SYSTEMIC SEX THERAPY

THIRD EDITION

Edited by
KATHERINE M. HERTLEIN,
NANCY GAMBESCIA, AND
GERALD R. WEEKS

ROUTLEDGE

"This well established and highly respected text has been revised with excellent contemporary references, resources, and several new chapters. For many years it has been my preferred and recommended text offering the complete resource to the clinician who intends to both understand the theory and to practice in a truly systemic manner."

Professor Kevan Wylie, M.D., FRCP, FRCPsych, FRCOG, *president, European Federation of Sexology; past president, World Association for Sexual Health*

"Today's social climate is rapidly changing and as such, sex therapists require knowledge, awareness, and appreciation of important issues that were not part of the sex therapy academic curriculum even a decade ago. This revised text, edited by Hertlein, Gambescia, and Weeks, provides new chapters consistent with the changes in the *DSM-5* and includes cutting-edge topics in sex therapy, including technology and culture. *Systemic Sex Therapy* is a highly recommended resource that should be required reading in all sex therapy training programs."

Talli Y. Rosenbaum, M.Sc., *certified sex therapist, Private Practice, Individual and Couple Therapy*

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Systemic Sex Therapy

Systemic Sex Therapy, third edition integrates couple and sex therapy to inform the treatment of sexual problems and to give beginning clinicians the abilities and confidence they need to produce change in their patients' lives.

Grounded in the Intersystem Approach, the book considers the biology, psychology, couple dyad, family-of-origin, and larger contextual factors of any sexual disorder or issue. Each chapter examines the definition and description of a sexual disorder or issue, its etiology, assessment, treatment, research, and future directions. This thoroughly revised edition presents 18 updated chapters consistent with the *DSM-5* and features new content on sexuality and aging, infidelity, sexual interest/arousal disorder, disability, and kink/BDSM. Experts in the field discuss all the major sexual dysfunctions along with new chapters on culture, technology, and their interplay with sexual functioning.

An essential text in the field, *Systemic Sex Therapy* sets out a conceptual framework for graduate students in couple and family therapy programs looking to develop a comprehensive, integrative understanding of sexual issues.

Katherine M. Hertlein, Ph.D., is a professor in the Couple and Family Therapy Program in the Department of Psychiatry and Behavioral Health at the University of Nevada, Las Vegas. She has over written over 100 publications and lectures nationally and internationally on couples, sex, and technology.

Nancy Gambescia, Ph.D., CSTS, is the director of the postgraduate training program in sex therapy at Council for Relationships, Philadelphia, PA. She has published numerous journal articles, book chapters, and six books on sex and relationship therapy, winning the 2016 book and integration awards from AASECT with Drs. Weeks and Hertlein.

Gerald R. Weeks, Ph.D., ABPP, CST, is professor emeritus at the University of Nevada, Las Vegas. Dr. Weeks has published 26 professional books on individual, couple, sex, and family therapy. He currently maintains a private-practice near Seattle, WA.

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Third Edition

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To Adam and Eric with love – KH
To Michael, Matt & Lauren – with love – NG
To Nancy Love – GW

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Nancy Gambescia, Ph.D., CSTS, is the Director of the Postgraduate Program in Sex Therapy at Council for Relationships, Philadelphia, PA. She is a clinical associate in Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. Dr. Gambescia has over 35 years of experience in teaching, supervising and working with individuals and couples. Dr. Gambescia is a Clinical Fellow and Approved Supervisor in the American Association of Marriage and Family Therapy (AAMFT) and a Clinical Member, Certified Sex Therapist, and Approved Supervisor of Sex Therapy in the American Association of Sex Educators Counselors and Therapist (AASECT). Also, she is a member of the Society for Sex Therapy and Research (SSTAR). Dr. Gambescia is a proponent of the Intersystem Approach, which is the organizing theoretical model for her writing, teaching and clinical work. Dr. Gambescia has coauthored 7 books and numerous journal articles and textbook chapters, which focus on relationship and sexual issues, receiving the 2017 book of the year award for *A Clinician's Guide to Systemic Sex Therapy (2nd ed.)* and the integration award from AASECT with Drs. Weeks

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Gerald R. Weeks, Ph.D., ABPP, CST, is Professor Emeritus in the Program in Couple and Family Therapy at the University of Nevada-Las Vegas. He is a licensed psychologist, Approved-Supervisor, and Clinical Fellow of the American Association of Marriage and Family Therapy, and is a Diplomate and Senior Examiner of the American Board of Family Psychology. Dr. Weeks has published 26 books, including "classic" texts in the fields of individual, sex, couple, and family therapy. In 2017, he was granted the book of the year and integration awards from AASECT with Drs. Gambescia and Hertlein. In 2009, he received the "Outstanding Contribution the Marriage and Family Therapy" award from the American Association of Marriage and Family therapy and the next year was named, "2010 Family Psychologist of the Year" by Division 43 of the American Psychological Association. One of his major contributions to the field of relationship/sex therapy is the development of a new paradigm of therapy known as the Intersystem Approach. Dr. Weeks has lectured extensively throughout North American and Europe on sex and couple therapy. Over the past 35 years, he has practiced, taught, and supervised sex, couple, and family therapy. He is currently in practice near Seattle, WA.

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Therapy within the Maudsley Hospital Clinic. She worked closely with Dr. M. Crowe and together they wrote, *Therapy with Couples: A Behavioural and Systems Approach to Relationship and Sexual Problems* (Blackwell Science, 2000), and also wrote *Intimacy in Crisis* (Whurr Publishers 1999) a comment on male female differences at moments of crisis within a relationship. She has also been Chair of the Family, Marital and Sexual Section of UKCP and a member of its Governing Board. She is now mostly retired but continues to write on relationship and sexual issues.

PREFACE

Purpose of the Book

Why were we motivated to write a third edition of *Systemic Sex Therapy*? The Intersystem Approach represents a paradigm shift in the field of relationship/sex therapy by providing a comprehensive and truly systemic/integrative model for working with sexual intimacy issues. The first edition was an edited volume that demonstrated the application of the Intersystem Approach to all the major sexual dysfunctions. The second edition helped to refine the application of this systemic paradigm by incorporating new research. It was used widely in the United States and Europe in couple/family therapy programs and other institutions promoting the advancement of sex therapy. We are, once again, encouraged by our colleagues and editors to produce a third edition of this popular book. In this third edition we are fortunate to present chapters from experts in each of the content areas. Some authors have updated their existing chapters while a group of new authors have joined in producing a text with increasing complexity and extensiveness in response to our changing social climate. The third edition reflects changes in the DSM regarding sexual dysfunctions, new research, and new techniques as well as treatment technologists from sexual medicine.

Target Audience

Psychotherapy professionals from various clinical orientations and various levels of training and experience have expressed interest in this book. These range from graduate and postgraduate students of couple, family and sex therapy to private practitioners who want to expand their scope of knowledge in working with relational/sexual issues. They express an interest in viewing any client system through a more comprehensive lens, increasing the possibility of more integrative treatment regardless of the clinical presentation. Our readers recognize the inherent need to examine all the factors leading to a sexual problem and the clinical efficacy of a systemic approach.

Theoretical Framework

Systemic Sex Therapy, third edition is a truly integrative and comprehensive approach to treating the most complex sexual and intimacy problems. It expands the understanding of a problem from an individualistic perspective to something much greater. The systemic

framework recognizes the interaction of several physical and behavioral domains simultaneously. Once the reader grasps this new framework, the Intersystem Approach, many new options are available for viewing the client-system. While this sounds like a daunting task, the reader quickly learns the tools necessary to address all facets of an issue. Our unique approach involves the partner and treats the couple, rather than the individual, as a unit. If there is no partner, viewing the individual within the context of this theory provides greater insight into causative factors and treatment options. Most importantly, our framework to psychotherapy surpasses that of the biopsychosocial model because of our unique inclusion of the contextual realities such as relationship, environment, situational stressors, culture and influences from the families-of-origin. It is more targeted or focused on the relevant systems involved in sexual problems and how these systems interact. We stated that our framework is comprehensive. It is broad enough to embrace other theoretical perspectives and treatment interventions, both physical and psychological. Thus, the therapist is not asked to give up their preferred therapeutic approach and techniques, but rather, to incorporate these into a much larger therapeutic framework.

Domains

The Intersystem Approach incorporates the simultaneous consideration of numerous domains: Individual issues, both biological and psychological, relational issues, family-of-origin influences on each partner, and larger contextual factors such as religion, culture, stressors and so on. The purpose of this approach is to gain as inclusive an understanding of the difficulty as possible in order to treat all the factors involved in the creation and maintenance of the problem.

Assumptions

One of our major assumptions is that many sexual dysfunctions reflect difficulties in the intimate relationship. This basic supposition has many implications for sex therapy that are highlighted in this volume. Some include:

- Sexual problems often reflect varying levels of relationship problems ranging from lack of communication to underlying intimacy problems.
- The resolution of the couple's problems is necessary to remedy many sexual problems.
- Unconscious influences in the couple's relationship may impede or sabotage the couple's ability to develop a more satisfying sexual relationship.
- A sexual problem in one partner may "mask" a sexual and/or relational problem in the other.
- The partners often contribute to the maintenance of sexual problems while trying to resolve them.
- Assignments to be performed at home are designed to be reciprocal. Each partner, not just the "symptomatic partner," is given respect and also benefits from treatments that enhance their relationship on multiple levels.
- Sexual problems may exacerbate couple issues or create new challenges for the couple.

Unique Features

We believe *Systemic Sex Therapy*, third edition has several unique features not found in any other texts on sex therapy: First, the couple as an interlocking system of behavior is viewed as the unit of treatment. Next, this volume uses a meta-framework where individual, couple, contextual and intergenerational factors are considered in both the etiology and treatment. Third, sexual and relational symptoms are treated simultaneously; there is no unnecessary bifurcation of treatment.

Advances in the field of sex therapy have been primarily medical for decades. Theory development leading to new treatment strategies and techniques has been virtually nonexistent. This text not only renders a new theoretical framework, but also encourages clinical innovation in the understanding and treatment of sexual problems. We describe technique, discuss the implementation, and provide case material to illuminate the use of the techniques.

Chapter Format

Each sexual dysfunction chapter of this text follows a standard format consistent with the Intersystem Approach, which illustrates factors that could produce the problem within the various domains mentioned earlier and then proceeds to discuss treatment depending on which factors are creating or supporting the problem. Our authors have creatively intertwined this outline with their own theoretical approaches. We find their presentations to be extraordinary. Each chapter begins with the definition or description of a disorder or a situation in which the client system is distressed and in need of change. Assessment dictates treatment when using the Intersystem Approach. It is important to take the clinician from the beginning to the end of treatment focusing on stages of treatment, techniques, implementation of techniques, and examples of how to implement techniques. We also provide a brief review of research supporting the treatment, and if possible, directions for future development.

Changes from the Previous Edition

The reader will note significant changes from the previous editions. In the *DSM-5* (2013), male and female lack of desire are divided into two different classifications and female interest and arousal disorders are comingled. We devote a larger chapter to Female Sexual Interest/Arousal Disorder in this volume. This chapter replaced female lack of desire and female arousal difficulties. We added new chapters on Sex and Aging, Technology, Cultural Impacts on Sexuality, and Infidelity. While the topic of sexual behavioral dysregulation is controversial at many levels, we presented a different perspective in this volume, which might reassure some and offend others. We are confident that this volume is the most theoretically encompassing of any text available on sex therapy. As a result, understanding etiological factors is greatly expanded which in turn allows for the creation of a more comprehensive treatment plan.

ACKNOWLEDGMENTS

There have been many people who have helped us in the creation of this book. First, we would like to thank the numerous contributors who have made this book a success. We consider ourselves very lucky to work with such an esteemed class of authors. Their insights, writing, and dedication to this project will surely shape the field of sex therapy, and we are appreciative of their significant efforts. We would also acknowledge the support from our family and friends throughout this endeavor. Thank you to Eric Hertlein, Michael Chenet, and Nancy Love, for providing us support during the completion of this project. We thank the staff at Taylor & Francis for their support of this project, specifically Clare Ashworth for giving us this opportunity to revise this text. We would also like to acknowledge the hard work of our graduate assistants in preparation of this manual, including Kaitlin Andrewjeski and Edmond Davis.

Finally, I (KH) acknowledge both the contributions made by Gerald and Nancy. Gerald has always been a steadfast supporter of my career, both in regard to the scholarship of sexuality but also in how to be a productive academic. His generosity, intellect, and insights on many papers and cases over time has been an incredible gift. I am very honored and humbled to have had a chance to learn from him. I am equally honored to have had a chance to work with Nancy. In this process, she helped me stay grounded when things were tough, taught me to think critically about the material, and brought her significant clinical and academic experience to bear as we organized the manuscript. I have learned a ton both about the field from these individuals, but also about professionalism and academia. I am very grateful for their mentorship and friendship and am proud of what we have created together.

1

THE INTERSYSTEM APPROACH TO SEX THERAPY

Gerald R. Weeks, Nancy Gambescia, and Katherine M. Hertlein

Introduction

The systemic approach to treatment described in this volume is grounded in a particular systems based, integrative theory known as the Intersystem Approach. The philosophical foundation for the Intersystem Approach grew out of a dialectic metatheory (Bopp & Weeks, 1984; Weeks, 1977; 1986). A simple way to describe dialectic metatheory is by thinking of it as a theory, which proposes how change processes occur between and among systems. Weeks (1987; 2005) began to formulate the basic structure of the theory, which is still used in the current iteration, but with refined and added conceptual material (Weeks & Gambescia, 2000; 2002). The Intersystem Approach is an ever-evolving theory, which *includes* and *integrates* various systems of behavior and, consequently, models of psychotherapy, each containing specific principles and techniques (Norcross, 2005; Weeks & Cross, 2004). Fundamentally, integrative psychotherapy involves a clearly articulated framework that informs a more comprehensive diagnosis or understanding of the problem and treatment (Van Kaam, 1969).[1]

The concept of integration is not new to the field of couple and family therapy (Gurman & Fraenkel, 2002; Lebow, 1997) as it is consistent with a systems approach to the complex issues that one encounters in working with family structures (Stricker & Gold, 1996). Integrative approaches have been used in play therapy (Green et al., 2015), social work (Yerushalmi, 2018), and in couple therapy (see, for example, Lebow, 2014; Morrissette, 2012), and supervision of couple's work (Betchen, 1995). An excellent example of the growing trend toward integration of different therapeutic approaches in couple therapy can be found in the fifth edition of the *Clinical Handbook of Couple Therapy* (Gurman, Lebow, & Snyder, 2015).

The Historical Lack of Integration in Couple and Sex Therapy

The biopsychosocial approach is becoming more common in informing sex therapy techniques and approaches (Berry, 2012; Denman, 2004; Meana & Jones, 2011). At the same time, the definition of a biopsychosocial approach is very broad and serves to acknowledge the importance of operating from a medically-informed perspective as well as applying a wide range of psychotherapeutic interventions (Berry & Berry, 2013). Biopsychosocial approaches are becoming more common as informing sex therapy techniques and approaches (Berry, 2012; Denman, 2004; Meana & Jones, 2011). At the same time, the

definition of a biopsychosocial approach is very broad and serves to acknowledge the importance of operating from a medically-informed perspective as well as applying a wide range of psychotherapeutic interventions (Berry & Berry, 2013). The three main areas in biopsychosocial models include a consideration of biological, psychological, and social perspectives.

Some biopsychosocial models do attend more specifically to couple dynamics and satisfaction in the treatment of disorders. An approach designed to work with older individuals spends a great deal of attention toward the consequences of aging on one's sexual life, but also incorporates elements of the couple's dynamic and communication patterns as important pieces of treatment (Bitzer, Platano, Tschudin, & Alder, 2008). In a biopsychosocial models attending to compulsive sexual behavior, specific areas in psychology that are relevant for assessment and inclusion in treatment include "including family intimacy dysfunction, attachment, interpersonal interactions, social learning, and conflicts stemming from cultural norms surrounding sexual behavior" (Coleman et al., 2018, pp. 5–6), as well as attention to one's history of adversity and attachment. The biopsychosocial approach for treating premature ejaculation includes the couple satisfaction in the social issues to be addressed (Mrdjenovich, Bischof, & Menichello, 2004). In the sexological model proposed by Jones, Da Silva, and Soloski (2011), most of the emphasis is on the addressing of Bronfenbrenner's ecological system (including the chronosystem) on a couple's sexual life, with far less emphasis on partner, biology, and family-of-origin issues.

The Intersystem Approach is a more intricate, highly developed, and specific application of a biopsychosocial approach. There is a domain specifically outlined for issues related to couples as well as family-of-origin. For example, in the model for premature ejaculation, the couple issues fall within the social, and there is no specific attention to family of origin issues, though there is some attention to early messages about sex (Mrdjenovich, Bischof, & Menichello, 2004). Finally, the interventions are not as specific as they need to be. Again, the premature ejaculation example the factors surrounding one's history of sexual knowledge and experience are to be treated with "sex therapy" (Mrdjenovich, Bischof, & Menichello, 2004) – a very broad set of interventions, dubious to be sure.

Historically, the Intersystem Approach pre-dated the biopsychosocial methodology in sex therapy as an integrative approach and most specifically as one that emphasized the combination of sex and couple therapy (Weeks & Hof, 1987). Considering the fact that couple and sex therapy concentrate on relational issues involving intimacy and sexuality, one would expect them to be joined theoretically and practically. Sex therapy, however, grew as a parallel and separate discipline/treatment modality from couple and family therapy. Although the two fields are slowly showing some signs of overlap, the intersection is small and inconsistent (Gurman, 2008). The consequence of the bifurcation of these fields includes the following:

1. Traditional sex therapy is non-systemic or individually oriented
2. A lack of theory in combined sexual science, research and practice
3. A lack of integrative training emphasis in credentialing professionals
4. A lack of integration of sex and couple therapy practice

Traditional Sex Therapy is Non-Systemic

While family and couple therapy fields have accepted a systems approach to treatment, a fundamental systemic theoretical framework has traditionally been absent in the field of

sex therapy. For example, Masters and Johnson (1966; 1970) provided the original accounts of the physiology of the sexual response and treatment of sexual dysfunctions but their approach was not systemic, even though the couple, rather than the individual, was the unit of treatment. The partners were not viewed as the client system – rather, the basic unit of treatment was the individual and the problem was believed to reside in just that individual who displayed the symptoms. As such, the ostensibly asymptomatic partner often acted as an assistant to the therapist in carrying out assignments that focused on the symptomatic partner. A few years later, Kaplan (1974) attempted to bridge the gap between traditional psychodynamic and more contemporary behavioral approaches. Although Kaplan (1974) recognized the importance of resolving relational conflict in promoting sexual satisfaction, her approach was not systemic or truly integrative. In fact, Kaplan's approach used the "bypass" technique to circumvent relational problems in order to focus on sexual symptoms from an individually oriented behavioral/psychodynamic perspective. LoPiccolo and LoPiccolo (1978) incorporated the element of mutual responsibility in their sex therapy approach, approximating one aspect of what we now know as systemic sex therapy. They recognized the reciprocal nature of sexual dysfunctions and, accordingly, treated the couple as a unit. Unfortunately, their approach was guided by several ideas rather than an integrative theory.

The next generation of sex therapy models promoted a greater emphasis on medical, cognitive, behavioral, and psychodynamic approaches. As such, these models did not contribute to a systemic, integrative theoretical framework (Leiblum, 2007; Leiblum & Rosen, 1988; 2000). At present, the field of sex therapy continues to be dominated by cognitive/behavioral theory and, more currently, the medicalization of sexual issues.

The Intersystem Approach has engendered the greatest paradigm shift in the field of sex therapy, but is far from universally accepted. The framework involves the simultaneous consideration of multiple domains of any client-system. This systemic and truly integrative theoretical approach has been utilized in sex therapy and also for the treatment of any individual, couple or family problem. Moreover, it naturally intersects the modalities of individual, couple and family therapy because it is systemic. The application of the Intersystem Approach has been implemented in major professional texts concentrating on erectile disorder (Weeks & Gambescia, 2000), sexual desire disorders (Weeks & Gambescia, 2002), infidelity (Weeks, Gambescia, & Jenkins, 2003), and sex therapy (Hertlein, Weeks, & Gambescia; 2015; Weeks, Gambescia, & Hertlein, 2016).

A Lack of Theory in Combined Sexual Science, Research, and Practice

Another major problem in the field of human sexuality and sex therapy is the lack of theory and theory-informed research. This means most of the articles published are about data and therefore do not provide theory-based or theory-driven research in sex therapy. In 1998, *The Journal of Sex Research* highlighted this problem in a special issue on theory. This issue of the *Journal of Sex Research* includes a number of mini-theories in the field of human sexuality and very few in the area of sex therapy, none of which attempted to offer an integrative perspective.

Through the publication of *Integrating sex and marital therapy: A clinical guide*, Weeks and Hof (1987) presented an approach, which specifically recognized the need for the integration of sex and couple therapy as a minimal requirement for these fields. It was the first book to demonstrate how an integrative approach could be used in treating a range of sexually related issues. Other theorists have argued for the integration of sex therapy into

other fields of psychotherapy. Widerman (1998), in the *Journal of Sex and Research*, advocated that human sexuality and sex therapy concepts, treatment approaches, and research be integrated into the broader fields of psychology, psychiatry, social work, nursing, and other health care and social sciences.

A Lack of Integrative Training Emphasis in Credentialing Professionals

The standards of training for the professional organizations devoted to couple and sex therapies are needlessly fragmented. For example, organizations such as AAMFT (American Association for Marriage and Family Therapy) and ACA (American Counseling Association) require only minimal training in the areas of human sexuality, sexology or sex therapy. In fact, COAMFTE-accredited programs (Commission on Accreditation for Marriage and Family Therapy Education, 2017) do not delineate a specified amount of sexuality training in their programs' requirements. In the latest Standards on Accreditation, human sexuality is subsumed under the category of Biopsychosocial Health and Development Across the Life Span. This course covers a large range of topics meaning sexuality could only be a small part of the course.

In brief, both accreditation bodies mentioned earlier set standards for couple therapy training as part of their accredited programs, but essentially fail to adequately address sexuality and training in dealing with sexual dysfunctions. This is unfortunate as couple and family therapists and professional counselors are ineffectively prepared to assess and treat sexual issues, which are so commonly associated with individual, couple and family problems. Likewise, the American Association for Sex Educators, Counselors and Therapists (AASECT) is the only sex therapy organization that offers certification for sex therapists (American Association of Sexuality Educators, Counselors and Therapists, 2014). Their criteria for certification as a sex therapist require that applicants must have some couple training in their graduate program. If they do not have graduate coursework then candidates for certification as a sex therapist must acquire what we consider minimal training in couple and systems theory and practice.

In our experience, many AASECT certified sex therapists, especially those who have been certified for many years, do not have any or minimal systemic training in how to work with a couple, nor have they had any intensive training in couple therapy. Additionally, the AASECT supervisor must be an experienced sex therapist, not necessarily a practitioner who has a working knowledge of couple and family systems, systems theory and systemic therapy (American Association of Sexuality Educators, Counselors and Therapists, 2014). See www.aasect.org/aasect-certified-sex-therapist-supervisor.

In summary, the organizations which establish the training standards for couple and sex therapy each suggest training in the "other" field but do not support such a suggestion in requiring any significant amount of training in curriculum or licensure/certification standards. On the other hand, each accrediting body does set rigorous standards for training within their own respective field. In addition, for those who attend national conferences in both fields it is obvious how little the two arenas intersect. The ideal sex therapist has training in individual, couple, sex, and family therapy.

The Lack of Integration of Sex and Couple Therapy Practice

As a consequence of historically poor integration of couple and sex therapy theory, the lack of a systemic sex therapy metatheory, fragmented training, bifurcated teaching

programs, segregated professional organizations, and so on, the actual practice of sex and couple therapy are often performed by different practitioners. We have attempted to remedy this difficulty by offering an integrated approach to couple and sex therapy in our publications, education, and supervision. We believe making a referral of a couple with a sexual problem to another therapist who treats only the sexual problem is poor clinical practice and the converse would be true for a sex therapist who refers a couple for couple therapy. The referral could send a message that the sexual/couple problem is too complicated, serious, and untreatable, etc. Clients often feel hopeless and the recommendation to the "expert" reinforces their sense of pessimism. Alternately, unrealistic expectations for a "cure" can be generated by the fragmentation of treatment. The couple could construe that seeing a therapist just for a sexual or couple problem will ensure that the specialist will be able to resolve their problem. Moreover, the therapist from whom they seek treatment already knows the couple's issues and is in a good position to make the links between the sexual and relational problems. Sexual and relational satisfactions are correlated, each promoting and influenced by the other. Similarly, sexual and relational dissatisfaction perpetuate each other. Sexual issues are embedded in the relationship and relationship concerns express themselves in sex. Since these areas are interconnected relationally, why treat them in isolation?

The Intersystem Approach

Both couple therapy and sex therapy should have an integrated framework, systemic orientation, and comingled techniques to treatment. The Intersystem Approach was generated from a metatheoretical position that all systems of behavior reciprocally interact and utilizes major domains of behavior in which to conceptualize human behavior and therapy. A metatheory is a theory about theories and often considered a branch of epistemology. Metatheory provides some of the rules, principles, and suggests the need for integrational concepts that allow us to understand and treat behavior from a larger perspective. The Intersystem Approach balances attention to the individual, couple, and family system, as well as the larger systems in which we live. This framework integrates five specific domains of behavior:

1. Individual-biological/medical
2. Individual-psychological
3. Dyadic relationship or couple dynamics
4. Intergenerational influences (patterns, values, attachment style, etc.)
5. Contextual factors such as society/culture/history/religion/physical environment

This paradigm is now embraced by many sex/couple therapists as reflected in the number of couple and family programs that used the earlier editions of this text and the continuing success of multiple editions.

Major Domains of the Intersystem Approach

Individual-Biological/Medical. Each partner brings to the relationship a unique biological makeup and medical issues that change over time. It is imperative that the therapist considers biological factors and medical concerns and their impact on a couple's sexual relationship. For example, in the treatment of erectile dysfunction, therapists are well

advised to assess for any medical problems potentially contributing to the dysfunction, such as cardiovascular disease and prescription medications. For example, therapists should acquire a list of all medications, dosages, action of the medications, and duration of medication treatment. Another example of the impact of biological issues on the sexual functioning of both partners is the man with erectile dysfunction and his female partner with menopausal symptoms. The physical issues and related psychological/relational factors must be addressed.

Individual-Psychological. The therapist assesses the following in each partner: psychological make-up, personality traits or disorders, other psychopathology, intelligence, temperament, developmental stages, deficits, attitudes, values, defense mechanisms, and so on. Sexuality is learned and expressed through the unique lens of one's psychological composition. For example, a person suffering with depression may not feel desire to engage in sexual activity, particularly if the depression is related to the relationship in some way. One's sexual beliefs may also have been acquired in such a way that elicits guilt about particular sexual activities, thus inhibiting the sexual response.

Dyadic/Couple Relationship. Although it is important to assess how each partner influences the relationship, the Intersystem Approach makes a quantum leap and addresses how these individual influences manifest within the couple by affecting how the partners manage such issues as conflict, communication, intimacy, roles, and so on (Weeks & Fife, 2014). From this perspective, the couple is more than the two individuals who are seen from a strictly individual perspective. Every aspect of their relationship is part of a reciprocal system with partners influencing the other at all levels. Thus, they form a complex interlocking system of behavior through which they channel forces from all the other domains of the Intersystem Approach. Although systemic therapists are trained to conceptualize the couple as an interlocking system, this way of looking at the couple may become lost. If one partner presents with a clearly defined issue and the other doesn't, it is easy to overlook the contribution of the non-symptomatic partner. For example, a couple may present with the female partner showing a clear lack of sexual desire. The male partner may have adequate desire and be asymptomatic. However, his behavior toward her may be an important factor in suppressing her sexual desire.

Family-of-Origin Factors. Individuals learn about relationships and sexuality in their families. Internalized messages about sexuality can be obvious or covert and they find expression within the intimate relationship. For example, some families do not discuss sexuality openly. Consequently, children in these families may conclude that sexuality is inherently unspeakable and, thus, bad. In such cases, future expression or discussion of sexuality is often minimized. This can be problematic as these children become adults and begin to struggle with their emerging sexual feelings. They may, in turn, tell themselves that they are "bad" for having sexual feelings, thus impacting their self-esteem and inevitably their relationships. Some parents are overt in their condemnation of sexual behavior, again creating internal struggles for their children as they grow into adulthood and develop intimate relationships. Therapists can assess for information about family history via a relationship/sexual genogram (see Belous et al., 2012; Berman, 1999; Berman & Hof, 1987; DeMaria, Weeks, & Twist, 2017).

Society/Culture/History/Religion. Sexuality is viewed through the lens of one's culture (Hall & Graham, 2012; Hall, 2016) and other factors such as race, ethnicity, socioeconomic status, physical environment and situational stressors. Couples are helped to understand how sexual beliefs, expectations, preferences, and behaviors originate from their background; the culture and history (i.e. time period, generational influences) in

which they were raised are psychologically embedded in the individual partners and expressed in relationships. These external influences shape one's customs, and values around sexuality and sexual expression. As norms change, couples should work to understand the extent to which culture and contemporary society have played into their decision-making, values, and behaviors as a couple. Other situational or contextual factors such as stress, finances, natural and man-made disasters can also interfere with sexual enjoyment.

In short, the Intersystem Approach was designed to *integrate* all five domains, which may be affecting sexual functioning. An integrative perspective begins during the assessment phase with a case conceptualization of the couple. Treatment follows from the case formulation. The treatment plan integrates causative factors from all the relevant domains for any particular couple. Implementation of treatment is inclusive, flexible, and may involve different units of treatment, but usually the couple, and a variety of techniques/modalities.

Figure 1.1 shows the four major domains (collapsing Individual-Biological/Psychological) and illustrates some assessment ideas. Treatment approaches can be extrapolated from these domains/assessment concepts. The examples are by no means exhaustive.

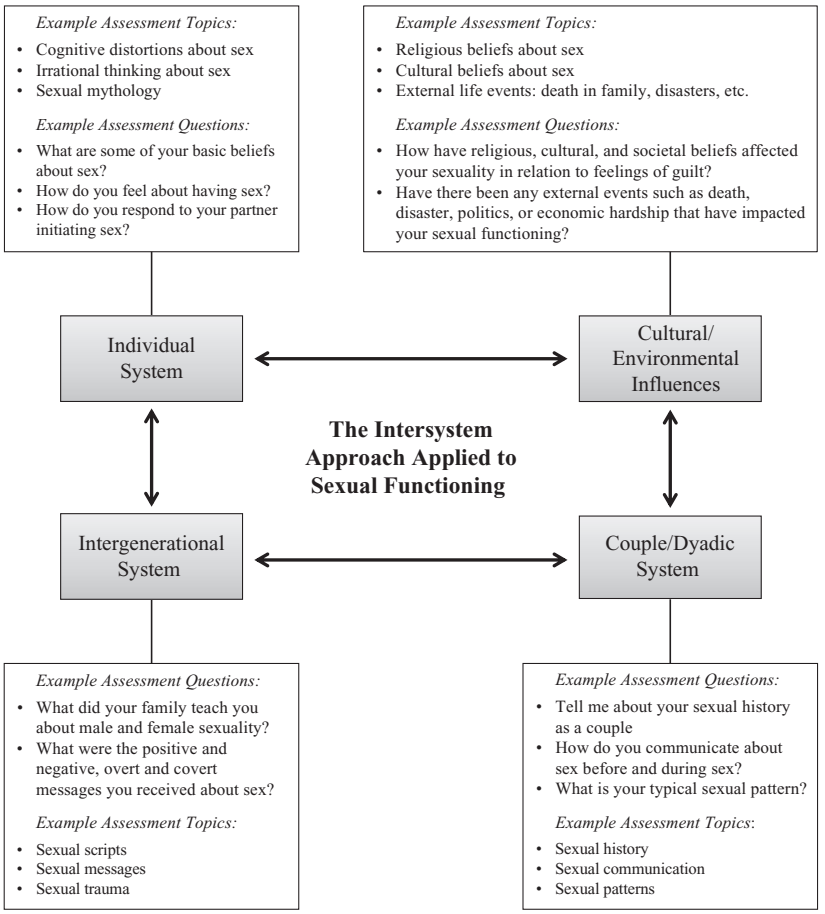

Figure 1.1 The Intersystem Approach showing the four major systems and examples for sex therapy.

Integrational Constructs of the Intersystem Approach

Integrational constructs are clinical tools that help us link or better understand behaviors across the different behavioral domains. The Intersystem Approach has multiple domains to which the therapist must simultaneously attend (individual, couple, family-of-origin, outer influences). The integrational constructs apply only to the individual, couple, and family-of-origin domains. Numerous therapeutic approaches can be applied to each domain such as cognitive therapy within the individual domain and so on. Integrational concepts are not specific to any one domain, but apply in each domain, thus helping us to see or tie together the different domains of behavior.

In our prior edition, we described three theories from which we extracted integrational constructs. These constructs allow us to treat problems at a deep level of complexity.

1. Social Interactional Theory (Strong & Claiborn, 1982)
2. Triangular Theory of Love (Sternberg, 1986)
3. Attachment theory (DeMaria, Weeks, & Twist, 2017).

Social Interactional Theory

This integrational construct cuts across and ties together the domains of the Intersystem Approach. Social Interactional Theory is divided into two major categories: intrapsychic components and interactional components.

Intrapsychic Components. *Interpretation* is the meaning ascribed to an event, behavior, or problem. This is relevant to couples in that they may construe their partner's behavior inaccurately or may not understand the intent of the behavior. One's understanding of another's behavior is often grounded in previous experiences and learning histories. *Definition* is how each partner describes the relationship. As such, definitions (conscious or unconscious) and expectations can infiltrate one's view of a relationship and influence cognitions, affect, and behavior. If these expectations are not articulated or are unconscious, communication problems or conflict may develop between the couple and it then becomes incumbent upon the therapist to help the couple address the unspoken disappointments in expectations.

Prediction addresses the notion that to some degree, we have a tendency to try to determine one's behavior, thoughts, or a particular outcome. Couples in sex therapy may not complete homework assignments, for example, because they anticipate or predict failure. If one partner avoided the homework, then the other partner may begin to predict they will continue to avoid the homework and not progress in therapy.

Interactional Components. Three interactional components (Congruence, Interdependence, and Attributional Strategy) address the systemic aspects of relationships. *Congruence* refers to how a couple shares, agrees or defines things. Partners may have a high level of congruence meaning they tend to see things the same way or a low level of congruence meaning they tend to see things differently. The construct may also refer to behavioral congruence (e.g., both wanting sex frequently or one wanting sex frequently and the other much less so). *Interdependence*, another concept of the interactional theory, relates to the extent to which a partner depends on and trusts the other will meet their needs. This can include how one meets the other's emotional as well as sexual requirements. *Attributional Strategy* refers to the manner in which partners ascribe meaning to an event. In this context, it specifically means whether a couple relates in a linear or circular fashion to one

another. In a linear attribution strategy, couples attribute their partner's behavior (effect) to a stimulus (cause). A husband, for instance, might report that his wife "makes" him angry when she asks him about household chores. Blaming is the hallmark of negative linear attribution and is highly correlated with relational dissatisfaction (Gottman, 1994). In circular attribution strategies, partners examine the impact of their behavior on the other. They understand the interlocking nature of the relationship and the reciprocal influence that each has on the other.

Triangular Theory of Love

Sternberg, a social psychologist, believed that there are three components of love: 1) commitment 2) intimacy, and 3) passion, and that each of these components interact with one another in our relationships. The first component of the triangle, commitment, refers to the cognitive element of love; that is, the determination of whether couples desire to stay together. Intimacy, the second component, describes the amount of closeness partners feel toward one another. This includes the extent of trust in the relationship, feelings of mutual respect, and the bond each would describe they have to the other partner. The final component of the triangle is passion or the affection, feelings of longing to be together, and the sexual attraction a couple demonstrates in a relationship. As we mentioned earlier, these three constructs can be examined within the individual, couple, and family (Sternberg, 1986).

Attachment Styles

The Intersystem Approach also incorporates attachment theory, specifically attachment styles, as an integrational construct. (See DeMaria, Weeks, & Twist, 2017). The patterns of emotional connection between people are established in the family of origin and may remain fixed or may become modified in subsequent dyadic relationships, such as the choice of a life partner, how one relates to their significant other, and manner of connecting to one's children.

Our reading of mainstream sex therapy literature finds the concept of attachment theory/styles to be virtually absent. Attachment styles are a key variable to how we relate to others, especially in intimate relationships. Sexual expression in a relationship occurs at many different levels such as physical, mental, emotional and spiritual. For each attachment style, there are some predictable ways of relating sexually. For example, individuals with avoidant attachment styles tended to separate sex from emotional intimacy, have sexual fantasies involving emotional distance, had sex less frequently with a close partner preferring masturbation, one night stands, or casual sex, and avoided giving and receiving affection (Marsh, 2017).

Clinical Use of Integrational Constructs

Choose any one of the integrational constructs. These constructs are designed to help us understand behavior across domains. We can start with any domain since a construct may be expressed anywhere. For example, a partner may enter a relationship expecting fidelity. This *definition* of what it means to be partnered was learned in the family-of-origin and in the greater society. Once infidelity occurs, the partner may then believe that everyone cheats. The infidelity has led to the creation of a new individual definition of fidelity. The

definition of fidelity has changed as a result of an event in the couple relationship. This concept that all partners cheat may become internalized (individual domain) and is taught to their children (intergenerational transmission), who in turn internalize it and express it in their relationships. For example, a mother may warn her daughter that all men cheat as a result of her dyadic experience. The daughter may withdraw sexually or emotionally in relationships thinking that any man she is with will eventually cheat. Understanding meaning across the domains gives the clinician's a broader perspective. As a result, a problem occurring in a couple in treatment may have its origins in another relationship, the family-of-origin, or the particular way an event was individually interpreted and internalized. The same would apply for all the integrational constructs listed. The therapist can then help the couple understand different aspects of their relationship as a result of what they experienced or learned in their own personal experience, their intimate relationships, their family-of-origin, and the larger context.

Bringing It Together: An Integrative Paradigm

A major void in the field of sex therapy is the conspicuous absence of theoretical integration of the many sexual and psychological treatment modalities. With few exceptions, the field lacks the necessary theoretical integration of areas such as couple and sex therapies, medical, and individual treatments. An integrative/systemic paradigm shift, such as the one proposed in this text, encourages sex therapists to develop an understanding of the problem within different domains, which then leads to an integrative approach to treatment, and a more comprehensive perspective on sexual dysfunctions.

The use of the Intersystem Approach encourages therapists and researchers to consider etiology and interventions from multiple domains with attention to the entirety of human experience. The Intersystem Approach is a work in progress. We are cautious of approaches that are offered as "complete" theoretical models. Integrative approaches to psychotherapy are still young. The field of sex therapy is still quite young. We are confident of the basic framework or the domains of behavior. The integrational constructs will probably expand over time and become more refined. The clinical implementation of the theory is aspirational. How many therapists are well trained in individual, couple, sex and family therapy? Each approach to therapy has a large body of knowledge and an array of treatment approaches and techniques. Most therapists start with a basic body of knowledge and preferred therapeutic techniques. The Intersystem Approach does not require that anyone sacrifice any of their training. The aspiration is to keep adding and adding through the use of the different domains and all that is associated with that domain in terms of etiology and treatment. The outcome is a comprehensive and integrative treatment approach that dissects a problem and treats numerous segments simultaneously.

Note

1. Integration is different from the practice of eclecticism, which is an ad hoc selection of theoretical approaches applied to a specific situation. Eclecticism tends to be intuitive whereas integrative approaches have an underlying theory.

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2

THE PROFESSION OF SEX THERAPY

Current Challenges

Peggy J. Kleinplatz

Introduction

This chapter will review the history of sex therapy and recent trends in the field including the medicalization of sexual dysfunction and responses to medicalization. The professional life of the sex therapist will be described, highlighting the various sex therapy organizations, the personal and professional process of becoming a sex therapist and the ethical principles of sex therapy. Finally, the controversy over the distinctiveness of sex therapy – or lack thereof – and therefore, whether or not certification of sex therapists is warranted, will be considered.

The History of Sex Therapy

Throughout the twentieth century until the development of sex therapy, sexual problems were either unspoken or the province of religion, philosophy and to a minor extent, medicine. They were often discussed in "marriage manuals", which had some nifty little ideas about how much sex was desirable, which kinds were appropriate and for that matter what constituted sex (Van de Velde, 1926). Whatever ideas they put forth were based on the values and beliefs of the era, with no basis in sexology, that is, the scientific study of sexuality. In addition, sexuality was a major focus of the work of psychoanalysis, which dealt with the whole person and his/her development rather than targeting sexual problems for treatment. Although psychoanalysis had the advantage of aiming for substantive personality change (Freud, 1917; 1963), it was time-intensive, hardly cost-effective, and dealt with the individual alone rather than the couple or society, that is, the context in which sexual difficulties tend to arise and be manifest.

In the late 1940s and early 1950s, the work of Kinsey and his colleagues (1948, 1951) helped to revolutionize what could be studied by sexologists by seeking to describe and categorize the spectrum of normal sexual behaviors. The popularity of Kinsey's work, even though it was highly controversial, helped to pave the way for the study of the physiology of sexual response in the laboratory by Masters and Johnson (1966). Their findings mapped out the sequence of the four stages of what they termed the "Human Sexual Response Cycle", consisting of excitement, plateau, orgasm and resolution. This laboratory research in turn laid the foundations – and provided the credibility – for Masters and Johnson's 1970 text, *Human Sexual Inadequacy*, which described the sexual disorders and their treatment. This seminal book essentially created the field of sex therapy. Sexual

problems came to be defined largely in terms of deviations from the physiological norms found among subjects engaging in sexual acts in the lab. Deviations from Masters and Johnson's model of the Human Sexual Response Cycle later came to be reified as the criteria for defining sexual disorders in the American Psychiatric Association's various editions of the *Diagnostic and Statistical Manual of the Mental Disorders* (DSM).

The evolution of sex therapy and the current status of sexual problems and their treatment cannot be understood without further attention to the basic precepts and concepts elucidated by Masters and Johnson. William Masters, a gynecologist, became interested in the scientific study of sexuality and specifically, the treatment of sexual disorders. He was joined in his investigations and in the development of a treatment paradigm by social scientist, Virginia Johnson. The foundation of their work was consistent with Master's training as a physician. One of their major precepts was that sex is a biological function, not unlike urination, defecation or respiration (1986). Much of their clinical work was aimed at eliminating psychosocially imposed obstacles (e.g., ignorance, fear, guilt and shame) to sexual function so that "natural" functioning could re-assert itself. They stated that 90% of sexual problems were likely to be psychogenic and the remaining 10% of organic origin. (Although the discourse popular in the current Zeitgeist is reversed and would suggest that 90% of sexual problems are of organic etiology and only 10% are psychogenic, the mind-body dualism prevails/endures.)

A second, major precept proposed by Masters and Johnson was that the relationship should be the focus of treatment rather than targeting only the symptomatic patient. Regardless of which individual presented the problem, the couple would be required in therapy to achieve a solution. Ironically, they have been criticized for giving only lip-service to the importance of the relationship in creating and/or maintaining the problem (Weeks, 2004, 2005); the use of surrogates as part of their treatment paradigm betrays their belief that although two people may be necessary to effect symptom amelioration, the interchangeability of the partners suggests a neglect in this model of the role of the *intimate* relationship and the couple *system* in sexual problems. In short, the early pioneers talked about working with the couple, but did not conceptualize or intervene systemically.

The treatment approach they developed consisted of brief, behaviorally-oriented couple therapy with a strong educational component intended to target the symptoms of sexual dysfunction. The success of Masters and Johnson's approach as first reported in 1970 led to great interest in sex therapy and laid the groundwork for the entire field over the next decades. Unfortunately, the paradoxical effect of this "success" led to widespread acceptance of their methods without due consideration of underlying theoretical foundations – or lack thereof – allowing the prevailing assumptions to remain unexplored (with distinct exceptions, e.g., Kleinplatz, 2001, 2012; Peterson, 2017; Wiederman, 1998).

During the 1970s and 1980s, Masters and Johnson's work began to be critiqued for ignoring subjective aspects of sexual response such as desire, psychological arousal during sex and satisfaction thereafter (Kaplan, 1977; 1979; Lief, 1977; Zilbergeld & Ellison, 1980) as well as for unorthodox reporting of outcome data, making it difficult either to interpret their findings or to replicate them. Helen Singer Kaplan, trained in psychoanalysis, emphasized the need to assess for not only "immediate" factors blocking sexual response but also "remote", developmental factors which might affect personality and relationships. Ironically, despite her insight as to the role of historical factors, she emphasized that "fortunately", it was easy enough to remediate symptoms without needing to deal with underlying dynamics except in recalcitrant cases (Kaplan, 1974). In 1977, both Kaplan and Harold Lief described the desire disorders as particularly common and vexing. The desire

disorders were more complex than could be accounted for by studying the physiology of sexual response alone.

In the years that have ensued, sex therapy has consisted primarily of brief, directive couple therapy and often, individual therapy blended with psychoeducational counseling and using "homework" assignments. Sex therapy has historically been rather effective in treating the symptoms of sexual dysfunctions, at least as compared with mainstream psychotherapy's track record in treating its most prevalent presenting problems, e.g., depression and anxiety. As such, sex therapy assumed brand name proportions, becoming the "Kleenex™" of psychotherapy, without much attention to the ill-defined, poorly explored assumptions implicit in our treatment methods (Kleinplatz, 1996). A variety of sex therapists have attempted to articulate, broaden and integrate treatment paradigms to focus more extensively on a wider and deeper array of issues, particularly relationship and systemic factors, including Weeks (1977, 1994; Hertlein, Weeks, & Gambescia, 2015; Weeks & Hof, 1987) in formulating the Intersystem model, Schnarch (1991, 1997) and the Crucible model, Metz and McCarthy (2005, 2011, 2012) and the Biopsychosocial Approach to Sex Therapy, more recently McCarthy's revised Psychobiosocial Approach (McCarthy, Koman & Cohn, 2018; McCarthy & McDonald, 2009), Ogden (2006, 2018) and the 4D Wheel (i.e, mind, body, heart, spirit) model and Kleinplatz (1996, 1998, 2004, 2007, 2010, 2014, 2017) and the Experiential model developed by Mahrer (1996, 2012).

Recent Trends in the Field

The burgeoning attention that was starting to be focused on the need to integrate sexual and couple therapy was suddenly deflected by the introduction of Sildenafil citrate (i.e., VIAGRA) in March, 1998. The introduction of a pharmacological intervention for treatment of a sexual dysfunction was not new, in and of itself; however, the ease of administration combined with a curiously, sex-negative, socio-cultural environment and the relative theoretical void with which to make sense of this option provided a perfect opportunity for media spotlight on quick-fix solutions for sexual problems.

Some history is useful to situate "the VIAGRA moment" in context: In a society that has long been ambivalent, at best, about sex education, let alone comprehensive sexuality education, the pull toward dealing with sexual problems as if they are somehow separate from the rest of our lives is irresistible. It is as if the people with sexual difficulties, the surrounding society, the pharmaceutical industry and clinicians collectively entered into a silent pact: Let's just conspire to keep our sexual difficulties sealed off from the rest of the context in which they come into existence, are perceived as problematic and require "fixing". Let us collude to treat the symptoms of sexual dysfunctions as if the symptoms are the (possibly underlying) problems themselves. Let us prop up the sagging penis as if that alone will take care of his (and his partner's) deflated spirits, as if hard penises are all we need for sex, and as if sex equals intercourse. Let's talk about our genitals – if we must talk about them at all – as if they are mechanical objects in need of repair rather than parts of whole persons silently asserting their discontent at unfulfilling intimate relations.

Such a pact was not so easy for as long as the treatment itself was unduly painful or cumbersome, as was the case with the biomedical treatment of erectile dysfunction prior to VIAGRA. Throughout the 1990s, my practice (and that of many colleagues) was replete with men who reported being diagnosed with "leaky blood vessels" (Kleinplatz, 2004). The major medical treatment for erectile dysfunction at that time had been the use of intracavernosal injections of papaverine, phentolamine and prostaglandin E_1 to produce rapid,

firm and long-lasting erections. (It remains the treatment of choice for many men who cannot use the phosphodiesterase type 5 inhibitors (PDE-5 inhibitors), for example, because of potentially dangerous interactions with nitrates). The popularity of this treatment, however, was limited by the queasiness engendered by having to inject oneself in the penis (Althof et al., 1989; Althof & Turner, 1992; Irwin & Kata, 1994). It was hardly pleasant and difficult to administer inconspicuously. (Even more so, it violated the belief system that proclaimed sex, defined as intercourse, was supposed to be "natural and spontaneous". I was struck by how quickly this epidemic of "leaky blood vessels" disappeared at precisely the same time that the little blue pills appeared on the market (Kleinplatz, 2004). The latter were much easier to swallow.

The field of sex therapy was forced to react to the easy availability of a new, relatively safe and effective, non-intrusive method for treating erectile dysfunction without the theoretical foundations with which to conceptualize this innovation. It was as though the field was thrust into a collective (albeit silent) identity crisis (Giami, 2000), attempting to ascertain how to deal with this new option (e.g., as merely another intervention, adjunct, rival, ally, diagnostic tool) while unsure of our own clinical and professional objectives. How were we to deal with the new kid on the block while still unclear on who we want to be when we grow up?

In 1994, Schover and Leiblum warned of the encroaching medicalization of sex therapy. Long before the field had begun to grapple with its theoretical lacunae, "the VIAGRA moment" had arrived. In the interim, we had neglected to identify the basic questions a science of psychotherapy practice must encounter, while continuing to act as if we had all the answers (Kleinplatz, 2003; 2012). Here are just a few fundamental questions: What is sexuality? How are we to understand sexual experience? What is the basis/origin of sexual desire? Why do some things seem powerfully erotic to some people, abhorrent to others and irrelevant to still others, leaving them cold? Are all people capable of some kind of sexual feeling? What is "normal" sexuality? What is the relationship between "normal" and "abnormal/dysfunctional" sexuality and what can we learn about one from the other? What is optimal sexuality? What kinds of sex do we want to promote? How are we to conceptualize sexual problems? What is the context in which certain things come to be defined and come into existence as sexual problems? What are the meanings of those difficulties for the individual, the couple and the system? What should our goals be in dealing with sexual problems? Whereas it had been simple enough to ignore our own assumptions when we were the only game in town, with the introduction of VIAGRA the time was well overdue for us to (re-)consider the provisional principles underlying sex therapy praxis.

The Medicalization of Sexual Problems

Over the last 20 years, the lacunae in our fundamental theoretical underpinnings allowed "sex therapy" to devolve increasingly into treatment of *symptoms* of sexual dysfunctions and disorders. Correspondingly, there was a loss of focus on the men and women who deserved our attention to the complex intrapsychic, systemic and psychosocial meanings of their suffering. In this void, the increasing medicalization of sex therapy emerged in the forms of new pharmacological treatments, new organizations and conferences designed to teach non-sex therapist physicians the rudiments of prescribing these drugs, and the marketing of not only the drugs but a new discourse on sexual difficulties. Advertisements blanketed American television, magazines and other media announcing first Pfizer's Viagra and later, two other PDE5 inhibitors, Lilly's tadalafil (Cialis) and Bayer's vardenafil

(Levitra). Each ad exhorted the audience or reader to "Ask your doctor." Unfortunately, since 2000, the increasingly sex negative atmosphere has led to funding cutbacks for teaching in sex therapy and even basic training in medical schools about human sexuality and its problems has *declined* (Bayer, Eckstrand, Knudson, Koehler, Leibowitz, Tsai, & Feldman, 2017). Shindel and Parish (2013) have described the current training as "scant or absent" in many medical schools. The majority of medical students in the U.S. and Canada feel uncomfortable talking about sex with patients, unprepared to do so, inadequately trained to do so or in most cases, all of these (Leonardi-Warren, Neff, Mancuso, Wenger, Galbraith, & Fink, 2016; Malhotra, Khurshid, Hendricks, & Mann, 2008; Shindel, Ando, Nelson, Breyer, Lue, & Smith, 2010; Wittenberg & Gerber, 2009). Physicians are even less prepared to take a sexual history with LGBTQ patients (Hayes, Blondeau, & Bing-You, 2015). Thus, prospective patients have been instructed to contact physicians who were increasingly ill-equipped to handle the newly-created demand for their services. The pharmaceutical industry funded conferences that taught physicians about urological aspects of erectile dysfunction with little attention to the sexological or relational dimensions. This fit quite well with the marketing of the discourse touting that 90% of erectile dysfunction was of organic etiology while only 10% was psychogenic or relational in origin. That notion, in turn, was especially appealing to individuals and couples who preferred to blame the malfunctioning penis rather than be forced to delve too deeply into the possibility of personal or interpersonal problems. Thus, the drugs, the industry, the clinicians and the social discourse managed to jointly create a situation in which the patient's penis was working while the man attached – or detached – was ignored.

In addition, the off-label prescription of other drugs for sexual difficulties was promoted increasingly in the 1990s and thereafter. Selective serotonin re-uptake inhibitors (SSRIs) were recommended increasingly as a treatment for rapid ejaculation. Drugs such as PAXIL (GlaxoSmithKline), intended originally as anti-depressants, demonstrated an adverse impact on sexual desire and response, diminishing or even preventing orgasm in many patients. The SSRIs succeeded in slowing down men's ejaculations and were therefore used as an adjunct to or instead of conventional sex therapy for treatment of rapid ejaculation (Althof, 2007; Waldinger, 2003). The SSRIs are also used in combination with anti-androgens to control paraphilic behavior.

The phenomenal amount of attention garnered by VIAGRA led to great interest in the development of a female equivalent (Hartley, 2006) and the introduction into the clinical lexicon of the new phrase, "Female Sexual Dysfunction" [FSD]. Pharmaceutical companies began to lay the foundations for a biomedical discourse of the nebulous FSD. Hypothesis after hypothesis was put forth as to the etiology and treatments of FSD. First came the mechanics and hydraulics hypothesis of FSD, suggesting that just like men, women needed more blood flow to their genitalia. In 2004, after eight years of research on the effects of Sildenafil with women, Pfizer withdrew Viagra from further clinical trials with females claiming that women, unlike men, were just too complicated (Harris, 2004). Thereafter, the hormonal hypothesis was promoted (Hartley, 2006; Moynihan & Mintzes, 2010). Ubiquitous "experts" spoke in the media as if it were a given that desire or lack thereof was a direct result of levels of testosterone. It came as a surprise to the lay public in December, 2004 when the FDA rejected unanimously Proctor and Gamble's bid to seek approval for Intrinsa, their proposed testosterone patch for low desire in women. Two studies released shortly thereafter affirmed the *lack* of correlation between androgen levels and female sexual desire (Davis, Davison, Donath, & Bell, 2005; Wierman, Basson, Davis, Khosla, Miller, Rosner, & Santoro, 2006). Next, the notion that desire is all in the brain was

popularized just as Palatin Technologies undertook clinical trials for their Bremelanotide nasal spray, while Boehringer-Ingelheim sought FDA approval for their prospective desire drug, Flibanserin. Twice, the FDA rejected Flibanserin. However, upon the third try – and after a controversial "even the score" campaign from its manufacturers – Flibanserin, now sold as Addyi, was approved in 2015 in the US. Three subsequent reviews and meta-analyses (Gao et al., 2015; Jaspers et al., 2016; Robinson et al., 2016) found it was not even as (in)effective as promised – an increase of 0.5 satisfying sexual events per month – by its manufacturers (currently Sprout Pharmaceuticals). Interestingly, the sales of Addyi have been underwhelming, leading to the withdrawal of the marketing approach with the promise of re-introduction and re-branding in 2019. Given the scale of enormous potential profits, new drugs remain in the pipeline though at present, the search for pharmaceutical solutions leaves much to be desired. The emphasis on biomedical interventions for sexual problems was also apparent in the use of Botox injected into the vaginal opening in combination with dilators for the treatment of vaginismus (Pacik, 2010).

It is noteworthy that with each of these new, biomedical interventions, the target of treatment was the symptom of the identified patient rather than on the system in which the difficulty was generated, situated and came to be perceived as problematic, thus marking a complete reversal of Masters and Johnson's original formulation of the nature and focus of sex therapy.

New professional organizations, often sponsored by the pharmaceutical industry, were formed and began to provide continuing education for physicians, especially gynecologists and urologists in treating sexual dysfunctions (see later). Although there is a serious need for physicians to be trained in the comprehensive care of patients' sexual difficulties (Frank, Coughlin, & Elon, 2008; Moser, 1999; Shindel et al., 2010), the instruction in many of these instances was largely about the high prevalence of sexual dysfunction and the need to be on the lookout for them, checklists to evaluate for their symptoms and pharmacological information. The psychosocial and interpersonal contexts in which problems are generated were largely overlooked.

In 1998, Irwin Goldstein, (the urologist who first introduced sildenafil citrate [1998]) founded the International Society for the Study of Women's Sexual Health (ISSWSH) which was made up primarily of physicians, rather than clinicians trained/identifying as sex therapists. (It had followed the establishment in 1982 of the International Society for Impotence Research, which subsequently changed its name and is now known as the International Society for Sexual Medicine [ISSM]. The vast majority of its members are urologists.) New journals, notably the *Journal of Sexual Medicine* (published by ISSM) were established. In 2013, three more journals devoted to medical aspects of sexual problems began publication: *Sexual Medicine, Sexual Medicine Reviews* and *Current Sexual Health Reports*. By contrast, the unfortunate demise in 2000 of the *Journal of Sex Education and Therapy* further illustrated the shift since the 1990s towards fragmentation of the field.

Responses to Medicalization

As the medicalization of sex therapy grew, so too did the developing resistance to and backlash against it. During the early 1990s, sociologists (e.g., Irvine, 1990; Jeffries, 1990; Reiss, 1990) had begun to criticize the field of sex therapy. They stated that the treatment of clients' problems, one-on-one without attempting to change the social environment in which these problems are generated, maintained and treated, allows clinicians to make a profit by helping individuals adjust to a troubled norm while sustaining the dysfunctional

status quo intact. In the successive years, sex therapists, too, began to question openly the tenuous, tacit assumptions built into our beginnings (Kleinplatz, 1996; 1998; 2003; 2012; Schnarch, 1991; 1997; Tiefer, 1991; 1996; 2001; 2012; Weeks & Hof, 1987). These shaky foundations made it easier for the field to be co-opted by reductionistic, biomedical models; correspondingly, they made it easy for the pharmaceutical industry to market treatments for sexual dysfunctions to clinicians and the lay public and to achieve "buy-in".

In 2000, in response to the growing medicalization of sexuality and sexual problems, a group of sexologists coalesced under the leadership of Leonore Tiefer and proffered an alternate diagnostic framework for conceptualizing sexual difficulties. The Working Group for a New View of Women's Sexual Problems (Alperstein, et al., 2002) recommended that all women's (and later, men's) sexual problems be assessed in terms of socio-cultural, political or economic factors; problems relating to partner and relationships; psychological and medical factors. The call for multi-dimensional approaches to assessing and dealing with human sexuality has been welcomed in some quarters (e.g., Ogden, 2006, 2018) and been dismissed as regressive, outmoded, "feminist" complaints by others.

As a result of these trends, the field has moved increasingly to splintering of the profession(s) (Kleinplatz, 2003; 2012). Although the demand for help with sexual problems continues unabated, the nature of the services provided often depends on which type of clinician with what type of training the client/patient happens to see. Perhaps more often, particularly in the United States, it is less a matter of happenstance and related instead to health insurance coverage (or lack thereof). It has been particularly disturbing that much health insurance will not reimburse consumers for couple therapy. Although the increasing emphasis on "empirically supported treatments" and "best practices" seems logical enough, the most expedient treatment with the most clear-cut effectiveness in reducing symptoms of sexual dysfunctions may not be in the patient's best interests in an area as complex as sexuality. Studies of pharmaceutical interventions may show impressive results when criteria for effective outcome are "more restricted and unidimensional" (Heiman, 2002, p. 74) than in studies of individual or couple therapy. However, most couples are seeking more than "erections firm enough for penetration" or to be free of "vaginal spasms preventing intercourse"; they are hoping for sex that is desired and worth wanting, a feeling of connection with their partners during sex and feelings of shared contentment thereafter (Kleinplatz, 2010; 2011; 2017; Kleinplatz, et al., 2018).

At this time, the treatment of sexual problems and concerns often occurs in a fragmented fashion, with a need for richer paradigms and more integrated clinical care. Although there have been calls for inter-disciplinary training for decades (c.f., Moser, 1983) numerous institutional obstacles, real or perceived turf wars, and the lack of a coherent, cohesive and multi-dimensional theoretical framework have impeded comprehensive care. The increased attention to symptoms of sexual problems in recent years presents clinicians with a remarkable opportunity to broaden the discourse around sexuality itself, to consider anew what men and women truly aspire towards as sexual beings, as partners and how we can help them attain their goals.

Professional Sex Therapy Associations

The oldest of the major North American sexology organizations is the Society for the Scientific Study of Sexuality (www.sexscience.org), founded in 1957, which focuses primarily on research into sexuality broadly rather than being limited to sex therapy alone. Its interdisciplinary membership of 700 or so sexologists consists largely of academics. The Society

for Sex Therapy and Research (www.sstarnet.org/) was founded in 1975 and has maintained a relatively constant membership of proximately 275 sex therapist/researchers whose primary focus is on sexual difficulties and treatment of them. The primary, international, credentialing body for sex therapists is the US-based American Association of Sexuality Educators, Counselors and Therapists (AASECT at www.aasect.org). AASECT was founded in 1967 and currently has approximately 2,800 members with an applied focus, of whom the majority are certified as sex therapists. In addition, sex therapists in Ontario, the most populous Canadian province, can be certified by the Board of Examiners in Sex Therapy and Counselling of Ontario (BESTCO). (See www.BESTCO.info) founded in 1975. There are approximately 35–40 BESTCO certified sex therapists at any given time. Although their model of training and evaluation and certification is not renowned outside Ontario, it probably deserves to set the standard for the profession (see later). As stated earlier, both ISSWSH and ISSM are comprised overwhelmingly of physicians who may treat sexual disorders in male or female patients respectively but who are not trained as nor identify as sex therapists.

The Personal and Professional Process of Becoming a Sex Therapist

Many students are curious about the process of becoming a sex therapist. Some assume that it must be a very glamorous field, with regular appearances on talk shows, in Cosmo or YouTube. Others assume that becoming a sex therapist mostly requires a hearty appreciation for the joys of sex. The reality is neither so gilt-edged nor so simple. Becoming a sex therapist requires first and foremost that one become skilled at individual and couple therapy. That is, the process of becoming a sex therapist presupposes prior training and expertise in psychotherapy per se. Only those who are adept at psychotherapy (and licensed accordingly within their jurisdictions, as discussed later, at least if they are seeking to be certified by AASECT or BESTCO) will qualify for training in sex therapy. This requires graduate or doctoral level training in one of the fields that licenses psychotherapists, typically, clinical psychology, social work, marital and family therapy or medicine. (Others are possible, too, e.g., graduate degrees in counseling, depending on the jurisdiction and possibility of licensure.)

Above and beyond one's qualifications and license to practice psychotherapy, prospective sex therapists require fundamental knowledge of sexology and advanced training in sex therapy. AASECT (see http://aasect.org/certification.asp) requires that candidates for certification as sexuality educators, counselors and therapists acquire at least 90 hours of course work covering such basics as the history of sexology, knowledge of sex research and literature, the anatomy and physiology of sexual response, developmental, socio-cultural and medical factors affecting sexual values and expression, gender roles, relationship issues, sexually transmitted infections and prevention issues, sexual abuse and its consequences, sexual orientation, sexual minorities, etc. In addition, prospective sex therapists require a minimum of 60 graduate course hours on sexual difficulties and how to deal with them in therapy. Among other things, this includes knowledge of the DSM sexual dysfunctions, gender dysphoria and paraphilias as well as the more common problems (e.g., sexual desire discrepancy, disappointment with sex, lack of "connection") that bring individuals and couples into the offices of sex therapists; the major intrapsychic, interpersonal, psychosocial and organic causes of sexual problems; theory and methods of assessment, diagnosis and clinical intervention (i.e., psychotherapeutic and medical) with sexual problems; models and methods of couples/systemic sex therapy; knowledge of the role of

the sex therapist in working with other health professionals, whether generalists or specialists; ethical issues and decision-making in sex therapy and techniques for assessment of outcome. In addition, the sex therapist requires specialized knowledge of how other clinicians' interventions (e.g., treatment of depression, diabetes, cardiovascular disease, cancer) affect, engender, or exacerbate sexual problems. My own therapy practice is sometimes dominated by the need to sort through the overlay/underlay of iatrogenic disorders that complicate and can even distract from the work of individual and relational sex therapy. The role of the sex therapist today increasingly requires skill at advocating for one's clientele with other health care practitioners who often have diminished time to investigate sexual problems or concerns. Sex therapists are also situated to advocate for sexual minorities within other systems.

Above and beyond didactic information, sex therapists are expected to complete several years of supervised, (via direct observation or audio/video recording) clinical training (generally at the post-graduate level) in the practice of sex therapy with a wide array of clients. These are to include therapy with individuals, couples and sometimes, groups, men and women, sexual minorities and learn to deal with a broad range of DSM disorders and other sexual concerns.

Both AASECT and BESTCO require that all certified members engage in a process of personal reflection and sexual values clarification. Sexual Attitude Reassessment (SAR) workshops, generally lasting a weekend or so, challenge participants to examine their own feelings, attitudes and previously untested beliefs about sexuality in all its diversity and complexity. SARs involve experiential learning processes in small groups led by trained leaders who encourage participants to become aware of their own philosophies of sexuality and sexology. Therapists are to be become aware of their own personal and professional limits and of the kinds of situations or clients they may not be ideally suited to serving well.

In addition to these requirements, BESTCO requires a three-year period of clinical training, supervision and attendance at all, twice yearly, two-day meetings, to become certified as a sex therapist. Thereafter, attendance at all meetings is a requirement for maintaining one's certification. Much of the sex therapy literature refers to a "biopsychosocial approach." Unfortunately, this is often merely lip service (McCarthy, Koman & Cohn, 2018; McCarthy & McDonald, 2009). By contrast, BESTCO meetings are truly interdisciplinary and are characterized by a remarkable atmosphere of mutual respect, collegiality and desire to learn from one another's experience and expertise. All BESTCO members must be full, clinical members of the American Association of Marital and Family Therapists or must otherwise document and demonstrate competence in couple therapy before being allowed to enter the three-year apprenticeship period. The primacy of skill in couple therapy and the heavily, interdisciplinary component make BESTCO unique within sex therapy associations. Although the primary theoretical orientation is systemic, there are psychodynamic, experiential and cognitive behavioral approaches, too. BESTCO also has the distinction of requiring a series of examinations, at least one of which entails a case presentation in front of the entire BESTCO membership, with written synopsis and bibliography, before one can be certified as a sex therapist.

Some practitioners are trained and certified as sex counselors rather than sex therapists. The major distinction is that sex counseling tends to be rather brief and focused on problem-solving around time-limited concerns (e.g., choice of contraceptives, safer sex practices, dealing with sexual assault) rather than more intensive psychotherapy. Sex counselors tend to be employed in such agencies as Planned Parenthood or work in the community as nurses, guidance counselors, etc., rather than in psychotherapy practice as such.

Both AASECT and BESTCO have increased their number of compulsory supervision hours and/or years of apprenticeship over the last five years. Ironically, the Internet has enabled would-be sex therapists to accrue continuing education [CE] credits of questionable value online; the ubiquitous advertising of online training towards instant "qualifications" in the field has led to renewed consideration of what it actually takes to become certified in sex therapy.

BESTCO began responding to this challenge in 2015 by convening an interdisciplinary, committee, Chaired by Victoria Winterton, MD, to delineate core competencies in sex therapy. The final document (in preparation) will be used in future supervision and examination procedures to assess trainees' readiness to become certified as sex therapists. Having served on this committee from the outset, I have been struck by the difficulty and complexity of identifying the essential skill sets and fundamental knowledge required for clinical practice. Our emphasis has been on assessment over treatment. If a trainee can articulate a coherent, theoretical rationale for delving into the factors that he/she considers crucial, a correspondingly consistent therapy approach stands to emanate from that perspective. Ironically, we have been tasked with finding what is at the essence of our field when professionals have behaved as though the field is atheoretical; as such, we have developed a cross-theoretical set of principles for assessment and clinical practice and hope that the resulting tool will contribute to closing the gaps in the field.

Ethical Principles of Sex Therapy

Sex therapists are expected to study and follow the codes of ethics of their respective disciplines. AASECT members are also required to adhere to the organizations' code of ethics for sex therapists (see http://aasect.org/codeofethics.asp). Issues such as integrity, confidentiality, clients' autonomy, dealing with therapist-client power differentials, and avoiding dual relationships are particularly salient in sex therapy, given the vulnerability that clients generally feel in revealing highly taboo and often hidden material. Similarly, ethical principles such as respect for diversity in values, sexual orientations, gender and sensitivity to human rights issues – each important in all psychotherapy – take on added dimension and importance in sex therapy.

Some lay people wonder if sex therapy entails talk therapy only or whether treatment will involve sexual contact with the therapist or even between the partners while in the therapist's office. In fact, no sexual contact between therapist and clients is permissible. While clients are often given "homework" assignments (e.g., sensate focus exercises) for the couple to share at home and then discuss during the following session, it would be unethical to have clients engage in sexual activity with the therapist present.

Some confusion may be a remnant of the sensationalistic publicity surrounding the early days of Masters and Johnson's work with surrogate partners. (The confusion and controversy were re-ignited by the 2012 film "The Sessions", which depicted an actual 1980s case of surrogate partner therapy with a severely disabled man.) Masters and Johnson believed strongly that effective therapy required a couple present and refused to offer individual therapy. When men presented for therapy alone, a surrogate partner was provided in order for these clients to engage in the accompanying homework. (Single women were presumed able to find their own sex therapy partners.) Masters and Johnson eventually gave up their work with surrogates out of fear of legal threats and possible repercussions. The use of surrogate partners has continued as an adjunctive component of some sex therapy although it is not widespread. Surrogate partners are now trained and

regulated by the International Professional Surrogates Association (IPSA). See www.SurrogateTherapy.org. These individuals are trained to work with sex therapists and their clients and have their own code of ethics. In all instances, they are to use touch appropriate to the client's needs as assessed by the sex therapist; it is incumbent whenever physical contact is used as any component of treatment for the therapist to justify the use of whatever touch is prescribed in terms of the standards of care and clinical goals appropriate to the case.

Is Sex Therapy a Distinct Modality? The Case for Certifying Professionals

Controversy has simmered over whether or not sex therapy is a distinct modality and therefore, whether certification of sex therapists should continue. In 2009, Binik and Meana called for the abolition of sex therapy certification. They argued that the theoretical basis of sex therapy was negligible and therefore the study of it, presumably the foundation for professional development in any field, was nonsensical. On this point there can be little dispute (Kleinplatz, 2003; 2012; Wiederman, 1998). Binik and Meana then argued that the psychotherapy techniques used in the treatment of sexual dysfunctions are hardly unique to sex therapy: The major interventions, including psychoeducational counseling, cognitive-behavioral homework assignments, learning of communication skills and bibliotherapy are used rather extensively for a wide array of purposes by other varieties of psychotherapists. There is no technique used by sex therapists that is unique to sex therapy alone. This reasoning too, is solid. Then what, if anything, makes sex therapy special? Binik and Meana would say that the time is well overdue to strip away the illusion of distinctiveness.

What makes sex therapy unique is the knowledge about human sexuality and sexology that practitioners must acquire during the training process. Unfortunately, this knowledge is increasingly difficult to obtain while misleading and flat out erroneous information about sexuality is ubiquitous, especially on the Internet. In North America, public and graphic discussion (and sometimes, display) of sex is omnipresent, and paradoxically, individuals feel increasingly alone with their sexual difficulties. The misinformation found on television the Internet and the magazines we see at check-out stands and in physicians' waiting rooms continue to scare people and leave them feeling sexually defective (Kim & Ward, 2004; Kleinplatz, 2013; Ménard & Kleinplatz, 2008). The media are replete with misleading stories about the role of technique in sexual fulfillment, gender differences in arousal, sexuality and aging, "normal" levels of desire, hormones, sexual orientation, etc. Ignorance and myths combined with the resulting fear, shame and sense of inadequacy are precisely why so many of us continue to have extensive waiting lists. Unfortunately, the same lack of knowledge found in the lay public pervades the ranks of clinicians; none of us is immune to the consequences of being raised in a sex-negative culture. It is precisely in order to counter these effects that it is compulsory for certified sex therapists to undertake the aforementioned coursework in the study of human sexuality and to attend a SAR.

In an ideal world, such course training would be unnecessary. Our childhood and adolescent years would prepare us for adult sexual relations, thus curtailing somewhat the need for help with sexual problems. Family or school-based sexuality education could be relied upon to combat the entertaining but fictitious and ludicrous images of sexuality that pervade Internet pornography. Or failing that, given the crucial role of sexuality in personal wellbeing, all mental and medical health care providers would naturally receive considerable training in sexology in the course of their undergraduate and graduate

schooling; they would then be prepared to help clients/patients deal with their sexual difficulties. Not only is that not the case at present, but the cutbacks to training in human sexuality in recent years have made the required knowledge increasingly and abysmally inaccessible within medical schools and within clinical psychology programs (Burnes, Singh, & Witherspoon, 2017, Miller & Byers, 2009, 2010). That means that we cannot rely on the garden variety mental health or medical professional to know much about human sexuality and its problems. Such a clinician cannot be expected to be comfortable or skilled in responding to and dealing with the full array of complex clients'/patients' sexual problems or concerns, let alone broaching them in therapy.

As such, the major purpose of sex therapy certification remains consumer protection. Most certified sex therapists can rattle off a series of horror stories, where we have been brought in to take care of the casualties produced by other, duly licensed health care providers: the woman who is told she will need long-term therapy because she is unable to reach orgasm during intercourse; the "impotent" man who is treated for the childhood origins of his fear of women when he has not been assessed until too late for diabetes mellitus; the woman who is given some lubricant for her lack of arousal when in fact, her relationship is so filled with vitriol she should be advised to listen to the wisdom of her dry vagina; the couple who are distressed about their sexual desire discrepancy are told to "just compromise", when sex is merely the battleground for far more complex power dynamics; the infertile couple who are told to "just relax" when they find themselves paralyzed by the rigors of infertility treatment, and the list continues …

More frighteningly, because "sex therapist" is not generally a registered title – with only two notable exceptions in North America, that is, in the state of Florida and the province of Quebec – anyone can advertise him/herself as having an interest/expertise in treating sexual problems or even claim to be a sex therapist. In such instances, clients/patients assume they are in competent hands when there is no assurance of any skill, knowledge base or clinical training to correspond with the clinician's claims. (And of course, sometimes, those advertising their willingness to deal with sexuality are not clinicians at all and are offering an entirely different service.) Thus, whereas we should hope with Binik and Meana that certification in sex therapy will ultimately become unnecessary (2009), at this time, certification serves to protect the public from ignorant, incompetent and unscrupulous "health care" providers.

