan, everyday activities, etc.) in order to cultivate the kind of attention and presence that we want them to bring to sexual experience (Mize & Iantaffi, 2013).

Once they are familiar with mindfulness, and there is some therapeutic rapport, clients can bring mindful attention to whatever kind of sex that they are engaging in, in order to become more aware of this experience and what is going on for them. I have found this particularly helpful, for example, with clients who are concerned about their engagement with pornography (see Barker, 2013b). Often such clients are quite unaware and tuned out whilst they are looking at porn. Approaching it with mindful attention can be extremely helpful in revealing what it means to them and helping them to explore their sexual desires and anxieties more fully. Additionally, mindful engagement during the times when they choose not to engage with porn (sitting with the urge rather than trying to dismiss it or to act upon it) can lend a sense of increased control over the situation (Goldmeier, 2013).

Mindful attention can help clients to produce rich phenomenological descriptions of different kinds of sexual experience. The fulfilling/non-fulfilling comparison described earlier can also be very useful for exploring the meanings of sex for each particular client, as well as their biopsychosocial experience of sex. An appreciation of the benign diversity of consensual sexual experience and fantasy is vital here (Rubin, 1984). Practitioners should educate themselves on any sexual identities and practices with which they are unfamiliar in order to approach them in an accepting manner, or refer on if they are unable to do so (Richards & Barker, 2013). It is also important that the therapist remains open to the multiple potential meanings of any sexual experience and/or difficulty, rather than making assumptions about what will be positive or negative for the client. For example, an orgasm can be experienced as anything from a peak of pleasure to a frightening loss of control; a bite from a partner as anything from wonderfully exciting to completely terrifying; and loss of erection as anything from deeply shaming to a huge relief (Barker, 2013b).

As well as mindful engagement in sex being a useful way of exploring sexual difficulties, it is, of course, also a helpful way of addressing those very difficulties. Once they have explored their patterns of attachment and aversion and their biopsychosocial experiences of sex, clients can be introduced to ideas and practices that have been described throughout this chapter. This should help them to cultivate a more non-grasping approach to sex and to approach sex in a more present, embodied manner, as well as recognizing how difficult this often is. They might experiment with different sexual practices and fantasies, attempting to tune into and communicate their desires (Barker, 2013e), and with gently shifting the assumptions and patterns that have been central to their sexual suffering.

Something that is missing from many forms of mindfulness-based sex therapy, given their rather individualistic Western psychological focus, is the fact that mindfulness, in its original form, was interwoven with the ethical treatment of oneself and others (Barker, 2013b, 2013d, 2014). It can be very useful to bring mindful practices relating to compassion, loving-kindness, and ethics, into mindful sex therapy. These are particularly helpful for exploring the ideas around consent in sexual behaviour, which were highlighted earlier and which should be central to mindful sex. As Mize and Iantaffi (2013) put it:

> …adopting mindfulness as a form of self-study, [people] are able to observe themselves with curiosity and acceptance and without judgment. They can listen to their bodies for information about what feels good, what does not feel good, when boundaries are being violated, when they want to say no and when they want to say yes. They can be surprised by the wisdom of their bodies and guided by that wisdom to make intentional choices about their sexual behavior. (p. 65)

In this way, sex itself can become a mindful practice, bringing us full circle and enabling the client to take from mindful sex therapy a set of skills and ideas which may be useful in both their sexual and daily lives. As Sommers (2013) said, "making love, in a fully attentive mode, can, in fact, be a form of mindful meditation" (p. 87). We can use sex to cultivate a mindful way of being and as a way to notice—with gentle curiosity—patterns of grasping/hurling away, how we separate from our bodies and protect or defend ourselves, and how the social operates through us in our thoughts, feelings, and sensations. Thus, we can develop a ground-up therapy, which is rooted in mindful understandings, looking to the Buddhist theories and practices of the past in order to inform the future of sex therapy.

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28

Integrating Sexual Partners into Pharmacological Sex Therapy

Helen M. Conaglen and John V. Conaglen

Overview

Ellis'(1918–1928) description of sexual responding as a sequence of events associated with male arousal, tumescence, and detumescence set a framework from which the majority of recent discussion and exploration of sexual problems has developed. Masters and Johnson (1966) elaborated the male sexual response model, and supplemented that with their physiologically-based descriptions of female responding. Subsequently, their proposed response pattern of arousal, plateau, orgasm, and resolution was added to by Kaplan (1977) and Lief (1977), each of whom separately concluded that desire was a further essential element in the sexual response cycle. These separate "phases" proved useful for clinical assessment of sexual problems and as specific foci for intervention. Sexual dysfunction was defined as a lack of satisfactory responding in any one or several of the response phases. Early sex therapies, such as those introduced by Masters and Johnson (1970), were targeted at these distinct dysfunctions, but within a context in which "patients are accepted only if they come for therapy as members of the marital unit and are mutually committed to the … premise that there is no such thing as an uninvolved partner in a marriage where sexual dysfunction exists" (Masters & Johnson, 1970, p. 31).

Semans' (1956) stop-start technique—developed for the treatment of rapid or early ejaculation—was an early example of modern sex therapy treatment for a specific sexual dysfunction. Semans saw the need for partner involvement and recommended "three explanation sessions of the technic [sic]." He described: "one for the patient alone, another for his wife, and a third for the couple together." His method was advanced by Masters and Johnson (1970) with a specific squeeze technique added, to further assist the man to delay ejaculation with the help of his partner. Thus, early in the recent history of sexual dysfunction, most therapy for sexual difficulties was "couples therapy." This dyadic approach to assessment and management changed with the development of medical treatment for individuals with sexual dysfunction.

Initially, the development of surgical interventions and then pharmaceutical means to alleviate erectile dysfunction (ED) led to the mistaken impression that sexual dysfunction equated to individual problems with erections, with the partner often forgotten by the clinician.

A more appropriate approach to the clinical management of sexual dysfunction is framed around the phases of sexual response, and includes consideration of the impact of the symptoms and the treatment approach on the couple's sexual relationship. This chapter will cover the dysfunctions associated with each of the phases of sexual response, outlining the potential pharmaceutical approaches for each aspect of that cycle, and further discussing the usefulness

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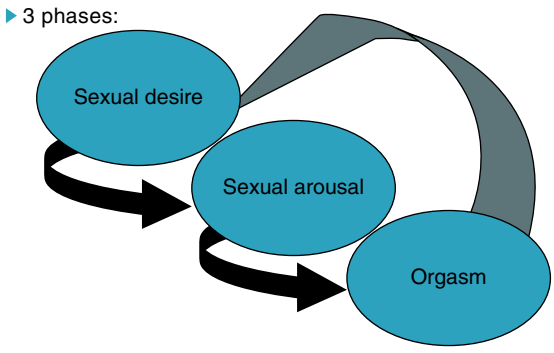

Figure 28.1 Illustration of the sexual response cycle.

of partner involvement in therapies for each area. Recommendations described in the literature and clinical examples are included, demonstrating the value of the couple being the focus of sexual dysfunction assessment and therapy, even in cases in which pharmaceutical approaches are being employed.

Most of the literature on incorporating couples into pharmacological treatments has focused on heterosexual couples; however, many of the suggestions can serve as the basis for tailored interventions with same-sex couples as well. We will also refer readers to chapters specific to sex therapy with sexual minorities elsewhere in this volume (Cohen & Savin-Williams, this volume; Spencer, Iantaffi, & Bockting, this volume).

The sexual response cycle

A useful graphic for making clinical sense of the phases of sexual function is shown in Figure 28.1. Using this framework, it is possible to understand how one phase may be disturbed but others less so; an example of this might be the development of erection difficulties while the man still has an active interest in sexual activity. Further, the separation of arousal from orgasm also explains the ability of men to ejaculate despite a less than full erection. Similarly, some women describe themselves as having low desire but no problem with arousal or orgasm once they engage in sexual activity. Pinpointing the aspect of sexual response that is most affected is important in assessment and is essential for the development of an adequate approach to pharmacological *or* psychological treatment. However, given the involvement of two persons in partnered sexual activity, the possibility exists for several points of difficulty, and therapy must take all of these into account. For instance, the pharmaceutical treatment of ED may be unsuccessful if the man's partner has no wish to engage in sexual activity because she has her own sexual desire or sexual pain problems. Assessment of the patient's needs should always include some understanding of the partner issues as well. As stated before, sexual dysfunction is a couple's difficulty, and both partners will be involved in any successful resolution.

General Principles for Integrating Couples into Medical Treatments

Schover (1989, p. 93) suggested that prerequisites for medical solutions *without any concurrent sex therapy* for men with ED include:

1 Good general psychological coping.
2 Good skills in both partners in initiating sex and requesting specific techniques during lovemaking.

3 Agreement between partners on sexual frequency and variety of sexual techniques.
4 Good skills in expressing nonsexual affection.
5 If in a committed relationship, good satisfaction for both partners.
6 History of continuing noncoital sex to orgasm for both partners in spite of erection problem.
7 No sexual dysfunctions other than ED.
8 Clear organic cause for ED.

These criteria could also apply to sexual dysfunctions beyond ED. Most clinicians will recognize that such a range of skills and partner agreement is uncommon in clinical situations, whether the issue is ED or another sexual disorder. So clinicians face the challenge of how to involve both partners into concurrent sex therapy in order to enable the best responses to medical interventions. Often this will mean the utilization of a multidisciplinary approach to provide the psychosocial content to accompany the medication.

One of the most theoretically important (and often overlooked) issues in pharmaceutical sex therapy is that of prescribing sexual medications for two—the individual with the presenting problem and his/her partner. Shtarkshall (2007) suggested clinicians should consider the impact of a prescription (e.g., a medication for ED) on the partner of the man involved. Biopsychosocial issues, such as the partner's readiness to resume lovemaking, the man's approach to his partner, and the partner's attitude to medication assistance with lovemaking, can play a role in the uptake of prescribed medical therapy (Althof, 2002). This raises an important second issue: The clinician needs to understand who that partner is. It is possible that the man or woman may not be sexually active with his or her spouse, but with some other person. Dealing carefully with this question can be an important aspect of correctly tailoring therapy in such cases.

How a medication is going to affect a couple—rather than solely the presenting patient—deserves careful thought and is applicable, not only in the ED context, but also when prescribing for any sexual dysfunction and when prescribing for non-sexual problems if the medication involves potential sexual side-effects. However, the range of sexual effects induced by various medications is very broad, and cannot be adequately covered here. (For reviews, see Conaglen & Conaglen, 2013; Segraves, 2003; Verhulst & Reynolds, 2009.) The remainder of this chapter will focus on current pharmaceutical interventions intended to assist with sexual dysfunctions and examine how one might involve both members of a couple in the treatment process. The rationale for this can be summed up in the following comments:

> Many physicians prescribe medications while failing to ask questions about their patients' relationships, ignoring any underlying psychological or systemic issues at play. Often, the partner is omitted from the decision to take medication. As a result, individuals continue to suffer from associated relationship dynamics—dynamics that may continue to plague the couple's sex life or other nonsexual areas. … Despite the evidence supporting the correlation between relationship and sexual problems, many professionals still look to the individual symptom bearer as the sole identified patient. (Betchen, 2009)

This issue speaks to the necessity for both psychologists and physicians to have sufficient training to be able to comfortably ask their clients about sexuality (Træen & Schaller, 2013).

General suggestions

Attendance at consultation Whether someone who is seeking medication to help with a sexual problem arrives for their consultation with their partner is often a matter of circumstance. Sometimes partners cannot attend due to other commitments, some do not wish to crowd the

patient or do not wish to attend, and some do not know about the appointment. However, if the referring clinician has suggested both members of the couple attend the first appointment, this can be very helpful in terms of involvement during subsequent therapy. Some practices find it useful to explain in their informational brochure that the partner will likely be seen at some stage of treatment. Alternatively it might be suggested to the person presenting with the difficulty that they bring their partner to a subsequent appointment, thus opening the possibility for a more thorough couple assessment and more effective therapeutic options.

Seeing both partners together serves to balance the treatment by holding both members responsible for their sexual relationship, helps to ensure that the clinician is viewed as neutral rather than blaming of the identified patient, and increases the chance that the couple will envision their problem as systemic rather than the sole responsibility of one partner who presents with symptoms or a disorder (Berman, 1982). When couples have been nonsexual for a time because of a sexual problem, dissatisfaction can result in blaming of one by the other, distancing, resentment, and a loss of intimacy in the relationship.

Assessment of partner's needs The documented history of treatment non-adherence with devices and medications for sexual problems demonstrates that a singular focus on one partner and his or her symptoms in isolation from the couple context can frequently lead to lack of use of the implant or appliance or discontinuation of the pharmacotherapy. This is particularly well-documented for ED treatment. Thus, several authors have recommended the involvement of partners in initial assessments along with an understanding of the partner's needs prior to ED treatment decision-making (Al-Shaiji & Brock, 2009; Althof, 2002; Althof *et al.*, 1989; Kramarsky-Binkhorst, 1978; Son, Park, Kim, & Paick, 2004).

Alternative strategies for partner education The use of bibliotherapy is covered elsewhere in this volume (van Lankveld, this volume), and without going into detail here, provision of written material or visual resources—such as educational DVDs—can help involve the partner in the treatment when attendance at appointments is not possible.

Assessment of couples' sexual dysfunction Detailed advice on assessment of sexual dysfunction can be found in a number of sources, but the gold standard from a psychosocial approach involves both partners attending up to three sessions to enable a thorough assessment of each partner and their relationship in context (Halford, 2001; McCarthy & Thestrup, 2008; Wincze & Carey, 2012). After an initial greeting and explanation of the process with the couple together, one partner is interviewed alone while the other completes self-report questionnaires. The reverse occurs in the subsequent session, and both are seen together for a third session in which the therapist will be able to discuss the possibilities for interventions and treatment. The content of each interview will be similar to that outlined in previous chapters in this volume; the integration of both partners' points of view gives the clinician greater insight as to how any potential therapy might need to be tailored to the couple's needs. The assessment of one partner alone may provide a perspective tailored to suit that person's goals and aims; assessment of the other partner often alters the way a clinician might focus therapy and manage the initiation of medication. For example, a man presenting with erection difficulties assessed alone might be prescribed medication to assist his erections. However, assessment of his partner may uncover her dissatisfaction with some aspect of his behavior, for example, his use of internet pornography; thus, the clinician will address this issue with both, and focus on a best outcome for the couple rather than immediately prescribing an erection medication. Relationship issues are often uncovered as the detail of a sexual issue is revealed, and partners may have differing beliefs as to how and why their problems have occurred. The use of pharmacological sex therapy without addressing relationship or marital issues has been shown to be less effective than approaches attending to both aspects of a couple's functioning (Hartman & Daly, 1983).

How does a couples approach differ from seeing the individual? Not all sexual dysfunction referrals include both partners, so initially the assessment focus will be on the problem for which the referral has been made. However, with a couples focus, two issues immediately arise from any referral: (1) Does the partner of the referred person have any interest in sexual activity or any sexual difficulties of their own? (2) What effect has the referral problem had on the couple's intimacy, relationship, and sexual function? Because the answers to these questions involve understanding each partner's issues—and integrating therapy and medication within that couple's context—each area of dysfunction that may involve medication is briefly discussed below. Suggestions are made that may help the two partners better understand the most appropriate way to recover or revitalize their sexual relationship.

The primary goal of sex therapy—"to establish a comfortable, functional couple sexual style"—remains the same, whether pharmaceuticals are involved or not (McCarthy & Thestrup, 2008, p. 595); the challenge is to integrate the use of medication with the sexual focus of the couples therapy, enabling both partners to feel comfortable with the outcome. The couples therapist will need sufficient understanding of the pharmaceuticals involved to educate the couple and to anticipate the responses both partners are likely to experience while adjusting to any medical therapy.

Interventions Relating to Specific Aspects of Sexual Response: Implications for Couples

Interventions for low desire

Low desire in women The recently-published standard operating procedures (Bitzer, Giraldi, & Pfaus, 2013) suggested the therapeutic approach for low sexual desire in women is usually multidimensional and includes individual and couples psychotherapy and hormonal and psychopharmacological treatment.

Current hormonal approaches to low desire are limited in their efficacy. One strategy involves the administration of androgens. The Endocrine Society guidelines advise only short-term use of testosterone in women, and state that there is only an evidential base for testosterone use in women who are surgically menopausal (Wierman *et al.*, 2006). Although studies have shown some benefit with testosterone supplementation in women with the DSM-IV-TR (American Psychiatric Association, 2000) diagnosis of Hypoactive Sexual Desire Disorder (HSDD), conflicting evidence and debate regarding the clinical efficacy of testosterone remain (Woodis, McLendon, & Muzyk, 2012). Despite the FDA request for more safety data (Spark, 2005), there is said to be widespread off-label use of the testosterone patch Intrinsa (Proctor & Gamble). The patch has been approved and widely used in Europe for women suffering low libido following surgical menopause (Wilson, 2010). Even with increasing evidence for the efficacy of various testosterone preparations in women with low desire, there remains an issue with adequate measurement and monitoring of testosterone levels when this is the treatment chosen (Herold & Fitzgerald, 2003; Sarrel, 2006; Taieb *et al.*, 2003). Accurate measurement of female levels of testosterone are woefully inadequate (Davis, 2010). The couple needs to understand the potential for negative impacts of testosterone therapy on women when monitoring is inadequate and/or when supraphysiological (above the normal range) T levels are present; these can include acne, hirsutism, hepatic or lipid problems, and possible breast cancer.

Another potential cause of low desire in women is the presence of high prolactin levels. Although standard operating procedures suggest blood testing is not routinely needed in women with HSDD, it is important to investigate pituitary function in cases in which the medical history suggests such investigation; for example, symptoms of pituitary dysfunction include

loss of periods, lack of libido, milk secretion, and infertility (Bitzer *et al.*, 2013). Once a cause for the hyperprolactinemia has been established, treatment is usually medication with dopamine agonists such as cabergoline or bromocriptine. Clinical experience, rather than extensive research, attests to recovery of sexual desire where high prolactin has been reversed.

A "promising" alternative approach to treatment of low sexual desire has recently been developed by Sprout Phamaceuticals and approved by the US Food and Drug Administration (Mechcatie, 2015; Wilson, 2010). Flibanserin reduces serotonin activity and enhances dopamine and norepinephrine activity in the prefrontal cortex with the goal of improving sexual desire in women with desire problems (Stahl, Sommer, & Allers, 2011). Flibanserin (Addyi; Sprout Pharmaceuticals) was recently licensed following studies that confirmed its safety and moderate efficacy in women with low sexual desire, who experienced slightly increased numbers of sexually satisfying events after taking the medication (Jayne, Simon, Taylor, Kimura, & Lesko, 2012; Simon, Barbour, & Symons, 2013; Thorp *et al.*, 2012).

Even if women are prescribed and experience some benefit from pharmacological treatment for low desire, the benefits will inevitably be limited if there are ongoing relational factors that contribute to the problem. The treatment of women with low desire has been covered elsewhere (Both, Weijmar Schultz, & Laan, this volume), but it is worth reiterating that a woman with low desire may be responding to inadequate circumstances to foster her desire for partnered sexual activity (Brotto, 2010; Laan and Both, 2008). Her partner's sexual techniques may be part of the issue because desire will understandably diminish if sexual activity is unrewarding; in that case, an educational approach to improving the partner's understanding of the woman's sexual needs could be helpful. The quality of a couple's sexual experience can also be affected by the desire discrepancies they may be experiencing, with sexual activity undertaken during times in which the woman is experiencing less desire being less satisfying for both partners than sexual activity during times in which she shares her partner's interest in sex (Mark, 2013). Relationship counseling focused on increasing intimacy and affection also might assist the woman in recovering her interest in sexual activity. If the problem is related to negative sexual experiences in childhood, different approaches will be required (Hall, 2008; Maltz, 1991; Stephenson, Hughan, & Meston, 2012). With or without medication, attention to the couple's intimacy levels and relationship issues and adjustment of sexual expectations can play a part in assisting a woman with low desire to find renewed interest in sexual activity with her partner (Leiblum & Sachs, 2002).

Low desire in men Although standard operating procedures for assessment and hormonal treatment of low desire due to low testosterone levels in men are covered in a recent publication (Rubio-Aurioles & Bivalacqua, 2013), the article includes no discussion of the involvement of partners in assessment or treatment. Nevertheless, this is an important consideration.

Low sexual desire is an important presenting symptom of male hypogonadism, a common endocrine condition characterized by low levels of testosterone (T). Men are frequently encouraged by their partner to seek help, as the man's lack of sexual interest impacts on the couple's relationship. Once the cause of the hypogonadism is established, T replacement (TR) therapy is initiated. TR preparations include oral, transdermal, injected, and implanted therapies, each with their own benefits and physiological characteristics (Giagulli *et al.*, 2011). Evaluations of T delivery systems have suggested that hypogonadal men's partners may be at risk from exposure to T gels. Little other mention is found of the impact of hypogonadism and its treatment on a man's partner and the couple's sexual function. An evaluation of sexual desire and sexual function in couples where the man was receiving TR found that the female partners reported more satisfaction, less pain, and improved sexual function following his TR treatment (Conaglen & Conaglen, 2009).

Treatments affecting one partner potentially have important effects on the other, and for this reason it is very useful for partners of hypogonadal men to understand the TR their partner is

to receive and its impacts on the man and his interest in sexual activity. For a man who has been T deficient for some time, the initiation of TR can seem like a reawakening of interest in sexuality, which is similar to the level that occurs in one's teen years; this can be confusing and upsetting for the partner, who has often not been prepared for such an extreme outcome. This phenomenon of heightened sexual interest in the man may last for some months, but partners can be reassured that a "normal" level of sexual interest and activity is likely after some time. Men should be encouraged to masturbate if their level of sexual interest is greater than that of their partners during this adjustment period.

High prolactin levels are also associated with low sexual desire and hypogonadism. Just as with hyperprolactinemic women, it is important to establish the cause of the men's high prolactin levels. Often, treatment with dopaminergic agonists such as cabergoline can lead to resolution of low sexual desire and sexual function. It can be reassuring for partners to understand the physiological basis for low apparent interest in sexual activity.

Interventions for arousal problems

Female arousal issues Although the recent DSM-5 (American Psychiatric Association, 2013) has combined female hypoactive sexual desire and sexual arousal disorders, clinically these are two different areas for assessment and intervention. Studies of women with self-reported low sexual desire, as well as clinical experience, describe many of these women as experiencing no problems with sexual arousal when sufficiently involved in sexual activity (Brotto, 2010). These observations confirm the model Basson (2005) proposed regarding women with low desire, and emphasize the need for clinicians to understand a woman's context, including her partner's ability to make love and her wish to be involved, in order to unravel the intricacies of her lack of desire and/or "insufficient" sexual response.

For peri- and postmenopausal women, arousal can be affected by the fact that their dwindling estrogen levels result in thinning of genital epithelium, creating the potential for painful sexual experiences which diminish arousal and enjoyment (Graziottin & Leiblum, 2005). Estrogen deficiency significantly contributes to changes in the urogenital and vaginal epithelium, resulting in vascular remodeling and changes in innervation (Nappi & Polatti, 2009). Such changes, together with the lessening of vaginal lubrication, often result in dyspareunia due to microscopic tears. Artificial lubricants can assist with prevention of the superficial damage that can occur (Wincze & Carey, 2012). However, a useful and longer-term solution, when appropriate, is to maintain the health of the labial and vaginal skin through the application of topical estrogen, which will restore the flexibility and thus allow for more pleasurable sexual experiences. A systematic review of the literature showed that such topical applications, regardless of method of application, had a positive effect on dryness and dyspareunia compared with placebo (Suckling, Lethaby, & Kennedy, 2003). One caution for couples when a woman uses estrogen cream is a warning not to use the estrogen as a lubricant during sexual intercourse; such use can result in transfer of the estrogen content to the male partner and has the potential to estrogenize him rather than her (DiRaimondo, Roach, & Meador, 1980).

In combination with medical interventions, a woman having difficulty with arousal can be encouraged to better understand her own sexual response, first alone and then in collaboration with her partner. *Becoming Orgasmic* is an excellent self-help program that assists women with both arousal and orgasm issues and also suggests partner involvement once the woman is ready (Heiman & LoPiccolo, 1988).

Erectile dysfunction (ED) Male ED has attracted the most medical research of all sexual dysfunctions, and consequently it is the sexual dysfunction that has received the greatest number of novel therapies in recent decades. The surgical intervention involving the creation of an "artificial os penis," initially for patients with Peyronie's disease or those with damaged penises

(Loeffler, Sayegh, & Lash, 1964), set the scene for the development of prosthetic implants for men with erection difficulties. Scott, Bradley, and Timm (1973) first used an inflatable prosthesis, and Small, Carrion, and Gordon (1975) developed a malleable version of the implant. These developments began the "medicalization" of this sexual dysfunction (Tiefer, 1996).

In the first years after the use of these implants, a survey of partners of implant recipients (Kramarsky-Binkhorst, 1978) revealed pre- and post-operative issues for these women, many of whom had not had the opportunity to discuss the procedure with the surgeon before or after the man's operation. Pre-operatively, partners of men with diabetes worried about the potential risks of surgery; others were concerned that the need for the surgery was because they did not "turn their partners on." Post-operatively, some women were not aware of the surgery until surveyed about its benefits; others indicated that they did not want to engage in sex with their partner despite his increased ability to have an erection. Recommendations were made for the involvement of women in pre-operative assessment and for better communication among patient, partner, and doctors (Kramarsky-Binkhorst, 1978).

The development of vacuum constriction devices (VCD) and the use of self-injection therapy (Virag, Frydman, Legman, & Virag, 1984) for erectile problems were the next medical advances, and they were similarly followed by surveys of men and their partners to assess satisfaction (Turner, Althof, Levine, & Bodner, 1991). Self-injection therapy was reported to be very well received initially (Hollander, Gonzalez, & Norman, 1992), but dropout from treatment after an initial improvement led to questions about what changes were necessary to increase adherence (Althof *et al.*, 1987, 1989, 1991; Mulhall *et al.*, 1999). Turner and colleagues (1992) found VCDs more effective than self-injections, but the frequency of patient orgasm and level of patient and partner satisfaction peaked within a month of initial use of VCD and dropped to baseline levels over the remainder of the year surveyed. The drop in treatment use was reported as being due to discomfort, in the case of injections, and due to ineffectiveness, in the case of both of the home administered therapies (Turner *et al.*, 1992).

The next major event was the development of the oral medications, principally the phosphodiesterase type 5 (PDE-5) inhibitors—sildenafil (Conti, Pepine, & Sweeney, 1999; Goldstein *et al.*, 1998; Morales, Gingell, Collins, Wicker, & Osterloh, 1998), closely followed by tadalafil (Brock, 2002; Brock *et al.*, 2002; Rosen, Shabsigh, Kuritzky, Wang, & Sides, 2005), vardenafil (Porst *et al.*, 2001), and more recently, several other PDE-5 inhibitors (Paick *et al.*, 2007; Palit & Eardley, 2010). These oral medications gave men the option of an erection without devices or surgical intervention and were a major medical advance. However, the patients' lack of long-term adherence to successful medication again became evident (Sato *et al.*, 2007; Souverein, Egberts, Meuleman, Urquhart, & Leufkens, 2002). Answers as to why this dropout from therapy occurred, even when medications are safe, effective, and easy to manage, were sought by gathering data from men who had taken the ED medications (Jiann, Yu, Su, & Tsai, 2006; Klotz, Mathers, Klotz, & Sommer, 2005; Son *et al.*, 2004) and from their clinicians (Mulhall *et al.*, 2005; Sato *et al.*, 2007; Souverein *et al.*, 2002). Preference studies were conducted to see which medications were favored by the men (Giannitsas, Konstantinopoulos, Patsialas, & Perimenis, 2008; Govier *et al.*, 2003; Taylor, Baldo, Storey, Cartledge, & Eardley, 2009), and *eventually* the needs of their partners were also canvassed (Conaglen & Conaglen, 2008). Partners preferred medication that (1) suited their partner (some men cannot tolerate all the PDE-5s) and (2) allowed them time to revisit the sexual encounter without time pressure; in that study, the majority of women preferred the use of the longer-acting PDE-5s by their partner because it gave them time for relaxed encounters, spontaneity within a 36-hour window, and flexibility. Strategies for optimizing therapy outcomes outlined the ideal treatment process, including involving both partners in treatment and discussing issues beyond the achievement of an erection in determining successful sexual functioning (Al-Shaiji & Brock, 2009; Althof, 2002; Dunn, 2004). As mentioned above, the ethical issue of being aware that prescribing of ED medications is going to affect a couple rather than solely the presenting

patient deserves careful thought (Shtarkshall, 2007), and is not only applicable in the ED context but applies equally well to prescribing for all sexual dysfunctions.

There are many articles acknowledging the impact of a man's ED on his partner, some of which advocate the involvement of partners in the prescribing process for men with ED (Kaplan, 1990; Lentz & Stenchever, 2004; Sadovsky, 2009; Turner *et al.*, 1992). However, very few authors are specific about how this might be done. Approaches that explicitly combine psychological and medical treatments for ED *do* typically include partners (Rosen, 2000, 2007; Rosen, Miner, & Wincze, 2014). These combination treatments help overcome the well-documented difficulty that men and women have in accepting the need for psychological interventions (Rosen, 2007; Rosen *et al.*, 2014; Wincze & Carey, 2012); that is, a greater likelihood of acceptance of psychological interventions comes with their use in combination with medical therapies. The use of oral ED medications may also help to uncover other sexual issues. Once an erection can be obtained, relationship issues, ejaculation problems, or other sexual problems between the partners are highlighted, underscoring the value of combining psychological and medical interventions. Key areas outlined in the psychological component of the combination treatment include the difficulties couples face with initiation following a period of infrequent sex due to ED, problems of low desire or lack of enthusiasm for sex in either or both partners when men have been struggling with their erections, other sexual dysfunctions such as rapid or early ejaculation in the man and penetration or lubrication difficulties in the woman, and a couple's intimacy or relationship problems. Current experience with PDE-5 inhibitors strongly suggests that sexual pharmacology can be much more effective if employed in the context of a broader systemic model that fosters a comprehensive assessment and understanding of all relevant, interdependent systems (Perelman, 2005; Weeks & Gambescia, 2000).