Conclusions

Sex therapy provides a wonderful and deeply meaningful professional life. Sex therapists serve clients/patients who are searching for more sexual pleasure, fulfillment and intimacy. Given that sexual wishes, hopes and fantasies touch the core of human existence, sex therapy can prove profoundly rewarding. We serve the public uniquely, in that fewer mainstream, individual and couple therapists have the knowledge base, skill, training, and especially comfort level to deal in depth with complex sexual problems. More importantly, sex therapists are privileged with the opportunity to help people attain their most cherished and unspoken dreams, working not only to alleviate sexual disorders and dysfunctions but to allow couples to experience their own erotic potentials (Kleinplatz, 1998; 2004; 2006; 2010; 2016; Kleinplatz, Paradis, et al., 2018; Ménard, et al., 2008).

Resources

To locate a Certified Sex Therapist:

- American Association of Sex Educators Counselors and Therapists: www.AASECT.org
- The Board of Examiners in Sex Therapy and Counselling of Ontario: www.BESTCO.info

Major Sexology Associations and Opportunities for Continuing Education:

- American Association of Sex Educators Counselors and Therapists: www.AASECT.org
- Canadian Sex Research Forum: www.csrf.ca
- Society for Sex Therapy and Research: www.sstarnet.org
- The British Association for Sexual and Marital Therapy: www.basrt.org.uk
- The Society for the Scientific Study of Sexuality (SSSS): www.sexscience.org/

Distributors of Sex Toys and Educational-Sexually Explicit Videos:

- A Woman's Touch Sexuality Resource Center: www.sexualityresources.com
- Come As You Are (An especially useful resource for sex toys and aids for the disabled as well as the able-bodied): www.comeasyouare.com
- Good Vibrations: www.goodvibes.com

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3

WHAT EVERY SEX THERAPIST NEEDS TO KNOW

Jane Ridley and Nancy Gambescia

Introduction

Society is going through a period of rethinking and re-evaluating, which is destabilizing as well as energizing. Many individuals, couples and families are seeking help to find a healthier and improved approach to their lives. Also, individuals are finding their place within the complexity of relationship styles and sexual identities that are now more palpable within society. It is urgent today that more psychotherapists are trained systemically as current societal changes reach far beyond the individual client system.

Western society is becoming a multi-cultural, multi-ethnic, multi-religious blend where attention to and an understanding of each other's family and culture of origin is essential. Rapid cultural changes are enabling individuals to speak more openly about aspects of their personal lives, which previously would have been kept private or indeed secret. This may include the impact of sexual or abusive experiences upon the lives of our clients in addition to questions about their core gender identity and gender orientation. Often such experiences have left individuals feeling damaged, scarred or vulnerable. The "Me Too" outcry is also impacting individuals, relationships and the culture of the work place. More than ever, individuals are sharing past and present experiences of sexual harassment, assault and abuse.

Lesbian, gay, bisexual, transgender (LGBT), and genderqueer (not subscribing to conventional gender distinctions) individuals are seeking major changes in attitudes within society related to the complex issues of gender fluidity. Indeed, the very language we use is being challenged. For example, "Kink" is a term now commonly used to describe any type of sexual behavior previously considered unconventional (Hall, 2018). Within the context of a therapeutic relationship, one must be sensitive to these aspects of our client's lives. More specifically, the therapist must have a good working knowledge of the forms that gender, sexuality and relationships can take. This involves a greater understanding of issues relating to clients with diverse identities as well as therapists identifying and resolving their own personal biases (Davies & Barker, 2015). Within such a fluid environment it is essential that highly trained systemic therapists are available to provide a "safe space" within which clients can find their own personal direction.

Additionally, the therapist must be able to navigate the ever-changing world of technology, the medicalization of psychotherapy, neuroscience, biology and genetics. In such a changing world, a sex therapist needs to be resilient, flexible, and capable of adjusting to new learning and at the same time be firm about their own and others' boundaries. The

demands are not just academic but also occur legally, ethically and personally. Personal questioning by the therapist will occur in a variety of contexts: the self, motivation for interventions, one's own sexual orientation, moral and social codes, prejudices, and excitements. New thoughts, feeling and fantasies are likely to emerge, which may be troubling as one's current moral or ethical code, will be questioned. It is essential that therapists allow themselves to monitor and share reactions with supervisors and colleagues. Learning to respond to the clients' world with empathy and without judgment is stretching and enriching. A central aspect of being a sex therapist is one's own curiosity, openness, and preparedness to learn, without prejudice.

A sex therapist is also a citizen and as such is constrained by the laws and codes of ethics of professional associations relating to sexual behavior presenting the therapist with increasingly difficult personal, moral, ethical and therapeutic dilemmas. Ethical, religious or social attitudes towards sexual behaviors, such as masturbation, pornography, homosexuality or pre-marital sex, can conflict with "therapeutic interventions" considered to help the client. Moreover, the sex therapist is challenged about how to report rape, sexual abuse, the use of the Internet for grooming of children, or downloading explicit sexual material relating to children. In addition, guidelines designed to assist the therapist in making a diagnosis can cause concerns. For example, there continues to be considerable debate regarding the accuracy of the *DSM-5* (American Psychiatric Association, 2013).

Less controversially, the sex therapist must have a clearer knowledge of the anatomy and physiology of male and female sexuality and the sexual response cycle. The impact of life events and aging upon sexuality must be understood within an historical context of the individual, couple, family, or social network, as well as ethnic or religious affiliations. Physical and mental health, the use of drugs or alcohol, domestic violence, previous sexual or emotional abuse, traumatic experiences all have an impact upon an individual and, consequently, a couple's sexual life. Specialist knowledge and skills need to be learned to work with these client systems. The pressure to seek evidence-based therapeutic approaches to sex therapy continues. Cognitive-Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Mindfulness based therapies are viewed as significant therapies, which can target and treat traumatic experiences effectively. These need to be understood and integrated into any approach to sex therapy.

Unravelling the interaction between organic, individual, relational, social or environmental factors can make the therapist feel part of a tangled web with few boundaries. These skills depend upon an awareness of the complex interaction between the physical aspects of sexuality and the individual's internal and external psychological world as well as the social network surrounding the individual or couple. Thinking and working systemically greatly facilitates this process. The current helpful therapeutic focus on mindfulness seems to be a creative response to this complexity (Brady, 2013; Burch & Penman, 2013).

The Search for Guidelines

The demands of the professional within this ever-changing environment are great. Moreover, therapists are increasingly faced with ethical and legal questions. It is expected that the sex therapist demonstrates intelligent openness to learning, an ability to be empathic with individuals with diverse backgrounds and orientations, an awareness of one's own gender and sexual orientation and an acknowledgment of one's personal needs, prejudices and political stance. At the same time the therapist should be able to respect the autonomy of the client. In Great Britain and the United States, codes of ethics are clearly spelled out

in the College of Sexual and Relationship Therapists (COSRT) and the American Association for Sexuality Educators, Counselors and Therapists (AASECT) respectively (www.cosrt.org.uk; www.aasect.org). Both professional organizations clarify and emphasize that the right to self-determination of the client is a core value.

Another guideline for the psychotherapist is the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013). In this text, the therapist is asked to make clinical judgment calls about psychiatric diagnoses. First, "clinically significant distress" has been re-emphasized as crucial to the diagnosis and treatment of sexual difficulties. Never before was level of distress taken so importantly. For example, where a woman is not distressed by her lack of interest in a sexual relationship, but her partner is, what judgment does the therapist make? It is important to note that much previous research did not pay attention to the level of distress. Second, the importance of clinical judgment is also stressed, for example, is there sufficient stimulation as judged by the clinician when asking about sexual disorders? It is not sufficient to simply check off the symptoms in the diagnostic criteria without noting other specifiers and contributory factors. Clinical training is required to recognize when signs and symptoms exceed normal ranges.

Sex Therapist as a Citizen

A sex therapist is also a citizen, and, as stated, is constrained by laws relating to reporting knowledge of acts of sexual abuse as relating to children. Children are now more protected by laws, which therapists need to both understand and respect, as the welfare of the child is paramount and that safeguarding children is everyone's responsibility. Some of these individuals will certainly be engaged in psychotherapy, whether they identify as victims or abusers. The sex therapist needs to understand the laws sufficiently to know what constitutes sexual assault, for instance, which may vary from country to country and state to state. Sexual assault is actually harder to define than you think. According to the United States Department of Justice, sexual assault is "any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent" (www.justice.gov/ovw/sexual-assault). Such complex legal issues are increasingly becoming part of the sex therapist's everyday world, and need to be understood as a citizen and a therapist who assumes certain legal responsibilities.

Therapist Resilience and Client Reactions

In such a changing world, the sex therapist needs to be resilient and flexible, able to adjust to new learning, and be prepared to question their judgments, prejudices or political opinions. An inevitable aspect of increasing knowledge regarding sexuality, and the rich variety of sexual life styles and sexual behavior, is the challenge this provides to training and experienced therapist's sense of self. During the process of acquiring more knowledge about sex therapy, troubling thoughts, feeling and fantasies may emerge. Guilt, excitement or shame accompanied by powerful sexual thoughts or wishes may be intertwined, sometimes distressingly. It can feel like an overwhelming experience.

Part of this process of doing sex therapy is acknowledging that the client will, at the same time, be learning about and reacting to the therapist. Clients will be noticing and judging therapist responses and attitudes, and will have feelings or fantasies towards the therapist. The therapist rapidly becomes a part of the client's system, and how clients

perceive the therapist will influence the outcome of therapeutic work together. Being open to the client's reactions is sometimes a scary learning experience, but is ignored at your peril.

Approach to Therapy

Historically, sex and relationship therapy developed down separate theoretical routes (Ridley, 2006). More recently, there has been a movement towards an integrative approach enabling therapists to select, from the rich range of theoretical options, the approach most suited to each particular client. Crowe and Ridley (2002) describe a hierarchy of alternative interventions which offer the therapist guidelines on why and when to choose which approach, and when it may be useful to move up or down the hierarchy during therapy to an alternative intervention. Weeks and Hof (1994; 1995) utilized the Intersystem Approach for this purpose. The impact of newer knowledge regarding biology and genetics, imaging and research into cognition are adding layers which, as the information becomes more concrete, can be included within an integrative and systemic approach (Kraly, 2006).

Clarity about the therapist's use of theory, and the ability to move between theories is an essential skill and a component of the Intersystem Approach (Weeks, Odell, & Methven, 2005). Throughout this book the Intersystem Approach is used when assessing the impact upon the individual's sexual function, the interplay between their psychological makeup and the interpersonal and social environment one inhabits. This parallels Crowe and Ridley's (2002) assessment framework.

Sexuality and Sexual Behavior: Changing Social Norms

If one accepts that society is experiencing rapid change, then the concept of norms becomes increasingly complex, particularly when focusing on specific individuals, couples or families. One learns from clinical experience that sexual behavior is affected by changing family values and social or religious beliefs, taboos and anxieties, and also by the stress which change brings. Clients may ostensibly reject their religious upbringing, but the social norms e.g. habits, customs, beliefs or taboos which they rejected, are often deeply ingrained in their psyche and do still affect their behavior. A strange mixture of change and stability co-exist in this uncertain world. Over time, however, attitudes about sexuality have been slowly changing, such as the acceptance of same sex behavior was increasing in the general population (Mercer et al., 2013).

To illustrate changing norms and the contradictions set up in society, consider the fact that in 1973 the American Psychiatric Association ceased to consider homosexuality as pathological, declaring homosexuals as "normal" or at least as normal as heterosexuals. The category, homosexuality, was removed from the *DSM-II* (American Psychiatric Association, 1973). This redefinition of homosexuality "undermined laws, civil commitment procedures and the practice of therapy itself" (Nichols & Shernoff, 2007, p. 393).

Wellings and Johnson (2013) reveal major changes in sexual norms over the last century, including earlier onset of sexual activity, increasing numbers of older people who are sexually active, and weakened links between sex and reproduction. More recent research reveals the later onset of sexual activity in American adolescents. In seven large, nationally representative surveys of U.S. adolescents, fewer adolescents in recent years engaged in sexual behaviors, such as sexual intercourse (Abma & Martinez, 2017; Twenge & Park, 2017) perhaps because digital sexual behaviors, such as sexting, were not assessed.

Another changing social norm is observed by in the *National Survey of Sexual Health and Behavior* (Herbenick, et al., 2010) In this study, an increasing percentage of women reported having had an orgasm at their most recent sexual event. If these statistics remain consistent, there may be a new norm regarding frequency of orgasm for women.

Newport (1997), who examined the social norms writes, "The concept of a norm is mysterious because it refers to a concept which exists 'out there' as part of culture, but is something which generally, unlike laws, for example, is never written down or codified formally" (p. 1). When examining social norms, it is important to remember that disapproval of behavior does not mean that people refrain from it. Adultery is still one of the most widely cited grounds for divorce in Great Britain. Physical sexual exclusivity may be more important to women than to men, although paradoxically men may expect their partners to be faithful to them (Ridley 1999; Wellings, Field, Johnson, Wadsworth & Bradshaw, 1994).

Sexual Minorities

Kinsey and co-workers (1948; 1953) were among the first to study and publish material regarding sexuality in America between 1938 and 1952 and opened up sexual behavior as an appropriate area for scientific study. The controversial yet popular Kinsey Reports demonstrated the fluidity of sexuality, finding that sexual behavior, thoughts, and feelings towards the same or opposite sex were not always consistent across time. As stated previously, the reversal of homosexuality as a mental disorder created another major shift in social norms.

The legal acceptance of gay and lesbian long-term relationships in the United Kingdom through the *Civil Partnership Act* (2004) was based on and respected changes in the perceptions of sexual behavior in Britain. Under the Act, same-sex couples can register a civil partnership, which has almost the same legal effects, rights and obligations as marriage does for heterosexual couples. The *Marriage (Same Sex Couples) Act*, which allows same-sex marriage in England and Wales, was passed by the Parliament in July 2013 and enforced in 2014 according to the Government Equalities Office. The Supreme Court legalized same-sex marriages in all of the United States in 2015 requiring all states to issue marriage licenses to same-sex couples (Chappel, 2015). Legalization of same-sex marriages was perhaps the most obvious sign of changing social norms towards the acceptance of same sex relationships.

Another area of controversy regarding sexual norms involves the right of individuals to engage in specific sexual practices. Much of the resistance to the acceptance of anal or oral sexual contacts between consenting adults in private tend to come from church organizations or affiliations. Both American and British data indicate that around 25% of heterosexual couples have had anal intercourse, and suggest that, "oro-genital contact may be experienced by increasing proportions of those who have not yet had vaginal intercourse … as a risk reduction strategy in the face of AIDS" (Wellings, Field, Johnson, Wadsworth, & Bradshaw, 1994, p. 157). It is noteworthy that "stimulating the rectum, could add to the quality of orgasm" for women, and may account for the "experience of orgasm in men receiving mechanical stimulation of the prostate during anal intercourse" (Komisaruk, Beyer-Flores, & Whipple, 2006, pp. 7–8). This is one of many aspects of sexual behavior demonstrating that norms are complex, difficult to define, and constantly change with blurred boundaries (Popovic, 2005; 2006).

Professional organizations can also be at odds with what society accepts. Paraphilias for example, as defined by the American Psychiatric Association are "intense and persistent

sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" causing "distress or impairment" (American Psychiatric Association, 2013, p. 685). Are we therefore to assume that unless there is clinically significant distress, paraphilias can be placed within the normal spectrum of human behavior?

The Aging Population

By the year 2030, nearly 20% of people in the United States will be 65 years or older (Bradford & Meston, 2007). Worldwide, adults 60 and over are the most rapidly growing population (World Health Organization, 2002). Many myths and misconceptions inhibit the understanding the sexual needs and desires of this population (Hodson & Skeen, 1994). Contrary to some myths, the sexual life of the older couple may slow down but continues into late age. It is understandably, dependent upon factors such as the availability of a partner, and the impact of illnesses and the medications used to treat them. Normative sexual changes, which do occur, affect men and women slightly differently.

Sexual norms concerning the aging population are changing gradually with the help of the aforementioned statistical data and dissemination of accurate information about sexuality and aging by organizations such as American Association of Retired Persons (AARP), a foundation that offers financial and informational support to seniors in the United States (www.aarp.org). Age UK, a British charity for older persons, has an informative web page, "Sex in Later Life," which explains normative age-related sexual changes and sets correct expectations about the sex lives of older persons. See www.ageuk.org.uk.

The sex therapist will encounter prejudice and misinformation in clients and will need to offer psychoeducation about typical changes of aging and sexuality. The therapist must be on guard against their own biases regarding aging. Myths about sexuality and aging and a lack of awareness of the needs of the older person, can compromise the therapeutic alliance.

Sexual Abuse, Rape, Domestic Violence

Until the 1960s, sexual abuse of girls and its impact on their future sexual selves and sexuality was rarely discussed (Jehu, 1988). Greater awareness, often through clinical experience, enabled the issue of the abuse of males to be raised. Within the context of a discussion about norms, what does this mean? Was sexual abuse seen as an acceptable aspect of family life until the twentieth century? Do rape and domestic violence fall into this same category? Such dilemmas are part of the role of a sex therapist and can be difficult to resolve.

The *DSM-5* (American Psychiatric Association, 2013) has clarified that rape is not a mental disorder but is a crime (Allen, 2013). There are those who still do not wish to accept that rape is a crime. Many keep silent about personal experiences of rape or violent abuse, as they do not trust that authority figures, or family, will be supportive. Genital mutilation is illegal within Britain, but is still performed within some British cultural groups and is often understood as a necessary religious or "circumcision ritual" providing the therapist with real ethical dilemmas within therapy. Slowly change is occurring and although genital mutilation was made illegal in 1985 with laws being expanded in 2003 and 2015, the first ever prosecution of a mother genitally mutilating her daughter occurred on March 8, 2019 at the Old Bailey in London (Drearden, 2019).

Tiefer (2002) questions the way sexuality has been understood and corralled by "experts who know a lot about the body mechanics rather than those who understand learning, culture and imagination" (p. 134). She prefers to understand sex as an aspect of human potential, but its interpretation within each society as a social construct. She also wonders whether sex is a talent such as music or mathematics and writes, "to insist that everyone is equally talented at sex is fraudulently democratic" (p. 156). Her view of normality is challenging and well worth thinking through. For the sex therapist working with clients whose norms are not their own requires sensitivity, which is respectful of the client.

Conceptualizing Sexual Difficulties

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association has been evolving since the first publication in 1952. The criteria for sexual dysfunctions reflect both the norms and new scientific studies and have changed dramatically throughout the years, mirroring advancements in the understanding of sexual disorders (IsHak & Tobia, 2013). Earlier sexual diagnoses were based on the linear model of the sexual response proposed by Masters and Johnson (1966) and refined by Kaplan (1974). Subsequent research questioned the strict distinction between phases of the sexual response, particularly for women. *The DSM-5* corrected for the previous inaccuracies and attempted to refine sexual diagnoses based on the most current research (American Psychiatric Association, 2013). For women, the *DSM-5* has combined sexual desire and arousal disorders forming a new diagnostic category, Female Sexual Interest/Arousal Disorder (FSI/AD). Another diagnosis, genito-pelvic pain/penetration disorder, now combines vaginismus (painful spasmodic contraction of the vagina in response attempts at penetration) and dyspareunia (sexual pain) (American Psychiatric Association, 2013). Binik, Meana, Berkley and Kalifé (1999) argue cogently that sexual pain is not about sexual problems but more related to pain and fear of pain and should be treated as such. Low or absent desire in men, called Hypoactive Sexual Desire Disorder (HSDD) is now classified as a diagnosis only for men, Male HSDD. Male orgasmic disorder was changed to delayed ejaculation, the "male" adjective was dropped from erectile disorder, and premature ejaculation remains unchanged. Male dyspareunia does not appear in the sexual dysfunctions chapter of the *DSM-5*. Finally, sexual aversion disorder was deleted from the sexual dysfunctions chapter of the *DSM-5* (American Psychiatric Association, 2013). See IsHak and Tobia (2013) for a review of *DSM-5* changes in diagnostic criteria for sexual dysfunctions.

Some clinicians and researchers prefer the use of the International Classification of Diseases (ICD), instead of the *DSM*. The World Health Organization, which produces the *ICD*, utilizes samples from large multicultural global populations. Many clinicians and researchers feel the changes proposed in the forthcoming *ICD-11* will be more empirically valid than those in the *DSM-5* (American Psychiatric Association, 2013).

The changes to the nomenclature and controversies over sexual diagnoses reflect changing trends in the field of sexology and efforts to better describe sexual problems based on available empirical research. The sex therapist must stay current with the evolving trends and research in sexual function and dysfunction. A thorough assessment and proper diagnosis of the client, or client system, is essential. It is the basis of the treatment plan and therapeutic approach chosen. For the new recruit into sex therapy, or for the experienced therapist seeking more training, the present discussions are invigorating, if also confusing.

The Sexual Response Cycle

Masters and Johnson's (1966) study of human sexual response cycle is a landmark in the understanding of male and female sexuality, built upon by succeeding clinicians and researchers. They set the direction that sex therapy would travel for many years. An appreciation of the anatomy and physiology of sexuality is necessary but undue emphasis has led to a mechanistic view of sexuality. Focussing upon the context and complexity of sexuality helps to avoid this. Sexuality cannot be separated from the total environment within which the individual or couple inhabit. Their social, religious, ethical, community and familial systems and individual makeup, will all have an important influence upon their understanding of and response to sexuality.

Four Phases

Masters and Johnson (1966) divided the sexual response cycle into four specific phases through which the individual progresses from excitement, to plateau, orgasm, and finally resolution. Significantly they described this as a "purely arbitrary design" which "is inadequate for evaluation of finite psychogenic aspects of elevated sexual tensions" (1966, p. 7). Women are described as "having the response potential of returning to another orgasmic experience from any point in the resolution phase" which they describe as the "multiple orgasmic expression" (1966, p. 65). Although aware of male/female differences, these tend to get lost in their excitement at discovering "similarities, not the differences" (1966, p. 8) between the male and female sexual response. These overlooked gender differences in the sexual responses of men and women were later addressed by Basson (2007) and Ridley (1999) while Petersen and Hyde (2011) suggested we may be making too much of these differences.

Male/Female Similarities and Differences

In both men and women, Masters and Johnson (1966) described two principal physiological changes throughout the four stages. These changes are similar in both genders: increase in blood flow to various parts of the body (vasocongestion), and an increase in muscle tension (myotonia) leading to orgasm. Detailed genital and extra-genital physiological changes in the female or male were noted as they moved through the phases of the cycle.

In terms of gender differences, Masters and Johnson (1966) went to some lengths to emphasize that, although the clitoris and penis are anatomically similar, the clitoris does not respond as quickly as the penis to stimulation whether direct or indirect. Moreover, they pointed out the need for the clitoris to be stimulated to enable female orgasm. The vagina was studied with similar intensity. They found that as excitement continued vaginal lubrication occurred on the walls of the vagina somewhat like sweat forming on the skin. This lubrication made penetration easier and avoided pain associated with a non-lubricated vagina. They commented that psycho-sociological pressures have played a trick upon the two genders: fears of performance in the female about achieving orgasm, and in the male towards erection. Their work eventually identified erectile and ejaculatory problems for men and problems relating to penetration and orgasm in women. These became categories established within *DSM-III* (American Psychiatric Association, 1980). This distinction had the two-fold impact of having sexual problems taken seriously, while emphasizing the medical and physical aspects of sexual arousal without attending to the psychological dimension of sexual desire.

The Significance of Desire

Kaplan (1974, 1995) challenged Masters and Johnson's focus on the physiology of sex adding the crucial dimension of sexual desire. She believed, as a result of her clinical experience, that Masters and Johnson had missed this first and critical phase of the sexual response cycle, and thus ignored sexual problems relating to desire. As a result, Hypoactive Sexual Desire disorders were included in *DSM-III* (American Psychiatric Association, 1980). While the state of sexual desire, or lack thereof, remained a focal point of diagnosis in men, eventually the concept of sexual desire in women was replaced by the term, "interest" in 2013 when the *DSM-5* instituted the new diagnosis, FSI/AD (American Psychiatric Association, 2013). The empirical data supporting this merged disorder are in the early stages of development.

The Complex Female

An intense and fascinating debate is occurring, regarding the complexity of female sexuality. Beverly Whipple has carried out detailed research into the nature of the female orgasm, best summarized in Komisaruk, Beyer-Flores, and Whipple (2006). Their study offers us the first detailed scientific analysis of all aspects of the female orgasm. While Whipple and her associates were more interested in the anatomy and physiology of female orgasm, another researcher was more interested in the nature of female desire and sexuality. Basson (2002, 2007) and Basson et al. (2003) sought to redefine the nature of female sexuality, with emphasis on the sexual interest, motivation, arousal and pleasure. The non-linear model developed by Basson assumes that women approach sexual encounters from a position of neutrality. If they are comfortable with the level of intimacy in the sexual encounter, they may move to a position of receptivity to sexual activity, sexual desire, and arousal and orgasm if desired (Wylie & Mimoun, 2009). Men and women experience these phases of the sexual response quite differently.

The Dual Control Model

The Dual Control Model provides a useful biomedical theoretical framework with which to understand much of the variability in the human sexual response. Originally, this model was used to explain problems of sexual control such as premature and delayed ejaculation in men (Bancroft & Janssen, 2000). Theoretically, two opposing systems constantly fight to control and balance sexual arousal. The sexual excitation system promotes sexual arousal, and the sexual inhibition system impedes arousal. Later, when scientific investigations involved women, researchers found significantly higher levels of excitation in men and inhibition in women (Bancroft, Graham, Janssen, & Sanders, 2009). Women are more likely to express inhibitory factors relating to lack of trust and concerns about sexual functioning. Finite conclusions are difficult to draw but the concepts of an inhibitory system, which may work against the excitatory system, certainly resonate with clinical experience.

Balancing Medical Aspects of Sexuality

An over-emphasis upon the physical and medical aspects of sexuality can develop in both the client and practitioner (Hart & Wellings, 2002; Tiefer, 2002). When sexual difficulties are viewed as an illness or purely physical, a medical solution is usually sought. Within the

Intersystem Approach to psychosexual therapy, the aim is to look beyond the immediate physical/medical options and take into account environmental, social and relationship difficulties, which may have an impact. Clinical experience suggests that men often prefer to seek a "pill" as a solution, rather than looking at social or relationship questions. The arrival of Viagra and similar prosexual drugs has provided such an opportunity (Ashton, 2007) and has improved many men's sexual lives. Personal or interpersonal difficulties emerge later if the oral medication is not effective, in some cases unmasking personal and interpersonal difficulties. The pill may "fix" the erection but does nothing to heal a broken relationship.

A search for a drug for women with low libido has resulted in the eventual approval by the United States Food and Drug Administration, in 2015, of pill that purports to increase sexual desire in women. This medication, Addyi®, has recently been used by women to address the biological aspects of sexual desire with mixed reviews. It has come under considerable dispute regarding research methods prior to release, questionable efficacy, and a high side effect profile (Jaspers et al., 2016).

Read and Mati (2013) draw attention to drug companies using their financial might to manipulate public and professional opinion by promoting the idea that the right pill can remedy any sexual problem. Illnesses such as depression, diabetes or heart disease can have a serious impact upon the quality of life, including the sexual life. Essential medication can treat the illness but may impact negatively upon sexual abilities. Working with clients to find an appropriate balance between these conflicting elements requires an ability to take seriously the physical and medical circumstances faced by each client, and the impact medication may have on sexuality. It often requires the therapist to work closely with medical colleagues, and over-time developing a collaborative approach so that the clients receive the most appropriate help.

Conclusion

This chapter has emphasized the fluid nature of society today, with many changes occurring at a rapid pace. When considering a career as a sex therapist, whether as a novice or experienced practitioner seeking specialization, you may want to ask yourself if you can accept the personal and professional challenges this field presents. Wanting to help is not good enough. A wide knowledge base must be learned during which your value system and prejudices will be challenged. As new knowledge is learned you will again be asked to review your previous and long held beliefs about sexuality and conscious and unconscious assumptions that are expressed through your work. The practice of sex therapy requires openness to new experiences, flexibility in one's treatment approach and firm ethical boundaries. The easy availability of sexual knowledge and/or sexual behavior displayed on the Internet often means that clients have "new experiences," which can be unsettling for them and for you. This may test your ability to understand the client's reactions, especially to ideas or images that are out of the norm. Examining your own emotional and sexual responses under supervision will become part of your regular routine. Understanding the multi-layered interaction between the inner/outer world of the client, client system, modern technology, and the wider social context may involve setting aside previously held perspectives. Acknowledging the limits of one's knowledge and skill will help the therapist seek advice or consult with other therapists or specialists when necessary.

Being prepared to question attitudes as to what is normal, to value others whose way of life is different from your own, to learn from good research and evidence based practice,

to practice within the law, however complex, and to collaborate with medical and psychiatric specialists while continuing to value the whole person can test us all: but these are essential requirements of a sex therapist.

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4

MALE HYPOACTIVE SEXUAL DESIRE DISORDER

Kathryn Hall

Introduction

"L'appetito vien mangiando"
Appetite comes as you eat.

(P.C. a client reciting an old Italian adage)

Helen Singer Kaplan (1979) and Harold Lief (1977) added a phase of sexual desire to the human sexual response cycle described by Masters and Johnson (1966). Since that time, there has been a growing recognition that sexual desire is not simply the prerequisite phase of sexual responding, but rather a complex phenomenon all on its own. Sexual desire is variously described as a motivational state, a physiological reaction, an emotional or cognitive condition or some combination of these (Regan & Berscheid, 1996). Clinicians and researchers now discuss responsive versus spontaneous desire (Basson, 2001), dyadic and solitary desire (Dosch, Rochat, Ghisletta, Favez & Van der Linden, 2016), as well as an acknowledging that desire functions differently in different stages of a relationship (Mark & Lasslo, 2018). Levine (1987) described desire as the energy brought to sexual behavior that not only precedes sexual arousal but also accompanies arousal throughout sexual activity. Levine notes that male desire is dependent on contextual cues, situational and relationship factors and level of stress. Men's sexual desire is often purported to be stronger in intensity and frequency than women's desire (Baumeister, Catanese & Vohls, 2001) but others have argued that male and female desire, while sharing many similarities (Janssen, McBride, Yarber, Hill & Butler, 2008) may also be qualitatively different (Wallen, 2000).

Men who have little or no desire for sex may be diagnosed with Hypoactive Sexual Desire Disorder, or HSDD. According to the fifth edition of the Diagnostic and Statistical Manual (*DSM-5*) (APA 2013) the following four conditions must be met for a diagnosis of HSDD:

1. Deficient or absent sexual thoughts or fantasies.
2. Deficient or absent desire for sexual activity.
3. Must be of six months duration or longer.
4. Must cause clinically significant distress.

Interestingly, the severity of this disorder is classified not by the deficiency of the desire, but by the level of distress the disorder produces – mild, moderate or severe. HSDD may

be of lifelong duration or acquired, which presupposes a period of "normal" sexual desire. HSDD is further divided into generalized or situational subtypes, the latter referring to men who experience desire in some situations (e.g., masturbation, internet pornography, extra-marital relationship) but not in others (e.g., with spouse or long-term partner). HSDD that is both acquired and situational is generally considered to be the most common subtype of the disorder (Brotto, 2010; Maurice, 1999), leading Meana and Steiner (2014) to suggest another meaning for HSDD – hidden sexual desire disorder. They coined this term to refer to men who have high levels of sexual interest for partners or sexual activities that are outside the bounds of their committed relationship and which are kept secret from their partners. An example of acquired and situational HSDD would be a preference for masturbating to internet pornography, or an extra marital affair. McCarthy and McDonald (2009) describe a similar pattern for primary (lifelong) HSDD in which they note:

> The core issue is usually a sexual secret. By order of frequency, this includes; 1) a variant arousal pattern (deviant arousal is much less common); 2) a preference for masturbatory sex rather than intimate couple sex; 3) a history of poorly processed sexual trauma; or 4) a conflict about sexual orientation.
>
> (p. 59)

Low frequency of sexual activity is not considered a diagnostic marker for HSDD as sexual activity, especially partnered sex, is affected by factors other than desire (religious beliefs, partner availability, relationship factors, health).

More recent research has looked at dyadic and solitary sexuality as being related to different sexual and psychological processes. Dyadic sexuality is likely to encompass not only sexual desire, but also the desire to express love or to improve intimacy or enhance self-esteem. Solitary sexual activity may involve not only a motivation for sexual release or a way to reduce sexual frustration, but may also include coping with negative emotions and help with falling asleep or relaxing (Dosch, Rochat, Ghisletta, Favez & Van der Linden, 2016). Not much, if anything is known about low desire in gay or bisexual men. The majority of research and clinical reports are specific to heterosexual men.

Prevalence

In epidemiological surveys a surprising number of men report a lack of sexual desire. However, there is a great deal of variation in estimated prevalence with figures that range from 3–41% of the population (Brotto, 2010). Conservative estimates place the overall prevalence of low desire in men between 15% and 25% (Lewis et al., 2010; Meana & Steiner, 2014). Lack of desire is clearly related to age, with older men more frequently reporting problems (Eplov, Giraldi, Davidsen, Garde, Kamper-Jorgensen, 2007; Fugl-Meyer, & Sjogren Fugl-Meyer, 1999; Laumann, Paik & Rosen, 1999). In a community sample, the prevalence of sexual desire problems in gay men (32.4%) was similar to that reported by heterosexual men (Peixoto & Nobre, 2016).

The increased prevalence of erectile dysfunction (ed) in older men (Rosen, Miner & Wincze, 2014) is associated with decreased sexual desire (Corona et al., 2013). Health (physical and psychological) and the health of one's partner are also factors as are individual and relationship stress (Christensen et al., 2011; Corona et al., 2004). When surveying men from the same country or culture, no difference is found between ethnic groups in reports of desire problems (Brotto, 2010). It is unclear whether there are cultural

variations in the experience of sexual desire as the very few cross-cultural studies suffer from methodological problems that preclude definitive conclusions (Hall & Graham, 2014).

Most if not all of the aforementioned epidemiological surveys do not specifically address duration of low desire or the distress caused by it, so it is unknown how many of the men reporting low desire would actually meet the criteria for a diagnosis of HSDD. Indeed, more men report low desire than seek treatment for the problem (Laumann, Glasser, Neves & Moreira, 2009; Najman, Dunne, Boyle, Cook & Purdie, 2003). One might conjecture either that the prevalence estimates are grossly inflating the actual number of men that suffer from HSDD or that shame might cause men to hide the problem rather than seek help. Men are also less likely to be referred to sex therapy clinics if their complaint is first made to a medical practitioner (Kedde, Donker, Leusink & Kruijer, 2011). Men who do present for sex therapy often do so because of the distress of their partner and so again, the low prevalence in clinical samples may reflect the fact that low desire in men is not problematic in all relationships. Furthermore, it is also possible that men with low desire are more likely to suffer from related sexual dysfunctions, which then become the presenting complaint.

Comorbidity with Other Sexual Dysfunctions

Sexual desire problems in men have long been known to be associated with erectile difficulties with over 45% of men reporting both (Fugl-Meyer & Fugl-Meyer, 2002; Segraves & Segraves, 1991). Fugl-Meyer and Fugl-Meyer noted that men with low sexual interest also suffered from early ejaculation (26%) and that in heterosexual relationships partner sexual dysfunctions were also concurrently experienced (39% had partners with lubrication difficulties and 24% had anorgasmic partners). Apfelbaum (2000) makes a compelling case for HSDD being a precipitating factor in some cases of delayed ejaculation where the preference is for solo masturbation over partnered sex. Although there is a coincidence of desire and arousal/orgasm problems in men, there is still sufficient evidence that HSDD in men and erectile dysfunction represent separate diagnostic categories (Brotto, 2010).

Etiology

Individual Medical Factors

Some endocrine disorders such as hyperprolactinemia (excessive levels of prolactin) and hypogonadism (low levels of testosterone) have direct and negative effects on male sexual desire (Bancroft, 2009). Among the other medical conditions that can contribute to low sexual desire hypothyroidism, cardiovascular disease, cancer, depression, and anxiety disorders rank high (Clayton & Ramamurthy, 2008). In addition, the medications used to treat these and other problems may also be implicated in HSDD. Most notably, SSRIs (selective serotonin re-uptake inhibitors) have been found to reduce desire in men (Clayton, 2013). Given the comorbidity of HSDD and other sexual dysfunctions, it may be assumed that medications that negatively affect other sexual functions (erections, ejaculation) will also have an indirect effect of lowering sexual desire. When a substance or medication is known or presumed to be responsible for low desire, the diagnosis is not one of low sexual desire but of Substance/Medication-Induced Sexual Dysfunction. When low desire is attributable to a medical condition, a diagnosis of HSDD would not be made according to the *DSM-5* (APA, 2013). Nevertheless, in clinical practice it is often difficult

to separate out the contributions of physical and psychological factors. Men with physiological risk factors for low desire will still present for sex therapy treatment. HSDD, even when attributed to a physiological condition will inevitably have psychological and relational consequences. Psychological, relational and physiological factors thus become intertwined and mutually reinforcing.

Testosterone

The sharp increase in the number of prescriptions written for testosterone can be attributed to the erroneous belief that the lowered testosterone levels associated with healthy aging are responsible for men's reduced interest in sex, which can then be reversed with the administration of testosterone (Baillargeon, Urban, Ottenbacher, Pierson & Goodwin, 2013).

There is no evidence that administering testosterone to healthy men with normal or even borderline T levels increases sexual desire (Corona et al., 2014). Acknowledging that sexual desire may involve either the desire for sexual release (solitary sex) or the desire for partnered sex (dyadic desire) may help make sense of the competing claims made about testosterone and sexual desire in men. A recent longitudinal study of sexual desire found no association between testosterone levels and desire for partnered sex in healthy men. The association of testosterone and levels of desire for solitary sexual activity was mediated by stress. In men with low self reported stress, testosterone was more positively associated with a desire for solitary sexual activity than was evident for men with higher stress levels (Raisanen, Chadwick, Michalak & van Anders, 2018). Desire for partnered sex is more complex than can be explained by the action of a single hormone.

Individual Psychological Factors

Anxiety, especially that resulting from poor body image or inaccurate beliefs about sex may be related to HSDD (Weeks & Gambescia, 2015; Wiederman & Sarin, 2014). Other mental health problems such as depression can result in low desire, even if the depression is situational and not biologically based (George, Norris, Nguyen, Masters & Davis, 2014).

Attachment styles have recently been investigated in terms of desire for partnered versus solitary sexual activity. An avoidant attachment pattern and high motivational tendencies to avoid threatening or negative situations is associated with low desire in men (Dosch, Rochat, Ghisletta, Favez & Van der Linden, 2016). The effect of attachment pattern on sexual desire may be mediated by motivational factors; men with anxious attachment styles may seek sex to establish or re-establish emotional intimacy, while men with avoidant attachment may initiate sexual activity for hedonistic pleasure without concern for establishing an intimate connection (Birnbaum, Weisberg & Simpson, 2011; Mark & Lasslo, 2018).

Other sexual dysfunction. Low sexual desire can often be secondary to another sexual dysfunction (Fugl-Meyer & Fugl-Meyer, 2002) and may even be secondary to worry about another sexual dysfunction. For example, Brad, a 24-year-old medical student, was worried about his sexual performance after his former girlfriend ridiculed him for having premature ejaculation. It was not clear diagnostically that Brad suffered from premature ejaculation, but the thought that he was a poor sexual partner decreased his desire as sexual thoughts and fantasies now invoked anxiety.

Intergenerational Factors

Child sexual abuse. A history of child sexual abuse (CSA) might well fit under the etiological heading of personal factors. However, since CSA occurs in the context of a child's life, which is intertwined with his family, it is important to include it in this category. The effects of CSA are strongly correlated with the family's response to the abuse (Lalor & McElvaney 2010). Although they are often victims of incest, boys are more often abused by someone outside the home, including family friends, coaches, teachers and other older adults (Stoltenborgh, van IJzendoorn, Euser & Bakermans-Kranenburg, 2011). Intergenerational sexual contact is not always experienced as abuse (even if it is criminally defined as such) and CSA does not inevitably lead to sexual dysfunction in adulthood (Hall, 2017). For example, Carl was 12 years old when his 19-year-old cousin masturbated him. Carl was grateful for the experience and years later when he was suffering from sexual difficulties with his wife, he wished for someone to teach him how to have sex the way his cousin had taught him to masturbate. On the other hand, Mike was 15 when he was molested by his high school wrestling coach. It was a traumatic experience that left Mike feeling depressed and suicidal throughout his adolescence. Years later, Mike had low desire for his wife, whom he loved very much. He could not bear the thought that his sexual advances would ever be unwanted, so he had muted his own desires to the point that he was unaware of having them.

Religiosity and culture. While most, if not all, religions proscribe certain sexual behaviors or privilege some sexuality (usual heterosexual, marital, procreative sex), the degree to which a family interprets and adheres to their religious injunctions can influence sexual reactions later in life (Hall & Graham, 2012). The negative impact of transgressing cultural dictates regarding sex has been linked to guilt and sexual dysfunction in women (Woo, Morshedian, Brotto & Gorzalka, 2012). The same may apply for men.

Couple/Relationship Factors

Relationship conflict. Sexual desire is experienced differently in the early stages of a relationship as compared to later stages of long-term relationships (Mark & Lasslo, 2018). It has been theorized that domesticity and the attendant feelings of safety and familiarity may often diminish desire, which is fueled by excitement, danger and distance (Morin, 1995; Perel, 2007). Men, however, often cite a high degree of conflict within a relationship, as well as chronic or repeated feelings of anger and resentment, as factors responsible for their lack of desire towards their partner (Corona et al., 2004; Mark & Lasslo, 2018). Clinical experience often reveals that men may be unaware of the resentment they carry and so also unaware of its impact on their desire. In cases involving relationship conflict, the loss of desire is situational and men may then find another outlet for their sexual interests (e.g., internet pornography, another partner).

A high initial level of attraction and sexual desire is predictive of the maintenance of desire in long term relationships as is the current feeling that one's partner finds you sexually attractive (Murray, Milhausen, Graham & Kuczynski, 2017). Positive perceptions of one's partner also help maintain sexual desire. For example, Shrier and Blood (2016) found men had higher desire for their partners if they both perceived and valued emotional stability in those partners. The same appears to be true for perceptions of partner autonomy and supportiveness (Ferreira, Fraenkel, Narciso & Novo, 2015).

Stress appears to impact sexual desire differently for men and women. While perceived stress reduced the desire for partnered sex in women, it had the opposite effect on men,

increasing the desire for partnered sexual activity. Stressful times are therefore likely to have opposing effects on sexual desire in heterosexual couples and may lead to or increase relationship conflict (Raisanen, Chadwick, Michalak & van Anders, 2018). Thus, research confirms clinical experience.

In addition to general life stress, couples may also share anxiety about sex. Such couples will often stick to a standard sexual script even if these scripts are no longer, or never were, entirely satisfying. A rigid adherence to a sexual script (e.g., men must initiate, men don't need foreplay) is associated with reduced sexual desire (Sanchez et al., 2005), especially if the man does not identify with the role as defined in the script (e.g, macho, dominant) (Katz & Farrow, 2000). Sexual monotony is consistently found to be related to low sexual desire in long term relationships (Carvalho & Nobre, 2011). To be clear, monotony is not an inevitable outcome of long-term relationships and the finding that sexual desire wanes over the course of a relationship is not necessarily true for men (Klusman, 2002; Murray & Milhausen, 2011). Other factors related to relationship duration may be responsible for a decline in sexual desire and may affect women more so than men. An unfair division of labor, the stress of childcare and poor body image associated with aging may impact women more than men in terms of their sexual desire. Relationship satisfaction, good communication, attraction to one's partner, and making sex and the relationship a priority are all related to sexual satisfaction and the maintenance of sexual desire in long-term relationships (Mark & Lasslo, 2018; Traen, Štulhofer & Carvalheira, 2013).

Partner Sexual Dysfunction

Male HSDD can also be secondary to sexual dysfunction in his partner. Knowing that one's partner is not interested in sex (in general or with them) understandably diminishes a man's desire (Murray, Milhausen, Graham & Kuczynski, 2017). Partners of women who experience pain during sexual activity may lose desire for sex because they have no wish to hurt their partner (Bergeron, Rosen & Pukall, 2014). This same issue – the wish not to inflict suffering on a partner, is also relevant for partners with chronic illness (Enzlin, 2014) or disability (Mona, Syme & Cameron, 2014). Men may lose interest in sex if their partner is disinterested and/or fails to become aroused or is not orgasmic. Men want to please their partners, and men's desire is often contingent upon the pleasure they are able to give (Morgentaler, 2013).

Assessment

The stigma attached to low desiring men may result in the problem being hidden behind another sexual disorder or complaint. The possibility of HSDD should be investigated in all cases presenting for sex therapy, but may be especially relevant in the following situations:

1. Couples presenting with low frequency or no sex in their marriage.
2. Other male sexual dysfunction, including erectile dysfunction and delayed ejaculation.
3. A single man complaining of difficulty engaging in romantic relationship.

Even when patients self diagnose: "I just don't have any desire for sex," a thorough assessment is necessary for a diagnosis of HSDD. The *DSM-5* (APA 2013) makes it clear that clinical judgment is used to determine whether sexual desire is deficient, or whether low

desire is an expected adaptation to stress or other life situation (age, health status). This requires the diagnosing clinician to be aware of research regarding these factors and not to rely on supposition (e.g., a belief that older men lose desire).

Diagnostic Dilemmas

Sexual desire vs. sexual motivation. It is important to distinguish between sexual desire and sexual motivation. Many men, even men with low desire, are motivated to be sexual. Basically, they want to want to have sex. Most men coming to therapy, even if "dragged" by their partner, want to be sexual. The reasons may range from "I want to be normal," "I don't want to disappoint or hurt my partner," to "sex is a healthy part of a relationship …" The difference between desire and motivation is the difference between craving that chocolate cake and thinking: "It's my birthday, I should have a piece of that cake."

Sexual desire vs. sexual arousal. Some men may complain of a lack of desire, when in reality they are failing to become aroused and attain an erection. Some men believe that they should have an erection before any sexual activity begins. While this may have been the case for many of these men in their younger years, the lack of erection does not necessarily indicate a lack of desire (Janssen, 2011). When assessing for sexual desire problems, there is an opportunity to educate men and their partners about normative age-related changes in sexual functioning. It is helpful for men and their partners to know that as men age, they require physical stimulation to achieve erections, when once visual stimuli or fantasy would suffice.

Asexuality. While asexuality and lifelong, global HSDD may have much in common, the distinguishing feature is the lack of distress among asexuals. Asexuality is considered to be rather rare, with estimates placing it at roughly 1% of the general population (Bogaert, 2004). However, since asexuals may experience discord in their intimate relationships, relational distress may be mistaken for distress about absent sexual desire leading some asexuals to be misdiagnosed with HSDD.

Desire discrepancy. In order to diagnose HSDD, desire has to be deficient or absent, not simply lower than his partner's level of desire. Differences in level of desire between partners can cause a great deal of interpersonal distress and relationship discord. Concern about the adequacy of sexual performance, including level of desire, can lead to a cycle of worry and worsening of sexual functioning. Desire discrepancies are not uncommon among couples, not only in overall levels of desire (she wants sex more often than he does), but also on particular occasions (she wants sex tonight and he does not). The myth that real men want sex all the time can leave a man who does not want to have sex with his interested partner feeling inadequate. Most sexual activity in committed long term relationships takes place because one person (the one who desires sex in that moment) successfully initiates the activity. Individual or relationship distress due to sexual asynchrony may indicate unreasonable expectations of self or other (he should always be interested in sex), relationship problems (including power imbalance) or inadequate or inept initiation (he doesn't know his partner is signaling an interest in sex). Because there are no standard definitions of what constitutes deficient desire, clinical judgment is paramount in making the differential diagnosis regarding deficient or discrepant desire.

Assessment Tools

Questionnaires can sometimes be helpful in the evaluation process. While they should never be used in place of an in-depth clinical interview they may supplement or inform

the interview. The *International Index of Erectile Function* (IIEF; Rosen, Cappelleri & Gendrano, 2002) is a validated measure that assesses erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall sexual satisfaction in men. It can be used to help determine whether there are co-morbid sexual dysfunctions and then the clinician can follow up to determine whether these other dysfunctions are the result of low desire or have contributed to the deterioration of desire. The *Female Sexual Function Index* (FSFI; Rosen et al., 2000) assesses desire, as well as arousal, lubrication, orgasm, satisfaction, and pain in women. Again, it can be used to determine whether there exist concomitant sexual problems in the female partner and whether these problems contribute to the HSDD, are the result of being with a partner who has little desire or whether they are independent of the HSDD. For a measure of the overall quality of the sexual and intimate relationship in a heterosexual couple, the *Golombok-Rust Inventory of Sexual Satisfaction* (GRISS; Rust & Golombok, 2007) can provide the starting point for more in-depth exploration. The sexual genogram provides a way of diagramming and therefore clarifying intergenerational dynamics relating to sexuality, masculinity and their intersection (Marsh, 2017).

It is strongly recommended that any evaluation of HSDD include a medical evaluation. If the medical evaluation accomplishes nothing else besides assuring the man that he is healthy, it will have accomplished something. Many men worry that they have low testosterone (T), and a simple blood test performed by the patient's general practitioner will usually suffice to allay concerns, or on rare occasions indicate a problem. Free or bioavailable T is the measurement of most interest since it indicates the amount of T available to travel through the blood and bind to receptors (van Anders, 2012). However, even an estimate of overall T is useful. A preliminary test indicating low T will often require replication. If there is a concern, a referral to an endocrinologist for further evaluation or treatment is necessary. It is important to note that a prescription for testosterone in a man with normal T levels will not increase sex drive (Rajfer, 2000). A urologist can also investigate testosterone deficiency and may need to be consulted in cases where there is a question of low desire secondary to sexual dysfunction. For example, a urologist can rule out an organic basis for erectile dysfunction. Furthermore, the potential impact of medications and medical conditions can be reviewed with the patient's physician to determine which, if any, medications may be modified or changed in the event that they are contributing to the desire disorder.

Clinical interview. The clinical interview will be the cornerstone of the evaluation of HSDD. It is strongly recommended that the initial assessment follow a format involving four meetings; first seeing the couple together, then seeing each member of the couple alone and then discussing the assessment with the couple together again. In this way relationship dynamics can be observed and detailed histories of the individual can be obtained, as well as investigating for the presence of sexual secrets. Patients, however, are not always comfortable divulging sexual secrets in the first few sessions with a therapist. The evaluation will be ongoing with treatment and the savvy therapist will remain alert and open to the possibility of further disclosures. Individual sessions interspersed in ongoing couples' therapy should be considered. An important caveat regarding individual sessions in the context of couples' therapy is the need to clearly establish boundaries regarding confidentiality with all parties prior to any individual meetings.

In the first session, the couple is present. This reinforces the relational context of the desire problem. At this time, it is possible to see how the couple relates to each other and to assess their level of intimacy, hostility, attraction, and commitment to each other. In this first meeting the therapist can provide some education about the

relational nature of sexual desire and reduce the shame that the male partner may be feeling (I'm not a *real* man). While reducing shame may be a goal for therapy, treatment begins from the first contact with the couple and in this way is difficult to separate from assessment.

In the couple's session the history of the relationship, a detailed exploration of their sexual experiences together and the course of the problem should be explored. Questions may include:

- When was the last time the two of you were sexual together?
- Why did you have sex on that occasion? (e.g., felt close, wanted to try to fix things, wanted to conceive, to avoid a fight)
- (Given the time lag to the present session) Is that (e.g., 3 weeks) typical in the past 6 months? In other words, in the past 6 months is the frequency of sex about once every 3 weeks?
- When did you first notice a problem (this may differ depending on who is answering the question)?
- What, if anything, have you tried to do to fix the problem?
- Tell me about the last time you had sex together.
  - Ask specifically about who initiated, how, what the response was, what sexual activities occurred, was there orgasm for one or both? (Ask the couple if this is a typical or usual pattern, in this way the therapist can determine how rigidly the couple adheres to a sexual script).
- What are your expectations or goals for therapy? What would your sexual life look like if therapy is successful?

The goal of individual sessions is to assess for individual factors that might be relevant to the problem, especially sexual secrets, but also dissatisfaction with the current sexual repertoire, which the individual client may not have felt comfortable discussing with his or her partner present. In cases where there is a sexual secret, the goal is to destigmatize the secret, to bring it out in the open where it can become part of the treatment. While individuals should rightfully expect confidentiality about their disclosures during their individual session, discussion should be initiated into how the material that was privately discussed can be integrated into the treatment of the couple. If an ongoing extra-dyadic sexual or emotional relationship is revealed, this would be a contraindication to couples' therapy, which would have to await resolution of the conflict (e.g., the involved person would have to end the extra-dyadic relationship). In all cases, it is essential that both members of the couple understand the rules of confidentiality before proceeding with the individual evaluation sessions. All parties should complete signed informed consents at the initial meeting.

As part of the detailed individual sexual history in which intergenerational and developmental factors are explored, levels of desire in other circumstances (e.g., a preference for swinging, solo rather than dyadic sex, fetish or bondage interests) as well as desire in past and other concurrent relationships, fantasy, masturbation, and pornography should be investigated. Lack of physical attraction to the current partner is also best explored individually, especially if the partner has changed physically in some way (e.g., illness, disability, serious weight gain/loss). The individual session is the time to ask detailed questions regarding cognition during sexual activity, and to assess for distraction or negative thoughts that may interfere with sexual desire. Men with sexual dysfunction have

negative and distracting thoughts more often than do men without sexual problems including; concern about erections ("I must get an erection and if I have an erection I must successfully use it"), anticipation of failure ("this is not going anywhere") and lack of erotic thoughts (Nobre & Pinto-Gouvela, 2008).

McCarthy and McDonald (2009), noting the probability of sexual secrets in cases of HSDD, suggest asking about orgasms – how many in the last month, and by what means? This can lead to inquiry regarding masturbation (how often do you masturbate?), fantasy, or other variant arousal such as a fetish. (What do you think about when you masturbate, or when you have a sexual daydream? What type of pornography catches your attention? What websites have you visited?) These questions also open up the possibility of inquiring about the mismatch of sexual orientation (e.g., a man realizes that he is primarily attracted to other men but wishes he was attracted to his wife). The paucity of research on sexual desire disorders in gay or bisexual men makes empirically based assessment recommendations for same sex couples difficult. At a minimum, a heterosexual therapist treating men in same sex relationships must not apply heterosexual standards of normal, ideal or healthy sexuality. Therapists need to be aware of the variance in sexual behavior and attitudes inherent in the gay community and be open to learning from their gay (and other sexually variant) clients (Nichols, 2014).

Other questions that may be asked in the individual session include:

- In what ways is this sexual relationship different from other relationships (assess for attraction, intimacy, relationship satisfaction)?
- When you are having sex, what are you thinking about? What thoughts are going through your mind?
- How often do you have sexual thoughts, for example when you see an attractive person, or look at erotic material online?
- How often do you masturbate or pleasure yourself when you are alone, whether to orgasm or not.
- Do you feel that it is more pleasurable having sex on your own (masturbating) than having sex with your partner? If so, why do you think this is the case?

Note that these questions regarding masturbation, fantasy and pornography use all assume that the individual is engaging in those activities. It is easier for a man to correct a misperception in the direction of saying "No, I don't use pornography" than to admit to something he may fear will be negatively judged.

Treatment

Sexual desire disorder in men is complex. Therefore, as Weeks & Gambescia (2015) aptly note, treatment cannot follow a short protocol-based model but must be comprehensive, flexible, and tailored to each couple. The goal of systemically based sex therapy is an improvement in the sexual relationship, and so sexual symptoms will always be the primary focus of treatment. Nevertheless, concurrent intervention regarding etiological factors (e.g., relational conflict, stress, intimacy problems) is almost always a necessary part of treatment for the majority of sexual complaints. If relationship distress is high, reducing marital or relationship conflict prior to initiating sex therapy interventions is crucial to the success of treatment. Concurrent medical intervention may be required if physiological factors are contributing to desire problems.

Sex therapy interventions that are particularly helpful for HSDD will include some or all of the following:

- Distress-Reduction
  Given the stigma often associated with low desire in men, the first therapeutic task should be to prepare the couple for therapy by reducing the distress they have been experiencing and improving motivation for treatment, for both partners. It is often important to educate the couple about sexual desire and HSDD, highlighting the fact that low desire is not an uncommon problem for men. Using information gleaned from the assessment, the problem is then reframed. Instead of "He has a sexual dysfunction" the couple now agree: "*We* have a sexual problem that *we* need to work on". Weeks and Gambescia similarly discussed the importance of reframing in the treatment of ED (Weeks & Gambescia, 2000). The techniques of motivational interviewing (Miller & Rose, 2010) may be very helpful at this point in therapy. Motivational interviewing increases readiness for change and emphasizes the collaborative nature of therapy.
- Proscribing the Problem
  In the beginning stages of treatment, sex therapists often prohibit problematic sexual activities (e.g., intercourse). In the case of HSDD, all sexual contact is prohibited except for that prescribed in therapy. This alleviates the need for sexual desire and allows the low desiring partner to stop trying to regain his desire for sex. Desire is a wish for something one does not currently have and the obligation – for example, "I have to have sex" – diminishes desire (Hall, 2004). This also alleviates the stress and anxiety his partner may feel, as the partner may otherwise wonder: "Will we have sex tonight?" This is often referred to as response anxiety.
- Sensate Focus Exercises
  Sensate focus involves a hierarchy of structured touching exercises designed to assess and redress problems with sexual skills, communication and the experience of pleasure. Importantly, sensate focus exercises are aimed at reducing performance demand (arousing one's partner or getting aroused oneself) concentrating instead on being able to stay in the present and attending to one's own experience of being touched (Weeks & Gambescia, 2016; Weiner & Avery-Clark, 2014). The couple is encouraged first to use non-verbal communication during sensate focus to indicate the kinds of touching that they really enjoyed. The emphasis is on the positive, what he or she enjoyed, which helps not only improve the quality of the sensate focus exercises but also to repair the hurt one partner may have experienced from feeling undesired. The therapist purposefully times the exercises to proceed at a slow pace (sensate focus I, which is non genital touching, may occur 4–6 times over a period of two months), so that the low desiring partner will have the opportunity to *want* more activity rather than feeling burdened by having to perform. Desire is reframed as a positive state that can be enjoyed rather than as a feeling that must be immediately satisfied and therefore disappears.
- Positive Anticipation, Curiosity and Improving the Sexual Repertoire
  In addition to the anticipation felt as a result of the sensate focus exercises, desire can be rekindled by encouraging the couple to explore and develop their sexual interests (McCarthy & Wald, 2015). A homework assignment may involve browsing through sex books or manuals, shopping (even if not buying) sex toys, lingerie etc … During the exercise the clients are prompted to be curious – "What would

this be like? What would this feel like? Would I enjoy this?" Each member of the couple is encouraged to keep a list of things they would like to introduce to their sexual relationship. This can be shared in therapy. Not only is desire increased by this exercise, but also improvements may be made to the couple's sexual repertoire, which may have become stagnant at this point in time. It is incumbent upon the therapist to normalize the sexual interests shared by the individual members of the couple and to facilitate the sharing of ideas in a respectful and supportive manner.

- Simmering

  Essentially simmering works on the notion that a pot of water set to simmer will come to a boil more quickly. This technique was first described by Zilbergeld and Ellison (1980) and is especially relevant for the low desiring man, but may also be helpful to his partner. Essentially the client is advised to pay attention to any sexual feelings that occur throughout the day. Then he is encouraged to develop the fantasy further, in essence "to run his own x-rated movie" (p. 312). He does this for a few minutes, then he lets the image fade. Later, he is advised to recall the fantasy and to re-engage with it several times a day if possible. After he can do this exercise successfully, he is advised to incorporate his partner into his fantasy, essentially fantasizing about his partner and then ultimately initiating some sexual activity (letting his partner know in advance that he would like to be sexual).

  A variation on simmering involves the couple engaging in a required number of small activities each day such as; flirting, complementing each other, affectionate touches, kisses that linger longer than the proverbial peck on the cheek, and romantic texts or emails. This improves the overall tone of the relationship and makes for a smoother transition to sex. In essence this sex therapy technique builds on the work of John Gottman, who in a series of prospective longitudinal studies of married couples, found that happy couples had a ratio of 5:1 positive to negative behavioral interactions (Gottman, 1994).

- Cognitive Behavioral Therapy (CBT)

  Directly challenging irrational thoughts that may interfere with sexual desire is an important component of sex therapy for HSDD. Often the challenge is enough to get clients to rethink and therefore to change their behavior. Some common myths and misperceptions include:

  a. You can only initiate sex if you already feel desire.
  b. Men are responsible for initiating sex.
  c. Men are always ready for sex and only refuse an unattractive or undesirable partner.
  d. An erection is a necessary sign of desire, and the lack of an erection means a lack of desire.

  Therapists should be familiar with the literature that refutes many of these myths, but may also simply challenge these beliefs by asking why? Often when clients reflect on these beliefs, they come to understand that the beliefs are irrational, or are based on outmoded ideas. In addition to challenging irrational beliefs, some coaching may be necessary to help clients with behavior change necessitated by the change in belief systems (e.g., coaching on how to initiate sex if you are not feeling sexual desire, but have the thought that it is time to reconnect sexually with your partner).

Focusing on positive reasons for having sex (creating intimacy, expressing positive feelings) has been found to increase sexual desire. Research shows that a "homework" task to focus on the positive reasons for having sex increased desire and sexual satisfaction in the pursuant week(s) (Muise, Boudreau & Rosen, 2017).

- Cognitive Refocusing, Mindfulness
  Men who have low desire are often distracted during sex and have nonerotic thoughts (Nobre & Pinto-Gouvela, 2008). Teaching mindfulness may help men attend to and be more aware of both internal and external cues for sexual excitement. Internal cues may be sexual thoughts, sensations of arousal and positive emotions of love and intimacy). External cues may include indications of partner desire, or sexual cues such as a partner's naked or scantily clad body (Brotto & Heiman, 2007; Dosch, Rochat, Ghisletta, Favez & Van der Linden, 2016). For clients who are not predisposed to meditation, the directive to focus on what they are doing and experiencing, without criticism, is often sufficient. This technique can be enhanced by adding positive commentary: "I am caressing my partner's skin. I like this, her skin feels smooth, I am enjoying this …" When men's thoughts are focused on enjoying physical intimacy, they are more likely to experience high sexual desire (Shrier & Blood, 2016).
- Jump Start Desire by Bypassing It
  When it is apparent that sexual desire is present during sex, but does not precede sex ("I never feel like having sex, but when I do I always enjoy it and wonder why I don't want to have sex more often") the couple can be encouraged to "jump start" desire by having sex without first having desire. It is helpful to explain that desire can be responsive, in other words desire can be sparked by the sexual arousal experienced during sexual activity (Basson, 2001). Sexual activity, engaged in for a variety of reasons, can and often does produce sexual excitement, and in response to this arousal, sexual desire will manifest as the desire for continuing and or increasing the sexual stimulation. The idea of engaging in sexual activity first may extend to engaging in some solo sexual activities. The low desiring partner can use fantasy (see the simmering technique described earlier) to become aroused prior to initiating partnered sex. This will help his partner regain a feeling of being desired. In terms of using internet or other forms of pornography to jump start desire, it must first be determined whether pornography can be used to bridge the desire gap or whether it has been used in the past to distance a man from his partner. If so, it would likely be used for the same purpose again (McCarthy & McDonald, 2009). In this case, couples may be advised that sharing erotica (such as reading erotic stories) is an activity to be done together and never separately. Erotica is here used to refer to less graphic portrayals of sex when compared to pornography, and reading material together is less likely to result in the emotional distancing that might occur when viewing pornography.

Clinical challenges are presented when the problem is lack of attraction to one's partner. If the lack of attraction can be mediated (for example a man with a shoe fetish may persuade his wife to wear high heels and she may oblige), the therapist may help the couple negotiate this change. If the lack of attraction is due to a physical feature that is unchanging (e.g., age) the dual control model (Bancroft & Janssen, 2000) is helpful conceptually. Very basically this theory posits that men experience both sexually excitatory and sexually inhibitory signals. Sexual desire and arousal will result if the number of excitatory signals

is greater than the number of inhibitory factors. Sex therapy can be utilized to improve the balance in favor of the excitatory signals. For example, Jake was married late in life to a lovely woman his age. He felt that she was a wonderful companion to him, but since his sexual experiences had for a long time been limited to pornography, he was turned off to his wife's graying pubic hair and other signs of her age. He began to obsess about these features and soon lost desire for sex with her. In therapy he learned to focus on the positive physical features he enjoyed, the sensations he experienced from being touched and the emotional attachment he felt to his wife, which then increased his desire and sexual pleasure.

Case Vignette

Doug and Jan came to therapy complaining of a low frequency of sex (once every two months) due to Doug's disinterest. Jan was exceedingly distraught about the problem, while Doug seemed upset, not about the lack of sex, but about the fact that Jan was unhappy: "*I don't know what's wrong with me. I'm sorry*". The frequency of sex had declined during the marriage but had become alarming low to Jan over the last year and a half.

Jan and Doug are married (13 years) and have two school age children. Jan is a stay at home mother with an active social calendar which includes planned weekends away with Doug, dinner parties with friends and travel. Doug said he appreciated and enjoyed these efforts but still he was "*not in the mood*". Both described their relationship as "very good". In their individual sessions Jan reiterated her distress and confessed to be perplexed by Doug's sexual disinterest while Doug openly discussed his unhappiness with the relationship and described feeling controlled, micromanaged and demeaned by Jan. At one point, Doug recounted an incident where Jan had admonished him for how he had loaded the dishwasher. "I can't do anything right!" Doug felt this way about sex, it had to be the way Jan wanted with no room for variation. When I asked why he did not raise these issues with Jan, Doug stated that he did not want to hurt her feelings. He explained that early in the marriage he had a brief affair. While Jan never found out, he had asked her for a divorce, which he retracted after Jan was hospitalized for what appeared to be a major depressive episode. Doug was left feeling guilty. He spent the next 10 years trying to be the best husband he could be. This left Doug with no outlet for the well of small hurts and frustrations that had built up over the years, except to withhold his desire. He did have a sexual outlet however. He was a regular client of a masseuse who provided "happy endings". He tipped her well and imagined that he was her favorite customer.

Doug agreed to stop going to the masseuse and devote his full attention to the sexual relationship with his wife, at least as long as they were in therapy. Sex therapy was focused on helping Doug and Jan come up with a more flexible and arousing sexual script. As Doug had feared, Jan felt that there was a right way to have sex, and this is what they were doing. Variations that interested her involved rose petals on the bed, incense or candles burning, and romantic music playing. None of these things were meaningful to Doug (they were neither objectionable nor exciting). Jan was putting a lot of energy into improving the sexual relationship. Doug was reluctant to initiate anything new for fear he would be criticized. They were enacting what they had put into place years ago – Jan would try and Doug's lack of response would convey to them both a hopelessness that sex could be better. This justified the long past affair and the current masseuse, and was a (passive) way for Doug to express his anger. While Jan knew there was something wrong, her rigid sexual attitudes made her look to Doug as the problem and not the sex itself. So, I took over

asking them to make small modifications in their sexual script. These involved changing positions for oral sex and intercourse, switching the timing of activities so that sex did not inevitably end in intercourse, experimenting with different types of manual stimulation, as well as some more romantic or atmospheric touches. Doug and Jan were compliant with the exercises, but Jan initially approached them with apprehension and anxiety. Doug continued to struggle with low desire, timing the exercises to coincide with a build-up of guilt "*I have to have sex now, Jan has been so patient.*" He had difficulty getting aroused and in these early stages of therapy he never reached orgasm.

Interspersing individual sessions helped Jan cope with her rigidity regarding "proper" sex and helped Doug process his guilt about the affair and as therapy went on, his guilt about the masseuse. Conjoint sessions focused on improving communication about sex and processing anger while acknowledging Jan's current mental stability (she can bear his anger, she can deal with the anxiety of trying new things). Agreeing to modifications in their sexual script in session and then having Doug be responsible for implementing the changes at home relieved Jan of the futility of pleasing Doug and allowed Doug to build the skills and confidence to be more sexually assertive. Mindfulness exercises helped Doug focus on the pleasurable physical sensations rather than ruminating about failure or criticism. Progress was slow but eventually Jan became less anxious and Doug became more sexually aroused and orgasmic. Once sexual exercises were no longer being prescribed, the frequency of sex declined somewhat but Doug discovered, to his delight, that he missed sex and *wanted* to have sex with his wife. At the end of 18 months of therapy, Doug and Jan were happy with sex occurring about twice a month, complete with arousal and orgasm for them both. Doug did not return to the masseuse. He and Jan purchased a sex book to provide them with material to keep the variety in their sex life.

Treatment Efficacy – Research and Future Directions

Recently there has been increased interest in studying the maintenance of sexual desire in long term relationships (Mark & Lasslo, 2018) and the information gleaned from these studies is now being incorporated into treatment protocols (c.f. Muise, Boudreau & Rosen, 2017). Research will yet be needed to determine which factors responsible for maintaining desire can be learned and utilized to increase desire in low desiring men.

Despite millions being spent in pursuit of an effective drug for desire, none has yet been found. Hopefully the field of social neuroendocrinology (the study of how social behaviors influence hormones in social context), may provide answers that a strictly biological approach cannot. There is a growing awareness that when it comes to sex, biological, relational, emotional and cultural context is essential to understanding and improving sexual health and happiness (Heiman, 2013; van Anders, 2012). You won't find that in a pill.

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5

SYSTEMIC TREATMENT OF ERECTILE DISORDER

Nancy Gambescia and Gerald R. Weeks

Introduction

ED is the persistent inhibition of a man's sexual arousal and erectile capacity, precluding his ability to engage in satisfying sexual experiences. Men with ED often report symptoms of depression and anxiety related to sexual performance (Yafi et al., 2016) as well as low self-esteem, lack of confidence, and other distressing emotional symptoms. Partners of men with ED, troubled by the sexual difficulty, often experience diminished sexual interest, confidence, and satisfaction (Chevret, Jaudinot, Sullivan, Marrel, & De Gendre, 2004; Rubio-Aurioles et al., 2009). Over time, this disorder can contribute to relationship dissatisfaction and the avoidance of sexual intimacy.

ED often encompasses multiple layers of psychogenic, relational, and contextual dynamics, although organic features can progressively influence the clinical presentation as the man ages. Presently, psychotherapeutic research about ED has not progressed although there is an acceleration of medically oriented research involving etiologies and remedies. The combination of sex therapy with medical treatment produces the best outcome in cases with combined organic and psychogenic etiologies, especially when the partner is involved. The Intersystem Approach, used throughout this volume, offers a comprehensive, integrative method for assessing and treating ED.

Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (*DSM-5*) describes the psychological presentation of ED (American Psychiatric Association, 2013). At least one of following three diagnostic criteria must be present in almost all or all (75–100%) occasions of sexual activity: (1) Distinct difficulty in obtaining an erection during sexual activity; (2) Noticeable difficulty in maintaining an erection until the completion of sexual activity; and (3) A marked decrease in erectile rigidity. Additionally, the symptoms will have persisted for a minimum duration of six months approximately (American Psychiatric Association, 2013). *Lifelong* ED is an extremely rare presentation in which the man has always had this problem. *Acquired* ED occurs in men who have previously had satisfactory erections and is more typical. The onset of acquired ED can be gradual or sudden. *Generalized* ED occurs in all situations, partnered or alone. *Situational* ED is more common, occurring only with certain partners, in specific circumstances, or during particular types of stimulation.

In the *DSM-5*, the term *severity* is used to categorize the degree of psychological distress about the aforementioned symptoms. Distress is a subjective phenomenon and must be assessed within the context of the man's age, relationship, environment, and other physical and psychological risk factors.

The associated features supporting the diagnosis of ED in the *DSM-5* include a number of elements: underlying medical influences in the man, the sexual status and health of his partner, relational problems, psychological influences, situational stressors in the man, and cultural, religious, and other contextual considerations. Additionally, the man's sexual symptoms are not caused by another psychiatric problem such as major depressive disorder, commonly prescribed medications, substance or medication abuse, another medical condition that fully explains the ED, or other sexual dysfunctions such as the lack of desire (American Psychiatric Association, 2013).

Prevalence

Epidemiological studies consistently demonstrate a gradual increase in ED with age due to the development of underlying comorbid medical conditions (McCabe, et al., 2016) such as cardiovascular disease, diabetes, and the medications used to treat them (Healya, Nourya, & Manginb, 2017). Nonetheless, ED is not an inevitable consequence of aging. Modifiable lifestyle factors, such as smoking, obesity and inactivity, also can increase the prevalence of organic ED. Younger men are least likely to develop ED, with a prevalence of between 1–10% in men under 40 years of age. In men over 70, between 50% and 100% will report ED (Lewis, et al., 2010). The prevalence statistics do not distinguish between psychogenic and organic ED. Also, the pervasiveness of ED is roughly similar in heterosexually identified men and gay men, though some studies report a slightly higher frequency in gay identified men (Shindel, Vittinghoff, & Breyer, 2012).

The Intersystem Approach

The Intersystem Approach is an extensive therapeutic framework, which systematically integrates many theoretically based treatment modalities. This approach provides the lenses necessary for viewing all facets of ED and the valuable tools needed for treatment. The etiology and treatment are considered within five specific domains simultaneously: (1) Individual *biological* considerations; (2) Individual *psychological* factors; (3) *Relational* dynamics; (4) *Intergenerational* (family-of-origin) influences; and (5) *Contextual* elements such as society, culture, religion, and environmental stressors. The desired outcome of the Intersystem Approach is the accomplishment of sexual satisfaction for the man or the couple and not merely a concentration on erectile capacity (see Weeks & Gambescia, 2015).

Assessment

Individual Biological Issues

In organic etiology, the onset of erectile difficulty is typically gradual and the duration is long term (Montorsi, et al., 2010). ED with a sudden onset and short duration suggests a psychogenic etiology (Shamloul & Ghanem, 2013). In general, if a man awakens from sleep with firm erections, the cause, most likely, is predominantly psychogenic (Segraves, Segraves, & Shoenberg, 1987). Even when the etiology is largely organic, the man and his

partner will need assistance in discussing relational impacts, negotiating alternate sexual strategies, and deciding about the various treatments for ED (Weeks & Gambescia, 2000).

Organic ED is regarded as a risk marker for underlying cardiovascular disease and other physical etiologies that require medical intervention (Burnett, et al., 2018). Additionally, evidence supporting the empirically significant relationship between modifiable risk factors and ED is increasing (Kloner & Schwartz, 2011). As such, the first component of the assessment addresses the man's medical history, health status, physical strengths, illnesses, disabilities, family medical history, and so on. The health status of the partner is also considered in the biological portion of the assessment.

The therapist should be aware of the more common health conditions that cause or are associated with ED: *Vascular changes* resulting from diabetes, heart disease, and hypertension, account for 75%–80% of organic ED (Vlachopoulos, Jackson, Stefanadis, & Montorsi, 2013); *Structural abnormalities*, including Peyronie's disease and atherosclerosis; *Endocrine malfunctions* including diabetes and hypogonadism (the latter is a condition in which the testes do not produce sufficient testosterone); *Systemic illnesses* creating general physical debilitation, which include: liver, renal, respiratory, and cardiovascular disease; the use of certain types of *medications*, including antihypertensives, antiandrogens, and major tranquillizers. Up to 60% of patients taking selective serotonin reuptake inhibitors report some form of treatment-emergent sexual dysfunction (Healya, Nourya, & Mangin, 2017). Other organic contributory influences include: *Neurological disorders* associated with ED including Alzheimer's disease, Parkinson's disease, and injuries to the spinal cord; *Iatrogenic factors* causing tissue damage from operative procedures or radiotherapy to the prostate; and *Injury* to the spinal cord, brain, blood vessels, ligaments or nerves which provide pathways for erection (Awad, Alsaid, Bessede, Droupy, & Benoıt, 2011).