Interventions for orgasm problems

Female orgasmic disorder Pharmacotherapy is not commonplace in female orgasmic disorder; rather, the recently published standard operating procedures (Laan, Rellini, & Barnes, 2013) for this disorder encourage the involvement of partners in behavioral therapy particularly in cases in which the anorgasmia is occurring during partnered sexual activity. The *Becoming Orgasmic* program mentioned above is a useful, well-structured way to encourage women to become more sexually aware; it has empirical support and is widely used (Heiman & LoPiccolo, 1988). Although the research evidence for efficacy is less plentiful, the PLISSIT approach, in which the clinician initiates permission-giving, limited information, and further therapy if those are not sufficient; cognitive therapy to address distressing or unhelpful cognitions, emotions, and behaviors; behavioral techniques such as directed masturbation and sensate focus strategies; mindfulness and yoga techniques; and various combinations of all of these are also useful (Kempeneers, Andrianne, & Bauwens, 2013; Laan *et al.*, 2013). Partner involvement is an important part of many of these therapeutic approaches.

Ejaculation problems Of the two ejaculation disorders—early ejaculation and delayed ejaculation—early ejaculation is the more common and the focus of most of the research on pharmacotherapy. Early ejaculation has an impact on partners, although the extent of this impact is often overestimated by men who have the problem (Byers & Grenier, 2003). The Semans' start-stop technique was one of the first therapeutic strategies that involved both partners in sex therapy, and it is the most frequent clinical approach to treating early ejaculation. It requires partner involvement once the man has understood his own arousal patterns and "point of inevitability" (Semans, 1956). However, medication has also been used to assist men in delaying ejaculation. The use of selective serotonin reuptake inhibitors (SSRIs) in the treatment of early ejaculation developed as a result of a serendipitously-discovered side-effect

of these antidepressants (Montague *et al.*, 2004); it had been noticed that these medications delayed ejaculation in men who had not had sexual problems prior to taking them. More recently dapoxetine, which is similar to other antidepressants but which is a short-acting medication, with a short time to serum concentration and rapid elimination, has been developed as a treatment for rapid or early ejaculation (Pryor *et al.*, 2006). It has been found useful in about a third to half of men with early ejaculation difficulties, but its effects are also enhanced by combining the medication with cognitive therapies and with sex therapy involving the man's partner (Betchen, 2009; Hoy & Scott, 2010; Steggall, Fowler, & Pryce, 2008). Some see the value of the medication as providing a stable platform for a couple to work with the behavioral exercises outlined by Semans, allowing them to develop better sexual function so that eventually they do not need the medication (Althof, 2005).

Case Example

Jeff was a 54-year-old electrician who presented to his family physician with lack of interest in sex. His doctor referred him on to me (JVC), but asked him to have a blood test done first. When Jeff arrived for his first session, we noted that his T was low, but as we discussed his issues, he turned out to be very interested in sex but afraid of failing when attempting intercourse. He also mentioned that his blood test had been done in the early evening on his way home from work. He was asked to get an early morning repeat T test after it was explained that, when T is measured in afternoon or evening, it is naturally low as the hormone fluctuates diurnally. His sexual history revealed that Jeff had early morning erections, but difficulty with his erections when he engaged in sexual activity with his partner. He had been avoiding intercourse because of the difficulty maintaining his erection, so it was suggested that his partner come with him to the second session. His partner, Patsy, was a 50-year-old, postmenopausal woman, who admitted she did not want to have sexual intercourse too often because it caused her so much discomfort. She mentioned how she and Jeff seemed to be drifting apart and said that she missed the togetherness their sex life had fostered earlier in their relationship. Both spoke about their recent occasional attempts at intercourse: He felt anxious and concerned that he would not make her happy because his erection was softer than in the past. She was fearful of pain during and after penetration but knew the interaction was important to them as a couple. We discussed using one of the oral PDE-5 inhibitors, and the couple went away with a sample pack of four tablets. When they returned a few weeks later, they said the tablets had not worked very well. Jeff was still worried that he wouldn't ever be able to make his partner happy sexually again. Meanwhile, Patsy had begun using a prescribed estrogen cream regularly, and this had made her feel less dry. She thought sex might not hurt as much if Jeff was able to manage it in the future. This subtly added to Jeff's concerns. We discussed how his worries could be overruling the benefits from the ED medication. We discussed the reasons why people have sex—how connection between partners is more important than the "hardness" of his penis. They went home with strategies to renew their intimacy and with instructions to engage in a graded series of sensual activities, reducing Jeff's anxiety about being sexual with Patsy. Several weeks later, they had retried the PDE-5 inhibitors with success and then had managed sex without the tablets. His confidence had returned, and her enjoyment of their intimacy had intensified his arousal, so he had fewer concerns about performing adequately. On their final visit, they reported that their relationship was back on track, and although they had less frequent sex than when they were younger, it was more satisfying for both of them.

Conclusions

This chapter has reviewed sexual dysfunctions using a phase framework and has described partner issues with respect to various combinations of pharmaceutical and sex therapy interventions for couples experiencing sexual difficulties. By detailing partner issues within the phase framework, we hope clinicians will be better able to include and involve partners in the assessment and pharmacological treatment of couples' sexual difficulties.

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29

Self-Help and Biblio-Sex Therapy

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Introduction

Professional treatment is not ubiquitously available for individuals suffering from sexual problems. Reasons for this may include financial burden; geographical distance; physical limitations, including low mobility; and psychological obstacles to treatment-seeking. Various forms of "minimal interventions" (MIs) in the treatment of sexual dysfunctions have been proposed to meet the needs of people in these situations. MIs include bibliotherapy (self-help with the use of a therapy manual), self-help groups, telephone-based therapy, video therapy, internet-based therapy, and computer-based treatments (see Almås & Landmark, 2010). In addition to serving people who might otherwise not have access to professional help, MIs are also used in stepped- and matched-care models to match the intensity of professional guidance as closely as possible to the psychological resources of the help-seeker and the severity of his or her problem. Individuals with adequate problem-solving skills and motivation and relatively less severe problems thus may find solutions for their problem that are—both psychologically and financially—cost-effective.

MI strategies, also called "self-help therapies," exist for a wide range of mental and physical health problems (see Watkins & Clum, 2008) and can be subdivided into (1) generic, (2) problem-focused, and (3) technique-focused approaches (Pantalon, 1998). A generic approach to self-help focuses on common aspects that can be identified in many different mental health problems and disorders, such as low problem-solving skills or negative health attitudes. Problem-focused methods, in contrast, provide tools for assessment and treatment of specific problems, such as directed masturbation training for orgasmic disorder. Technique-focused methods typically provide tools that can be used for various types of problems. Examples are manuals that help the user to learn the application of conditioning principles (e.g., Kass & Stauss, 1975) or cognitive restructuring (Mintz, Balzer, Zhao, & Bush, 2012; van Lankveld, 1993, 2004) in the treatment of sexual disorders. Another relevant distinction among MI strategies is between totally self-administered approaches and those with limited therapeutic assistance.

Available self-administered self-help interventions for sexual dysfunctions are bibliotherapy; video therapy; and computer-assisted sex therapy, either using a program installed on a desktop or laptop computer (Binik, Servan-Schreiber, Freiwald, & Hall, 1988; Binik, Westbury, & Servan-Schreiber, 1989) or delivered through the internet (Connaughton & McCabe, this volume; McCabe & Price, 2008; McCabe, Price, Piterman, & Lording, 2008; van Diest, van Lankveld, Leusink, Slob, & Gijs, 2007; van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009; van Lankveld *et al.*, 2006). Telephone therapy and internet therapy using text-based or video-chat communication require direct therapist involvement. Some of these interventions,

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including bibliotherapy, have flourished and are used by numerous individuals and couples seeking help for sexual and other problems. For this purpose, hundreds of new self-help books are published every year. This chapter will further focus on bibliotherapy in the treatment of sexual dysfunctions.

Bibliotherapy for Sexual Dysfunctions

Bibliotherapy refers to self-help approaches in which printed material is used to present psycho-educational information or a description of an intervention. The interventions that have been "canned" into bibliotherapy for sexual dysfunctions have thus far been based on methods that are regularly delivered in face-to-face treatment settings, such as sensate focus therapy (Masters & Johnson, 1970) and cognitive therapy (Maultsby, 1975; see Hawton, 1995, and Leiblum & Rosen, 2000, for reviews). Bibliotherapy is often applied within unassisted self-help formats, but it has also been used as adjuvant treatment, combined with face-to-face sessions (Gillan, Golombok, & Becker, 1980; Halvorsen & Metz, 1992; McCarthy, 1984, 1989).

Barbach (1974), Heiman, LoPiccolo, and LoPiccolo (1976), Mintz (2009), and Zeiss and Zeiss (1978) published commercially available self-help manuals in English for individuals with sexual dysfunctions. Hengeveld (1994), Slob and Vink (2002), van Lankveld (1993, 2004), and Waldinger (1999) published self-help manuals in Dutch.

Therapeutic elements in bibliotherapy for sexual dysfunction

Several bibliotherapy manuals for sexual dysfunctions are based on traditional sex therapy techniques (Masters & Johnson, 1970). This treatment type is learning-oriented, and both partners are encouraged to gradually expose themselves to increasingly difficult aspects of their sexual interaction. To achieve this, the treatment elements are translated into written programmed instructions describing the various steps that can subsequently be taken. The instructions typically include: (1) a relational frame of reference in which sexual problems are diagnosed and treated; (2) a "ban" on intercourse in the first stage of change; (3) a series of sensate focus exercises intended to produce a non-threatening atmosphere in which partners can start touching each other's body without demanding "a sexual performance" of themselves or of their partner; and (4) a framework of communication between partners, who mutually disclose their desires and anxieties with regard to sexual contact. Many authors consider the sensate focus exercises to be the crucial ingredients of this treatment (Avery-Clark & Weiner, this volume; Masters & Johnson, 1970; Heiman, 2002; Heiman & Meston, 1997). They generate new, positive experiences for both partners during sensual touching, which are facilitated by the non-demanding, sensation-focused nature of the exercises.

Other self-help approaches for sexual dysfunctions are based on cognitive theory (Maultsby, 1975; Mintz, 2009; van Lankveld, 1993). Face-to-face cognitive treatment has been found successful as a treatment for sexual dysfunction, including male erectile dysfunction (Everaerd & Dekker, 1985) and female sexual desire disorders (Trudel *et al.*, 2001). The cognitive approach has been translated into a bibliotherapy format for various types of sexual dysfunction (Mintz *et al.*, 2012; van Lankveld, Everaerd, & Grotjohann, 2001) as described in more detail below.

Mechanisms of change in bibliotherapy for sexual dysfunctions

Since sex therapy emerged in the 1970s, both bibliotherapy and therapist-delivered sex therapy have heavily relied on clients' self-regulation (Scheier & Carver, 1988). For example, the sensate focus exercises, which often form the core elements of therapeutic change in sex therapy,

have most often been performed in the privacy of the couples' homes, not in the therapist's office. This is different from what happens when treating other psychological disorders or relational problems. Most therapeutic exercises, for instance, exposure to threatening stimuli in the case of phobias, are regularly performed while the therapist is present in the feared situation. The current practice in face-to-face sex therapy of relying on the client to perform unmonitored homework assignments limits the therapist's opportunities to observe whether and how exercises are performed. This leads to the situation in which sex therapists necessarily rely on self-reports from clients and partners as to what happens in the privacy of the couple's bedroom. This clearly creates a problem if both partners jointly persist in avoiding exposure to the beneficial experiences by failing to perform the homework assignments. To illustrate this point, it has been demonstrated that counteracting behavioral avoidance in women with lifelong vaginismus by introducing therapist-assisted exposure to the feared stimuli (i.e., vaginal penetration) was very efficacious in enabling vaginal intercourse (ter Kuile, Melles, de Groot, Tuijnman-Raasveld, & van Lankveld, 2013). This is in comparsion to regular treatment for lifelong vaginismus in which many treated clients and their partners were found to continue their pattern of avoidance behavior, resulting in disappointing responses to treatment (van Lankveld *et al.*, 2006). In the regular face-to-face approach of sex therapy, moreover, the therapist can only give non-contingent feedback and reinforcement. This means that, more so than with professional help for other behavioral or emotional problems, in sex therapy—whether delivered in a face-to-face or in a bibliotherapy format—self-reinforcement will probably play a more crucial role than therapist reinforcement. Given these typical limits of face-to-face sex therapy, the mechanism of change in face-to-face sex therapy and biblio-sex therapy is likely similar.

Behavioral self-regulation theory suggests a process of therapeutic change when self-help is successful (Scheier & Carver, 1988; see also Sbrocco & Barlow, 1996, for a review of self-regulation in the context of sexual dysfunction). Essential elements of the process are:

1 setting goals—identifying what would qualify as a successful outcome;
2 taking behavioral steps to obtain this outcome;
3 evaluating personal perception of whether goals are met;
4 comparing that personal perception to the pre-identified criteria for a successful outcome; and
5 if judged successful, continuing the behavioral steps, and if not judged successful, altering the behavioral steps.

The elements of the process are reiterated within a feedback loop. In their meta-analysis, Febbraro and Clum (1998) showed that elements of self-regulation that were incorporated in self-administered treatments—including goal-setting and monitoring of the discrepancy between set reference criteria and actual performance—contributed positively to the outcome of treatment for major depression, anxiety disorders, and health-related problems in adults. Face-to-face contact with a therapist and contact through postal mail were equally efficacious, and both were superior to self-monitoring alone, suggesting that only a minimal intensity of contact, direct or indirect, is required for positive outcomes in cognitive-behavioral therapy. Including multiple components of self-regulation yielded incremental effect sizes. For instance, adding feedback from a therapist to patient's self-monitoring alone was found to have a large effect size ($D = 0.80$). Adding the element of goal-setting to self-monitoring yielded a moderate effect size ($D = 0.60$). Thus, variation in the extent to which self-regulation elements are included in bibliotherapy methods might account for part of the variability in their effects. Although these findings support the relevance of self-regulatory components in MI therapies, Febbraro and Clum's (1998) meta-analysis did not include studies of bibliotherapy or other self-help approaches specifically for sexual dysfunctions.

Efficacy of Bibliotherapy for the Treatment of Sexual Dysfunctions

The large number of self-help manuals that are available in bookstores and through the internet for women and men experiencing problems with their sexual functioning reveals the existence of a large market for this approach. However, even with such an abundance of methods to choose from, there is no guarantee that help-seekers will find an adequate and effective method for their particular problem. Most of the available bibliotherapy methods have not been tested empirically (Hubin, De Sutter, & Reynaert, 2011). Not only might this lead to disappointment if the self-help attempt does not bring a solution to the sexual problem, but unsuccessful application of self-help strategies may lower the help-seeker's confidence in the usefulness of professional sex therapy that might be required in his or her case. Distinguishing efficacious therapies from inert or potentially dangerous therapies is therefore important. Equally relevant is research that is aimed at identifying the mechanisms and key ingredients of bibliotherapy that account for its effect, as well as the conditions predicting the effect of bibliotherapy for particular individuals. In the following paragraphs, a review of empirical studies in the field will be reported, including the contributing elements of bibliotherapy for sexual dysfunctions.