Individual Psychological Considerations

The partner's reactions to ED can mitigate or exacerbate the situation. For the man, apprehension is experienced sexually and typically manifests as performance anxiety. *Performance anxiety* causes the man to perceive that he is not getting an erection fast enough, that the erection is not firm enough, or that it does not seem to last long enough. Once a man experiences even a single episode of ED, he may anticipate future erectile problems, and increasingly use negative thinking, which makes it more difficult to obtain subsequent erections and diminishes perceptions of self-worth. Moreover, many men tend to use their sexual functioning at a younger age as a baseline for current erectile capacity. Getting an erection can take longer as the man ages; this fact may be misinterpreted as a sexual performance problem rather than a normative change in sexual functioning.

Depression, anxiety, low self-esteem, lack of confidence, poor body image, and adherence to rigid gender ideals are often experienced in men with ED (McMahon, 2014). While empirical evidence does not always document bidirectional causality between psychological correlates and ED, our clinical observations confirm that the aforementioned symptoms are major contributors to, as well as consequences of ED. Also, arousal and erectile problems are highly prevalent in men with mental illnesses, such as schizophrenia and bipolar disorder (Waldinger, 2015).

Men with ED also report a lack of assurance that they can control the outcomes of sexual interactions. This risk factor perpetuates their sense of hopelessness and lack of self-worth (Abdo, Afif-Abdo, Otani, & Machado, 2008). Also, they have a tendency to blame themselves for ED and may be susceptible to generalized self-blame about any negative

sexual experience (Rowland, Kostelyka, & Tempela, 2016). ED can trigger or be a consequence of other sexual dysfunctions such as male hypoactive sexual desire disorder and early ejaculation. In addition to assessing for the presence of other sexual problems in the man or his partner, the therapist must also be attentive for sexual secrets resulting from undisclosed emotional or sexual trauma, sexually compulsive behaviors, hidden paraphilias, or infidelity as these factors can interrupt sexual functioning at all phases of the sexual response cycle.

Other psychological risk factors specific to the man should be explored in an individual or conjoint format. Is he anxious during penetrative sex? Is he afraid he will ejaculate too soon? Investigate the man's sexual attraction to his partner. How similar is the partner to his preferred arousal template? The therapist should inquire about masturbatory fantasies, preferences, frequency, and practices. Also, ask about pornography use and other factors that serve to arouse him. Does his partner agree to engage in sexual activities he finds erotically stimulating? Finally, is he experiencing a lack of sexual desire masquerading as ED?

Relationship Factors

A great deal of the Intersystem assessment evaluates the couple's resiliency in dealing with the man's ED (Weeks & Fife, 2014). While positive relationship elements can buffer the impact of sexual problems, couples experiencing ED often report varying levels of distress. The therapist will want to evaluate general relationship dynamics, strengths, vulnerabilities, communication patterns, sexual satisfaction, conflict resolution modes, and the couple's capacity for intimacy. It is imperative to assess the partner's response to the problem and how they might be contributing to or maintaining the erectile difficulty. For example, we have noted the majority of women are empathetic and sympathetic when their partner's experience ED, but partners who are critical, angry, hurt, or impatient can exacerbate the problem by adding to the man's anxiety.

Independent of other relationship issues a couple might be experiencing, the man with ED carries the burden of his own anxiety about sexual performance in addition to concerns about his partner's distress (Rowland & Kolba, 2018). Sexual partners of the man with ED often worry about their desirability and develop their own sexual difficulties such as diminished sexual desire or avoidance of sex. Sexual dissatisfaction arises because the couple is not feeling the pleasurable sensations of arousal; rather, they are worrying about what could go wrong. This circular pattern of sexual distress will eventually contribute to lower relationship satisfaction.

Another lens for gauging the relational impact of ED is to consider age-related markers such as menopause, aging, and their impact on the couple's relationship. Are the partners in similar or different developmental stages and to what degree are their respective personal experiences unifying or polarizing? For instance, aging men might be burdened with the physical and psychological consequences of "andropause" in which testosterone levels and erectile resilience might be compromised. If he is partnered with a woman who is experiencing menopause or post menopause, their sexual and relational satisfaction can be considerably affected. Jannini and Nappi (2017) use the term "couplepause" to emphasize that ED can occur in a complex contextual developmental environment that has profound effects on both partners.

A thorough relational assessment will occur organically as the couple engages in treatment and the therapist directs the process. As stated previously, sexual problems become embedded in the relationship dynamics, and vice versa, each influencing the other. The

therapist should be observant of independent relational risk factors, such as anger, resentment, or power struggles as these problems will maintain or worsen the couple's experience of sexual problems.

Research has consistently demonstrated that sexual and relational satisfaction are strongly correlated; communication functions as a mediating variable (Yoo, Bartle-Haring, Day, & Gangamma, 2013). The therapist should ask the couple directly about contentment within their overall relationship and with their sexual relationship. Additionally, the therapist will want to evaluate the couples' ability to communicate specifically about sexual likes and dislikes as sexual self-disclosure and discussion of sexual preferences serve as the most favorable forms of sexual communication (Brown & Weigel, 2018) even among older sexually active couples (Gillespie, 2017). Finally, couples reporting enduring sexual satisfaction experience the following: frequent sexual activity, a variety of sexual activities, consistent orgasms, mood setting for sexual activity, and communication about sex (Frederick, Lever, Gillespie, & Garcia, 2016).

Intergenerational Influences

Much of what is learned about affection, love, intimacy, and gender roles, is acquired, overtly or covertly, within the family-of-origin. Through the transgenerational learning process, messages about sexuality comingle with emotions and expectations regarding intimacy and sexuality. In many instances, accurate sex information is not acquired within the family or through structured educational channels, and misinformation can be highly detrimental to healthy sexual functioning. In fact, the belief system of the man with ED often contains sexual mythology, negative automatic thinking, and sexual guilt. Frequently sexual misinformation is transmitted through a legacy of secrecy within the family-of-origin. The lack of communication about sexuality sends a strong negative message that sex is something unspeakable and therefore wrong or bad. Many families hold secrets regarding pregnancies, abortions, abuse, affairs, and sexual orientation of family members. The individual knows that events have occurred in the family but does understand the back-story. Left to their own devices, they are unable to make sense of what actually happened or why certain events are not discussed. Sexual secrecy, ignorance, internalized sex-negative messages, boundary violations, family dysfunction, and sexual abuse can have profound negative effects on sexual functioning. Intergenerational risk factors, including attachment styles, can be accessed and deconstructed through the use of sexual genograms, which render a multi-dimensional perspective regarding sexuality (DeMaria, Weeks, & Twist, 2017).

We have seen remarkable improvements in sexual comfort once there is a clear understanding of a man's internalized belief system, transgenerational dynamics, and sexual expectations. Moreover, his partner's internalized beliefs about sexuality are also processed as their response to ED reflects deeply held beliefs about love, intimacy, and sexual expectations.

Contextual Elements

Sexuality is understood within the context of sociocultural norms, beliefs, preferences, customs, and values. Cultural factors contribute to a person's self-schema and sexual script, which provide guidelines for the development of sexual attitudes, expectations, and behaviors (Aumer, 2014). If sexual partners follow similar scripts, expectations, and

perceptions, their distress should be relatively low (Wiederman, 2005). Typically, however, various overlapping sociocultural forces can be contradictory within the individual and between partners, creating difficulties in ascribing meaning to and understanding of sexual interactions.

Contextual forces endlessly affect the couple, influencing relational and sexual satisfaction. The therapist will assess for unremitting risk factors related to race and socio-cultural and religious beliefs in addition to situational stressors such as finances and occupational stress. To practice effective sex therapy in the treatment of ED, the clinician must grasp the meaning of diverse environmental issues for the man and his partner, help them in understanding the origins of contextual stressors, and work to deconstruct barriers to intimacy with sensitivity and respect (Hall & Graham, 2014).

The Sex History

The foundation of Intersystemic assessment of ED is the comprehensive sex history of each partner. Thorough attention is given to the presenting problem, allowing for discussion of feelings and thoughts about the causes and consequences of the sexual symptoms. It is helpful to ask what measures the partners have taken to correct the situation on their own. This question permits discussion of feelings of skepticism, often because they have tried to remedy the problem, have been unsuccessful, and fear they are beyond hope. Encourage dialogue about a sexual time line, beginning with their first intimate experience together, including qualitative and quantitative information. Always be attentive for the presence of additional sexual problems in the man with ED and his partner. Explore their cognitive scripts and the potential disjuncture between individual and relational schemas (Masters, Casey, Wells, & Morrison, 2013).

Flexibility is essential in terms of what is asked, pacing questions to the tolerance of the couple and pausing to clarify responses. Open-ended questions are useful at first, with subsequent progression to more specific queries about the problem. Clarify the rationale for questions used in order to increase compliance and reduce anxiety. It is beneficial to normalize a question, placing it in a greater context of occurrence, such as "many people experience periods of anxiety during sexual activity, when does this happen to you?" With any sex history, it is important to track the kinds of sexual activity during which man has erectile difficulty. Does it occur during solo sexual activity, with or without the use or pornography, fellatio, or anal penetration? If the therapist maintains an exclusive focus on coitus, this information could be unseen.

After the initial conjoint sessions, it is usually beneficial to incorporate separate sessions to cover material that might be awkward to discuss in the presence of partner. The individual sessions are not only useful for the man with ED but for the partner to describe their frustrations and other processes they might be withholding for fear of making matters worse. The therapist runs the risk of discovering that either partner is holding a secret. It is beyond the scope of this chapter to discuss how to handle secrets in therapy but an experienced therapist will have a procedure in place for such situations. For additional information see Weeks, Gambescia and Jenkins (2003).

Treatment

The treatment for ED is tailored to the unique needs of the man and his partner. The goal of treatment is to reduce psychological distress, recover self-esteem, improve quality of

life, and enhance sexual functioning and satisfaction for the couple. The couple's definition of sex and intimacy is expanded, thereby establishing a wider repertoire of sexually pleasurable activity. Additionally, treatment provides an occasion for the man and his partner to discuss how and when to use medical options, to make lifestyle modifications, and process relationship concerns that contribute to or result from ED.

Psychological Treatments

Since the Intersystem Approach is integrative of numerous treatment modalities, the therapist must be adequately trained in working with individual and couple systems and flexible in using a number of psychological treatments concurrently. Medical therapies are often used in combination with psychotherapy in the treatment of ED; the combined approach is more successful in promoting sexual satisfaction and compliance than the use of either psychotherapy or medical treatments alone (Althof, 2006; Mobley, Khera, & Baum, 2017).

Promoting Systemic Thinking

The principal goals of treatment are to help each partner to see their role in the development and maintenance of sexual symptoms and to overcome obstacles to intimacy and sexual satisfaction, regardless of the etiology. The therapist involves the couple in discussions about the connection between sexual fulfillment and relational satisfaction, helping them to see how ED may stem from relational causes not previously expressed or considered. Conversely, experiencing ED might have contributed to relationship dissatisfaction. Sometimes preexisting sexual problems or those in response to ED, such as the lack of sexual desire or premature ejaculation, will surface during treatment. The couple is aided in discussing how they felt about their sexual relationship prior to and during the emergence of ED and other concerns that they may currently have.

Reframing the Symptom

The technique of reframing is a way to help the man and his partner to change the cognitive or perceptual meaning of the symptom from something purely individualistic to serving a function for the couple. The reframe helps the partners to see the sexual symptom as not solely residing within an individual. The therapist must be comfortable and experienced in using this technique and it can be extremely valuable when employed judiciously. For instance, ED can be framed as a way to maintain a "safe and comfortable" distance between the partners both emotionally and physically. Additionally, it might provide a way, albeit unpleasant, to avoid conflict about sexual intimacy within an individual or between partners. The couple can eventually be helped to comprehend that the sexual symptom did not just happen, that underlying relational issues have contributed to and maintained the erectile difficulty, and that these factors can be revealed and addressed in treatment. Ultimately, they can believe that resolution is tangible once these factors are understood and treated (Weeks, Fife, & Peterson, 2016).

Supporting Realistic Expectations

The medicalization of ED treatment has contributed to the notion that sexual disorders are purely physical and easily corrected with medication alone. This overly simplistic

misconception can generate pessimism when psychotherapy does not produce immediate results or contributes to noncompliance with psychological therapies. The man and his partner will eventually grasp that ED is a symptom with layers of potential etiologies. The therapist helps the couple to identify and correct the underlying risk factors that maintain the sexual symptom and leads them to construct realistic expectations of sexual enjoyment given their preferences, ages, and physical ability. This process is interactive with the therapist continuously offering accurate information about normative sexuality or challenging unrealistic expectations as they are expressed behaviorally or verbally. Optimism is encouraged through repeated small successes that result in measurable and steady progress.

Changing Cognitions

Couples dealing with ED typically obsess and worry about sexual performance. Additionally, the anticipation of a problem and self-monitoring that occurs during sexual activity interferes with pleasure and perpetuates ED. In other words, the man is not focusing on the totality of the sexual experience but hyper-focused on his erectile ability. Yet, it is not performance anxiety alone that produces the sexual difficulty, but the dysfunctional catastrophic thinking associated with it (e.g., "I am going to lose my erection again." "My partner will leave me." "I am not a man; I am a failure"). Female partners often experience negative cognitions related to their self-worth or attractiveness or they entertain misattributions about the ED (e.g., "He must be having an affair." "Is he gay?"). The therapist helps the couple to recognize irrational thoughts, stop them, and replace them with factual cognitions about sex, and the relationship.

Additionally, men with ED often report that the penis "has a mind of its own," failing to recognize how situational stressors that can interfere with sexual arousal. Cognitive restructuring helps the couple to expand their focus beyond sexual performance to understand that ED is a complex problem which is often a consequence of life distress, relationship problems, and, perhaps, organic factors. Broder and Goldman (2013) discuss a cognitive staging model that interrupts catastrophic thinking and promotes the understanding of emotions and motivation of each partner as they progress through treatment. They encourage the couple to generate a series of steps or stages that they will attain as they approach higher levels of sexual/relationship satisfaction. Each stage reassures incremental control over feelings and behaviors.

Reducing Anxiety

The relationship between anxiety and sexual dysfunction is well documented in the clinical literature (Dèttore, Pucciarelli, & Santarnecchi, 2013). Sexual anxiety is common and can manifest in various ways, and two forms are particularly damaging with respect to ED: *performance anxiety* and *response anxiety*. As stated, the former appears in anticipation of sex or during sexual intimacy. For instance, in ED the couple focuses on the man's penis and awaits erectile failure rather than concentrating on pleasurable sensations. Response anxiety is the belief that one should feel more desire for the partner than they currently experience or to force the feeling of desire. Cognitive interventions, psychodynamic suggestions, mindfulness practices, and psychoeducation promote recognition and reduction in sexual anxiety. Furthermore, the partners learn to appreciate the damaging effect of anxiety on pleasure and intimacy.

Correcting Mythology

We often find that our couples are uninformed about normative sexual functioning and fail to challenge internalized sexual misconceptions. Misunderstandings about sex perpetuate unrealistic performance expectations and ultimately foster disappointment and sexual dissatisfaction. A particularly destructive belief is that sexual arousal should be automatic and unrelated to feelings, desires and preferences. Another especially toxic mythological belief is the equation of erectile capacity with self-worth, which is often based on the idea that sex must involve penetration and orgasm of his partner. This misconception must be reviewed and directly challenged with accurate information about sexual functioning. Other gender based sexual cognitive distortions involve the woman's preference for intercourse to other non-coital sex. Correcting mythology in addition to other therapeutic strategies will reduce sexual anxiety and cognitive distortions and ultimately foster sexual satisfaction.

Enriching Communication Skills

Clinically, we find that our couples often have difficulty expressing feelings about life stressors, worries, concerns, and so on. They seem to believe that if a problem is not acknowledged or discussed, it will disappear. They do not appreciate that unexpressed feelings can and will interfere with sexual enjoyment. Moreover, they are embarrassed to discuss sexual preferences and desires due to internalized negative messages about intimacy and sexuality. Another factor contributing to poor sexual communication is the lack of comprehension of normal sexual structures and functioning. With specific relevance to ED, some couples fear that speaking about it will worsen the symptoms; thus, the therapist must carefully guide them to release the underlying fears and apprehensions tied to the sexual symptom. Additionally, many men may misconstrue genuine support from their partners as humiliating or evidence of a profound problem. The therapist's role is to correct such misattributions, noting that motivations and intentions are frequently misunderstood, especially in sexual matters.

It is necessary to explain how clear communication about sex improves sexual fulfillment and overall relationship satisfaction. Direct, unambiguous communication is demonstrated by the therapist and validated during sessions. We encourage speaking for oneself in an honest and non-judgmental way and reflective listening, an active process in which the receiver restates the content and reflects back the feeling tone of the sender's message. In sexual communication, the therapist corrects misinformation, clarifies ambiguous language used by the partners, and provides strategies for using correct terminology in sessions and at home.

Psychoeducation

Through recommending readings (bibliotherapy), and other reliable Internet resources, accurate information about sexuality can be discussed in session and at home. A couple can use these resources to help them understand the etiologies and treatment of ED and other factual information about sexuality. The authors have found that reliable resources can normalize sexual experiences, preferences, and outcomes. In addition, sex toys such as vibrators, lubricants, and other devices once avoided by the couple can be introduced through helpful websites (see Weeks, Gambescia, & Hertlein, 2016). It is

crucial that the therapist is well informed, comfortable, and able to suggest and review sources of sexual information. Psychoeducation is an indispensable component of the treatment of ED as it enhances communication, enables opportunities for clarification, corrects mistaken beliefs, increases comfort, decreases anxiety, and allows the couple to make informed decisions about treatments that would be beneficial for them (see Gambescia & Weeks, 2006).

Homework

Homework has always been the hallmark of sex therapy and is a strategic constituent of the Intersystem Approach. While many do not like the term homework (vs. homeplay, assignment, experiment) or the concept, at-home assignments serve countless beneficial functions such as reinforcing what the partners have already learned in session and applying these skills to new situations. Ultimately, homework reduces the anxiety and dysphoria associated with ED by introducing concrete methods to interrupt negative thinking and behavior, and by promoting incremental success instead of failure. Homework expands the learning experience from the office to the home, extending overall therapeutic efficacy (See Gambescia & Weeks, 2007). The art of giving homework has been underemphasized in the sex therapy literature. Cognitive/behavioral assignments for treating ED contain basic components of: psychoeducation, bibliotherapy, communication skills, and sensate focus exercises. Creating and discussing a sexual genogram at home elucidates internalized misinformation, sexual scripts and related expectations, familial intimacy patterns, and other barriers to sexual arousal. Additionally, Weeks, Gambescia and Hertlein (2016) reviewed a detailed systemic application of sensate focus structure, function, and practice. Constructing and deconstructing homework assignments is a collaborative process, although the therapist clearly takes the lead.

Expansion of the Sexual Repertoire

It can be challenging for the man with ED and his partner to unlearn old self-defeating expectations and patterns. An objective of treatment is to help the couple to reset expectations about normative sexual anatomy, functions, and realistic expectations. The couple learns that levels of interest may vary within the individual and between partners and that sexual desire is not always synchronous. Further, enjoyable sex does not necessarily focus on a solitary goal of coitus.

The couple is educated about the role of non-erotic distraction in sexual disorders in order to help them recognize its occurrence and shift their thinking back to their intimate connection (Anderson & Hamilton, 2015). The antidote to erotic interference is mindfulness-based sensuality, in which intimate touching is encouraged as a goal in itself rather than a performance orientation. This approach serves to interrupt the cycle of physical avoidance that is so destructive to relational satisfaction. Graduated sensual touch exercises and mindfulness techniques help the man and his partner to practice erotic and non-erotic touch *in the moment*, and without distraction or judgment. Further, mindfulness interventions promote empathy, compassion, affection, and connection. See Stephenson (2016) for a comprehensive review of the mechanisms behind many mindfulness-based therapies for sexual dysfunction.

Relapse Prevention

Relapses are an expected part of treatment, especially in states of negative emotion, interpersonal conflict, and social pressure. Identifying and anticipating the negative connection between stress and sexual arousal will help the couple to remain optimistic in the presence of a setback. They can be reminded to use the cognitive-behavioral skills they have acquired while the therapist works to uncover other issues that might be triggering relapse. Terminating treatment too soon can generate setbacks. Additionally, when the therapist sets a pace that is too fast, especially around homework, therapy is very likely to fail and that failure may be called a relapse rather than a therapist-induced problem. Determine that therapeutic goals have been successfully accomplished, underlying concomitant factors are addressed, and the couple has a plan to return for future sessions as needed and as scheduled.

Medical Treatments

In cases where organic etiology is suspected, the man is required to see a physician, preferably with his partner. Some urologists have a sub-specialization in sexual medicine. If the couple is considering medical intervention, the therapeutic setting is a safe space to review the advantages and risks associated with all medical treatments for ED and also to discuss lifestyle modifications, which can reduce the severity of ED. We believe that in cases where the ED is primarily organic there are still individual/relational factors at work, which can only be processed in a non-medical setting or with therapy.

Oral Medications

Phosphodiesterase type 5 (PDE5) inhibitors are the first line medical treatments for ED (Rew & Heidelbaugh, 2016). Essentially, oral agents produce relaxation of the musculature surrounding the corpora cavernosa (erectile tissue) of the penis, thereby increasing blood flow into the penis during sexual stimulation. Oral agents do not stimulate libido or desire; they promote vasodilation necessary for erection if the man is aroused. PDE5 inhibitors vary in dosage, onset, and duration of action. This fact is unknown to many couples we have treated. For some men, a shorter acting oral agent is the better choice. For others, a longer acting agent allows more opportunities for sexual activity. Desired frequency and sexual capacity should be considered when considering an oral agent. Often, older men who plan to have sex only once over a weekend, for instance, might feel more comfortable with a shorter acting oral agent.

Presently, there are four PDE5 inhibitors in the United States that are approved by the Food and Drug Administration (Patel & Bennett, 2016). These include sildenafil (Viagra), vardenafil (Levitra), tadalafil (Cialis), and avanafil (Stendra). While all have comparable efficacy and side effect profiles, Cialis has the longest duration. Side effects, while generally mild and well tolerated, could include headache, reddening of the face and neck (flushing), indigestion, and nasal congestion. Cialis® may cause muscle aches and back pain. Priapism (a persistent and usually painful long-lasting erection) is rarely associated with oral agents but must be treated medically if it occurs. PDE5 inhibitors are contraindicated when taking Nitrates because the blood pressure could drop to an unsafe level. Excessive amounts of alcohol when taking PDE5 inhibitors should be avoided because the interaction can cause a drop in blood pressure. Up to 35% of men taking oral agents fail to respond to this treatment due to underlying medical conditions (Shamloul & Ghanem,

2013). Currently, newer pharmacologic treatments such as non-PDE5 inhibitors are under investigation for the treatment of ED (Patel & Bennett, 2016).

The following treatments for ED can be used in conjunction with oral therapies or used alone if the man does not respond to oral therapies. The therapist should discuss and demonstrate the use of specific devices used to treat ED, allowing the couple to obtain information and express concerns. Photographs, digital images, and descriptions are easily accessible online, although it is more helpful to have these devices available for psychoeducational purposes.

Vacuum Constriction Device

With this noninvasive method, a clear plastic cylinder is placed over the penis and air is drawn from the cylinder. Reduced air pressure within the cylinder helps pull blood into the erectile tissue of the penis, producing tumescence. Blood is trapped through the use of an adjustable tourniquet placed around the base of the penis prior to applying the vacuum device; it is removed after sexual relations. Although some men and their partners are satisfied with this appliance, particularly older couples, roughly half discontinue use despite efficacy (McMahon, 2014).

Tourniquet

A tourniquet alone can be used to help maintain erectile tumescence if the man has difficulty maintaining an erection. A soft adjustable loop device is placed at the base of the penile shaft in order to retain the blood in the penis during arousal and orgasm. The device is tightened when the erection is sufficient and removed after the completion of sexual activity. Bruising is a possible side effect and the tourniquet should not be used for lengthy periods of time.

Intracavernosal Injection

Penile injections are highly effective and safe in the treatment of ED. A single or various combinations of vasodilators is injected directly into the erectile tissue of the penis with a small needle prior to anticipated sex. The erection is immediate and predictable although unrelated to sexual desire. Each man requires an individualized dosing regimen. Proper education about administration is necessary. There are several common side effects that can be prevented with proper education, such as pain, bruising, and fibrosis. The discontinuation rate is over 50% (Klaassen & Lewis, 2015) for a variety of reasons including negative partner response.

Intraurethral Medication

A tiny pellet is inserted into the penile urethra with a thin plastic applicator approximately 15 minutes prior to sexual relations. The pellet contains a vasodilator, which dissolves within the urethra and is absorbed into the erectile tissue, promoting tumescence. Theoretically, a resulting erection can last for an hour; however, efficacy is often more limited than the injection mentioned earlier, and many men experience burning after insertion. Success rates are between 43% and 69% (Shamloul & Ghanem, 2013). Many men discontinue intraurethral treatment due to an inadequate response or side effects.

Penile Prosthesis

Penile implants are recommended if other treatments for ED are unsuccessful. In general, the satisfaction rate is high in recipients and their partners (Faller & Kohler, 2017). There are two general types: semi-rigid and inflatable devices. In each method, the devices are surgically inserted into the erectile tissue of the penis enabling tumescence sufficient for sexual activity. The flexible semi-rigid implant can be manipulated into different positions for sexual relations or for rest. The penis is always slightly erect, and the device can be difficult to conceal. The inflatable prosthesis can be filled or deflated through activation of a pump controlling the flow of fluid, which is located in a reservoir in the lower abdomen or the scrotum. This device is used when an erection is desired and deflated when penile flaccidity is desired enabling better cosmetic results. Since it has more working parts, it could malfunction. The major drawbacks to penile implants are infection and malfunction of the hydraulic device (Faller & Kohler, 2017). Once a penile prosthesis is implanted, the erectile tissue is permanently altered, and it is impossible to achieve an erection if it is removed.

Promising Medical Advances in the Treatment of ED

Since the last publication of this text, numerous advances in the medical treatment of erectile dysfunction have been reported. The therapist should be familiar with these methods in order to answer questions and provide information to the couple. The treatments discussed in this part of the chapter are considered *restorative* or *regenerative* medical therapies for ED. The Sexual Medicine Society of North America has not approved the techniques, although preliminary findings, in some cases, have been encouraging. Physicians are currently using them in medical practices specializing in sexual disorders.

Intracavernous Stem Cell Therapy

Stem cells are derived from several areas in the body such as adipose (fat) tissue and bone marrow. These cells are believed to be capable of renewal and regeneration of damaged tissue (Reed-Maldonado & Lue, 2016). Stem cell therapy for ED involves removing stem cells from the individual and transplanting them into the erectile tissue of the penis through injection. Treatments last for several months if efficacious. While stem cell therapy has been used in other areas of medicine for decades, preliminary results have been encouraging in the treatment of ED (Reed-Maldonado & Lue, 2016). Many questions need to be answered about the exact mode of action and overall safety of this procedure.

Low Intensity Shock Wave Therapy

Low-intensity extracorporeal shockwave therapy (Li-ESWT) is a noninvasive treatment that has been used in many medical contexts. Acoustic waves are delivered through a device into damaged tissues or organs to enhance healing. When used for the treatment of ED, Li-ESWT is a simple office procedure performed over time. Theoretically, the acoustic waves serve to regenerate and create new blood vessels in order to increase blood flow to the penis. The goal of treatment is to restore natural erectile functioning in men with ED. This procedure might be more helpful for men with mild ED or who are also taking oral agents (Rizk, Krieger, Kohn, & Pstuszak, 2018). Thus far, the data regarding efficacy has

been inconsistent, according to the Young Academic Urologists Men's Health Group (Fode, Hatzichristodoulou, Serefoglu, Verze, & Albersen, 2017).

Intracavernous Platelet Rich Plasma Therapy

Another restorative injectable treatment for ED is Platelet Rich Plasma Therapy (PRP), which has been used in numerous medical settings to promote wound healing and tissue regeneration with varying degrees of success. Essentially, blood is drawn from the individual and the centrifuged in order to extract a concentration of platelets suspended in a small amount of plasma. Since platelets play a fundamental role in healing, this concentrate should regenerate penile functioning. The PRP concentrate is injected into the erectile tissue (corpora cavernosa) of the penis where growth factors theoretically repair damaged cells and stimulate the production of new cells (Matz, Pearlman, & Terleck, 2018). The frequency of injections is determined by the degree of improvement of erectile capacity. Currently there is a paucity of empirical scientific data regarding the beneficial effects of PRP and ED.

Noncompliance with Medical Therapies

Despite efficacy, second line treatments for ED are often discontinued. The dropout rate can be explained by numerous burdensome logistic problems with the vacuum apparatus and unpleasant methods of administration of pellets and injections. First line oral medications, although popular, also carry surprisingly high discontinuation rates of roughly 50% (Carvalheira, Pereira, Maroco, and Forjaz, 2012). A combination of factors can lead to discontinuation of PDE5 inhibitors, such as non-effectiveness, embarrassment about drug-assisted erections, and fears about physical safety. Relationship factors must be considered and addressed when making decisions about treatments for ED. Our clinical observations are supported by research findings that, despite seeking treatment to improve sexual functioning, relationship factors, such as partner sexual disinterest, contribute to abandoning treatment (Althof et al., 2010; Hong-Jun et al., 2016). Resuming sexual activity after a period of dormancy can disturb the delicate yet fragile intimate homeostasis maintained by the couple. Perhaps the intimacy fears of one or both partners hinder their motivation to be sexually intimate, or other preexisting relationship problems can influence noncompliance. Additionally, using oral agents can introduce pressure or an expectation to engage in a greater quantity of sex than is desired by one or both partners. It is plausible that the prior focus on the ED symptoms distracted the couple from the now obvious dysfunction in the "asymptomatic" partner such as lack of desire. The couple might have become so burdened by ED symptoms and the concomitant performance anxiety that the motivation for satisfying sexual activity is low.

Conclusion

We believe the most pressing issue in treating ED continues to be the medicalization of this problem; ED is often regarded as a physical difficulty that is treated solely by medical solutions. In brief, many men want a pill to fix their ED in isolation from other psychogenic contributory factors; yet, often effective prosexual medications and other devices are discontinued. In the majority of cases we have treated, relational issues contribute to noncompliance despite efficacy. It is our conviction that the combination of sex therapy with

medical treatment would produce the best results. Moreover, we have found that partner involvement is psychosexual therapy will yield the most successful outcome as advocated by Mobley, Khera and Baum (2017).

A glaring gap in the literature is the absence of empirical research comparing men who took an oral medication vs. those who took an oral medication and did so in the context of ongoing sex therapy. Until this hypothesis is resolved empirically, we strongly suggest combing medical treatment with sex therapy when medical treatment is indicated. We urge researches to investigate this question and the pharmaceutical companies producing prosexual medications to seek an understanding of why their drugs are abandoned despite efficacy. Perhaps a warning should be issued with each prescription: do not use without consulting a sex therapist.

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6

A NEW SYSTEMIC TREATMENT MODEL FOR COUPLES WITH PREMATURE EJACULATION

Master Conflict Theory

Stephen J. Betchen and Nancy Gambescia

Introduction

Since the last publication of this chapter, there has been minimal empirical research informing the psychological causes and treatments of Premature Ejaculation (PE). Conversely, medical investigations regarding male orgasm and orgasm disorder are considerably more robust. The psychotherapy approaches (cognitive, behavioral, and psychodynamic) used decades ago remain the mainstay of treatment, but now with the addition of psychopharmacology. In an interesting chapter on this topic, Waldinger (2016) makes the case for the need for well-designed controlled studies of the psychological aspects of PE. He explains that historically, PE might not have been experienced as a sexual problem because there was not as much pressure on the man to sustain an erection for longer durations to participate in satisfying sexual relations (p. 134).

PE is a common and distressing sexual problem for the man and his partner. Men with PE tend to blame themselves for the sexual and relational dissatisfaction that result from this disorder and perceive their overall quality of life as lower than that of men without PE (Rowland, Kostelyka, & Tempela, 2016). They carry the burden of their own sexual anxiety and sense of loneliness in addition to concerns about their partner's distress (Rowland & Kolba, 2018). In fact, female partners of men with PE are distressed when ejaculation occurs rapidly. These women also report that they suffer from sexual anxiety, poor sexual quality, and distress about their sexual relationships (Verze, Arcaniolo, Imbimbo, Cai, & Venturino et al., 2018). They often report that the man is more preoccupied with sexual performance than sexual connection.

In this chapter, we will review the existing information on the assessment and treatment of PE while elaborating on a systemically oriented treatment modality, Master Conflict Theory (Betchen & Davidson, 2018), which expands the repertoire of conceivable etiologic factors as well as the possibilities for enjoyable sex.

Prevalence

The prevalence rates of PE tend to be quite inconstant depending on numerous empirical challenges, such as the lack of a universally agreed upon definition, differences in methodology, and the tendency for men to under or over report the incidence of PE. Zuckerman

(2015) attributes the underreporting of PE to shame and embarrassment about the disorder. In comparison to erectile dysfunction (ed.) sufferers, those with PE internalize their symptoms and take the blame for them rather than attribute them to external factors such as a medical condition or a relationship problem (Rowland, Mikolajczyk, Pinkston, Reed, & Lo, 2016). Alternately, many studies on the disorder suggest inflated rates, in part, because men were included who occasionally, not consistently, experienced early ejaculation, according to Althof, Abdo, Dean, Hackett, McCabe, and McMahon et al. (2010). Shaeer and Shaeer (2011) emphasize that sexuality issues are too sensitive to assess via direct contact. As a remedy, they utilized the Global Online Sexual Survey (GOSS) to afford their subjects greater anonymity.

PE is considered by some to be the most common male sexual disorder (Namavar & Robati, 2011) with rates ranging from 20–30% internationally (Andersson & Abdel-Hamid, 2011). Others believe the percentage of men with either lifelong or acquired PE is "closer to 8–10%" (Serefoglu, 2013, p. 50). The second International Society of Sexual Medicine (ISSM) PE Guidelines Committee determined that the prevalence of *lifelong* PE was no higher than 4% of the general population (Althof, et al., 2014). These findings are lower than many expected. There is insufficient evidence to render similar data on acquired PE.

Regarding men who have sex with men (MSM), Shindel, Vittinghoff, and Breyer (2012) report a dearth of quantitative research concerning sexual dysfunction "due in large part to a lack of validated, quantitative instruments for the assessment of sexuality in this population" (p. 576). In their study of 2,640 MSM, the authors found that PE was consistent across age groups and that risk factors were similar to heterosexual men with the disorder: younger age, lower urinary tract symptoms, and a lower number of sexual partners. Additionally, penetration duration criteria have been established for MSM and men who engage in noncoital sex. Since PE is so distressing for all men and their partners, our treatment approach can be modified for all forms of sexual expression.

Definition of PE

The *DSM-5* (American Psychiatric Association, 2013) defines PE as "a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it" (p. 443). The disorder must be present on all sexual occasions for at least six months, cause significant distress, and not be the result of a nonsexual emotional disorder, relationship issue or substance or medical condition. The *DSM-V* made further distinctions between the two major types of PE: *Lifelong* (in which the man has always had the problem) and *Acquired* (after a period of normal functioning).

Other specifiers include generalized and situational types, and degrees of severity. Diagnostic features such as the idiosyncratic nature of the sexual partner, relationship dynamics, vulnerability, psychiatric comorbidity, stressors, cultural/religious factors, medical factors, age, genetic factors, and drug use are also included in the evaluation process (American Psychiatric Association, 2013).

Waldinger and Schweitzer (2008) postulated that the definition of PE should include 4 subtypes of PE with each type having a distinct clinical profile. This definition was the result of epidemiological research in the general population in 5 countries. This classification is often more clinically useful than the lifelong/acquired dichotomy as it reduces the risk of over diagnosing premature ejaculation (Rajkumar & Kumaran, 2014).

1. *Lifelong PE*: early ejaculation occurs nearly every time with every partner beginning with the first sexual encounter.
2. *Acquired PE*: early ejaculation occurs at some point in the man's life.
3. *Variable PE*: early ejaculation is inconsistent and sporadic but normal given the variability of the ejaculatory process.
4. *Subjective PE*: men who believe they have the problem but do not meet the diagnostic requirements. A man with subjective PE might have imagined early ejaculation but has a normal intravaginal ejaculatory latency time (IELT) and an ability to control ejaculation.

It is important to understand the term IELT, as it is often used in research. It is the time from the moment of vaginal penetration until the moment of intravaginal ejaculation. The most accurate way to measure the IELT is the use of a stopwatch. Using this measure, PE occurs if the man ejaculates within one minute of vaginal penetration.

The Sexual Response

Masters and Johnson (1966) first described a linear model of the physiologic sexual response cycle based on clinical observation of sexual responses. During the first phase of this cycle (sexual arousal/excitement) the blood supply to the erectile tissues of the penis (the corpora cavernosa) increases, creating an erection. Kaplan (1979) later added a psychological state of desire, which theoretically precedes psychological and physical arousal. (This phase is now believed to occur before, during, and after physical arousal.) The plateau phase follows in which arousal intensifies. Orgasm occurs during the height of sexual excitement with the release of sexual tension through rhythmic contraction of the perineal muscles and reproductive organs.

Orgasm consists of two components that occur simultaneously: emission and ejaculation. In the first component of orgasm seminal fluids move through the internal structures of the testes and are deposited at the back of the penile urethra. Emission is characterized by a sense of ejaculatory inevitability (point of no return). The orgasm cannot be stopped although the ejaculate is not visible yet. The second co-occurring stage, ejaculation, is when the entire ejaculate is propelled from the penis, usually after a few contractions. A state of resolution completes the cycle as the body returns to normal. Following orgasm in men there is an age dependent temporary stage, called the refractory period, in which the penis is refractory to stimulation.

The human sexual response is mediated by neurobiological, vascular, endocrine, and other influences that we cannot discuss here due to space limitations. Essentially, PE occurs when the man cannot moderate or cease sexual arousal prior to the point of ejaculatory inevitability and reaches orgasm before it is desired. PE is considered a disorder of the orgasm phase of the male sexual response cycle. See Alwaal, Breyer, and Lue (2015) for an informative discussion of the physiology of orgasm and ejaculation.

Etiology

To date, the ongoing clinical and empirical research on PE suggests two possible causative factors: organic (physical) and psychogenic. One approach to understanding PE is to appreciate that it occurs along a continuum with purely organic presentations at one end and purely psychogenic at the other. Even in cases with a primarily organic etiology, this

condition is so distressing to the man and his partner that psychogenic reactions usually co-occur. In this chapter, we divide the multiple etiologic factors into five major domains: 1) Individual/Biological, 2) Individual/Psychological, 3) Relational, 4) Family of Origin, and 5) Contextual/Environmental (Weeks & Gambescia, 2015).

Individual/Biological

Much of the literature asserts that lifelong PE is believed to have a mostly organic etiology and thus is considerably different from situational PE in presentation and treatment. Lifelong PE carries a less optimistic success rate for treatment. In this case the man and his partner are helped to adjust to an intractable physiologically based situation (Waldinger, 2016).

Neurological. There are several mechanisms that can theoretically explain a genetic predisposition to any form of PE. Normally, certain forms of serotonin throughout brain pathways exert an inhibitory role on ejaculation. Serotonin disregulation might elucidate a genetic tendency towards PE in some men and can also explain why certain serotonin reuptake inhibitors can prolong IELT (Althof et al., 2014). Waldinger (2016) proposes that a "dynamic" interaction of various neurobiological and genetic factors that can predispose a man to PE (p. 140).

Penile hypersensitivity is another neurologically based etiologic factor in PE: "The sensitivity of the glans penis, the organ triggering ejaculatory reflex, undoubtedly has an important role in the ejaculatory mechanism, and possibly in some forms of PE" (Jannini & Lenzi, 2013, p. 85). Other neurological risk factors for PE include cerebrovascular disease, traumatic brain injury, Parkinson's disease, and epilepsy (Abdel-Hamid, Abdel-Razek, & Anis, 2013).

Hormonal. Studies of the endocrine system and its impact on the ejaculatory process have yielded some valuable results. Corona et al. (2011) confirmed that all hormonal parameters such as thyroid stimulating hormone, prolactin, and testosterone can significantly and independently contribute to IELT variation. The authors also confirmed that PE and delayed ejaculation (DE) are two ends of a single continuum: high testosterone levels were characteristic of PE while DE was associated with lower levels. Type II diabetes mellitus (El-Sakka, 2003) was found to be a factor in the development of PE.

Sexual Comorbidity. PE was found to correlate significantly with erectile disorder (ed.) (Rowland et al., 2010). In fact, declining erectile functioning is the main cause of acquired PE according to Palmer and Stuckey (2008). In an effort to avoid losing an erection, the man increases stimulation and inadvertently causes PE. Additionally, in an attempt to control premature orgasm, the man becomes anxious and also distracted, losing focus on sexual excitement and consequently suffering erectile loss. Finally, after frequent failed attempts at penetration, concomitant sexual anxiety, and partner distress, PE can degenerate into chronic erectile failure. Another version of sexual comorbidity between PE and ED involves the partner who experiences sexual problems such as lack of desire or discomfort. In this situation, the man might rush stimulation or lose arousal in order to diminish the partner's distress.

Urological. Problems with the genito-urinary system have long been linked to PE. Diseases of the prostate are common correlates. Liang et al. (2010) found a high prevalence of PE in men with chronic prostatitis. Varicocele (enlarged veins in the testes) and monosymptomatic enuresis (involuntary urination without other symptoms to explain it) have also been found to be risk factors in the development of PE (Boonjindasup, Serefoglu, & Hellstrom, 2013).

Substance Abuse. PE can develop from the chronic use of or withdrawal from certain substances, particularly opiates. Some users reported that opiate use had alleviated their PE, and that they were afraid to stop using for fear their PE would return (Chekuri, Gerber, Brodie, & Krishnadas, 2012). Arackal and Benegal (2007) found that men who are alcohol dependent can develop PE. The authors noted that the amount of alcohol consumed was the best predictor: the heavier the drinker, the greater the risk. It was reported in the *DSM-5* that PE can also occur following withdraw from alcohol (American Psychiatric Association, 2013). Many alcohol abusers have avoided PE through using alcohol, but once they adjusted their drinking habits their PE often returned (Betchen, 2001, 2009).

Individual/Psychological

PE could also be a cause or consequence of emotional issues in the individual, such as anxiety, depression, vulnerability to embarrassment and guilt, social phobia, low self-confidence, negative body image, and psychosocial stress (American Psychiatric Association, 2013; Rowland & Cooper, 2013). In most cases of PE, performance anxiety is driving the sexual problem. Lack of sexual experience, idiosyncratic masturbation patterns, and youth have been associated with PE in the clinical literature, yet no empirical validation of these factors has been documented.

Cognitive-behavioral sexologists viewed PE primarily from a behavioral and social learning perspective (Metz & McCarthy, 2003). Abdo (2013) wrote that some men who experience lifelong PE "appear to lack dating or interpersonal skills as well as specific sensual and sexual physiologic knowledge and skills" (p. 213). We have treated several men who have suffered from PE in part because they had little to no sexual experience. As a result, they were unable to recognize increasing sexual arousal and control their ejaculatory reflex.

According to psychoanalytic theory, PE is the consequence of a man's unconscious conflicts with women. Abraham (1917/1949) believed the disorder, which he termed *ejaculatio praecox*, to be anchored in a repressed sadistic struggle against the mother which in real time manifested in a desire to give a female partner something of himself that he values (i.e., his semen), but also a need to exact revenge (i.e., PE). The conflict was believed to be symptomatic of "the disappointments of love to which as a child his mother subjected him, and which he finds repeated again in later years" (p. 297).

Relational Factors

Partners must cooperate with one another to create a healthy sex life. Cognitive-behavioral and psychodynamic systems therapists believe that PE, particularly the acquired type, can be symptomatic of relational problems. Power or control struggles, poor communication, fear of commitment, fear of intimacy, and unrealistic expectations regarding sexual performance have been cited (Abdo, 2013). While dyadic factors have been attributed to PE, the disorder was also found to have a negative impact on a couple's overall relationship (Althof, 2013; Rajkumar & Kumaren, 2014).

A power or control struggle may ensue when partners differ in their sexual demands. A man suffering from acquired PE sought couple's therapy because his long-time girlfriend became critical of his sexual style. She preferred to have intercourse "fast and hard," with no let up until she achieved a "vaginal orgasm." If her boyfriend ejaculated before she reached her goal, she would disparagingly compare him to her past lovers. The boyfriend

"hated fast sex." He soon became less caring about his girlfriend's needs and in turn, gave up control of his ejaculatory reflex. A destructive control struggle emerged.

Effective communication is an important factor in a couple's sex life. The wife of a middle-aged man gave her husband an ultimatum to attend couple's/sex therapy or she would divorce him. Apparently, the husband could only delay his ejaculation for several seconds during intercourse, an acquired problem. When he was finally able to communicate his anger and hurt regarding his wife's threat to divorce him, she apologized and told him that his PE made her feel that he didn't care about her. The husband's ejaculatory control soon returned.

PE can emerge out of a sexual atmosphere wrought with pressure and anxiety. A woman 20 years her husband's junior presented with him for couple's/sex therapy because he was exhibiting PE. For many years the husband functioned well sexually but as the relationship began to deteriorate (because of other factors such as age and value differences), the wife became more and more demanding in bed until her husband could last no more than a few seconds following penetration. On more than one occasion he ejaculated before penetration because his wife had insisted on prolonged foreplay. His solid erection was attributed to his sustained attraction to his wife, but his PE was symptomatic of the enormous pressure he was under.

Family-of-Origin Factors

PE has been found to be symptomatic of internalized emotional conflicts emanating from the family-of-origin (Betchen, 2010; Betchen & Davidson, 2018). Conflicts can be passed down from generation to generation and manifest in the same or different symptoms. Bowen (1978) referred to this as the *multigenerational transmission process*. Bowen suggested using a genogram as a tool to assess significant family-of-origin influences. DeMaria, Weeks, and Blumer (2014) also employed the genogram to assess sexual influences (see *Assessment*).

A man with lifelong PE presented for treatment at his wife's insistence. It was determined that his PE was symptomatic of a cruel and erroneous message he received repeatedly in his family-of-origin: He was told by his father and older brothers that he had a "little penis." His father also told him that he would have a hard time satisfying a woman someday. Carrying this devastating message from his family-of-origin, the man didn't attempt intercourse until he was in college. Even then he needed the help of alcohol or drugs to allay his anxiety. Once he married and cut back on the substance use, the PE became evident. His PE symptom was believed to be a metaphor for his feelings of inferiority, which his wife reinforced every time he ejaculated too quickly and "robbed her of a vaginal orgasm."

Contextual/Environmental Factors

PE is a geographic and culture-dependent symptom (Namavar & Robati, 2011). Studies utilizing data from the Global Study of Sexual Attitudes and Behaviors (GSSAB) found that rates in Non-European West (27.4%), Central/South American (28%), East Asia (29.1%), and Southeast Asia (30.5%) were similar; rates in Northern Europe (20.7%) and Southern Europe (21.5%) were lower (Laumann et al., 2005). However, PE rates in Middle Eastern countries (12.4%) were found to be significantly lower. One possible explanation is that circumcision, a procedure that actually diminishes the sensitivity of the glans, is

common among Jewish and Muslim men in this region (Namavar & Robati, 2011). Nonetheless, religious, cultural, ethnic, and other environmental variables, such as stress, could influence sexual behavior and should be explored when assessing for PE.

Growing up in a home with rigid religious values and/or a strict moral code can produce internal sexual conflicts. Negative attitudes towards sex (e.g., sex is dirty) can do the same. We have treated men with PE who grew up in households that either failed to mention a word about sex or did so in a negative manner. Even if marital sex was sanctioned, the anti-sexual messages received in their youth oftentimes made it difficult for these grown men to enjoy sexual activity to its fullest. As a compromise, they allowed themselves to have sex (and in many cases to procreate) but hastened the activity in an attempt to circumvent the pleasure of orgasm.

Even religious groups that encourage sex between spouses in a relatively positive manner can, because of their laws, create sexual skill deficits leading to PE and other sexual disorders. In treating Hassidic Jews, we found the concept of refraining from premarital sex in conjunction with isolating from the popular culture/media to be important factors in their inability to control the ejaculatory reflex. See Hall and Graham (2013) for a more elaboration on cultural contexts and sexual pleasure.

The Treatment Model

A systemic model has been found to be particularly effective with those couples who suffer from sexual disorders such as PE (Betchen, 2015; Betchen & Davidson, 2018). The model proposed herein combines aspects of psychoanalytic conflict theory (Freud, 1910/1957) and psychodynamic family-of-origin work (Bowen, 1978) with basic sex therapy principles and exercises (Kaplan, 1989). The approach also acknowledges advances made in the medical treatment of PE, but it shows that medical treatment may be fraught with the same underlying psychological issues. The objective of this approach is to help couples uncover and resolve any unconscious conflicts, rooted in their families of origin, responsible for sexual symptoms.

A conflict is defined as a predominantly unconscious, internalized fight or duality within each partner that, if out-of-balance, can produce relational and sexual symptoms. For example, if each partner has a *success versus sabotage (*i.e., *big vs. small)* conflict (Betchen & Davidson, 2018), one side of each of them wants to achieve their goals and the other side resists. When a conflict is unbalanced or tipped too far for too long a period of time, the homeostasis of the dyadic system is disturbed and symptoms may emerge. In this case, if one partner becomes too successful, the other partner may then attempt to rebalance the conflict (e.g., sabotage that partner's success), escalate the imbalance (e.g., increase his/her own level of resistance to succeed), or end the relationship (e.g., choose loss over the discomfort of a newly balanced conflict). It is not hard to imagine why conflicts regarding success can show up in the bedroom.

Behavioral sex therapy exercises (Kaplan, 1989) are employed at the discretion of the clinician. They may be deemed unnecessary if the clinician believes the couple can resolve their symptoms without behavioral intervention or viewed as inappropriate given the depth and intensity of the underlying conflict. Exercises may be assigned simultaneously with psychodynamic work or follow it after certain resistances have been removed.

A medical evaluation is usually mandatory but some of the PE sufferers have obtained a urological evaluation prior to seeking sex therapy. This issue presents a paradox: men with PE tend to avoid seeking medical help because of embarrassment (Shabsigh, 2006); but

because our society is far more medically than psychologically oriented, most men seek medical attention for sexual disorders first. Sex therapy is oftentimes perceived as a last option.

Assessment

The assessment process is usually performed with both partners in attendance. The first question asked is what brings them to treatment. Each partner is allowed relatively equal opportunity to present their perspective. If one partner attempts to dominate, the therapist is to gently intervene in order to maintain therapeutic balance, a key ingredient in couple's therapy.

After forming a clear understanding of what each partner perceives as the chief complaint, the therapist assumes control and begins asking each partner a series of questions about their individual and relational lives. The genogram is used as an assessment tool to record what the therapist deems as significant information. The sexual life of an adult, which plays a major role in the life of a couple, is highly influenced by family history. Incorporated into the genogram is a sexual examination of each partner's sexual history and current sexual status (DeMaria, Weeks, & Blumer, 2014). The evaluation can be completed in one or two sessions, depending on the complexity and cooperation of the couple. However, the genogram process is ongoing as the clinician can, at any time, add new information or make adjustments to his/her initial hypothesis.

Medical/Pharmacological Treatment

Immediately following the assessment, the man should be referred for a physical examination (if he has not had one recently). Preferably, the exam should be performed by a urologist with a background in working with sexual dysfunctions. While there is still no universally approved medication to treat PE, many physicians rely on the off-label daily use of antidepressant selective serotonin reuptake inhibitors (SSRIs) because delayed ejaculation is a known adverse effect of these antidepressants. The most commonly used SSRIs are paroxetine (Paxil), fluoxetine (Prozac), sertraline (Zoloft), and citalopram (Celexa). Prolonged use of SSRI therapy can cause hypoactive sexual desire disorder, ED, anorgasmia, weight gain, and sleep disturbance. See Gur, Kadowitz, and Sikka (2016) for a detailed review of current therapies for PE.

Recent outcome studies on these drugs prompted Waldinger (2013a) to write, "Without doubt, daily SSRI treatment is effective in delaying ejaculation" (p. 231). While Waldinger did not claim that SSRIs work for every man, he reported that an adequate ejaculation delay occurs in approximately 70–80% of PE sufferers within a 1–3 week period.

Dapoxetine (Priligy) has emerged as the most effective oral treatment for all forms of PE (Althof & McMahon, 2016; Jian, Wei, Ye, Li, & Wang, 2018). Dapoxetine is similar to other SSRIs in that it is a very strong inhibitor of the serotonin reuptake transporter. Moreover, because of its short half-life, it is believed to be better suited as an on-demand treatment of PE (Park, Park, Kim, Baek, & Lee et al., 2017). Unlike the long-acting SSRIs, Dapoxetine has been found to produce a lower incidence of undesirable sexual side effects, and because it is taken as needed it is less likely to be discontinued (McMahon et al., 2011). In a meta-analysis of randomized controlled trials, Dapoxetine was found to be significantly more effective than placebo in treating PE (Li, Liu, Wu, Fan, & Dong, 2018). The drug is considered safe and effective and this group of researchers found no need for future

trials. It is approved in 50 countries for the treatment of PE (Althof & McMahon, 2016). Unfortunately, the Food and Drug Administration (FDA) has not approved Dapoxetine in the United States; yet, many men purchase it from other countries because of its efficacy. A small observational Korean study investigating Dapoxetine discontinuation determined that when participants dropped out of the two-year study, they felt the drug was too expensive, that PE is not curable, and that it needed to be used every time they had sexual relations (Park et al., 2017). Cultural factors notwithstanding, this study underscores the need for psychoeducation and sex therapy in conjunction with pharmacotherapy.

Tramadol is an oral opioid analgesic commonly used to treat pain, but also has delayed ejaculation as a common adverse effect. Initially, Tramadol use was encouraging but it is associated with more adverse effects and less efficacy than the SSRI's (Gur, Kadowitz, & Sikka, 2016). There is insufficient evidence regarding long-term outcome and tolerance and some concern that users of this medication may be exposed to potential abuse, dependence, and addiction (Palmer, 2009).

Topical creams and sprays can be effective in delaying ejaculation in men with lifelong and acquired PE (Anaissie & Hellstrom, 2016). These anesthetics act by reducing sensitivity to the glans penis. Topical treatments have almost no systemic adverse effects and can be used as needed. These anesthetics are particularly attractive because they can be used on an as-needed basis. (Gur et al., 2016). They can, however, produce penile and vaginal numbness; the latter will require the use of a condom to prevent vaginal numbness (Rowland et al., 2010). The topical application is a report of a dose-metered lidocaine-prilocaine spray used in Europe. Porst and Burri (2018) believe it might become a popular treatment due to affordability and ease of use.

Phosphodieterase type 5 (PDE-5) inhibitors, which were originally developed to treat ED, are sometimes employed to treat PE (Hellstrom, 2010). As noted earlier, many PE sufferers have comorbid ED. The PE may be the cause or result of ED (Linton & Wylie, 2010). While several studies have demonstrated the efficacy of PDE-5s in treating men with acquired PE and associated ED, the drugs were not effective in treating those with lifelong PE who did not have erection problems (Palmer, 2009). However, Gökçe, Halis, Demirtas and Ekmekcioglu (2010) found that PDE-5s prolonged IELT and that penile rigidity was also better in post-ejaculatory period. The authors suggested that their findings support the usage of PDE-5s to treat lifelong PE. Asimakopoulos, Miano, Agro, Vespasiani, and Spera (2012) specifically studied the impact of PDE-5s on PE sufferers without ED. The authors found that the PDE-5s served to enhance IELT as monotherapy or in combination with other drugs.

Male clients with PE should be informed that the body sometimes adjusts to medication or a spontaneous remission of any drug-related sexual problem that may occur. This may be the case for SSRIs. As always, medical treatment must be discussed and carefully monitored in the event that a medication change is necessary or that a client is suffering from an adverse reaction.

Behavioral Exercises

We have found that behavioral homework exercises can be helpful in working with PE. The exercises can be performed by the man alone or with partner involvement. The outcome is usually better if the partner is involved. The first step in behavioral exercises is psychoeducation about the sexual response and about the physiology of orgasm. The man and his partner must understand about the stages of orgasm, particularly the point of

ejaculatory inevitability, as they will learn to cease stimulation prior to that point. Additionally, the therapist explains the two phases of the male orgasm, emission and ejaculation, and that these are distinct processes although they occur simultaneously.

Treatment of PE involves behavioral techniques that promote awareness of sensations as they build and also learn how to regulate the degree of arousal experienced. The man and his partner ultimately learn that they are in charge of arousal and orgasm and that these processes do not have to occur spontaneously. With practice and time, the man and his partner can see the progress in sustaining an erection for longer and longer periods prior to ejaculation.

The first of the behavioral exercises is a simple series of steps involving intimate touch that can be assigned for "at home" extension of the work that occurs in treatment. The therapist carefully explains that the goal is to become aware of the feelings associated with touching and being touched. Behavioral exercises should be assigned judiciously when the couple is ready. Carefully planned touch in acceptable increments should be recommended only if the experience is tolerable to both partners. The level of stimulation and pacing of sensual touch increases as per the tolerance of the man and his partner. They should never feel rushed. The purpose of this exercise is to become aware of how the sensations can change over time. They are also instructed to focus on what is pleasurable or perhaps not pleasurable and to redirect the partner if necessary. The focus is on mindful appreciation of sensations in the moment without judgment. Sensual touch is intended to interrupt the cycle of avoidance that so often occurs with sexual problems. Sensual touch exercises can be assigned to anxious couples as a primer for more genitally focused exercises.

The following exercises can be used in all cases of PE, although there is greater success with acquired rather than lifelong forms of ED. We will not give a comprehensive description in this chapter because these exercises are discussed in great detail in our companion text, *A Clinician's Guide to Systemic Sex Therapy* (Weeks, Gambescia & Hertlein, 2016). The techniques are as follows: 1) The New Sensate Focus Technique, 2) Stop Start Technique, 3) Stop-Slow Technique, 4) Squeeze Technique, and 5) Quiet Vagina Technique.

It must be stated that there is no body of empirical research to validate the efficacy of the behavioral approaches mentioned here. These techniques are used clinically and discussed often in clinical papers. Most therapists find them to be helpful in many cases of PE. They can be used alone or in combination with medical treatments. Additionally, they can be incorporated into the Master Conflict Therapy Model described in this chapter.

It is quite common for one or both partners to sabotage exercises. Many partners refuse to cooperate in performing them; some leave little or no time to practice; others make up their own exercises despite the clinician's instructions. The clinician should be as clear and detailed about the exercises assigned. Insisting that the couple agree on the time, place, and frequency of the assignments, as well as who is to initiate and for how long, which may avert confusion and preempt conscious or unconscious sabotage. To avoid a partner feeling taken advantage of by the exercise process, the clinician might want to discuss whether the partner wishes to be satisfied prior to beginning each exercise.

The behavioral approach to sex therapy makes it easy for the clinician to assign exercises as if reading a cookbook. However, because couples differ in introspective ability, motivation, levels of resistance, degree of experience, and level of sexual difficulty, the exercise regimen offered should be considered a general framework for treatment and not one automatically applied in the same way to all couples.

Uncovering Relational Conflicts

In order to uncover any individual conflicts that may be responsible for the PE symptom, the clinician must carefully examine a couple on two levels: *Interactional* and *Psychodynamic*. On the interactional level, the clinician observes the couple's interactional style and searches for contradictory patterns indicative of conflicts and collusions that are symptomatic of their sexual symptom. For example, during the treatment process a wife was threatening to leave her husband if he failed to get his PE under control. She asked him numerous times over the years to seek treatment and he only recently acquiesced. After many attempts to sabotage his exercises, the husband began to gain ground but the closer he got to success, the less cooperative his wife became.

This contradictory behavior begs the question: *Does or doesn't the wife want her husband to function better sexually?* According to theory put forth in this model, the answer is: *She does and she doesn't want her husband to gain control over his PE.* She allowed him to avoid treatment for years and now that he's progressing, she's sabotaging the process. One can ask the same question of the husband. He procrastinated long enough before he sought treatment and he sabotaged his exercises numerous times before he got on track.

Uncovering Psychodynamic Conflicts

Some couples have an indication that their interactional style is contributing to their PE, but few are aware of the psychodynamic conflicts that contribute to the sexual disorder. The clinician may use the genogram to help the couple bring their conflicts into consciousness by investigating each partner's family-of-origin. The objective is to help the couple to see the connection that exists between the past and the present, between the conflicts, their current relational interactions, and the associated PE symptom. This process continues throughout the therapy.

The genogram of a male client with acquired PE revealed that he was never able to satisfy any of the women in his life. His mother was very critical of him, and his father was too passive a man to intervene on his son's behalf. The man's first wife was a materialistic woman. She demanded that he shower her with gifts and allow her an open checkbook. Although the client functioned well sexually with her, she nevertheless left him for another man as soon as the client could no longer afford to keep her in the manner to which she had become accustomed. The client was traumatized.

A man presented for treatment of PE at the insistence of his second wife who refused to attend sessions. It was determined that he was so anxious about losing his wife and experiencing another divorce that he could not perform. The more sexually disabled the husband became the more he upset his wife. While she did not leave her husband, as he neared gaining control over his PE, she told him that she was never attracted to him and that she did not want to have sex with him ever again. He needed medication to cope with this news. There was also some concern that he might harm himself. Part of the man wanted to be loved and accepted and the other part seemed to have an unconscious desire to be rejected. This dynamic indicated an *acceptance versus rejection* conflict (Betchen & Davidson, 2018).

With the aid of the genogram, the man was able to track his conflict-pattern back to his family-of-origin. He soon realized that he was playing his father's somewhat helpless role and marrying rejecting women, like his mother. The genogram also depicted this conflict in the client's relationship history as far back as high school, a discovery that

was instrumental in convincing the PE sufferer that he has had this problem for a long time, and that it was causing him a great deal of pain.

Resolving Conflicts

In order to resolve a conflict, both partners must accept the fact that a gain on one side means a loss on the other. Partners do not seem to like this notion and will spend a lot of time trying to find a way to "have it all." They do so even after their conflicts are made clear to them. People fear change no matter how tough their situation is. The ability to choose a different way of life usually depends on the degree of anxiety partners can tolerate, and their ability to bear frustration.

The previously mentioned client felt that he was being mistreated by his second wife; he knew full well that she would never have sex with him again. But he was also afraid of challenging her for fear she would leave him. He had a big decision to make: challenge his wife and risk another divorce or live on her terms. He came to grips with the fact that he would suffer a loss either way. The question is would the gains outweigh the losses.

While going through the so-called differentiation process, the client eventually realized that if he decided to become more assertive in his relationships (demand to be accepted for who he was), he would have to accept that his father's passivity might have been just as detrimental to him as his mother's rejection, maybe more so. He would have to feel more comfortable internalizing a more masculine presence rather than view this as "behaving like his mother." Ultimately, it is each partner's choice as to whether they want change. It is the clinician's job to show them the conflicts, discover where they've come from, and to help them to explore their options. If the client decided to stay with his wife on her terms, it was his choice.

Termination

Treatment success is dependent on the alleviation of the PE symptom. While improved individual differentiation and a more functional couple interactional style are often prerequisites for success, if the PE is found to be solely organic in origin and is treated successfully with medication, treatment will obviously be brief. In most cases, however, the PE symptom will not dissipate until psychodynamic conflicts have improved; this often takes longer (Betchen & Davidson, 2018). In other instances, the PE symptom is alleviated but the underlying conflicts produce another symptom (i.e., symptom replacement); in this situation, the clinician should warn the couple that their underlying problem remains and gently encourage them to continue treatment. They should also know that their PE symptom could return if they end prematurely. The termination of a case is usually a decision made by the couple and the clinician together. The termination process may take one or several sessions to accomplish. The couple should be made aware that they could return for treatment anytime they feel the need.

Future Considerations

In recent years, medical science has made some significant strides in the treatment of PE, particularly the lifelong type, believed by many to be organic in origin. Dapoxetine, the first drug specifically developed to treat PE, has yet to receive final approval by the FDA, despite its popularity in other countries and its efficacy.

Researchers continue to explore off-label medication use to treat PE; however, because studies have consistently indicated that the disorder returns soon after stopping drug use, Waldinger (2013b) suggested that a more realistic goal would be to continue to develop new drugs that not only delay ejaculation, but produce more tolerable side effects, if any side effects at all.

Pharmacological progress is encouraging, but it also presents the danger of relying too heavily on a medical solution to treat PE. In their efforts to alleviate discomfort, many physicians still prescribe medications without asking about their patients' relationships. In turn, many patients continue to suffer from troubling systemic dynamics and their associated sexual symptoms. Those with acquired PE are more likely to fall victim to a purely pharmacological approach because this type of PE is more likely to emanate from relational and psychological origins. More than ever, sex therapy with a qualified practitioner should be a requisite for pharmacotherapy.

The model presented herein is integrative and systemic, reflecting the conflict theory approach to treating couples with sexual disorders. It contends that exposing a couple's internalized conflicts, determining the origins of these conflicts, and helping the couple differentiate from the deleterious influences of their families of origin, from which these conflicts have emanated, can result in their resolution. The alleviation of any accompanying sexual symptoms such as PE is expected to be a byproduct of this process (Betchen & Davidson, 2018).

Ultimately, this chapter calls for clinicians to be broad-minded in the treatment of couples with PE. It is particularly important for clinicians to consider the causal factors that may be behind the disorder as well as the treatment options available to help couples achieve greater overall intimacy and a higher level of sexual functioning.

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7

THE COMPLEX ETIOLOGY OF DELAYED EJACULATION

Assessment and Treatment Implications

Sallie Foley and Nancy Gambescia

Introduction

Delayed Ejaculation (DE) is a poorly understood, rarely occurring sexual disorder. It involves the delay or absence of orgasm that results in personal and relational distress. The man with DE has little difficulty in sustaining an erection for long periods of time, yet he is often unable to ejaculate without excessive stimulation – or at all. With DE, the erection is not an indicator of sexual desire. The taxonomy of this disorder has changed considerably over time, giving some indication of the difficulties in coming to agreement about not only what it is, but also how to effectively treat it. For instance, DE has been called inhibited ejaculation, retarded ejaculation, ejaculatory incompetence, male orgasmic disorder, impaired ejaculation, impaired orgasm, delayed orgasm, inhibited orgasm, anejaculation, and ejaculatory inhibition (Abdel-Hamid & Ali, 2017). Of all the male sexual disorders, DE relies most on clinical and anecdotal observations for treatment. The few available empirical studies for treatment of ED yield inconclusive results (Althof & McMahon, 2016).

Defining DE

According to the *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders, fifth edition*), DE is sexual disorder in which a man is unable to ejaculate during sexual activity despite the presence of adequate sexual stimulation and the desire to ejaculate (American Psychiatric Association, 2013). Specifically, there must be a marked delay in, infrequency, or absence of ejaculation in sexual activity 75% to 100% of the time. The delay in ejaculation is distressful for the man and not within his control. Nonetheless, the clinical research is replete with evidence that DE can have a significant negative bearing on the man's sexual relationship and on his partner (Rowland & Kolba, 2018). This is especially impactful if the couple is attempting to procreate.

As with other sexual dysfunctions, it is important to accurately ascertain whether DE is lifelong or acquired. Lifelong DE is extremely rare. Most cases are acquired after a period of normal functioning. Another distinction to be made is if the DE is generalized (all situations) or situational (occurring only under certain conditions or with specific individuals or during solo sexual activity). Approximately 2.5% of men with DE suffer from the generalized type (McMahon, 2013). When assessing for DE, it is also important to determine if the level of distress for the man suffering with this disorder is mild, moderate, or severe.

(the *DSM-5* does not include the partner in the distress criterion.) Regarding associated features of DE, five general areas are discussed in the *DSM-5* as potentially contributory to this disorder (American Psychiatric Association, 2013). These contributory factors are consistent with the Intersystem Approach to DE:

1. Relationship problems such as partner sexual problems or partner health status
2. Relationship factors such as poor communication or desire discrepancies
3. Individual vulnerabilities such as history of sexual abuse or other psychiatric comorbidities such as anxiety depression or situational stressors
4. Cultural or religious factors that serve as inhibitors against sexual activity, negative attitudes toward sexuality
5. Medical factors relevant to the prognosis

From the description in the *DSM-5* (American Psychiatric Association, 2013), one sees problems in this diagnosis. The clinician is put in the position of having to judge whether the sexual stimulation is adequate, sufficient, and the man's excitement has been normal. If DE is situational or intermittent, for instance, and only occurs in the presence of a partner when trying to have intercourse, the clinician is also going to address that partner's reactions to the problem as well as any interpersonal dynamics contributing to DE. The *DSM-5* does have a separate classification for sexual disorders caused by medication or drug abuse, called Substance/Medication Induced Sexual Dysfunction, and DE can be a consequence of the initiation, increase, or discontinuation of a substance or medication (American Psychiatric Association, 2013).

Some clinicians prefer to use another definition based on measurement of how long a man sustains an erection before he ejaculates. This measurement is obtained during heterosexual intercourse. The intravaginal ejaculation latency time (IELT) greater than 22–25 minutes is considered the diagnostic criterion for DE (Gray, Zillioux, Khourdaji, & Smith (2018).

Physiology of Orgasm

In order to understand DE, we will briefly review the physiology of the male orgasm. It is important to understand and distinguish the two phases of the male orgasm: emission and ejaculation. These processes typically occur simultaneously, but in reality, they are distinct activities regulated by separate neural pathways (Althof & McMahon, 2016). Emission begins after physical/psychological stimulation with the closure of the urethra at the bladder neck to prevent the release of urine from the bladder during orgasm. The internal structures such as the vas deferens, seminal vesicles, prostate, and ejaculatory ducts contract and deposit seminal fluid (sperm, semen, and prostatic fluid) into the penile urethra. The man experiences ejaculatory inevitability; thus, the orgasm cannot be stopped during the emission phase because it is already in process. Ejaculation encompasses the continued movement of seminal fluid into the penile urethra and expulsion of fluid from the penis. The contractions of the musculature of the pelvic floor enable ejaculation. The processes of emission and ejaculation involve complex central nervous system activities, adequate nerve transmission from the spinal cord to the internal and external genital structures, and brain stimulation. Additionally, neurotransmitters such as serotonin, dopamine, and norepinephrine are also involved in the physiology of ejaculation (Abdel-Hamid & Ali, 2017).

Any psychological condition, medical disease such as diabetes, medications such as (SSRIs) and major tranquilizers, or surgical procedures that interfere with the brain or the nerve supply to and from the genitals can cause DE. Additionally, DE is associated with aging, most likely because of decreased penile sensitivity and other age related comorbidities (Abdel-Hamid & Ali, 2017).

Orgasm is a physical and emotional process that primarily originates in the brain and central nervous system and has significant personal variation. The time it takes for a man to ejaculate is inconsistent and believed to be influenced by both physical and psychological factors. While orgasm is usually associated with ejaculation, it is not essential to orgasm. Hence, pleasurable orgasms may still occur in men who no longer have a prostate (the organ that produces most of the seminal fluid) or who have had injuries to the spinal cord. Appreciating both the mental and physical factors involved in these important processes allows us to understand ejaculatory disorders, as disruptions of these phases.

The Etiology of DE

The etiology of DE is often a combination of individual psychogenic factors, relational issues, and, in some cases, organic predispositions. Clinicians treating DE will need to approach it as a couple's problem to solve, even if the man is carrying his own fears, anxieties and disappointments. Perelman and Watter (2016) discuss some of the etiologic assumptions connected to DE such as intimacy fears, pregnancy concerns, hidden sexual preferences, ambivalence or hostility towards the partner, and introjected misinformation about sexuality. Any of these fears/concerns will affect the intimate partner and sexual/relational satisfaction. Men with DE carry the burden of their own anxiety about sexual functioning and they also worry about the lack of partner satisfaction and the impact of the sexual problem on the relationship (Rowland & Kolba, 2018). Ultimately, individuals with DE feel like the song from the Rolling Stones, they "can't get no satisfaction." Moreover, the partner's reactions always need to be considered in assessment of the etiologic factors associated with DE. The lack of empirical data, varying theories about cause, and the different algorithms for treatment all point to a sexual dysfunction that is not well understood, requiring an eclectic approach to treatment (Sadowski, Butcher & Köhler, 2016).

The problem of arousal without ejaculation is further complicated by two myths in dominant culture – one that frustrates the therapist, the other the client. The first myth is that many clinicians do not seek the sex therapy skills in treating DE because they think that it is so unusual that they'll rarely see it in their practices. Primary (lifelong) DE is indeed rare, but acquired DE is increasingly common due to medications (i.e., antidepressants) and because of problems associated with an aging population. With aging there is often an increase in chronic illness, more changes in blood flow, penile sensitivity, and medication usage (Di Sante, 2016). This may lead to intermittent DE or increasing difficulty with ejaculation associated with partner intimacy arousal.

The other myth that bedevils clients more than therapists is the urban legend that in sexual interaction, the man who can "go longer" is the gold standard for sexual satisfaction (Zilbergeld, 1999). In fact, partners of men with DE are often dissatisfied, frustrated and feel personally rejected. For men with DE, there can be feelings of inadequacy both in sexual function and in self-image (Robbins-Cherry, Hayter, Wylie, & Goldmeier, 2011). Due to frustration and low self-esteem, a man may avoid sexual interaction as well as talking about this sexual problem. Many couples lack skills in discussing sexual concerns

with each other, resulting in avoidance rather than problem solving. It is quite possible that many years may elapse before getting help.

Perelman (2016; 2017; 2018) identified three masturbatory factors associated with DE: 1) idiosyncratic masturbatory style that cannot be easily replicated by partner stimulation, 2) disparity between the man's preferred erotic fantasy and the reality of his actual partner, and 3) frequent masturbation. Perelman recommends a therapeutic approach to these masturbatory issues as well as other etiologic factors called the "sexual tipping point model" in which the man learns to recognize and control factors that accelerate or decelerate sexual arousal. Masturbatory patterns may need to change as a result of self-stimulation patterns that contribute to the DE.

To summarize, it is not easy to treat DE and to ignore any part of the complex etiology is a mistake. However, DE can be treated successfully for some and managed more successfully for others. The couple/sex therapist should expect treatment to be integrated and comprehensive. The most useful approach to treating DE is to combine rather than separate the biological, relational, psychological, social, intergenerational, environmental, and cultural factors. In short, to utilize the Intersystem Approach on which this volume is based (see Chapter 1).

Prevalence

There is a lack of a consistent definition and numerous variations in research procedures in estimating the prevalence of DE. Nonetheless, the prevalence is believed to be low. Most therapists treating sexual problems will encounter couples experiencing DE but it is not a common presenting problem. In general, the prevalence rates of DE are reported to be 1% (lifelong DE) to 4% (acquired DE) of sexually active men (Di Sante et al., 2016). The acquired form is especially prevalent in men using serotonin reuptake inhibitor (SSRI) antidepressants and in older men (Di Sante et al., 1016). Also, DE may be underreported because it can co-occur with other sexual dysfunctions like erectile dysfunction or low sexual desire. In fact, Apfelbaum (2000; 2001) believed that DE is often a manifestation of low sexual desire.

The Intersystem Approach

The Intersystem Approach to assessing and treating sexual dysfunctions is useful in addressing the known or suspected causes and subsequent treatment of DE. This approach has a framework with five components or domains: individual/biological/medical, individual/psychological, dyadic relationship, family-of-origin, and contextual (e.g. society/culture/history/religion). The therapist's case formulation comprises information organized in all five domains for both etiology and treatment. The Intersystem Approach is particularly useful in sex therapy because it is integrative, guards against the clinician's neglect of any component, and assures systematic formulation and interventions. In the following section, the etiology of DE will be examined within the five domains of the Intersystem framework.

Individual: Physiological/Medical

As discussed, the etiology of DE is not well understood and is thought to be a complex mix of the individual/biological/psychological, couple, and intergenerational. There are a number of possible biological causes for DE. Some researchers hypothesize that DE is

caused, at least in part, by slower bulbocavernous reflexes, less sensitivity in the penis, and a too-high penile sensory threshold (the opposite of premature ejaculation) (Di Sante, et al., 2017). There may also be congenital anomalies or abnormalities due to pelvic trauma or surgery. DE may also result from spinal cord injury, multiple sclerosis, diabetes, and low testosterone levels. Further, Common surgical procedures have been associated with delayed orgasm or ejaculation such as radical prostatectomy, transurethral resection of the prostate, and bladder neck surgery (Gray, Zillioux, Khourdaji & Smith (2018).

Medications use is often associated with DE. Offending medications include but are not limited to: anticholinergic, antiadrenergic, antihypertensive, psychoactive, SSRI and other antidepressants, antipsychotic, and medications associated with the treatment of obsessive-compulsive disorder (Di Sante, et al., 2016). Alcohol can also cause DE, although a review of research indicates that alcohol and DE have not been systematically studied. Again, the clinician relies on clinical case reports since there is a lack of empirically based study of causation. Additionally, the prevalence is, higher, particularly in older men and in those who are depressed or take medications, such as selective serotonin reuptake inhibitors (SSRIs), that impede ejaculation (Perelman, 2016).

Individual: Psychological

The psychotherapy literature provides no new empirically based information about etiologic factors and DE. The psychotherapist is left with the typical arsenal of assessment and treatment modalities. Years ago, Apfelbaum (2000; 2001) theorized that DE results from an individual being out of touch with his own sensory experience in the presence of another person. The man cannot "let go of control" and attends to his own pleasure. Also, he is overly concerned about his partner's reactions. Apfelbaum also suggested that DE is really a form of a desire/arousal dysfunction – particularly if the man is not orgasmic with his partner, but can self-stimulate to orgasm. He prefers his own auto-arousal and is not able to fully relax and be reciprocal with his partner. He maintains an erection, but it is automatic and not pleasurable. In addition, there may be fears about being inadequate that lead to the man being overly goal directed.

If a man has DE that is situational and he is able to masturbate to orgasm by himself, but cannot orgasm with a partner, it is hypothesized that he may have difficulty with loss of control in front of another person or have fears of hurting or being hurt by the other (Hartmann & Waldinger, 2007). Performance anxiety can contribute significantly to an overuse of "what works" (e.g. idiosyncratic masturbation techniques and fantasies) further perpetuating the problem especially when paired with a couple's poor sexual communication – a potent and highly frustrating downward spiral can result.

Anxiety disorders present special challenges in sex and relationship therapies. Bancroft and Janssen (2000) propose a theory of erectile dysfunction related to centrally mediated anxiety in either the fear of performance or anxiety related to outcome of performance. The individual with DE may be similarly challenged, resulting in over control of his sexual response or his relationship (Baucom, Stanton, & Epstein, 2003). A clinician must remember the role of anxiety in DE and question, "Is there underlying anxiety that may have been present well before the event of DE or is there underlying anxiety that has been created by the event of DE?" Intermittent DE, often experienced by men over 50, may cause increased anxiety and relationship stress (Foley, 2005).

Finally, Perelman (2018) postulated that men with DE have difficulty in modulating the degree of arousal versus the inhibition of arousal. In his "sexual tipping point model," he

advocates that arousal is not a binary process but one in which the man is constantly tuning up or down his level of arousal. Clinical awareness of this psychobiological process provides another etiologic factor to consider when evaluating for DE.

Relational Issues

Relationship factors often play a role in both generalized and situational DE. Causative influences can include insufficient pleasure in the interaction, the man's holding back as a way of gaining power, ambivalence about commitment, over-concern about "pleasing the partner," difficulties the couple may have in facilitating his communicating of necessary and adequate stimulation, and disparity between fantasied partner and the real partner. They may be anxious or overprotective, avoiding or downplaying the DE (Wittmann, et al., 2014). Eventually, Men with DE and their partners often become distressed and anxious about having sex, therefore penetrative sex occurs less frequently (Perelman & Watter, 2016).

The heterosexual partner of the man with DE often feels that she or he is to blame for not being attractive enough or skilled enough to facilitate ejaculation (Robbins-Cherry, Hayter, Wylie, & Goldmeier, 2011). There can be a degenerative, spiraling effect when both people experience feelings of failure and inadequacy, leading to a couple's avoidance of sex. Sometimes the man with DE will fake orgasms in order to please his partner. The sexual interaction thus becomes mechanical and disconnected, performance oriented without pleasure, serious not playful (McCarthy & McCarthy, 1998). Eroticism, sexual playfulness, intimacy, mutuality, and spontaneity – central to a couple's sexual pleasure – are usually absent.

Secondary sexual dysfunction of inhibited sexual desire or erectile dysfunction can occur. Situational DE can result from (or perpetuate) relationship dissatisfaction and problems the couple are experiencing outside the bedroom (Rosen, Heiman, Long, Fisher, & Sand, 2016). A man who is conflicted about his relationship may not experience pleasurable relaxation and sensation necessary for orgasm (Weeks & Gambescia, 2015).

Intergenerational Causes

Intergenerational causes may include faulty or nonexistent sexual education and overly critical, strict religious orthodoxy. Hypotheses about intergenerational influences abound and there is no empirical data to support the theories (Hartmann & Waldinger, 2007). It is possible that early experiences of punitive shaming either if caught masturbating or being sexually curious can lead to difficulties with DE. Some men report feeling conflicted about aggression, either because of overly aggressive parental figures or because of severe restriction of any form of normal aggressive activity. These men may become anxious about showing "aggression" or "selfishness" during sexual activity with a partner (Hartmann & Waldinger, 2007). Men may receive messages and sexual scripts that run the gamut from thinking that real men ejaculate easily and every time, to thinking of sex as sport and that real men should be detached and not intimate. A past history of trauma can also create conflicts that can manifest in DE, including the confusion of arousal and aggression, or association of shame with pleasurable arousal.

Sociocultural Factors

Culture and socialization contribute to a person's formation of sexual identity and influence sexual functioning. In North America, men are taught to be independent,

self-sufficient, and protective of partner and family. Advertising also has a stake in promoting this "mighty man" sexual performance image. Zilbergeld (1999) calls this predominant image of male sexuality the "fantasy model," observing that North American culture views the penis as "two feet long, hard as steel" and can go all night. This prevalent cultural model is constrictive and can make mighty men into anxious performers who have difficulty staying connected with their own sensations, partner intimacy, and a realistic understanding of what sexual responsivity looks and feels like. The cultural paradigm stressing these characteristics is a potent socializer. Men may be hesitant to admit they have a problem with DE and feel even more shame if they must seek help.

Establishing Openness and Safety in Sex Therapy

Assessing DE may occur in individual or couples treatment. The process of asking questions and seeking information about the problem will be interwoven with information that the therapist provides to the client both about the processes and about the dynamics of interaction between the therapist and the client (Weeks, Gambescia, & Hertlein, 2016). At the beginning of treatment, the therapist explains how the psychotherapy proceeds and gains the client/couple's agreement to participate in this process. In the absence of empirically based algorithms for treatment, the clinician must rely on skillful piecing together of individual, couple, and intergenerational contributors to the problem. There are also other common considerations when beginning the assessment process.

As the clinician moves through the assessment questions, the clinician will clarify to the client what a sex therapist is – many people are referred and have no idea what they will encounter when meeting a sex therapist or what will happen in a sex therapy session. The clinician then proceeds to ask how the individual or couple was referred for therapy, if either has ever sought sex therapy or psychotherapy before and if so, what that experience was like for him or them. Following the client's line of reasoning for choosing a specific therapist will provide information about how this client assesses his own situation, fantasies he may have about "instant cures" or pace of treatment, and general level of awareness of how psychotherapy works. It is useful to explore how long the client knew about the possibility of sex therapy but waited to begin.

It is important to discuss the gender of the therapist with the client and question if this was an important consideration in selecting the therapist. For some, the therapist's gender is not an important issue. But most clients will have feelings one way or the other about the effect their therapist's gender has on their comfort level in talking about sexual concerns. Clients may feel strongly that they do not wish to discuss their sexual problems with a woman either due to embarrassment or due to feelings that she "could never understand" what he is going through. Conversely, the client may feel that talking to a woman is easier because a male therapist would make the client feel more inadequate, less masculine. In fact, in a research study involving 65 couples randomly assigned to a man, a woman, or a dual sex-therapy team, there was no significant difference in treatment outcomes (LoPiccolo, Heiman, Hogan, & Roberts, 1985). However, there could be initial issues with the degree of comfort with the gender of the therapist.

The therapist may predict that at times the client/couple will feel frustrated or experience a loss of hope. The therapist may even request that if the client/couple becomes so frustrated that they are considering terminating that they will first come in and talk with the therapist before ending treatment. The therapist's prediction of frustration and despair and the invitation to discuss even matters of disappointment with the therapist

serves as a parallel process mirroring the way that the couple will eventually learn to talk constructively with each other about disappointments without disengaging from sexual interaction.

The assessment takes several sessions and usually includes at least one individual session with each partner. In individual sessions, a greater emphasis can be placed on developmental history; social, cultural, and religious influences; and any concerns that may be difficult for the individual to raise with the partner present.

Treatment of DE

A variety of psychological remedies have been suggested for treatment of this disorder but data describing efficacy are limited (Sadowski, Butcher, & Köhler, 2016). Nonetheless, treatment must be tailored to the specific clinical presentation of the man and his partner. Current treatments that could be used to DE include but are not limited to psychoeducation, cognitive-behavioral therapy, insight oriented exploration of underlying conflicts, masturbatory retraining, mindfulness, and couple therapy.

More specifically, Cognitive behavioral therapy involves implementing homework (sometimes referred to as homeplay). These sensual touch assignments help the couple to take responsibility for creating an intimate connection and conditions for intimacy to occur. See Gambescia and Weeks (2007) for further elaboration on homework assignments. Weeks and Gambescia (2016) discuss a systemic approach to sensate focus exercises commonly used during homework. One purpose of sensate focus is to decrease anxiety which may be inhibiting ejaculation. Mindfulness-based sensorimotor assignments help the man to increase sensory awareness and competence (see Brotto, 2018). Insight-oriented strategies reduce self-blame and judgment and increase feelings of self-acceptance. Couple-focused strategies promote intimacy and mutuality as well as further sexuality education and positive sexual interaction for the couple. The overall goal of increasing competence, self-acceptance, and furthering mutuality are the base for a more successful resolution to the problem of DE. Any or all of these approaches can be incorporated into the Intersystem Approach.

The treatment of DE may take only a few months when the problem is primarily the result of sexual misinformation and mild anxiety and the client is able to engage in specific behavior change – like more direct stimulation and personal focus on pleasure. DE, however, is more often a treatment of behavior accommodation, where longer term issues are uncovered and certain aspects of personality "are what they are," meaning resistant to change. In these cases, ejaculation may be accomplished occasionally, but DE remains intermittently and must be accommodated and "lived with" for some indefinite period of time. In other words, the goal of treatment should be to improve the problem or the way the problem is perceived rather than beginning with the idea that treatment is to learn to achieve ejaculation in certain ways and with a certain frequency. This goal is consistent with the idea of sex being mutually satisfying to the couple no matter how that is achieved.

Medical/Biological Approaches and the Individual

Individual approaches to treatment include a respect for possible biologic and genetic precursors of DE. At this time, there are no medications approved by the United States Food and Drug Administration that specifically treat lifelong or acquired DE. Despite limited efficacy, there are many medications reported in the literature suggested to treat

DE. Cabergoline (used to treat over production of prolactin) and Bupropion (an antidepressant) are the two most commonly used (Sadowski, Butcher, & Köhler, 2016).

It is possible for some individuals, whose DE is associated with not reaching adequate sensory thresholds, can be helped by the use of vibratory stimulation although the evidence of efficacy is limited (Sadowski, Butcher, & Köhler, 2016). In one presentation of lifelong DE, the individual purchased a small battery-operated vibrator which he learned to use and found stimulation pleasurable against his upper inner thigh, on his perineum, and at the base of the shaft of his penis. He used the vibrator to successfully achieve sensory thresholds to orgasm while masturbating alone. He was not currently in a partnership so it is not possible to tell if he was able to successfully ejaculate with a partner. He was cautioned by the sex therapist about "idiosyncratic masturbation" and learned to masturbate to ejaculation without the vibrator.

If the individual is taking any medication that may contribute to DE, it is recommended that the clinician work with the treating physician to adjust or alleviate medication interference whenever possible. This may include, for instance in the case of some SSRIs, the possibility of reducing the dosage, switching to another medication with fewer side effects, or possibly adding a medication (for instance, bupropion) where appropriate. Explaining to the client that medication dosing/switching/adding will require teamwork, an inquisitive attitude, and patience is important in the client's tolerance of this sometimes long and frustrating road of treatment.

It is often possible that an individual with DE will develop erectile dysfunction. In these cases, the person may be helped by treatment with medications used to treat erectile dysfunction. There are some clients who do not have erectile dysfunction, but experience a positive placebo effect from taking prosexual medications, such as Sildenafil or Tadalafil, while treating DE. Developing patience in treatment is not easy for clients and some clients respond more positively when they feel they are "doing something." The benefits of this must always be weighed against the drawbacks that may include the client thinking that medicines are the preferred route of treatment, a commonly held belief in the United States.

Sensory Defensiveness or Anxiety Treatments and the Individual

Having noted the central role that anxiety or obsessiveness plays in either helping to create or further problems of DE, the introduction of anxiety reduction techniques is a significant part of sex therapy for DE. These techniques are essentially cognitive behavioral techniques and begin with teaching the individual mindfulness and breathing techniques, progressive relaxation, and increasing sensory tolerance (Metz & McCarthy, 2007).

For many individuals with DE, there may be problems with sensory defensiveness – a condition in which normal sensory input, like certain smells, tastes, sounds, or touch, may be experienced as overwhelming and anxiety producing (Curtis, 2001). For instance, an individual who is mucus averse and dislikes open mouth kissing or the sensation of vulvovaginal "wetness" may have difficulty reaching the necessary sensory threshold for ejaculation in the presence of a partner because the normal wetness or slipperiness of sex is uncomfortable for the individual. In these situations, it is necessary to teach techniques of increasing sensory tolerance through progressive desensitization to not only touch and wetness, but also to the amount or intensity of the experience, focusing on intimacy and closeness rather than on performance (Metz & McCarthy, 2007). A client may select the homework assignment of exploring different types of kissing without further sexual

demand, increasing tolerance for open mouth kissing and tongue exploration. Or, a client who is unable to ejaculate during intercourse may experiment with the sensation of non-demand "wetness" and "closeness" by taking showers with a partner and learning to explore genitals, use lubrications, even rub his penis against his partner's body while they are both "wet all over" in the shower.

Masturbation Flexibility and the Individual

As stated, many individuals with DE have strong idiosyncratic masturbation patterns that have been in place a long time. Using an educational approach, the sex therapist encourages the individual to reconsider the inflexible masturbation pattern and begin to slowly branch out both in stimulation – by using different positions and different intensities of touch when self-stimulating – and by using different fantasies or visualizations when self-stimulating. The technique is especially useful when the DE is situational and involves a partner but is not present when the person is masturbating alone. The sex therapist explains to the individual that increasing his flexibility in masturbation will translate into being more capable of openness to partner touch and flexible response to arousal in partnership. Keep in mind the client may feel that the current form of masturbation is the only thing that works in order to ejaculate. Developing a collaborative plan with the client and couple is the best way to move the man to try different masturbatory patterns both alone and with the partner.

Clinicians sometimes observe that a client may become aware that he does not like his partner and is using DE to get his body to speak for him. In some cases, DE has been the beginning of the end for the relationship and has led the client to explain he has no real sexual interest in the partner, which has, in turn, led to the couple's decision to separate. However, other couples have used this awareness to address the reasons why there is no sexual interest and rededicate themselves to creating a positive and playful relationship with the hope that this will lead to more positive interactions in the sexual relationship.

Increasing Awareness of Outside Influences

Sex therapy often reduces anxiety and self-criticism by exploring the sources of external messages that have influenced the client and encouraging new perspectives about the meanings of those messages. Often a process of reframing takes place. Weeks (1994) points out that exploring the real intentions and realistic assessment of behavior can help the client reach different conclusions about the meaning of a sexual behavior like DE. If he has considered himself to be "inadequate," "withholding," "uncaring," or "over the hill," it will be helpful to explore with this individual the other meanings that DE can carry. Notably, a therapist can remind the client that many individuals with DE are very caring and are actually being overly responsive or attentive to their partners. They are committed to not being aggressive, selfish, or overwhelming their partner with their own sexual needs. They may suffer from a lack of sex education and are self-conscious about their sexuality. And they may just be trying too hard, not having pleasure, pressing on because they feel the demand to perform. Hopefully, the client can begin to see the ways in which he has been burdened by these negative beliefs that often stem from either faulty intergenerational messages or social expectations he has inculcated. The client may advance this insight orientation by using the therapy to understand the background family history that helped create those intergenerational messages about sexuality that were so negative about sexual involvement. Some clients realize that

early messages about sex being dirty, immoral, or shameful have contributed to anxiety in sexual interaction. At times, the insight may include a memory of having been caught masturbating as a child – memories that are inevitably connected with having displeased the adult and memories that led to negative feelings about sexual pleasure. A client may also reflect on the cultural messages he learned about his own sexuality and sexual performance, messages from television, magazines, the Internet, that stress performance not pleasure, and disconnection of the man from his penis and his partner. He may also recognize that he was socialized not to seek help from others for his problems.

Finally, sex therapy may stimulate awareness of grief and loss for the individual who has struggled with the problem. Understanding that he has a right to grieve and that sexual dysfunction is a loss that "no one brings over a casserole for" can create an environment of openness and therapeutic alliance. The very process of talking in sex therapy, grieving, and gaining new information about sexual function can lead to decreased performance anxiety and increased self-esteem. The couple will need psychoeducation in grief work regarding that which cannot be "fixed" – a necessary base to establishing a sexual relationship that accommodates DE (Foley, 2015).

Couple Techniques

If a client with DE has a partner, it is crucial to include that person in the treatment if at all possible. The partner will need an opportunity to dispel myths, grieve the presence of the problem, and engage positively in finding more successful ways to interact. The couple will be helped through increasing psychosexual skills with graduated homework assignments, decreasing performance pressure, and increasing comfort and playfulness (Metz & McCarthy, 2007). Couples who are capable of relaxing and playing together may be helped by the therapist introducing the concept of "borrowing competencies" from other parts of their relationship. The therapist asks the couple to discuss when and how they relax and play together. For instance, if this couple enjoys playing cards, hiking together, or any other shared activity, the therapist can point out that the couple knows how to experience pleasure and playfulness that can be borrowed over into the now "too serious" sex life. This can contribute to a more comfortable focus on non-demand physical playfulness including non-genital massage – touch that is not sexually or genitally focused. The therapist continues to point out that playfulness requires a focus on one's own sensory experience, i.e., being selfish at the same time one is engaged in partnership.

Treatment is often linear or step-by-step, beginning with non demand playfulness, building pleasurable experiences and then proceeding on to non demand physical playfulness and sensate focus exercises. The couple learns to increase comfort with increased erotic stimulation, thereby decreasing self-consciousness. Couples need to be reminded that trust in being physical, erotic, and sensual takes time.

The therapist may find that there is disappointment on the partner's part to the "slow" pace of therapy or therapeutic interventions. It is important to "hear the partner out" when concerns arise as well as continue to assess how the couple sustains friendship and intimacy. It is often important to remind them of the progress they have made rather than the goal they think they should have achieved at a particular point in treatment. The therapist encourages the partner and person with DE to see themselves as a team engaging in desensitizing techniques, reducing performance anxiety, and increasing sensuality. The partner may need to be encouraged to continue to understand her/his own sexual response as separate and important.

Work with couples should include intergenerational messages about sexuality for both individuals. When suggesting the couple try any technique, it is important that the couple feels they have the choice to do the assignment. The sex therapist can offer a range of two or three different possible assignments and the couple makes the decision which one they will try (Weeks & Fife, 2014).

In addition, couples can each create their own "desire" checklist of behaviors/interactions that they enjoy. They can work together to create pleasant and pleasurable places in which to enjoy sex (Foley, 2005). Some couples have rigid to unrealistic sexual scripts of how they want their sexual interaction to proceed and these scripts may need discussion and modification in sex therapy. For example, one highly orgasmic woman expected her partner to orgasm when she did or very shortly thereafter. Establishing the expectation that sexual interaction will be about mutual pleasure while decreasing the focus on perfect performance is an important part of modifying sexual scripts (Foley, Kope, & Sugrue, 2012). Some couples need to work on "reading" each other's body cues and use massage, dance, or exercises to learn to mirror each other's movements, increasing comfort in being together.

Not only do couples work together to create scripts and homework, but also schedule times to be sexual – an oft overlooked and often necessary option for busy couples. The scheduling of sexual interaction also decreases the likelihood that excuses/resistance will prevent the assignments from being practiced. Many couples report that they must grieve their idealization that sex "should" be spontaneous. This grief work may be a part of therapy for the couple as well.

If an individual with DE has avoided intercourse for some time and he is partnered to a post-menopausal woman, she may have some vaginal atrophy if she has not been engaging in penetrative sex (Foley, 2005). If intercourse is resumed after a time of no sex, a woman may have dyspareunia (painful sex) (Foley, Kope, & Sugrue, 2012). These women may put pressure on their partner to ejaculate as quickly as possible from the outset. She may need to investigate the use of a localized estrogen replacement (like Vagifem®, Estradiol®/Estrace® cream), as well as practice penetration with fingers, a penis-shaped vibrator, or vaginal dilators before resuming sexual intercourse. Discussion of lubrications should be included in the sex therapy as well (Foley, 2005).

Intersystem Approaches in Three Therapeutic Situations

If a man with DE does not have a partner, the sex therapist might recommend he use a vibrator with masturbation, encourage further sexuality education, increase his understanding about intergenerational messages from his childhood, and recommend flexibility in masturbation techniques so that the client does not become overly dependent on "one way." Clients can also learn to "pleasure to arousal" for 10 or 15 minutes without focusing on or attempting orgasm, followed by shifting their focus to other things and allowing arousal and erection to abate. Practicing this emphasis on pleasure over performance often helps with intermittent DE and alleviates some of the anxiety over how quickly he ejaculates.

If a client with DE also has anxiety or sensory defensiveness with his partner, the sex therapist will need to predict a longer course of treatment, addressing the client's tendency to retreat to self-stimulation, educate about the role of anxiety and sensory defensiveness, and help his partner to address reactivity or disappointment in sexual situations. Encouraging non demand pleasurable touch, increasing intimacy behaviors and language, and

encouraging focus on the couple's friendship and other resiliencies may provide the necessary ingredients for change. This approach may also work for couples with the intermittent DE that many men experience with aging.

In more complex presentations, especially for those clients who must overcome trauma or untangling pleasurable sexual responsivity from fear about intimacy or vulnerability, the course of therapy must include that which was discussed earlier, as well as help the individual or couple work to integrate insights about their individual and shared histories, reducing feelings of shame or isolation. A flexible use of both individual and couples' sessions may be needed where traumatic experiences or histories of childhood neglect have resulted in an adult tendency to too rapidly withdraw from connection to partner. Homework assignments must be flexible and slowly paced. A coherent narrative of the trauma experience may need to be developed piece by piece (Naparstek, 2004; Scaer, 2001; Solomon & Siegel, 2003). Finally, the couple will need to be reminded to reduce idealizations of "perfect sex" and become more accepting of sex that is "good enough" most of the time (Metz & McCarthy, 2007).

In summary, since the etiology of DE includes a wide range of potential contributory factors, such as neurological damage, hormonal imbalance, and psychosexual/relational issues, treatment must be comprehensive and integrative of the etiologies.

Future Directions

The diagnosis and treatment of DE is an area that needs further study and collaboration among different disciplines to develop a more definitive diagnosis, especially because it is a complex diagnosis. The diagnosis of DE will be affected by both the rising numbers of aging men in the boomer generation and the increasing numbers of men using medications that may affect ejaculation and orgasm. This increase in prevalence should prompt more research on DE, both medically and psychologically. At this time, there is no medical treatment for DE. The psychological treatments specific to this disorder are not new. There is no empirical attention to the necessity of combining medical and biological treatments for DE (Perelman, 2016a).

The Intersystem framework directs our attention to understanding as many of the etiological factors as possible and then developing a comprehensive and flexible treatment approach. The ultimate goal is to help the couple develop a satisfying sexual relationship rather than to focusing on specific treatment goals.

Note

Sallie Foley wrote the original chapter and it was updated by Nancy Gambescia in the 2015 and current editions.

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8

SYSTEMIC TREATMENT OF SEXUAL INTEREST/AROUSAL PROBLEMS IN WOMEN

Nancy Gambescia and Gerald R. Weeks

Introduction

In 2015, when *Systemic Sex Therapy*, second edition was published, there was a lack of empirical information about Female Sexual Interest/Arousal Disorder (FSIAD); consequently, we focused our discussion on the most frequently reported sexual problem, Female Hypoactive Desire Dysfunction (HSDD). FSIAD is complex, because it is inclusive of the many aspects of physical and psychological interest and arousal in women. Further, this diagnostic category involves many influences related to the individual partners, the couple's relationship, intergenerational influences, and other factors such as race, culture, ethnicity and other contextual stressors. We will begin by describing concepts and language central to the understanding of FSIAD.

Terminology

Sexual Desire

This elusive construct is difficult to define. There is little agreement among researchers, clinicians and our clients about the meaning of sexual desire. Furthermore, the experience of sexual desire is qualitatively and quantitatively different for women and men, though recent research has focused more on desire disparities within each gender rather than focusing on gender differences (Mark, 2015). In general, sexual desire is often explained as an appetite, wish or drive moving the individual to seek sexual gratification (Levine, 1987) and a psycho-physiologic state, which is influenced by physical and psychological health, relationship significance, culture, and other contextual factors. The target of sexual desire is personal; for some, desire leads to sexual gratification while for others, the objective is to increase emotional closeness to a partner. In women, sexual desire fluctuates and often wanes with age, duration of the relationship, over familiarity with the partner, and other factors (Sims & Meana, 2010). Finally, sexual desire in early relationships is often characterized as more spontaneous while in long-term relationships desire typically occurs in response to context or relational cues (Basson, 2001a). The notion of spontaneous vs. responsive desire is more a theoretical than empirically based construct.

Sexual Interest

Over the past decades, various models of the sexual response in women have been scrutinized and scientifically investigated. Ongoing dissatisfaction with the linear models spearheaded scientific inquiry into a more accurate understanding of sexual motivation in women. As a result, the term, *interest*, replaced desire for women as it was believed to more accurately reflect a significant portion of the female sexual experience. While *interest* is the substitute lexicon, it is often used interchangeably with desire. Similar to desire, sexual interest represents the willingness to engage in sexual activity. Interest involves the attention to and awareness of sexual feelings that could lead to, accompany, or result from sexual activity.

Sexual Arousal

The physiological genital responses related to sexual interest involve genital and extra genital (throughout the body) vasocongestion (swelling of bodily tissues caused by increased blood flow). Vaginal lubrication, which is a result of increased blood flow to the genitals and subsequent swelling of the genital structures, is often studied as a marker for sexual arousal in women. Laan and Everaerd (1995) scientifically demonstrated that genital arousal alone is not necessarily an indicator of subjective sexual arousal and vice versa. They proposed that both genital and subjective indices must be present in order to adequately measure subjective arousal in women (p. 69). Moreover, recent research regarding the female sexual response supports the fact that sexual interest and arousal may occur simultaneously or that sexual interest may precede or follow physical sexual arousal (Basson, 2001a). As such, sexual desire does not produce arousal but occurs in response to it (Lann & Both, 2011). The complex combination of subjective interest in sex and the associated physical genital sensations are now recognized as one process rather than two (Basson, 2010). The diagnosis, FSIAD, acknowledges that significant numbers of women have little or no sexual interest or arousal and many are distressed about it. Disinterest in sex is one of the main presenting problems for women in couple's therapy (Ellison, 2002).

Sexual Concordance

Concordance is the term used in many empirical studies to describe the relationship between the subjective experience of sexual interest and genital sexual arousal (Chivers, 2010). Yet, for many women sexual interest and physical sexual arousal are often out of sync or discordant. Briefly, this means women are either not aware of the relationship between physical arousal or sexual interest or they are completely unaware of feelings of genital arousal. It also has been scientifically demonstrated that the sexual concordance is higher in men than women (Chivers, 2010; Laan & Janssen, 2007) perhaps because women attend more to external, social and relational contextual cues when assessing their emotional states than men do (Brotto, Pennebaker & Roberts, 1992). In addition, due to genital anatomy, women may feel less physical stimulation (as compared to men) and this factor may contribute to the lack of accuracy in detecting genital responses (Laan & Janssen, 2007). The implicit sexual goal for women, therefore, would be to learn to recognize and improve the concordance between erotic thoughts, feelings and fantasies and the physical arousal that occurs when desirous of sex (Brotto, Chivers, Millman & Alberta, 2016). Thus, it is reasonable to expect that when women are interested in and receptive to

sexual stimuli, they would feel sexual longing and also experience genital arousal simultaneously but that sexual desire might not occur first or at all.

Motivations for Sex

Before we begin our discussion of FSIAD, we would like to challenge the notion that sexual desire is the prime motivation for having sex. Why do people have sex? Meston and Buss investigated this question by (2007) surveying over 1,500 undergraduate students using a list of 237 reasons for having sex. Twenty of the top twenty-five reasons for having sex were identical for men and women. Most of the reasons had little to do with sexual desire, which may include the lack of interest in sexual activity. A factor analysis revealed four main factors and thirteen sub factors, which motivate people to have sexual relations. These included: 1) physical reasons such as stress reduction, pleasure, physical attractiveness, and seeking a new experience; 2) attaining goals, for example, increasing social status, revenge, utilitarian goals, and obtaining resources; 3) emotional reasons such as love, commitment and expression of emotion; and 4) insecurity factors such as boosting self-esteem, duty, pressure from partner, or mate guarding). Although the sample consisted of young and mostly unmarried subjects, the findings were consistent with other reposts of reasons for having sex such as Ronson, Milhausen and Wood (2012).

The Meston and Buss (2007) study raises many questions about the role of interest in having a sexual interaction. Undoubtedly, interest may or may not lead to sex, and if it does, we cannot simply assume the outcome is always pleasurable or satisfying.

More recently, Muise, Boudreau and Rosen (2017) examined two overarching motivations for having sex: approaching a positive goal (relationship satisfaction, physical pleasure) or avoiding a negative outcome (partner disappointment or relational conflict). They empirically validated that when people have sex for positive reasons, there is greater relational and sexual satisfaction and higher sexual desire during sex. They found that when participants were given a task to consider past positive sexual experiences, those in the approach group reported higher sexual desire and satisfaction. This study is interesting because it uses positive anticipation and other cognitive techniques to enhance interest and satisfaction in sex.

Mark and Laszlo (2018) proposed a conceptual model for understanding why people continue to be motivated to have sex in long-term relationships. They performed an extensive literature review on non-clinical samples finding that sexual interest ebbs and flows over the duration of a relationship, varies within and between individuals, and is strongly influenced by contextual factors. Interest/desire discrepancies are common in committed relationships. While many of the studies reviewed involved heterosexual, white, monogamous dyads, Mark and Laszlo (2018) offer a template for future research.

A final clinical consideration in sexual motivation is the fact that sexual frequency is not an accurate measure of sexual interest. A count of satisfying sexual events per month does not illustrate qualitative or contextual aspects of sexual interest. As stated, women will have sex for many reasons (to reduce anxiety, to help fall asleep), not just because they are interested in or desirous of having sex. Women often agree to a sexual encounter in the absence of interest to please their partner. Moreover, as we will discuss later in the chapter, relationship dynamics and other contextual factors strongly influence sexual interest for women (Mark, Herbenick, Fortenberry, Sanders & Reece, 2014).

Female Sexual Interest/Arousal Disorder

The diagnostic criteria for FSIAD as listed in the *DSM*-5 (American Psychiatric Association, 2013) describe the lack of, or significantly reduced, sexual interest and/or arousal. Woman must manifest at least three of the following states in order to qualify for the diagnosis. *Absent or reduced:*

1. Interest in sexual activity
2. Sexual/erotic thoughts or fantasies
3. Initiation of sexual activity (and typical unreceptiveness to a partner's attempts to initiate)
4. Sexual excitement/pleasure in almost all or all sexual encounters (roughly 75–100%)
5. Sexual interest/arousal in response to any internal or external sexual cues
6. Genital or non-genital sensations during sexual activity in all or almost all sexual encounters.

These symptoms must have persisted for a minimum of *six months* and cause clinically significant *distress* to the woman (mild, moderate, or severe). FSIAD can be a *lifelong* condition in which absence of sexual interest is a typical state for the woman. Alternately, when an individual has experienced a change in her sexual appetite, the term *acquired* is used; desire has been present, normally for a period of several years, but there has been a noticeable decline in desire over time. The change can be gradual or precipitous. A woman with *generalized* lack of interest/arousal does not have a sexual appetite under any circumstance regardless of the partner or situation. Typically, she does not engage in sexual fantasy or any type of self-pleasuring. The *situational* type, on the other hand, is marked by desire, which occurs in certain situations or with specific partners. For example, the woman might feel desire when alone, but not with her established partner.

Prevalence

A literature review specifically on FSIAD revealed limited information on the prevalence of this disorder since it was first described in the *DSM*-5 in 2013. Some published articles on FSIAD cite statistics about female HSDD or FSAD, generalizing these data to FSIAD, particularly the data on desire problems. Further, prevalence rates are affected by the distress criterion, and its inconsistent application to studies of female sexual desire (see Meston & Stanton, 2017). While women experience more genital arousal difficulties as they get older, many report less distress over time. When adjusted for distress, prevalence rates for FSIAD are significantly reduced. Due to the lack of empirical data on the diagnosis and validated treatments of FSIAD, some believe the diagnosis has no clinical usefulness (Clayton & Valladares Juarez, 2017).

Discussion

In the *DSM-IV-TR*, HSDD and FSAD, were identified as separate entities, even though there is significant co-morbidity between the two (Brotto & Luria, 2014). The task force for the *DSM-5* recognized the substantial overlap between arousal and desire. Moreover, empirical studies have demonstrated that many women cannot differentiate between

sexual desire and arousal (Brotto, Graham, Binik, Segraves & Zucker, 2011; Laan & Everaerd, 1995).

Controversy abounds regarding this newer umbrella diagnostic category of FSIAD, which theoretically captures women with HSDD and FSAD. Critics assert that combining two diagnoses into a single category could result in: creating a more difficult standard to assess and treat women's interest/arousal issues, and the potential exclusion of some women with low interest and low arousal, limiting their access to medical and psychological treatment (Clayton, DeRogatis, Rosen & Pyke, 2012). Further, Balon and Clayton (2014) assert that there is no scientific evidence for the FSIAD diagnosis and that it has no clinical utility. Their commentary discusses a multitude of empirical and clinical difficulties with this diagnosis. O'Loughlin, Basso and Brotto (2018), in an attempt to support the diagnosis, performed an evaluation of women with FSIAD who also met the criteria for moderate-marked HSDD. They found that the FSIAD diagnosis is broad enough to include women with HSDD. This is only one example of evolving support for the diagnosis of FSIAD. See Graham (2016) for a detailed review of the rationale behind these major changes and the challenges faced in the implementation of the FSIAD diagnosis.

Frost and Donovan (2015) suggested that given the high percentage of desire problems in women (up to 55%), fluctuations in sexual desire might be a normative response to contextual life situations, such as childrearing and menopause, and other situational stressors. Moreover, while the prevalence of desire problems is quite high, reported distress in women is often low. The problem is often magnified by her partner's response to the woman's lack of interest in sexual relations, rather than her fundamental distress. Further, traditional treatments have been unimpressive in curing a disorder that Frost and Donovan (2015) believe does not exist. Treatment might be more effective if it is focused on the relational distress caused by the lack of sexual interest and the contextual/environmental conditions that perpetuate FSIAD.

It should be stated that some sexuality researchers object to gender based stereotypical definitions of normalcy with regard to sexual interest, arousal and desire. In a short commentary on Brotto and Yule's (2016) article on asexuality, Chasin (2017) warned that clinicians should not assume that increasing sexual interest/desire is the "only or best" therapeutic approach to reducing distress about FSIAD (p. 634). Some women might prefer to live a life with little or no sexual interest.

Several clinicians and researchers propose the use of the ICD (International Classification of Diseases), instead of the *DSM-5*. The World Health Organization, which produces the ICD, utilizes multicultural global samples; therefore, this diagnostic system is viewed as a more valid tool for "data driven" diagnoses than the *DSM-5* (Clayton & Valladares Juarez, 2017, p. 269). The changes proposed in the forthcoming ICD-11 suggest that sexual disorders will be categorized only after rigorous scientific research and clinical trials and will therefore be more valid.

The new criteria for FSIAD will satisfy some clinicians/researchers and not others. Meana (2010) explained the multifaceted nature of sexual desire and showed the complexity of the concept suggesting that the benchmark for desire has been more male-oriented or spontaneous. This is desire that just happens. Many other theorists and researchers have emphasized the responsive nature of desire, or desire which is in reaction to the initiation of some kind of sexual activity (Basson, 2001b). Meana (2010) suggests that rather than a dichotomy between the two, there may be a continuum of desire, all of which may be responsive, but individuals with what is labeled spontaneous desire may have a low threshold

for sexual stimuli, whether internal or external, and those with the label of responsive desire may have a high threshold for sexual stimuli. While these data do not apply directly to FSIAD, the clinical usefulness cannot be overlooked. Clearly, detailed large-scale well-designed research will need to be performed on the FSIAD diagnosis in order to prove clinical validity and usefulness.

Theoretical Models of the Sexual Response

Masters and Johnson (1966) proposed a model based on four stages of the physiological sexual response. During the first three stages (excitement, plateau, and orgasm) there is ever increasing physical arousal and, by implication, increasing desire. In the fourth stage, there is resolution or relaxation and reduction in arousal and, by implication, decreased desire. Kaplan (1977) and Lief (1977) built on the Masters and Johnson model (1966) by adding desire as a distinct psychological phase at the beginning of the sexual response cycle, which triggers the subsequent physiological responses. These models were simply descriptive of what happens during the sexual response cycle, but did not explain what produces desire.

Levine (1992) developed a model consisting of three components: 1) drive or the biological dimension that leads to spontaneous desire, 2) expectations or the social dimension, and, 3) motivation or the psychological dimension. The three components work together in determining whether or how much sexual desire occurs.

Basson proposed a non-linear model with complex and reciprocal influences among various components (Basson 2001a; 2001b; 2007). The female sexual response is more complex and circular than male sexual functioning. With women, desire for increased emotional closeness and intimacy or overtures from her partner are usually required to trigger sexual desire. Basson proposes that, for the most part, women experience responsive sexual desire (a response to sexual stimuli) rather than spontaneous desire, which is more common in men. To date there is a lack of strong empirical data supporting the differentiation between reactive and spontaneous sexual desire (Hayes, 2011; Mark & Lasslo, 2018).

A Goal Response Model of Sex developed by Boul Hallam-Jones and Wylie (2008) suggests that motivation for sex may be for hedonistic reasons or to enjoy the moment (pleasure) or it can be for eudemonic reasons that are more practical in nature such as maintaining a relationship or acquiring material security. The Goal Response Model incorporates cognitive, physiological and emotional components. Basically, there is a stimulus, which creates sensory processes, which in turn leads to cognitive processes.

Consistent with the earlier-mentioned study, Brotto's (2010a) review of the empirical literature on diagnostic criteria found increasing support for a model which suggests that sexual desire in both men and women is triggered by a "competent sexual stimulus" (p. 2025). These stimuli may be consciously recognized or unconsciously experienced. Thus, Brotto (2010b) is arguing against the idea of spontaneous desire, proposing that there is always a trigger for the experience of desire. Brauer, van Leeuween, Janssen, Newhouse, Heiman and Laan (2012) reached the same basic conclusion in another review of the literature.

Mark and Lasslo (2018), in a systematic review of the literature, offered a conceptual model for understanding sexual desire in long-term (non-clinical) relationships. Their approach included three broad foci through which to assess sexual desire: individual, relational, and societal contexts. The Mark and Lasslo (2018) model is inclusive of some of the domains of the Intersystem Approach. It also focuses on constructs such as pleasure, eroticism and satisfaction rather than purely physiological processes as in linear models.

Kleinplatz and colleagues (2018) reported a useful conceptual model describing optimal sexuality, which represents years of scientific inquiry. Her empirical research reveals that optimal sexual experiences do not just happen. The first step is to unlearn misinformation that creates disappointing sex and then to acquire mindfulness tools to help immerse the self in erotic sensations sex while forming a strong connection to the partner. Her contributions throughout the years provide a valuable antidote to sexual disinterest and disappointment.

Another model of sexual interest/disinterest is more related to brain functioning. Bancroft (2010) presented a Dual Control Model, which suggests that the interaction between sexual excitation and sexual inhibition are intrinsically related to neurophysiology. In short, he is relating sexual activity or lack thereof to anatomically discrete brain structures. This model explains much of the variability in human sexual responses, inhibitors to sexual interest and arousal, and factors that promote enjoyable sexual functioning. More recently, Nagoski (2015) utilized the dual control model in a popular psychoeducational text, which identifies and normalizes the common gender differences in sexual reactions. Much more neurophysiological research is needed to further identify which structures within the brain respond to excitatory or inhibitory stimuli and why. As the field of neuropsychology develops, we may eventually gain a more biologically based model for sexual interest/desire.

Realistically, there is no grand model that can account for sexual interest/desire given all the variables that have been found to both increase and decrease sexual desire.

The Intersystem Approach

Based on the Intersystem Approach (Weeks, 1994; 2005), assessment and treatment must be inclusive of multiple systems or domains:

1. The physical/biological issues of each individual in the client system
2. Psychological factors affecting each individual in the client system
3. The couple relationship
4. Intergenerational (family-of-origin) influences on each partner
5. Contextual domains (race, culture, ethnicity, history, religion, political, economic, etc.)

Assessment of Etiologic Factors

Female sexual interest/arousal disorder does not occur in a vacuum. We conduct a thorough investigation of the multiple causes of this complex and perplexing disorder and look within all of the domains of the Intersystem to determine etiology: the individual partners (physical and psychological factors), the couple's relationship, intergenerational factors, and contextual stressors.

The Individual: Biological Risk Factors

There are many normative physical states that can produce fluctuations in desire and arousal in women. Fatigue, hormone imbalances during phases of the menstrual cycle, and breastfeeding can reduce interest in sex. Typically, these states are transient, self-stabilizing, and do not produce persistent lack of interest in sex. Some medical risk factors are more

constant, such as postmenopausal estrogen deficiency and persistently low testosterone levels; these states will chronically interfere with sexual interest, desire and arousal. Various other medical conditions can be contributory such as diabetes and thyroid dysfunctions. Others include chronic arthritis, which makes sex painful, and surgeries or medical procedures, which may have interfered with normal sexual functioning such as removal of the ovaries (see Crenshaw & Goldberg, 1996; Maurice, 2007). The iatrogenic effects of many commonly used prescription medications can be another contributory factor in low interest/desire. Any condition that causes a disruption in the central nervous system processes affecting neurotransmitters and other chemical substances in the brain can reduce interest in sex. These conditions do not constitute the diagnostic criteria for psychogenic FSIAD.

Most therapists treating low sexual interest/arousal are not physicians, yet they must assess for physical disorders that could cause or contribute to the condition. Often, a medical consultation is a necessary part of treatment. The therapist must be comfortable interfacing with medical professionals such as neurologists, urologists, endocrinologists and gynecologists. Although a woman may be struggling with a biologically based loss of interest in sex, the couple system is the recipient of all treatments. The goal is to promote adjustments designed to restore intimacy to the relationship.

The Individual: Psychological Risk Factors

Psychological risk factors in the individual partners can be expressed within the context of sexual intimacy, thus giving rise to the development of low sexual interest or desire. These involve but are not limited to: anxiety, depression, negative cognitive distortions, inaccurate beliefs about sex, poor body image, a tendency to fuse sex and affection, career overload, and related sexual problems. In such cases, the therapist may be tempted to turn the focus of treatment to the partner with the lack of desire, but it is imperative that a systemic stance is maintained (Weeks & Gambescia, 2002).

Fears of intimacy or other interpersonal fears in one or both partners could place a couple at risk for the development of low sexual interest/arousal since emotional and physical intimacies are closely related. Working on sexual desire may be hampered by one partner's fear of intimacy anger, rejection, abandonment, exposure, or dependency (Weeks & Treat, 2001). Psychiatric factors such as obsessive-compulsive disorder, and sexual orientation conflicts can contribute to the development of low FSIAD. Further, historical factors such as sexual abuse and emotional trauma can inhibit desire. It is important for the therapist to assess in all of these areas.

Cognitive considerations. The literature clearly shows that women suffering from sexual disorders experience more negative and inaccurate beliefs compared to women without sexual difficulties, making them more vulnerable to critical self-schemas (Géonet, DeSutter & Zech, 2013). The negative self-schemas can be about the self or the relationship, triggering feelings of anxiety, guilt or shame. The presence of negative cognitions will directly inhibit sexual interest and arousal (Weeks, 1987; Weeks & Gambescia, 2002). A recent study of young women in a clinical setting found that women with FSIAD and associated distress experienced more subjective disgust in responses to erotic stimuli than the control group in the study. As expected, disgust led to avoidance of sexual behavior (DePesa & Cassisi, 2017). Cognitions related to disgust will need to be identified and deconstructed.

Based on our clinical experience we also believe that the individual who is able to experience sexual interest and arousal is actually having positive sexual thoughts while the

individual who lacks interest has an absence of sexual thoughts or has a number of negative sexual thoughts. In many cases these thoughts are automatic, unconscious or simply not noticed by the individual. From the onset of treatment, negative sexual cognitions are noted regarding the self, the partner, the relationship, the family of origin, etc. This aspect of the assessment helps to determine which of the thoughts can be changed through cognitive therapy techniques, and to further gage other problems in the relationship that must be addressed through couple therapy or the reprocessing of early family dysfunction and trauma.

Specific to the lack of sexual interest and desire, Carvalho and Nobre (2011) and Nobre and Pinto-Gouveia (2009) found that the best predictors of the lack of interest/desire were restrictive attitudes, concerns or anxiety about performance, and a lack of erotic thoughts in an erotic or sexual context. The treatment model proposed by Carvalho and Nobre (2011) for assessing and treating low interest/desire involved examining negative sexual cognitions, changing those negative cognitions to positive cognitions where appropriate, and using the other thoughts as a guide to assessing other factors that needed to be changed. In another review of the literature, Géonet, Sutter and Zech (2013) came to the conclusion that negative cognitions play a central role in low desire. They also suggested that negative cognitions, sexual schemas, and beliefs should be therapeutic targets. These research findings are consistent with our clinical experience.

Similar to the earlier-mentioned research, cognitive distraction is another consideration when assessing for low interest and arousal. In sexual situations, the woman thinks about non-sexual themes instead of focusing on pleasurable sensations. For instance, a woman's mind can wonder from the erotic experience as she concentrates on what she thinks she should be feeling (response anxiety) or what her partner might be experiencing, thus she carries the burden of worrying about the couple's sexual experience (Rowland & Kolba, 2018). Treatment would involve shifting attentional focus to pleasurable erotic sensations and by introducing novel sexual stimuli (Alvarez & Garcia-Marques, 2011; Laan & Everaerd, 2011).

Additionally, Brauer et al. (2012) suggested it was not the attentional focus alone that determined sexual interest, but the positive associations attributed to the stimuli. Sex-positive associations produced stronger desire. Conversely, the lack of sex-positive associations may be either the cause or the result of low sexual interest and desire. Strengthening sex-positive associations, such as the rewards of a sexual experience, (whether it is a feeling of closeness to one's partner or an orgasm) could help to increase desire.

Relational Risk Factors

Empirical studies and clinical experience underscore the correlation between relational satisfaction and sexual fulfillment (Morokoff & Gilliland, 1993). Partners who communicate sexual preferences, experience sexual variety, engage in intimate touching, cuddling, etc., and set the stage for sex (among other factors) report satisfying sex (Brown & Weigel, 2018; Frederick, Lever, Gillespie & Garcia, 2016). Conversely, problems with sexual interest, desire and arousal are often associated with relationship dissatisfaction. For example, women with low desire tend to report greater degrees of marital distress and less relational cohesion (Trudel, Ravart & Matte, 1993). Other common relational risk factors include contemptuous feelings, criticism, defensiveness, power struggles, and toxic communication (Gottman, 1994). The etiological factors mentioned earlier are presented in a

highly compressed form. Readers interested in doing a thorough assessment of desire disorders should consult our text on this subject (Weeks & Gambescia, 2002).

Intergenerational Risk Factors

Many of the aforementioned risk factors, such as anti-sexual beliefs and negative sexual self-schemas, are learned within the social and familial contexts of each partner. It is essential that the therapist explore intergenerational legacies and other messages regarding sexual intimacy that have been ingrained consciously or unconsciously. In one example, the couple presented for treatment of the woman's lifelong disinterest in sex. She was raised in an extremely religious household and learned that sex was for procreation and not personal enjoyment. Although she recognized that her beliefs did not make sense, she found it difficult to observe her own body, engage in erotic thoughts or solo sex, and enjoy sexual intimacy with her husband. Treatment required a flexible format of individual and conjoint sessions, psychoeducation, bibliography, correcting mythological cognitions and ultimately acceptance of her right to enjoy all of the intimate benefits of marriage.

Contextual Risk Factors

Systemic sex therapy recognizes that culture is central to a person's life.[1] Sexuality is interpreted through sociocultural beliefs, customs, values, and norms, all of which affect the ability to enjoy satisfying sex in relationships (Hyde, 2010; Kimmel, 2007; Money, 1986). Internalized messages about sexuality are frequently distorted through culture, religion, racism, and sexism (Hall & Graham, 2013; McGoldrick, Loonan & Wohlsifer, 2007). Often, unrealistic messages about romantic love and sexual behavior are perpetuated through all forms of media. These messages and images can lead the woman to feel less feminine, attractive, and desirable, compared to social norms. Negative feelings about falling short or the lack of sexual perfection can decrease sexual desire.

It cannot be emphasized enough that a woman's race, culture, religion are profoundly ingrained contributors to the sexual context. The therapist should investigate directly about the woman's deeply held beliefs that affect feelings and cognitions about sex. Other situational environmental variables may fluctuate and can also serve to inhibit a woman's interest in having sex. As stated previously, these stressors may be related to workload, financial worries, job stressors and other daily hassles.

Many of the assessment procedures mentioned earlier are all clinical in nature. The clinician or researcher who wishes to conduct an evaluation that includes psychometric devices may also use instruments that have been empirically validated for female clients. The reader should keep in mind that most clinicians prefer to conduct a clinical history rather than use a survey.

Treatment Strategies

The basic treatment strategies for FSIAD are driven by the etiological factors described earlier. Some are more individually oriented while others deal with the couple, family-of-origin or biological issues. As an introduction to the basic treatment strategies for sexual problems, we would like to call attention to some general indications and contraindications for moving into the treatment of FSIAD.

Indications for Treatment

Whether FSIAD is the presenting problem or is reported during the course of treatment, the therapist must recognize its significance to the couple, and address their concerns about the lack of sexual interest. Furthermore, the therapist should expect to encounter additional individual and relational issues at any point during treatment. Even though concerns that emerge might seem insurmountable, most issues are treatable, although their position of importance may vary during the progression of therapy. Often, the clinician must balance the pressure to treat the lack of interest versus addressing other obvious problems. It is always important to educate the couple by setting the expectation that FSIAD can be a cause or consequence of other emotional and relational concerns. Psychoeducation will promote compliance during a temporary shift away from the presenting problem.

The therapist must carefully assess if treatment is indicated or contraindicated by considering the following indications: partners have generally positive sex beliefs and want to experience desire again; both partners are relatively free from psychiatric problems that can impede treatment; and the couple is motivated to work on the sexual problem, do the required assignments and attend sessions as scheduled. The following problems might appear to be contraindications to treatment but they are not: an inability to break the cycle of negative sexual cognitions and obsessive thoughts that interfere with building sexual interest and arousal; if a partner has withheld historical information about, physical, sexual, or emotional abuse or sexual addiction, and is willing to share and work on this information; negative sexual attitudes based on religious beliefs or internalized negative sex messages from the family of origin, and the resulting sexual guilt; stress from situational life stressors that affect one or both partners; the normal physiological changes of aging, and the willingness to accept accurate information. Other indications for treatment include: treatable relational difficulties in negotiating issues of power, control, inclusion and autonomy; the couple's sexual script has not been successfully negotiated or the partners may have different preferences or misinformation; ineffective communication, unresolved anger, and unmet expectations; low interest related to other sexual difficulties in either partner; the presence of response anxiety; or a medical condition known to affect sexual interest.

Contraindications for Treatment

The systemic treatment for FSIAD *not* appropriate when: the partner with FSIAD does not wish for or care about sexual interest; the problem is viewed as solely belonging to the partner who lacks interest and the other partner is unwilling to participate in the therapy; there is untreatable discord in the relationship or the inability to work together cooperatively; there is a lack of commitment to the relationship or treatment; covert ongoing sexual compulsivity or active addiction in one or both parties; and presence of a significant psychopathology in either partner.

Addressing Pessimism and Skepticism

In most cases, our couples have struggled with low sexual interest for months or years before seeking treatment. Often, they have attempted to repair the problem on their own, have failed, and then resigned themselves to a passionless relationship. Consequently, they

enter treatment with a sense of pessimism and skepticism because they cannot imagine how talking about a sexual problem could possibly alleviate it. FSIAD is a complex phenomenon and difficult to change. The therapist should anticipate that the couple will enter treatment reluctantly and be pessimistic about the outcome. Explaining that pessimism is a natural response to a difficult situation should help to normalize the couple's failed attempts. Support them for their efforts to correct the problem even if previous attempts have failed.

Maintaining a Systemic Focus

Couples often view the symptomatic partner as the one with the problem. They must be educated to think systemically. This involves helping them to recognize that FSIAD is a relationship problem. One systemic technique is the *therapeutic reframe* in which the therapist helps to conceptualize the low desire in a different way (Weeks & Fife, 2014; Weeks & Treat, 2001). The therapist reframes the low desire by asking focused questions that become more and more directed in order to help the couple appreciate how relational problems may have contributed to the lack of interest, helped to maintain it, or created another layer to the lack of interest which is systemic. For example, one reframe would be to say that the low interest partner has created distance in the relationship because the couple could not tolerate too much closeness. The therapist emphasizes that the couple struggles together and will need to work together to resolve how they will relate to each other sexually. In those cases where the lack of interest is an individual medically related problem, the way the couple copes with the situation may influence the degree of desire felt and the way sexuality is expressed. A possible reframe for this situation would be to suggest that the couple has had to struggle to find others ways of relating and being close which has in turn helped them develop more intimacy than ever before in spite of the desire problem.

Setting Realistic Expectations

If couples can learn to expect that sexual interest is not necessarily constant, enduring or predictable, they might be less distressed about it (Herbenick, Mullinax & Mark, 2014). Iasenza (2016) suggests that if women engage in sexual activity under relaxed circumstances, sexual interest and arousal would eventually emerge. Conversely, if they hold the expectation that orgasm-driven sex, accompanied by copious desire is the only indicator of sexual interest, they will be disappointed or distressed. An important part of sex therapy currently is to educate and encourage the woman and her partner that sexual desire will happen eventually if they learn to focus on their own erotic sensations. This explanation is sometimes a hard sell as some women fear that they have fallen out of love with their partner or that they will never recover their sex drive.

Promoting Intimacy

The theme of sexual intimacy is central to the systemic treatment. During treatment, partners share their respective beliefs about what it means to be sexually intimate, to identify discrepancies in their definitions of intimacy, and to work toward a common meaning. Next, the therapist works with the couple to expand their definition of sexuality to include intimate, sensual, and erotic behaviors that do not necessarily include sexual activity such as romantic activation (dating), and non-genital caressing. Finally, the couple is helped to consider enlarging their sexual repertoire.

The fundamental goal of treatment is to restore sexual interest and other forms of physical connection to the couple's relationship. Since the treatment of FSIAD also addresses the relational problems that contributed to or were a consequence disinterest in sex, it is essential that the therapist is qualified and knowledgeable about couples and sex therapy techniques and knows the circumstances under which the techniques will be most effective. Also, we suggest that couples must be active participants in their treatment. They should be aware of why a strategy is being used and what the outcome is expected to be. This collaborative effort will increase compliance.

Finally, many women feel powerless with respect to owning and controlling their sexual feelings. They believe that sexual gratification is something that happens to them. Throughout the process of therapy, the woman and the couple gradually learn that sexual interest and satisfaction are created, fostered, practiced, and nurtured. The couple must be willing to give top priority to treatment by setting aside time to do the prescribed cognitive behavioral assignments and attending sessions on a regular basis. Ultimately, they must take responsibility for their sexual intimacy.

Lowering Response Anxiety

A woman may continuously monitor and worry about her lack of sexual desire rather than enjoying sensual or sexual activity. Response anxiety is the belief that one should experience more desire for their partner than they currently feel at any point of time in their relationship. One critical component to the treatment of FSIAD is lowering the response anxiety and to do so, we use several techniques. First, the therapist educates the couple by explaining the concept. Cognitive strategies such as thought stopping and thought substitution are useful to confront irrational ideas that foster response anxiety, such as the equation of sex and intercourse. In this case, the definition of sex is broadened to include behaviors that are less likely to cause response anxiety, such as non-coital sensual or sexual touching. Also, through the use of mindfulness based cognitive techniques, the low interest partner is given permission to feel whatever they feel, without judgment or trying to force sexual interest (Sipe & Eisendrath, 2012).

Addressing Affect

The therapist will need to attend to the level of affect expressed by each partner by helping them to communicate about feelings rather than staying fixed on content. For instance, the woman with FSIAD may appear to have a lack of affect and seem sexually withdrawn. Conversely, the higher desire partner is often more emotional, frustrated and pessimistic. The unpleasant feelings expressed by the higher desire partner may have the effect of causing avoidance of any situations that might lead to sex. In these instances, the therapist should help the partners attend to and discuss their style of expressing emotion. Also, they are helped to inquire about rather than ascribe motives for each other's feelings. This process helps the couple become more aware of their patterns of interaction, and the emotional barriers to expressing and experiencing feeling of sexual interest. This work is ongoing throughout all stages of treatment.

Cognitive Work

Cognitive therapy is indispensable in the treatment of FSIAD. Negative cognitions about sexual intimacy, the self, and the partner directly contribute to the lack of desire by

preventing the emergence of enjoyable sexual thoughts and fantasies. This cognitive mechanism is powerful and has strong behavioral consequences. Further, couples develop interlocking sets of irrational beliefs that perpetuate sexual problems; these beliefs need to be explored, interrupted, and changed conjointly. A woman with low desire might think, "I'm just not interested in sex." Her partner might also think, "She isn't interested in sex, so why initiate anything." These two interlocking thoughts help to perpetuate sexual avoidance.

The partners are helped to identify interlocking irrational sexual beliefs and to replace them with more positive, factual cognitions. Also, they are encouraged to engage in erotic thoughts and fantasies to promote prosexual cognitions and feelings. Each partner learns to monitor his or her thoughts or behaviors in order to determine when the nonproductive thought has started again. The negative automatic thought needs to be stopped and consciously replaced with positive sexual thought, such as replaying a positive sexual encounter, enjoying a sexual fantasy or thinking of erotic thoughts. This process creates a state of positive anticipation for the next experience. Eventually, erotic thoughts become more natural and automatic (Beck, 1976; 1995; Weeks & Hof, 1987; 1994).

Communication

Communication work is at the core of systemic sex therapy and a vital element in the treatment of FSIAD. The woman with interest/arousal problems is helped to express her sexual needs, wishes, preferences, and concerns and her partner is encouraged to be responsive and supportive. There is an abundant body of literature that reinforces the correlation between sexual and relational satisfaction with communication serving as a mediating variable (Byers, 2005; Montesi, Fauber, Gordon & Heimberg, 2010). More specifically, sexual self-disclosure is a common factor in achieving sexual satisfaction. Brown and Weigel (2018) examined factors that serve to promote sexual self-disclosure and stressed the importance of a safe relationship context, which enables partners to learn about each other's preferences and dislikes. Clearly, their model has therapeutic utility particularly in determining which circumstantial factors will promote (or cause an avoidance of) sexual self-disclosure.

Mindfulness

Mindfulness practices have become increasingly valuable in the treatment of sexual disorders (Brotto, 2018). Specific to FSIAD, women are helped to focus on bodily sexual sensations, in the present moment, without judgment, while avoiding distraction (Pyke & Clayton, 2015). These conditions can help her to recognize the subjective experience of sexual interest and physical arousal (Brotto, Chivers, Millman et al., 2016) and help to increase her attention to physical sexual cues (Silverstein, Brown, Roth & Britton, 2011). Brotto and Basson (2014) reported the results of a group therapy approach to mindfulness therapy. They found that treatment significantly improved sexual desire, arousal, and overall sexual satisfaction. In another study, women participated in mindfulness tasks in which subjective interest and genital arousal were monitored in a laboratory setting. The outcome revealed that subjective and genital concordance was greater in the mindfulness group (Velten, Margraf, Chivers & Brotto, 2018).

In a pilot study using mindfulness based cognitive therapy, women with FSIAD attended eight weekly group sessions and completed at-home mindfulness exercises

(Paterson, Handy & Brotto, 2018). Compared to a baseline, the women who completed the program reported improvement in sexual desire and overall sexual functioning in addition to diminished sexual distress. The data from this study could lead the way to larger scale studies and continued applicability of mindfulness based cognitive therapy for women with FSIAD.

Systemic Homework

The therapist treating FSIAD must play a directive role in session and also outside the therapy hour through the prudent use of assignments to be performed at home. Assignments are given to both partners, not just the woman with sexual disinterest. For instance, homework for the individual partner(s) includes prescriptions regarding physical exercise, guided imagery, gradual exposure to sexual material, directed masturbation and exposure to fantasy through bibliotherapy or selected visual materials (Gambescia & Weeks, 2007). Homework for the couple incorporates sensate focus, communicating sensual and sexual wishes and needs, and conflict resolution exercises (Weeks & Fife, 2014; Weeks & Gambescia, 2002). The couple is also directed to explore intergenerational messages regarding sexual intimacy, pleasure, and entitlement to sexual satisfaction on their own. The continuous use of homework assignments will promote compliance and prevent relapse of the sexual symptoms (Muise, Boudreau & Rosen, 2017).

The use of non-demand incremental touch exercises to be performed at home combined with guided cognitive restructuring can effectively help to uncover more and more negative thoughts as the touching progresses. In our companion text, *A Clinician's Guide to Systemic Sex Therapy, 2nd edition* (2016) and chapters to follow, we will describe a variety of treatment techniques, including Sensate Focus. We often use Sensate Focus in conjunction with other techniques. Intersystem treatment is comprehensive and inclusive of many of the techniques, which address multiple etiologic factors and creates a synergy that a single technique would not produce.

Treating Other Sexual Dysfunctions

In clinical settings, we have found that it is not unusual for a woman and her partner to have more than one sexual problem. It is possible that FSIAD might be related to another sexual difficulty such as physical discomfort during sex, erectile dysfunction, or trouble with orgasm. Often women need a competent sexual stimulus from their partner in order to feel responsive to sex. If the partner worries about sexual performance, the invitation for sex might not be robust. The role of the therapist is to educate the couple in how other sexual dysfunctions in either partner might contribute to the development and maintenance of FSIAD. More importantly, the couple is encouraged to make a commitment to working on all elements of the dysfunction, not just the low sexual interest.

Working with Intimacy Fears

Fears of intimacy and closeness, whether conscious or unconscious, are often exhibited through one's behavior and may be an unconscious motivator in cases FSIAD. In fact, we believe that underlying fears of intimacy can manifest in many ways, including a variety of sexual dysfunctions. Intimacy fears must be examined in both partners since they will become imbedded in the couple's relationship. The therapist educates the couple about

the many reasons why individuals might fear intimacy so that they understand the concepts and will be willing to discuss the related issues as they apply to them (see Weeks & Fife, 2014). In FSIAD cases, a few factors related to underlying fears of intimacy are seen more frequently than others. For example, the fear of losing control or of being controlled (loss of identity and autonomy) may be manifested in the relationships through a power imbalance that is so severe that one partner is perceived as a parent and the other as a child. This issue has the potential to make sex feel nearly incestuous (Weeks & Gambescia, 2002). When there is a fear of losing control for a woman, she may unconsciously turn off sexually as a way to say symbolically that "this is my body and I am ultimately in control of my sexuality."

There are several guidelines for treating intimacy fears. First, identify the fear. Next, use cognitive therapy techniques to help neutralize the negative thoughts associated with the fear and replace the negative thoughts with appropriate and adaptive cognitions. Then, work to disrupt the pattern of avoidance that results from the fears generated by the negative thoughts. It is important for each partner to validate the fearful partner's emotions without agreeing with them, as agreeing would lead to continued avoidance of the feared stimuli and, consequently, the behavior. The historical basis for the fear is also explored. Once the client understands the origin of the fear, they may see that it was adaptive when they were younger, but the fear is now unnecessary.

It is essential that the therapist and couple explore the ways in which each person in the relationship contributes to the problem rather than placing the blame solely on the person with the low sexual interest. We often see that when one partner has a strong underlying fear of intimacy the other partner may have a similar fear. It is no accident they are together. The underlying fears of intimacy on both sides are interlocking and usually deeply entrenched and require extended work ranging from cognitive therapy to intergenerational work.

Working with Conflict and Anger

Many women with low or absent interest in sex have experienced anger and frustration over a protracted period of time. For some, the anger has become chronically suppressed or circumvented, making it very difficult to feel desire toward one's partner. Eventually, the woman avoids most emotional contact in order to avoid stirring up her chronically suppressed anger. Additionally, sexual feelings become suppressed and fused with the noxious emotions of anger, frustration, disappointment, helplessness, etc. The woman must be helped to understand that anger, if expressed, need not destroy the partner or the relationship (Lerner, 2005). A variety of techniques can be implemented to promote appropriate expression of anger. See Weeks & Gambescia (2002) for a broader explanation of this topic.

Creating an Erotic Environment

Weeks and Gambescia (2002) recognized the need to create an intimate sexual environment by creating realistic expectations, developing an ego-syntonic view of sexuality, being responsible for one's own sexual desire, and expressing desire through solo sex. Considering the results of the Sims and Meana study (2010) it would also seem important to focus on some of the following therapeutic goals: defining what is erotic and enacting erotic scenarios, building romantic/sexual fantasies, being more creative and experimental,

viewing oneself as a sexual being with many sexually positive attributes, making a date night that may or may not lead to sex, share equally in household responsibilities, learn the difference between having sex and making love, trying different ways to initiate, showing more affection just for the sake of showing affection or unlink it from sex, communicate more about sexual needs, wants, and desires, maintain good self-care, stay active and exercise, have a clear sense of self, view lovemaking and sex as a pleasure, accept compliments, compartmentalize time to be a sexual being rather than mother, employee, or chore-doer, and think of other ways to re-vitalize desire and a sexual relationship.

Family-of-Origin Work

We have described a number of factors that can contribute to low interest/desire arising from introjected messages originating in the family-of-origin. In treatment, we work conjointly using a sexual genogram format (DeMaria, Weeks & Twist, 2017) and ask about what the partners observed in their parents' relationship regarding affection and intimacy, and the overt and covert messages about sex, love, intimacy, etc. that were demonstrated within the family. It is always interesting to hear the partner's observations about the other's family of origin. We promote self-awareness by challenging internalized beliefs, and we use a technique that helps the woman affirm her sexuality. We call this technique her "Sexual Bill of Rights." She is asked to write the most powerful and compelling statements about what she is entitled to sexually. In most cases, the initial few drafts do not represent sexual autonomy and ownership of her sexuality. The therapist provides feedback and asks the woman to keep working on it, sometimes with the assistance of her partner, until she has embraced her right to experience sexual interest/desire and express her sexual freedom.

Medical Therapies

We are therapists and will want to treat FSIAD problem from a psychotherapeutic perspective. Since interest and arousal problems often have a mixed etiology, some knowledge of medical therapies is useful in understanding how various psychobiological treatments may be combined. A variety of prosexual remedies are currently available to enhance the sexual appetite. Most of these preparations are nutritional supplements and remain unregulated by the FDA (Food and Drug Administration).

In 2015, the FDA approved Flibanserin for the treatment of female HSDD, two years after the diagnosis was removed from the *DSM-5*. This drug is marketed for premenopausal woman, eliminating a large group of women who could benefit from its effects. (It is not FDA approved for post-menopausal women.) It must be taken daily. The side effect profile is significant and includes dizziness (9.2%), somnolence (8.3%), nausea (6.5%), and fatigue (3.7%) according to the package insert (2016). Alcohol consumption while taking this drug is contraindicated because it can cause low blood pressure and fainting (Clements & Thompson, 2018). Flibanserin does not work for everyone; half the women in clinical trials reported no increase in sexual desire. The action of the drug is unknown but it is believed to inhibit dopamine production thereby promoting sexual desire. It also affects other brain neurotransmitters responsible for excitement and inhibition (Both, 2017).

From its inception, there has always been significant political and scientific debate surrounding Flibanserin. The risk/benefit analysis is significant with many women reporting

only incremental gains in sexual interest despite frequent, troublesome side effects. Further, many researchers and scholars contend that we do not understand HSDD (hence, the category change to FSIAD) and since female interest and desire is multifaceted and poorly understood, pharmacotherapy is insufficient to treat it (Anderson & Moffatt, 2018; Both, 2017). Finally, others contend that FSIAD is not a disorder but a normative state for many women.

Other central acting pharmacologic agents are used off-label to increase sexual desire in women such as Bupropion (an antidepressant) and Buspirone (an antianxiety drug). Research into other centrally acting medications had been ongoing specifically investigating the influence of neural pathways that regulate sexual desire (Stahl, 2010).

Hormonal therapy is often used to treat the lack of sexual desire in women, specifically the off-label use of testosterone in postmenopausal women. This treatment is not FDA approved. Testosterone is recognized as an important component of the sexual appetite in men and women as it promotes sexual desire, curiosity, fantasy, desire, and behavior (Crenshaw & Goldberg, 1996; Krapf & Simon, 2009). Davis, Davison, Donath and Bell (2005) found that some women with low testosterone levels do not experience desire problems and most women with low desire have normal testosterone levels. Brotto, Bitzer, Laan, Leiblum and Laria (2010) have written the most comprehensive and critical review of medical therapies for low desire in women finding inconclusive, contradictory, or marginally significant results.

Relapse Prevention

The therapist should help the couple to understand that sexual desire is maintained through active social, sensual and sexual contact with one another. Accordingly, the therapist assists the couple in relapse prevention by including strategies that include affectionate statements, erotic talk, and sensual touching and caressing. One of the signs that a couple is relapsing during therapy is their non-completion of the homework assignments. A thorough discussion needs to take place in order to uncover the possible reasons for a setback and the couple is reminded to plan a schedule for at home exercises and sexual dates to spend with one another.

Paradoxical strategies can also prevent relapses (Weeks & Gambescia, 2002; Weeks & L'Abate, 1982). One strategy is to ask the couple to identify and predict the ways that they might sabotage their progress during and post-therapy. Therapists can also ask the couple to predict the factors that might provoke the recurrence of low desire. Asking the couple to think about these factors will increase the likelihood that these problems will not arise. Finally, once the couple starts to avoid sex, the pattern becomes self-perpetuating and low desire may return. If a couple agrees to have sex on a regular basis and accept the fact that variability will exist in the degree of interest and satisfaction, they have the opportunity to improve the quality of their sexual interaction over time.

A comprehensive biopsychosocial approach is the key to relapse prevention in the treatment of FSIAD. In a conceptual paper specifically about the assessment and treatment of FSIAD, McCarthy, Koman & Kahn (2018) present a biopsychosocial model, similar to our Intersystem Approach. FSIAD is a complex disorder and a comprehensive treatment approach is necessary to address numerous etiological risk factors and ensure that the couple remains engaged in treatment.

Research

Clinical publications about FSIAD are beginning to surface but, to date, there are a few completed research studies and clinical papers to direct the clinician in the assessment and treatment of FSIAD. Publications thus far have focused on the investigation sexual concordance, mindfulness approaches to treatment, and numerous cognitive and behavioral techniques as cited in the body of this chapter. Most commonly, the data support an individualized biopsychosocial clinical assessment and treatment approach with the woman and her partner, consistent with the Intersystem Approach.

Conclusion

The Intersystem Approach is comprehensive and integrative of numerous etiologic factors and related treatment modalities. FSIAD is complex, as it involves many influences related to the individual partners, the couple's relationship, intergenerational influences, and other factors such as race, culture, ethnicity and other contextual stressors. The template for treatment is modified for each individual and/or couple system. This approach is characterized by a number of apparent contradictions. First, although one partner ostensibly expresses the symptom, FSIAD is a relational problem. Next, low or absent sexual interest is not simply a sexual problem; often, it is a reflection of other problems in the relationship. Also, the woman may appear unemotional; yet, the sexual symptom is often a way of indirectly expressing strong emotions related to herself or her partner. Finally, the woman might appear to be totally disinterested in sex. In effect, she is often distressed and wants to feel desire for her partner, yet this desire cannot be forced or it will further diminish the sexual appetite.

The therapist must be equipped with a variety of individual and couple therapy techniques that are used judiciously as timing and flexibility are critical. Moreover, the therapeutic strategies must be shared with the partners in order to ensure their cooperation. The approach initially developed by Weeks and Gambescia (2002) and updated in this chapter, has a number of treatment components that are congruent with the various common etiologies reported. Given the multifactorial nature of FSIAD, the treatment can last anywhere from six months to two years. In order to keep a couple involved in therapy for this length of time, they need to see the relationship between her symptoms, the contributing factors, relational issues, and incremental progress in alleviating those factors. The most important treatment consideration is the systemic nature of the problem and the need for the couple to work together in resolving it.

Note

1. See our chapter on culture later in this text.

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9

FEMALE ORGASMIC DISORDER

Marita P. McCabe, Katherine M. Hertlein and Edmond Davis

Introduction

The American Psychiatric Association views female orgasmic disorder as a psychological problem for the woman due to the delayed, infrequent or absent ability to experience orgasm or "markedly reduced intensity of orgasmic sensations" (APA, 2013, p. 429). As with other psychiatric disorders, the symptoms need to be present for a minimum of about six months, cause distress, and not be better caused exclusively by another psychological disorder, severe relationship problems, the effects of a substance/medication, or a medical disorder. This disorder can be a lifelong or acquired condition can occur in all situations, partnered or alone (generalized) or in specific situations with certain partners.