Challenges in investigating effects of self-help therapies

The effectiveness of face-to-face treatment has been established for several types of sexual dysfunctions, based on the criteria of the American Psychological Association's (1995) Task Force for *well-established* and *probably efficacious* treatments (see also Heiman & Meston, 1997). These include "well-established" treatments for lifelong anorgasmia in women using directed masturbation exercises, for erectile dysfunction using systematic desensitization, and for premature ejaculation using stop-start and squeeze techniques. A "probably efficacious" treatment for acquired female anorgasmia is the combination of (1) psychoeducation, including sexual skills training and partner communication skills training, and (2) directed masturbation training. The effectiveness of therapist-administered face-to-face cognitive-behavioral therapies may serve as a reference point for the relative efficacy and cost-effectiveness of bibliotherapy. In the following paragraphs, different types of evidence for the effectiveness of bibliotherapy for sexual dysfunctions will be reviewed.

A specific design problem in the outcome research into bibliotherapy, in particular for sexual dysfunctions, has to do with the core aspects of self-help approaches. An individual who wants to start working with bibliotherapy searches in a bookstore or on the internet for a seemingly viable and attractive method. The person starts reading and implementing the self-help method without further delay. An investigation into the effectiveness of bibliotherapy, however, often requires an initial contact with the investigator and baseline assessment of information that is needed to enable comparison with data collected at later moments during the process. An essential difference with treatment outcome research of bibliotherapy and face-to-face treatment is that the latter inherently requires direct contact with a therapist, who can introduce the study for which the individual is invited to participate; thus, the research situation for evaluating face-to-face therapy is not substantially different from the natural situation. In contrast, the research situation for bibliotherapy is rather different from the natural situation for bibliotherapy, and this may cause problems with the ecological validity of the findings. The disruptive effect of baseline assessment in bibliotherapy research may be even larger in the study of sexual problems due to the highly covert nature of these problems compared with many other psychological and medical problems. The impact of such pre-bibliotherapy contact on the results can be investigated using a Solomon four-group study design in which post-treatment data are compared for study participants in both intervention and control groups who both did and who did not have pre-bibliotherapy assessment

(Solomon, 1949). However, this places an extra burden on investigators of bibliotherapy in terms of the required numbers of study participants; thus, most studies have not utilized this rigorous design.

Research on the efficacy of bibliotherapy for sexual dysfunctions

The efficacy of bibliotherapy for sexual dysfunctions has been investigated in a number of controlled treatment studies comparing participants who received active bibliotherapy with participants who did not receive treatment at all, who received it after completion of the post-test data (i.e., waitlist control), or who received a psychological placebo. Dodge, Glasgow, and O'Neill (1982), for instance, compared a minimal-contact bibliotherapy group with a wait-list/information control group in women with either lifelong or acquired anorgasmia. Wait-list participants received a 40-page informational brochure on human sexuality, not the self-help manual. After treatment, participants in the bibliotherapy group experienced orgasm during sexual intercourse significantly more often than control group participants. The bibliotherapy group's gains at post-treatment were maintained at six-week follow-up.

In addition to individual outcome studies, meta-analyses have been performed compiling the results of single outcome studies, thus increasing analytical power. Some meta-analyses have included bibliotherapy studies for sexual dysfunctions among studies of other problem types, while others were dedicated to sexual dysfunctions only.

Over the years, meta-analyses of bibliotherapy were able to include growing numbers of empirical studies of bibliotherapy for sexual dysfunctions. Gould and Clum (1993) published the first meta-analysis of 40 bibliotherapy studies for various mental health problems. In their analyses, bibliotherapy for sexual dysfunctions yielded one of the largest mean effect sizes (ES = 1.86), compared with a mean ES of 0.76 across all mental health problems investigated. This large effect size, however, was based on only a single study (Dodge *et al.*, 1982). The authors noted that more published studies on bibliotherapy for sexual dysfunctions were initially retrieved but were rejected for inclusion because they did not incorporate an adequate control condition, failed to randomly assign eligible participants to study arms, did not use valid assessment measures, did not collect adequate follow-up data, or did not report sufficient details of the statistical analyses to enable calculation of effect sizes. In a later meta-analysis of self-help interventions (Marrs, 1995), data from four studies of bibliotherapy for sexual dysfunctions could be aggregated, including the Dodge *et al.* (1982) study described above. Again bibliotherapy for sexual dysfunctions was shown to yield the highest effect size (ES = 1.28) of all mental health problems that were addressed, with a mean ES of 0.57 across all 70 studies included in the meta-analysis. The most recent meta-analysis by van Lankveld (1998) included 12 controlled studies of bibliotherapy that were all exclusively aimed at the treatment of sexual dysfunctions. Most of the studies that were eligible for this meta-analysis were outcome studies of bibliotherapy for male and female orgasmic disorders. This meta-analysis yielded a mean ES of 0.68 at post-treatment (0.50 when weighted for sample size). This ES is considerably smaller than prior ES estimates. Furthermore, the effects at post-treatment assessment were found to be largely lost at follow-up assessment. Note that the more recent meta-analyses included more studies but also reported lower average effect sizes of the effects of bibliotherapy for sexual dysfunctions. In addition, studies based on smaller numbers of participants tended to show larger mean ESs (van Lankveld, 1998) than those based on larger numbers of participants. As the results of investigations with larger numbers of participants can generally be considered more robust, it seems safe to conclude that the treatment effect size of bibliotherapy is lower than earlier meta-analyses suggested.

Since the publication of the most recent meta-analysis (van Lankveld, 1998), a large randomized controlled clinical trial in this field was conducted in the Netherlands

(van Lankveld *et al.*, 2001). Heterosexual couples ($N = 199$) who met criteria for a sexual dysfunction according to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000) were randomly assigned to either a cognitive-behavioral bibliotherapy format—based on a combination of sensate focus therapy and rational-emotive self-analysis—or to a wait-list control condition. Couples in the treatment group were given a manual (van Lankveld, 1993) and were offered therapeutic assistance through telephone contact with a sexologist over a 10-week treatment period. All treated participants reported a higher post-treatment frequency of sexual interaction with their partners and general improvement of their sexual problem compared with the control. Male participants reported lower post-treatment ratings of problem-associated distress compared with the control group. The gains that were obtained with respect to the increased frequency of sexual contacts and lower problem-associated distress, however, were mostly lost at the 10-week follow-up assessment. In subgroups of participants with different types of sexual dysfunctions, specific effects were found. Female participants with both lifelong and acquired vaginismus reported relief from pain and discomfort during vaginal penetration attempts at post-treatment, as well as at follow-up assessment. In contrast, female participants with dyspareunia reported increased complaints with pain and discomfort upon vaginal penetration at post-treatment assessment and at follow-up. In this study, compliance with the demands and recommendations in the bibliotherapy manual was assessed and found to vary widely. The self-estimated time spent reading the manual varied from zero to 40 ($M = 5.4$) hours for male, and from zero to 30 hours ($M = 6.1$) for female participants. The number of completed rational-emotive self-analyses ranged from zero to 35 ($M = 1.2$) for male and zero to 20 ($M = 1.1$) for female participants. The number of different sensate focus exercises that were performed during the treatment period ranged from zero to six ($M = 1.0$) for male and zero to six ($M = 1.2$) for female participants. The total number of times individuals performed any exercise ranged from zero to 40 ($M = 5.1$) for male participants and from zero to 40 ($M = 4.3$) for female participants. Compliance with the recommendations and assignments in the manual as reported by both partners was found to positively covary with outcome at post-treatment and follow-up. Male participants who made more efforts at solving their sexual problem, as observed by their female partner, exhibited stronger post-treatment effects than male participants who made less effort according to their partners. In female participants, higher compliance was also shown to be associated with higher post-treatment effects. Female participants whose partners rated their effort as larger (i.e., performing more rational-emotive self-analyses and more often asking for therapist support) were found to report higher gains at post-treatment. These factors, however, did not predict treatment outcomes in female participants at the 10-week follow-up assessment.

Mintz and colleagues (2012) more recently compared unassisted bibliotherapy for women complaining of low sexual desire with a wait-list control. Women in the intervention group were given a self-help book and took all steps that were outlined without further therapeutic guidance. The treatment period was six weeks. Compared with participants in the control group, women in the bibliotherapy condition reported significantly greater improvement in sexual functioning after treatment on measures of sexual desire, sexual arousal, sexual satisfaction, and overall sexual functioning. At follow-up, women in the intervention group reported maintenance of the progress they had made regarding their sexual desire and their overall sexual functioning.

In sum, a number of comparative studies have been published that assess the efficacy of several variants of bibliotherapy for male and female sexual dysfunctions. Although studies in the first decades of research in this area mainly focused on orgasmic disorders, more recent investigations included other dysfunction types as well. The efficacy of bibliotherapy in this field generally compares favorably with no-treatment comparison groups when assessed

immediately after the treatment/study period. Loss of gains after treatment termination is reported in many cases when follow-up data are considered. This is similar to many face-to-face treatments for sexual dysfunction. The impact of assessment-related biases on these results remains to be examined in the future. Nevertheless, the outcome data, as described, warrant the use of a number of self-help manuals for sexual dysfunction that are commercially available in the English language (Barbach, 1974; Heiman *et al.*, 1976; Mintz, 2009; Zeiss & Zeiss, 1978) and in Dutch (van Lankveld, 2004).

In addition to the study of basic efficacy, research has been performed to identify the effective elements in bibliotherapy for sexual dysfunctions. In several studies, bibliotherapy plus therapist support (via telephone, email, or face-to-face) was compared with bibliotherapy alone. When data from these studies were compiled in a meta-analysis (van Lankveld, 1998), bibliotherapy with additional therapist support was found superior to totally self-administered bibliotherapy, although this difference reached only borderline statistical significance. The better results for minimal-contact self-help—compared with unsupported bibliotherapy—in the treatment of sexual dysfunctions is in line with meta-analytic findings related to self-help studies for other mental health problems, both without (Febbraro & Clum, 1998) and with the use of internet-based methodology (Spek *et al.*, 2007).

What bibliotherapy can tell us about non-specific factors

Compared with the psychotherapies for other mental health problems, sex therapy research has failed to address the relative contributions of different sources of variability in therapeutic outcomes. These sources are often clustered into, respectively, the specific content of the intervention (and its theoretical background), client variables (including severity of pathology, motivational strength, coping skills, attitudes toward sexuality and sex therapy, and personality features), therapist variables (including therapist allegiance, level of expertise, and empathic skills), context variables (including partner participation, duration of treatment, use of adjuvant treatments), and a group of so-called "common" or "non-specific" factors (including the quality of the working alliance between the client/couple and the therapist, the provision of a clear and explicit rationale for treatment, the instillation of hope to demoralized help-seekers, and the display of a firm belief in the healing potential of the treatment by the professional). Numerous investigations of the mechanism of therapeutic change in other mental disorders have demonstrated the efficacy of specific therapeutic strategies compared with withholding treatment, placebo treatments, or rival treatment strategies. But there is also a firm body of evidence supporting the contribution of the therapeutic alliance to therapeutic outcome (Goodheart, Kazdin, & Sternberg, 2006). Another way to demonstrate the relative contribution of non-specific factors—including therapist attention and quality of the working alliance—versus the specific content of interventions to treatment outcomes is by systematically varying the intensity of the therapeutic contact within various types of self-help and therapist-delivered treatment.

A small number of studies have been published that addressed the relative contributions of non-specific factors to the outcome of treatment for sexual dysfunctions (for reviews, see Hawton, 1995; Heiman & Meston, 1997; Rosen & Leiblum, 1995). It is noteworthy that the research of self-help therapy formats has additionally shed some light on the contribution of therapists' efforts and characteristics, and of the working alliance between therapist and client in studies in which self-help was compared with regular therapist-administered treatment. For instance, similar effects were found when comparing a bibliotherapy and a group therapy format in the treatment of women with lifelong anorgasmia (Mathews *et al.*, 1976). The contribution of common factors to the outcome of bibliotherapy and other therapy formats warrants continued research effort.

Cost-effectiveness of Bibliotherapy for Sexual Dysfunctions

In addition to the issue of basic efficacy of bibliotherapy for sexual dysfunctions, its cost-effectiveness is an important consideration. Relative cost-effectiveness refers to the balance between the effect sizes and the direct and indirect costs incurred by choosing each of the rivaling treatment options. The standard methodology used to measure cost-effectiveness has thus far not been used to investigate bibliotherapy versus other treatment options for individuals with sexual dysfunctions. However, the relative cost-effectiveness can be gleaned from published comparisons of bibliotherapy with regular therapist-directed treatments. If the effect size of bibliotherapy versus therapist-administered treatment differs, estimating the cost-effectiveness from this type of research is not feasible, because both effects and costs have to be quantified and standardized to allow for a full evaluation of the relative cost-effectiveness. However, if both treatment formats have equal effect sizes, bibliotherapy, especially when used without any additional professional assistance, will be more cost-effective, as it can be assumed to incur lower costs for individuals compared with therapist-delivered treatment.

An example is a study published by Mathews *et al.* (1976). The authors compared the effects of the "directed practice" and "counseling" elements of Masters and Johnson's (1970) sensate focus model of therapy for sexual dysfunctions. The directed practice element in this model referred to the detailed instructions for exercises that users were recommended to perform to enhance their sexual functioning—for instance, clitoral stimulation for women with anorgasmia or start-stop exercises for men with premature ejaculation. The counseling element referred to the face-to-face contacts in which clients received professional guidance from a therapist. Thirty-six couples with heterogeneous sexual difficulties participated in the study. Couples were randomly assigned to one of three therapeutic formats: systematic desensitization plus counseling, directed practice plus counseling, or directed practice with minimal therapist contact. The gender of the partner with the dominant sexual problem was counterbalanced across treatments and therapists. The conditions with face-to-face contact comprised 10 weekly treatment sessions. The minimal-contact condition consisted of weekly exchanges of letters plus three client-therapist contacts: at the start, at a session in the middle of the treatment period, and at a final session. The effects of the various conditions were not significantly different on any of the outcome ratings.

In another study, bibliotherapy with limited therapist support by telephone was compared with regular therapist-administered group therapy and with wait-list control in women with lifelong vaginismus (van Lankveld *et al.*, 2006). Both the group therapy and the bibliotherapy were manualized and comprised psychoeducation, relaxation exercises, gradual exposure to feared stimuli, cognitive therapy, and sensate focus therapy. Participants in the therapist-guided group format attended 10 two-hour group sessions. Groups included six to nine participants. The therapeutic assistance during minimal-contact bibliotherapy was limited to six 15-minute telephone contacts delivered in two-week intervals. Overall, the effects of treatment were found to be small, and the proportion of participants who were able to have intercourse after treatment termination was not different between participants in the bibliotherapy (18%) and the group therapy conditions (9%). However, both treatment formats were superior to the wait-list control group. In the latter, none of the participants was successful in terms of being able to have intercourse. At follow-up assessment 12 months after treatment termination, 21% of the group therapy participants and 15% of the bibliotherapy participants reported having had intercourse. This was not a significant difference. These results can be considered to indicate higher cost-effectiveness for the minimal-contact intervention format, given its lower costs. Note, however, that this rudimentary way to estimate cost-effectiveness does not take into account indirect costs that might be incurred by couples in the minimal-contact condition, for instance, because they consult other professionals during the treatment period.

A number of comparisons between bibliotherapy and therapist-administered sex therapy, however, showed different effects for the two conditions, rendering cost-effectiveness investigation impossible in the absence of specific health technology assessment methodology. For instance, the proportion of anorgasmic female participants that were able to experience orgasm after treatment—either with partner or during masturbation—was lower in minimal-contact bibliotherapy compared with therapist-delivered sex therapy (Hahn, 1981; Heinrich, 1976). In other studies, bibliotherapy was found to yield superior outcomes compared with standard sex therapy. Morokoff and LoPiccolo (1986) assessed the ability of women to have an orgasm in different sexual stimulus situations following termination of treatment. A higher proportion of women became orgasmic during masturbation, during masturbation using a vibrator, during intercourse with their partner, and during sexual interaction with their partner when using a vibrator after finishing minimal-contact bibliotherapy, compared with therapist-guided sex therapy. A similar result was found by Hahn (1981).

This heterogeneous pattern of results implies that face-to-face therapeutic guidance does not, in all circumstances, have a superior outcome compared with minimal-contact self-help treatments, such as bibliotherapy. At least for some sexual dysfunctions, bibliotherapy can be recommended because of its potentially higher cost-effectiveness ratio. In a stepped care model of help, bibliotherapy seems warranted as the treatment of first choice for some sexual dysfunctions. More intensive—and expensive—treatment may be pursued if bibliotherapy is not effective. Note, however, that a more formal cost-effectiveness investigation of bibliotherapy for sexual dysfunctions using standard health technology assessment methods is warranted.

Why it is Important to Consider Bibliotherapy as a Treatment for Sexual Dysfunctions

Sexual dysfunctions are highly prevalent problems in humans. For example, a survey in the Netherlands of more than 4,000 adults between 18 and 71 years of age showed that lifetime prevalence of unspecified sexual dysfunction—meeting DSM-IV-TR dysfunction and distress criteria—amounted to 16.7% in men and 19.5% in women (Kedde & de Haas, 2006). In a later survey among more than 8,000 adolescents and adults between 15 and 71 years of age, the prevalence numbers were even higher—19% in men and 27% in women (Kedde, 2012). It has been suggested that the number of individuals in the community who suffer from all types of physical or mental health problems and who start using a form of self-help probably exceeds the number of contacts with healthcare professionals (Dean & Kickbush, 1995). In cases in which individuals suffer from sexual problems, this ratio might be even more heavily skewed towards self-help due to the highly private nature of sexual problems, which can be assumed to strongly promote a reluctance to disclose such problems to others, including professional care providers. However, the private nature of sexuality might, at the same time, obscure the volume, the nature, the process, and the outcomes of such self-help initiatives.

Help-seeking trajectories

Help-seeking behavior has been described as a staged process (Wills & De Paulo, 1991). In the first stage, the individual self-identifies a problem, attempts self-help strategies, and initiates informal contact with a partner, relatives, and friends. In the next stage, the individual seeks help outside of his or her personal network—from a family doctor, a religious leader, sometimes even a hairstylist. It is only in the last stage that the help-seeker turns to a specialist-professional, such as a gynecologist or urologist, a psychiatrist, a psychologist, or a sexologist. Catania, Pollack, McDermott, Qualls, and Cole (1990) demonstrated the presence of this sequence of help-seeking behavior among people with sexual problems in a field study in the

US. Eighty per cent of individuals with sexual problems first sought informal help (first stage). That same percentage of participants reported having attempted some form of self-help. All of the participants who consulted specialized helping professionals (third stage) had sought informal help before doing so, and 88% reported having tried some form of self-help. Similarly, Shifren *et al.* (2009) found in their more recent survey that more women with distressing sexual problems consulted informal sources (42%) than formal professionals (35%) for help. These findings suggest that self-help approaches, including bibliotherapy, occupy an important position when individuals start seeking help for their sexual difficulties. Only after covert or inconspicuous types of help have failed to solve their problem do men and women with sexual problems appear willing to disclose their sexual problem to a general or sexual healthcare professional. This is also reflected in the low self-disclosure rate of sexual dysfunction in the offices of gynecologists (Bachmann, Leiblum, & Grill, 1989; van Lankveld, ter Kuile, Kenter, van Hall, & Weijenborg, 1996), urologists (van Lankveld & van Koeveringe, 2003), and family doctors (Shifren *et al.*, 2009). Compared with spontaneous self-disclosures in the doctor's office, the number of patients who report suffering from sexual dysfunctions is substantially greater if the doctor initiates the conversation about issues of sexual functioning and sexual satisfaction (van Lankveld & van Koeveringe, 2003). Given that self-help approaches, such as bibliotherapy, are likely being widely used already, it behooves the sex therapy community to research these approaches further and consider integrating them into more traditional therapy.

Treatment intensity geared to level of client's need: stepped care and matched care

The amount and intensity of supportive interaction between the client and therapist can vary when using bibliotherapies. Glasgow and Rosen (1978) distinguished four levels of contact intensity. At the first level, client–therapist interaction is limited to the contacts needed for assessment purposes. At the second level, minimal-contact therapies are found. Limited contact with a therapist is included in the early stages of treatment to provide an introduction to the method for the client. Any clarification questions that the client might raise can be answered. Limited therapist support during the treatment period can also be included in the protocol, and that can be provided by telephone, in face-to-face contact, or through email or video-chat. This type of support is sometimes aimed at increasing treatment integrity and enhancing the participant's compliance. At the third level, more intensive "therapist-assisted" bibliotherapy is provided in which client–therapist interactions occur more frequently. The professional is more prominently present and can be involved in directly supporting the client to clarify the bibliotherapy manual and to provide more extensive rationales and explanations. The client, however, remains the main protagonist in working through the steps that are outlined in the bibliotherapy manual. At the fourth level, standard "therapist-delivered treatment" is found. The professional takes the lead and guides the therapeutic process. The most important psychological change processes are staged in the consultation room. Homework assignments may be an important, but secondary, element of treatment, and written or audiovisual material may be used as an adjuvant therapeutic element.

Several stepped-care models have been suggested to guide policy-makers and practitioners to design and implement interventions for individuals suffering from sexual dysfunctions, so that practitioners might adapt the intensity, the pervasiveness, and the costs of sexual healthcare to the characteristics and needs of the help-seeking individual. An early model, termed PLISSIT (Annon, 1974; see also Mintz, Sanchez, & Heatherly, this volume), which has been referred to in numerous publications, aimed to fine-tune the length, intensity, and comprehensiveness of the professional help to the variable characteristics of men and women suffering specifically from sexual problems. PLISSIT stands for Permission, Limited Information, Specific Suggestions, and Intensive Treatment. Permission represents the lowest level of intensity

and is sufficient for individuals with sexual problems who merely require a professional's permission to experience their sexuality as they do. This may be the case, for example, when the person experiences difficulties in accepting his or her homosexual orientation. Another example is when one has come to experience sexual arousal with the help of a type of stimulation that one considers embarrassing, but which is not harmful to the person nor to others. Limited Information represents the next higher level of intensity in which psycho-education may suffice to assist a help-seeking person in accommodating his or her physical or mental condition, such as when surgical cancer treatment has effected bodily changes that affect sexual functioning. A professional who gives information on new ways of providing erotic stimulation may open up a road to change. At the next level of Specific Suggestions, advice may be provided to perform specific exercises at home, requiring follow-up contacts with the professional to monitor and further guide the therapeutic process. Specific Suggestions may be more invasive if they involve discussing intimate details of the sexual anatomy or of sexual behavior. In some cases, recommending sensate focus exercises will take place at this level of Specific Suggestions. At the most intensive level, Intensive Treatment is situated. This may be a necessary level of service when physical or psychological comorbidity complicates the problem. A number of consultations may be required to enable a therapeutic process in which various problem elements and their interconnections are addressed. In order for such a program to be effective, it may be necessary first to establish a strong therapeutic working alliance.

Self-help interventions, including bibliotherapy, are located at the lower end of the PLISSIT model, as are more recent models of stepwise delivery of healthcare (Bower & Gilbody, 2005). The principle of stepped care holds that the least intensive intervention for a particular problem is provided as a first step. If evaluation after a period of treatment has revealed that the client's goals are not met, then the next intervention in the hierarchy is initiated, and so on. Matched care, as opposed to stepped care, implies that the type and intensity of professional help is matched to the particular characteristics of the client and his or her problem, bypassing less intensive types of help that are assumed not to be efficacious or sufficient in a particular case (van Straten, Tiemens, Hakkaart, Nolen, & Donker, 2006). Although matched care, to be successful, would require the identification of robust and reliable predictors for the successful match of client and problem features with the type of help, this has not been achieved for most mental health problems, including sexual dysfunctions. Thus, bibliotherapy to date seems like a useful application of a stepped-care approach.

The Future of Bibliotherapy

The self-help approach to sexual problems has been the subject of a considerable number of empirical investigations. Bibliotherapy in various formats is the type of self-help that has been most thoroughly researched. The evidence needed to warrant broad applications of bibliotherapy to the field of sexual dysfunctions, however, is still scarce and fragmented. The efficacy of bibliotherapy has compared favorably with no-treatment alternatives, although the gains that were reported immediately after treatment tended to diminish at follow-up. Differences between outcomes in bibliotherapy and standard forms of face-to-face sex therapy have been small or absent. Although the outcome research in bibliotherapy for sexual dysfunctions has yielded promising results, the progress in this field currently seems to have slowed. Although one might be inclined to think that bibliotherapy can or should have been replaced with internet-based interventions, this has not deterred researchers in other areas of mental health research from continuing to conduct successful research into bibliotherapy (Nordin, Carlbring, Cuijpers, & Andersson, 2010). In a similar vein, the rapid pace at which sexual self-help books are still being published does not suggest a lag in consumer interest. Further testing through methodologically sound trials is, of course, required.

In particular, the effects, costs, and benefits of bibliotherapy and certain forms of internet-based self-help should be compared (also see Connaughton & McCabe, this volume). Bibliotherapy and unassisted internet-based therapy for sexual dysfunctions share a common characteristic, in that they provide information and therapeutic recommendations in a "canned" fashion. Although they may contain flexible recommendations that the user can adapt to his or her personal conditions, the intervention is presented as a more or less fixed entity of information. This is in contrast with therapist-assisted interventions within other minimal-intervention formats and in regular face-to-face therapy, both of which allow a more tailored approach. Differences between bibliotherapy and unassisted internet-based therapy for sexual dysfunctions are also apparent. Internet-based approaches enable the use of branching techniques, thus disclosing maximally relevant details of the method while hiding irrelevant material. Bibliotherapy manuals, on the other hand, may offer a more comprehensive overview of all details of the presented method that is not possible in internet-based manuals, which can only display the information in as far as it fits on a screen. Future research appears warranted to compare the (cost-)efficacy of bibliotherapy and unassisted internet-based therapy for sexual dysfunctions and potential predictors of their usefulness in different patient groups and conditions in which they can be applied. In the meantime, bibliotherapy for sexual dysfunctions continues to be widely used, and it represents a potentially cost-effective way to reach a wide audience.

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30

Internet-Based Sex Therapy

Catherine Connaughton and Marita McCabe

Introduction

Internet-based therapy, also known as online therapy, e-Therapy, eHealth, web-based therapy, e-Counseling, and cyber-therapy, is becoming a widespread and popular therapeutic medium for mental health information and support. Similar to self-help methods, such as self-help books and instructional videos (see van Lankveld, this volume), internet-based therapy offers privacy and convenience to clients and is accessible to geographically isolated members of the community. In addition, the internet provides a platform for online therapist contact (in various formats) and online group therapy, while still maintaining anonymity and privacy for clients.

Due to the common perception of sexuality as private and sensitive in nature and due to the embarrassment and shame that often surround sexual difficulties, the use of internet-based sex therapy has been advocated for some years (e.g., Cooper & McLoughlin, 2001; Leiblum, 2001). In particular, the anonymity and privacy inherent in internet-based therapy may be especially helpful in attracting clients with sexual difficulties who may otherwise delay or avoid treatment opportunities. Over the past decade, clinicians and researchers in this field have begun to assess the effectiveness of internet-based sex therapy for a variety of male and female sexual difficulties. This chapter will present an overview of current approaches to internet-based therapy and the various formats that this approach can take. The chapter will then present the adaptation and application of sex therapy interventions for internet-based treatment. A review of the research studies evaluating internet-based sex therapy over the past decade will also be presented, along with a discussion of the effectiveness of these approaches, with particular attention to client suitability as well as ethical considerations relevant to online therapies. Finally, implications for clinical practice and future directions will be explored.

Internet-Based Approaches to Mental Health: An Overview

Internet-based interventions have been successfully used for a variety of mental health problems such as anxiety disorders (Aydos, Titov, & Andrews, 2009; Cuijpers *et al.*, 2009; Hedman *et al.*, 2011), depression (Moritz, Schilling, Hauschildt, Schröder, & Treszl, 2012; Spek *et al.*, 2007), eating disorders (Zabinski, Wilfley, Calfas, Winzelberg, & Taylor, 2004), and substance abuse and other addictions (Alemi *et al.*, 2007; Gainsbury & Blaszczynski, 2011). In a meta-analysis evaluating the effectiveness of internet-based psychotherapy in 92 studies covering a range of mental health concerns (e.g., anxiety, depression, eating disorders, stress), it was found that the overall mean weighted effect size for internet-based therapy was similar to the

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average effect size of traditional face-to-face therapy (Barak, Hen, Boniel-Nissim, & Shapira, 2008). As well as demonstrating that clients experience treatment gains from pre- to post-test, various studies have also demonstrated longer-term benefits of internet-based therapies (e.g., Carlbring, Nordgren, Furmark, & Andersson, 2009; Hedman *et al.*, 2011).

Format and feature options of online therapies

Although all internet-based therapies share common features such as web page access and written content, they also vary substantially in the formats adopted, the therapeutic techniques utilized, and the degree of interactivity and therapist assistance offered. In particular, they can be *synchronous* or *asynchronous* and can include a range of strategies to increase client engagement.