There are different ways to achieve orgasm through stimulation of female genital structures such as the clitoris or vagina (Costa, Miller & Brody, 2012; Wallen & Lloyd, 2011). In fact, many women use a combination of stimulation to the vagina and clitoris in order to achieve orgasm (Pfaus, Quintana, Mac Cionnaith & Parada, 2016). One study noted a specific association with body movement, not just clitoral rubbing, as a way to achieve orgasm (Bischof-Campbell, Hilpert, Burri & Bischof, 2018). In addition to the anatomic foci of erotic stimulation producing female orgasm, other dimensions of physiologic orgasmic capacity are identified in the literature such as intensity and duration, which can vary during different sexual encounters (Pfaus, Quintana, Mac Cionnaith & Parada, 2016; Masters & Johnson, 1966). The literature supports the diverse nature of the female orgasm reported by our clients; for some women, specific stimulation of genital structures can predictably produce orgasm but, at times, the intensity and duration can seem beyond their control.

Intersystemic Etiology of Anorgasmia

Women describe a number of factors that can reliably contribute to achieving orgasmic capacity: sexual positions that stimulate the clitoris; sexual self-esteem; sexual communication; positive qualities of the partner and the relationship; learning about what one finds pleasurable via masturbation; and the use of vibrators and other sex toys (Kontula & Miettinen, 2016; Nekoolaltak, Keshavarz, Simbar & Baghestani, 2017; Pfaus, Quintana, Mac Cionnaith & Parada, 2016; Rowland, Cempel & Tempel, 2018). Conversely, a broad range of factors is related to the development of anorgasmia in women such as sexual ignorance, stress, cognitive distraction, medications/substances and other biological, intergenerational,

individual and relationship influences (McCabe, 1991). The contribution of these factors to anorgasmia, consistent with the Intersystem Approach, is discussed later.

Individual Biological Factors

A number of studies have confirmed that medical conditions such as heart disease, multiple sclerosis, hypertension, asthma and thyroid problems can adversely affect orgasm. Other associations to anorgasmia include overactive bladder, which negatively affects female sexual health and diminishes sexual desire and capacity to achieve orgasm during intercourse (Juliato, Melotti, Junior, Britto & Riccetto, 2017). Additionally, medications can have a pronounced impact on orgasm (Basson, Rees, Wang, Montejo & Incrocci, 2010). For example, sexual functioning and orgasm is affected, in part, by oral contraceptive use (Lee, Low & Ang, 2017) and contraceptive implants (Chapa, Ramirez & Dawson, 2017). Additionally, it is well established that selective serotonin reuptake inhibitor (SSRI) antidepressants are often implicated in difficulty or failure to achieve orgasm (Bala, Nguyen & Hellstrom, 2018).

Individual Psychological Influences

There has been little investigation of the individual psychological factors associated specifically with female anorgasmia. It has been suggested that stress, levels of fatigue, sexual identity concerns, health problems, and other individual attributes and experiences may alter sexual responsiveness (Rowland, Cemplel & Tempel, 2018). Clinically we have seen that, any of these factors can inhibit orgasm. Anxiety also plays a role in sexual functioning (Basson & Gilks, 2018; De Lucena & Abdo, 2014). Performance anxiety and high stress levels were associated with orgasmic dysfunction among women (McCabe, 2005; McCabe & Giles, 2012). Women with eating disorders demonstrate problems in sexual activity, such as the lack of desire and orgasm difficulties (Hamilton, 2017). Numerous other factors are substantiated in the literature as associated with anorgasmia: sexual ignorance, fear, sexual misinformation lack of interest, guilt, concerns about attractiveness, and shame (Nekoolaltak, Keshavarz, Simbar & Baghestani, 2017). Finally, Costa and Brody (2011) discovered anxious attachment styles were correlated with less consistency in vaginal orgasms.

Relationship Factors

In general, couples who report higher levels of general relational satisfaction also report having a higher level of communication on both sexual and nonsexual topics, which, in turn, is positively associated with sexual satisfaction (Mark & Jozkowski, 2013). Conversely, relationship difficulties were strongly associated with sexual dysfunction for women, but not as strongly for men (McCabe & Cobain, 1998). Specific to anorgasmia, women are often unable to communicate their specific desires regarding physical stimulation, intensity, and focus of stimulation (Kelly, et al., 2006; Witting, et al., 2008). In addition, partner variables, such as lack of experience, knowledge about sexual stimulation, or indifference to her arousal can contribute to anorgasmia. Further, dysfunction in the partner can play a role. Levels of sexual satisfaction showed a particular deterioration among the anorgasmic groups (McCabe & Cobain, 1998). It may be that the negative attitudes to sex impede the development of sexual intimacy, causing not only

sexual dysfunction yet also a breakdown in other aspects of the relationship. According to Travis and Travis (1986), intimacy is developed through a range of sexual and sensual contracts. A discomfort with non-genital and genital touching impedes the development of intimacy, which, in turn, leads to a breakdown in relationship functioning and on to sexual dysfunction in one or both partners. Consistent with this proposal, McCabe and Giles (2012) found that both relationship satisfaction and sexual intimacy predicted higher levels of sexual functioning among women with orgasmic dysfunction.

Intergenerational Influences

Difficulties in the process of socialization during childhood are considered an important predictor of adult sexual dysfunction. The development of misconceptions about sex, negative attitudes towards sexual pleasure, and problems with sexual orientation or gender identity often occur within the family of origin and may negatively influence sexual functioning in adulthood. In our work with clinical couples, introjects from the family of origin serve as etiologic factors and need to be deconstructed. The use of a sexual genogram is useful. (See DeMaria, Weeks & Twist, 2018.) The clinician will also want to assess for the occurrence of sexual abuse during childhood (Rellini & Meston, 2011). It is difficult to determine the manner in which intergenerational factors may specifically affect female anorgasmia. Much of the literature links events in childhood and adolescence and overall levels of sexual dysfunction in adulthood without tying these events to specific disorders (McCabe & Giles, 2012).

Sociocultural Factors

Ramage (2004) asserts that sexual misinformation and inaccurate sexual education can be key factors in the development and maintenance of sexual problems in women, and this can certainly affect orgasm problems. The myth of the vaginal orgasm continues to be a culprit in the development and maintenance of female anorgasmia. This myth incorporates a false distinction between the vaginal and the clitoral orgasm and women using clitoral stimulation to achieve orgasm are considered to be dysfunctional. (Gerhard, 2000). It may be this type of mentality that reinforces women's sexual scripts and in part, underscores women's tendencies to fake orgasms (approximately 48% of women report having faked an orgasm as compared to 18% of men) (Muehlenhard & Shippee, 2010).

Prevalence

Significant numbers of women are unable to experience orgasm through coitus. Clinically, these women report they are not receiving sufficient clitoral stimulation prior to or during penetration. In some instances, coital alignment is not producing enough clitoral stimulation. In many instances, woman can achieve orgasm with a partner extra-coitally prior to coitus and, if aroused enough, might be able to orgasm again during penetrative sex. As stated, some couples lack the communicative skills to negotiate the accommodations necessary for orgasmic capacity. Other examples of anorgasmia can present as difficulty to reach orgasm despite sufficient, directed, self or partner clitoral stimulation. Such women report that they cannot sustain sexual fantasy, feel embarrassed, self-conscious, or distracted. For some, cultural, religious, ethnic or racial prohibitions are triggered by arousal. See the chapter in this text, which focuses specifically on Culture and Sexuality.

Empirical studies consistently reveal that the average prevalence of orgasm dysfunction to be hovering around 40%, with approximately 10% of women reporting they never achieve orgasm through intercourse (Adegunloye & Ezeoke, 2011; Giles & McCabe, 2009; Graham, 2010; Herbernick, 2018; Kontula & Miettinen, 2016; Ramezani, Ahmadi, Ghaemmaghami, Marzabadi & Pardakhti, 2015). In another study, approximately 45% of women reported difficulty reaching orgasm half of the time with one-quarter of women stating they are not able to achieve orgasm 75% of the time, and 30% stating they cannot reach orgasm all of the time (Rowland & Kolba, 2016).

Assessment

The detailed assessment of all of the etiologic factors mentioned earlier should involve the couple if the woman is partnered. The therapist will want to understand all of elements that contributed to anorgasmia from the perspectives of both partners in order to gain a clear understanding of the manner in which they contribute to this sexual dysfunction. It is also important that the clinician have a clear understanding of the nature of the sexual dysfunction. To this end, the clinician needs to assess the frequency of orgasm, when anorgasmia occurs, whether anorgasmia is primary or secondary, partial or complete, and the length of time the problem has been in place, and if other events co-occurred with the development of the anorgasmia. It is also useful to question the woman and her partner on why she is seeking treatment at this time and what expectations/goals they have for therapy. In addition, it may be the case that a woman is unsure that she had an orgasm, thus warranting education. Finally, the lack of orgasm may be the result of lack of stimulation, too much stimulation, or related to the fact that the clitoris is dynamic and stimulation in one position does not mean the stimulation will remain the same.

Treatment

Treatment programs for sexual dysfunctions, including anorgasmia, frequently lack adequate research methodology, which makes it difficult to empirically evaluate their effectiveness. Often the clinician relies on clinical experience and case reports. Nonetheless, the therapist will need to note the length of time the problem has been present and the extent to which the couple has accommodated to her anorgasmia. A systemic approach is necessary in order to note how the relationship may have adjusted to incorporate the dysfunction. The treatment will incorporate a number of approaches that will disrupt the couple's current level of dysfunction, and the therapist may be met with resistance.

Psychoeducation is a crucial element of treatment. This process involves masturbatory training in order to achieve orgasmic consistency. See *Becoming Orgasmic* (Heiman & LoPiccolo, 1987) and *For Yourself* (Barbach, 1975). Directed masturbation is an effective strategy for women with primary anorgasmia (Heiman & Meston, 1997). This process involves providing education to women about the ways to achieve orgasm, and then providing them with strategies and permission to explore their body. This process of self-exploration allows the woman to discover what is sexually arousing for her, what feels pleasant, and what is difficult or unpleasant. The woman is encouraged to use a mirror to examine her genitals in the early stages of this exercise, to be mindful her sensations, to alter her cognitions regarding masturbation, and to use sexual fantasies to enhance her sexual response (Brotto, 2018).

Herbenick, Fu, Arter, Sanders, and Dodge (2018) performed an Internet based study of 1055 American women, related to orgasm, sexual pleasure, and genital touching. The results are as follows: 18.4% reported that intercourse alone was sufficient for orgasm, 36.6% reported clitoral stimulation was necessary for orgasm during intercourse, and 36% reported their orgasms feel better if their clitoris is stimulated during intercourse. The treatment of anorgasmia should incorporate these findings as preferences for genital touch location, and style is extremely diverse.

For women to transfer her orgasmic response in masturbation to sexual interaction with her partner, she and her partner may need to use additional stimulation of the woman's genitals during sexual intercourse. The woman needs to learn to communicate her sexual needs to her partner and guide the partner on how to stimulate her. During sexual intercourse, it is important that the coital alignment technique (Heiman, 2007) is used, which increases the level of clitoral contact as well as the orgasmic frequency (Herbenick, et al., 2018). This technique positions the man's pelvis in alignment with the woman's pelvis and moves his pelvis rather than thrusting. Finally, many women incorporate the use of a genital (clitoral, vulvar, vaginal) vibrator while alone or during partnered sexual activity and find it helpful.

Medical treatment strategies for anorgasmia are not considered in detail in this chapter. This is primarily due to the focus being on psychological interventions, and because hormone replacement and other pharmaceutical approaches have not been shown to be effective in the treatment of this dysfunction (Jenkins & Mulhall, 2015). See Kope (2007) for a summary of medical approaches to the treatment of anorgasmia. Furthermore, there is no currently approved medication for the treatment of orgasmic dysfunction.

Studies seem to demonstrate that psychological interventions for anorgasmia are most effective if they utilize cognitive and behavioral strategies (Omidi, Ahmadvand, Najarzadegan & Mehrzad, 2016) and focus on intergenerational, intrapersonal and interpersonal factors that may contribute to the women's sexual dysfunction. Earlier clinical studies support the adoption of cognitive behavioral approaches, including strategies employed in the Intersystem Approach (Heiman, 2007).

McCabe (2001) implemented a psychologically focused treatment based on cognitive behavioral principles. It was a 10-session program that focused on enhancing communication between the partners, increasing sexual skills and lowering sexual anxiety as well as performance anxiety. Both cognitions and behaviors that impeded functioning in these areas were addressed. Homework exercises comprised cognitive strategies and behavioral exercises to enhance communication between partners, as well as sensate focus exercises. Therapy was successful for 36 women who presented with anorgasmia pre-therapy; only six women experienced problems in this area post-therapy.

The results of this study questions exactly what demonstrates successful psychotherapy. does successful therapy only entail a complete absence of sexual dysfunction post-therapy? This dilemma demonstrates the difficulty of defining success in therapy, and the importance of a complete description of pre-therapy and post-therapy levels of sexual dysfunction, as well as other associated measures of sexual functioning.

Effective Strategies from Previous Research

Hucker and McCabe (2012) conducted a review of the most effective treatments on a range of female sexual dysfunctions. From this review, it was clear that for orgasmic dysfunction, masturbation training, which resulted in women having a greater comfort with

their body, was an important ingredient in successful therapy; however, communication skills training and couple therapy was also shown to be effective in improving the orgasmic response of women. In fact, using these strategies, the results of the studies demonstrated an improvement in marital functioning as well as orgasmic response. Hucker and McCabe (2013) found that a mindfulness-based online treatment for female sexual dysfunction led to improvements in sexual and emotional intimacy as well as communication in the treatment group compared to the control group. As noted earlier, there has been limited research that has examined the effectiveness of treatment strategies for anorgasmia; however, levels of both communication and performance anxiety appear to be important factors to address in the treatment of this sexual dysfunction.

Communication

A lack of communication between partners about their sexual relationship appears to be a factor related to anorgasmia in women (Everaerd & Dekker, 1982). In this study, sex therapy consisted of sensate focus and sexual stimulation exercises, with a ban on intercourse. The communication training included exercises for active and passive listening, verbalization and reflection of feelings, productive conflict management, and assertive behavior.

Both communication and sexual skills training, together with measures to reduce anxiety, were used in the treatment of primary and secondary anorgasmia by McGovern, McMullen, and LoPiccolo (1978). Women with primary anorgasmia improved markedly in orgasmic responsiveness whereas the women with secondary anorgasmia did not. This led the researchers to suggest that marital therapy might be more appropriate for the latter, since these women reported more dissatisfaction with their marital relationships than did the women experiencing primary anorgasmia.

Performance Anxiety

Past failure to achieve orgasm can elicit self-defeating and distracting thoughts about whether the woman will be able to achieve orgasm this time. The enthusiasm of an insecure partner, who regards her orgasmic response as an assurance of his or her own competence, can be perceived by the woman as pressure on her to achieve orgasm. Fear of rejection or feelings of obligation towards the partner may lead her to accept her partner's sexual overtures, despite apprehension about her ability or desire to respond fully. As sexual activity continues, she tries to will her response, wanting to become so aroused that orgasm will be triggered, but afraid she might "turn-off" or that her partner might become impatient or irritated at her slowness. She mentally monitors her own and her partner's response, unable to allow herself to relax and enjoy the sexual stimulation for its own sake. She can no longer trust her own natural sexual response to maintain and intensify the arousal process through to orgasm; rather as spectator – demand her body's response. At the same time, her partner is also a spectator as he or she physically attempts to bring her to orgasm, wondering what he or she is doing wrong when she does not respond (Masters & Johnson, 1970). This view is reinforced by Kaplan (1974; 1983) who regarded obsessive self-observation arising out of fear of failure to be the single most immediate cause of female anorgasmia. The original proponents of performance anxiety, Masters and Johnson (1970) attempted to deal with this problem by exploring a wide range of sexual activities other than intercourse which may well have lengthened the time involved in sexual play

before intercourse occurred. Elements of this program are still evident in treatment programs for anorgasmia and are an essential element in the program described shortly.

Systemic Treatment Framework

As noted at various points of this chapter, female anorgasmia is likely to be caused, precipitated and maintained from a range of intergenerational, individual and relationship factors. After an adequate assessment of the nature of the anorgasmia and the factors that relate to this sexual dysfunction, it is important that treatment address the multitude of issues that currently maintain this dysfunction. Consistent with the systemic treatment framework, the following program has been implemented for the sexual dysfunction of women with anorgasmia (McCabe & Delaney, 1991; Purcell & McCabe, 1992). We have found that these aims are best addressed in therapy by the use of three interrelated treatment strategies: communication exercises, sensate focus exercises, and guided fantasy.

Communication Exercises

Communication exercises are devised to improve the quality of the couple's relationship, and develop and explore emotional responses of the woman. Questions address all aspects of the relationship, both sexual and nonsexual. Both partners are instructed to share their feelings with their partner regarding a particular issue. Different issues are discussed; feelings are expressed. Additionally, partners explore their responses to body massage and genital stimulation.

Sensate Focus Exercises

These exercises comprised of non-genital, then genital pleasuring, and finally intercourse in a graduated pattern. A detailed description of sensate focus strategies is outlined in a chapter in the first edition of this book and was refined in a chapter in the *Clinician's Guide to Systemic Sex Therapy* (Weeks, Gambescia & Hertlein, 2012).

Fantasy

Some women may have difficulty accepting themselves as sexual persons and experience a high level of guilt in association the physical aspects of the sexual encounter. Progressive fantasies should be aimed at enhancing the acceptance of oneself as a sexual person and to lower performance anxiety. Directed fantasies progress from the romantic, interpersonal aspects of the relationship within a romantic setting. Once arousal in this setting is tolerated and then enjoyed, the fantasies can become more sexually explicit. Both the emotional and physical aspects of sex are presented so that the development of both types of involvement can be explored to foster sexual functioning. Fantasies are also tied to increases in sexual arousal (Dekker & Everaerd, 1988).

Research and Future Directions

A promising area for the treatment of female orgasmic disorder is the use of online approaches. Jones and McCabe (2011) found an effective online strategy that focused on masturbation training in combination with communication skills training and sexual

exercises to enhance the relationship and improve orgasmic capacity. Hucker and McCabe (2013) later found that the addition of mindfulness enhanced treatment effectiveness. Although the attrition from these Internet based programs is high (McCabe & Jones, 2013), it is not substantially higher than attrition from face-to-face therapy. Future research needs to focus the use of more focused integrated psychological interventions or combination therapies.

Case Vignette

Client

A husband and wife, aged 31 and 29 years respectively, were married for 18 months, having lived together for 12 months prior to the marriage. Both tertiary-educated professional people, they had met while working together and became friends. Upon first meeting, the wife had just emerged from a broken first marriage and subsequent divorce. The sexual relationship in that first marriage was not good. She had several affairs in which she enjoyed sex, experiencing orgasm during sexual interaction but not during intercourse. During her current marriage, she enjoyed sex, but her frequency of orgasm was reported as having fallen to 25% during sexual activity. She had not experienced orgasm during intercourse at all, was beginning to lose interest in sex, and came to therapy looking for more enjoyment. Her loss of interest in sex began when she and her now-husband moved in together. She also reported no anxiety about sex and a rather neutral attitude towards it in the original family home. The husband, who came from a very religious background, described family attitudes as neutral towards sex. He reported no other sexual relationships, either past or present. There was a concern about premature ejaculation but he was reassured that his concern was unfounded. He enjoyed sex and seemed to function well. There was no admission of any anxiety about sex, just enthusiasm for his wife to enjoy it more and experience orgasm during intercourse. Both partners worked in demanding jobs. In the coming months they planned to start a family.

Treatment Program

The program involved nine sessions with the therapist.

Session 1. Specific information was given about the program with joint and separate interviews being conducted. Partners were educated about the nature of secondary orgasmic difficulties. The concept of performance anxiety was introduced and its effects on the sexual response of both men and women were explained. The cooperation of the male partner in being neither too enthusiastic nor ambivalent about his wife's sexual response was elicited. A temporary ban on any sexual activity, until allowed by the therapist in the context of the sensate focus program, was prescribed. Communication exercises were introduced, and the time commitment required by these and the sensate focus program made clear. The format of the individual therapy sessions was briefly outlined and the process of guided imagery/fantasy was introduced.

During this informative session, important features emerged. First, both partners lived busy, professional lives, often with meetings of further study outside of working hours. Next, they did not think of themselves as having a sexual problem, but thought that the wife's diminishing enjoyment of sex could become a problem if not addressed. Finally, their goal of treatment was to increase the wife's enjoyment. She currently experienced orgasm 25% of

their sexual interactions but had never experienced it during intercourse in either this relationship or her previous one. Also noted was the husband's enthusiasm for his wife to enjoy sex more and his disappointment that he would not be coming to all the sessions with her. Both partners commented that their sexual relationship had been very good and non-problematic before they began living together. Both partners admitted to having difficulty resolving conflict, being more likely to withdraw into silence rather than express feelings.

Both husband and wife came from similar lower middle-class, socio-economic backgrounds. Both had grown up in intact families with one or more siblings of the opposite sex. Religion was an important factor in the early life of both partners. The wife had a Protestant background, the husband, Catholic. In both homes, the children could ask questions and talk about sex; however, discussion was not encouraged, and parental attitudes were described as neutral. There was no display of physical affection, either to spouse or children in either household.

The wife had a steady boyfriend at age 17, and this developed into a sexual relationship even though she felt both guilt and anxiety regarding intercourse and deemed it as unpleasant. Otherwise there were no other unpleasant or traumatic sexual experiences during this time. She was sexually responsive and orgasmic with her present partner before they formed a permanent relationship. Currently, she felt negative about sexual fantasy, sexual secretions, and masturbation but positive about foreplay and manual orgasms when her husband provided the stimulation. She also regarded sex as important in their relationship and looked for a certain equality in both sexual and non-sexual activities. Within this current relationship, however, there were conflicts not satisfactorily resolved about the division of household labor and time spent at the work place. Concerning her present problem, she thought that previous negative experiences and lack of sexual knowledge had contributed to it. She also recognized that fatigue, mood and duration of foreplay influenced her ability to become aroused.

Sessions 2–7. These therapeutic sessions were for the woman alone and occurred at weekly intervals. The first half of each session was devoted to a review of the past week and its prescribed activities. It included counseling on any relationship and sexual issues that had surfaced because of the communication or sensate focus homework. How to deal with self-monitoring and performance concerns were described, i.e., by thought-stopping, focusing on bodily sensations, feelings and by incorporating the latter into concurrent fantasies, either self-generated or based on the fantasy imagery presented during the therapy sessions. The experiences that were brought to therapy were used to discuss cognitive, behavioral and relationship enhancing strategies to address any negative thoughts or responses. Only one fantasy was presented in each session following brief relaxation instructions. Fantasies were drawn from Nin's book of fantasies (Nin, 1978; 1979). At the conclusion, the woman was invited to talk about her response, about aspects she found sexually arousing or maybe troubling in some way. Progressively each of the stages of sensate focus was introduced during these six sessions.

Session 2. The communication exercises were reported as going well, with additional relationship issues being spontaneously raised. One such issue concerned working late, in that, while it was accepted that the husband did, it was not acceptable to him that the wife did. All but two of the communication questions were completed. The guided imagery session was found enjoyable, relaxing and non-threatening. During this session the woman was encouraged to explore her own body. She was told to use a mirror to help her examine her genitals, and to touch her breasts and genitals while engaging in sexual fantasy to see what types of touching she found pleasurable.

Session 3. The communication exercises continued to bring forward issues for discussion that had not been broached by the couple before. All the questions were tackled. The importance of the wife's work was clarified. The couple found that listening to each other's expression of feeling with no attempt to problem-solve, was a new and refreshing experience. During the session, the communication of sexual feelings in a positive and nonrejecting way was discussed, with some modeling by the therapist in the use of appropriate phrases. The women revealed anxiety both about undressing in front of her male partner and about being aware of his sexual arousal. She was encouraged to explore at home, in fantasy and in practice, aspects of undressing she might find sexually arousing to herself. She was also encouraged to explore her own body and when she felt comfortable, masturbate using a vibrator in order to enhance her sexual pleasure and become familiar with the types of stimulation that she found pleasurable. These techniques were important for her to experience sexual arousal, also to discover how to guide her husband in techniques to increase her arousal and orgasmic response.

Session 4. The sensate focus sessions prescribed for the previous week, at first, had been for relaxing, but now the woman was finding them sexually arousing as well. Her husband was reported finding the massage enjoyable. The communication exercises continued to open up discussion between the couple in such a way that they were able to resolve misunderstandings that had arisen. They had come to realize that the woman liked to plan ahead whereas her husband preferred more spontaneous activities. At the same time, it was also recognized that the therapy program necessitated some planning of sexual activity, which would work against the desired spontaneity of normal sexual activity even to the extent of inducing anticipatory performance anxiety. Another issue arising through the communication questions concerned the woman's poor body image. It was suggested that she ask her husband what he liked about her body as he massaged her and later, she repeats those phrases to herself while standing naked in front of a mirror.

Session 5. By using the sensate focus exercises, they discovered enjoyable ways of touching each other. The husband was encouraged to respond to the guidance provided by his wife in terms of what she found pleasurable in both the general as well as genital body pleasure. As an example, the wife needed to provide guidance on pleasurable techniques for clitoral stimulation. Despite this, the wife communicated that she was beginning to feel under some pressure from the program, and proceeded to describe sensitivity to having her nipples, and clitoris touched. This called for reassurance that the sensate focus exercises that would explore different ways of touching and being touched. Sometimes only a very gentle indirect approach might be pleasurable. There seemed to be no pattern of masturbation at all, so it was suggested that she might like to explore herself, determine what she found pleasurable, then she could guide her husband's touch when they were together. She was encouraged to engage in the suggested activities out of a sense of curiosity and desire to know her own body only when she was ready. At no time was anything to be tried just because she felt she "had" to due to the program.

Session 6. Career issues continued to be a focus of discussion for the couple. The husband had been able to voice his concern that, because she went to evening committee meeting, of a professional nature, this might indicate she did not need him. Another area of concern was the woman's plans for improving the house. Her husband was not able to tell her that he found the prospect of more work at home a burden. Through the communication exercises the role expectations that the couple had of husband and wife were now emerging and being discussed and negotiated. With the sensate focus, the woman was finding a re-awakening of her sexual feelings and discovering there was very little she

didn't enjoy. She was even discovering that being touched around the nipple area could be pleasurable. Her use of fantasy during sexual interaction was only occasional, and it was used to ward off distracting thoughts; however, she had been reading erotic stories 'to get in the mood' before their mutual sexual activities.

Session 7. Their commitment to the communication exercises was evident again, with five of the seven questions being completed with seemingly a good level of self-disclosure on both sides. With the allowing of non-demand intercourse, old anxieties returned as the woman felt under pressure to perform on the two occasions that the couple had intercourse. She did not like manual concurrent stimulation of her clitoris, finding it almost painful. She was again encouraged to explore this more slowly, at first on her own, and then guiding her partner's hand in any way that she found pleasurable.

In the preceding week, the use of fantasy had not been enough to alleviate her anxieties. The woman was encouraged to continue with the non-demand (i.e. non-orgasmic) intercourse phase of the program, putting no pressure on herself to be orgasmic, but focusing on any pleasurable sensations that arose. Only when she could relax and feel enjoyment, was she advised to allow the possibility of orgasm. A further therapy session was considered but decided against. The couple seemed to need time to assimilate what had been happening and to explore the new techniques in their own time without the pressure of reporting back to the therapist.

Session 8. The aim of this session was to review progress and problems and assess the readiness to terminate therapy or need to extend it. An appointment was made for a follow-up session two months later. This session reviewed the influence of the program on both sexual activity and the overall relationship. In the preceding week, the communication question on clitoral stimulation had provoked discussion between the partners and it came up again in this session. It was explained by the therapist that this form of stimulation during intercourse was, for many women, the only way they were able to experience orgasm during intercourse. Husband and wife differed over the idea of self-stimulation during intercourse and compromises were discussed. During the joint session the woman herself made a connection between her ambivalence about expressing her own sexuality as well as her sexual difficulties and said this was something she planned to work on. She said she felt more relaxed about their sexual relationship but that constantly having to decide what she liked or didn't like during their sexual activity was a distraction. This suggested that she was still feeling some performance pressure from the program.

In the separate interview, the woman again reported little use of fantasy. She was disappointed she had not accomplished more during the program and reported that orgasm happened on less than 25% of their sexual encounters. She was finding sex, however, more relaxing and enjoyable and felt hopeful of future improvement. She expressed some concern that her husband seemed depressed, but she did not know why.

In the interview with the husband it became clear that for him the relationship had reached a crisis point over the issue of beginning a family and that his wife was unaware of this. He had been unable to share with her his feelings of inadequacy about supporting her and a child. These feelings had affected his commitment to the program, fearing the possibility of impregnating his wife each time they had intercourse. He was encouraged to raise this issue as a communication question in the following week, stressing the urgency of doing so.

Session 9. Follow-up. Two months later. The aim of this session was primarily a review of what had been happening since the couple had attended the post-therapy session and to note any changes that had occurred since that time. The issue of parenting

had been raised and some resolution reached. The woman had been surprised at her husband's concern and ambivalence about becoming a father. The husband had now become more amenable to the idea and even talked of some positive aspects of having a child. The relationship seemed to have stabilized with a new level of understanding. Both husband and wife, when asked separately, commented that everything was going well. The partners seemed to have confronted and come to terms with some of the role pressures each was facing.

The woman remarked on feeling much more relaxed and happier about their relationship, and her own sexuality. She said they had bought two popular sex manuals, and that she was reading them and enjoying the stories of Anais Nin. She was also now finding fantasy useful and enjoyable, both before and during lovemaking. She was experiencing orgasm more often, about 50% of the time, but not during intercourse.

Telephone follow-up (six months post-therapy). The woman reported that the improvement in their sexual relationship had been maintained, that she was experiencing orgasm in about 50% of sexual interactions, but not during intercourse.

Discussion

The eventual increase in the woman's orgasmic frequency from 25% to 50%, combined with a fall in performance anxiety, as well as the overall rise in sexual satisfaction for the woman suggests that the therapeutic focus on performance anxiety was appropriate. Finding that the effects of therapy were not fully realized until after the end of therapy gave credence to the client's comment that therapy was itself perceived as imposing performance demands. The focus on sexual arousal led to the uncovering of areas of anxiety about particular sexual activities and a deeper ambivalence about female sexuality. This in turn, led to the recognition that both sexual anxiety and performance anxiety can co-exist in one client, expressing both the demand to be non-sexual as well as orgasmically sexual. On the behavioral level these demands can make a woman reluctant to express her sexual preferences. On the other hand, they can lead to performance pressures, with associated fears of failure, and from both the woman and her spouse to experience orgasm more often. All the components of therapy, counselling, the use of fantasy, sensate focus and communication exercises were too well integrated to allow any assessment of individual contributions. The communication exercises were found invaluable in allowing marital issues to surface and to find some resolution.

The goal of the program was remission of the symptoms of secondary orgasmic dysfunction by reducing performance anxiety and intensifying sexual arousal. For the woman in this case vignette, some symptom remission was achieved in conjunction with a reduction in performance anxiety. Whether there was intensification of arousal is unclear. There appeared to be an increase in sexual communication and decrease in performance anxiety, which seemed to be associated with an increase in relationship factors, sexual satisfaction and orgasmic response. Sexual anxiety, as measured by the questionnaire, persisted at a relatively low but stable level. Anxiety about particular sexual activities and female sexuality however, did surface during therapy sessions. Some attitudinal change towards various sexual activities was achieved, along with reports of increased sexual enjoyment and feelings of relaxation about sex.

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10

PAINFUL INTERCOURSE

Genito-Pelvic Pain Penetration Disorder

Evan Fertel, Marta Meana and Caroline Maykut

Introduction

A sex therapist alone is unlikely to comprehensively assess or effectively treat the painful intercourse without the concurrent (rather than sequential) collaboration of one or more other health professionals (Binik & Meana, 2009). A sex therapist, however, may be ideally suited to coordinate the effort, if he/she has an understanding of the multidimensionality involved. The effort is a considerable one, as Genito-Pelvic Pain Penetration Disorder (GPPPD) can be a difficult problem to resolve. The present chapter provides an overview of GPPPD and its etiology, along with guidance for assessment and treatment.

Definition and Description

GPPPD is a relatively new diagnosis originally appearing in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*; American Psychiatric Association [APA], 2013). The *DSM-5* explicitly delineates GPPPD as a diagnosis that applies only to women. In the prior edition of the DSM (*DSM-IV TR*; APA, 2000), women who experienced pain or difficulties with penile-vaginal intercourse were diagnosed with dyspareunia or vaginismus. A diagnosis of dyspareunia required recurrent or persistent genital pain with sexual intercourse and was applicable to men also; a diagnosis of vaginismus required a recurrent or persistent involuntary spasm of the outer third of the vagina sufficiently intense to interfere with intercourse. Women with dyspareunia presented with pain but women with vaginismus presented with what they perceived to be the impossibility of penetration and varying degrees of pain. The rationale for collapsing these two disorders under a new classification and set of criteria emanates from 20 years of research that (1) supported a conceptualization of dyspareunia as a pain disorder that interfered with sex rather than as a psychosexual disorder that resulted in pain, and (2) found little evidence for the vaginal spasm that purportedly distinguished vaginismus from dyspareunia; vaginal hypertonicity is found in both *DSM-IV* disorders; anxiety and avoidance appeared to be the more reliable distinguishing factors. The rationale for excluding men from the diagnosis of GPPPD appears to lie in a lack of research on male dyspareunia (Binik, 2010a; 2010b) and the supposed rarity of the condition in men (Sungur & Gündüz, 2014).

A diagnosis of GPPPD requires the persistence of one of four 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, (4) tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (APA, 2013). The difficulty has to have lasted for a minimum duration of approximately six months, cause clinically significant distress, and not be better explained by a non-sexual mental disorder or as a consequence of severe relationship distress or other significant stressors, or attributable to the effects of a substance/medication or another medical condition.

In addition, GPPPD has two specifiers: whether the dysfunction is *lifelong* (present since the individual became sexually active) or *acquired* (the problem began after a period of normal sexual function) and the level of distress experienced (*mild*, *moderate*, *severe*). Finally, the text of the *DSM-5* emphasizes the importance of assessing five potential influences on GPPPD: (1) partner factors, such as partner sexual dysfunction and health status; (2) relationship factors, such as desire discrepancies and poor communication; (3) individual vulnerabilities, such as history of abuse or body image concerns, psychiatric comorbidity, or stressors such as socio-economic difficulties or caretaking; (4) cultural or religious factors that impinge on sexual expression or pleasure; (5) medical factors relevant to etiology and treatment (APA, 2013).

In the five years since the debut of GPPPD in the *DSM-5*, there does not appear to be any published prevalence data using the new diagnostic criteria. Epidemiological studies on the old diagnoses of dyspareunia and vaginismus, however, provide a good sense of how common this problem is. Prevalence estimates for dyspareunia have ranged from 14–34% in younger women and 6.5–45% in older women (van Lankveld et al., 2010). Vaginismus, diagnosed primarily via its characteristic intercourse-related anxiety and intense avoidance of the activity rather than by vaginal hypertonicity, is substantially rarer with estimates ranging from .4–6% (ter Kuile et al., 2015). More recent meta-analyses examining clinically significant sexual pain in women across the globe indicate prevalence from 6 to 31.6% with rates varying by geographic region (Koops & Briken, in press; McCool et al., 2016).

Etiology

The etiological literature here reviewed is based on the old diagnoses of dyspareunia and vaginismus as there have yet to be studies on the etiology of GPPPD. As dyspareunia and vaginismus are encompassed within GPPPD, the reader can simply consider them to be different presentations of GPPPD.

Individual Physiological Factors

There are many physiological factors that can result in pain with intercourse such as acute and chronic diseases, including pelvic inflammatory disease, endometriosis, and urinary tract and yeast infections. Changes in vaginal structure, elasticity, and lubrication associated with menopause-related reductions in estrogen can also be contributory (Bergeron, Corsini-Munt, Aerts, Rancourt & Rosen, 2015; van Lankveld et al., 2010). Hysterectomy, other genital procedures, chemotherapy and childbirth with and without episiotomy have been linked to persistent painful intercourse (Alligood-Percoco, Kjerulff & Repke, 2016; Meana, 2012).

The most common type of intercourse pain appears to be genital (rather than pelvic) pain called provoked vestibulodynia (PVD) (Harlow, Wise, & Stewart 2001). PVD is

characterized by a burning pain experienced on the vulvar vestibule (entry of the vagina) when pressure is placed on it by any stimulus (e.g., penis, tampon, speculum) (Moyal-Barracco & Lynch, 2004). In addition to a burning sensation, some women describe their pain as raw, irritating, itchy, sharp, stabbing, tearing or an overall feeling of pressure (Henzell, Berzins & Langford, 2017). Pukall et al. (2016) provide a comprehensive overview of the pathophysiology of vulvodynia, particularly PVD, while emphasizing the potential biological underpinnings as complex and interactive. PVD has been linked to recurrent vaginal infections, and hormonal changes including early and prolonged use of oral contraceptives. Pelvic floor abnormalities (e.g., hypertonicity, hypotonicity, myofascial conditions) also have a strong association with genital pain and difficulties with penetration (Pukall et al., 2016; ter Kuile & Reissing, 2014). Sometimes, the extent to which hypertonicity is a cause or a consequence of painful intercourse can be unclear, although making this distinction may not be that important to treatment efforts.

Individual Psychological Factors

Most women with GPPPD do not differ from controls on psychological factors other than pain-related expectancies, cognitions, and affect. In fact, research has repeatedly shown that the following factors are associated with higher pain intensity in women who have pain with intercourse (Henzell, Berzins, & Langford, 2017; Desrochers, Bergeron, Landry, & Jodoin, 2008; Meana, 2012): somatic hypervigilance, pain catastrophizing, fear of pain, negative attitudes about sexuality, distraction from sexual cues, anxiety, negative causal attributions for the pain, feelings of low self-efficacy in coping with pain, depressive symptoms.

Increasingly, the fear-avoidance model of chronic pain is being invoked to illustrate the negative feedback loop in women with GPPPD (Engman, Flink, Ekdahl, Boersma & Linton, in press). Intercourse pain produces fear and catastrophic cognitions, which lead to a somatic hypervigilance that magnifies painful sensations, ultimately resulting in a woman avoiding sexual intercourse as much as possible. The vast majority of women with GPPPD report no history of sexual abuse (e.g., Khandker, Brady, Stewart & Harlow, 2014). Additionally, it is essential to assess for other comorbid psychological conditions in the woman or her partner as these individual factors can complicate the clinical picture.

Couple Factors

General dyadic relationship adjustment has not been linked to painful intercourse (Blair, Pukall, Smith & Cappell, 2015; Pazmany, Bergeron, Verhaeghe, Van Oudenhove & Enzlin, 2014). This may be, in part, because couples whose relationship does not survive the experience simply do not present to research studies or to psychological therapy. Additionally, controlled studies comparing women and couples with and without sexual pain are scarce.

Partner perceptions of, and reactions to, the problem of PVD are now being repeatedly associated with pain intensity in the woman, as well as with well-being and sexual function in both partners (Pukall et al., 2016; Rosen & Bergeron, 2018). The determining reactions appear to be whether the partner is highly solicitous, negative, or facilitative. Partners who score high on solicitousness generally halt all sexual activity at the first hint of the woman's discomfort, thus reinforcing avoidance and precluding experimentation with the possibility that the discomfort may be tolerable or even overpowered by increasing arousal.

Negative partner responses (e.g., hostility, anger) also predictably have adverse outcomes including increased pain, decrements in sexual functioning, and diminished sexual and relationship satisfaction (Bergeron, Corsini-Munt, Aerts, Rancourt & Rosen, 2015). Alternately, facilitative partner responses characterized by encouraging the woman and positively reinforcing her attempts to have sex are associated with lower pain reports and greater well-being and sexual function in both the woman and her partner (Rosen, Bergeron, Sadikaj & Delisle, 2015).

Both a woman and her partner's motivations/goals for engaging in sex appear to play a role in the experience of sexual pain (Rosen & Bergeron, 2018). For example, compared to women without sexual pain, women with sexual pain are more likely to have sex as a means of avoiding relationship conflict (avoidance goal) and less likely to engage in sex for the purpose of pleasure (approach goal) (Dubé, Bergeron, Muise, Impett & Rosen, 2017). In couples experiencing female sexual pain, lower avoidance motivations and higher approach motivations are linked to greater sexual function (Muise, Bergeron, Impett & Rosen, 2017; Rosen et al., 2018) and less intercourse pain (Muise, Bergeron, Impett, Delisle & Rosen, 2018).

Intergenerational Factors

There is no research directly investigating family-of-origin factors related to the onset of painful intercourse; however, there is growing evidence of genetic influences on general pain sensitivity and chronic pain conditions (e.g., Henzell, Berzins & Langford, 2017). Specific to PVD, a single study supports a familial predisposition (Morgan et al., 2016), and a body of research highlights the potential involvement of genes regulating inflammatory response, sensitivity to hormonal changes, and serotonergic-related pain sensitivity (Gerber, Bongiovanni, Ledger & Witkin, 2002; Heddini et al., 2014; Lev-Sagie & Witkin, 2016). Environmentally, the implication of negative sexual attitudes and childhood sexual abuse or victimization as possible risk factors for sexual pain indirectly suggest that family-of-origin factors may be involved in some cases. Lack of education about sexuality may also emanate from a particularly restrictive upbringing or one in which sexuality was considered a taboo subject. These links, however, are only speculative.

Societal/Cultural Factors

While prevalence data highlights differences in the rates of sexual pain by geographic location (Koops & Briken, in press; McCabe et al., 2016), vast methodological disparities make it difficult to empirically determine the impact of societal/cultural factors on painful intercourse. In a 2016 meta-analysis, McCool et al. subcategorized locations by type of sexual regime and found more gender unequal and male centric societies as having higher rates of female sexual pain. Also, there is some suggestion that religious orthodoxy may be a risk factor for the development of vaginismus (ter Kuile & Reissing, 2014), which has also been found to be more prevalent in less educated women and in first-generation immigrants to Western Europe (Öberg, Fugl-Meyer, & Fugl-Meyer 2004). These empirical findings are consistent with our clinical work involving religiously orthodox couples.

More generally, women continue to be socio-politically disempowered in comparison to men and their sexuality remains central to their socio-culturally defined sense of worth. This can translate into the stigmatization of women who encounter problems with their sexual function. Indeed, in a qualitative study of young American women with dyspareunia,

Donaldson and Meana (2011) found embarrassment and fear of stigma to be primary reasons given for not reporting the problem or seeking help. Historically, women who have resisted sexual activity for one reason or another have been denigrated and had their femininity questioned. Against this backdrop, it would not be surprising if many women with intercourse pain experience a sense of inadequacy and unspoken pressure to persist with partnered sex, sometimes silently, despite significant pain. This societal overlay on a distressing set of symptoms can contribute to their exacerbation.

Assessment

Although GPPPD is classified as a female sexual dysfunction, it is essentially a couple problem. Sometimes the couple will present for therapy; however, often, women assume they will be engaging in individual therapy. They believe they are the ones with "the problem". Correcting this misattribution is the first important therapeutic intervention. Most partners can be persuaded to participate, as they are generally motivated to resolve the sexual dilemma.

Involving a gynecologist is essential but will require the therapist to identify gynecologists in their community who have a special interest and expertise in genital pain, as the elusiveness of a straightforward cure leaves many physicians reluctant to invest themselves fully in the treatment process. Some women with the symptoms of vaginismus will never have had a gynecological examination and believe that it is not possible. Gynecologists familiar with this disorder, however, usually succeed in performing the examination.

Preliminary Assessment and Consultation

Pain is the primary presenting complaint in GPPPD and thus it should be assessed first. Essential questions include:

- Where exactly does it hurt when you have or attempt sexual intercourse? (A diagram or model of the genital and pelvic region will be very helpful here).
- Describe the pain in terms of intensity (1–10 scale) and quality (descriptors like "burning" or "tearing").
- When does the pain start (before, during, or after penetration)?
- How long does the pain last?
- Do you always have pain with intercourse or does it depend on certain conditions (e.g., fatigue, menstrual cycle, level of arousal)?
- Do you have genital or pelvic pain with other sexual or non-sexual stimulation (e.g., finger insertion, oral sex, tampon insertion, gynecological exam)? By genital pain, we mean pain felt directly in the vulvar or vaginal area; by pelvic pain, we mean pain in your lower abdomen.
- Do you ever have genital or pelvic pain spontaneously, without any stimulation?
- In your lifetime, when did you start having pain with intercourse (from the first time you had intercourse or did it start later)?
- Is the pain at the opening of the vagina (introitus)?
- Is the pain deep in the pelvis? Do you feel it in the lower abdomen?
- To what extent does the pain interfere with intercourse? How often does the pain result in interruption/discontinuance of intercourse or prevent intercourse altogether?

- To what extent do you or your partner anticipate pain during intercourse?
- To what extent do you or your partner engage in efforts (direct or indirect) to avoid having sexual intercourse?

Once the woman and her partner meet with an experienced gynecologist, the sexual functioning of both the client and her partner should be the immediate next target of assessment. Most important to cover are the perceived impact of the pain on their sexual life (frequency of intercourse and other sexual activity, desire, arousal, orgasm, satisfaction of both partners), as well as the existence of co-morbid sexual dysfunctions in the woman or her partner. In addition to the *Female Sexual Function Index* (FSFI: Rosen et al., 2000) for women and the *International Index of Erectile Function* (IIEF; Rosen et al., 1997) for men, Rosen, Glowacka, Meana and Binik (2018) provide a comprehensive review of the most psychometrically sound measures of sexual dysfunction. Specifically focused on genital pain, the *Vulvar Pain Assessment Questionnaire* (VPAQ; Dargie, Holden & Pukall, 2016) is a comprehensive assessment measure applicable to any stage of the treatment process.

The cognitive and coping styles of both partners are also important to assess. Why do they think they have this problem? What do they fear? What do they think it means, if anything? How do they cope with it? Self-administered measures can also be useful at this point. Of particular relevance would be the *Pain Catastrophizing Scale* (PCS; Sullivan, Bishop & Pivik, 1995) and the *Vaginal Penetration Cognition Questionnaire* (VPCQ; Klaassen & ter Kuile, 2009), which assesses maladaptive cognitions about sexual intercourse. Additionally, the *Painful Intercourse Self-Efficacy Scale* (PISES; Desrochers, Bergeron, Khalifé, Dupuis & Jodoin, 2009) could prove useful in gauging respondent's perceived capacity to engage in sex or to achieve certain levels of pain management.

Given recent data on the importance of partner reactions, it is also important to assess the extent to which partners are engaging in solicitous, negative and/or facilitative responses. Asking the couple to keep a diary of their intercourse attempts that includes perceived and actual partner responses, as well as pain intensity and other sexual outcomes of interest can be very helpful. More generally, it is imperative that the temperature of the relationship be taken at this stage, in part because treatment will rely to a great extent on the ability of the relationship to navigate the challenges of treatment.

Treatment

Initial Stage: Education, Goal Setting, Anxiety Reduction

Education is an integral part of the initial stage of therapy. Most clients may know little about the anatomy and constituents of the vulva, let alone GPPPD and its treatment. Thus, it is essential that the therapist be well-versed in the outcome research on diseases of the vulva and associated medical interventions. In the context of the initial assessment and gynecological findings, it is time to calibrate expectations and set reasonable treatment goals (Curtin, Ward, Merriwether & Allison, 2011). At the beginning of therapy, clients are often filled with hope that this problem will finally be resolved. The literature, however, indicates that the complete resolution of genital pain is often difficult to attain. While hope is integral to treatment, expectations also need to be realistic. Aligning client expectations with the empirical data and setting goals that aim at pain reduction and increases in sexual function and satisfaction are central to the therapeutic effort. Although most clients are hopeful as they start therapy, they are also understandably anxious. The therapist can help

allay the anxiety in the initial stage of therapy by starting to address some of the less threatening aspects of the pain problem. The following are techniques that can be instrumental in the first stages of therapy:

Reinforcing help-seeking. The client and her partner should be commended for addressing the problem. They should be informed that failing to address the issue would likely only have made it further degenerate – that confronting the pain problem indicates strength and will, both of which auger well for treatment outcome.

Validating the experience of pain. Many women experiencing pain with intercourse have been told that or wonder if the pain is "in their heads" or a somatic manifestation of intra-psychic or relational conflict. Emphasizing that their pain is real is crucial. It is also important to explain that the exploration of well-being, sexual function, and/or their relationship reflects an understanding that these issues can have an impact on the pain, not that they are the "real" problem.

Demystifying pain. Even seemingly inexplicable pain has its patterns. One way of transforming the pain from a mysterious tormentor to a more controllable force is to help the client to explore the conditions under which the pain is minimized and maximized. A pain diary can be very helpful in this regard, as clients monitor conditions when the pain occurred (e.g., emotions, thoughts, behaviors, arousal level, and relationship interactions before, during, and after the pain). For women who have stopped attempting sexual intercourse, this demystification may simply involve a retrospective analysis of factors that made it worse or better.

Decoding anxiety. Anxiety is not an inevitable reaction to the pain problem. It can be targeted and reduced or eradicated. Starting to do so using relaxation therapy techniques (e.g., imaging, breathing exercises, progressive muscle relaxation, mindfulness), cognitive re-structuring, and de-catastrophizing can be immediately useful.

Genital self-exploration. Many women who experience intercourse pain have developed an avoidance of their genitalia. They usually have not tried to explore and locate where it hurts. Getting women reacquainted with their genitalia can be useful for a number of reasons: (1) they can locate painful areas, (2) they can experiment with muscle exercises, (3) they develop self-efficacy, whereby they come to control certain aspects of their genitalia (muscle flexing).

Giving the woman control over penetration. Because penetration is painful, it is essential at the beginning of treatment to emphasize that the woman "calls the shots" in terms of whether penetration happens and in terms of its pacing. This intervention will immediately help with the pain experience as it will be her who agrees to it rather than her who is subjected to it. The distinction is crucial.

De-emphasizing intercourse. Letting the couple know that much of the work ahead will focus on increasing desire, arousal, and relational connectedness, rather than on increasing intercourse frequency, will relieve anxiety. Discouraging or even banning intercourse until a later stage in the treatment is usually indicated. Clients often experience these interventions as significant stress reducers that help them concentrate on the other aspects of the treatment.

Emphasizing affection and sensuality. Directing clients to increase their non-sexual demonstrations of physical affection is an important step. It is common for couples who have stopped having sex or greatly curtailed it to avoid all forms of physical contact. This damages their connectedness and alienates them from each other, both psychologically and physically.

Core Stage of Treatment: Connecting the Dots of Pain, Sex, Self and Partner

The treatment of GPPPD targets the interrelated domains of pain, sex, individual factors, and couple dynamics concurrently. This does not necessarily mean that every session has to cover these four domains. Some sessions will focus more on the sexual aspects than on the relational ones. Other sessions might fall exclusively into the domain of individual beliefs. That is perfectly natural and desirable. Treatment plans need to be responsive to snags along the way, as well as to the primacy of one domain over others in contributing to the disorder. But pain, sex, individual concerns, and couple dynamics all need to be juggled throughout the treatment. The neglect of any one of them can impact outcome negatively.

Pain and Physiological Processes

Addressing the gynecological consult. If the gynecologist consult has resulted in a recommendation for either a medical or surgical treatment component, the sex therapist is well-advised to further familiarize him/herself with the details of that recommendation to aid the client in making an informed decision and potentially help the client adhere to the treatment and adjust to its effects.

Coordinating with physical therapy. Following the gynecological consult, it is often appropriate for the client to be assessed and treated by a physical therapist who specializes in pelvic floor dysfunction (Rosenbaum, 2007). Such physical therapists can be found by accessing the national databases of the American Physical Therapy Association (www.apta.org) and the International Pelvic Pain Society (www.pelvicpain.org). Research indicates that physical therapy can result in pain reduction and improved sexual function (e.g., Morin, Carroll & Bergeron, 2017). Yet, it is important to emphasize physical therapy as an integrated component of a systemic approach to treatment as opposed to a standalone intervention (Rosenbaum 2018). Similar to the gynecological consult, it is advantageous for the therapist to gain a basic familiarity with pelvic pain physical therapy.

Addressing influences on pain. In the initial stage of therapy, women are asked to monitor influences on the pain experience, using a pain diary. This identification of exacerbating and alleviating factors can now be translated into specific interventions to improve the conditions under which sex takes place. The point is to learn from the diary and then try to instate the best possible conditions for sexual interactions (i.e, conditions that minimize the pain experience).

Sexual Interactions

Making quality time. Even couples who are not dealing with painful sex often fall into the trap of neglecting their sexual life. The result is that they either do not have sex at all or they have a routine, disengaged, and uninspired version of it. If you add pain to this scenario, the situation worsens considerably. Thus, the first change the couple needs to enact is prioritizing time and attention toward sexual interactions. Some couples find it useful to set aside special times during the week for their sexual encounters. Other couples find this overly staged and lacking in spontaneity. Scheduled or not, sex cannot be neglected.

Building desire and arousal. It is well known that painful intercourse impacts all stages of the sexual response. It is difficult for a woman to desire what hurts and/or to get aroused when she is anticipating pain. It may also be challenging for her partner to feel desire and

become or stay aroused to an activity he knows she finds aversive. The following are some suggested strategies for facilitating desire and arousal.

Enhancing self-perceptions of desirability. In order for most women to feel sexy, they have to believe in their own desirability. They have to find themselves attractive before they believe anybody else's assessment. Most women have ideas about realistic things they can do to make themselves feel more attractive. Hence, the therapist can work individually with each woman to heighten her sense of desirability, both cognitively and behaviorally.

Use of erotica (books or videos). Erotic materials that the client finds personally tasteful can facilitate desire and arousal in anticipation of a sexual interaction, as part of one, or privately by the woman alone.

Directed solitary masturbation. Women who experience pain with intercourse have often stopped engaging in any sexual activity, even masturbation. Introducing or re-introducing masturbation may be useful to build desire and arousal, as well as to reacquaint the client with her genitalia.

Heightening awareness of arousal. Because arousal is a relatively concealed phenomenon in women, many fail to attend to its physiological signs, such as lubrication and genital swelling. Heightening their awareness of the physiological feedback may increase subjective arousal. Moreover, since intercourse is likely to be less painful when the woman is aroused, it is useful for her (and her partner) to recognize the signs of arousal (e.g., lubrication, genital swelling) so that intercourse is not attempted until these signs are present.

Mindfulness. Related to heightening awareness of arousal is the more general principle of mindfulness which involves focusing on what is happening in the present in a non-evaluative way. Much of the anxiety that occurs during sex involves imagining negative outcomes. A mindfulness approach can help to focus the woman and her partner on immediately current sensations without the interfering anticipation of next steps (see Rosenbaum, 2013).

Expanding the sexual repertoire. Many people define sex exclusively as intercourse. The rest is considered foreplay and thus demoted to the status of preparations for the main event. It is thus not surprising that when couples have difficulties with intercourse, they have a tendency to drop all sexual interactions. What is the point of preparing for something that is not going to happen or that is going to feel bad anyway? Changing that focus is a good strategy for all couples and an essential one for couples who have painful intercourse. A couple who deprives themselves of non-coital sexual experiences because penetration is problematic is missing out on a potentially very satisfying sex life. Furthermore, increasing the emphasis on non-intercourse sexual acts can also have the effect of raising arousal levels, which in turn decreases the intensity of pain. The expansion of the sexual repertoire has traditionally been implemented through sensual touch exercises designed to shift the attention from the performance of intercourse and its attendant anxiety to the experience of sensual pleasure. This practice of sensate focus was first developed by Masters and Johnson (1970) but the technique was not further developed and made client-friendly until a chapter was written by Weeks and Gambescia (2009).

Promoting sexual communication. Even couples who claim to be very connected emotionally will often report that communicating directly about sex is difficult. This obstacle can result in enduring unpleasant sexual experiences and missing out on other satisfying experiences that could easily be introduced or increased. Many are uncomfortable vocalizing preferences during sex, but there are other ways to communicate. Teaching couples to express preferences nonverbally during sex can be a seamless way to enhance the experience.

Introducing levity into sex. For the couple who wants to maintain a sexual connection, sex needs to be taken seriously enough to prioritize it and to work on maintaining its vibrancy. On the other hand, many couples take what happens in any one sexual episode far too seriously. Clumsy attempts at arousing the partner are interpreted as reflections of personal inadequacy. Failure to "perform", as in the case in GPPPD, is often considered a disastrous event. Introducing a healthy sense of lightness and even humor into sex can be very liberating, as it relieves pressure and can also increase intimacy.

Individual Proclivities

Challenging sexual and relationship schema. Each member of the couple comes to therapy with a set of beliefs or schema about pain, sex and relationships. The therapist needs to remain sensitive to cultural values and not impose their world view on clients. Even within very restrictive sexual and relationship schema, the creative and culturally competent therapist can usually find room to work and improve the couple's situation.

Cognitive reframing. There are two cognitive styles that have been empirically identified in women who experience pain with intercourse: hypervigilance and catastrophization (Payne, Binik, Amsel & Khalifé, 2005). In relation to painful intercourse, hypervigilance refers to a cognitive style in which there is acute attention to and monitoring of pain cues, and of sensation in the genitalia, that could signal the onset of pain. Catastrophization refers to a cognitive style that infers the worst possible outcome (Sullivan, Lynch & Clark, 2005). A minor discomfort becomes an indication of irreversible physical damage. An insignificant argument signals the end of the relationship. The magnification characteristic of both hypervigilance and catastrophization can make the problem of painful intercourse much worse than it is. Challenging these distortions is an important part of therapy for women who experience painful intercourse. This can be accomplished with (1) education about the actual physiological consequences of pain with intercourse, (2) reality testing with the partner and the therapist, (3) exercises in which the client lists the evidence that supports and does not support her thoughts regarding what might happen when she has these sensations.

Coping reconstruction. Ineffective coping strategies also tend to be either avoidant or emotionally based. Evading intercourse and avoiding the problem overall are dead-ends. Using lay explanations of classical and operant conditioning paradigms, the therapist can explain how avoidance emerges as a coping strategy and why it is highly reinforcing and counterproductive. If resistance arises at different points in the treatment (and it usually does), it may be helpful to remind the client about the seductiveness and self-destructiveness of avoidance.

The emotionally-focused coping of many women who experience pain with intercourse (and their partners) can result in anger, hostility, depression, anxiety and shame. These emotional states can exacerbate pain and damage the client's (and partner's) well-being and their relationship. However, therapists can teach their clients how to regulate emotions, even when the pain persists. Emotional regulation involves the realizations that: (1) emotional reactions are often within a person's control – one can decide to submit to a feeling or not, (2) feeling something does not make it true, (3) it is not always useful to give free reign to a feeling, and (4) one can choose to feel something slightly different and more constructive. Emotional regulation is not about emotional repression. It is about not giving emotions more than their due.

Acceptance and mindfulness. Mindfulness involves the adoption of a nonjudgmental focus on one's experience of the present moment. Empirical investigation into the efficacy

of mindfulness-based interventions for painful sex is limited, but existing research is promising (e.g., Dunkley & Brotto, 2016). Acceptance is a core component of mindfulness. This may involve acceptance of pain, and an acceptance of oneself, in the moment; a practice that inherently entails an element of self-compassion. Preliminary research shows both pain acceptance (Boerner & Rosen, 2015) and self-compassion (Santerre-Baillargeon et al., 2018) to be associated with lower depression and anxiety in women with PVD, with greater pain acceptance also being correlated with less intercourse pain. When treating a complex condition such as GPPPD, where full resolution of pain can be an elusive outcome, developing the capacity to accept one's circumstances may be a significant component of treatment.

Relationship Dynamics

Encouraging individuation. In a relationship, it can sometimes be difficult to distinguish an individual problem from a relational one. Yet it might be the single most important skill to learn, both in terms of individual well-being and relationship adjustment. In other words, only whole people can have whole relationships. If we depend on our partner to make us feel whole and soothe our own existential anxieties, then any problem he/she has will necessarily feel threatening, even if it has nothing to do with us. Individuation is very relevant to couples dealing with painful intercourse. It is common for partners to present with concerns about what the pain means about the client's attraction or commitment to them, or for women to worry about how the pain makes their partners feel. This is a major stumbling block. It turns the pain into a symbol of relationship dysfunction when it most often is not, even if relationship dysfunction is present. An important component in therapy for GPPPD is the de-symbolization of the pain. Plainly stated, "the pain is not you, the pain is not your partner; the pain is not about you, your partner or the relationship; the pain is just the pain".

Managing partner reactions to the pain. Teaching partners how to replace solicitous (i.e., overly accommodating) reactions with facilitative (i.e., encouraging) ones is instrumental to breaking the cycle of avoidance. Both the woman and her partner have to discuss and define the line between the encouraging/reinforcing of attempts at intercourse and the toleration of discomfort, and the forcing of an activity too painful to hold any chance of pleasure.

Enhancing communication. If communication failures exist in other aspects of the relationship, they are likely to result in relationship conflict, which will inevitably trickle down to sexual interactions. If these sexual interactions are already complicated by pain, the result can be very damaging. Among the countless potential approaches to enhancing dyadic communication, the therapist can promote thoughtful assertiveness as a means of avoiding the common pitfall of mind-reading. While honesty can be difficult, withholding one's true sentiments is ultimately a pernicious practice. The therapist can promote tactful but truthful expression by helping the couple to sincerely address feelings while referencing specific partner behaviors.

Re-establishing a sexual connection. The re-establishment of a sexual connection can be greatly facilitated by infusing sexiness into the everyday. Sex therapist Stephen Snyder uses the term "simmering" to metaphorically describe this cultivation of erotic tension (see Snyder, 2018). This can be a French kiss as you go out the door on your way to work or a neck massage from behind when you are chopping onions for dinner. Even when sex happens at the end of the day, the foreplay starts the moment one wakes up. If sex has

become problematic, as in the case of GPPPD, flirting can even be experienced as pressure to have sex. The therapist can help here. By de-emphasizing intercourse or, in some cases banning it for some time, the infusion of this quotidian sexiness can be divested of its performance threat.

Addressing the function of pain in the relationship. A crucial systems intervention in the treatment of GPPPD is to address the function of pain in the couple dynamic. Clients can easily list all the ways in which the pain has negatively impacted their relationship. Much more difficult to face, however, are the ways in which an improvement in symptoms may be threatening. It is critical to identify these potential secondary gain threats, as they will likely be a significant source of treatment resistance. Questions of relevance to both partners would be:

How would your life change if you (she) no longer had pain with intercourse? Do you have fears about what might happen if the pain went away or improved? Can you think of any negative consequences to the resolution of symptoms?

A woman who is not attracted to her partner may fear that once the pain subsides, she loses her "legitimate" excuse for avoiding sex. An insecurely attached male partner may worry that once the problem resolves, his partner may leave him. Questions such as these help to understand the underlying function of the pain.

Challenges to Therapy

There are many challenges in the treatment of GPPPD. Perhaps the greatest of these is the coordination of multiple health professionals in the treatment plan. Clearly, treatment has to adapt to the constraints of any one case, but the optimal strategy is not only interdisciplinary, but involves a treatment team (e.g., a gynecologist, sex therapist, physical therapist) collaborating concurrently, as opposed to operating independently and/or sequentially (Binik & Meana, 2009).

A second challenge is balancing people's beliefs in the importance of spontaneity in sex and the structured nature of the assigned exercises. The therapist must tread lightly here and resist the temptation to schedule sexual interactions. Sex cannot become homework – there is nothing sexy about homework. In addition, treatment for painful intercourse rarely takes a linear course. Thus, it is wise for the therapist to be proactive and prepare clients to navigate the potential unbounded optimism of progress and discouragement that accompanies setbacks.

A third challenge is avoiding therapist-induced performance anxiety. When a therapist suggests or directs clients toward sexual exercises or activities, clients might feel pressured by the therapist to engage in sex. It is important that the therapist address the clients' experience and nonjudgmentally explore non-adherence to exercises with a focus on what the non-adherence signifies.

The final challenge is the definition of treatment success. Clients will likely be secretly or openly revising previously established goals as treatment progresses, and partners' goals may not fully align. Thus, ongoing clarification of goals and expectations can be helpful. Ultimately, as in the treatment of any sexual dysfunction, the most important treatment outcome is sexual satisfaction, rather than frequency of intercourse or orgasm. Sometimes that is the only aspect of the sexual experience that sex therapy impacts and yet, ultimately, that is the only thing that matters – how happy individuals are with their experience, be that what it may.

Conclusions

The last 20 years have evidenced a considerable research effort aimed at understanding the mechanisms and treatment of painful intercourse. The initial emphasis was on the properties of the pain and its sensory characteristics. This was a corrective and productive emphasis given the historical approach to painful intercourse as a somatic manifestation of psychosexual and relational problems. Now that GPPPD is recognized primarily as a pain disorder that interferes with sex, we must ensure that the research and clinical effort remain systems-focused and not lose sight of the fact that, regardless of etiology, any disorder that involves sexuality is likely to be significantly influenced by intra-psychic, interpersonal and societal/cultural factors.

One important future direction for research and clinical practice in regard to painful sex is the consideration of intercourse pain in men. With data suggesting a 3–5% prevalence of painful intercourse in men (APA, 2000; Pitts, Ferris, Smith, Shelley & Richters, 2008), having made GPPPD a strictly female sexual dysfunction in the *DSM-5* feels a little like a step backwards, as the *DSM-IV* did allow for the possibility of painful intercourse in men (heterosexual or gay). Similarly, there is limited research on the experience of genito-pelvic pain, including penetrative pain, in nonheterosexual women. Finally, individuals with disabilities are another group that needs more research and clinical attention, as a number of chronic illnesses and their treatments can result in painful sex.

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11

THE INTERPLAY BETWEEN MENTAL AND SEXUAL HEALTH

Kenneth Phelps, Ashley Jones, and Rebecca Payne

Introduction

Sexual health cannot be detached from mental health. Both are inextricably bound to quality of life and relational satisfaction. While vital to our overall well-being, these facets of health continue to share societal stigma, perpetuating misinformation and deterring from effective treatment. In a society that remains generally silent or shaming of these clinical areas, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychiatric Association (APA), 2013) continues to function as a voice for defining and studying their influence. Sexual dysfunctions, including disorders of arousal, desire, penetration pain, and orgasm, appear within the manual. These diagnoses of sexual function are certainly influenced by and influence other illnesses commonly treated by mental health and substance abuse professionals. Indeed, researchers have encouraged clinicians to explore whether mental health concerns are the cause or consequence of sexual complaints so treatment can be tailored appropriately (Brotto et al., 2016).

Moving beyond the classifications of the *DSM-5*, it can be said that all individuals journeying toward their sexual potential navigate complex waters of personal vulnerability, relational fragility, and beliefs influenced by generational and cultural factors. This journey is rarely uneventful, as people are reminded of their psychological blind spots and conditioned responses. Many struggle with psychiatric disorders, such as depression or anxiety, while others may find themselves in the tailspin of addiction or the repetitive behaviors of obsessive compulsive disorder (OCD). For some, sexual pursuits bring forward echoes of trauma or somatic manifestations of distress. The impact of this interplay between mental and sexual functioning often emerges as adolescents and young adults define their preferred sexual selves. In one recent study, 95.8% of the 15–26-year-old participants with a mental health disorder surveyed endorsed one item of sexual dysfunction and 38.9% met criteria for a clinical sexual dysfunction (McMillan et al., 2017).

Proper treatment, pharmacologic and/or psychotherapeutic, can go a long way in improving quality of life for those coping with mental illness. Unfortunately, psychotropic medication used to mend the struggles of the mind can at times worsen sexual functioning. Compounding this reality, adverse effects of drug treatment often goes unrecognized by prescribers and a paucity of data exists in the literature (Montejo et al., 2018). Psychotherapeutic approaches have their own misgivings, as many clinicians disregard sexual health or the relational climate. All hope is not lost, as poor outcomes can often be avoided

through use of proper psychoeducation, efficacious treatment modalities, and a comprehensive, systemically oriented care.

To provide treatment that facilitates satisfactory outcomes for individuals, couples, or families, systemic therapists must be armed with up to date knowledge of the bidirectional relationship of mental and sexual health. The purpose of this chapter is to do just that by: 1) reviewing the impact of various psychological symptoms (mood, anxiety, somatic, etc.) on sexual health; 2) discussing common effects of psychotropic medications, alcohol use, and illicit substances on sexual functioning; and 3) placing this knowledge within the consultation room of the biopsychosocial practitioner via case examples and collaborative treatment planning.

This last point of collaborative treatment planning may be especially important as a psychotherapist operating from the Intersystem Approach cannot practice in a silo. Discerning whether a sexual dysfunction accompanying a psychiatric illness may be a symptom of the illness, an unwelcome side effect of medication, predate the illness, or attributable to other causal factors (e.g. substance use, medical diagnosis) can be a complex, but necessary process in treatment planning (Clayton & Balon, 2009). This is best accomplished via a team of individuals utilizing the Intersystem Approach, considering the individual's biological vulnerabilities and psychological coping style, as well as the broader interactional and intergenerational systems (Weeks & Cross, 2004). While the following categories of psychological symptoms are presented separately for organizational purposes, it should be noted that co-occurrence of problems is typically the rule rather than the exception in clinical practice.

Depressive Disorders

Matt is a 35-year-old man who presented six months ago to an outpatient psychiatric office with complaints of worsening anhedonia, depressed mood, fatigue, decreased appetite, poor sleep, irritability, and feelings of worthlessness for the prior four weeks. He reported that he was having trouble completing work and recently received a below average evaluation from a supervisor. His partner, Tonya, has noticed his lack of interest in going out socially and in sexual activity. He reported that his relationship is strained and that he doesn't want to "drag Tonya down," but he just doesn't feel like doing anything. At that visit he was diagnosed with major depressive disorder, referred for psychotherapy, and started on a selective serotonin reuptake inhibitor (SSRI), an antidepressant medication.

At his follow up appointment, with combination pharmacotherapy and psychotherapy, Matt has seen drastic improvement in his depressive symptoms. When asked specifically about the symptoms he reported relating to intimacy, he reports that when he and his partner engage in sexual activity it "takes too long" and that he often doesn't "finish." Upon further exploration, he reports that he often terminates sexual activity before he is able to achieve orgasm and ejaculation, because of the length of time that it takes for him to complete sexual activity. Though he reports Tonya has been supportive, Matt frequently feels frustrated and has automatic negative thoughts of being "inadequate" and "a useless partner."

Symptoms

There are a number of psychiatric illnesses where depressed mood is a cardinal symptom (e.g. persistent depressive disorder, major depressive disorder, unspecified depressive disorder, bipolar disorder). Studies have estimated the prevalence of sexual dysfunction in

major depressive disorder to be between 35% and 70% (Schweitzer, Maguire, & Ng, 2009). Beyond sexual dysfunction, depression has been associated with sexual risk behaviors and increased use of sexual health services (Field et al., 2016). Unfortunately, sexual dysfunction can be a common side effect of not just the disorder, but also the pharmacologic treatments. Patients may be non-adherent or discontinue antidepressant medications that cause sexual dysfunction due to the difficult choice of improving their mood versus striving for sexual vitality (Schweitzer, Maguire, & Ng, 2009; LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013; Zemishlany & Weizman, 2008).

The case of Matt highlights the complex interface between depression and sexual health. First, symptoms of major depressive disorder (MDD) commonly lead to sexual difficulty. For instance, Matt experienced decreased interest and pleasure in activities, feelings of worthlessness, fatigue, irritability, and amotivation. All of these symptoms can affect sexual functioning. Burdensome thoughts of "dragging a partner down" or "being useless" would surely take a toll on a person's self-confidence, libido, and attunement to their partner. Neurovegetative symptoms of lethargy or low energy also make it difficult for a depressed individual to muster enough drive for sexual activity. Finally, some individual may have a worsening of their depression because of a primary sexual problem. For instance, Matt may be feeling "inadequate" because of his low desire or delayed ejaculatory response ("I'm so inadequate because I can't even please my partner or be present with her."). Conversely, Matt may feel inadequate because of something totally unrelated to sex such as his below average job performance ("I'm so inadequate because I do so much worse than my colleagues."), which could be attached to his sexual health ("I'm also not as good as other people at other things, like being a passionate sexual partner. I'm such a failure."). Untangling the nature of these thoughts and evidence supporting or refuting them may be an important piece of clinical care for the couple where one or both parties may be living with a depressive disorder. Likewise, exploring whether Matt's pharmacologic agent may play a role in his sexual health would be a vital consideration.

Antidepressant Pharmacotherapy

Neurotransmitters theorized to be involved in psychiatric illness and targeted in antidepressant treatment are also involved in sexual functioning, especially dopamine, serotonin, and norepinephrine (Zemishlany & Weizman, 2008). It has been reported in neuroscience literature that the mechanism of action for the sexual side effects of antidepressant treatment is associated with inhibition of dopamine release in the hypothalamus and mesolimbic pathway by serotonin (Bijlsma et al., 2014). Inhibition of libido, ejaculation, and orgasm has also been implicated with elevated levels of serotonin in the central nervous system (CNS) (Micromedex, 2018). Studies have suggested that the mechanism of action of the antidepressant agent is important. This is demonstrated by the lack of sexual side effects with bupropion (Wellbutrin), due to the impact on norepinephrine and dopamine, not serotonin, and serotonergic agents that have a specific serotonin receptor activity like buspirone (Buspar) and vilazodone (Viibryd) (Bijlsma et al., 2014).

Though still in use, older antidepressants, such as monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs), have largely been replaced by selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs). In a 2013 study, Gelenberg and colleagues examined sexual dysfunction in patients with depression who were treated with a SNRI and a SSRI. New-onset impairment of sexual functioning was most commonly reported during the first month of

treatment. In patients with depression who achieved remission, sexual dysfunction was less likely to be reported than non-responders (Gelenberg, Dunner, Rothschild, Pedersen, Dorries, & Ninan, 2013). Other studies show that in the first weeks of treatment, about 26–57% of men and 27–65% of women experience new sexual dysfunction or worsening of pre-existing sexual difficulties (Montejo et al., 2018).

While medication side effects are often an unwelcome byproduct to antidepressant treatment for most, there are instances where sexual side effects are utilized to help treat other sexual disorders. The prolonged time to orgasm and ejaculation with SSRIs can be used to treat premature ejaculation (Clayton & Shen, 1998; Micromedex, 2018). Decreased libido with SSRIs, among other treatment effects, has been used in the treatment of sexual offenders who have a paraphilic disorder (Garcia, Delavenne, Assumpcao, & Thibaut, 2013).

SSRIs are reported to cause sexual dysfunction in 30%–70% of patients (Micromedex, 2018). Indeed, antidepressant medications that are primarily serotonergic, like the SSRIs, are the most common culprits of sexual side effects. In a 2009 meta-analysis, Serretti and Chiesa examined different antidepressant agents and their rates of sexual dysfunction. Sexual dysfunction as a result of antidepressant treatment had higher rates than placebo. Serretti and Chiesa also ranked different antidepressants according to their levels of impact on sexual dysfunction (from highest to lowest): sertraline (Zoloft), venlafaxine (Effexor), citalopram (Celexa), paroxetine (Paxil), fluoxetine (Prozac), imipramine (Tofranil), phenelzine (Nardil), duloxetine (Cymbalta), escitalopram (Lexapro), and fluvoxamine (Luvox). There were several medications examined that did not have a significant difference in rates of sexual dysfunction compared to placebo; three of these being mirtazapine (Remeron), nefazodone (Serzone, which is off the market), and bupropion (Wellbutrin) (Serretti & Chiesa, 2009).