Synchronous and asynchronous methods Internet-based interventions utilizing asynchronous methods involve communications that are not in real time, which can include email therapy and electronic communication boards (see Figure 30.1). Asynchronous methods increase convenience because no specific timing of communication is necessary, but this can have the disadvantage of creating a time lag in communication. Synchronous interventions involve real-time communication between therapist and clients, which can include internet relay chat for individual counselling or online chat rooms for group discussion forums and group therapy sessions. Although both synchronous and asynchronous methods can be effective, it has been suggested that synchronous methods increase client engagement and better mimic

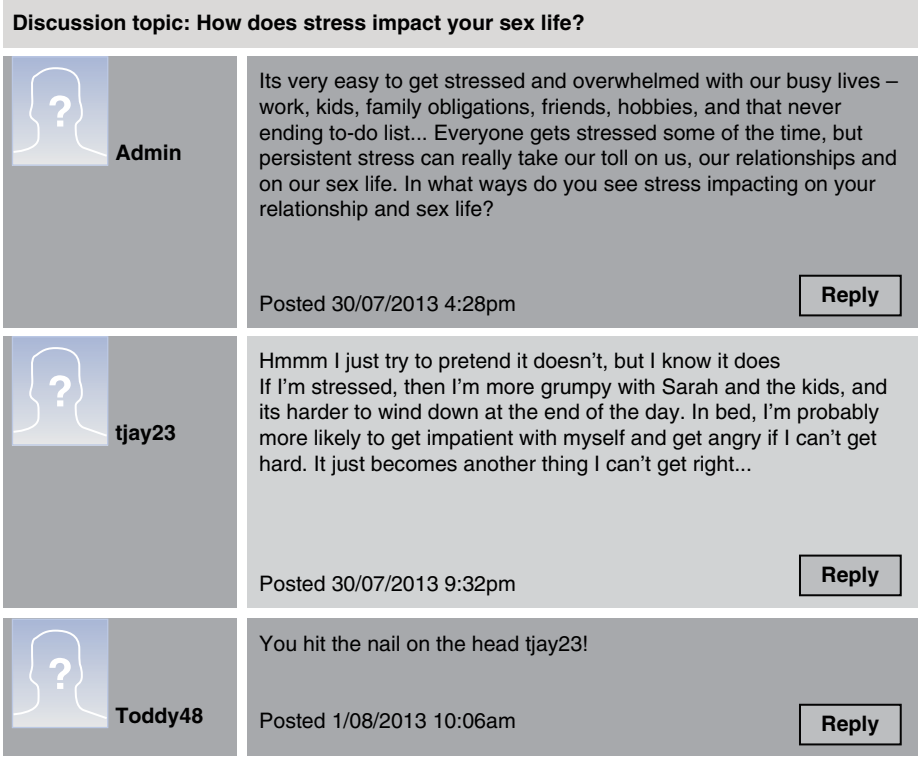

Figure 30.1 Example of an online asyncronous communication board.

face-to-face therapy interventions, compared with asynchronous methods (Alemi *et al.*, 2007; Tate & Zabinski, 2004; Zabinski *et al.*, 2004). A combination of synchronous and asynchronous methods also may be utilized to gain the advantages of both methods.

Therapeutic techniques A range of therapeutic techniques can be used over the internet, most of which are adapted from face-to-face therapy techniques. A large proportion of internet-based interventions for mental health problems utilize psychoeducation interventions or structured cognitive-behavioral therapy (CBT) programs, and it has been suggested that CBT techniques are especially well-suited to online delivery due to their structured nature (Robinson, 2009).

Because of the written format of internet-based interventions, reflective writing tasks, thought monitoring, text role-plays, and dialogue activities can be integrated into online interventions. These techniques may be especially helpful for challenging maladaptive cognitions and attitudes, cognitive restructuring, and behavioral rehearsal. Step-by-step instructions for cognitive and behavioral tasks can also be presented in an online format, whether through emails, website content, or during an online chat group. Group therapy techniques, such as brainstorming and perspective-taking, can also be utilized in online chat groups and may help to develop social support and enable validation and normalization of mental health problems. This may be especially helpful for clients who feel isolated because they live in remote areas or because they are dealing with sensitive problems, such as sexual dysfunctions.

Interactivity and usability Features of online treatment programs that increase general interactivity include web links, self-monitoring systems, online diaries, and video or audio clips. Interactivity with a therapist can be integrated through the use of email, message boards, and chat facilities. A survey of preferences of online users suggested that interactivity is valued in online programs and may be useful in increasing usability and engagement (Ferney & Marshall, 2006). Adopting a user-centered design process that focuses on a specific audience and enables appealing and user-friendly web pages has been recommended (Corry, Frick, & Hansen, 1997; Ferney & Marshall, 2006).

Advantages of internet-based interventions

Internet-based therapies decrease some barriers to receiving treatment, such as inconvenience; time constraints; and transportation difficulties associated with physical disability, travel costs, or geographical isolation. Online therapies also offer a sense of anonymity and invisibility, which cannot be achieved in face-to-face therapy, and this has been linked to reduced embarrassment and self-consciousness, as well as increased information disclosure (Cook & Doyle, 2002; Skarderud, 2003; Tate & Zabinski, 2004).

Other advantages that stem from the unique format of internet-based interventions include the possibility of more cost-effective methods of treatment and instant written records of client interactions (e.g., emails, chat sessions), which can be useful for therapists' reflection, treatment planning, evaluation, and supervision. These written records also allow clients to access transcripts of therapeutic interactions and revisit these between therapist contacts. In addition, online interventions with social components, such as chat groups and public message boards, allow for the establishment of social support from a safe distance. Internet-based interventions can therefore be interactive and draw together a community of people who may have previously been unable to interact, while simultaneously maintaining their anonymity. Finally, as the internet is available 24 hours a day, seven days per week, clients can access treatment when they feel motivated, have the time, and are emotionally and physically able to do so.

Disadvantages of internet-based interventions

One potential disadvantage of internet-based therapy is that the therapist may not be able to communicate as much support and empathy as is possible in face-to-face contact. Although this is a valid concern, evidence suggests that clients can form trusting, open, and comfortable relationships with online therapists comparable to the relationships achieved in face-to-face therapy (Cook & Doyle, 2002; van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009). Additionally, research suggests that clients are able to reach a similar level of emotional engagement in internet-based and face-to-face therapy (Alemi *et al.*, 2007; Rotondi, Sinkule, & Spring, 2005).

The use of text instead of spoken language also has the potential to create misunderstandings and inadequately convey meaning and empathy. Therapists may fail to pick up on nuance in written text, and without face-to-face contact, therapists may be prevented from picking up on auditory and visual cues, which may be important in assessing the patient's honesty, emotional state, and level of comfort (Althof, 2010). Additionally, some people may find it more difficult to express their experiences and feelings by typing them, rather than discussing them verbally. To address this concern, therapists and clients can utilize computerized text features to express themselves more accurately. For example, they can vary text fonts and styles (e.g., I guess I'm just *feeling blue*…), utilize upper and lower case text (e.g., You sound ANGRY!), use emoticons for visual representations of emotions and affect (e.g., ☺, ☹), and bracket behaviors (e.g., I'm feeling sick [cough cough]…). See Figure 30.2 for an example of these text features.

Another potential disadvantage with this new technology is that a client's speed of typing, reading ability, and computer literacy may become an issue when utilizing online interventions. Other technological issues that may be encountered include delays in online communication

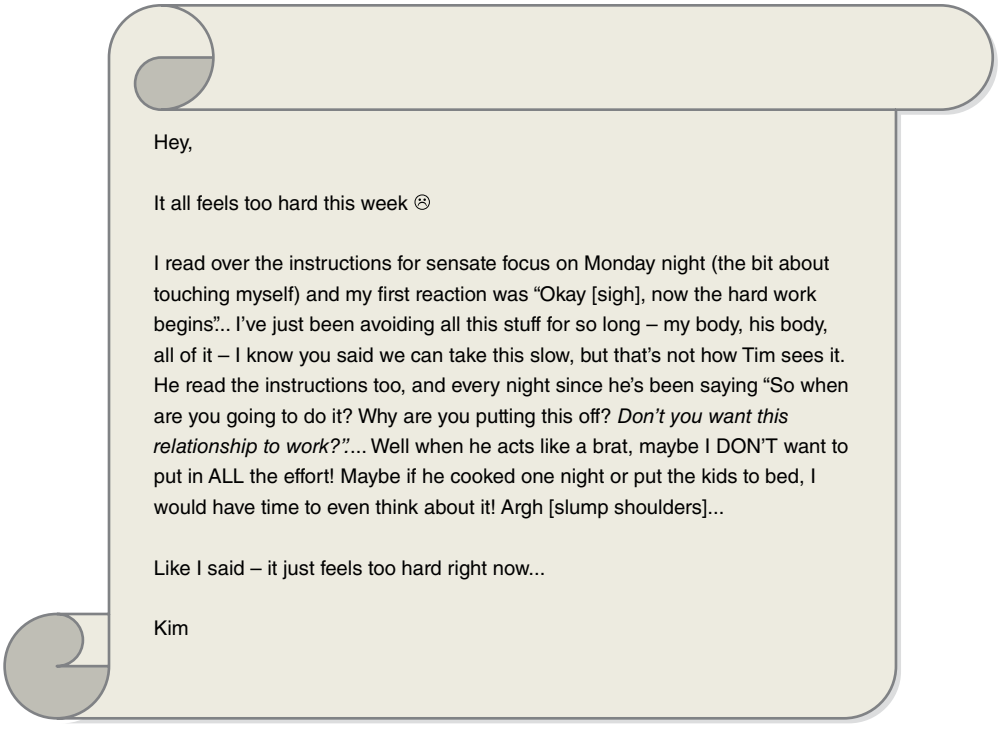

Figure 30.2 Sample email from client using text features to increase expression and clarity.

timing and internet connection problems. Further discussion of the potential challenges of internet-based sex therapy and suggestions for addressing them are included below.

Applications of the Internet in Sex Therapy

The use of internet-based psychotherapy as a potential treatment for sexual dysfunction has been frequently advocated in the literature (Cooper & McLoughlin, 2001; Hall, 2004; Leiblum, 2001). The onset of sexual problems often promotes embarrassment or anxiety, leading to resistance to discussing the sexual problems with a clinician (Fisher, Meryn, & Sand, 2005; Hall, 2004; Leusink & Aarts, 2006). For example, studies have shown that between 40% and 70% of men with erectile dysfunction do not consult a physician regarding their sexual problems (Kubin, Wagner, & Fugl-Meyer, 2003; Mirone *et al.*, 2002; Rosen *et al.*, 2004). By eliminating the need for face-to-face sessions, internet-based treatment enables men and women to address their problems within an anonymous context and in the safety of their home environment. Moreover, as Hall (2004) suggested, the elimination of face-to-face contact allows participants to feel comfortable disclosing large amounts of potentially embarrassing information very early in the therapeutic relationship.

Overview of Sex Therapy Interventions Adapted for Online Use

Various therapeutic interventions have been shown to be successful in reducing distress and sexual dysfunction symptoms for both men and women with sexual concerns. The general psychotherapy treatment goals for sexual dysfunction are to help the patient gain/regain confidence with their sexual performance, reduce performance anxiety, resolve interpersonal issues, and increase interpersonal communication (Althof, 2006). Treatments utilizing behavioral techniques, CBT, psychoeducation, and group therapy have been efficacious for the remediation of sexual dysfunction in men and women (e.g., Andersson *et al.*, 2011; Hucker & McCabe, 2014a; van Diest, van Lankveld, Leusink, Slob, & Gijs, 2007). The use of these strategies in an online format is discussed below.

Behavioral techniques

Traditional sex therapy (see Avery-Clark & Weiner, this volume) consists of behavioral techniques, such as sensate focus, which were first developed by Masters and Johnson (1970). Sensate focus requires couples to participate in a hierarchical series of non-sexual and sexual pleasuring exercises. It begins by focusing on non-genital touching, followed by sessions involving self-exploration of the genitals, shared genital exploration with partners, intercourse, and finally, orgasm. While participating in these tasks, men and women are instructed to focus on the sensations that accompany the experience with an absence of performance demand or excessive self-monitoring. For men, sensate focus allows them the opportunity to participate in sexual activity without the pressure of having to achieve an erection, perform well for their partners, or worry about experiencing an orgasm too early. It offers a shift in their focus from maladaptive cognitions, such as whether their erection is strong enough or whether they are satisfying their partners. For women, particularly those with anxiety in regards to their anorgasmia or low desire, sensate focus offers a gentle introduction to sexual activity with their partners without the pressure to engage in unwanted intercourse or experience an orgasm.

Masters and Johnson (1970) also utilized behavioral techniques specific to various sexual dysfunctions. For example, the "stop-start" technique targets men with premature ejaculation (see Rowland & Cooper, this volume), and teaches the man to gradually learn to control and/

or delay his ejaculation by allowing him to recognize and consciously decrease strong feelings of arousal and impending orgasm. In a systematic review of controlled treatment trials, Berner and Gunzler (2012) concluded that participants with premature ejaculation showed better outcomes when exposed to the stop-start technique than when assigned to a wait-list control group. Indeed, many specific behavioural sex therapy interventions have demonstrated good efficacy.

Internet-based sex therapy programs have utilized behavioral techniques as part of the treatment process. Hall (2004) conducted a pilot study aimed at evaluating a behavior-based internet treatment for couples presenting with various sexual dysfunctions, such as premature ejaculation, anorgasmia, delayed ejaculation, vaginismus, and erectile dysfunction. The sex therapy program involved improving sexual awareness, self-focus, and education, and it incorporated self-directed masturbation programs, such as the stop-start technique for premature ejaculation. Participants were assigned regular homework tasks, and email contact with a therapist was regularly available to participants to discuss problems during treatment. The number of email contacts between participants and therapist ranged from two to 23. Following treatment, of the eight participating couples, self-reported sexual function improved substantially in two couples, improved considerably in three couples, improved slightly in two couples, and did not improve in one couple. All participants reported improvements in self-awareness and relationship understanding, and six out of eight couples reported an increase in sexual knowledge. Hall (2004) acknowledged a number of limitations with the study, such as failure to include a control group, not providing a manualized treatment to all couples, and limited reliability and validity of outcome measures. Hall also noted challenges in implementing the internet-based therapy compared with face-to-face therapy, including greater difficulty in explaining the rationale for the behavioral exercises and encouraging participants to stay motivated. Despite these limitations, results from Hall's study provided some preliminary support for the use of the internet as a treatment modality for sexual problems.

Leusink and Aarts (2006) investigated the efficacy of electronic consultation in 219 men with erectile dysfunction. After participants completed the online medical history form, the authors provided treatment recommendations consisting of either prescriptions for PDE-5 inhibitors (e.g., Viagra) or combined medication and sensate focus exercises. The decision about the type of treatment was based on whether the erectile dysfunction was judged to be psychogenic or "mixed cause" (i.e., psychogenic and organic). If more intensive therapy was required, a referral to a sex therapy specialist was provided. When scores on the 5-item version of the International Index of Erectile Function (IIEF; Rosen *et al.*, 1997) were compared at pre- and post-test, 81% of men reported significant improvements in erectile functioning. However, a control group was not included, and the study could not ascertain whether the improvements in erectile functioning were as a result of participants seeking medication or as a result of consultation with the website.

Van Diest and colleagues (2007) conducted an internet-based sexual therapy program with 39 men with erectile dysfunction. Men with relationship problems, depression, or medical conditions were excluded. Treatment consisted of sex therapy based on Masters and Johnson's (1970) behavioral sex therapy approach, had a duration of three months, and was conducted entirely through email. Fourteen men (67%) reported an improvement in sexual functioning, with seven of those men reporting that the improvement was maintained one month after termination of treatment. Eight participants (21%) reported no change, and one man reported a deterioration following treatment. Despite the lack of a control group, the results are again somewhat encouraging evidence for the use of the internet in treating sexual dysfunction.