Early investigators explored the differing effects of psychotropic medications on the following phases of sexual response: 1) libido, 2) arousal, and 3) orgasm (Clayton & Shen, 1998). These researchers identified MAOIs and SSRIs as being associated with a lowered libido in both men and women, with no particular SSRI having lower rates of decreased sexual interest. Though there are case reports of decreased libido in women taking TCAs, this may be due to difficulty in achieving orgasm rather than decreased interest. For men, there is a reported discrepancy between what is noted in clinical practice (decreased libido) and what the evidence demonstrates (no decrease in libido). There is no significant evidence showing MAOIs, TCAs, and SSRIs cause problems with arousal in women. Much of the data on erectile dysfunction with TCAs, MAOIs, and SSRIs is limited to case reports in men. The most common sexual dysfunction associated with psychiatric medications in women is problems with delayed orgasm or inability to achieve orgasm. For men, TCAs and SSRIs both have demonstrated effects on orgasms. SSRIs can specifically cause anorgasmia or prolonged time to orgasm (Clayton & Shen, 1998).

Chokka and Hankey (2018) reviewed the literature regarding sexual dysfunction related to treatment for depression between 1993–2017 and created a schematic to help providers select medications. They summarized psychiatric medications into the following categories: "improves sexual functioning," "no significant effect on sexual functioning," "significant negative effect on sexual functioning," and "inconclusive." Based on this schema, bupropion would be the only antidepressant found in "improves sexual functioning" category (Chokka and Hankey, 2018). While bupropion works well for depression, it is not approved for use for anxiety disorders, which may be a limitation of patients with co-morbid illness. Medications classified in the "no significant effect of sexual functioning"

category were desvenlafaxine, vilazodone, vortioxetine. Duloxetine, levomilnacipran, and mirtazapine were found to be "inconclusive." The majority of medications reviewed in this chapter were found in the "significant negative effect on sexual functioning"; citalopram, escitalopram, fluoxetine, venlafaxine, sertraline, paroxetine (Chokka & Hankey, 2018).

There are many SSRIs, SNRIs, and other medications used for the treatment of depression. Of note, many of these medications are also used for the treatment of anxiety, posttraumatic stress disorder (PTSD), and OCD. Some of the medications also have indications for use for other non-psychiatric medical illnesses, like fibromyalgia and neuropathic pain. There are challenges in obtaining an accurate assessment of the incidence of sexual dysfunction in antidepressant treatment, as there are wide ranges reported in the literature, varied data collection methodologies, and lack of female population in study samples (Micromedex, 2013). Information on sexual dysfunction specific to each individual medication can be found in common pharmacology references. One example is Micromedex, a resource used by medical professionals to find detailed information about medications.

Upon further exploration, Matt reveals that he has no difficulty obtaining and maintaining an erection. He has nocturnal erections. He reports difficulty achieving orgasm and ejaculation with masturbation, which causes him frustration. Matt reports that his interest is improved from his initial presentation, but still less than what he would like. He also has developed some anxiety specifically around being able to achieve orgasm, since this has become a topic of discussion with Tonya.

Key Points

- Symptoms of depression, including anhedonia, loss of motivation, fatigue, and feelings of worthlessness, can influence sexual functioning.
- Overall antidepressant medication could potentially cause decreased libido, difficulties with arousal, and problems with orgasm and/or ejaculation. Each medication is different and therefore has variable rates of sexual side effects.
- Medication is most likely to cause sexual dysfunction within the first few weeks or month of treatment. Taking a careful timeline of events with sexual symptoms, depressive symptoms, and medication initiation is crucial.

Bipolar Disorders

Symptoms

Patients with bipolar disorder experience significant periods of hypomania or mania and depression. Changes in sexual activity can be significant manifestations of both manic and hypomanic symptoms. Individuals displaying these symptoms show increased goal-directed activities, decreased need for sleep, racing thoughts, distractibility, and grandiosity together during a circumscribed time period, with an interruption on functional ability in the case of mania (APA, 2013). The most notable display of sexual problems in mania includes hypersexuality and associated risky behaviors that may put an individual at greater probability for contracting a sexual transmitted infection (STI), having an unintended pregnancy, or being unfaithful in a monogamous relationship. The current research base around hypersexuality varies due to the operational heterogeneity of the term. Data does exist showing that couples where one member has bipolar disorder tend

to have lower levels of sexual satisfaction and incongruent sexual satisfaction between partners (Kopeykina et al., 2016). One might imagine that a partner's behaviors during a manic phase (e.g., constantly pursuing intimate acts, compulsively viewing pornography, engaging in flirtatious behavior or extra-relational affairs) would be challenging to navigate for a partner without bipolar disorder.

Conversely, patients who are in a depressive episode of bipolar disorder may show significant amotivation, fatigue, and lack sexual desire (APA, 2013). Similar to the depressive symptoms discussed in earlier sections, individuals within a depressive episode often meet clinical criteria for a sexual dysfunction, commonly showing the reverse of hypersexuality (i.e., low desire or hyposexuality) (Kopeykina et al., 2016). For some, reflecting upon their behavior during a prior manic episode may lead to self-critical and shame filled intrapsychic experiences. This may be coupled by a non-bipolar partner who is experiencing both anger or hurt from their behavior alongside worry or empathy for the emotional whiplash of this disorder. Thankfully, there are many psychotropic medications used to treat manic, hypomanic, or depressive phases of the illness, but they may have implications for sexual health.

Pharmacologic Treatment of Bipolar Disorder

Providers can utilize a variety of pharmacological treatments for bipolar disorder. Mood stabilizers and antipsychotics are commonly used, but medications like antidepressants may also be used carefully for stabilization of symptoms, with close monitoring for manic symptoms.

Mood stabilizers. The term mood stabilizers refer to medications used in the treatment of psychiatric disorders, particularly bipolar disorders, including: lithium, valproic acid (Depakote), lamotrigine (Lamictal), and carbamazepine (Tegretol). Antidepressants and antipsychotics have a larger breadth of reports on sexual dysfunction than mood stabilizers, and much of the data available for mood stabilizers is for patients with epilepsy (Montejo et al., 2018). Lithium has been implicated in decreased libido and ED, with about 1/3 of patients experiencing sexual dysfunction (Micromedex, 2018; Montejo et al., 2018). In men with bipolar disorder who were taking lithium and other medications, ED was reported (Clayton & Shen, 1998). Depakote has been associated with androgen level changes, ED, decreased sexual desire, and anorgasmia (Montejo et al., 2018). Carbamazepine was also found to have changes with hormone levels, sexual desire, and sexual dysfunction (Montejo et al., 2018). There is little data showing sexual dysfunction as a result of oxcarbazepine and lamotrigine treatment for bipolar disorder (Montejo et al., 2018).

Antipsychotics. In addition to psychotic illnesses, antipsychotics can be used for acute mania, maintenance treatment of bipolar disorder, as well as adjunctive treatment for major depressive disorder. It has been reported that in patients treated with antipsychotics for psychotic illnesses, about 38–86% of patients experienced sexual dysfunction (Montejo et al., 2018). Chlorpromazine (Thorazine) is a typical antipsychotic that is approved for the use of bipolar disorder in adults. Several other atypical antipsychotics; like aripiprazole (Abilify), quetiapine (Seroquel), risperidone (Risperdal), olanzapine (Zyprexa), lurasidone (Latuda), and ziprasidone (Geodon), have FDA approval for use in bipolar disorder. Abilify, Seroquel XR, and Rexulti also have approved indications for adjunctive treatment in depression and Zyprexa for use in depression with fluoxetine (Micromedex, 2018).

Antipsychotics have been shown in the literature to be associated with sexual dysfunction, but more studies are needed (LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013;

Micromedex, 2018). The most common reproductive side effects reported in clinical practice were ED and orgasm difficulties with short term treatment. With long term treatment, decreased desire was the most prominent side effect (Montejo et al., 2018). The overall rate of decreased libido with antipsychotics is about 38%, with high doses of the low potency antipsychotics being the most common cause. For women, antipsychotics have been reported to decrease libido, especially in ages 60–70 years old, and also to cause anorgasmia or delayed orgasm. For men, they have been associated with ED and orgasmic disorder or commonly a combination of ED and low libido (Clayton & Shen, 1998; Montejo et al., 2018).

Antipsychotic-induced sexual dysfunction treatments were examined in a Cochrane review, which highlighted the lack of studies regarding treatment (Schmidt, Hagen, Soares-Weiser, & Maayan, 2012). Antipsychotics vary in the specifics of their mechanisms of action, but many block dopamine and alpha-adrenergic receptors, and have antihistaminic and anticholinergic properties, which can lead to sexual dysfunction (LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013; Micromedex, 2018). These properties can cause many different effects, depending on the target receptor, including sedation, decreased peripheral vasodilation, and elevated prolactin (LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013). Some studies suggest that elevated levels of prolactin, which can be caused by antipsychotic medication, have been associated with an increase in sexual dysfunction (LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013).

Key Points

- Patients with bipolar disorder who are in a manic phase of illness may display sexually-related symptoms, like hypersexuality or risky sexual behaviors. Patients in the depressive phase of the illness are described in the aforementioned section.
- Mood stabilizers have less research data on sexual side effects than other classes of psychiatric medications (particularly antidepressants and antipsychotics). Mood stabilizers have shown the potential to cause ED, decreased libido, and anorgasmia in some studies.
- Antipsychotics are a class of medications that are used for many clinical indications, including bipolar disorder. There are many different antipsychotic medications with unique properties that can cause variable side effects. Short term treatment with antipsychotics was associated with erectile dysfunction and orgasm difficulties, while long term treatment was associated with decreased desire.

Anxiety Disorders and Associated Diagnoses

Symptoms

While sexual activity carries with it a certain amount of necessary anxiety – as a close cousin of excitement and arousal – many individuals suffer with debilitating anxiety that may actually inhibit functioning. Foundational research in the 1980s documented higher rates of sexual problems among those with anxiety disorders (Kaplan, 1988). More recent literature continues to associate anxiety with both orgasmic difficulties and sexual pain (Khandker et al., 2011; Leeners et al., 2014). Whether the restlessness and worrisome thoughts of generalized anxiety disorder (GAD) or the social isolation of agoraphobia, it is not surprising that anxiety and sexual problems often co-occur.

One of the most widely discussed anxieties of sexual activity is performance-based anxiety, which has been associated strongly with social phobia (SP) or social anxiety disorder in the literature (Heimberg & Barlow, 1988; Zemishlany & Weizman, 2008). Fear of humiliation and rejection in social situations are a key component of SP, which can lead to the pursuit of perfectionism when it comes to sexual activity. Striving for the perfect arousal or orgasm may decrease sexual functioning, as it detracts from nonjudgmental mindfulness to physiological sensations and the relational experience. For example, a male may become hypervigilant about obtaining or sustaining an erection, leading to loss of his erectile capacity from anxious thoughts. A woman may feel pressured by her partner to attain orgasm, but in doing so loses the intimate, loving mindset needed to shed her inhibitions. Research as far back as two decades ago shows women with clinical anxiety tend to have more difficulty with obtaining and enjoying orgasm, which has been duplicated over time (Labbatte, Grimes, & Arana, 1998; Leeners et al., 2014). Beyond pursuing perfection, individuals with SP had documented fewer sexual relationships, impairments in subjective satisfaction, lowered desire and arousal, and men were more likely to seek out prostitution to meet their needs (Bodinger et al., 2002).

When other diagnoses have been explored, OCD, PTSD, and panic disorder (PD) have often been associated with sexual difficulties. PTSD, grouped under Trauma and Stressor-Related Disorders in the *DSM-5* (APA, 2013), was found to be a significant risk factor for sexual problems among combat veterans, including ED and premature ejaculation (Letoureneau, Schewe, & Frueh, 1997). For many, the traumatic event suffered may include sexual violence leading to intrusion symptoms during sex, persistent avoidance of intimate activity, negative cognitions of self, and even dissociation. Some scientist practitioners have proposed that sexual problems in those living with PTSD may have to do with "the inability to regulate and redirect the physiological arousal needed for healthy sexual function away from aversive hyperarousal and intrusive memories" (p. 1107; Yehuda, Lehrner, & Rosenhaum, 2015).

Tabitha is a 20-year-old female who was sexually molested by her father from 10–12 years old. Tabitha was involved in treatment shortly after the discovery of the abuse. Showing progress, she eventually discontinued therapy around 14 years old. She recently had a relapse in symptoms, finding herself triggered throughout her day by sights, sounds, and smells. She also has recent difficulty sleeping due to nightmares of her father's violence, for which she has tried taking melatonin without improvement. This worsening of functioning occurred in the context of starting her first consensual sexual relationship with partner of two years, Keith. After their first sexual encounter Tabitha cried and had intrusive thoughts that she was "dirty" and "was just there for his pleasure." On their second attempt at intercourse, Tabitha felt extremely anxious and noticed profound pain with penetration. Since this encounter, Tabitha finds herself more tearful and low, whereas Keith has been more withdrawn due to not wanting to pressure Tabitha. Their overall intimate bond and nonsexual touching has decreased over the last few months.

The avoidance symptoms that may occur in individuals coping with PTSD may be mirrored in unique ways in persons dealing with OCD. OCD sufferers have more difficulty reaching orgasm and may be sexually avoidant (Aksaray, Yelken, Kaptanoglu, Oflu, & Ozaltin, 2001; Fontenelle et al., 2007). This is not surprising when considering contamination fears or rituals that may interfere with foreplay or sexual acts. A unique part of OCD includes sexual obsessions that are ego-dystonic, causing significant fright and often misconstrued by professionals as a sexual fantasy, sexual identity crisis, or paraphilia (Buehler, 2011). Emerging guidelines can help clinicians determine if sexually violent thoughts are a

part of the OCD pathology or may be aligned with a primary paraphilic disorder (Vella-Zarb, Cohen, McCabe, & Rowa, 2017). Similarly, the existing literature can be helpful to understand if concerns about sexual orientation (i.e., doubting one's sexual orientation) may be aligned with obsessional material or the exploratory mental process of finding who one is most attracted to in life (Williams & Farris, 2011). For those engaged in exposure with response prevention, the anxiety experienced when refraining from a compulsion can manifest into panic-like symptoms. Certainly, panic attacks, including those with panic disorder, have their own negative impact on sexual functioning given the heightened nature of this physiological experience (Clayton & Balon, 2009).

Body dysmorphic disorder (BDD), now classified as an OCD spectrum disorder by *DSM-5*, is diagnosed when an individual is preoccupied with an imagined or minor flaw in one's appearance, which is accompanied by repetitive behavior or mental acts in response to the preoccupation (APA, 2013). Most commonly, individuals have concerns about facial features, skin, hair, breasts, and genitalia (Phillips, 2002). The preoccupation and associated response, whether an act or thought pattern, are time consuming; yet despite this, most individuals exhibit little to no insight into this illness. Though few studies exist about this disorder or its impact on sexual dysfunction, demographic data from extant literature found the majority of individuals with BDD are unmarried and have never been married. Often, these individuals are self-conscious about the either minor or nonexistent flaw to the extent they feel ashamed and avoid engaging in sexual relationships (Phillips, 2002).

Pharmacologic Treatment of Anxiety

Treatment to alleviate anxiousness around sexual activity or to treat individuals with a pre-existing anxiety disorder that interferes with sexual functioning can improve one's sexual health. Unfortunately, some pharmacologic treatments for anxiety many cause significant sexual side effects. The most common pharmacological treatments for anxiety disorders include SSRIs, SNRIs, and benzodiazepines. Other medications (some off-label), like TCAs, hydroxyzine, and gabapentin are also used.

Many SSRIs and some SNRIs are FDA approved for the treatment of anxiety. These medications are commonly used to treat depression, and the information regarding sexual dysfunction due to these medications is discussed in the previous section. Benzodiazepines are a type of medication that is also utilized in treatment of anxiety, and can be prescribed for as needed use or for daily use. Sometimes benzodiazepines are prescribed for short term relief while an SSRI/SNRI begins to work, and other times they are continued long term. Benzodiazepines are considered a schedule IV controlled substance, which is different from the SSRI and SNRI medications. Benzodiazepines work through GABA receptors and patients can develop a physiological dependence, causing tolerance and/or withdrawal symptoms if the medication is not tapered. It is important that if a sexual adverse effect occurs and the patient desires to stop the medication, they work closely with their prescribing provider to do this safely, and avoid potentially serious withdrawal symptoms. Some examples of commonly prescribed benzodiazepines are alprazolam (Xanax), clonazepam (Klonopin), lorazepam (Ativan), and diazepam (Valium). Benzodiazepines act as a central nervous system (CNS) depressant, which can cause a decrease in libido (Micromedex, 2013). Benzodiazepines have been associated with decreased libido and even a report of increased libido. For alprazolam (Xanax), decreased libido has been found in 6–14.4% (Micromedex, 2013).

Another medication utilized for treatment of anxiety is hydroxyzine (Vistaril). This medication is an antihistamine and can be taken on an as needed basis or scheduled. Hydroxyzine is not a controlled substance, nor is it known to be associated with physiological dependence, tolerance, or withdrawal. It has antihistaminic, anticholinergic, and CNS sedating properties. Anticholinergic agents can adversely affect erections, while antihistaminic and CNS depressant medications can potentially cause sexual dysfunction (Micromedex, 2013).

Buspirone (Buspar) is a FDA approved medication for the treatment of anxiety in adults. It is not an as needed medication and is taken daily as monotherapy or as an adjunctive treatment with another medication, typically a SSRI or SNRI. The mechanism of action is largely unknown, it is not a controlled substance, and has not been shown to have an affinity for the same receptors as benzodiazepines. It has been shown to cause anorgasmia when in combination with fluoxetine in patients with OCD (Micromedex, 2018).

Key Points

- Many different anxiety disorders can cause or contribute to sexual dysfunction. The hallmark features of fear, worry, and anxiousness can interfere with all stages of sexual activity and in a person's confidence in performing and completing sexual acts.
- The first line pharmacological treatment for patients with anxiety disorders is often the SSRI/SNRI agents described previously in the depression section.
- Benzodiazepines are controlled substances that have been associated with decreased libido. They must be carefully prescribed, monitored, and discontinued since they are associated with physiological dependence.

Somatic Symptoms and Related Disorders

Somatic symptom disorder (SSD) occurs when an individual has one or more somatic symptoms (whether a medical diagnosis is present or not) that is distressing, disrupts daily life, and has excessive thoughts, feelings, or behaviors related to said somatic symptom(s) for at least six months (APA, 2013). The hallmark of this disorder is the distress caused by the symptom and the persistent and excessive time spent focusing on the symptom, which can manifest in a number of ways. Individuals may have persistent thoughts about the brevity or seriousness of the symptom, be persistently highly anxious about the symptom or their health in general, or substantially invest their time in matters related to the symptom (APA, 2013). The relationship between SSD, somatic symptoms, and sexual dysfunction has not been elucidated. In fact, the current literature contains very little on their convergence (Fanni et al., 2016), even though SSD has an estimated prevalence in the general population between 5–7%, which is not infrequent (Kurlansik & Maffei, 2016). By understanding the concepts of this disorder and the broader concept of somatization, one can hypothesize several potential areas of sexual dysfunction.

Sexual intercourse between partners in a relationship may be limited if one partner suffers with SSD. For example, if pain is the predominant somatic symptom, the affected partner may be disinterested in sex or fear sex, concerned the act could exacerbate existing complaints. This disinterest may be discouraging to the asymptomatic partner, increasing likelihood of dissatisfaction and relational discord. The preoccupation that accompanies a

SSD may be thoroughly time consuming for the affected partner, leaving little time or interest in sexual relationships. If pelvic pain is present, a woman may be quite reluctant to engage in any type of intimacy with her partner, not just sex. Further information would be needed to explore whether diagnostically this individual would more likely be experiencing genito-pelvic pain/penetration disorder, which can often be effectively treated in clinical practice.

SSD is more common in women than in men with a ratio of 10:1 (Kurlansik & Maffei, 2016). However, a recent study of men with a chief complaint of sexual dysfunction at an Italian outpatient clinic revealed a positive correlation between somatic symptoms and frequency of sexual dysfunction. Men with more somatic symptoms, and thus more sexual dysfunction, were typically older, more obese, less educated, and reported unhealthy habits such as drinking alcohol and smoking (Fanni et al., 2016). Individuals with SSD, regardless of gender, may be prescribed medications, such as opioids or SSRIs that also affect libido and sexual function.

Eating Disorders

Eating disorders include anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder, other specified eating disorders, and unspecified eating disorders (APA, 2013). Eating disorders are characterized by fear of gaining weight, attempts to thwart any weight gain no matter the method, and an unrealistic, distorted perception of body weight or shape. The majority of eating disordered individuals are involved in a relationship with a significant other (Pinheiro et al., 2010) and have high rates (up to 80%) of sexual disturbance (Segraves, 2010; Zemishlany & Weizman, 2008). Sex is often considered with disgust or even aversion (Zemishlany & Weizman, 2008) and nearly half of one sample reported either the absence of a sexual relationship or avoiding sex (Pinheiro et al., 2010). More specifically, patients with eating disorders report lower libido and endorse more negative affect during sexual intercourse compared to normative peers (Powers, 2002); women with either restricting or purging AN fared significantly worse in regards to loss of libido compared to women with BN or an unspecified eating disorder (Pinheiro et al., 2010). Psychiatric conditions such as mood disorders or personality disorders frequently co-occur with eating disorders. The comorbid psychiatric disorder itself and the treatments for these conditions (i.e., SSRIs) can also impact sexual function.

Substance Use Disorders

Drug and alcohol use disorders can have significant deleterious effects on sexual health and negatively impact relationships. As a sex therapist, it is important to be familiar with not only substance use disorders, but also problematic behaviors that may stem from use that do not meet criteria for a diagnosis. It is imperative to take a thorough substance use history from each partner when working with a couple with sexual dysfunction, as substance use is a known contributor to sexual dysfunction.

Taking a thorough substance use history from each partner should include information on: drug or drink of choice, quantity, frequency, symptoms experienced if the substance is not available, how long the substance has been used, and sequelae of use (i.e., blackouts, arrests). The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2016) has outlined guidelines for "at-risk" drinking patterns, which can be a useful resource to help quantify drinking. Additionally, it is important to obtain information about the development of the drinking or

drug use. The etiology of substance use is quite variable and often multifactorial. Psychiatric and substance use disorders are highly comorbid and frequently intertwined such that it can be difficult to discern the presenting symptom. For example, an individual with MDD may turn to cocaine or another stimulant for the euphoria to alleviate low affect. Individuals with SP may find that drinking alcohol acts as a "social lubricant," allowing them to interact socially with others with more ease (Morris, Stewart, & Ham, 2005).

Just as alcohol and drugs can be used to cope with an untreated psychiatric problem, individuals may use drugs and alcohol to facilitate relationships and enhance sexual performance. Alcohol may lower one's inhibition and anxiousness regarding sexual intercourse via modulating neurotransmitters like dopamine and transiently increasing luteinizing hormone (Crenshaw & Goldberg, 1996). Partners may drink anticipating an increase in sexual arousal or to experience an increase in sexual arousal (Crenshaw & Goldberg, 1996; George et al., 2011). Expectancy effects of alcohol play a large role in one's sexual response, though the exact function of expectancy has not yet been clearly delineated. Marijuana at low doses has been reported to enhance sexual function through disinhibition, relaxation, altered time and touch perception, increased sensuality, and increased eroticism (Crenshaw & Goldberg, 1996). Generally, partners may experience perceived benefits from low doses or amounts of substance use. However, as either one or both partners increase use to moderate or heavy amounts or more frequent use, sexual dysfunction is likely to occur as a result of physiological and psychological effects.

Problematic substance use can lead to prominent psychological distress. Initially, couples typically exhibit similar drug or alcohol use patterns, though eventually one partner may progress in regards to severity of use and consequences associated with use, which can create discord within the relationship. Women escalate from drug use to addiction more rapidly compared to their male counterparts (Becker, 2016). Men with alcohol use disorders may be more aggressive when under the influence, both verbally and physically, which in turn impacts relationships (Crenshaw & Goldberg, 1996). Couples may continue to encounter similar problems even when the partner using seeks treatment and is in recovery; trust must be rebuilt, self-esteem must rebound for both partners, and return to a healthy sexual relationship may take time and may not return to premorbid functioning.

Alcohol

Physiologically, substances have a significant impact on sexual function and health. Alcohol can diminish sexual responsiveness at levels of intoxication (0.06 blood alcohol level or above) (Crenshaw & Goldberg, 1996) in both men and women. Women experience less vaginal lubrication, but may continue to be more subjectively receptive to sex (Beckman & Ackerman, 1995), which may result in undesired behaviors or being taken advantage of sexually. Moderate alcohol consumption can result in inability of either partner to perform sexually; males are unable to get or sustain an erection and both men and women are unable to achieve orgasm. Sexual desire may be diminished, though this is controversial and appears to be different for men and women. Some studies note alcohol may increase women's sexual desire and may only lead to changes in sexual behavior in a minority of women, while others note decreased desire for both men and women with moderate alcohol consumption (Beckman & Ackerman, 1995; George et al., 2011; Miller & Gold, 1988; Peugh & Belenko, 2001). Furthermore, a woman's current menstrual cycle phase may possibly affect how she experiences the reinforcing effects of alcohol, though current study results are mixed (Moran-Santa Maria et al., 2014). Chronic medical

conditions such as cirrhotic liver, gynecomastia, and neuropathies can develop from continued alcohol use that could also impact sexual desire and function.

Using alcohol regularly before sex could be a potential indicator of problematic drinking and warrant further exploration of *DSM-5* criteria for an Alcohol Use Disorder (AUD). For example, in a large sample (N=17,491) of sexually active drinking adults surveyed in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), individuals with an AUD were six times more likely to use alcohol most or all of the time before sex compared to individuals without an AUD (Thompson et al., 2014). Obtaining a thorough history and pattern of alcohol use, including its temporal relationship to intercourse, can be a fruitful line of questioning.

Marijuana

Marijuana is the most commonly used illicit drug in the United States. In surveys conducted in the 1960s and 1970s, individuals reported that marijuana increased sexual desire, enhanced the quality of orgasm, increased the sensation of touching and physical closeness, and increased sexual pleasure and satisfaction for both men and women (Halikas, Weller, & Morse, 1982). Review of available studies, which vary in size and quality, on the impact of marijuana on sexual functioning has led to the suggestion that a dose dependent relationship exists, with lower doses of marijuana facilitating sexual functioning and higher doses impairing sexual functioning. Hypotheses for this relationship, if in fact it truly exists, have been proposed and range from alterations in time perception induced by marijuana, direct effects of marijuana on the brain, or the anxiolytic effects of marijuana, to name a few (Gorzalka, Hill, & Chang, 2010; Scimeca et al., 2017). Several studies have found that individuals experience decreased ability to achieve orgasm and dyspareunia with use of marijuana (Crenshaw & Goldberg, 1996; Johnson, Phelps, & Cottler, 2004; Smith et al., 2010). Marijuana has known effects on reproductive function with decreased luteinizing hormone and testosterone, as well as decreased sperm count and impaired motility (Fronczak, Kim, & Barqawi, 2012). There is a need for more information regarding the sexual consequences, both psychological and physiological, of marijuana use given its incidence and prevalence, particularly given the increasing legalization of recreational use in the United States over the past decade.

Opioids

Opioid medications or prescription pain killers are the second most commonly abused drug in the United States, next to marijuana (National Survey on Drug Use and Health (NSDUH), 2017). While heroin, also an opioid, has been abused in various forms for centuries in the United States and across the globe, addiction and misuse of opioid medications has risen dramatically in the United States since the 1990s and was identified as a national public health crisis in 2017 (National Institute on Drug Abuse (NIDA), 2018). Under these circumstances, the role of opioids in the long-term management of non-cancer related chronic pain has been increasingly scrutinized and recently found to be of limited benefit (Volkow & McClellan, 2016). The overarching goal of pain management, regardless of the type of pain, is improved functioning and quality of life, which includes sexual health. Opioid misuse, an opioid use disorder, chronic pain, or a combination of these factors could affect one's ability to engage in sexual intercourse or other sexual behaviors. Opioids have a well-known impact on sexual health and function. Opioids

inhibit hormones in the neuroendocrine system (GnRH and LH) that result in decreased testosterone levels and diminished spermatogenesis. Opioids can decrease libido and delay orgasm and/or ejaculation, which could benefit men with premature ejaculation (Crenshaw & Goldberg, 1996). Long term opioid use has been linked with hypogonadism and an increased risk of erection problems (Ramsey, 2013).

Stimulants

Stimulants, which encompasses cocaine, methamphetamines and amphetamines, are known for inducing euphoria. Other effects include autonomic nervous system activation leading to increased heart rate and blood pressure as a result of vasoconstriction, and psychological effects such as paranoia leading to hostility and aggression. Stimulants can have a variety of effects on sexual function. Individuals intoxicated on stimulants may experience an increase in sexual desire and libido, but have inhibition of orgasm (Crenshaw & Goldberg, 1996). Additionally, the euphoria associated with use may surpass sexual pleasure, leading to disinterest in intimacy with one's partner. With continued use of stimulants, individuals may experience erectile dysfunction and/or anorgasmia (Crenshaw & Goldberg, 1996; Chou, Huang, & Jiann, 2015).

Substances other than those noted here have clear implications on sexual health and lead to sexual dysfunction. For the purposes of this chapter, a brief overview was provided, but was not meant as a comprehensive review of each substance of abuse. It is important to consider and ask about other substances, such as anabolic androgens, designer drugs, inhalants, nicotine, "club drugs," and caffeine, that will not be explored further in this chapter. Cigarette smoking is a clear contributor to sexual dysfunction, primarily through vasoconstriction of vessels in the pelvic area, atherosclerosis, and effect on hormones, eventually leading to impotence (Crenshaw & Goldberg, 1996). "Club drugs," such as methylenedioxymethamphetamine (MDMA), also known as "Ecstasy," ketamine, a dissociative anesthetic, and gamma hydroxyl butyrate (GHB), a precursor of GABA, which is an inhibitory neurotransmitter, are known for increasing interpersonal relatedness and may be used specifically in anticipation of an expected sexual encounter. Among those with "club drug" use, one study found that the majority of individuals who endorsed Ecstasy and GHB use described sex as more pleasant with the drug (Shacham & Cottler, 2010).

A comprehensive review of the sexual side effects of prescription medications outside the classes noted earlier is also beyond the scope of the chapter. All too often, particularly in the case of chronic illness, individuals may see different physicians for different conditions. The interactions between multiple prescribed medications and the subsequent sexual side effects may be unknown, yet have a powerful influence on sexual health and functioning.

Ray and Nancy are a couple in their mid-40s. They have two adolescent sons and both work full time; Ray is a teacher and coach and Nancy is an administrative assistant. Several years ago, Nancy was in a motor vehicle accident in which she sustained several fractures of her vertebrae in the cervical spine. At the time, she underwent surgery and the vertebrae were stabilized. She was put on prescription pain killers and over the years, her use has escalated. Ray and Nancy are referred to you from Ray's primary care physician for help with "intimacy issues." Ray feels that he carries the burden of responsibility at home, as Nancy often comes straight home from work and goes to bed after having taken a number of painkillers, rising to return to work in the morning. He is responsible for cooking meals, transporting their sons to afterschool practices, and doing the cooking, cleaning, laundry, grocery shopping, and bill

paying around the house. He is worried about her losing her job as she frequently misses work, and is concerned about how they would manage financially should that happen. He and Nancy have attempted to have intercourse, but Ray is unable to sustain erection long enough to achieve orgasm. He has asked her to be more responsible around the house and recognizes the role that plays in his diminished desire for intimacy, but feels guilty in doing so because she frequently refers to the accident and the pain that she sustained from it.

Other Psychiatric Disorders

While this chapter was meant to cover the most common diagnoses and medications seen in clinical practice, a number of other psychiatric disorders can influence sexual functioning, including psychotic disorders, cognitive disorders, neurodevelopmental disorders, and personality disorders. The prevalence of sexual activity among patients with mental illness ranges between 44% to 80%; however, how mental illness impacts sexual relations has not been thoroughly investigated with the exception that certain classes of medications can cause sexual dysfunction and sexual dysfunction is more common in those with psychiatric disorders compared to the general population (Ecklund & Ostman, 2010).

Patients with psychotic disorders may have symptoms that interfere with sexual relationships. In fact, patients with schizophrenia in one study rated their satisfaction with sexual health as significantly lower than all other life domains surveyed (Laxhman, Greenberg, & Priebe, 2017). Positive symptoms, such as significant paranoia and auditory or visual hallucinations may lead to avoidance of personal relationships. The partner may notice the patient responding to internal stimuli and be fearful, resulting in distancing themselves from the patient. Alternately, patients may exhibit negative symptoms such as isolation, amotivation, and inability to respond appropriately to social cues, again leading to either disinterest or inability to build interpersonal relationships. In spite of the peculiarity of psychotic material at times, one study assessed the sexual fantasies of psychiatric inpatients with mood, psychotic, and personality pathology, showing that patient' sexual fantasies were largely comparable to a non-mentally ill sample (Colon Vilar et al., 2016).

People with psychotic disorders who are taking antipsychotics, may experience sexual side effects such as sedation, decreased peripheral vasodilation, and elevated prolactin (LaTorre, Conca, Duffy, Giupponi, Pompili, & Grozinger, 2013), as discussed in the earlier section on bipolar disorder. Elevated prolactin, can lead to amenorrhea and thus infertility, in women and galactorrhea in both men and women (Marken, Haykal, & Fisher, 1992). Some antipsychotic medications, namely typical antipsychotics and risperidone, are thought to be more egregious offenders in terms of prolactin elevation compared to other antipsychotic medications (Cookson, Hodgson, & Wildgust, 2012). Additional side effects of antipsychotics include both metabolic problems weight gain, glucose intolerance with increased likelihood for the development of diabetes, and hypercholesterolemia (Guenette, Hahn, Cohn, Teo, & Remington, 2013) and motoric symptoms, such as extrapyramidal symptoms, Parkinsonian symptoms, and tardive dyskinesia (Kane & Correll, 2010). Metabolic side effects with resulting weight gain and additional medical comorbidities can result in fatigue and overall poor health, leading to lower self-esteem, poor self-image, and increased sexual inhibition, which can impact sexual relationship. Motor side effects, whether acute such as with extrapyramidal symptoms like muscle rigidity or torticollis or chronic such as tardive dyskinesia with involuntary movements of muscle groups, can be significantly distressing when attempting to engage or engaging in a sexual relationship.

One area of clinical exploration in helping those with severe mental illness has been minimizing risky sexual behaviors (RSB). Literature identifying the efficacy of sexual health risk reduction interventions (often sexual health education programs) shows positive effects on contraceptive use, knowledge of HIV or STIs, and a general reduction in RSB rather than complete extinction of these behaviors (Higgins, Barker, & Begley, 2006; Pandor et al., 2015). Recommendations include integration of sexual education into current treatment of individuals living with more severe and persistent mental illness, which may also hold relevance for those with cognitive impairment.

A clinical concern for many practitioners includes inappropriate sexual behaviors (e.g. touching others, excessive masturbation, self-exposure) involved in patients with cognitive disorders, such as dementia. Estimates of inappropriate sexual behaviors in individuals with dementia, regardless of etiology – whether Alzheimer's, vascular, or Lewy body, ranges between 7–25% (Black, Muralee, & Tampi, 2005). There are several classes of medications that have been studied to target these behaviors, including antidepressants, antipsychotics, mood stabilizing agents, hormone modulators such as estrogens, antiandrogens and gonadotropin releasing hormone analogues, and cholinesterase inhibitors. The efficacy of these agents on reducing or resolving inappropriate sexual behaviors in patients with dementia remains largely unknown at this time, as studies have been small and include primarily case reports or case series (Ozkan, Wilkins, Muralee, & Tampi, 2008).

Management of RSB has been of concern within the broad category of neurodevelopmental disorders as well, including those living with intellectual disabilities, Autism Spectrum Disorder (ASD), and Attention Deficit Hyperactivity Disorder (ADHD), due to the impulsivity and lacking social skills for some individuals. Shining a light on this clinical area has helped disprove some outdated assumptions that those with ASD (and at times intellectual impairment) are less interested in developing their relational or sexual selves (Kellaher, 2015). As individuals with ASD navigate this complex terrain, systemic therapists may find themselves increasingly addressing the nuance of intimate communication within these couples. Additionally, families of adolescents with ADHD and comorbid conduct problems often need support given the association between behavioral symptoms and RSB (Sarver, McCart, Sheidow, & Letourneau, 2014). Another presentation that deserves mention is the coprophenomena (i.e., involuntary expression of socially unaccepted words or gestures) amongst individuals living with a neurodevelopmental motor disorder, such as Tourette's Disorder (Freeman et al., 2009). While this symptoms cluster tends to only occur for around 10% of patients, clinicians should familiarize themselves with examples of coprolalia (inappropriate words) or copropraxia (inappropriate gestures), that can be of a sexual nature, as these youth, adults, or families may need coaching in how to educate others about their complex and everchanging difficulties.

A final diagnostic area worth mentioning are the personality disorders, previously Axis II in the DSM-IV-TR. The interpersonal gymnastics required by partners of patients with personality disorders may make overall relational functioning, as well as sexual health suffer. Many of the personality disorders have significant interpersonal behaviors that may impact relationships, including sexual ones. Personality disorders included in Cluster A, known as the "odd" cluster, include schizotypal, schizoid, and paranoid personality disorders. In general, patients with Cluster A personality disorders exhibit a range of behaviors and affects such as suspiciousness, distrust of others, restricted affect, and even odd or unusual behaviors that greatly effects their ability to form and maintain interpersonal relationships. Cluster B personality disorders also known as the "dramatic"

cluster of personality disorders, include antisocial, borderline, histrionic, and narcissistic personality disorders. These disorders are characterized by pathologic emotional responsiveness, which can include inability to experience empathy and difficulty with emotional regulation and impaired ability to self-soothe, which results in lifelong interpersonal difficulties. One study demonstrated that about half of men in relationships with women with borderline personality disorder have a personality disorder themselves, further complicating relational dynamics. These relationships were characterized by frequent relationship instability with separation on average every six months (Bouchard, Sabourin, Lussier & Villeneuve, 2009). Cluster C personality disorders is also known as the "anxious" cluster and includes avoidant, obsessive compulsive (OCPD), and dependent personality disorders. Individuals with avoidant personality disorder may desire relationships, but anxiousness about how they are perceived by others dominates and impedes or prohibits them from doing so. Individuals with OCPD may exhibit a restricted range of affect and be controlling, while the dependent personality disordered patient may exhibit a strong fear of abandonment or separation, resulting in clingy and submissive interactions within a relationship (Hensley & Nurnberg, 2002). Emerging research by Collazzoni et al. (2017) and Grauvogl, Pelzer, Radder, and van Lankveld (2018) into the personality traits and mating strategies of the various clusters would be beyond the scope of this chapter, but may be of interest to the reader.

Role of the Systemic Therapist

The interplay between mind and body is frequently seen for those experiencing a mental illness as they traverse relational and sexual terrain. The intersystem model allows conceptualization from individual, couple, and intergenerational systems (Weeks, 1977; Weeks and Cross, 2004). This is necessary as the impact of diagnosed mental illness or subthreshold symptoms of psychological distress have a ripple effect on the person and their interpersonal network. As patients or clients work with providers to select treatment options that meet their unique needs, consideration of intervention at all these levels is necessary for the systemic therapist.

Multiple psychotropic options have been outlined in this chapter thus far. Upon reading the material, the systemic therapist is left with the questions: What is my role in discussing medications with a patient? What should I do if a patient directly inquires about a side effect? How should I handle knowledge of a patient's nonadherence? These are valid and necessary questions for psychotherapists to ask themselves when thinking about the biological portion of the biopsychosocial approach.

To answer some of these questions, it may be helpful to provide a brief story. One of the authors previously worked in a sporting store while in college. He worked primarily in the running shoe and athletic equipment portion of the store, rather than fishing or watersports departments. Since departments were closely placed, customers would often enter his department inquiring about specific fishing reels or watersports equipment. Rather than dismissing the question or attempting to provide thorough but possibly inaccurate information, he would ensure he understood their question, provide a small piece of information, and walk the individual back to the correct department so the appropriate associate could answer their question. In our perspective, this is how effective teams work in healthcare. Thus, if the patient with persistent depressive disorder enquires about lowered desire as a possible side effect of their antidepressant, the prudent therapist may inform the patient that,

> Low desire can be a side effect of some antidepressants. I would recommend that you call your medical provider after our appointment or make a note to discuss this at your next visit. You should stay on your medication as prescribed unless this is discussed directly with your doctor.

Utilizing skills in patient agency from the subspecialty of medical family therapy would be particularly relevant during this conversation (McDaniel, Doherty, & Hepworth, 2013). A direct phone call to the provider to outline the patient's concerns would also be advantageous. Exploration into other reasons for lowered desire (e.g. cognitive distortions, current relational functioning, impact of disorder, messages from family of origin or culture) would be warranted and encompassed in the psychosocial dimension of the biopsychosocial formulation. Ideally, the biological and psychosocial knowledge possessed by medical and non-medical professionals can be combined to ensure a thorough view of the presenting problems and inherent strengths.

The systemic therapist may draw upon a variety of evidence-based modalities to meet the needs of those presenting for treatment. Individual or relationally based cognitive behavioral therapy (CBT; Beck, 2011, Dattilio, 2013; Epstein & Baucom, 2002), Metz and McCarthy's Good Enough Sex Approach (2011), and mindfulness based approaches (Buehler, 2011; Linehan, 2014) hold particular utility in the consultation room. Additionally, multiple randomized control trials support the efficaciousness of Emotionally Focused Couples Therapy (EFT) for relational distress, including specific data supporting the utility of EFT in addressing sexual satisfaction in couples coping with infertility (Johnson, 2002; Soleimani et al., 2015; Wiebe & Johnson, 2016). A final area for referral for the systems practitioner draws from the power of group therapy approaches or interventions, such as Alcoholics Anonymous or Narcotics Anonymous.

A comprehensive approach to sexual health would not be complete without consideration of beliefs, sexual scripts, or trauma narratives passed down through generations (Weeks, 1977; Weeks & Cross, 2004). The socio-cultural landscape in which we live serves as an essential influencer on norms, values, and communication patterns for couples and families living with mental illness. Whether it is a trending topic on social media, magazine cover, or reality television show, these broader events in our culture have considerable implication for the manifestation of problems and solutions in our personal lives. For instance, a woman impacted by PTSD and clinical depression due to a history of sexual assault could be re-traumatized by the culture's handling of public survivors' narratives. To truly provide evidence-based, informed treatment, clinicians must consider how the person or family's presentation within the consultation room may be impacted at all these levels – individual, couple, and intergenerational.

Clinical Pearls

Work It Up

- All potential causes of sexual dysfunction must be worked up and ruled out. There may not be a singular cause, but a multitude of things contributing to the sexual difficulties.
- Potential biological contributors to sexual dysfunction are psychiatric illness, adverse effects from psychopharmacology, non-psychiatric medical illnesses, and adverse effects from non-psychiatric medications.

Set the Mood

- Ensure that initial inquiries are open ended to facilitate safety within the therapeutic context. Patients may not readily volunteer information related to sexual concerns. Without careful interview strategies, there will be an incomplete biopsychosocial assessment; thus, treatment planning and outcomes may suffer.
- Link questions about mental health to sexual health, be specific, and include language that normalizes the issue and also provides hope.

Let's Talk About Sex

- Assess for sexual and relational dysfunction along the sexual response cycle: desire, excitement, plateau, orgasm, resolution.
- Create a detailed timeline to develop a historical perspective of the sexual difficulty. The timeline should include psychiatric symptom presentation, initiation or discontinuation of medications for any illness, baseline changes in sexual activity, interest, or function, and significant life and relationship stressors.

Don't Hesitate, Collaborate!

- Collaborate with other providers. They may not be aware of the sexual health problem that a patient is having. Primary care providers and specialists can help evaluate and rule out medical causes of sexual difficulties and can examine medication regimens for potential dose changes, medication switches, or interventions that may help with sexual dysfunction.
- Do not allow ideas about other providers to be a barrier for collaboration. Utilize a team approach, with the patient or couple included, working together to establish specific treatment goals.

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12

SEX THERAPY WITH SAME-SEX COUPLES

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This chapter examines sex therapy with same-sex couples focusing on the social, historical, and cultural influences in both mainstream society and the minority subcultural communities in which LGBTQ people live. The authors assume that sex and gender variations are healthy and functional as long as they are consensual and that competent and ethical sex therapy requires practicing from a non-pathologizing model of mental health. We review the importance of language, identity labels, subcultural values, and the intersectionality of sexual orientation and gender, as well as race/ethnicity and other social statuses. Research, although scant, is discussed, and clinical narratives describe the assessment and treatment of sexual dysfunction commonly seen in same-sex couples.

Introduction: Definition of the Problem

It is undeniable that lesbian and gay people – at least in progressive western cultures – have made unprecedented social, political, and legal strides in the past few decades. Prior to that, same-sex sexual desire was viewed as a perversion, and acting on these desires could make one a social pariah – and possibly a criminal. Political and cultural upheaval has swept through civil life, and gay and lesbian couples have become increasingly mainstreamed, forming families sanctioned and supported by state governments. In the United States, the 2015 Supreme Court decision legalizing marriage is the most recent and visible event epitomizing changing attitudes.

According to 2017–2018 data from both Gallup Polls and the Pew Research Center, 4.5% of U.S. adults identify as gay, lesbian, bisexual or transgender, up from 3.4% just five years prior in 2012. This means over ten million Americans identify as LGBT, and of those, 10.2%, over one million, are married to a same-sex spouse (Newport, 2018; Masci et al., 2017). Gallup estimates that 61% of same-sex, cohabitating couples are married, bringing the estimate of how many lesbian and gay couples exist to 1.6 million, with gay men slightly more likely to be married than lesbians. One interesting statistic is that the percentage of LGBT-identified individuals married to opposite sex partners is higher than the percentage married to same-sex partners – 13.1%. This is probably because these figures conflate bisexual, trans and queer identified people into statistics on same-sex couples.

Self-identified bisexuals make up half of the LGBTQ population, even though they are much less likely to be open about this: only 28% are out to important people in their lives, as compared to 77% of gay men and 71% of lesbians. Thus, couple therapists are seeing more same-sex couples than ever, and more married same-sex couples, a significant

percentage of both whom same-sex and opposite sex couples who have at least one member who is bisexual. Bisexuals are both more common than and more closeted than gay men and lesbians and have been misunderstood in both mainstream and within LGBTQ cultures. Within LGBTQ communities, bisexuals have historically either been invisible or, when out, feared and mistrusted (Nichols, 2014). Too often researchers have defined the term "gay couple" in a way that has rendered invisible the fact that one partner is "homosexual" and the other partner is "bisexual," as if these differences are meaningless in terms of community, identity, sexual proclivities, or inter-relational dynamics. People who are bisexual have unique issues partnering in same-sex relationships due to the "mixed orientation" within the couple, including issues of identity management and community affiliation, with notable differences between men and women (Crofford, 2018).

Although specific focus on transgender people in relationships is outside the parameters of this chapter, it is important to understand that transgender people can identify as heterosexual, gay/lesbian, bisexual, or pansexual in identity, and some lesbian and gay couples (like some heterosexual couples) may have one or more transgender member/s. Whether or not the relationship is seen as "same-sex" can depend on multiple factors. The very concept of sexual orientation assumes the existence of two opposite sexes, a binary based in biological dimorphism which assumes that the biological similarity of the partners' bodies is the salient feature of the relationship. Male and female bodies are not, however, simply dichotomous. People with intersex conditions and those with gender-queer identities defy the binary: the very existence of transgender and queer identities challenges the stability of the sexed body (see Lev & Sennott, 2012; Lev, 2014). Increasing numbers of people are identifying as simply queer, which may include a lesbian, gay, bisexual, or pansexual sexuality, as well as trans, gender nonconforming, or gender non-binary identity. "Same-sex" sexuality might or might not be an attraction of two people born into the same bodies, and the words "same" and "sex," like the word homosexual, can often conflate and confuse, more than clarify.

We will look at sex therapy with same-sex couples through the lens of the principles of systematic family and couple therapy. A systemic approach is the only appropriate theoretical stance when working with clients from marginalized groups. The therapist must have an understanding of how mainstream attitudes impact individuals, couples, and extended family and friend networks, and some knowledge of their various social groups and communities where they live. In this chapter we focus on social, historical, and cultural influences, looking at both the mainstream culture in which LGBTQ people must function as well as at the minority subculture that supports and validates queer people and sets its own norms for behavior and identity. We will consider the impact of "minority stress" – the macro and micro aggressions LGBTQ people are likely to face on a regular basis – but also the effect of peer standards and values.

Historical Context of Same-Sex Couples

Social oppression and vilification of those who expressed same-sex desire was reflected in the fields of psychiatry and sexology that emerged in the 1800s. Sexual minorities became the target of medical, psychiatric, and legal interventions throughout the nineteenth century, resulting in criminalization and abusive reparative therapies like shock treatment and chemical castration. Homosexuality as a pathology was not removed from the diagnostic manuals until 1973, with residual sub-categories remaining until the printing of the *DSM-5*. This chapter assumes that sex and gender variations are healthy and functional as

long as they are consensual and that competent and ethical sex therapy requires practicing from a non-pathologizing model.

Within this historical context of oppression, it was inconceivable until recently for therapists to even formulate questions about same-sex sexual satisfaction or potential sexual problems within a model that assumed same-sex love was healthy. Therefore, the research is scant and that information about treating sexual dysfunction rarely includes same-sex couples.

The Impact of the Subcultural System on Same-Sex Couples

A systemic approach necessitates understanding the impact of culture on couples, not only the dominant culture, but also the LGBTQ or queer subculture. For queer people, the LGBTQ community is not only a place of support and validation; it is also, for many, their only family. LGBTQ people occupy a distinct place among stigmatized minorities, for other people generally can depend on family of origin for support. Queer people have historically been rejected – or at least misunderstood – by their birth families. They often form networks of queer and queer affirming friends, partners, ex-partners, and children that assume new and creative forms of family and tribe. The queer community is an amorphous entity that includes organizations, openly queer businesses and professionals, and virtual (Internet) spaces and groups as well as physical neighborhoods where LGBTQ people feel safe. For a couple, this community often plays the same role of validation and support for the relationship that the mainstream culture plays for non-queer people, and the existence – or absence – of this support system is an important treatment variable.

LGBTQ communities, like all minority subcultures, determines how its members describe themselves, what labels they use, and what characteristics, behaviors, and traits are expected to accompany one's self-definition. Those who do not fit neatly into a category face subtle pressure to hide or suppress characteristics that do not conform. For example, in contemporary queer subculture, there is still some pressure for bisexual people to label themselves gay or lesbian and suppress opposite sex attraction. There is also tension between those who identify as bisexual and those who identify as pansexual as to the definition, boundaries, and inclusivity of those identities. Similarly, there is debate and discourse about exactly who does and does not belong under the transgender umbrella.

This concept of identity labeling is quite important, and it has gone virtually overlooked in the scientific literature until recently. Social science and sexology research select subjects based on self-identification but interprets findings as though they were measuring some essential quality of human nature, something ultimately grounded in genes and brain structures. However, research on the relationship between sexual attractions, romantic attractions, behaviors, and identity labels indicates correlation is lower than expected between these variables for both men and women (Diamond et al., 2013; Fu et al., 2018). In other words, actual human sexual behavior and the complexity of self-designated identity labels do not always correlate strongly with attractions or even behavior. Thus, the categories with which we identify ourselves and others are social constructs, not material ones, even if those constructs ultimately derive from elements like erotic and romantic attractions, maybe even gender identity and expression that are based in our bodies and brains. Identity labels are a clumsy attempt to take confusing, complex phenomenon and distill them into discrete categories. It is a mistake to assume that a self-identified lesbian or gay man has never had pleasurable sex with an opposite sex partner, or isn't doing so currently.

A number of factors influence which identity labels queer people use and have used over time, but one of them is the pressure exerted by the dominant norms of the LGBTQ subculture. The labels queer people use are the identities that are currently available and acceptable within the communities they live in and depend upon for support as that shifts over time. When lesbians were supposed to only see themselves as butches or femmes that is how most women who were sexually attracted to women identified. As the labels *pansexual* and *bisexual* become destigmatized among younger people, more people are self-labeling that way. As the norms of LGBTQ culture change over time, the identity labels change, which means there is a strong generational cohort effect in the community. According to Beemyn and Rankin (2011), few transgender people under 40 label themselves *cross dressers*, and few over 40 label themselves *genderqueer*. Clinicians working with same-sex couples should be aware that the norms of behavior, expression, and even self-identification may be strikingly different for couples in their twenties than those in their forties or fifties.

There is also a strong geographic component to the circumstances that affect gay and lesbian individuals and couples. Since same-sex married couples are currently clustered on the coasts and in urban pockets (Bui, 2016), couples in rural and non-coastal areas will have less support from others like them. Pew Research Center data (Masci, Brown, & Kiley, 2017) indicates that only 12% live in LGBT neighborhoods, and 72% have never lived in such a neighborhood. Therapists working with couples outside of coastal urban areas must be aware that these couples may suffer not only from a lack of support from their families of origin, but also a relative lack of peer support.

The LGBTQ community is continuously evolving and shifting, in part because it is so intersectional. Intersectionality refers to the overlapping of different minority groups within an individual. For example, a Black bisexual trans woman represents the intersection of race, gender, gender identity, and sexual orientation. People who occupy places of complex intersectionality often suffer minority stress from multiple sources. But the multi-layered experience of their lives also gives them unique perspectives and perhaps frees them to create new identities and modes of self-expression.

In part because of intersectionality, the twenty-first century has seen the LGBTQ community truly become inclusive of sex and gender diverse minorities welcoming those who identify as asexual, intersex, members of the BDSM/fetish community, and polyamorous. At the same time, Savin-Williams (2005) has found that many young, queer people rejected labels entirely, identify as queer, or use newer identity labels like pansexual. In addition, Lisa Diamond (2008) found in a decade-long longitudinal study that young college women change identity labels frequently. They did not reject former labels nor rule out future change; instead, they were using identity labels to describe their current attractions, behaviors, and most of all, their current partner arrangement. They did not label their identities in an essentialist way, but rather saw them as changeable, what Diamond referred to as *sexual orientation sexual fluidity*. Recent research by Savin-Williams (2017) on what he calls "mostly heterosexual men" demonstrates that when given the option of a non-heterosexual identity label, men often readily adopt it. Savin-Williams' work demonstrates sexual fluidity among men, and is a further breakdown of the traditional straight/gay sexual binary. Intersectionality of orientation and gender can take many forms, for example there are female couples comprised of two trans women or a trans woman and a cisgender queer woman. There are also relationships where lesbian women date trans men and/or bisexual partners, and many couples experiencing the transition of one or both partners.

Couple Relationship and Family Patterns

In the past 40 years the gay and lesbian liberation movement has successfully challenged homophobic assumptions about sexual deviance, family relationships, love, marriage, and family-building. Research on same-sex couples has validated the strengths and resiliencies of lesbian and gay couples (Gotta et al., 2011; Gottman et al., 2003; Peplau & Fingerhut, 2007; Solomon et al., 2005). Same-sex couples express high levels of satisfaction, value intimacy, communication, and relational attunement, and have skills to resolve conflict constructively (Lev, 2015).

However, LGBT people still experience both macro and micro aggressions on a daily basis just by living in a homophobic and heteronormative culture. These include outright discrimination and bias, denial of their families, marginalization, and vilification of their sexual desires, which manifests in lifelong psychological and emotional challenges (Nuttbrock, 2010; Sue, 2010).

There is a substantial body of research indicating that "minority stress" has deleterious effects not only on gay and lesbian individuals, but on same-sex couples. Feinstein et al. (2018) found that HIV prevention strategies are not as effective in gay male couples whose members have a high degree of internalized stigma (also called internalized homophobia). Longobondi and Badenes-Ribera (2017) showed that intimate partner violence in gay and lesbian couples is related to both external sexual minority stressors and internalized stigma. In individuals who are part of a gay male couple, depressive symptoms were higher in those who experienced sexual orientation discrimination (Randall et al., 2017), although the strength of the couple relationship partially ameliorated this. Totenhagen, Randall, and Lloyd (2018) found internalized homophobia and a low degree of "outness" impaired relationship quality for same-sex couples. However, the process of coming out also builds strengths, referred to as "coming out growth" (Vaughn & Waehler, 2010), inoculating LGBTQ people with increased community support, enhanced skills at dealing with adversity and oppression, and increased honesty and authenticity in relationships. It is important for couple therapists to address the impact of minority stress and internalized stigma: Allen and Johnson (2017) discuss how the use of Emotionally Focused Therapy with gay male couples can make these unions more resilient and resistant to minority stress, and Garanzini et al. (2017) report great success in treating both lesbian and gay male couples using the Gottman method.

Despite the different circumstances of same-sex couples they are, in general, similar to "opposite" sex couples in many ways (Gotta et al., 2011; Gottman et al., 2003; Peplau & Fingerhut, 2007; Solomon et al., 2005). They move through similar stages of family life (dating, falling in love, partnering, living together, and planning for children) as heterosexuals do (Ashton, 2011). Lesbian and gay couples describe similarly high levels of relationship quality as well as stability. Research shows they resolve conflict skillfully, have high rates of communication, and are attuned to one another's needs (Jonathan, 2009). They express satisfaction and intimacy in their relationships and sex lives, which may be understood as a kind of relational resilience, specific strengths developed in the face of oppressive circumstances (Lev, 2015).

The data reveals a few important differences between same and different sex couples. According to recent census data, compared to different-sex couples, same-sex couples are less likely to be raising children (20% vs. 44%), more likely to have a college degree (46% vs. 32%), and more likely to be in the labor force (82% vs. 69%). Individuals in same-sex couples earn more money, perhaps because they are more likely to have college degrees

(Gates, 2013). Married same-sex couples are a few years younger than mixed sex couples. Same-sex female couples are four times more likely to have children than same-sex male couples (Bui, 2016). Joyner et al. (2017) analyzed a sample of 14,000 individuals from the National Longitudinal Study of Adolescent to Adult Health and found that lesbians and gay men reported shorter lengths of relationships than heterosexuals. Comparing mixed sex, male, and female couples, male couples have the highest dissolution rate of relationships, but the lowest rate of dissolution of cohabitating relationships, while female couples have the highest rate of dissolution of cohabitating relationships (Joyner, Manning, & Bogle, 2017). The authors of this study speculate that because men value autonomy in relationships more than women, gay men are more selective about living with a partner.

The most striking difference between mixed and same-sex couples, found consistently in research, is that gay male and lesbian couples are more egalitarian in almost every way than male-female couples (Gotta et al., 2011; Solomon et al., 2005). Same-sex couples are more financially independent and more likely to contribute to the household equally. In mixed sex couples, women do more housework than men and the chores are more likely to be split along traditional gender lines, while same-sex couples share housework equitably and do equal amounts of "feminine" vs. "masculine" chores. Same-sex couples have more equal levels of communication with each, contribute equally to the maintenance of the relationship, and have equal power in decision making. In other words, same-sex couples are relatively free of the gender stereotyping and power imbalances inherent in the still-sexist culture in which we live (Shechory & Ziv, 2007). In addition, they are better at resolving conflict than mixed sex couples. Sex therapists more familiar with working with mixed sex couples may find that these differences affect some aspects of their work. When relationship strife contributes to sexual dysfunction, the issues may be the same: money, household chores, and children. But the inherent, culturally ingrained assumptions about roles and power imbalances are absent and the partners are more likely to communicate well with each other. Many same-sex relationships seem inherently more "fair," and this may make the therapist's job easier. It is less common to see same-sex partners where one partner is stuck in an emotionally and financially dependent position relative to the other, although of course gender roles are not the only thing that produces dependency. Same-sex couples do not have the inherent imbalance that comes when the two partners have been socialized differently and have unequal access to power in the world outside the marriage. This is not to say that all same-sex couples are equally balanced in power; one partner may have more relationship power than the other by virtue of money, youth or attractiveness, or psychological dominance. But gender does not determine power differential the way it so often does in opposite-sex couples. In butch-femme identified lesbian couples, where gender may explicitly define roles, household tasks (although not always in the way outsiders presume), as well as play a strong role in sexuality, relationships are experienced as egalitarian, intimate, and communicative (Levitt, Gerrish, & Hiestand, 2003; Lev, 2008)

There are sexual differences between same-sex and mixed sex couples, and between male and female couples. Lesbians will most frequently present with absent or very low sexual frequency, but it will be common that both women are experiencing low desire in an otherwise well-functioning relationship. Gay male couples will frequently ask for help managing other sexual relationships outside of their partnership. Because of the considerable overlap between the BDSM, polyamory, and gay communities (Barker, 2013), same-sex dyads in sex therapy are more likely than mixed sex dyads to incorporate alternative sexual practices into their repertoire. Perhaps because many gay men and lesbians have

relatively broad sexual practices, same-sex couples have been found to "take more time for each other and each other's feelings of pleasure, place less emphasis on rushing towards orgasm, and focus less on simultaneous orgasms" (Sandfort et al., 2001, p. 5). Most research finds that male couples have the highest frequency of sexual activity and female couples the least, with mixed sex couples in between. Female couples report a broader range of sexual activities, and spend more time on any given sexual encounter than do mixed sex couples (Holmberg & Blair, 2009; Blair & Pukall, 2014). In fact, female couples define sex more broadly than either male or mixed sex couples (Scott et al., 2018). And women in same-sex couples orgasm far more frequently than women in mixed sex couples (Frederick et al., 2018; Blair & Pukall, 2014). The Frederick et al. study found 86% of lesbians reported that they always/usually orgasmed compared to 65% of heterosexual women, and these findings have led some to speculate that women's orgasms are hindered by phallocentric imperatives (Willis et al., 2018). Research has long demonstrated that gay men are less likely to pursue monogamy in long term relationships (Green & Mitchell, 2008). Solomon et al. (2005) reported that nearly half of the gay men in his research reported sex outside of their primary relationship. However, non-monogamy is not associated with less couple satisfaction or commitment (LaSala, 2004).

Lesbian Sexuality and Sex Therapy with Female Dyads

Although lesbian sexuality has a long and passionate history, it cannot be separated from women's oppression. It has not been easy for women to come out of the closet and live openly as lesbians until the rise of the women's liberation movement. Certainly, butch-femme communities thrived before this era; however, influence of the feminist movement has been mixed – fostering greater freedom and sexual exploration for women, as well sexual conflicts within this movement, for example, between anti-pornography and pro-sex activists. While sexual freedom as a rallying call has never had the importance for most queer women that it has to gay men, there is still an ethos of sexual openness and experimentation not found in heterosexual culture. The lesbian community has fostered a strong sex radical movement unparalleled among heterosexual women (Nichols, 1987). Additionally, lesbians have always explored sensuality, erotic expression, gender dynamics, and other aspects of sexual play. Moreover, in recent years the lesbian community has struggled with the inclusion of trans women and trans men and others on the gender spectrum. Queer women's communities have often been places where women have explored kinky sex, polyamory, and a wide range of gender expressions. Researchers found that lesbian couples often have a lessening of sexual behavior and little or no genital contact over the course of their relationship, often referred to as "lesbian bed death" (Hall, 1984; Loulan, 1990). This raises important questions about this phenomenon. Do women have a biologically lower sex drive than men (i.e., if no men are present, pushing for more sex, will desire fade?), or does this reflect female socialization, since women have learned to be sexually receptive and therefore do not know how to ask for or initiate sex? Part of the problem may be the way we measure sexuality. If sexual behavior is measured by penetration, number of orgasms, or genital contact, perhaps researchers' phallocentric, heteronormative perspective is missing the actual passion and sexuality between women (Nichols, 2011). Since lesbian couples have egalitarian relationships with high degrees of intimacy and communication and are skilled at conflict resolution, how do we resolve this discrepancy between these happy, but sexless, partnerships? Iasenza (2002) notes that lesbian sex may be less frequent and genitally focused, but it is more sensual. Research has shown that

lesbians spend more time on the average sexual encounter than do heterosexuals; using the measure of time spent on sex rather than sexual frequency, lesbians might be just as sexually satisfied (or perhaps more so) than their straight counterparts, especially if one considers the fact that lesbians orgasm at much higher rates than heterosexual women (Frederick et al., 2018; Iasenza, 2002). Although lesbian couples are more likely to be monogamous than gay men, female couples often openly discuss non-monogamy. Open communication is important to lesbians, even if they appear to be no more likely than heterosexual couples to actually practice consensual non-monogamy (Gotta et al., 2011; Solomon et al., 2005). Gender has long been a salient area of exploration of lesbian couples. Butch/femme dynamics were the accepted norm before the beginning of lesbian-feminist communities in the 1970s (Nestle, 1992) and have remained a constant expression of sexual desire within postmodern communities (Loulan, 1990; Levitt, Gerrish, & Hiestand, 2003; Lev, 2008). Butch and femme are not merely "roles" that are "played" by lesbians, and are most certainly not a mimicking of heterosexual gender roles, but rather erotic expressions of sexual and gender identities that exist within lesbian communities. Russo and Owens-Reid (2014) wrote a blog post challenging the heterosexist assumptions about how gender works in lesbian relationship. They comment on the question often posited to lesbians, "If you like girls that look like boys, why don't you want to date boys?" with the retort, "If you like boys so much, why don't you want to date my girlfriend who "looks like a boy?" Their point is that "looking like a boy" is a particular lesbian erotic presentation (Loulan, 1990; Nestle, 1992), and has little to do with heterosexual posturing, or traditional gender identities, but speaks to a specific lesbian eroticism. There has, however, been limited contemporary scholarship that challenges the enduring salience on gender dynamics in lesbian relationships. This invisibility in the research is a missed opportunity to raise questions about lesbian sexuality. What does the research reveal, as well as conceal, about female couples? Is it possible that certain research tools privilege particular "kinds" of couples, i.e., those who are most out or educated or those who are white and privileged? Although there are broader options for relational dynamics available for lesbians today, butch/femme identities, female masculinity, femme expression, and the exploration of gender dynamics across sexual orientations not only still exists in lesbian couples, but have continued to expand within the postmodern world.

Case Vignettes

Lisette and Rosa. Lisette casually mentioned that she and Rosa had a more active sex life in the summer than in the winter. When questioned, she shyly admitted that in the summer they tended to sleep in the enclosed porch, which felt more private than their bedroom, which was above the landlady's bedroom. They often felt they she could hear them and this inhibited their already infrequent sex life. Upon exploration, Lisette shared that she once came up behind Rosa to hug her while she was doing the dishes, and Rosa froze and pushed her away. She was concerned that neighbors would see them embracing. Although this couple was legally married in the state in which they lived, and had been partners for years, they were still coping with layers of internalized homophobia that was particularly focused on behavior that could be interpreted sexually. This also manifested in the bedroom. Lisette admitted that she had a hard time telling Rosa what she liked. She said that sometimes she kept moving her body over, hoping that Rosa would understand where and how she wanted to be touched, but that Rosa just joked that they would fall off the bed if she kept moving. Lisette did not have the language to discuss her body parts, or her

desires, in a way that felt empowering, and not "dirty." Working together in sex therapy, they were able to talk about these concerns, learn a mutually acceptable language to discuss their sexual desire, and become more playful sexually. This involved meeting with each of the women separately and completing a thorough sexual history, which included the values of their families about sexuality, how they learned to talk about body parts, and the individual narratives of their own coming out stories. Then the couple met together and shared their stories. Slowly (and very shyly), with support and encouragement in the consulting room, they began to verbalize how they would like to be touched, and what their visions for their sexual pleasure would look like. Sessions focused on topics like "getting caught," "being seen," and being visible as lesbian women – not just as friends or even wives, but as erotic partners. Rosa shared and began to explore and deconstruct messages received in her Catholic family about sexual desire, and Lisette shared how women's bodies were seen as "dirty" in her family. Ultimately, the women decided to buy their own home so they didn't have to be so constrained by their landlady – a home with enough distance from the neighbors that Lisette joked, "We could even moan loudly and no one would hear."

Jo. Jo presented in therapy wearing masculine clothing, and sporting a short haircut. She was dating a woman she had met at work who had never had a sexual relationship with another woman. This had been a pattern for Jo. She enjoyed seducing straight women, who found the sexual attention she gave them incredibly hot, but often struggled with ambivalence about Jo's gender presentation. They liked her masculinity, but also often chided her about it. They could rarely commit to being in a relationship with another woman, and Jo had been left many times for a man when her lovers were ready to "settle down." Jo thought that all "real lesbians" were butches, and since she was attracted to very feminine women, she felt "doomed" to never find a woman who really understood her and desired her. Jo saw being a lesbian as an act of "aloneness," and had been raised to believe in her religious and rejecting family that if she continued to live "that way," she would never find a partner. Despite Jo's outward sexual presentation as a bold dyke, she lived with self-hatred and confusion about her gender, her sexuality, and her desire. In therapy, was encouraged to explore what it would mean for her to find a femme lover, another lesbian who had a more feminine presentation but was clearly interested in lesbian sexuality, and who respected and honored Jo's masculine sexual stance. Jo resisted the idea that such women could even be found, but through Internet chat rooms, butch/femme dating sites, and even a lesbian cruise, she was able to realize that she did not need to continue dating rejecting heterosexual women. It was a powerful healing to find a lesbian lover who had no desire to be with a man, adored and enjoyed her masculine sexuality, and saw their relationship as whole, and hot, and queer.

Gay Male Sexuality and Sex Therapy with Male Dyads

There is more research on gay male sexuality than on lesbian sexuality. Gay male sexuality is often referred to as "MSM" (men who have sex with men), which is behaviorally precise since many MSM are not actually gay identified. However, research on MSW sexuality is narrowly in focused on HIV prevention. As Sandfort and de Keizer (2001) write: "Because sexual behavior is a major route of HIV transmission, and gay men constitute a major risk group … a vast number of studies have been conducted focused almost exclusively on safe versus unsafe sexual practices." (p. 3). Research on MSM have found higher overall rates of self-reported sexual dysfunction among gay men: 74% of gay men report some kind of

sexual dysfunction, as compared to 30–50% of heterosexual men (McDonough et al., 2014). Bancroft and colleagues (2006) also report that gay men have higher rates of anxiety about sex, and that gay men report more erectile dysfunction. Several studies have found that the most common sexual problem reported by gay male couples is the same as for mixed sex couples – discrepancies in desire for sex between partners. Gay men report problems with sexual compulsivity less frequently than heterosexual men; however, male dyads also report sexual problems rarely encountered in mixed sex or lesbian couples, such as aversion to anal sex and painful anal sex (Sandfort & de Keizer, 2001).

Clinicians working with male dyads must take into account the ways in which gay male sexual behavior is different from that of heterosexual men. In particular, it is impossible to work with male couples without addressing issues of consensual non-monogamy. There is, in fact, an increasing number of people of all sexual orientations seeking out open/consensually non-monogamous relationships (Boyd, 2017), often referred to as polyamory. A committed relationship with more than two partners is sometimes referred to as a triad, or polyship. Although the percentage of gay male couples in open relationships has declined from nearly 100% pre- the AIDS epidemic to closer to 40–50% now (Parsons et al., 2012; Solomon et al., 2005), clinicians are still quite likely to be working with non-monogamous couples and to be called upon to help partners to negotiate such agreements or to help resolve conflicts over non-monogamy. Generally, gay men are more sexual than women or heterosexual men, both in frequency of sex and number of different partners. Therefore, therapists may need to examine their own internalized norms about this common sexual practice to avoid developing negative judgments of gay male clients. While same-sex couples are, overall, more egalitarian than mixed sex couples, that does not mean that "roles" are equal in the bedroom. Especially when anal sex is practiced, two men may assume active or passive "roles," which broadly correspond to "top" and "bottom," or "insertor" and "insertee." Many men are flexible in their roles, but sometimes problems arise when both men prefer one role over the other (Moskowitz & Garcia, 2017). In addition, when erectile dysfunction is an issue, it is usually an issue for the anal sex "top," as the "bottom" can participate fully with a flaccid or partially erect penis. The most common sexual acts among gay men are oral sex and mutual masturbation; male dyads do not assume that anal sex will be included in every, or even any, sexual encounter (Hart & Schwartz, 2010), unlike heterosexuals, who tend to assume that penile-vaginal penetration is by definition "sex." Concern about HIV transmission strongly affects gay male sexuality even though AIDS is currently a treatable medical condition. In the United States, most new cases of HIV transmission occur among gay men, and the numbers continue to increase (Centers for Disease Control, 2013). Unprotected anal intercourse (UAI), called "barebacking," is the most common mode of transmission, and it is sometimes practiced among gay men (Shernoff, 2006). It is difficult to understand this without considering the sub-cultural system that influences gay men and male dyads, and without understanding the historical context. Early Gay Liberationists celebrated joyous, abundant, frequent sexuality among men. Free of constraints, some men in urban gay communities could have had hundreds, even thousands of sex partners. Sex became a way of sharing and connecting with other men, and for some gay men it was and is a spiritual, transcendent personal and communal experience. Sex served, and still continues to serve, functions of intimacy and pleasure, but also of connection to community, gay pride, identity, ecstatic "peak" experiences, and spirituality. Once the reality of sexual transmission was accepted, by the mid-1980s prevention efforts began, efforts that focused on getting tested for HIV, using condoms, reducing the number of different partners, and on "eroticizing" safe sex

(Shernoff & Bloom, 1991). Rates of new infection dropped dramatically among gay men until the last decade, and now new infections are again on the rise. Prevention efforts have expanded beyond "safe sex" messages to include harm-reduction techniques like "serosorting," the practice having UAI only with men of your own serostatus. The latest prevention method is called PrEP – Preexposure Prophylaxis, which involves taking small oral doses of antiretroviral drugs on a daily basis while still HIV negative. PrEP reduces the risk of HIV transmission in about 50% in gay men, even among those who are having unprotected anal sex. It is controversial for reasons ranging from the practical to the sex negative (Crary, 2014), and the debate currently divides the gay male community, as some AIDS activists and organizations advocate for its use as a harm-reduction technique while others discourage its use as encouraging promiscuity. Arguments against PrEP, include the fear that PrEP will lead to a reduction in condom use, and that those who do not follow a consistent regimen will develop strains of HIV resistant to antiretroviral medications. Supporters of PrEP counter that rates of sexual transmission are rising among gay men, especially youth, because a significant number are already not using condoms, and that PrEP will protect those men currently engaging in UAI (Mantell et al., 2014). Recent research has shown that most seroconversions do not occur as a result of sex with multiple partners, but rather as a result of UAI between committed partners (Mustanski & Parsons, 2014). This is a finding of major importance, because most prevention efforts have been aimed towards men who are single or who are contracting HIV as a result of extra-dyadic sex. Therapists should be aware of this and be comfortable to discuss prevention efforts in sex therapy. Many couples have rules that require using condoms with extra-marital sex partners but not with each other, and are transmitting the virus between them when they believe themselves to be "safe."