To test the effectiveness of an internet-based program compared with a wait-list control, van Lankveld *et al.* (2009) administered an internet-based sex therapy program to 98 men

(58 with erectile dysfunction; 40 with premature ejaculation). The treatment program was an identical design to van Diest *et al.* (2007), as described above, with the exception that, in 23% of cases, additional medication was advised by the therapist, based on whether the therapist and participant agreed that pharmacological intervention could be helpful in supporting the psychological treatment. Sexual functioning was "much" or "somewhat" improved in 40 participants (48%). Specifically, in men with erectile dysfunction, the program group was superior to wait-list control, with men in the treatment group reporting improvements in erectile functioning, sexual desire, sexual self-confidence, and sexual satisfaction. Men with erectile dysfunction who also used medication to support psychological therapy reported higher levels of sexual satisfaction, sexual self-confidence, and post-treatment erectile functioning than men who did not use medication. However, these results did not reach statistical significance due to the small number of men receiving medication (i.e., four men). Results of the program also indicated that, among men with premature ejaculation, the internet-based treatment was not superior to a wait-list control, although a trend in this direction was observed. The authors concluded that internet-based treatment for male erectile dysfunction was efficacious and that online interventions for premature ejaculation required further research.

Cognitive-behavioral therapy (CBT)

Given the complex interaction between anxiety and cognitive inference in sexual disorders, face-to-face interventions utilizing both behavioral and cognitive components have typically generated successful outcomes. In a review of the literature on couples with sexual dysfunction, Berner and Gunzler (2012) found that CBT successfully improved the sexual functioning of men, particularly those with erectile dysfunction. In women, CBT was also found to be effective for the treatment of hypoactive sexual desire disorder and was somewhat effective for the treatment of vaginismus. Couples therapy using CBT resulted in significantly improved overall sexual functioning for women (Gunzler & Berner, 2012).

CBT programs for sexual dysfunction often include a component directed at improving communication within the couple's relationship (Jones & McCabe, 2011; McCabe & Price, 2008; Trudel *et al.*, 2001). Relationship factors, such as communication difficulties, lack of intimacy, and poor relationship satisfaction have been shown to be associated with sexual dysfunction in both men and women (Althof *et al.*, 2005; Basson, 2000; McCabe, 1997; Rowland *et al.*, 2004). Communication exercises assist the couple in addressing problems related to their current sexual functioning, as well as general relationship problems. Communication exercises often take the form of discussing questions, writing letters to each other, and conversing on a range of sensitive topics that the couple are likely to have avoided outside of therapy.

For example, McCabe (2001) evaluated the effectiveness of face-to-face CBT for treating various male and female sexual dysfunctions. The treatment program consisted of 10 sessions that focused on enhancing communication between partners, increasing sexual skills, and decreasing sexual anxiety. Sensate focus and communication exercises were assigned as homework tasks. Maladaptive cognitions were addressed during face-to-face therapy sessions. Among participants who completed the program, 44% of females and 53% of males no longer had a diagnosis of sexual dysfunction. Van Lankveld, Everaerd, and Grotjohann (2001) also utilized a 10-session face-to-face CBT program in treating 199 couples with sexual dysfunction. The program was presented in the form of a self-help book, and instructions for completing the program were provided during a preparation session. The program included sensate focus, communication exercises, and psychoeducation. Van Lankveld *et al.* (2001) found a significantly greater improvement in sexual functioning in the treatment group compared with a wait-list control. However, these treatment gains were not sustained at a 10-week follow-up.

Online CBT and male sexual dysfunction CBT has the advantage of being a "package program," in that the content is structured and can be easily delivered over the internet (Robinson, 2009). In one of the first studies to investigate the effectiveness of online CBT for sexual dysfunction, McCabe, Price, Piterman, and Lording (2008) applied the treatment to men suffering from erectile dysfunction and compared the internet-based intervention with a control group. The online CBT program, entitled *Rekindle*, consisted of three main treatment components: sensate focus, communication exercises, and unlimited email contact with a therapist. The program was divided into five stages, with each stage building on the foundation of previous stages. It was suggested that participants spend two weeks on each stage. Forty-four men started the study (24 treatment, 20 control), and 31 men (12 treatment, 19 control) completed the study. Men in the treatment group reported significantly greater improvements in erectile functioning, sexual relationship satisfaction, and sexual relationship quality in comparison to the control group. These improvements in sexual and relationship functioning remained stable over the three-month follow-up period for men in the treatment group.

In an extension of this study, McCabe and Price (2008) compared the effectiveness of *Rekindle* used alone with the *Rekindle* program combined with the use of phosphodiesterase type 5 (PDE-5) inhibitors in the treatment of male erectile dysfunction. Both the combined therapy ($n=7$) and the psychological intervention only ($n=5$) groups demonstrated improvements in sexual functioning and relationship satisfaction from baseline to post-program measures. Interestingly, significant differences were not observed between treatment groups. The authors suggested that, if complicating medical factors or a high severity of erectile dysfunction exists, *Rekindle* may be best utilized in combination with medication, but for others, *Rekindle* alone may be sufficient to address the problem. The study was limited by a small sample size; however, the results are encouraging for the effectiveness of online administration of CBT for erectile dysfunction.

Andersson *et al.* (2011) also investigated the effectiveness of an internet-based CBT program compared with a control group to address erectile dysfunction. A seven-week program was delivered to participants assigned to the treatment condition (39 men). Homework assignments were completed, and the participants could contact the therapist via email. Participants in the control group (39 men) had access to an online discussion forum in which they could send anonymous messages to each other to discuss their erectile difficulties and helpful ways of coping with them. At post-treatment, the intervention group had significantly greater improvements in erectile performance compared with the control group. No significant improvements were found in relation to depression or anxiety for either the treatment or control groups.

Overall, the treatment of male sexual dysfunction through the internet, based on post-treatment measures, appears to replicate the treatment findings of face-to-face therapy for men with erectile problems (Heiman & Meston, 1999). However, given that studies have not demonstrated sound efficacy for the online treatment of premature ejaculation (van Diest *et al.*, 2007), it is difficult to compare the effectiveness and relative ease of internet-based versus face-to-face treatment for this sexual dysfunction.

Online CBT and female sexual dysfunction Despite the relatively large number of studies investigating face-to-face treatment of female sexual dysfunction, only two studies were located that have used the internet as a treatment modality for women with sexual concerns. Jones and McCabe (2011) conducted a study evaluating the effectiveness of an internet-based CBT program, entitled *Revive*, for women experiencing various female sexual dysfunctions within a heterosexual relationship. A total of 39 women participated in the study (17 in the treatment group and 22 in the control group). *Revive* consisted of sensate focus, communication exercises, and unlimited email contact with a therapist. The main aim of the email contact was to address maladaptive cognitions as well as individual and relationship problems impacting sexual functioning (Jones & McCabe, 2011). The program consisted of five stages, with each

stage expected to take approximately two weeks to complete. Partners were expected to participate in the sensate focus and communication exercises. Female sexual functioning and relationship functioning were assessed pre-test, post-test and at a three-month follow-up using the Female Sexual Function Index (Rosen *et al.*, 2000), the Sexual Function Scale (McCabe, 1998), and the Personal Assessment of Intimacy in Relationship Scale (Schaefer & Olson, 1981). It was found that the women who completed the *Revive* program improved significantly more from pre- to post-test on measures of sexual desire, arousal, lubrication, orgasm, sexual satisfaction, and pain compared with those in the control group; however, 33% of participants in the treatment group still experienced sexual problems more than 50% of the time after treatment completion (Jones & McCabe, 2011). The treatment group also reported significantly greater improvements than the control condition in sexual intimacy, emotional intimacy, and communication, but differences were not found for overall relationship satisfaction. Gains remained stable over the three-month follow-up period, and some participants reported further gains in sexual functioning during the post-intervention period. These results provided preliminary support for the use of internet-based psychological therapy for mixed female sexual dysfunctions as an alternative to face-to-face sex therapy.

Recently, Hucker and McCabe (2014a) created an online, mindfulness-based CBT program for female sexual dysfunction that was designed to extend prior research regarding the internet-based treatment of female sexual dysfunction. Titled *Pursuing Pleasure*, the program contained sensate focus, communication exercises, and unlimited email contact with a therapist, and was the first online treatment for sexual dysfunction to incorporate mindfulness exercises. *Pursuing Pleasure* was also the first online treatment for sexual dysfunction to utilize online chat groups as a platform for cognitive therapy and social support. As well as aiming to improve women's sexual functioning, the program aimed to target relationship factors involved in female sexual functioning. Women who completed the *Pursuing Pleasure* program demonstrated significantly greater improvements in sexual intimacy, emotional intimacy, and communication compared with the control group. This is consistent with past evaluations of online treatment for female sexual dysfunction (Jones & McCabe, 2011), and is not surprising given that the program consisted of communication- and intimacy-based exercises. Despite these improvements, the treatment group did not report significantly greater improvements in overall relationship satisfaction compared with the control group, and this is also consistent with prior research (Jones & McCabe, 2011).

Psychoeducation

It is particularly important to include education about etiological factors of sexual dysfunction in online treatment programs. In particular, participants may need information about the role of biological factors, such as age, in male and female sexual dysfunction, and about the high comorbidity of medical factors, such as cardiovascular disease, in male sexual dysfunction (Laumann, Paik, & Rosen, 1999; Laumann *et al.*, 2007). Some other educational areas that are often included in sex therapy programs are common sexual myths, a thorough description of the female and male sexual response cycle, common sexual changes related to life stages, and realistic sexual expectations (Basson, Wierman, van Lankveld, & Brotto, 2010; Hawton, 1985; LoPiccolo & Stock, 1986). Although the inclusion of such information may not necessarily lead to symptom change, it has been suggested that the absence of such psychoeducation may lead to low success rates in the treatment of sexual dysfunction (LoPiccolo & Stock, 1986). The inclusion of comprehensive psychoeducation in internet-based interventions for sexual dysfunction may help to alleviate performance anxiety, to normalize sexual experiences, and to expose unhelpful beliefs and attitudes that may be addressed through cognitive therapy. Education and training in the use of sexual fantasy, sexual aids, and sexual skills to expand a couple's sexual repertoire have also been used in interventions for female sexual dysfunction

(Brotto, Basson, & Luria, 2008, Brotto, Heiman *et al.*, 2008; Heiman & LoPiccolo, 1988). Although psychoeducation has been included in recent internet-based sexual therapy programs for women, such as the program developed by Hucker and McCabe (2014a) as described above, it has yet to be included in a study of online treatment for male sexual dysfunction.

Group therapy via chat groups

Group therapy techniques have also been used in many of the studies evaluating face-to-face psychological treatments for female sexual dysfunctions (e.g., Brotto, Basson *et al.*, 2008; Brotto, Heiman *et al.*, 2008; Smith, Beadle, & Shuster, 2008). Group processes that have been found to be helpful in the treatment of female sexual dysfunction include self-disclosure, normalization, validation, social support, learning from other's experiences, and offering guidance and support to others (Gehring & Chan, 2001; Milk & Kilmann, 1982).

Chat groups are one way in which group therapy processes can be implemented online, particularly by supplementing the email exchanges in internet-based sex therapy treatment programs (Jones & McCabe, 2011). By providing an opportunity for participants and the therapist to interact in real time, participants may have the opportunity to explore maladaptive cognitions and attitudes and associated affect. To date, Hucker and McCabe's (2014b) *Pursuing Pleasure* program has been the only internet-based intervention for sexual dysfunction to use online chat groups in addition to email contact. The chat groups functioned as an interactive way to engage women in cognitive therapy and offered them a space to discuss challenges and barriers to change that arose over the course of the treatment. Previous research by Jones and McCabe (2011) found considerable difficulties engaging women in email therapy during the treatment. By utilizing online chat groups, not only did women in Hucker and McCabe's (2014b) program have an extra medium by which to undertake cognitive therapy, but the chat groups also appeared to assist in the development of the therapeutic relationship and, therefore, encouraged women to engage more in the email therapy. Feedback provided by participants suggested that one of the most helpful aspects of the online chat groups for women with sexual dysfunction was the ability to communicate with other women experiencing similar difficulties and to obtain and deliver social support in an anonymous forum. Another theme to emerge from the chat groups was that women did not often get to talk about sex and sexual difficulties with their friends or family and that they, therefore, had a limited ability to gain support, validation, and normalization outside of therapy.

Sexual dysfunctions are sometimes perceived as embarrassing and even shameful (Barak & Fisher, 2003; Fisher *et al.*, 2005; Hall, 2004). The feedback obtained from the study by Hucker and McCabe (2014b) suggested that providing women with sexual dysfunction with an opportunity to have their experiences validated and normalized by their peers was incredibly important to them, and it was potentially a significant factor in the long-term benefits of the online female sexual dysfunction treatment. Online chat groups also have the ability to bring together a community of people who may have previously been unable to interact (Tate & Zabinski, 2004) while also maintaining anonymity. Future studies should aim to incorporate chat groups into online treatment programs for men and couples.

Challenges and Considerations for Internet-Based Sex Therapy

Maintaining communication between the therapist and client and keeping clients engaged in treatment can be a challenge in any therapeutic program. However, internet-based sexual therapy programs offer unique challenges to the delivery of the program, such as issues with the therapeutic alliance, internet difficulties, high attrition rates, lack of contact with partners, and issues with time zones and timing.

Therapeutic alliance

Forming a therapeutic alliance over the course of therapy is fundamental, given that research has demonstrated that the therapeutic relationship is one of the common factors in successful treatment outcomes (Donahey & Miller, 2000). Many studies have demonstrated that an effective therapeutic relationship can be established over the internet and that an online therapeutic alliance can be comparable to those established in face-to-face therapy (Alemi *et al.*, 2007; Cook & Doyle, 2002; Rotondi *et al.*, 2005). Feedback from participants in internet-based sexual therapy programs has provided particularly encouraging evidence that a strong therapeutic relationship can be achieved. For example, van Diest *et al.* (2007) found that participants reported that a confidential relationship was obtained with the online therapist and that they felt the therapist was empathetic. Hucker and McCabe (2014b) reported that comments in the chat groups and emails, as well as qualitative feedback from the online assessment, demonstrated that the participants were willing to form a trusting, honest, and open relationship with the therapist. Participants also stated that the therapists expressed empathy, validation, and use of humor, and that the therapists' follow-up contacts with individuals (after concerns were raised in chat groups) assisted them to form a strong therapeutic alliance in the program.

Technical requirements and challenges

Technical difficulties with internet-based sexual therapy programs are no different from any mental health programs offered online. However, as reported by Hucker and McCabe (2014b), particular issues arose with the online chat groups. These included slow or unreliable internet connections, resulting in delays in the therapist and participants responding to each other, and connection problems, resulting in some women arriving late, dropping out, or missing the chat groups altogether. Recommendations regarding the minimum internet speed required in order to access chat groups would be beneficial for future programs.

Qualitative feedback from participants has also indicated that internet-based therapy requires substantial writing skills and that participants have found it difficult in the beginning to write about their sexual experiences and functioning (van Diest *et al.*, 2007). Despite this, participants also remarked that writing was often easier for them than talking about their problems. As noticed by Hall (2004), writing is often included as part of the therapeutic process even in face-to-face therapy because writing allows clients to reflect on their emotions and feelings, reading back and rewriting until they feel that they are accurately expressing themselves. However, when participants are under pressure to post responses to chat groups in real time, those without strong writing or typing skills may struggle to participate.