Case Vignettes

Frank and Jarad. Frank and Jarad came to treatment for help restoring a sex life that had flagged after Frank discovered in a routine annual physical that he had seroconverted. Frank realized he had been deceived by an outside partner with whom he had an ongoing sexual relationship, who had claimed to be HIV negative. Frank had not transmitted the virus to Jarad, however, and Jarad was not angry at Frank for his mistake. Frank was diligent about taking the "cocktail" of drugs aimed at preventing his HIV from becoming active. However, their sex life with each other ceased after Frank's diagnosis, and Frank avoided sex outside the dyad as well. The therapist, after investigating the possibility that Frank's decreased sex drive was a side effect of the medications, determined that Frank was avoiding sex with Jarad for fear of "contaminating" him. He was averse to outside sexual partners as well, wary of being deceived again. In therapy, Frank revealed feelings of deep shame and humiliation for having contracted HIV, and thoughts that his body was "toxic." Frank needed some individual sessions to work through these feelings. He was old enough to remember people dying of AIDS in the 1980s and 1990s, and during those years he had internalized the feelings that male bodies, especially the penis and semen, were "contaminated," feelings that were extremely common at the time (Shernoff & Bloom, 1991). EMDR and cognitive-behavioral reframing of his thoughts helped diminish the intensity of these negative feelings considerably. Jarad, for his part, was extremely patient, consistently re-assuring, and willing to wait over a year for Frank to be able to be sexual. This was easier for Jarad because, like many gay male couples, the men had an open relationship and Jarad occasionally had sexual encounters with others. In addition, in therapy the men

learned the value of frequent, tender cuddling and physical contact. Slowly they were able to resume a sex life with each other, albeit more limited than it had been before. Moreover, Frank was never comfortable with having his own extra-marital sex again. He felt so deeply betrayed by the outside lover who had infected him that he could not feel open and free sexually with anyone but Jarad. Frank accepted this without bitterness; however, after he became HIV positive, he never prioritized sex in his life quite as much as he had done before.

Alberto and James. Many gay men become connoisseurs of sex by virtue of experience and number of sex partners. This can sometimes work against them. Alberto and James had been in a monogamous marriage for eight years, and gradually over the years James' interest in sex had declined. At the point they entered treatment, they rarely had sex, something which frustrated both men. When they attempted, James often had erectile problems. The quality of the rest of their relationship was positive and healthy. James was 15 years older than Alberto and much more sexually experienced. His many casual sexual encounters had always followed a narrow and rigid sexual script; opportunities for sex had been so abundant for him that he simply rejected partners who did not match his criterion for sexual style. James' sexual "lovemap" involved being "seduced" by his partner in a particular way that involved finesse and subtlety. Alberto's sexuality was more expansive and flexible, but his natural style involved being boisterous, enthusiastic, and a little rough. Over the years, James had found this mismatch between his internal erotic script and Alberto's sexuality became increasingly important, and he grew less and less interested in sex. Alberto was dissatisfied with the infrequency of sex, but he also complained that the narrowness of James' interests left him bored. The therapist learned these things during individual sessions with each partner. After diagnosing the script discrepancies, the sex counselor held a couples session explaining that these "mismatches" existed and that therapy would consist of helping the men communicate their specific needs and learn how to fine-tune their sexual encounters. James and Alberto were also told that because of their different sexual desires, their sex together might never be as "hot" as sex had been outside the relationship. This was particularly hard for James to hear. He had spent many years accustomed to having easy access to "hot" sex through multiple partners, but he came to accept it. In general, however, the men understood the concept of a "mismatch" much more easily than many mixed sex couples would; gay men tend to have a pragmatic approach to sex. Getting the men to communicate their needs was fairly easy as well. They were encouraged to watch a variety of pornography together and discuss it afterwards, pointing out what they each found particularly arousing. What was more difficult was teaching Alberto to be more subtle and nuanced in his approach. It did not come naturally to him, and the therapist needed to do some "coaching" to help him develop finesse. But James ultimately responded to Alberto's attempts to seduce him in the way he desired. He was moved by Alberto's efforts, and that made it easier for him to "stretch" to expand his sexual repertoire to accommodate his partner's desire for novelty and experimentation.

Summary and Conclusions

A systemic approach to sex therapy with same-sex couples involves considering the historical context of Western society's treatment of those who exhibit these desires, the current social and political climate, and the influence of the LGBTQ community on behavior, beliefs, and identities of its members. The clinician should be aware of the complex intersectionality within the "queer" subculture and how this impacts the dyad, e.g., the couple may include one or more members who is transgender, practices BDSM, or is bisexual,

and committed partners may have an agreement and rules about sexual and/or romantic relationships outside the dyad. By considering the systems context of same-sex dyads, appreciating the particular stresses and pressures exerted by both the mainstream and the minority cultures, and understanding the ways lesbian and gay male relationships reflect those stresses and pressures, will help sex therapists increase their effectiveness working with same-sex couples.

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13

TREATING THOSE WHO STRUGGLE WITH SEXUAL DESIRES[1]

David J. Ley

Introduction

As an advocate for treatment utilizing an evidence based, non-shaming model of sexual health, I invite mindfulness, caution and self-examination in clinicians who are asked to treat people who report struggles to control their sexual behaviors. For many years, treatment of these types of issues has largely been the purview of the sex addiction industry. Unfortunately, the treatment theories and approaches employed in the sex addiction model are rooted in a view of sex, which is contrary to the sexual health principles endorsed by sex therapists.

In response to the inherent conflict between the principles of a sexual health model and the approaches of the modern sex addiction treatment industry, the American Association of Sexuality Educators, Counselors and Therapists (AASECT) took the historic step in 2016 to issue a position statement rejecting the construct of sex addiction in sexual therapy (AASECT, 2016). In it, they identified an over-arching desire to avoid pathologizing consensual sexuality, described a lack of support for sex addiction as a mental health disorder, and found that training in sex addiction was not adequately informed by accurate knowledge of human sexuality.

Clinicians hold tremendous responsibility as we render diagnoses and recommend treatment. Ethical and therapeutic diagnosis and treatment requires that we be aware of the risks and limitations of our knowledge. When it comes to sexual issues, unfortunately, the field of medicine and mental health have a long, tragic history of allowing moral and social biases to intrude upon clinical judgment and treatment. Women were diagnosed as nymphomaniacs and subjected to invasive, non-consensual and life-altering treatments, in many cases merely for admitting that they liked and wanted sex (Groneman, 2000). In the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual, masturbation itself was diagnosable as a mental illness, under the code 317.1 (APA, 1952, p. 97). Healthcare is susceptible to influence by social and moral sexual concerns, and that influence can and has resulted in malpractice and harm to innocents. We are ethically compelled to exercise extreme caution as we diagnose and treat issues that present as sexual behavior problems, understanding their history and context, and modifying our approaches based upon new data. To ethically support patients, it is critical that our treatment of sexual behavior problems be grounded in a foundation of sexual health, rooted in an affirmative model, and address individuals in a holistic, comprehensive manner.

Historical Context of Sex Addiction

The concept of sex addiction was introduced into the modern lexicon in the late 1970s and 1980s. Early proponents of the concept framed homosexuality itself as an addiction, and the sex addiction movement has a long history of describing non-monogamous and non-heteronormative sexual behaviors as pathological (Reay, Attwood & Gooder, 2015). The AIDS crisis of the early 1980s contributed to significant changes in the perception of male homosexuality, bisexuality, and sexual promiscuity. Countless gay and bisexual men reacted to the AIDS crisis by perceiving their struggles to exert control over their sexual desires as a disease. These men identified as sex addicts, and some even became sex addiction therapists, as ways to try to increase control over their socially-condemned sexual desires, and to share this method with others (Kort, 2015). In a current, very large, non-clinical sample, LGBTQ individuals were the largest group identified as "at risk" for diagnosis, using criteria based on the Hypersexual Disorder construct (Bothe, Bartok, et al., 2016). Hypersexual Disorder was a proposed diagnosis in the Diagnostic and Statistical Manual (DSM)-5, but was ultimately rejected by the APA, due to concerns about risk of over diagnosis (Reid & Kafka, 2014). Throughout the sex addiction clinical literature, gay and bisexual sexualities are commonly identified as problematic. Expectations of monogamy, and condemnations of casual sex underlie clinical judgments of sexual practices, which are, in many cases, part of LGBTQ culture and communities, with no clear evidence that these practices are indeed harmful.

What is commonly called sex addiction is a label without explanatory power applied to a heterogeneous group of people and problems (Cantor, et al., 2013). There are countless terms applied to this behavior, including sex addiction, sexual impulsivity/compulsivity, hypersexual disorder, nymphomania, satyriasis (excessive or abnormal sexual desire in a man), erotomania (delusion of another person being infatuated with them). The field uses varying theories of etiology and diagnosis, each generating its own school of thought and approach. These terms and theories shift over time, largely in response to social shifts towards sexuality. These idiosyncratic approaches have inhibited evaluation of the underlying principles in these issues, and promote treatments for which there is no evidence of effectiveness in the area of sexual problems (e.g. Grubbs et al., 2015b; Reid, 2013).

This is a critical point for clinicians to understand. There is a dearth of evidence that treatment for sex addiction has a positive effect, diminishes problematic symptoms, improves quality of life or resolves relationship conflicts over sexuality. Traditional sex addiction treatment is almost entirely based upon concepts of 12-step group treatment, a model based largely upon religious concepts, not clinical ones. Recent work suggests that 12-step treatments may have a positive effect in fewer than 10% of people referred, and may potentially have a harmful effect in many people sent to such programs (Dodes & Dodes, 2014; Fletcher, 2013). Sex addiction treatment programs and therapists often incorporate a variety of treatment and assessment methodologies, without an overarching theoretical framework. None of these treatments are clinically supported for such problems.

Clinicians frequently ask, "Well, what SHOULD we call it then?" I suggest that this search for a single label may be misleading. The terms used in this debate do matter, as the terms guide and define theories and interventions. Currently, terms such as "compulsive sexual behavior" (CSB) or "out of control sexual behavior" (OCSB) are growing in popularity, representing a rejection of the dominance of the sex addiction model. The term compulsive implies theory and etiology from anxiety disorders, where compulsions are

behaviors engaged in to seek relief from intrusive thoughts and related anxiety. Unfortunately, without adequate distinction of compulsive sexual behavior from compulsions in anxiety disorders, inappropriate and unsupported comparisons may be implied.

Out of control sexual behavior is the term suggested by Braun-Harvey and Vigorito (2016, p. 28), who acknowledge that what they are describing is the subjective feeling of being out of control, as opposed to behavior that is actually uncontrollable. The nuance of this distinction may be lost in layperson discussions, and terms such as under-controlled or diminished control might convey some of the missing elements of perception and choice (Reid, 2016). It is unlikely that any single term is ever going to be adequate or effective in describing such a wide range of heterogeneous behaviors with complex, interacting motivations and effects.

These sexual behavior problems may be indicative of other problems, or may simply be symptoms of other issues. Numerous studies suggest that sex and pornography use are ways in which males attempt to cope with negative emotions (e.g. Wright, 2012). A 2016 European study of self-identified sex addicts found that 90% had a diagnosable psychiatric disorder, most commonly mood or anxiety disorders, and that 60% had at least one diagnosable paraphilic disorder (Wery, et al., 2016). A common symptom of paraphilic disorders is extreme sexual preoccupation and high levels of sexual behaviors, focused on interests other than physical interaction with phenotypically normal, consenting and mature individuals. Unfortunately, this sexual preoccupation and drive may be mislabeled as sexual addiction, without clinical acknowledgment of the other sexual symptoms. In this chapter, I ultimately argue that it is the job of treating clinicians to conceptualize these behaviors at deeper, richer levels than a single term can capture. Sexuality is a heterogeneous, complex, highly over-determined behavior that includes a bewildering, ever-evolving range of experiences and desires. A clinical or diagnostic approach towards such varied phenomena must be equally complex. The effective and informed sexual health clinician approaches these issues in an individualized manner which identifies and addresses underlying mental health problems, sexual disorders, moral conflicts or relational conflicts, which are contributing to the current reports of sex-related problems. Sexual behavior problems, which may lead to people seeking treatment, are best seen as symptoms of varied problems or conflicts, rather than the problem itself.

It is important to attend to the sometimes extreme consequences and risks attributed to sexual behavior difficulties, ranging from exposure to sexually-transmitted infections, to spending large amounts of money. Unfortunately, while evidence grows about the numbers of people who feel distress over their sexual desires, there remains relatively little non-anecdotal data about the prevalence and severity of such consequences in this group, compared to the population at large. These findings suggest that, at this time, clinicians may be most effective by directing clinical interventions towards the distress associated with difficulty controlling sexual urges (Dickenson, Gleason, Coleman & Miner, 2018).

Researching Subjective Difficulties with Sexual Self-Control

Those reporting difficulties controlling their sexual behaviors do not appear to engage in more frequent sexual behaviors than others. Sex addicts are seen by others and by self-report as having executive function deficits in areas such as impulsivity and self-control, particularly in regards to their sexual behavior, though neuropsychological testing has revealed that sex addicts may demonstrate no measurable problems in impulse control or executive functioning, and laboratory research finds that sex addicts display no

greater difficulty controlling their sexual arousal (Reid et al., 2011; Winters, Christoff & Gorzalka, 2010).

Numerous studies have provided evidence that multiple variables contribute to reports of problems with sexual self-control. Self-identification as addicted to pornography has been found to be predicted by moral conflict and religiosity and not by levels of pornography consumed (Grubbs, et al., 2015a). Men labelled as hypersexual or sexually compulsive most often differ from other highly sexual but untroubled men, by being religious, not heterosexual, viewing pornography negatively and holding more negative attitudes about one's own sexuality. The frequency of sexual behaviors does not distinguish these men, from other non-disordered males (Štulhofer, Jurin & Briken, 2015). There is no causal evidence indicating that sexual behaviors result in neurological changes in the brain, as is seen in of the brain scans associated with substance use disorders, and pre-existing neurologically-influenced traits such as libido and sensation-seeking explain more of the variance in self-identified sex addicts' behavior (Prause et al., 2015; Steele et al., 2013).

The use of pornography, particularly via the Internet, has become a central focus of discussions of sexual self-control problems. The ease of access to this material on the Internet has been blamed for a rise in problematic use of pornography, though research suggests that variables such as affordability, access and anonymity do not explain variations in use of this material (Byers, et al., 2004). There is a clinical and social assumption that pornography is intrinsically different, in content and effect, from other forms of media and that it has qualitatively and quantitatively unique effects. For instance, in studies which examine reports of problematic use of pornography, "extreme" use of pornography has often been quantified as daily use, and in one representative study, as a mere 17 minutes of pornography use a day, which is far less than average consumption of other media such as television (Wordecha, et al., 2018).

A unique, clinically relevant element to pornography use is that it is accompanied by masturbation (Prause, et al., 2015). Consumption of pornography typically ends when an individual achieves an orgasm, more so in males (LoPresti & McGloin, 2018). Thus, pornography use is best conceived of, as a tool to enhance or facilitate masturbation. Claims of effects of pornography use are better framed as effects of masturbation to pornography, and research finds that the links between pornography and relational happiness are best explained by variance in masturbation, not pornography (Perry, 2018). This leads to the recommendation that clinicians include a person's attitudes towards masturbation in their formulation of an individual's problems related to pornography.

Griffin, et al. (2016) found that when men view their sexual behavior and desires as incongruent with their morals, they are more likely to report under controlled problematic sexual behaviors. Grubbs, Perry, Wilt and Reid (2018) published a meta-analysis of pornography addiction research and concluded that the frequency of use of pornography itself does not predict problems with this medium, but that an individual's religiosity does. They suggest that Pornography Problems due to Moral Incongruence (PPMI) appear to be the driving force in many of the people who report dysregulated, uncontrollable, or problematic pornography use. Religiousness was significantly predictive of the moral incongruence these individuals felt with their sexual behaviors, suggesting that religiosity and sexual moral conflicts are intrinsically linked. The stronger the moral conflict an individual felt over their sexual behaviors, the higher the level of difficulty they report feeling in attempts to control their sexual behaviors. Feeling "out of control" of one's sexual urges did not predict higher levels of sexual behavior or pornography consumption, but did contribute to greater feelings of distress over these desires and behaviors. Higher levels of moral

conflict over ongoing pornography use predict higher levels of stress, anxiety, depression, diminished sexual well-being, as well as religious and spiritual struggles. In a separate study by Perry and Whitehead (2018), pornography use predicted depression over a period of six years, but only in men who morally disapproved of porn use.

Efrati (2018) found that attempts by religious individuals to suppress sexual thoughts actually led to an increase in these sexual thoughts. He suggested that when a religious individual attempts to suppress their sexuality in order to be virtuous, it might, paradoxically, increase the frequency and intensity of these sexual desires and thoughts. More religious individuals may exert more effort in their sexual suppression, thus furthering the intensity of this rebound effect. This spiralling problem may then result in feelings of dissatisfaction and dysphoria in life. Belief in God and higher levels of religiosity may increase the degree to which individuals perceive themselves as addicted to pornography, and seeing oneself as addicted to pornography predicts greater levels of anger, low self-esteem, and anger towards God (Wilt, et al., 2016).

Clinically, these varied findings suggest that instead of assessing sexual behaviors or pornography use in people who seek help for these issues, clinicians and therapists may be best served by first assessing a person's religiosity and their moral attitudes about sex, pornography, and masturbation. In therapy, instead of trying to change people's porn use patterns, clinicians may be more effective through increasing self-awareness of this moral conflict and helping patients to make their values and behavior congruent. Conflict between morality and sexual behavior may be resolved by changing one's sexual behavior *or* by changing one's values *or* simply by helping people become conscious and mindful of this internal conflict. Helping people to consciously examine and consider their religious beliefs about sex, masturbation and porn, with modern, adult, self-determining eyes, may help them reduce the pain and suffering caused by this moral conflict. It may be normal for people who are younger and struggling in life to also struggle with managing and accommodating their sexual desires. Rather than suppressing a person's sexuality, a sound clinical strategy may simply be to let time do its work, while the clinician focuses on assisting the patient in improving their life as a whole, developing and enhancing coping skills, personal resources and problem-solving strategies.

Simply assuming the validity of a patient's self-report that they "feel" that they cannot control their sexual behavior is not supported by research, and is not conducive to effective treatment. Braun-Harvey and Vigorito cleverly depict this, saying: "We often illustrate this dilemma with a medical parallel. A patient walks into his doctor's office and says "Doc, I have cancer." And the doctor says, "Well, at least we don't have to run all those tests. Let's start treatment." (2015, p. 57). A Swedish study (Oberg, Hallberg, Kaldo, Dhejne & Arve, 2017) found only 50% of a small sample of people who self-identified as having "hypersexual disorder" actually met the criteria which had been developed for this proposed diagnosis. Similarly, urologists have described that young males who present for treatment with the self-diagnosis of pornography addiction can be challenging patients, resistant to addressing underlying emotional issues or exploring alternative approaches recommended by the clinician (Reed-Maldonado & Lue, 2016). Unfortunately, disagreeing with the patients' self-diagnosis may result in treatment rejection and patient's "shopping" for a clinician who will support their self-diagnosis. Clinical skepticism in these areas is valuable, so long as it is framed within a caring, empathic and supportive framework.

Compulsive Sexual Behavior Disorder in ICD-11

In 2018, working groups of the World Health Organization proposed inclusion of Compulsive Sexual Behavior Disorder (CSBD) in the 11th edition of the International Classification of Disease (Kraus, et al., 2018). The ICD is the international coding manual, of diagnosis labels and associated diagnostic codes. ICD-10 includes a diagnosis of "Excessive Sexual Drive," code F52.7, which is subdivided into "Nymphomania" and "Satyriasis." Nymphomania and Satyriasis are antiquated terms no longer accepted as useful or valid diagnoses in most developed health systems, due in part to the long history of sexism and racism embedded in these constructs. Excessive Sexual Drive in ICD-10 does not give a benchmark for determining what is "excessive." The proposed CSBD diagnosis includes greater levels of detail, and is suggested for inclusion as an Impulse Control Disorder, not as an addiction. There is general professional agreement that there is not yet definitive information or data to support the notion that sexuality can be addictive, with similar processes to drugs. (APA, 2013, p. 481; Kraus, et al., 2018).

In the CSBD diagnostic description, WHO effectively excluded a significant majority of those who self-diagnose or are in treatment with reports that they cannot control their sexual behaviors. By excluding those people struggling with primary moral conflicts; mood disorders; paraphilic disorders; adolescents, and those who self-identify as having problems due to sex but show no impaired control (such as individuals who self-identify as sexual addicts when their sexual behavior become public and result in scandal or consequences) they've potentially ruled out many of the people currently seeking treatment as sex addicts. No research currently offers clarity as to the number or type of individuals who will still warrant this diagnosis after accurate application of these exclusions.

The WHO decision to adopt CSBD may have little impact in the United States, for many years to come. It is likely that the US won't adopt ICD-11 before 2025, without specific legislation (Berglund, 2018). As a result, the CSBD diagnosis will not be billable or formally diagnosable in the U.S. healthcare system for many years, and additional research may further inform that decision. When countries do implement new editions of the ICD, they sometimes do so selectively. In Sweden and Finland, diagnostic codes for paraphilias such as Sadism or Masochism were excluded, based on concerns that the diagnoses were stigmatizing, and reflected moral judgments rather than medical ones (Nitschke, Mokros, Osterheider & Marshall, 2012).

Applications to Sex Therapy

Given this volume of information and research about the various complex issues, which underlie patients reporting (or being described as) feeling out of control of their sexual behavior and desires, treatment must be guided by a thorough and holistic assessment. Simply because an individual describes their sexual desires or behavior as uncontrollable, or blames personal or psychological problems on their sexuality, does not necessarily mean that we as clinicians should assume this self-diagnosis accurate nor render treatment based on this subjective self-report. Attempting to distill all of this research and history into assessment guidelines, the sex therapist must complete a thorough evaluation, exploring religiosity, moral conflict, mental health, comorbid sexual disorders, sexual satisfaction, sexual orientation, medical history, and the social context of the reported sexual problems. Not all of these components will necessarily result in a clinical diagnosis. As Braun-Harvey and Vigorito (2016) argue, clinicians must consider the possibility that patients sometime

seek treatment for behaviors which are actually healthy, and are problematic only because of a conflict, either within the individual or their environment. It is not the role of healthcare to "fix" a condition or behavior, which is healthy. Sexuality is an overwhelmingly positive, beneficial and healthy human behavior. Sexual frequency is associated with a long list of health benefits, including improved cardiac and prostate function, improved relationship quality, increased life satisfaction, and even longevity. Even pornography use is associated with increased knowledge of sexual anatomy, increased sexual novelty within relationships, is experienced as overwhelmingly positive in subjective reports, and is even associated with decreased rates of sexual violence within societies. (See Whipple, 2007 for benefits of sexual expression.) The following research demonstrates personal and social benefits of pornography exposure to sex (Hesse & Pedersen, 2017; Diamond, 2009; Hald & Malamuth, 2008; Kohut, Baer & Watts, 2016; Ley, Prause, & Finn 2016; McKee, 2007; Štulhofer, Busko & Landripet, 2010; Watson & Smith, 2012).

Clinicians faced with patients reporting problems related to sexuality, reports of problematic high-frequency sexual behavior, and subjective experiences of loss/lack of control of ones' sexual desires or behavior must then ask a core question: Why is a typically healthy behavior associated with problems in *this* specific individual? This forces the clinician to begin to approach these issues without an assumption of homogeneity, and with a curious, inquisitive, data-driven strategy in order to identify the underlying causes, conflicts and contextual elements which may explain this effect and thus guide treatment.

There are currently no well-normed, well-designed and well-researched assessment instruments that have reached a level of sufficient validity to formally recommend a clinician adopt them in standard practice. Screening instruments commonly available online in this area may create more rigidity in a patient's self-diagnosis. In my clinical practice with such patients and self-reported problems, I have commonly employed, a variety of clinical instruments assessing issues such as: mood and depression; medical symptoms; sexual sensation seeking; personality characteristics; sexual attitudes and values, and sexual satisfaction. There are measures used in research, and available for free, which assess consequences related to sexual behaviors, and hypersexual behaviors, though these measures are limited by basis upon self-report by individuals who are currently experiencing distress. Any of these assessment strategies may be helpful in developing an intervention approach which seeks to increase a person's insight into their sexual conflicts, and which may decrease their feelings of sexual dyscontrol. These interventions must often include psychoeducational components around sexuality, consistent with the educational foundation of the sex therapy PLISSIT Model (Taylor & Davis, 2007).

Assisting in Resolving Sexual-Moral Conflicts

Religiosity is, according to extant research, the best predictor of a moral conflict over sexuality. Sadly, when people within religious communities seek help for their sexual concerns, they are often encouraged to suppress or "battle" their sexuality, or sent to treatments such as sex or porn addiction programs, where their sexual desires are portrayed as a form of sickness, and the concepts of sexual purity are idealized (Shermer Sellers, 2017). These approaches to sexual experiences and feelings may create a feedback loop of shame, guilt and self-hatred, which, at the least, exacerbate sexual difficulties, or at worst, are the true root of reports of sexual self-control difficulties.

Sexual shame is an internalized feeling that ones' sexuality and erotic desires are abnormal and disgusting, and results from interactions with ones' culture, relationships,

and self-judgment (Clark, 2017). People can overcome sexual shame in their lives, without abandoning their religious values and beliefs. Schermer Sellers (2017) suggests ways to assist people develop a new sexual ethic, resolving moral conflicts over sexuality through intentionally developing alternative sexual values. She identifies the core need to help religious people create a new, self-determined moral framework for their sexuality, one that they choose and develop as adults, which focuses on intentionality, authenticity, consent, honesty and mutuality. This approach assists people struggling with sexual shame to overcome it, not by rejecting themselves, but instead, by deciding who and how they want to be sexual, from a place of information rather than ignorance. Offering sexual education about the range of human sexuality, sexual diversity, and acknowledging struggles that conservative religions have with sexuality in the world, are ways to empower people to begin making their own decisions about how to integrate their sexual selves, with their spiritual selves. It is only when a person accepts their sexuality as an aspect of themselves, and not something that is external to them, that a person can truly begin to heal from sexual shame. Then, and only then, can they evaluate their sexuality from a position that supports their own health, in a way that promotes healthy sexual values, in their lives, relationships, and even their soul.

It is factors involving moral incongruity or sexual satisfaction, not excessive sexual behavior itself, that contribute significantly to the experience of feeling that one's sexuality is out of control or problematic. Attending to these conflicts must become a central component of a treatment approach for reported difficulties with sexual self-control. An informed clinical approach to the subjective experiences of lack of control is to assist the patient in recognizing that feeling out of control is not the same thing as *being* out of control (Klein, 2012). This then helps to begin separating the sexual behavior from the feelings about the behavior, and to begin examining the origins and experiences of those feelings, which often directs back to underlying moral or religious conflicts.

Clinically, therapists can help people through application of mindfulness techniques, values sorting exercises, anxiety and mood treatment, motivational interviewing, education and moral exploration. The conflict here is not the sex itself, though sexual behaviors are often a distracting and tempting target. The problem is that people choose to explore or experience sexuality without ever exploring or resolving their negative moral feelings towards the sex they desire or enjoy. Many religious people simply haven't been prepared with language or ways to understand and explore this conflict, without encountering shame, condemnation or rejection.

Unfortunately, exploring this internal conflict can be difficult. In the experience of myself and many other therapists, many people may be reluctant to explore the idea that their sexual problems stem from a religious-sexual conflict. This resistance may lie in the patient themselves, or in their family, spouse or religious community. Unfortunately, like so many modern issues, the more contradicting evidence we present, the stronger a person's opposition may become. It is best framed as an invitation to a patient to explore and discuss how their sexual values can be consciously and mindfully applied to their understanding of their sexual expression.

Clinical Interventions for Subjective Self-Control Difficulties

As described throughout this chapter, there is a paucity of research examining the effectiveness of treatments for self-reported difficulties with sexual self-control. Effective healthcare treatments should ideally be guided and informed by evidence and research,

and must adapt and change as information grows. This facilitates better outcomes, prevents potential harms, increases the efficiency and cost-effectiveness of services, and is an ethical requirement of licensed practitioners. Unfortunately, this is an area where there has been extremely little research, due largely to the stigma associated with sexual problems, and with the previously unchallenged dominance of the sexual addiction model. However, with increased attention to the issues described in this chapter the focus of research is beginning to change.

Cognitive behavior therapies with individuals who are identified as hypersexual have shown some evidence for success (Hallberg, et al., 2017) Cognitive behavioral therapy, with its attention to harm reduction, reinforcement, planning, and cognitive distortions offers, in my opinion, some of the most hopeful interventions for addressing sexual problems, by assisting the individual in reframing this problem as a behavior, as opposed to a character flaw. Challenging cognitive distortions around sexual behavior offers opportunity to see the behaviors in different ways, and to create opportunities for change, in behavior and attitudes.

Acceptance and Commitment Therapy (ACT) (Hayes & Strosahl, 2004) and the strategies of Motivational Interviewing (Rollnick & Miller, 1995) offer compelling approaches to help patients recognize the ways in which their distress is related to their struggles to control their inner lives, thoughts, feelings and desires. In these models, clinicians help patients acknowledge that their efforts to control a behavior may worsen their distress, and be less effective than enhancing commitment and motivation towards change. These approaches offer potential clinical value through their non-judgmental approach to the behavior, such as sex, and their strategies for acknowledging the complex values and motivations that underlie complex behavior.

The approaches discussed here stand in sharp contrast to 12-Step groups, which utilize a core addiction model, based upon an assumption of disease and pathology, and was originally designed to provide help to individuals struggling with drug and alcohol problems. This model has proliferated into a variety of non-substance related problems though no current research supports the effectiveness of 12-Step approaches for sexuality issues. 12-Step groups are inherently based on spirituality, and non-religious patients may find these groups uncomfortable. There are many different sexuality-focused 12-Step groups, and some have explicit heterosexual and monogamy-based expectations which LGBTQ patients may experience as shaming and harmful. Unfortunately, in many areas of the country, patients may not have access to different groups nor an ability to select ones with which they may encounter fewer difficulties. Clinicians may do well to educate patients about these issues to support informed choices.

There are increasing references in clinical literature to the use of psychotropic medications to treat sexual behavior problems (Efrati & Gola, 2018). These include the use of anti-depressants such as SSRI's or other centrally acting medications, which may sometimes help in reducing urges to engage in sexual behavior. The cost/benefit analysis of side effects will need to be discussed in treatment. Most of these medications are used "off-label" or not designed specifically for distressing sexual symptoms. When used to treat underlying disorders, they may be appropriate. Application of these pharmaceutical treatments, in the absence of a thorough assessment to identify the complex factors contributing to self-reported sexual control difficulties, is fraught with ethical and clinical concerns.

Case Descriptions

I find it effective to illustrate a nuanced, sexual health-informed approach through offering case examples. The following descriptions offer snapshots of the individualized, strengths-based strategy for which I advocate.

Jerry: Jerry was a 32-year-old male who came to me for treatment, self-identifying with concerns that he was addicted to porn. His wife suggested he seek treatment, as she was upset at him choosing to masturbate to porn, rather than have sex with her. This is, in fact, a common report and issue identified in much literature. However, this case involved many more factors, as opposed to just porn. For instance, further assessment identified that Jerry and his wife worked different shifts; Jerry during the day, and his wife at night. When his wife came home from work, interested in sex, Jerry was in bed, tired, needing sleep for the next day. They'd never communicated or negotiated about scheduling sex to accommodate their work schedule. Jerry and his wife were also distressed that he sometimes lost his erection during sex, though he shared he had no difficulties during masturbation to porn. This, clinically, led us to acknowledge a significant physical health issue: both Jerry and his wife were clinically obese. Missionary-style sex, his wife's preferred position, was extremely physically challenging for Jerry. Better nutrition, health and exercise, as well as permission and encouragement to explore other sexual positions which might accommodate their bodies, helped the couple to experience more pleasurable sex with decreased erectile concerns. Finally, I helped Jerry and his wife discuss how frequently each was interested in sex. While Jerry was interested in sex 3–4 times a week, his wife was interested in sex about twice a week. They negotiated a discussion, which they'd never had previously, which led to a mutual agreement about the frequency of sex and masturbation, leading ultimately to successful resolution of treatment.

Roger: Roger was a 53-year-old male who was referred to me, having been diagnosed as a sex addict by his wife, two former therapists and their pastor. Roger had been married to his wife, his only marriage, since they were in their early twenties, having married in 1987, at a time when both were afraid of contracting HIV, particularly Roger who had a history of same-sex behaviors. Throughout their marriage, Roger struggled with infidelity and control of his sexual behaviors. He'd been caught multiple times engaging in casual sex through personals ads, going to adult bookstores and engaging in unprotected sex with other males, and had recently lost his job, caught viewing pornography at work. Roger had very high levels of depression and sadness, feeling extraordinary levels of shame over his inability to control his sexual desires and had contemplated suicide on multiple occasions. During our first session, I asked Roger what kind of pornography he was caught watching, and he described that it was gay porn. In fact, all of the sexual behaviors reported by Roger, identified as evidence of his sex addiction, were with other men. With education and assistance, Roger identified in therapy that he was a bisexual male, who was, at this time in his life, more interested in sex with other men, than with women. But, Roger was not at all interested in a romantic relationship with other men, and was only interested in a loving, romantic connection with his wife. However, throughout their marriage, Roger's wife had shamed and punished him, whenever she became aware of him being interested in other men. Our therapy then shifted direction from his past treatments, from attempting to control or change Roger's behavior, to helping him to acknowledge and accept his bisexuality, and to see his sexual thoughts towards males as a normal and healthy part of his identity. We used cognitive behavioral strategies to address Roger's depression, increasing his exercise, self-care and attention to the ways in which he thought about himself and his

sexuality. As we did so, Roger gained increased feelings of self-control over these sexual thoughts and desires, as he accepted them, as opposed to attempting to suppress and eradicate them. Roger was still a person in a mixed-orientation marriage, faced with the contemplation of infidelity, attempting to negotiate a consensually non-monogamous relationship, or ending the marriage. These were complex, challenging issues for him to wrestle with, which had gone unacknowledged due to a focus on controlling his sexual behaviors. In our last session, Roger described to me, "I used to pray to God to take away these sexual thoughts, and now I'm thanking Him, for making me a more complex person with the capacity for a greater, richer experience of life and love."

Adrian: Adrian was a 56-year-old male who sought treatment following approximately twelve years of attending sex addiction 12-step programs, as well as multiple treatment episodes in intensive outpatient treatment for sex addiction at programs in Los Angeles. Adrian sought treatment from me, describing that despite many years of sex addiction treatment, he didn't feel it was working and he was still struggling with his sexual behaviors. Adrian saw me "in secret" from his wife, because he worried that if she searched my name, she would learn of my opposition to the concept of sex addiction, a concept that she very strongly embraced. Adrian was a financial/banking executive, married for 25 years with no children. Starting around 15 years ago, he began secretly visiting massage parlors where he engaged in sexual encounters, and also engaged in multiple affairs. He had a history of several sexually transmitted infections, at least one of which he had also passed to his wife. Each time these behaviors were revealed, he returned to sex addiction treatment, largely to appease his wife and maintain his marriage. In therapy, he described that he did not feel he was addicted to sex, though he used that language in treatment and in groups, in order to avoid being labelled as "resistant." During treatment, we focused on identifying the varied functions and rewards of these sexual behaviors. Adrian felt significant insecurity about his wealth, and felt more comfortable in lower economic settings, which were more consistent with his upbringing in poverty. Similarly, he felt insecure with his wife, threatened by her wealthier upbringing, education and status. Though he had a high libido and interest in sex, sex with his wife had decreased significantly over the past ten years, with the couple averaging sex about once a month. He felt unable to confront or argue with his wife, but felt more power over her, when he engaged in secret infidelities. Adrian had no hobbies, and few areas in his life where he took care of himself, or allowed himself to feel rewarded. Treatment focused on helping Adrian to increase self-care activities other than sexuality, as well as education and role-play to help him practice communication with his wife. The couple was referred to marital therapy, but his wife refused, perceiving these issues as solely Adrian's problems. In therapy, Adrian discussed divorce, but decided that he was unwilling to lose his wife and their marriage. We then explored ways in which he could express his anger and feelings of powerlessness in a manner other than risking his own health and physical safety. Adrian was surprised, and confronted me once in therapy, "Aren't you supposed to make me stop cheating on my wife?" he asked. "I wasn't aware that infidelity was a mental disease," I replied. "The job of therapy is to help you have the resources and skills to make the best decisions, for you. I think there are ways you CAN make better decisions, but it's not my job to tell you what those decisions should be." Though he continued to visit massage parlors about once a month, he began taking and using condoms, and acknowledged that his choice to seek these encounters was intentional and volitional. On one occasion, towards the end of our treatment, Adrian reported that he had recently gone to a massage parlor, but before getting out of his car, had "gone through my inventory," reviewing all the various emotional functions of these experiences,

and "checked in" with himself. Adrian laughed that he spent so much time on this process, that he ran out of time to go into the establishment, but that he had realized he felt okay with himself at that moment, if he did or didn't complete the behavior. Adrian and his wife moved shortly thereafter, as he took a promotion to a higher position in a northeast city. He requested a referral to a new therapist, one who also didn't subscribe to the addiction model.

Carlos: Carlos, a 31-year-old male, referred for treatment while on probation for numerous drug-related criminal charges, mostly involving methamphetamine. Carlos was a gay male and disclosed that he was HIV positive, though he was currently on retroviral treatment. During assessment, Carlos self-described as a sex and porn addict, reporting that he didn't feel he could control his sexual behaviors. During intake, he was diagnosed with borderline personality disorder and substance use disorder. Carlos was first referred into substance use intensive outpatient treatment, but after numerous instances in group therapy where he engaged in unprovoked verbal attacks on other patients and instigated arguments, he was referred to individual therapy. In therapy with me, Carlos admitted that he enjoyed stirring everyone up, "so they feel like I do." Carlos was living in a sober group home, and wanted to focus in therapy on ways in which he felt he'd been mistreated by fellow residents, who were angry at him for engaging in disruptive and manipulative behaviors. Carlos shared that when there was "drama around, it makes me feel like when I am high." Carlos disclosed that, when high, he often engaged in unprotected sex with partners who were unaware of his HIV status, but simply said "they know the risks." In therapy, Carlos was extremely animated, delighted to recount tales of the interpersonal conflicts that swirled around him. Though Carlos initially agreed in therapy to attempt to work on reducing this "drama," in order to pursue healthier relationships and sexuality, he became angry when therapy focused on behavioral interventions to address these conflicts, as opposed to reinforcement of his emotional reactions. Carlos was ejected from his group home, due to a physical conflict with another resident. In therapy afterwards, he acknowledged that he had provoked the fight, because he had been bored and irritated with housemates, but that he didn't feel he deserved to be ejected. Eventually, after several such episodes, Carlos was discharged unsuccessfully from treatment, and referred for treatment for borderline personality, though he refused to attend this treatment. This case illustrates what certainly some might call sex addiction. Nonetheless, this also demonstrated the need to always stir up drama based on his borderline personality disorder and substance abuse. His rejection of treatment for these problems would lead to a poor diagnosis and simply saying he was a sex addict was more acceptable than dealing with the deeper issues.

Conclusion

It is critically important to recognize that healthcare, including mental health and sex therapy treatment, can do great harm when we allow treatment to be based on morality rather than science. The historical approach to what has been defined by self or others as uncontrollable sexual behavior represents the intrusion of moral judgment and lack of sexually informed approaches. Self-reports of difficulties with control of sexual behavior should not be taken at face value. The report of sexual dyscontrol is not equivalent to objective evidence of impaired sexual self-control. Accepting a patient's statement that their behavior is uncontrollable, and joining with the patient to suppress their sexual behaviors, could create social and personal harm, without adequate evidence that these

harms are counterbalanced by personal or social benefit. Though there can be significant personal and health risks to uncontrolled sexual behaviors, it appears at this time that effective interventions to reduce these risks involves treating underlying mental health disorder, substance use disorders and addressing unresolved moral and relational conflicts.

Subjective report of sexual self-control difficulties is clinically important, insofar as the clinician utilizes this disclosure to guide further inquiry. Many individuals with varied causes, etiologies, motivations and sexual behaviors, may identify sexual dyscontrol in treatment. This complex heterogeneity is critical to address and conceptualize, in order to most effectively and ethically approach these matters. Treatment and diagnostic approaches that do not consider the complexity and diversity of sexuality run the risk of inadvertent pathologization, and may perpetuate cycles of sexual shame. Sexual shame, arising from unaddressed moral conflicts between religious sexual prohibitions and sexual desires, contributes greatly to perceptions of sexual self-control difficulties, and interferes with behavioral change. Similarly, self-control difficulties may emerge from other problems involving relational sexual satisfaction, psychological, medical or sexual disorders. Sexual self-control problems are best perceived as symptomatic of underlying conflicts and the effective sex therapist works to assist patients in understanding, recognizing and addressing these conflicts.

Note

1. The editors understand the issue of problematic sexual behavior is highly controversial. In the second edition, we selected an author who presented an addictions-based approach. In this edition, we selected an author who presented an alternative to the addictions approach.

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14

UNIQUE FACTORS IN THE INTEGRATION OF AGING AND SEXUAL HEALTH

Jennifer Hillman

Introduction

Sexuality represents a lifelong need and basic human right regardless of age or disability status (World Health Organization, 2010). General societal attitudes toward sexuality among older adults in the U.S. vary widely from negative and restrictive to positive and permissive. (In contrast, attitudes toward sexuality and aging in other countries, like India and China, remain essentially negative.) Traditional attitudes in the U.S. are rife with negativity and stereotypes including those of "dirty old men" and "sad, lonely queens [gay men]." In contrast, contemporary attitudes encompass more positive and permissive attitudes, often fostered by media portrayals of older, attractive, generally healthy, heterosexual community-living adults like sexually aggressive female "cougars" and men able to engage in lengthy periods of penetrative sex after embracing the use of performance enhancing drugs.

The expression of sexuality among older physically and medically ill, institutionalized, and LGBT adults, however, remains essentially invisible in mainstream society, and is typically stigmatized as unusual, disgusting, or shameful (Hillman, 2012). As noted, socially acceptable forms of sexual expression among older adults, including those alluded to in mainstream media, include participation in heterosexual intercourse; all other forms of sexual activity and expression are devalued by comparison. In addition, many Americans have adopted a medicalized view of sexuality and aging (see Potts, Grace, Vares, & Gavey, 2006), which espouses the erroneous belief that any sexual disorder can be remedied easily, and exclusively, by taking a pill. The medicalization of sexuality essentially overlooks the role of cultural status, health status, psychological status, religious beliefs, family-of-origin issues, and partner dynamics upon an older adult's sexual health and functioning (Hillman, 2012). The unfortunate reality is that many older adults' care providers and family members, as well as older adults, themselves, have internalized these either traditional, highly negative, restrictive attitudes toward sexuality and aging, or these more contemporary and permissive, but narrowly defined heterosexual and medicalized views (Potts et al., 2006).

Sexual Behavior and Dysfunction among Older Adults

Older adults, as a population, are significantly more heterogenous than homogenous when compared to other age groups in terms of health status, marital status, educational level,

income level, and living arrangements (e.g., community living vs. institutional living). This heterogeneity also extends to older adults' sexual desire and participation in a variety of sexual activities and behaviors throughout the lifespan. A landmark U.S. population-based study of community-living older adults revealed that 73% of adults aged 57–64 years of age, 53% of adults aged 65–74 years, and 26% of adults aged 75–85 years of age reported that they were sexually active in the past year. Among those sexually active adults in the 75- to 85-year-old age range, more than half (54%) reported that they had sex at least two to three times per week. Adults from all age groups reported that they engaged in a variety of sexual activities including masturbation, kissing, hugging, fondling, oral sex, vaginal sex, and anal sex. Older men were more likely to engage in partnered sexual activity than older women, and higher levels of self-reported health were associated with increased participation in sexual activity (Lindau, Schumm, Laumann, Levinson, O'Muircheartaigh, & Waite, 2007).

Approximately half of the sexually active men and women in this national study reported that they experienced at least one sexual problem, and nearly one third reported that they experienced two or more sexual problems. Among men, the most common sexual problems included erectile dysfunction (ed.) (37% of all men), diminished interest (28%), premature ejaculation (28%), anxiety about their sexual performance (27%), and inability to orgasm (20%). Additional epidemiological findings suggest that ED increases with age (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994); approximately 40% of men in their 40s, 50% of men in their 50s, 60% of men in their 60s, and 70% of men in their 70s reported having ED. Among women in the U.S. (Lindau et al., 2007), the most prevalent sexual problems were diminished interest (43%), vaginal dryness (39%), inability to orgasm (34%), and genito-pelvic pain during vaginal intercourse (17%).

In addition, consider that many participants in Lindau et al.'s (2007) nationally representative study reported that they were not sexually active in the past year. Older women without a healthy partner were significantly less likely to engage in sexual activity than older women with a healthy partner. Significantly more women (35%) than men (13%) also indicated that participation in sexual activity was "not at all important" to them. This belief that sex holds no importance in one's life was expressed most often by men and women in the oldest age group (i.e., 75–85 years of age), and by older women who did not have a partner.

The Impact of Normative Aging

Changes in the Sexual Response Cycle

Aging does introduce some changes to older adults' sexual response cycle. In older women, defined here as women age 50 and older, normative age-related changes associated with menopause, including a reduction in estrogen production, typically lead to a reduction in the size of the uterus, cervix, and ovaries via changes in collagen production. The decline in estrogen production during menopause also results in thinning and a loss of elasticity in the vaginal lining, and a decrease in vaginal lubrication. These vaginal changes can cause pain during intercourse unless they are treated with water-based vaginal lubricants or hormone therapy (Mayo Clinic, 2018). As reported by one 56-year-old, postmenopausal female client, *I was so relieved to learn that it was 'normal' for me to need to use some kind of lubricant during sex. My partner was getting worried that I just wasn't as interested [in sex] anymore, and I knew that wasn't true!* It is notable that providing clients with even basic

information about age-related changes in sexual physiology and functioning can alleviate many couples' underlying relationship issues, in which one partner (often inaccurately) blames the other for a lack of love, sexual interest, and even infidelity.

In older men, defined here as age 50 and older, normative age-related changes include a decline in the production of testosterone (see Hillman, 2012, for a review). It typically takes an older man longer to obtain an erection, often with more physical stimulation. In addition, an older man's erection tends to be less firm, and orgasm and ejaculation may be delayed. For many men who suffered from premature ejaculation when they were younger, this extended time period between arousal and ejaculation can be a welcome change. Older men also have a longer refractory period (time after orgasm when penis is unresponsive to stimulation).

To address such age-related normative changes, many men turn to performance enhancing drugs like Viagra and Cialis. (The use of these, and other PDE-5 inhibitors, as well as detailed information about ED and its multiple treatment options can be found in Chapter 5 of this volume.) While the medicalization of elderly sexuality has allowed many adults suffering from sexual dysfunction to engage in new and effective medical treatment, including access to performance enhancing drugs for ED, it has also spawned a very narrow view of what represents "normal" sexual functioning. Unfortunately, this medicalized view often includes the perception that individuals at any age, at any cost (see Potts et al., 2006), can and should engage in penetrative intercourse, typically with the help of a "magic pill." In fact, many older adults reflect upon their increasing age and changing relationships, and report that they often enjoy other sexual activities as much as, or even more, than penetrative sex. Many older men and their partners also fail to recognize that, even with the help of performance enhancing drugs, a man requires sexual interest and desire, and sometimes manual stimulation to obtain an erection firm enough for penetration.

Providing education about these age-related normative changes in sexual functioning, as well as basic information about the use of Viagra and other performance enhancing drugs, can typically empower older clients and their partners. As illustrated by one 60-year-old female client, *I'm so glad to learn that my [long-time] boyfriend's desire to use Cialis isn't because he was getting bored or disinterested in having sex with me. And I'm really glad I know how that stuff really works now because we both kind of freaked out when he used it for the first time and nothing really happened … It might sound kind of weird, but we figured out that I really don't mind starting off by giving him [oral sex to help him get an erection] if I can lay down next to him in bed, and he rubs my back while I do it. I'm just so glad we got to talk about it.*

Increased Emphasis upon a Range of Sexual Activities

It is essential that therapists help older clients, and others who work with older adults, to expand their definition of sexual behavior and expression to include a broad range of activities (see Potts et al., 2006). Sexual activity can range from the individual, sensual pleasure of applying scented hand lotion, to reading romance novels, viewing pornography, and masturbating with a dildo or other sex toy, to engaging in the aforementioned activities with a partner, to holding hands, sitting, walking, or dancing with a partner, to heavy petting with a partner, to engaging in penetrative oral, vaginal, or anal sex with a partner. Because biological changes associated with normative aging and illness can make it difficult or impossible to engage in penetrative intercourse, which can be associated with guilt, anger, decreased self-esteem, and depression in both men and women (Cogen &

Steinman, 1990), it is vital to help older clients expand their repertoire of pleasurable sexual and sensual activities. Some clients may also need help or permission to grieve over their loss of participation in certain sexual activities, like penetrative sex, that may have, for better or worse, helped define their identity as a man or a woman.

A Call for Systemic Therapy

Systemic sex therapy, which incorporates biological, psychological, dyadic, intergenerational, and sociocultural factors (Weeks, Gambescia, & Hertlein, 2016), appears tailormade for addressing the heterogeneity of clients from an aging population. The use of a systemic approach leads sex therapists to assess and address an older client's biology (e.g., normative age-related changes; the impact of acute and chronic illnesses; prescription, (over-the-counter, and recreational drug use), psychology (e.g., affect, cognitions, and behaviors including participation in high-risk behavior), dyadic or couple's issues (e.g., the availability and health status of a partner), intergenerational factors (e.g., family of origin, family by choice, and adult children), sociocultural factors (e.g., general societal attitudes, internalized stereotypes and stigma; religion and religiosity; the medicalization of sexuality and aging) and environmental factors (e.g., an independent vs. institutional setting; care providers' knowledge, attitudes, and training; public policy.) With the number of older adults in the U.S. expected to swell to more than 88 billion by the year 2050 (U.S. Census Bureau, 2010), it behooves sex therapists who are increasingly likely to see an older adult client in their practice, to familiarize themselves with this multi-dimensional, contextual perspective.

Benefits of a Sexual History

The process of sex therapy with older adults is quite similar to that of sex therapy with younger adult clients. However, because older adults often have limited experience with health care providers who are comfortable discussing their sexuality, there are multiple benefits to "starting at the beginning" in sex therapy with a comprehensive sexual history. For example, research in primary care suggests that only 50% of those physicians ask their older patients about their sexual health, and less than 10% even ask their older patients if they are currently sexually active (Ports, Barnack-Tavlaris, Syme, Pereta, & Lafata, 2014). It is essential that therapists normalize an older client's participation in a sexual history (e.g., I ask each of my clients these questions as standard practice.) Asking older clients in sex therapy to reflect upon "Has anyone ever asked you these kind of questions before?"; "What is it like for you to talk about your sexual health and history?" and "What is it like to have someone [from a different generation, gender, or race] ask you about your sex life and sexual health?" can yield vital information and help strengthen the therapeutic relationship. Participating in an open, non-judgmental sexual history sets the stage for older adults to experience and trust that they will be treated like a unique individual who deserves to have a healthy sex life, and not like a one-dimensional stereotype. As stated by one 78-year-old female client, *It is such a relief to be treated like an adult instead of like a child. Just because I'm older doesn't mean that I need to be coddled or protected.*

Taking a Team Approach

The use of a team or interdisciplinary approach can significantly inform sex therapy with older adults. Building collaborations and referral networks with medical providers who

specialize in primary care, cardiovascular, gynecological, urological, oncological, endocrine, psychiatric, and hospice care can significantly increase the likelihood that older adults (and their partners) who experience sexual dysfunction can obtain assistance from a sex therapist. Such collaborations can be clearly beneficial, as research suggests that many physicians who encounter an older patient with sexual symptoms, compared to a younger patient with the same symptoms, give them a poorer prognosis and are less likely to refer that patient to a sex therapist (Gewirtz-Meydan & Ayalon, 2016).

Assuming an Expanded Role

One way that sex therapy can differ when working with older versus younger clients is that therapists must often assume multiple roles to help address a client's intergenerational, sociocultural, and environmental challenges. For example, an older client living in a nursing home who wishes to masturbate in private may face significant discrimination from professional caregivers. In this case, a sex therapist may find herself engaging in interventions that include staff consultation and training, and even professional advocacy to help change the nursing home's official policy on residents' sexual rights. In another example, an older client in home-based hospice care who is widowed but cohabitating with a new partner may have adult children who demand that hospice care staff prohibit their parent's participation in intimate, sexual activities "because their mother just wouldn't do that to their father, even on her deathbed." Here, the sex therapist may elect to engage in both adjunctive family therapy to help those adult children address issues of unresolved grief and staff training to help empower their client's personal rights.

Associated Ethical Issues

On a practical note, sex therapists who adopt a systemic approach and assume such expanded roles to meet the needs of their older clients often face a variety of ethical dilemmas. For example, should a sex therapist working with an older client bill for clinically indicated family therapy sessions as a part of their previously approved number of individual sessions, or is it necessary to submit another care plan for approval? To what extent can a sex therapist bill for consultation with a client's cardiologist or ombudsperson? Who is going to pay for a therapist to engage in nursing home staff training on behalf of a specific client when that client's insurance carrier will not? To what extent is a sex therapist ethically or morally obligated to help arrange for another provider to provide essential staff training when they do not have the financial resources, time, or inclination to offer that pro bono service themselves?

If an older client in an assisted living facility or nursing home would clearly benefit from institutional policy change, and their sex therapist is unable to bill for time spent drafting letters and calling administrators and legislative representatives, to what extent is that sex therapist morally, if not ethically, obligated to participate in that advocacy? If their older client is unable to advocate for themselves, and no immediate family or friends of choice are willing or able to advocate on their behalf, would contacting the local ombudsperson on the client's behalf be enough? There are very few, clear "right or wrong" answers in response to these, and other ethical and moral quandaries. Seeking peer consultation, information, and training from various professional organizations (e.g., local Area on Aging; American Association of Sexuality Educators, Counselors and

Therapists; Clinical Geropsychology's Division 12 Section II of the American Psychological Association; The Gerontological Society of America; Psychologists in Long-Term Care) can be helpful.

The Impact of Illness

Eighty percent of older adults suffer from one chronic illness, and 77% suffer from two or more (National Council on Aging, 2017). The impact of even one chronic illness upon an individual's quality of life can be devastating. Unfortunately, many health care providers, as well as lay people, fail to consider that an older adult's quality of life includes their sexual health. For example, 38% of older women and 52% of older men with heart failure reported that their sex life was important to them, and that it was directly related to their quality of life (Hoekstra, Jaarsma, van Veldhuisen, Hillege, Sanderman, & Lesman-Leegte, 2012).

The 10 most common chronic illnesses among older U.S. adults (National Council on Aging, 2017) include hypertension, high cholesterol, arthritis, coronary heart disease, diabetes, chronic kidney disease (CKD), heart failure, depression, dementia, and chronic obstructive pulmonary disease (COPD). These and other chronic illnesses can negatively affect an older adult's sexual health, both directly and indirectly via the side effects of prescription medication. Fortunately, sex therapists can provide older adults with chronic illnesses, their partners, and care providers with essential information and recommendations for intervention and adaptation.

Diabetes

For the more than 12 million older adults in the U.S. diagnosed with diabetes, clinical care guidelines emphasize the assessment and treatment of ED (Ramlachen, 2017), which affects more than half (55%) of older men suffering from diabetes (Lindau et al., 2010). Only limited attention has been paid to the sexual symptoms of older women with diabetes. It is important to note that diabetes can cause diminished levels of vaginal lubrication in women, as well as diminished sexual interest and a decreased ability to orgasm in both women and men. As reported in a national population study (Lindau et al., 2010), one third of older women with diabetes declined participation in partnered sexual activity as a result.

Although estimates suggest that nearly half (47%) of older men and one third (29%) of older women with diabetes discuss sexual matters with their health care provider, the vast majority (79%) of those older patients did so only when they, themselves, initiated the conversion. It also would be important to assume that new clients (of all ages) in sex therapy remain unaware of the linkage between poorly managed blood sugar levels and increasing damage to the body's nerves and arterial blood vessels, including those in the clitoris, vagina, scrotum, and penis. As noted by one 75-year-old male client, *I would have never come here [to sex therapy] if my wife hadn't read about [the effect of] diabetes on ED in one of her magazines. We would never have known.*

Cardiac-Related Illnesses

Cardiac-related illnesses typically cause considerable sexual dysfunction. For example, 40% of men with high blood pressure report experiencing ED, and more than 60% of women with heart disease experience diminished sexual interest, vaginal dryness,

decreased genital sensation, and diminished ability to orgasm (Kriston, Gunzler, Agyemang, Bengel, & Berner, 2010). Older women (76%) and men (81%) with heart failure report having significant sexual dysfunction including ED, diminished interest and arousal, and inability to orgasm (Jaarsman, 2017). Patients themselves report that dyspnea (i.e., shortness of breath), fatigue, and a general inability to engage in even moderately vigorous physical activity prevents them from engaging in many sexual activities including penetrative sex (Lainscak & Anker, 2015).

A common fear among older clients with cardiac disease and their partners is that they will experience another cardiac event, and perhaps even die, if they engage in sexual activity. Not surprisingly, older adults under cardiac care due to congestive heart failure (as well as high blood pressure, heart attack, and stroke) want information from a care provider about how to manage their symptoms and their sexual activity and relationships with partners (van Driel, de Hosson, & Gamel, 2014). Because health care providers often fail to initiate discussions about sexual activity with their older patients, even when they are engaged in cardiac rehabilitation (Kolbe, Kugler, Schnepp, & Jaarsma, 2016), sex therapists can help provide vital information. For example, the energy required to engage in penetrative sex is generally equivalent to the energy required to climb two to three flights of stairs; kissing, hugging, and fondling requires significantly less cardiac energy and may serve as an acceptable alternative. Participating in intercourse with a familiar partner in a familiar setting also requires less energy expenditure than sex with a new partner in an unfamiliar setting. Sex therapists can also remind their clients that they cannot dispense medical advice and that clients should always obtain medical testing and approval from their cardiology care team before resuming participation in any sexual activity.

Age-Related Symptoms in Depression

Individuals suffering from clinical depression typically experience diminished energy, feelings of sadness, feelings of guilt or worthlessness, insomnia or hypersomnia, and diminished interest in previously enjoyable activities – including sex. Many care providers overlook signs of depression in their older patients, especially if they occur in consort with personal loss or a chronic illness like Alzheimer's disease, cancer, or Parkinson's. (See Fiske, Wetherall, & Gatz, 2009, for a review.) It becomes critical for sex therapists to educate their clients that depression is not a normal part of aging, and that older adults often display symptoms of depression quite differently than younger adults. Older adults, compared to their younger peers, are less likely to report that they feel sad, guilty, or worthless. Instead, older adults with depression are more likely to report having impaired concentration and memory, somatic symptoms like low energy, general aches and pains, and a lack of interest in previously enjoyable activities. Many older adults, including older men, display an irritable and angry, rather than depressed, mood.

To add to these challenges in making an accurate diagnosis of depression among older adults, the majority of older adults actually endorse the myth that depression is an unavoidable part of aging, and typically believe that depression is something that they should handle on their own (CDC, 2018c). A primary therapeutic intervention is to educate an older client that depression represents an actual medical disorder that is amenable to diagnosis and treatment. Consider a 76-year-old client who reported, *I never knew that depression could explain why I don't want to have sex with my partner anymore. She's been complaining that I've been so angry these days and that I just don't want to go out or do anything [sexually.] I feel like it's actually OK to get treatment [for depression] now that I*

know this is from a chemical imbalance in my brain, and not because I'm getting old and just "losing it." I really thought that to be depressed you had to just sit around and cry all the time. That's just not me.

For many aging adults who engage in subsequent treatment for depression, additional challenges ironically often include sexual side effects from commonly prescribed antidepressant medications, including diminished interest and arousal, vaginal dryness, ED, and inability to orgasm. (Please see Chapter 5 in this volume for additional information.) Sex therapists can help educate their older clients about these potential sexual side effects and empower them to communicate more effectively with the prescribing provider. Engaging in role plays with older clients can often be helpful, especially if that client ascribes to more traditional beliefs that "the doctor knows best."

Breast Cancer

A woman's overall risk for being diagnosed with breast cancer increases significantly in the later decades of life, and may be related to changes in estrogen. Unfortunately, breast cancer and its treatment in older women can lead to significant changes in sexual health due to the presence of fatigue, grief, depression, vaginal dryness, and alterations in body image and perceived sexual attractiveness. Studies suggest that up to 60% of women with breast cancer experience sexual dysfunction, particularly during active treatment (Webber et al., 2011). Increased age has also been associated with challenges in making decisions regarding reconstructive surgery after mastectomy, and in reestablishing a caregiving role with romantic partners and younger family members. A recent study (Stabile et al., 2017) revealed that women over the age of 50 with breast cancer had some specific preferences in terms of sexual health education. Although they preferred that their health care provider broach the subject initially, women over the age of 50 were primarily interested in receiving written information, followed by an opportunity to discuss that information face-to-face. Their interest in obtaining online information about sexual health and functioning was minimal, even if they had unlimited internet access. Clearly, sex therapists should be included in any oncological treatment team.

Incontinence

Although not considered a chronic illness, urinary incontinence affects many community-living older adults and has a clear negative impact on sexuality. More than half of older community-living women (51%) and one quarter of older community-living older men (25%) experience urinary incontinence (Gorina, Schappert, Bercovitz, Elgaddal, & Kramarow, 2014). Urinary incontinence is caused by a variety of factors and can be classified as stress, urge, or overflow (see Garrett & Tomlin, 2005, for a review.) Stress incontinence occurs when the pelvic floor muscles and urethral sphincter becomes damaged or weakened, often after childbirth in women. Bladder leaks typically occurs during coughing, sneezing, and exercising. Obesity can also produce stress incontinence in both men and women. In urge incontinence individuals experience an overwhelming, frequent need to urinate. Urge incontinence occurs when bladder muscles become overactive, typically due to urinary tract infection (UTI), constipation, M.S., Parkinson's disease, medication side effects, and alcohol and caffeine use. In overflow incontinence (also called urinary retention) urine leaks involuntarily from a chronically full bladder. Overflow incontinence in men and women is caused primarily by physical obstructions

from constipation, bladder stones, and an enlarged prostate in men, and by some neurological conditions.

In terms of sexual functioning, stress and urge incontinence typically occur during intercourse and orgasm, whereas overflow incontinence can occur at any time. Most suffers experience embarrassment, shame, and fear about having leaks, and withdraw from sexual activity (Garrett & Tomlin, 2005; Hillman, 2012). Although most older adults use absorbent pads to manage their symptoms, urinary incontinence is highly treatable and can often be addressed with prescription medications, surgery, pelvic floor exercises, reduction of an enlarged prostate, weight management, reduction in the use of alcohol and caffeine, and treatment of UTIs and constipation. Probably the most important thing sex therapists can do is educate their clients that urinary incontinence is not a normal part of aging, and that effective treatments are usually available. Reliance on absorbent pads should only be considered a last resort.

To help manage symptoms during sex (Hillman, 2012), therapists can advise older clients to avoid drinking large quantities of liquids and to empty their bladder before engaging in sexual activity. Assuming positions that place less pressure on the bladder (e.g., the "top" position) during sex can also help. As discovered by one 69-year-old female client with incontinence who was just beginning pelvic floor treatment, *We decided to take your suggestion and just have sex in the shower. The water is so hot that neither of us even notice if I leak anyway! And we put a little plastic chair and some of those grippy [floor] strips in there just to make things easier. I still miss having sex in my own bed, but I'm starting to feel like myself again and my husband is beyond thrilled.*

Unique Age-Related Risks for STIs

Middle-aged and older clients share unique age-related risks for contracting STIs that range from HIV/AIDS and hepatitis C to syphilis, gonorrhea, and chlamydia. Sex therapists are in a unique position to educate their clients about these risks and can help their middle-aged and older clients who may be, or who already are, infected with an STI seek out appropriate testing and medical treatment, to communicate more effectively with their health care providers, and maintain an optimal quality of life. Although most people in general society believe otherwise, increased age does not provide protection from exposure to, or the acquisition of, STIs. Advanced age also does not prevent older adults from engaging in high-risk behaviors like sharing needles for drugs (including insulin as well as recreational drugs) and having unprotected sex with multiple or high-risk partners.

Sex therapists can expect that their older clients are significantly less likely to have accurate knowledge about STIs and their transmission than their younger clients. Although the majority of primary care physicians (70%) regularly discuss individual risk factors for STIs like HIV/AIDS with their patients under the age of 30, less than half of those primary care doctors (40%) even broach the subject with their patients age 50 and older (Ports et al., 2014). It is important to educate clients that post-menopausal women are at increased risk for contracting STIs because normative age-related changes to the vaginal wall make it more likely for them to experience micro and macroscopic tears during sexual activity, increasing their exposure to sexually transmitted pathogens. (See Hillman, 2012, for a review.) Because older adults also tend to experience an age-related decline in the functioning of their immune system, both older men and women, when compared to their younger peers, are less successful at fighting off pathogens, including those responsible for STIs.

HIV/AIDS

More than 50% of all people currently living with HIV in the U.S. are over the age of 50. With advances in anti-retroviral therapy, many people who become infected with HIV can view it as living with a chronic illness rather than being dealt with a death sentence. However, adults over the age of 50 infected with HIV are more likely to die sooner and experience HIV associated dementia, increased side effects from HIV-associated therapies, and more social isolation than younger adults with HIV. Adults over the age of 50 are also more likely to receive an initial diagnosis of AIDS when compared to younger adults, who are more likely to receive an initial diagnosis of HIV. It also is important to note that up to 17% of all new cases of HIV/AIDS occur among adults over the age of 50, and that these new infections typically occur as a result of male-to-male sex, heterosexual sex, and the sharing of hypodermic needles with HIV infected partners. Black and Latino elders also face a greater risk of infection (12 and 5 times, respectively) than older adults from other ethnic groups (Centers for Disease Control; CDC, 2018b).

Adults over the age of 50 face additional, unique risk factors for HIV infection compared to their younger counterparts. Health care providers and adults of all ages often assume that older adults simply do not engage in high-risk behaviors like IV drug use (which could include the sharing of needles for insulin), unprotected sex with multiple or high-risk partners, and participation in male to male sexual activity. Health care providers are also more likely to avoid discussing participation in high-risk activities with their older patients, no national HIV/AIDS programs are available for education or prevention, many middle-aged and older adults assume that they are not at risk for contracting STIs "like young people," and many post-menopausal women do not worry about using condoms because they associate them only with pregnancy. In fact, many older women have never independently purchased condoms or attempted to negotiate for condom use with a partner (Hillman, 2012).

Hepatitis C

In terms of other STIs, older adults identified as baby boomers are five times more likely to be infected with hepatitis C than younger adults, and most people with hepatitis C have no idea that they are infected. Hepatitis C is spread via blood-to-blood contact, which could occur from past or present participation in a variety of sexual activities, IV drug use, getting a tattoo with unsterilized equipment. (Individuals who had blood transfusions and organ transplants before 1992 are also at increased risk.) If untreated, hepatitis C can lead to significant liver damage and eventual death. Many aging clients are surprised to learn that each year in the U. S. more people die from hepatitis C than AIDS. Fortunately, a variety of treatments for hepatitis C are available, and some newer antiviral medications can even eradicate the virus from an older adult's system. Consistent with recommendations from the CDC, sex therapists can encourage clients born between 1945 and 1965 to get tested for hepatitis C, even if they appear asymptomatic (CDC, 2018a).

Case Example

A 61-year-old client, *Marsha*, entered into sex therapy, reporting that she wanted to try dating after being divorced for more than 15 years, and was worried about *what to watch out for and do*. She entered sex therapy at the recommendation of her granddaughter, who

learned about sexuality and aging issues during her nursing program in college. Marsha was shocked to learn, *My granddaughter was right [about my potential risk for contracting STIs]! It kind of makes me sick, but you really can't just look at someone and know if they are 'clean' or not. I hate the idea of dating now with all of this going on, because when I was dating my ex-husband, everything just seemed so simple. I mean, AIDS didn't even exist and I never even heard of hepatitis C. And, I never even thought about catching gonorrhea or chlamydia or any of that!* After exploring various aspects of her sexuality, including her changing body image and attitudes about sex while dating, Marsha reported that she was interested and willing to learn about condom use. One of her homework assignments was to explore the options and purchase some latex condoms and a water-based lubricant, either on-line from the privacy of her own home or in a brick and mortar store, and to bring those items along to her next session.

During her next session, Marsha learned how to use a condom correctly by practicing on a banana, and responded playfully, *Wow. I never learned about this in school!* She also engaged in some role-plays in therapy designed to help her practice and feel more comfortable about negotiating condom use with a potential sex partner. Marsha announced in therapy a few weeks later, *So I leaned back, smiled coyly, and told my date, 'Ok. Before we go any further, you either wrap it or pack it!' just like we practiced and my granddaughter told me to say. At first Tom looked at me funny, but then he realized what I meant and we both laughed. Then he excused himself for a moment, took a condom out of his dresser drawer, and put it on [correctly] without me having to say another word about it. I didn't even have to get [a condom] out of my purse, but I did pull out my KY [jelly]. And, using that went ok, too! I thought it was a little messy, but Tom sure didn't seem to mind.* It also is interesting to note that the primary intergenerational factor in this clinical case was unrelated to family of origin issues, but the influence of a grandchild.

Special Populations

LGBT Elders

Many sex therapists will find themselves working with older clients who self-identify as lesbian, gay, bisexual, or transgender, and need to be aware of many of their unique age-related challenges. In terms of cohort effects, current LGBT elders were alive when homosexuality was still identified as a mental disorder and, for some who are old enough, even as a crime. Only with the advent of the *DSM-5* (American Psychiatric Association) in 2013 has the diagnosis of Gender Identity Disorder been changed to Gender Dysphoria, in part, to help minimize the stigma often associated with a transgender identity. Unfortunately, pervasive heterosexual and cis-gender social norms, and related discrimination still represent a common experience for many LGBT elders, particularly within the health care system.

The pervasiveness of discrimination is so common that a national survey of middle-aged and older LGBT adults (MetLife Mature Market Institute, 2010; Witten, 2014) revealed that the majority of those adults feared being discriminated against by a health care provider, and nearly half of those surveyed reported that they would attempt to hide their minority sexual orientation or transgender identify from a health care provider. One can only assume that this deception, deemed necessary by many LGBT elders, would include hiding their sexual orientation or transgender status from a sex therapist, as well, particularly if another care provider referred them. Sex therapists can be conscious that

many older LGBT adults may need special encouragement to openly discuss their sexual history, and current sexual needs and desires in treatment.

Hospice and Palliative Care Clients

Older adults' interest in, and expressions of, sexuality do not automatically diminish or disappear in the throes of a painful or terminal illness. Unfortunately, many health care providers have failed to receive the education and training needed to help them address their patients' familiar needs for sexual expression and intimacy in hospice and palliative care settings. As a result, many practitioners avoid discussing the issue, and cite embarrassment and lack of information as their primary reasons for not doing so. Still other care providers rationalize the issue; "If sex is important enough to one of my hospice patients, they will bring it up, and then, of course I will talk to them about it." (DeLamater, 2012; Stahl, et al., 2018).

To complicate matters already associated with death and dying, individuals in hospice care may worry that their romantic partner no longer finds them physically or sexually attractive, while partners of individuals in hospice may want to engage in sexual activities with their partner but worry that they may be too frail or ill to participate or experience pleasure. Helping these couples speak openly about their concerns, and work through these issues is a vital part of sex therapy. In general, it is essential that older adult clients, their partners, family members, and professional caregivers recognize that participation in a variety of sexual behaviors at the end of life can be important, pleasurable, and life affirming.

Many hospice patients report that sharing special, intimate time with a partner allows them to make and savor final, positive memories in the face of impending death and fears of pain. Still others report that masturbation remains an important enjoyable and relaxing activity as long as they are afforded the appropriate level of privacy. As noted by one 83-year-old client in hospice, *I am taking life by the horns for as long as I can. Every day I get to hug and kiss [my partner] is a win for me. Sure, we can't have [penetrative] sex like we used to, but sometimes this is even better. I can't imagine not being able to hold and kiss [my partner.] Sometimes that's what gets me through the day … I like how [my therapist and I] got my hospice nurse to help hang up my IV on the right side of the bed and to time my pain meds so that when [my partner] and I lay together [in the early evening], nothing gets in the way and hardly anything hurts.* As indicated in this case example, clients at the end of life often expand their definition of sexual behavior to include the widest range of behaviors possible; being able to hold hands or simply lying together in bed, touching, can be incredibly intimate and satisfying. Enabling older clients at the end of life to maintain the greatest amount of privacy and autonomy possible, while maintaining their personal safety and access to palliative care, can provide them (and their partners) with clear psychological benefits.

Long Term Care Residents

A lack of official policies and training. The World Health Organization (2010) asserts that sexual health for individuals in institutional settings includes the presence of an affirming environment, appropriate training for health care workers, and freedom from sexual discrimination. Unfortunately, the prevalence of these critically important elements appears quite limited in long-term care settings like nursing homes, assisted living centers, and

prisons (Hillman, 2012). Older adults in long-term care often face a variety of barriers to the healthy expression of their sexuality including restrictive (or absent) institutional policies, restrictive attitudes among staff, a lack of staff training, and even negative and restrictive attitudes among other residents.

A national survey of nursing home directors (Lester, Kohen, Stefanacci, & Feuerman, 2016) revealed that only 37% of nursing homes have a formal policy regarding resident's participation in sexual activities. Even more alarming, 12% of those nursing homes with an official policy required that a family member or guardian give permission for a *cognitively intact* resident to engage in sexual activities like masturbation, viewing pornographic materials, and participation in partnered sexual activity. Such restrictive policies can be compounded by staff members' negative and restrictive attitudes (Bouman, Arcelus, & Benbow, 2006). Nursing home staff have expressed significant distress and even panic when older residents engage in sexual expression, and particularly when this sexual expression is consistent with an older resident's LGB or transgender identity (Di Napoli, Breland, & Allen, 2013; Hillman, 2012). Unfortunately, less than one third of nursing home staff receive training to help their residents maintain optimal levels of sexual health, even if they have expressed a desire to obtain such training (Lester et al., 2016).

Although sex therapists typically engage in work with individual clients and their partners, sex therapy with older residents in long-term care settings may necessitate, at a minimum, an examination of institutional policies and staff members' knowledge and attitudes about sexuality. Consider these statements from a 76-year-old community-living male client with a cognitively intact female partner who recently moved into a nursing home to receive assistance with daily care needs due to her MS, *I just want to have some privacy when I visit her! I mean, come on, we lived together for the last 15 years! Maybe we want to fool around a little. We both miss being together. The nurses get so upset and say that they just can't find a private room for her. I think they are just making excuses because they don't like the idea!*

Additional challenges for LGBT residents. Residents in long-term care and other institutional settings who identify as LGBT face additional challenges in relation to their sexual health and expression. LGBT residents who openly engage in sexual activities and behaviors consistent with a minority sexual orientation and transgender identity often experience discrimination and hostility from both professional caregivers (Di Napoli et al., 2013) and fellow residents. Such discrimination can range from physical abuse, withholding of care, and social rejection to verbal abuse, name calling, and malicious gossip (Hillman, 2012). Also, consider that several middle-aged and older transgender participants in a national study actually reported that, in response to fears of sexual discrimination and related, substandard care, they would rather engage in euthanasia or commit suicide than move into a nursing home (Witten, 2014).