Attrition online

Attrition rates for internet-based treatment for sexual dysfunction have varied significantly in the literature. Rates of 35% (Jones & McCabe, 2011), 47% (van Diest *et al.*, 2007) and up to 71% (McCabe *et al.*, 2008) have been reported, and dropouts have generally occurred between pre-test and the first few weeks of the program. This is somewhat comparable to the dropout rate for face-to-face therapy for sexual dysfunctions, which is approximately 30–52% (Hawton, Catalan, Martin, & Fagg, 1986; McCabe, 2001; Sarwer & Durlak, 1997).

Email contact with the therapist can make it easy for the participants to remove themselves from treatment due to limited social pressure to explain or rationalize their decision to discontinue. The main self-reported reasons for dropping out of the programs were that the sexual relationship that drove them into therapy had broken down, the participant did not believe the program was suitable, the participant was not motivated to change or address the issue,

and the participant was unable to commit sufficient time to the program (Andersson *et al.*, 2011; Jones & McCabe, 2011; McCabe & Price, 2008; van Lankveld *et al.*, 2009). Van Lankveld and colleagues (2009) also reported one reason for discontinuing with the program was that, by completing the online questionnaire before commencement of the program, it "lowered the threshold to consult our family doctor." In other words, answering online questions about their sexual dysfunction may have made them feel comfortable and confident enough to address their concerns in a face-to-face modality.

Other reasons cited for discontinuing the program were related to the participants' partners. Commonly cited reasons were that the partner was unwilling to participate in the program in general, the partner was unwilling to participate specifically in graded exposures or communication exercises, or the partner viewed the treatment as unsuitable for him or her (McCabe *et al.*, 2008; van Lankveld *et al.*, 2009).

Further analyses of the dropout group in comparison with those who completed the program and post-treatment measures indicated that the dropout group's age was significantly lower and the duration of their primary sexual relationship was significantly shorter than those who completed the program (van Diest *et al.*, 2007). Jones and McCabe (2011) also found that those who failed to complete the program reported significantly less relationship satisfaction and intimacy at pre-test than the completers. These results may provide useful guidance for therapists who are considering inclusion and exclusion criteria for internet-based programs for sexual dysfunctions.

Participant engagement and motivation

An individual's high motivation to change has been consistently related to successful treatment outcomes in face-to-face therapy (Hawton, 1985; Hawton, Catalan, & Fagg, 1991; Hawton *et al.*, 1986; McCabe, 2001). Motivation levels may influence the degree of engagement in therapy, the amount of homework completed, and the individual's expectations of treatment success. Varying levels of participant motivation have been found in the internet-based sexual therapy literature. For example, Hucker and McCabe (2014a) attempted to maintain engagement of clients through initiating email contact from the therapist in the form of reminders, "check-ins," and motivational messages. However, Hucker and McCabe (2014a) acknowledged the challenges associated with determining the appropriate level of email contact. They decided to utilize particular time points to send reminders and check-in emails to participants (i.e., at the beginning of a new stage, in the middle of a stage, at the end of a stage). It was also decided that when a participant had not engaged in email contact for over two weeks (even after therapist contact), the therapist would initiate email contact to check in with the woman and offer a motivational message.

It has been suggested that men may be particularly difficult to engage and keep motivated in an internet-based treatment for sexual dysfunction (McCabe *et al.*, 2008). The asynchronous nature of email contact can result in participants delaying or forgetting to respond to contact from the therapist. In previous studies, participants have also expressed frustrations at not being able to pose follow-up questions to the therapist immediately and at having to wait until the therapist responded to queries or concerns about the program (van Diest *et al.*, 2007). These are all factors that may influence the level of engagement and motivation with online sexual therapy programs.

Degree of contact

Internet-based programs have provided varying degrees of contact with a therapist. Email contact has been suggested as a method to provide regular support and encouragement throughout the program, as well as a medium for targeting resistance, maladaptive cognitions,

performance anxiety, and relationship concerns arising from sensate focus exercises (McCabe *et al.*, 2008). In one study, the number of email consultations with the therapist ranged from two to 23 contacts across participants (Hall, 2004). In another study, contacts ranged from one to 21 (van Diest *et al.*, 2007). This suggests that contact with the therapist may be recommended but that some clients, more than others, may be motivated to continue working through the manualized programs without the support of the therapist. Other studies investigating mental health issues have concluded that it is not the frequency of contact with the therapist that is most important in determining outcome, but rather the quality of the therapeutic relationship (Klein *et al.*, 2009).

Partner engagement and couple dynamics

A number of internet-based interventions for sexual dysfunction have included the partners of participants in treatment, due to the consistently demonstrated association between partner involvement and treatment success (Jones & McCabe, 2011; McCabe, 2001; McCabe *et al.*, 2008). However, partners may feel anxious about their private lives being discussed with a third party, feel blamed for sexual and relationship problems, and feel worried about how the treatment will influence their relationship. If clients are able to communicate with their partners about these common worries during sexual dysfunction treatment, it is possible that a stronger partner alliance may form and potentially lead to lower attrition rates among participants and better treatment outcomes. In their study with women, Hucker and McCabe (2014a) provided psycho-educational handouts to male partners; still, both the female participants and the male partners expressed the desire for even more partner involvement in the treatment process for female sexual dysfunction. However, Hall (2004) reported that even when partners of participants were invited to exchange emails directly with the therapist, it was difficult to engage partners in email therapy.

Timing and time zones

Online programs offer the flexibility of participants working through programs at their own pace. This allows the client the autonomy to progress through treatment as they feel ready. However, clients may be resistant or hesitant to move on to later stages of programs due to fears about or challenges with the content or due to lack of motivation to continue the program. Difficulties can also arise when participants have the ability to communicate with each other, such as in chat groups, but are at different stages of the treatment process. It has been suggested that, due to the heterogeneous nature of sexual difficulties, a flexible manualized treatment approach is beneficial and best accommodates different treatment needs (Hucker & McCabe, 2012).

As internet-based treatments can reach help-seeking clients across the globe, issues with time zones and synchronous contact, such as chat groups, can occur. Hucker and McCabe (2014b) reported that, although women were informed that the chat groups would take place in Australian Eastern Standard timing, women from other time zones experienced difficulties in calculating the timing. This resulted in women arriving late or missing chat groups, particularly when the timing changed due to daylight savings in Australia. This is an important consideration when utilizing methods such as chat groups for internet-based sexual therapy.

Ethical Considerations and Suitability of Clients

Internet-based interventions introduce new ethical issues to the practice of psychotherapy, especially those surrounding confidentiality and informed consent. Although no therapy medium is free of risk, the nature of online materials increases the risk of confidential information

being viewed by unauthorized parties. It is therefore the responsibility of the therapist to communicate confidentiality limits to clients and take appropriate measures to ensure optimal confidentiality, such as using encryption and password-protected websites, email accounts, and chat rooms.

Informed consent for online psychotherapy involves providing the clients with sufficient information about the service being offered, such as what the treatment involves, the credentials of the service provider, the limits of confidentiality, and the potential benefits and risks of the service. Information regarding frequency of contact, protocols for technological problems, and the computer literacy and reading skills necessary for treatment should also be relayed prior to therapy commencement (Australian Psychological Society [APS], 2004). Additionally, there is a risk that the therapist may overstep professional liability by providing a service to clients in a geographical location in which they are not licenced to practice. For example, if the client's country of residence is outside of where the therapist is registered to practice, assessing whether the therapists' professional indemnity insurance is still valid is essential.

Internet-based treatments of sexual dysfunctions raise particular ethical considerations, including considerations about the inclusion of partners in treatment. Firstly, it is not generally required that partners have direct contact with the therapist; thus a certain amount of trust is required that the partner is engaged and motivated to participate in therapy. Additionally, although the therapist generally has direct access to the participant via email or online chat, it is uncertain whether accurate information regarding homework tasks and psychoeducation are being relayed to partners (Hall, 2004).

Certain groups have been identified as being less suitable for internet-based treatment. These groups include clients experiencing distortions of reality or suicidal ideation, and those who are currently victims of sexual and/or physical abuse (Abbott, Klein, & Ciechomski, 2008; Australian Psychological Society, 2004). Generally, any person with acute mental illness, who may require a high degree of support and therapist involvement in treatment, would not be appropriate for internet-based sexual therapy. The suitability of clients should be assessed before the commencement of therapy. For example, Van Diest *et al.* (2007) reported that more than half of those who applied to participate in their study were excluded, predominantly due to depressive symptoms, serious relational problems, and alcohol abuse.

Hucker and McCabe (2014a) suggested that women in a relationship with high levels of discord or physical/sexual abuse, women with low motivation to address their sexual problems and relevant relationship issues, and women with a sexual dysfunction of a primarily biological etiology may not be suitable for internet-based treatment of sexual dysfunction. However, in the latter instance, internet-based treatment may still be effective as a supplementing therapy to address other etiological factors that may be involved in the sexual dysfunction. In support of these suggestions, both the studies by Jones and McCabe (2011) and Hucker and McCabe (2014a) have demonstrated that women with high motivation, an appropriate reading level, and a stable, supportive relationship are most likely to benefit from internet-based treatment for sexual dysfunctions.

McCabe *et al.* (2008) suggested that when erectile dysfunction is severe, or has been present for a significant period of time, a manualized internet-based treatment approach may not be intense enough to ensure successful treatment outcomes. In fact, a number of internet-based studies reported that the majority of participants indicated improved sexual dysfunction and reduced distress related to their sexual dysfunction, but for many participants the symptoms of the sexual dysfunction had not been resolved completely (Andersson *et al.*, 2011; Jones & McCabe, 2011; McCabe *et al.*, 2008). These findings are similar to findings of previous face-to-face studies of the psychological treatment of sexual dysfunction (Hawton *et al.*, 1986; McCabe, 2001). Thus, for men with more severe or longer-lasting symptoms, internet-based sexual therapy may best be conceptualized as only one component of their treatment plan.

A number of studies have also excluded participants who are taking particular medications, due to the negative impact that pharmacological treatments may have on sexual functioning, or participants with medical conditions, due to the strong association between physical health and sexual functioning (particularly erectile functioning; El-Sakka, 2008; McCabe & Connaughton, 2014b). It should be recommended to clients that assessment and monitoring by their physician may be beneficial in combination with the internet-based psychological therapy.

Implications for the Treatment of Sexual Dysfunction

Although internet-based sexual therapy is a relatively new field, early studies have shown it to be an efficacious treatment modality. These findings have several implications for the way psychotherapy can assist in the treatment of sexual dysfunctions more generally. For example, van Diest *et al.* (2007) suggested that internet-based sexual therapy may give clients the language and information to begin to address their problem, and thus may help them gain confidence to consult a specialist in face-to-face therapy for additional treatment. Because the early stages of counseling are important to the formation of a quality therapeutic alliance, internet-based sexual therapy may be utilized as a tool of initial engagement in the treatment of clients who are embarrassed, shamed, or otherwise intimidated and reluctant to address the issue in face-to-face interpersonal communication; once an online alliance has been formed, face-to-face therapy may be less frightening.

The sexual dysfunction literature has demonstrated that people with sexual problems are reluctant to consult with a physician about their difficulties due to embarrassment and anxiety (Hall, 2004; Leusink & Aarts, 2006; Rosen *et al.*, 2004). As internet-based sexual therapy allows clients to maintain anonymity, it is reasonable to expect that clients may seek this form of treatment earlier following the onset of the problem. Therefore, clients may be able to get help before the sexual dysfunction progresses to a severe level, and clients may be at less risk of developing secondary sexual dysfunctions; for example, some men develop premature ejaculation in response to untreated erectile difficulties.

It has been suggested that the administration of internet-based psychological programs are a cost-effective modality for treatment (Abbott *et al.*, 2008; Alemi *et al.*, 2007; Tate & Zabinski, 2004). Not only are such treatments convenient for clients, but travel costs—such as petrol, public transport, and parking—can be avoided entirely. Those who are time-poor can still access appropriate treatment, and additionally, online programs have the ability to reach a wide clientele simultaneously; thus, waitlists for treatment may be limited or nonexistent. With a growing body of evidence that suggests that the internet is a viable source for sexual therapy, there is increased pressure for health insurance companies to provide rebates in support of those seeking treatment via online methods. However, the true cost-effectiveness of internet-based sexual therapy may need to be established before this will occur.

Recommendations for Future Research

Given that internet-based therapy is a relatively new treatment modality for sexual dysfunctions, there are a number of topics that require further research. Mindfulness has been suggested as one technique to reduce cognitive and affective distraction and performance anxiety during sexual activity, and to increase awareness of pleasurable sensations (Brotto, Krychman, & Jacobson, 2008; Silverstein, Brown, Roth, & Britton, 2011; see also Barker, this volume). Mindfulness has been incorporated into CBT treatments for female sexual arousal and desire disorders by first developing nonsexual mindfulness skills through the practice of daily

mindfulness exercises, and then transferring these skills into sensual and sexual activities (Brotto, Basson *et al.*, 2008; Brotto, Heiman *et al.*, 2008; Brotto *et al.*, 2012). Mindfulness has already been utilized in internet-based interventions for other disorders such as stress and anxiety (Cavanagh *et al.*, 2013) with positive results. Only one study to date has included mindfulness in an internet-based treatment program for female sexual dysfunction. Hucker and McCabe (2014a) found that, when compared with the control group, women who completed the program demonstrated significant improvements in sexual and emotional intimacy, communication, and sexual functioning, as well as significant reductions in self-reported female sexual dysfunction symptoms and associated distress. This study highlights the need to complete a similar evalution for men with sexual dysfunction.

A number of studies of internet-based sexual therapy have only targeted those with one specific sexual dysfunction, such as erectile dysfunction (e.g., McCabe *et al.*, 2008; van Diest *et al.*, 2007). Research has demonstrated a high comorbidity of the various sexual dysfunctions among women (Basson, Brotto, Laan, Redmond, & Utian, 2005; Giles & McCabe, 2009) as well as men (El-Sakka, 2008; McCabe & Connaughton, 2014a). By extending research to include those with comorbid sexual disorders, such as co-occurring erectile dysfunction and premature ejaculation, the generalizability of the treatment findings is likely to be greater. Additionally, many studies have recruited participants who are in relationships and are heterosexual. Further research needs to investigate the effectiveness of internet-based sexual therapy for the broader population by recruiting those who are single and those in same-sex relationships.

Although some online studies have included partners in the treatment of sexual difficulties (e.g., Hucker & McCabe, 2014a; Jones & McCabe, 2011), recommendations for alternative methods to involve partners have been suggested in the literature. For example, engaging couples through the use of webcams, Skype, and smartphone applications may be useful adjuncts to online sexual therapy programs (Hall, 2004; Hucker & McCabe, 2014a). This also enables the sex therapy field to remain up-to-date with technological advances, especially in the face of new generations of clients and their high comfort with and reliance upon new technology.

Conclusion

The internet as a treatment modality is particularly well-suited to problems that provoke anxiety, embarrassment, and shame, such as sexual dysfunctions. Although the field of internet-based sexual therapy has only been investigated within the last decade, the limited research that has been conducted has demonstrated it can be an effective and anonymous alternative to face-to-face therapy. The accessible and flexible nature of online treatment for sexual dysfunctions offers many advantages to both clients and therapists. Further research is required in order to investigate particular therapeutic interventions such as mindfulness, as well as to establish best practice recommendations for the online treatment of sexual dysfunctions.

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