A 66-year-old transgender client living in a nursing home related, *I got so mad when [my care aide] pulled my red panties out of my laundry and pranced around the room with them, laughing. I mean, I wear them under my clothes so I don't make other people uncomfortable, and then she has the nerve to make fun of me about it! The next thing I know, everyone at dinner [in the nursing home's communal dining hall] is talking about it.* In this case, consultation with the nursing home director and staff training emerged as essential interventions. (Fortunately, brief yet apparently effective eLearning programs are now available for long-term care staff members; Jones & Moyle, 2016.) The fact that this older client felt driven to mask and hide her true gender identity also became a central focus in treatment.

Sexual consent capacity. Certainly, nursing home directors and other long-term care administrators have a clear responsibility to balance the individual needs and rights of individual residents to engage in sexual expression with their need to protect all residents' health and personal safety (Hillman, 2017). Sexual problem behaviors in long-term care can occur when residents engage in masturbation in front of other residents and staff, sexual abuse (e.g., physical and verbal) of other residents, sexual abuse of staff and other caregivers, and participation in sexual activity with residents who are unable to reject those advances or provide informed consent. On the one hand, older adults in long-term care settings typically rate their sexuality as moderately to highly important in their lives (Mahieu & Gastmans, 2015). Alternatively, older adults in long-term care settings may suffer from a variety of acute and chronic illnesses (e.g., Alzheimer's disease) that can significantly impair their cognitive functioning. To provide appropriate sexual consent (Hillman, 2017), older adults need to 1) maintain basic knowledge of sexual activity and their consequences, 2) engage in logical reasoning about their participation in various sexual activities, and 3) be able to voluntarily refuse participation in any sexual activity.

An older adult's sexual consent capacity cannot be predetermined (e.g., in a living will) or determined by proxy by that adult's spouse, partner, or adult child. It is important to note that sexual consent capacity exists on a continuum. For example, one resident with Alzheimer's disease may have the capacity to consent to participation in hugging and kissing, whereas another resident with Alzheimer's disease may have the capacity to consent to mutual masturbation and heavy petting. Sexual consent capacity can also be expected to change as an older adult's cognitive status changes; reassessment at various points in time is often necessary. Although beyond the scope of this chapter, practice recommendations are available for sex therapists who wish to determine an older adult's sexual consent capacity (i.e., Hillman, 2017; Syme & Steele, 2016). An interdisciplinary team approach, coupled with the use of detailed clinical observations, resident interviews, neuropsychological testing, is required.

Future Directions

With the burgeoning of the older adult population, older adults' needs for referrals to, and assistance from, sex therapists familiar with the unique issues and challenges often faced by older adults will only increase over time. Attending to the sexual health of older adults is essential as well as inherently personal; all individuals, if they live long enough, will become members of this historically underserved population.

Developments in the use of telehealth, particularly for older adults in institutional and rural settings can be explored from both the perspective of both practice and research. The use of technology among aging adults, including computer and smart phone access, for pornography, the purchase of condoms, lubricants, and sex toys, information about sexual health, on-line dating, and virtual support groups should also be explored. Just as with younger adults, some older adults may benefit from using on-line pornography while other older adults may benefit from minimizing their use.

As noted previously, sex therapists can also be called upon to engage in advocacy and training. For example, the CDC (2018a, 2018b) could be encouraged to recommend initial testing for HIV and Hepatitis C for all adults over the age of 64 even if they report that they are not in a high-risk group. Therapists can also advocate for mandatory training among nursing home care staff that includes the establishment of official institutional policies that help maintain an older resident's privacy and autonomy. Additional calls for

advocacy include training for the assessment of sexual consent capacity among institutionalized elders, and increased rights for LGBT elders in long-term care, and referrals to sex therapy from primary care providers. With education and advocacy, the future of our nation's sexual health should be bright.

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15

TREATING INFIDELITY

Stephen T. Fife and Lauren Creger

Introduction

Infidelity is one of the most common reasons couples seek therapy. Despite this fact, therapists report that affairs and relational betrayals are especially challenging to treat (Fife, Weeks, & Gambescia, 2008; Whisman, Dixon, & Johnson, 1997). When couples enter therapy for infidelity, they often are simultaneously experiencing heightened emotions, serious relationship distress, and uncertainty about the future of their relationship. Untreated, infidelity may result in significant emotional, relational, familial, and financial consequences. However, if a couple commits to working on their relationship, increased commitment to each other or the therapeutic process, understanding, communication, and intimacy can be achieved and the couple can overcome the affair. While there is abundant information available about infidelity, empirical research and clear treatment guidelines are lacking, leaving therapists feeling ill-equipped to support clients through this common presenting problem (Blow & Hartnett, 2005b). This chapter provides an overview of treating infidelity that includes: definitions and types of infidelity, etiology, assessment considerations, discernment counseling, a five-phase treatment approach, and future directions for research. Much of the conceptual framework of this chapter derives from the seminal book on infidelity published by Weeks, Gambescia, & Jenkins, 2003.

Definition and Description

Although there are many ways infidelity is defined in the clinical literature, a broad definition of infidelity fitting for the scope of this chapter is "any form of betrayal to the implied or stated contract between partners regarding intimate exclusivity. With infidelity, emotional and/or sexual intimacy is diverted away from the committed relationship without the other partner's consent" (Fife, Weeks, & Gambescia, 2007, p. 1). This definition parallels another in which infidelity is indicated when there is a "secret sexual and/or romantic involvement" outside of a committed relationship (Lusterman, 1998, p. 186). This conceptualization focuses on commitment and secrecy over specific behaviors and sexual activity, making room for more nuanced betrayals to be accounted for.

Regarding language, the terms *participating partner* and *non-participating partner* will be used in this chapter to denote the partner who engaged in infidelity behaviors and the partner who was betrayed, respectively. Like the aforementioned definitions, these terms are more inclusive of different types of relationships and infidelity than other language

seen in the literature such as extradyadic sex and extramarital involvement. Infidelity can occur in marriages and dating relationships, and in dyadic or open relationships with multiple partners. For some, sexual intercourse is a clear marker of crossed boundaries, while kissing or hand-holding alone may qualify as infidelity by others. Additionally, the terms participating and non-participating partner move away from pejorative limiting labels.

Although many think primarily of sexual affairs, there is no single definitive definition of infidelity used by all researchers, clinicians, and couples (Hertlein, Wetchler, & Piercy, 2005). Even though most couples have an implicit understanding that a commitment to fidelity exists in their relationship, what that entails is rarely explicitly stated, and partners may disagree about what constitutes betrayal. This ambiguity has implications for knowing whether infidelity has occurred, how often it happens in relationships, and how to treat it in its various forms.

Prevalence

The prevalence of infidelity is hard to determine, especially given its broad definition and secretive nature. When looking at prevalence data, it is important to consider that people may have different ideas about what counts as infidelity. This is particularly true if researchers define it differently and assessment questions leave room for ambiguity or interpretation. Participating partners may also minimize their actions, or they could have a difficult time remembering specific instances of infidelity over time or the number of partners they have had outside of their established relationship (Blow & Hartnett, 2005a).

Many researchers have made attempts to estimate the general frequency of infidelity. Some examples are listed here.

- 20 to 40% of married partners have had an extramarital affair (Atkins, Baucom, & Jacobson, 2001; Marín, Christensen, & Atkins, 2014)
- 50 to 70% of men and 35 to 55% of women reported to have engaged in infidelity behaviors (Marett, 1990; Martin, 1989; Thompson, 1984 as cited in DiBlasio, 2000)
- 60% of men and 45% of women have engaged in infidelity (Glass & Wright, 1992)
- 24.5% of men and 15% of women have engaged in infidelity (Lauman, Gagnon, Michael, & Michaels, 1994)

Given the challenges noted here, it is not surprising there are vast differences in prevalence estimates. Despite the irregular numbers, some patterns have been found. Wiederman (1997) analyzed data from the General Social Survey conducted in 1994 with a sample of over 2,000 respondents. Similar to the statistics listed here, he found more men reported infidelity than women. Moreover, Wiederman noted that the frequency of affairs seemed to increase for men as they aged up to 70, while the highest incidence for women was between the ages of 30 to 50. Continuing with gender differences, Thompson (1984) found that men were more likely to engage in sexual infidelity and women were more likely to be involved in emotional infidelity.

Of course, not all couples who experience infidelity seek professional help. However, a significant percentage of couples seeking treatment from marital and couple therapists have experienced infidelity. In a survey conducted by Humphrey and Strong (1976) of clinical members of the American Association of Marriage and Family Therapy, therapists reported 46% of couples seeking help reported an affair in their relationship. A decade later, a replication of this study showed higher rates, with some therapists reporting the majority of their caseload had experienced infidelity (Humphrey, 1985). Atkins, Baucom,

and Jacobson (2001) reported that approximately 50% to 65% of couples presented for therapy as a result of infidelity. These three studies highlight the need for therapists to be knowledgeable about working with couples through this relationship challenge.

Etiology and Typologies of Infidelity

A wide variety of risk factors can make relationships susceptible to infidelity. What is peculiar about the etiology of infidelity is that, despite slightly more permissive attitudes about it than society has historically held, most people do not think approvingly of infidelity (Labrecque & Whisman, 2017). If the cause is not determined biologically or medically, and partners in a committed relationship do typically not seek out infidelity initially, how does this relationship phenomena occur? Norona et al. (2018) suggested that engaging in infidelity is often a process of "sliding" rather than "deciding." They listed some risk factors that illustrate what may occur for the participating partner during this sliding process. These include: unmet needs, having opportunities to engage with a different partner, alcohol use, appealing factors in the infidelity partner, needing more attention, desiring novelty, and an avoidant attachment style.

Allen et al. (2005) provided additional detailed information about the etiology of infidelity that builds on the risk factors listed here. They offer a time-based framework to help organize and better understand factors that contribute to infidelity. Their six stages are: predisposing factors, approach factors, precipitating factors, maintenance of the infidelity relationship, disclosure or discovery, and short- and long-term responses. The framework further organizes the factors into four source dimensions: the involved (or participating) partner, the spouse (or non-participating partner), the relationship, and the larger context. This framework can also be utilized in infidelity assessment and prevention.

Several writers have worked to develop typologies of affairs based on clinical observations of infidelity. These typologies aim to describe the nature of the infidelity or the motivation behind it. Therefore, they are also useful in providing insights into how people come to engage in infidelity, the needs they are trying to get met, and factors that may put relationships at risk for emotional and sexual betrayals.

Pittman (1989) identified four common patterns of infidelity: accidental encounters, habitual philandering, romantic affairs, and marital arrangements. The accidental encounter is a single occurrence of infidelity behavior, usually accompanied with or brought on by drinking; being with friends at a bar, strip club, massage parlor, etc.; or being propositioned by someone. Partners that engage in habitual philandering exhibit a consistent pattern of being disloyal to a primary partner and changing additional sexual partners, all while agreeing that such a pattern can be problematic and addictive. People who seek out romantic affairs are, in a sense, in love with love. The participating partner engages in infidelity to recapture the intense feeling of being in love, in order to escape from life's difficulties, they may be facing in their already established relationship. Lastly, in some marital arrangements, partners implicitly agree about a need to create distance and avoid the problems of their marriage. One or both partners might engage in an affair in order to accomplish this goal.

Emily Brown (1991) developed one of the first and most widely known set of affair typologies. Brown's five types of affairs are described here:

- Conflict-avoidant affairs. These affairs are designed to help the couple avoid having to deal with their conflict. Emotional energy is drained from the relationship and

invested elsewhere. The fights that might occur about other parts of the relationship are distracted by the affair. Unfortunately, attempts to resolve disagreements are avoided.

- Intimacy avoidant affairs. Some partners can only tolerate a certain amount of closeness. When the partners begin to feel too close, someone is compelled to do something to create more distance. Infidelity is one of many strategies, which serves the purpose of creating distance, thereby maintaining an equilibrium that is safe but lacking in intimacy.
- Compulsive sexual behavior. Sometimes a partner may have a compulsion to seek sexual experiences outside of the primary relationship, in spite of psychological distress or significant impairment in functioning (Kraus, Voon, Kor, & Potenza, 2016; Turner, 2009). Their sexual acting-out may have little to do with the quality of the relationship and is related first and foremost to their addiction.
- Empty nest affairs. This type of affair is similar to the intimacy avoidance type. With children in the home the couple may have grown used to a lack of closeness, or maybe even focused on the children to avoid closeness. With children grown-up, the couple may experience emptiness in their relationship. The affair serves to fill the void within the relationship by becoming the new distraction. The marital intimacy equilibrium, therefore, remains undisturbed.
- Out the door affair. Sometimes one partner wants to leave the relationship but cannot leave without having another partner. They cannot tolerate being alone or thinking that they may never find anyone else. Thus, they may engage in infidelity in order to transition from the pre-established relationship into a new one.

Lusterman (1998) suggested three additional types or motivations for infidelity. Entitlement affairs reflect situations when the participating partner believes they are entitled to engage in infidelity behavior, unaccompanied by emotional attachment or commitment. The tripod affair refers to the phenomena of using an affair to stabilize a pre-established relationship that is not working. Third, the exploratory affair is used to explore another relationship when the pre-established relationship is not working, but the participating partner has not decided which relationship to commit to.

Assessment

A thorough assessment is critical in order to develop a treatment plan tailored to the circumstances and needs of each couple. Just like people have different perceptions of what infidelity is, couples' responses to relationship betrayal can vary (Atwood & Seifer, 1997). For many couples, an affair amounts to a serious relationship trauma, and some non-participating partners may experience symptoms of post-traumatic stress disorder in their unfolding reactions and hurt (Glass & Wright, 1997; Spring, 1996). Given the shock that may come with the discovery of infidelity, it is important to assess for PTSD symptoms, as well as safety and coping concerns. The presence of intimate partner violence, addiction, suicidal ideation, mental and physical health challenges, and any other potential safety concerns should also be screened. Clinicians should also ask clients about their methods of coping and sources of social support during this difficult time.

Infidelity Assessment Topics

With infidelity, a comprehensive assessment is likely to be an ongoing process. Yet it is critical to ask about certain topics at the beginning of treatment. If the infidelity was disclosed prior to the start of therapy, the clinician should assess how much the non-participating partner already knows. If infidelity is disclosed in the course of couple therapy, the purpose and course of treatment will need to be reevaluated. Assessment must also be viewed as a process in situations when one or both partners are unsure about whether they desire to remain in the relationship. More information about mixed agenda couples will be shared later in the chapter.

The following topics can help therapists to complete a comprehensive assessment of the infidelity and its impact on both partners and the relationship (Fife et al., 2007; Gordon, Baucom, & Snyder, 2004; Weeks & Fife, 2014, Weeks, Gambescia, & Jenkins, 2003). An in-depth, careful assessment can help therapists understand their clients' social and historical context, which can help prevent therapists from taking sides with one of the partners, making assumptions, working from premature conclusions or decisions.

The type of infidelity. Contemporary literature focuses on three types of infidelity: physical or sexual, emotional, and cyber or Internet (Hertlein & Piercy, 2008). Partners may have participated in a single type of infidelity, or a combination of the three types. It is important to assess for the type of infidelity of the participating partner, as the type of infidelity engaged in by the participating partner may shape treatment. For example, Blow and Hartnett (2005b) suggested that "emotional infidelity may be much more difficult to treat and have far poorer outcomes than a one-night stand on a business trip" (p. 194). The type of infidelity could provide insights into the couple's challenges and the participating partner's motivations.

The frequency, duration, and location of the affair. Frequency and duration are extremely important factors. Just how long did the affair last? Was it one week or two decades? The dynamics involved in these situations, and the motivations behind them, would be very different. Long-term affairs tend to stabilize a relationship that is not working. As a result, they can be very difficult to stop; the attachment between the affair partners may have grown strong to the point the participating partner cannot choose between relationships. Regarding location, if an affair occurred in a person's home (i.e., in the bedroom), the symbolic meaning for the non-participating partner can be substantial and may result in significant sadness or anger ("How could you have sex in our bed with him/her!?"). Sometimes affairs occur in a person's office, or in a more neutral space like a hotel. The Internet is another place where more and more people are "meeting" for emotional and "cybersex" affairs. Lastly, texting is also a medium by which infidelity can occur. The frequency and medium of communication should also be assessed.

The number of past and present sexual partners. This assessment category focuses on the history of past infidelity. For individuals who report only a single or few infidelity partners, their need for other partners outside their pre-established relationship should be explored. Partners who report large numbers of sexual partners should be evaluated for potential sexual compulsivity challenges.

The gender of the affair partner. While heteronormativity could lead us to assume an affair as involving a person of the opposite sex, sometimes affairs are with members of the same sex. In some cases, this fact indicates that the partner is gay or bisexual but living in a heterosexual relationship. In other cases, it represents having explored a curiosity. The

secrecy of the infidelity could be layered with the participating partner's shame about their sexual identity or desires, or fear of being discovered.

The level of the sexual activity. Sexual activity can occur along a continuum from verbal or written exchanges to intercourse for the purpose of impregnation. The therapist will want some idea about the actual behaviors that were experienced, and if/how each partner views them as infidelity. The level of activity could range from exchanging texts, sexually explicit text messages, to sexual intercourse at a hotel.

The degree of emotional involvement and attachment. Glass and Wright (1992) found that, generally, men tend to have affairs for sexual reasons and women for emotional reasons. Women are more likely to link sex and love while men are more likely to view the two as being separate entities. Therefore, it is useful to explore the level of emotional intimacy that might have been established and how attached the partners feel toward each other.

Relationship of the affair partner to both partners. Generally, it is easier for a couple to handle an affair when the infidelity partner is someone the non-participating partner does not know personally. Unfortunately, many cases of infidelity involve people who are close to both partners, such as a friend or family member. When the infidelity partner falls into one of these categories, the non-participating partner's sense of betrayal is undoubtedly multiplied – it is a double betrayal: by one's partner and the other person.

The degree of secrecy, lies, and deception around the affair. Some participating partners will come forward and admit to having had or even thinking about an affair. More commonly, however, partners will hide or deny the affair until they are confronted. Infidelity with a long history (several weeks to months) usually involves considerable deception. The participating partner must keep compounding their lies in order to maintain the relationship and its secrecy. This pattern of deception creates an overlay on the infidelity; it impacts the couple's ability to restore trust. The non-participating partner is not only hurt by the betrayal, but also is upset over the fact that their partner deliberately and consistently lied to them to keep the affair alive or hidden.

Whether the affair(s) were unilateral or bilateral. In most relationships that experience infidelity, there is just one participating partner. In other couples, both partners have had affairs. Though it is relatively uncommon for couples with two actively participating partners to present for treatment. Assessing for infidelity history, however, may reveal that each one has had one or more affairs, be it emotional, sexual, and/or cyber. It is then relevant to determine whether an affair may have been a form of retaliation against the other partner's affair.

The degree of implicit approval or consent by the betrayed partner. Without question, most people strongly disapprove of infidelity. There are also some couples that clearly know about the presence of infidelity in their relationship and accept it. There are usually conditions to these affairs, like being informed before they happen, being assured they are for sex only, and keeping them discrete. Also in existence are open marriages and other forms of consensual nonmonogamy. It must be iterated that people can agree to nonmonogamous or open relationships and still feel rightfully betrayed by instances of infidelity. These couples may come to therapy when one partner is consistently breaking the rules that have been agreed on or when one feels threatened that an emotional involvement beyond the set boundaries is taking place. Lastly, a small percentage of couples tolerate infidelity to preserve the appearance of a marriage and/or for financial security.

Social and cultural context of the infidelity. A couple's social group, community, ethnic/cultural group, and religious affiliation all play a role in how the partners perceive

and respond to infidelity. As shared earlier, some couples belong to sexually permissive social groups such as swinging clubs. Affairs are tolerated and even accepted to the extent they conform to the norms of the group. The group may operate independently from the beliefs of the greater community or culture it is situated in. While religious communities typically sanction marriage and disapprove of affairs, some groups exhibit less tolerance than others. To demonstrate cultural competence and respect for diverse clients, therapists need to assess infidelity within each of these contexts. Note that partners might hold different interpretations of their cultural norms.

Assessment Utilizing the Intersystem Approach

Weeks (1994) developed the Intersystem Approach for couple and family therapy, which has been applied to the treatment of infidelity by Weeks et al. (2003) and Fife et al. (2008). This model's foundation acknowledges the interaction between the individual, couple, family, and social systems within which they are embedded (Weeks & Cross, 2004; Weeks & Gambescia, 2015). Using this model to guide assessment and exploration of what the clients are bringing to therapy can lend itself to more thorough treatment that acknowledges the complexity of the human experience, relationships, and therapy. The model's five domains can be used to help break down and organize infidelity assessment.

Individual/biological/medical. Assessment at this level will largely focus on physical well-being of each partner, with questions addressing medical illnesses or other physical health issues that may influence them individually and relationally. In cases of infidelity, it would also be helpful to ask about any developmental crises, sexual health, and sexual orientation and identity.

Individual/psychological. Assessment of this domain will focus on each client's mental health. Questions will focus on mental and emotional well-being, symptoms of mental illness, cognitive distortions, irrational beliefs, and defense mechanisms (Weeks & Fife, 2014). This may include current and past mental illness or emotional struggles.

Dyadic relationship or couple dynamics. Therapists working from a systemic perspective will naturally explore the dynamics of the couple relationship. Assessment may look at the couple's relationship history, styles of communication, patterns of interaction and conflict, sexual and emotional intimacy, and so forth (see Weeks & Fife, 2014). Interactional factors that have a relationship with infidelity include infertility challenges, difficulties in establishing a loving relationship, fear of intimacy, and disagreements and conflicts over gender roles and dynamics (Westfall, 2000).

Intergenerational influences. Intergenerational assessment will focus on the influence of each partner's family of origin, both historically and in the present. It might include anniversary reactions, scripts, boundaries, relationship cutoffs, triangles, attachment styles, and closeness or distance present in relationships along with the resulting strengths and/or challenges (DeMaria, Weeks, & Twist, 2017; Weeks & Fife, 2014). In cases of infidelity, family of origin may influence both partners' stance toward infidelity. Intergenerational assessment can be facilitated through a focused genogram interview regarding infidelity and other interpersonal betrayals (DeMaria et al., 2017). Beyond the family of origin, the family life cycle could provide risk factors for infidelity. Problems can often be traced to the age(s) of the couple's children. For many couples, the birth of the first child disrupts the relationship's equilibrium. And as seen in Brown's (1991) empty nest typology, the departure of the last child can be a joyous celebration, or it could come with intimacy challenges.

Contextual factors. Attitudes about sex and fidelity are influenced by a number of contextual factors, including one's culture, social attitudes, history, and perhaps religion. Therapists should seek to understand the influences of these on the couple and how this is related to their understanding of fidelity. Partners from different cultural backgrounds, for example, may define infidelity differently or have different expectations regarding fidelity in relationships. Therapists might also ask about social and cultural attitudes regarding gender and infidelity.

Discernment Counseling

For cases of infidelity, a critical component of assessment is to learn about the couple's intent to remain together. Therapists must be cautious about assuming the couple's goals merely because they have sought out therapy following infidelity. Some couples might enter into therapy ready to work on their relationship. With commitment communicated by both partners, the therapist and couple can move forward with treatment. Since many relationships dissolve after emotional or sexual betrayal, therapists must also be prepared to work with couples who are not committed, ambivalent, or not in agreement about preserving their relationship (Fincham et al., 2006). Without commitment to address the infidelity and work on the relationship, couple therapy cannot be effective. In these cases, with mixed agenda partners, discernment counseling is strongly recommended (Doherty et al., 2016).

Discernment counseling seeks to "help couples have greater clarity and confidence about a direction for their relationship, based on a deeper understanding of their relationship and each person's contributions to the problems" (Doherty et al., 2016, p. 248). This is not to be used when someone has already made the decision to leave the relationship. Discernment counseling is a brief process (one to five sessions) with a focus on individual conversations between the therapist and each partner. At this time, individual sessions are prioritized over couple sessions and interventions to make space for conversations tailored to the different concerns and needs of the "leaning out" and "leaning in" partners (Doherty et al., 2016). Upon completion of the discernment counseling sessions, the couple selects one of three paths: stay together without undergoing treatment, breakup or divorce, or commit to six months of therapy with divorce and infidelity relationships off the table.

The individualized conversations included in discernment counseling could be especially insightful for both participating and non-participating partners prior to treatment for infidelity. The therapist could provide the couple with psychoeducation about how the shock of the infidelity discovery or disclosure (experienced by either partner), emotional reactivity, and intense feelings of guilt, pain, and betrayal could be clouding their ability to make decisions about their relationship. The partners might make threats to dissolve the relationship out of anger or hurt, or rush to escape the situation caused by the infidelity. Individual sessions, described next, might provide time for partners to diffuse the intensity and express their emotions prior to jumping into premature decision-making.

Individual sessions with the non-participating partner. In individual sessions with the therapist, this partner might want to process the hurt they are experiencing, without the risk of being vulnerable in the presence of the participating partner. Vulnerability involves trust and in cases of infidelity, the trust between partners has been violated. Non-participating partners might also want to discuss their family history of infidelity, experience of their relationship, grief over the loss of the relationship they thought they had, and fears about where their relationship is going. The therapist must encourage them to work

through their feelings to understand and control them in order to make decisions about treatment and their relationship.

Individual sessions with the participating partner. The participating partner may have stopped the affair or be in the process of trying to stop it. It is suggested that the therapist be firm in informing the couple that progress cannot be made in the relationship if the affair continues. Truly ending the infidelity means that all contact must also come to an end. If the participating partner ends the infidelity, they could likely experience sadness, or even depression, at the loss of the relationship. It is understandable that the non-participating partner might have little patience or empathy for the participating partner's experience of loss, as it could feel like further betrayal. Participating partners, consequently, might minimize their emotional involvement with the infidelity partner when the non-participating partner is in the room, making individual sessions opportunities for more accurate assessment. A large part of the therapist's role in individual sessions with this partner is to help them grieve the relationship while simultaneously supporting them in preventing the relationship from starting again. The therapist can also coach the participating partner through what to say to the infidelity partner: they are working on their primary relationship and need to be fully committed. If the participating partner is fearful of completely ending the affair, the therapist can offer a six-month hold with the explanation that if after the six-month period the relationship is not working, they can leave the relationship knowing they tried their best without the presence of the infidelity relationship.

The therapist could also provide the participating partner with psychoeducation about infidelity relationships. One insight about the nature of affairs that could be provided is that the daily life stressors that most couples must work through together do not challenge infidelity relationships. Relationships formed out of infidelity have a quality of novelty, a powerful source of sexual desire. When participating partners are trying to commit to one relationship, it can be helpful for them to hear that the pre-established relationship does not have a chance compared to the new one, and the novelty of the new relationship will also deteriorate with time. Finally, the time-limited and artificial nature of an affair relationship, plus the fact that most participating partners will not recognize shortcomings in the infidelity partner, suggests a considerable amount of projection. In many cases, the infidelity partner is a projection of a parental or an idealized figure. Moreover, the idealized figure often has traits the participating partner would like to have but instead perceives them as lacking. The projective aspects of the relationship are opportunities for therapeutic work. The therapist could help the participating partner appreciate the qualities present in the non-participating partner. When the idealized projection is a search for the missing in oneself, then the therapist can help the client through self-esteem work, goal setting, and personal development.

Questions to ask the participating partner in individual sessions (Adapted from Chapter 18, Weeks & Fife, 2014):

1. How did you meet the person (or people) you engaged in infidelity with?
2. What was the attraction like?
3. Who initiated the relationship?
4. How were you feeling about yourself when this relationship started?
5. How were you feeling about your pre-established relationship when this relationship started?
6. What was going on in your life around the time this relationship started?

7. How attached have you become to this person? Do you think you love this person?
8. What has this relationship meant to you?
9. How has this relationship helped and/or hurt your pre-established relationship?
10. How has this relationship helped and/or hurt you?
11. Did you ever imagine that you would engage in infidelity?
12. How has this relationship challenged your ethical, moral, or value system?
13. What do you like most about this person/relationship?
14. What do you like least about this person/relationship?
15. How do you feel about ending this relationship?
16. How do you think this partner will feel about this relationship ending?
17. Do you think they will be able to let go of this relationship if you end it or do you think they will continue to pursue you?
18. Who else knows about this relationship?
19. Have you thought of ending this relationship or tried to end it unsuccessfully?
20. Has your partner thought of ending this relationship or tried unsuccessfully to end it?
21. How much mental energy does it take to keep both of your relationships going? Are you feeling worn down by this situation?
22. How do you think you will feel when it is over?
23. Do you think you might resent your partner in your pre-established relationship for having to end this relationship?
24. Have you ever had to end a relationship?
25. What has it been like when relationships have ended for you in the past?
26. Are you prepared to grieve over the loss of this person?

Treatment

Couples may enter therapy feeling at a loss for hope and control in their relationship due to infidelity. Clients have reported that they appreciate having a "road map" that outlines the course of treatment and what they might expect in the process of healing from infidelity, giving them a sense of newfound empowerment (Bird et al., 2007; Fife et al., 2008). Given the complexity of this relationship challenge, clinicians could also benefit from having some guidelines for therapy. This chapter presents the reader with a conceptual, multi-phase approach for the treatment of infidelity first outlined by Weeks et al. (2003). Fife et al. (2008) further elaborated on this conceptual approach. The phases, detailed next, are crisis management and assessment, systemic considerations, facilitating forgiveness, treating the factors that contribute to infidelity, and promoting intimacy through communication. Research suggests that infidelity treatment should attend to feelings of distress resulting from the betrayal and focus on the relationship as a whole, rather than isolating infidelity behaviors (Allen et al., 2005; Blow & Hartnett, 2005b). This approach to facilitating healing from infidelity provides a structure for therapists to follow in their work with couples seeking treatment for infidelity. Of course, each couple is unique and will require individual adaptation.

Phase 1: Crisis Management and Assessment

Crisis management and assessment may likely occur simultaneously to help people stay safe, process their emotions, and prevent hasty decision making about their commitment

to their relationship (Gordon et al., 2004). Assessment and commitment were discussed in the previous section of this chapter. The remaining parts of this phase are working through emotional reactions and rebuilding accountability and trust.

Emotional reactions. Much of the time in-session is devoted to talking about feelings as they emerge and shift throughout therapy. Intense feelings of shock, anger, and hurt may be frightening to both partners because they can seem endless and irrational. The therapist can help both partners learn how to acknowledge and validate each other's feelings. Once the couple is capable of doing expressing their feelings openly and honestly in the session, they must also agree that when they have a need to express their feelings at home, they should set aside specific time to talk about them. Safety around expressing these feelings in any context is essential. Being in touch with feelings, having the ability to communicate and validate feelings, expressing feelings in a non-hurtful way, and managing difficult feelings such as anger and hurt need to be mastered in the session prior to conversations outside of sessions.

In instances of infidelity, unexpressed and unresolved emotions are often channeled into a search for facts. Non-participating partners may seek every detail of the infidelity: with whom, how long, when they met, how many times, what the infidelity partner looked like, what they talked about, where they met, if gifts were given, and what happened sexually. This never-ending search for knowledge cannot be used as a substitute for processing feelings. However, some basic facts are useful for the non-participating partner to know to move forward: who the partner was, how long the infidelity lasted, how often they met, and where they met. More than this, and the non-participating partner may end up with information or images that could be too painful to overcome. When they feel a desire to ask questions, they should express the feeling or need behind it. The therapist can communicate, "You already know what happened; hearing it again may not be helpful." The desire many participating partners have is the assurance the affair is over and that their partner still finds them attractive and lovable. The more vocal the couple can be about their feelings and the more in tune they are with their needs, the less they will feel compelled to revisit the infidelity.

If emotional reactions do not seem to be progressing, medication might supplement therapy. Sometimes the non-participating partner can ruminate excessively or develop obsessive-compulsive thinking or behaviors related to the infidelity. The therapist should assess the premorbid functioning in this area and if the feelings about the affair, checking behaviors, and search for facts persist beyond what seems reasonable. Second, the grief reaction to infidelity may include symptoms of depression and anxiety. In some cases, these symptoms existed prior to the affair and went untreated. A psychiatric referral may be useful.

Accountability and trust. Infidelity can severely damage trust in a relationship, and rebuilding it is not an easy matter. The non-participating partner is injured by both the relationship betrayal and the lies and deception that accompany infidelity. The participating partner cannot simply apologize; trust must be rebuilt slowly through open communication, honesty, and accountability. After complex betrayal, the non-participating partner might question the words and actions of the participating partner. Participating partners must take responsibility for what they did and what has happened to the relationship as a result of the infidelity and be held accountable to supporting their partner. They must develop patience, realizing that their actions destroyed trust and lead to the ongoing hypervigilance and suspicions of their betrayed, non-participating partner. In order to alleviate these suspicions and demonstrate accountability, participating partners must

engage in clear communication and be careful to explain their comings and goings. For instance, when traveling, they could be expected to make calls home and be reachable by telephone. The basic information previously provided about the infidelity can offer clues to help the non-participating partner know that the affair has not restarted.

Phase 2: Systemic Considerations

In this phase the clinician can revisit the Intersystem Approach to help guide treatment, as individual, relational, intergenerational, and social/contextual factors should all be considered (Weeks, 1994; Weeks & Gambescia, 2015). Between the etiology and assessment sections of this chapter, a number of reasons were introduced to explain why someone might enter into infidelity. Many cases of infidelity have some connection with relationship dysfunction or dissatisfaction (Gordon et al., 2004). Thinking systemically, it takes both partners to create patterns of dysfunction; both partners may have contributed to putting their relationship at risk for infidelity, and healing will be something they have to work through together. Therefore, in the systemic considerations phase, couples must learn:

- How to make sense of what happened
- What the affair means to the couple, and
- What they can learn from the affair to prevent it from happening again

Reframing is a common, effective strategy in couple and family therapy. For treating infidelity, it involves helping the couple find another way of looking at their challenge, which has the effect of putting everyone on the same level and reducing single-sided blame (Bird et al., 2007). In order to reframe the infidelity, the therapist must work with the couple to learn about how the affair might have happened and the purpose it served. An effective reframe can enable the couple to find *meaning* in the infidelity. Both partners come to recognize a connection between their dysfunctional or vulnerable relationship and the infidelity as a symptom of it. Reframing can be a delicate process, as the non-participating partner may be very sensitive about feeling blamed or responsible for the infidelity. This is not a matter of blame, however, but rather helping partners to share responsibility for their relationship. Once this connection has been established, healing and rebuilding can be accelerated. This cognitive, reframing phase of therapy is usually brief, lasting only a few sessions. It lays the groundwork for forgiveness, treating the dysfunction, and increasing intimacy. With less emotional reactivity and a greater understanding of the infidelity, both partners can now participate in the therapy by working together with shared responsibility for their relationship.

Phase 3: Facilitating Forgiveness

Forgiveness is a critical factor in relationships (Fife, Weeks, & Stellberg-Filbert, 2011; Weeks et al., 2003). It is a process of making the conscious choice to abandon ill will and desired retribution that comes with no implication about the worthiness of the forgiven individual nor the status of reconciliation (Gordon et al., 2004; Murray, 2002). The way forgiveness is defined by the therapist, and presented to the clients, can impact its effectiveness as a therapeutic intervention (Butler, Dahlin, & Fife, 2002). Forgiveness is accepted more by clients when therapists explain how it is healing for the non-participating partner, rather than

excusing or condoning the behavior of the other (Butler et al., 2002; Hertlein & Brown, 2018). Self-of-the-therapist work surrounding forgiveness, what it means, and related values would be beneficial for clinicians supporting clients through any form of relational betrayal.

Unifying factors. Unifying factors that promote forgiveness are empathy, humility, relational commitment, and hope (McCullough, 2000; Worthington, 1998). Empathy helps to decrease defensiveness and increase softening. Humility allows the participating partner to take responsibility for their actions, and the non-participating partner to recognize that all people are human and can make mistakes. As empathy and humility are increased, commitment and hope for the relationship also increase. Commitment and hope can lead partners to invest more in the relationship. Commitment can also increase trust and safety, which can be a helpful foundation of forgiveness work (Fife et al., 2011).

Apology. A sincere apology from the participating partner can help the non-participating partner to forgive and heal. An apology, to be effective, should acknowledge the specific wrong and harm done, be genuine, and include a commitment to change (Couch, Jones, & Moore, 1999; Fincham, 2000; Fitness, 2001, Flanagan, 1992; Gold & Weiner, 2000). An apology may not be accepted immediately, and therapists can normalize this and acknowledge attempts. Still, sincere apologies that focus on the participating partner's behavior can help increase empathy and strengthen the couple's relationship.

Phase 4: Treating Factors that Contribute to Infidelity

Treating problems with commitment, passion, and intimacy. Treating these three factors can decrease a couple's vulnerability to future infidelity, since they are working on the infidelity as a symptom of unpredictable challenges rather than the problem in and of itself. Commitment was discussed in the discernment counseling portion of this chapter. The therapist can encourage commitment by having the couple emphasize positives in their relationship, share words of appreciation, and show affection. Supporting the couple through conversations about their sexual relationship and desire discrepancies could help reignite passion. Lastly, issues with intimacy could be treated by addressing fears of intimacy or dependence, and helping the couple explore ways they could grow closer (Weeks & Fife, 2009).

Exploring expectations. Infidelity can often be a symptom of unmet expectations between partners. These expectations might be related to roles, household or parenting responsibilities, finances, sex, and so on. Couples can reflect on the following in therapy (Sager, 1976, as cited in Fife et al., 2008, p. 321):

1. Expectations that the partner was clearly aware of and verbalized to the other partner
2. Expectations that the partner was clearly aware of but did not verbalize to the other
3. Expectations that the partner was or is not aware of and therefore could not or cannot be verbalized

Phase 5: Enhancing Intimacy through Communication

Infidelity may be a result of a lack of closeness and intimacy, stemming from communication challenges. It can also disrupt the intimacy already established in a relationship. Rebuilding intimacy is a critical component in the process of a couple healing from infidelity. To help combat lingering hurt and negative relationship patterns, therapists must

first help the partners explore the assumptions and judgments they might have about each other's intentions. The therapist could intervene in mind reading and negative communication by asking, "If your partner's intentions were good in this instance, how would you likely respond?" (Fife et al., 2008, p. 322). The clients would then be coached to communicate assuming their partner has good intentions and desires. Interventions therapists could employ to help couples practice and improve their communication include: speaking with I statements, using reflective listening, and offering validation in lieu of jumping in to share thoughts, opinions, or get defensive (Fife et al., 2008; Gordon et al., 2004). Other exercises that have helped couples develop self-awareness, self-expression, and communication include role reversal exercises, enactments or facilitated face to face conversations, and deliberate eye-contact, all with communication coaching from the therapist (Bird et al., 2007; Davis & Butler, 2004).

Many people think of intimacy as limited to emotional and physical domains. Premature efforts to facilitate sexual connection after infidelity could invite fear or anxiety in the couple. Communication and intimacy interventions presented by Fife (2016) could help a couple start to restore intimacy in less threatening ways. The therapist could offer psychoeducation about different aspects of intimacy, like friendship, humor, recreation, and creativity intimacy. Offering these ideas could help couples spend time together, have more things to communicate about, build connection, and expand their understanding of intimacy beyond previously held limiting beliefs about what makes up relationships and closeness.

Case Vignette

The following case illustrates a couple that successfully moved through the first phases of treatment and was committed to staying together: Jacob (Caucasian) and Ellie (Hispanic) had been married for ten years. They had three children, ages seven, five, and two. The couple came to therapy after Jacob recently disclosed to Ellie that he had been involved with another woman for several years. They subscribed to traditional gender roles, as Ellie worked part-time but was primarily a mother and took on the majority of the household duties. With her job, home-making, and three young children Ellie felt constantly busy, exhausted, and under-appreciated. Meanwhile, Jacob felt ignored, bored, and like he was Ellie's last priority. He expressed that soon after their second child was born life became all about the children, and their relationship was not as fun or romantic to him as it used to be. After learning about the infidelity, Ellie admitted to feeling torn: part of her wanted to leave the relationship due to the affair, but she also relied on Jacob financially and did not want to face judgment from her Catholic and Hispanic family members for pursuing a divorce. Upon hearing this information, the therapist guided the couple through discernment counseling and began treatment once both partners committed to six months of working on their relationship. The therapist also offered the couple words of hope for change and normalized their challenges. In therapy, the couple expressed their feelings to one another. Jacob took responsibility for his behavior, and they established a system of transparency and accountability in order to being rebuilding trust. They learned about the impact of the family life cycle, how becoming parents changed their romantic relationship. They explored the information they adopted from their families of origin about gender roles and recognized that they wanted to share more parenting and household responsibilities to make intentional time for their marriage. Over the course of treatment, the couple started to re-establish the intimacy Jacob had been missing through working to meet each other's needs, increasing communication, and devoting more time to shared activities.

Research and Future Directions

Although there is a relatively large body of professional literature on infidelity, there is very little empirical research on infidelity treatment. The gaps in infidelity research can be explained by confidentiality concerns, shame, and secrecy surrounding the topic. It could also be reasoned that a subject that is hard to define would consequently be equally difficult to research. Much of the existing research oversimplifies infidelity to extramarital sex, though questions remain about the validity of existing research, given the diversity of definitions, the variety relationship constellations, and non-heterosexual identifying couples generally being left out of previous research (Blow & Hartnett, 2005a). Prevalence data, which is presently outdated and inconsistent, needs to be gathered with more all-encompassing definitions of infidelity and different types of relationships. Blow and Hartnett's (2005a, b) review of infidelity literature called for more diverse research. Unfortunately, this void still needs filling. Their other suggestions for future research include a more in-depth exploration of differences in couples who engage in infidelity and those who do not, qualitative research about therapist and client experiences, and long-term study of the healing process after infidelity is discovered or disclosed. Lastly, detailing infidelity treatment informed by specific family therapy models is beyond the scope of this chapter. However, more clinical research is needed on best practices and the ability of different models to aid in the treatment of infidelity.

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16

CULTURE AND SEXUALITY

Kristen Mark and Katharine Haus

Introduction

In the context of sex therapy, it is crucial for clinicians to understand the intertwined nature of sexuality and culture for effective assessment and treatment of sexual issues. Culture is relevant to sexuality due in part to the variety of sociocultural factors that impact sexual development such as sexual orientation, race, gender, and religion. Utilizing a sociocultural lens to examine sexuality in a clinical setting can positively impact the assessment, alliance-building, and treatment plan of presenting sexual issues. Culture has the potential to influence the etiology of sexual problems and/or issues in the development of healthy sexuality in complex ways that are crucial to understand for effective treatment (Atallah, Johnsom-Agbakwu, Rosenbaum, Adbo, Byers, Graham, et al., 2016). Throughout this chapter, the term "culture" will refer to the shared ideas, values, practices, and beliefs of a particular group of people within specific spatial and temporal boundaries. Culture is ever changing, continuously affecting perceptions of sexuality and sexual behaviors. As such, sexuality is defined by the cultural time and space in which it resides. For this reason, the term "sexuality" will be considered both as a cultural construct based on the shared social understanding of sexual behavior and as an individual means of expression and experience (Parker, 2009; Stevens, 2015; Rye & Meaney, 2007).

When considering the etiology of sexual issues, culture can play a significant role in the development of healthy (or unhealthy) sexuality. For example, in the case of someone who was raised in a household that delivered the message that sex is dirty or sex is bad (a common issue in many cultural contexts, especially related to religion), the development of a healthy sex life may be more difficult due to how deeply established these messages can become. Negative cultural introjects can become a part of a pervasive script that can feed into numerous sexual issues ranging from difficulty reaching orgasm to trouble maintaining an erection. Since cultural background can play such a significant role in sexual expression and the meanings we make about sexuality and sexual behavior, the therapist is obligated to conduct a comprehensive cultural history in order to reach an effective treatment plan (Kleinman, 1988).

Consideration of the cultural context improves treatment outcomes; moreover, it is essential for ethical care. For instance, therapist beliefs and values about sex can influence clients' internalized beliefs regarding their own sexuality and sexual practices (Harding, 2017). It is crucial for sex therapists to fully understand and be comfortable with their own sociocultural lens prior to working with others. In fact, most sex therapy

training programs require therapists to assess their sexual values through experiential workshops such as the sexual attitude reassessment (SAR) workshop prior to certification. For instance, the SAR is a core requirement for the American Association of Sexuality Educators and Therapists (AASECT). Even the most conscientious therapist can unintentionally project biases, prejudices and lack of cultural knowledge during treatment, creating more internalized conflict in the client. Thus, it is essential that therapists recognize the role that culture can take in shaping norms and stigma (Harding, 2017).

Sexuality is inseparably linked to the context within which it exists; therefore, cultural beliefs and expectations reinforce one's reality. As noted, an understanding of the cultural context is paramount to successful treatment. Nonetheless, empirical evidence regarding effective culturally based treatment is limited (Atallah et al., 2016; Hall & Graham, 2013; Heinemann, Atallah, & Rosenbaum, 2016). Internalized attitudes and schemas around sexuality, gender, and the body impact the way sexuality is experienced (Kaschak & Tiefer, 2002). Sex therapists are accustomed to dealing with sexual difficulties that reflect the context within which sex exists rather than a purely physiological etiology. However, the consideration of complex cultural intersectionality in sexual problems may not be as obvious to clinicians (Kaschak & Tiefer, 2002; Nagoski, 2015; Rosenkrantz & Mark, 2018). Sociocultural variables influence many aspects of sexuality across the lifespan and may govern values, morals, and behaviors. For example, cultural expectations are what lead to the assumption of dominant categories such as heterosexuality, binary gender and cisgender identity, etc.

The Intersystem Approach (IA), used throughout this text, is a comprehensive and integrative approach to understanding how individual and systems theories are integrated for more comprehensive assessment and treatment (Weeks, 1986). The five domains of the IA include: 1) individual/biological; 2) individual/psychological; 3) the dyadic relationship; 4) family-or-origin influences; and 5) contextual factors. This chapter is dedicated exclusively to the fifth domain, contextual factors, which encompasses society, culture, race, ethnicity, religion, and other aspects of the human experience that interface with one's identity.

Sociocultural Contributors to Sexuality

Sexuality fulfills multiple functions for each culture, and can be driven by numerous motivators. Common among them is sex as a means for reproduction (Rye & Meaney, 2007; Stevens, 2015), demarcating social status, individual beliefs, social control, bonding, intimacy, desire, and for some, a means for work (Mark & Lasslo, 2018; Meston & Buss, 2007; Rye & Meaney, 2007; Stevens, 2015). Additionally, the motives for having sex that are considered appropriate have been found to vary based on culture (Hatfield, Luckhurst, & Rapson, 2010). Therefore, much of what determines what sexuality is and the sexual behaviors which are "acceptable" to a society stems largely from the culture in which it is found.

In each culture, sexuality is utilized by both individuals and groups as a means of survival and interaction, and is governed by unspoken regulations that differentiate between what is acceptable and unacceptable. These regulations are manifested through the beliefs, behaviors, and attitudes that people hold are also referred to as social norms (Fujii, 2019). These norms are learned and replicated from birth through socialization, as children learn from their peers the things that are expected of them. As norms vary from place to place, context can also determine how different sexual behaviors are conceptualized. For

example, in many Western cultures, a kiss on the lips is considered to be a sexual or romantic behavior, but this behavior is not universal, as it has been documented in only 46% of cultures studied (Jankowiak, Volsche, & Garcia, 2015). Kissing, in some contexts, may constitute an unusual behavior and may not be well received in a culture where this behavior is not a norm. Social norms can be helpful, for example, in deterring people from taking part in incestuous behaviors, but they can often also cause harm to people participating in everyday sexual behaviors such as displays of affection in Arab countries. Those whose behaviors are outside of the norm may also be punished, depending on the context of their culture. Norms regarding sexual behaviors, orientations and identities can generate fear and misunderstanding, and result in the stigmatization of sexual acts and groups of people. For example, heterosexism, or the discrimination toward diverse sexual orientations based on the idea that heterosexuality is "normal" is prevalent in many cultures. This can result in harm through discrimination toward non-heterosexual people (Szymanski & Mikorski, 2015).

Religiosity. Religiosity has been documented to have a significant impact on one's implicit and explicit attitudes toward sexuality (Abdolmanafi, Nobre, Winter, Tilley, & Jahromi, 2018; Turner & Stayton, 2014; Whitley, 2009). When sexual behaviors or attitudes do not align with the expectations of one's religion, shame, guilt, and often confusion can accompany a sexual problem. For example, Christianity has historically been highly condemnatory of sexual behavior occurring outside of heterosexual marriage (Hatfield, Luckhurst, & Rapson, 2010; Rye & Meaney, 2007). Some forms of Judaism and Islam also hold sex outside of marriage to be sinful, and view sexual behavior as existing solely for the use of procreation (Leeming, 2003; Stevens, 2015). Any sexual behavior that does not contribute to reproduction is considered adulterous, which contributes to the ways in which different behaviors are stigmatized (Ho & Hu, 2016). Because of the ways in which sexual behaviors are conceptualized in Judeo-Christian religions, many individuals report feelings of guilt and shame when fantasizing or masturbating. This perception conflicts with the fact that masturbation is normal and even beneficial to overall sexual health (Coleman, 2003; Kettrey, 2016). In such cases guilt is also induced by other forms of sexual expression, including fantasy, anal penetration, and same-sex sexual behaviors (Leeming, 2003; Stevens, 2015). Culture can also influence how aspects within the relationship are defined; e.g., some Muslim women determine their sexual satisfaction based on whether their husband is sexually satisfied (Abdolmanafi et al., 2018). For these reasons, discussing sexual behaviors and engaging in sexual behaviors may be difficult for people who are a part of any culture where religious beliefs are particularly strong or where their cultural scripts are heavily influenced by religion (Abdolmanafi et al., 2018; Yip, 2018).

Religion can also influence power dynamics surrounding sex, often centered around gender inequality. Judeo-Christian religions have traditionally framed women's sexuality as dangerous and enticing to men, reinforcing gender expectations regarding sexuality. We can see this reflected through biblical stories where women are depicted as seductresses (e.g., Delilah with Samson; Bathsheba with David) that lure their mates to danger or an untimely demise (Leeming, 2003; Rye & Meaney, 2007). This contributes to the idea that women's sexuality can be harmful when exercised independently. Additionally, traditional perspectives on sexuality in countries like China and Iran hold virginity to be of utmost importance, resulting in any premarital sexual behaviors as taboo (Abdolmanafi et al., 2018). Religion, therefore, may conjure feelings of unease and disproval towards the expression of sexuality, especially that of women. This can also result in internal conflict felt by those who engage in these behaviors or to issues with sexual satisfaction due to the guilt associated with the behavior (Abdolmanafi et al., 2018).

Take for example Laurie and Daniel, a heterosexual couple of Christian faith who saved their first intercourse for marriage due to strongly held beliefs about virginity and purity. Despite high satisfaction in the relationship, strong sexual chemistry for all other aspects of sexual intimacy, and expectations that first intercourse on their wedding night would be a magical and deeply intimate moment to bond them to one another, Laurie reported intense pain that resulted in an inability for Daniel to penetrate her vagina with his penis. They presented in couple's therapy four months after their wedding day, disappointed and frustrated that they were not yet able to consummate their marriage. This disappointment and frustration were negatively impacting other aspects of their relationship and they wondered if they had made a mistake by marrying one another, and had fears of whether they would ever have a "normal" sex life that could potentially lead to starting a family. Assessing this case for sexual pain problems could not be done without the consideration of the religious context within which Laurie and Daniel's relationship existed.

Race and Ethnicity. In many areas of the world, and especially in countries with histories of colonization, the sexuality and sexual experiences of those who are racially and ethnically diverse are impacted by residual elements of colonialism. Although many believe colonialism ended with the conquest, colonial subjugation still presents itself today, and is referred to as (post) colonialism (Balestrery, 2012). One way in which this presents itself is through expectations around sexuality and sexualized stereotypes. People of color are often sexualized to the point of fetishism, with many people of color feeling as though White people may seek them out solely for the stereotyped expectations (Hargons, Mosley, Meiller, Stuck, Kirkpatrick, Adams, & Angyal, 2018; Nadal et al., 2015). Additionally, those who believe their families will be disproving of interracial relationships are less likely to engage in them, which can create additional levels of pressure in relationships (Yahya & Boag, 2014). Sexualization and other subtle enactments of prejudice (microaggressions), can contribute to the ostracism experienced by minorities, as well as to minority stress. Minority stress is a form of discrimination that creates unique stress for individuals of a minority category (e.g., racial or ethnic minorities, sexual minorities, etc.) and research has shown that minority stress can uniquely contribute to problems with mental and physical health (Meyer, 2003; Meyer, 2015). These concepts can become particularly difficult to deal with when a minority sexual identity and a minority race/ethnicity intersect, creating unique considerations for clinicians treating sexual problems.

Consider the case example of a 21-year-old bisexual black man, Jonathan, exploring his first relationship with another man, a white 25-year-old gay man, Justin. In this case, Jonathan presented to sex therapy individually, complaining of difficulty with orgasm during sex with Justin. This is a situation-specific problem with orgasm (masturbation to orgasm is functional and orgasm has happened during intercourse with women previously) and although maintenance of erection has not been impacted, he does find himself having a hard time staying in the moment during sex. There are three primary considerations for a clinician working with this interracial same sex couple: 1) race relations, 2) sexual identity development, and 3) the complexity of the cultural expectations placed upon both men due to the intersectionality of their multiple minority identities. Assessment and treatment of this case without the consideration of those three cultural facets would be incomplete.

Geography. The geographic location of origin or residence can significantly impact sexuality, access to sexual health care, expectations, beliefs, and stereotypes held. Within the United States, there are many attitudinal differences between urban and rural spaces, one of which involves attitudes toward sexuality. For example, people who live in rural areas in the United States tend to hold more traditional religious values and maintain little cultural

variability, which leads to high stigmatization of sexual minorities within these communities (Swank, Frost, & Fahs, 2012). In cities, this is less often the case, as there is often a high concentration of educated, culturally and sexually diverse individuals, leading to development of greater flexibility in accepting behaviors that would be considered unusual in smaller communities (Swank et al., 2012). Discrimination based on location is not exclusive to the United States and has been found in other parts of the world. In China for example, rural areas have higher numbers of men, who oppress women through sexual violence at higher rates than those reported in urban areas (Trent & South, 2012). Additionally, consideration of cultural background of an individual who grew up in a very different geographical location or cultural climate from that which they currently reside will require attention in the etiology and treatment of sexual problems. For example, if a therapist is treating a couple who grew up in India but now reside in the United States, the consideration of the cultural norms of India need to be discussed. This does not require that the clinician know everything there is to know about every culture. However, the clinician must take time to learn from the client about what their experience has been and to not assume that their experience is consistent with customs of all geographic areas in India and North America.

Further, expectations held by family or norms created in childhood can provide a complex layer of cultural context to a sexual problem. The acculturation process can provide a useful perspective regarding the culture of origin of a client. A thorough personal history will assess the adaptation of immigrants from their culture of origin to the culture in which they are now surrounded, assess for their internalized beliefs, and apply techniques with which to discuss sexuality (Hinemann et al., 2016).

Take for example Preeti and Shubham, a couple married for 28 years, both born in India, moved to the United States together 20 years ago, and have raised two children together in the United States. A clinician may be tempted to assume that after being in the United States for 20 years and raising two US-born children, considerations of norms typical in India may not be relevant. However, Shubham recently lost his job and Preeti is successful in her career as a real estate agent, making her the primary breadwinner in the home for the past year. They are presenting in couple's therapy because their sex life has become stagnant during that time. The therapist can work with the couple to discuss customary gender roles in India, expectations Shubham and Preeti saw their parents having for one another and how that has translated to the expectations they have for themselves and for each other, and how these fit within their social script of marriage. Coming from a place of curiosity in cultural discovery can be helpful for the couple to articulate their expectations but also for the clinician to form their treatment plan in a way that is informed by the cultural context.

LGBTQ+ Identities. The term LGBTQ+ is used as an umbrella term to describe people of diverse sexual orientations and gender identities that exist outside of the confines of heterosexuality and the cisgender experience. Individuals within the LGBTQ+ community tend to form their sexual values from different sources than heterosexual cisgender individuals. This community often lacks explicit mainstream role models in general and especially with respect to sex (Mark, Vowels, Bennett, & Norwick, 2018). As depicted in prior sections of this chapter, the cultural consideration of LGBTQ+ identities often intersect with other cultural constructs. For example, internalized religious norms also indicate how accepting people are of diverse sexual orientations and behaviors (Rosenkrantz & Mark, 2018; Yahya & Boag, 2014). According to a meta-analysis conducted by Whitley (2009), an individual's religiosity is a strong indicator of how accepting they are toward gay men and

lesbian women; higher religiosity was associated with less acceptance. This is largely explained by the ways in which religion is condemnatory towards those who fall outside the confines of heterosexuality (Whitley, 2009). However, this socio-religious context can result in culture-specific guilt for heterosexual and LGBTQ+ individuals when discussing or engaging in sexual behaviors, as well as fear of judgment and rejection from social circles (Harding, 2017; Rosenkrantz & Mark, 2017). When sexual or gender identity is outside of what is considered acceptable by family and friends, clients may fear being denounced or excommunicated by the people they hold dearest. This is particularly crucial in cultures that place high importance on social support from family members and peers.

For example, Nicole, a 33-year-old bisexual woman, had spent most of her adolescent and adult life having sexual experiences with both men and women but had only seriously dated men, and thus never felt the need to come out to family or friends. However, Nicole met Jeanne, a 32-year-old lesbian with whom she started a sexual and romantic relationship. Once the relationship got more serious, Nicole realized it was important to come out to family and friends, but also feared rejection due to her pattern of having dated men up until now; she feared that they would not believe her or would think that this was "just a phase" as is a typical response to the bisexual community (Rosenkrantz & Mark, 2018; Vencil, Carlson, Iantaffi, & Miner, 2018). She is presenting in sex therapy with difficulty reaching orgasm in her current relationship, and the cultural consideration of bisexual identity and outness to family and friends will be crucial to successful assessment and treatment. Nicole's case may become further complicated if her relationship with Jeanne were to end and she dated a man again, her bisexual identity may feel erased, a term referred to as "bierasure" (Crofford, 2018; Rosenkrantz & Mark, 2018; Vencil et al., 2018). Working with clients to normalize the importance of identity validation and address binegativity in therapy, it is advised to assess sexual history inclusively, to assess both or all partners' attitudes towards bisexuality, then assess the ways in which these issues impact the relationship (Crofford, 2018). Additionally, affirmative therapy is an approach that recognizes and validates client's sexual orientations, and can be particularly useful when dealing with those who, like bisexual individuals, face a particular form of discrimination such as bierasure (Crofford, 2018).

The social hierarchy of class is a cultural consideration that inordinately impacts the LGBTQ+ population and is often ignored or left invisible, in part due to imbalanced access to healthcare (particularly mental health care), especially in the United States. Historically, mental health care has been viewed as a luxury only available to those of higher socioeconomic status (Rodriguez, 1998) or considered non-essential. Class discrepancies also presented themselves through colorism (a form of prejudice in which individuals are treated differently based on the social meanings attached to skin color), whereby wealth and upper class status were attainable for white people, but not people of color (Rodriguez, 1998). Additionally, although there are now counseling practices, specifically sexuality counseling and therapy, available specifically for members of the LGBTQ+ community, they may not always be accessible because of these socioeconomic differences. The intersections of class and sexuality have been and continue to be complex, contributing to different social expectations, perceptions and realities for LGBTQ+ individuals.

Take for example the case of Shauna, a transgender woman of color who is seeking sex therapy to navigate her sexual relationships before she seeks gender affirmation surgeries (note: not all trans people will seek gender affirmation surgeries and it is important for clinicians to recognize this also as a cultural consideration). In most cases mental health care is still a requirement prior to access to gender affirmation surgery, and this can be a

barrier for trans people seeking medical intervention due to the cost-prohibitive nature of mental health care in the United States. By the time Shauna reaches a sex therapist, there may very well be built up resentment toward the mental health medical system, impacting the ease of building therapeutic alliance. A clinician who affirms and validates Shauna's frustrations with the system and provides systemic support that goes beyond sex therapy is particularly important when dealing with the intersection of class, identity, and race. Therapists can discuss the meaning-making Shauna has around her genitals that do not match her gender identity, the experience of sexual pleasure, and the fears and excitement of dating as a transgender woman. Importantly, the clinician is also tasked with not minimizing the fact that transgender women of color are the most vulnerable group due to living at the intersection of racism, sexism, and transphobia (HRC, 2018). Providing support to Shauna for this reality is a crucial cultural consideration of the sex therapist.

Compounded Identities. As has been discussed in multiple examples earlier, when multiple minority identities are combined (e.g., Shauna, a transgender woman of color), the oppression can affect people of color differently and individually (Rodriguez, 1998). This combination of minority identities is referred to as a compound identity (Balestrerey, 2012; Crofford, 2018; Midoun et al., 2015). Compounded identities are often highly unique, and come with their own individualized experiences of microaggressions and minority stress. Individuals experiencing discrimination for both race/ethnicity and sexuality are not only experiencing each separately, but also an amalgamation that is greater than the sum of its parts (Balestrerey, 2012). When seeking treatment for sexual issues, these experiences present themselves differently for everyone, so it is important to be mindful of this when working with those who are racially, ethnically, and sexually diverse (Rodriguez, 1998).

For example, Ricky is a transgender Hispanic queer man who is partnered with a cisgender white queer woman, Natalie. They have been together for almost five years and they met during the beginning of Ricky's hormonal transition and top surgery (he did not undergo bottom surgeries). They present in sex therapy with issues of Ricky engaging in multiple instances of infidelity over the course of the past two years of which Natalie has just become aware. In addition to the assessment that would be typical in any infidelity case, the clinician will also need to make multiple cultural considerations, including but not limited to expectations for monogamy within the context of queer culture, Ricky's processing of his life as a queer transman in a committed relationship, Natalie's experience in being there as a supportive partner through the transition, and the interracial components of their relationship and the impact of cultural experiences in family of origin on the relationship. Acknowledging the compounded identities for both individuals in this relationship and for the dyad as a whole will serve the uniqueness of Ricky and Natalie's individual and relationship dynamics.

Sexual Scripts. Script theory proposes that one way in which culture shapes sexuality is in providing a guideline for behavior throughout the course of a romantic relationship as it becomes sexual. Proponents of sexual script theory hold that groups of different individuals are trained from birth to maintain similar ideas and roles in sexual interactions (Gagnon & Simon, 1973). One dimension of many cultures where these scripts are particularly evident is found within gender. Women are expected to be sexual gatekeepers, determining whether sexual behaviors will take place, but not actually initiating or desiring these interactions (Gagnon & Simon, 1973; Sanchez, Phelan, Moss-Racusin, & Good, 2012). Conversely, men are expected to take the opposite role, and actively and doggedly pursue sexual interactions with women (Gagnon & Simon, 1973; Sanchez et al., 2012).

These sexual scripts can be highly detrimental to heterosexual relationships, where women who prescribe to these scripts may begin to feel unfulfilled, and the men unwanted (Sanchez et al., 2012). These scripts also inhibit sexual communication between partners, a crucial component of sexual well-being (Sanchez et al., 2012). For example, sexual scripts provide us with the message that men should have high sexual desire, and be ready and willing to have sex at all times. For a couple whose pattern does not fit this script – e.g., when there is a sexual desire discrepancy in which the woman in the heterosexual relationship has higher sexual desire relative to her male partner – it can be more difficult to communicate about this discrepancy due to its not following the typical sexual script (Mark, 2015). Within same-sex relationships, which have already violated many of society's norms and ideas surrounding sexuality and sexual behaviors, issues with sexual scripts tend to be less problematic and sexual equality is more readily established (Klinkenberg & Rose, 1994; Sanchez et al., 2012). However, same sex relationships may face a lack of comfort with the inability to fit societal scripts that are so entrenched in a heterosexist society, based on feelings of internalized homophobia.

Take for example, Amanda, a 48-year-old cisgender lesbian and Patricia, a 50-year-old cisgender queer woman, who have been together for 12 years. Although Amanda has identified as a lesbian since she was in her mid-20s, she still struggles with internalized homophobia rooted deep within her from her very conservative and religious upbringing in the Bible Belt of the United States. This is demonstrated through a lack of public displays of affection toward Patricia, reluctance to post any pictures of them together on social media, and hesitation from Amanda toward any real commitment beyond living together. This bothers Patricia because she sees it as a lack of acceptance of their relationship. After all, Patricia was raised in San Francisco by a single mother who herself identified as queer and a sister who was always open and affirming of Patricia's identity. The two seek sex therapy because they have been feeling more like roommates than romantic partners over the past few years due to their infrequent and passionless sex life. Amanda is the primary initiator of sex, but Patricia is so bothered by the internalized homophobia (that she takes as a personal offense) and is rarely interested in having sex. Additionally, Patricia is going through menopause and has found the physical aspects of menopause to detract from her sexual functioning, further reducing her desire to engage in sex with Amanda. Clinicians would benefit from being equipped with recognizing the struggle in this relationship related to internalized homophobia and/or discussing in depth the lack of comfort Amanda may have with the inability to fit societal scripts that are so entrenched in our heterosexist society.

Sexual minority individuals also may face discrimination, which can result in negative mental health outcomes. However, when sexual minority individuals are in satisfying and well-functioning sexual relationships, they are less likely to suffer from negative outcomes (Mark, Garcia, & Fisher, 2015; Vencil et al., 2018). Relationship interventions in mixed orientation couples can be effective in navigating relationship conflict stemming from internalized stigma and also impact the mental health of the sexuality minorities involved.

Gendered Expectations. Within the context of sexual scripts, sexually scripted behavior is often gendered with expectations that men are pleasure-seeking and women placate men's desires. The focus of sexual interaction becomes fixated on male pleasure and orgasm. As these expectations are so strongly ingrained, many women have reported engaging in unwanted behaviors with male partners, "going along with" unwanted behaviors and prioritizing male pleasure (Fahs & Frank, 2012; Herbenick, Schick, Sanders, Reece & Fortenberry, 2015; Kettrey, 2016; Rosenkrantz & Mark, 2017). Many women additionally

report guilt and shame when unable to please their partners, and a large number of women actually report experiencing pain during vaginal and anal sex, but also report continuing to engage in the behavior to fulfill the needs of their male partner; effectively prioritizing their partner's sexual needs over their own discomfort (Herbenick et. al, 2015). Gender expectations place women's pleasure and their physical and psychological comfort as less important than the pleasure and orgasm of their male partners. The internalization of these expectations can be highly detrimental to pleasure and the sexual experiences of women, and should be viewed as a cultural plane of conflict in dissecting the experience of sexual problems.

The sexual scripts and gender expectations dictated by culture can result in the negative judgment of individuals when these norms are violated. This is called a sexual double standard, and occurs when individuals are judged at varying levels of severity for engaging in the same (or similar) sexual acts (Jonason & Marks, 2009). Typically, in these instances, women are judged more severely than men for engaging in comparable behaviors (Jonason & Marks, 2009). Some argue that the sexual double standard is disappearing, but there is still evidence for this when examining uncommon behaviors like engaging in threesomes or other types of mixed-gender multi-person sexual behaviors (Jonason & Marks, 2009; Thompson, Hart, Stefaniak, & Harvey, 2018) and clients may be influenced by these double standards. Jonason and Marks (2009) examined the sexual double standard in multiple studies, and found that when depicted as engaging in mixed-gender threesomes, women targets were being derogated more than men targets described in engaging in threesomes with the same number of male and female participants. Additionally, Kelley and Bazzini (2001) found that when being evaluated on providing a condom, women providing a condom were judged more harshly than men providing condoms, and even more harshly than those not using a condom at all. Despite the continued evidence for sexual double standards, studies have also indicated the presence of a reverse double standard. This body of literature is demonstrative of a discrepancy in judgment in the ways in which members of Western societies are viewed for sexual behaviors and judgments toward women as sexual beings (Emmers-Sommer, 2014). This is highly detrimental to healthy sexual expression, but negative judgment seems to be engrained in our cultural context.

For example, Keisa is a 25-year-old mixed race cisgender heterosexual female who presents in sex therapy to navigate condom use and improve her assertiveness during sex. She is not seriously dating anyone, but she is sexually active. At her last gynecological exam, she found out that she has HPV and the doctor told her that she probably got it from having sex with a man without a condom. She has always had trouble being assertive with her sexual health because she was always told that it was the man's responsibility. However, this has led her to multiple situations where she has been uncomfortable and had wanted to use a condom but didn't have one with her and didn't feel safe voicing that need. A crucial discussion related to the cultural context of the sexual double standard would be helpful in this case and working with Keisa to build self-efficacy with sexual consent, condom use, and her autonomy as a sexual being worthy of experiencing sex for the sole purpose of pleasure.

Additional Clinical Implications

The cultural context as it relates to sex and sexuality are complex, as beliefs are sometimes flexible, changing over time, and differing from person to person within a cultural group, determining whether people believe certain behaviors are acceptable or not. Within

Western society, changing beliefs have resulted in higher acceptance rates of same-sex marriage and consensual non-monogamy, two examples of many issues that should be respected by sex therapists regardless of where they personally stand on these topics (Hinemann et al., 2016). It is the ethical responsibility of a clinician to refer a client to a more qualified therapist if they do not feel like they can offer unbiased assessment and treatment. Given the tendency for most people to be raised within a sex negative context themselves, due to a variety of factors including religion, conservatism, or fear of sex positivity, many psychotherapy training programs lack a specific focus on sexuality within the curriculum (Burnes, Singh, & Witherspoon, 2017). Additionally, even within programs with a specific curricular focus on sexuality, a sexual values clarification exercise or a sexual attitude reassessment can provide valuable insight into the personal boundaries of a clinician's ability to deliver ethical care.

Culture is influential in defining what is considered acceptable in sexual interactions by ascribing roles of participants based on gender, religion, class, geography, power, scripts, etc., and determining what is considered normal within the complex layers of intersectionality. Culture determines the number of sexual partners that are considered "appropriate," the age at which people marry and first engage in sexual intercourse, and the sense of belonging or self-actualization that may be derived from a meaningful sexual relationship (or not). Sexual problems can be impacted or even created by culture.

In assessment, the sexual genogram provides a unique opportunity to gain insight into the cultural influences outlined earlier. The specific focus of a sexual genogram to examine themes associated with sexuality in the client's family and relational history (Belous, Timm, Chee, & Whitehead, 2012) and is very useful to provide the context of the person's history with pointed questions related to how one's environment may have impacted their behaviors, attitudes, and relationships. The clinician can easily integrate questions to the genogram that provide cultural context necessary to gain insight into the role of culture in the presenting sexual problem.

As clinicians treating sexual problems are susceptible to the influence of social norms and cultural beliefs, it is only right to assume that they are not without their share of stigma or discomfort. Harris and Hayes (2008) found that even when educated on sexuality and sexual behaviors, some practitioners had difficulty beginning discussions on these topics with their clients. Dermer and Bachenberg (2015), also describe the need for increasing therapist knowledge of sexuality. Education alone on these areas is not enough to increase comfort with the topics, and clinical supervision paired with education can assist in mediating feelings of discomfort that practitioners may have when speaking to their clients on potentially stigmatized topics (Dermer & Bachenberg, 2015; Harris & Hayes, 2008). By considering treatment approaches in the context of culture, clinicians can work to become more comfortable with their own sexualities in addition to discussing those of their clients. Sex-positive approaches and curiosity-motivated conversation despite lack of comfort could also lead to increased representation and advocacy for sexual minorities, and result in healthier cultural beliefs surrounding these topics.

This chapter was not intended to address every possible cultural influence in sex therapy, as that would be an impossible task given how dynamic and ever-changing the sociocultural context can be. Some examples of additional sociocultural influences in sex therapy that may be relevant to clinicians to consider include intellectual disabilities, sexual surrogacy, sexuality in older adulthood, fetishes or kink, consensual non-monogamy, or other sexual expressions existing on the "fringe" of sexuality. Engaging in a values clarification exercise or sexual attitude reassessment can be helpful with exposure to

some of these experiences that are not perhaps part of a clinician's typical sexual script or cultural context. Lack of comfort or knowledge can result in clinicians having a fear of lack of cultural competence, but curiosity and openness to alternative experience can be strong. If a clinician comes into the session with what "normal" sex looks like, this might be invalidating, as the idea of "normal" in the context of sex therapy is inherently problematic.

Conclusion

Considering the broad variety of ways that culture can shape and impact sexuality outlined here, the two are inextricable. Culture contributes to people's perceptions of sex and sexuality and attitudes toward their own and others' sex lives, thereby determining what is considered functional or dysfunctional (Bhavsar & Bhugraa, 2013). Culture contributes to the way disorders are conceptualized, the way gender roles are informed, and what sexual behaviors and orientations are considered appropriate and valid. Cultures that hold strong disproval of certain behaviors or identities can result in negative feelings such as deep-seeded shame or guilt for clients, and genuine fear of clinician judgment of their perspectives or behaviors can be highly influential in seeking therapy. The incorporation of clinical approaches that consider the experiences, internalized norms, and cultural values of individuals to reduce stigma around sexual expression is crucial for effective therapeutic care. Although a thorough sexual genogram that integrates cultural influences of clients can be useful, it should not be substituted for engaging in conversation with the individual to determine their perspective on how their beliefs and experiences impact the sexual issues they may be facing. By incorporating culturally informed, sex-positive approaches to sex therapy, clinical practice is made more accommodating with better outcomes for people who need it most, regardless of their culture of origin.

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17

TECHNOLOGY'S ROLE IN SEXUAL RELATIONSHIPS

Impediments and Solutions

Katherine M. Hertlein and Afarin Rajaei

Prevalence of Technology in Daily Life

It is rare that we have a moment in our lives where technology is not used. In fact, increasing amounts of our personal time is spent interacting with screens, gadgets, and smartphones. Over the last 20 years, our lives (and most notably our communication methods) have been taken over by technology. Half of the world's population is now connected to the Internet, which was up by 10% compared to last year (Hootsuites, 2017). The use of social media has increased by 8% year-on-year to go up to 37%; considering a better context, it is mentioned that half of a billion of all 2.789 billion social media users came from mobile (Hootsuites, 2017). As a survey in 2017 showed, 50% of total world population use Internet; 37% are active social media users; 66% are unique mobile users; and 34% are active mobile social users (Hootsuites, 2017). Given the fact that the way we find partners and love, relationships have changed significantly over the last few decades, combined with the rise of the Internet and mobile applications, therapists need to understand the effect of these technologies on couple (and sexual) relationships. The purpose of this chapter is to review the ways in which technology affects our relationships, with a specific focus on sexual satisfaction. We will also explore how technology can be used to augment sexual relationships in positive and helpful ways.

General Use of the Internet and Social Media in Interpersonal Relationships

The birth of Internet and mobile communication has changed the nature of communication in the past few decades (Goodman-Deane, Mieczakowski, Johnson, Goldhaber, & Clarkson, 2016). Smartphones and tablets users have powerful attachment to their devices (Hertlein & Twist, 2018), with 37% considering themselves to be highly addicted (Harwood, Dooley, Scott, & Joiner, 2014; Ofcom Report, 2011). One study reported 63% of businessmen/women expressed difficulty not using smart device for even one day (Lesonsky, 2011). The ability to communicate through various electronic devices has numerous advantages including maintaining connection between geographically separated family and friends as well as increasing relationship well-being (Grieve, Indian, Witteveen, Tolan, & Marrington, 2013; Wang & Wang, 2011). Regarding social media use, those relationships where users post and give more information about what is happening in their relationships tend to have higher relationship satisfaction (Goodman-Deane et al., 2016).

On the other hand, some impact may be negative at times. For example, just having a phone present interferes with our cognitive processing (Thornton, Faires, Robbins, & Rollins, 2014). For example, Toma and Choi (2015) found that couples who post on each other's walls are the ones who do not stay together. A number of scholars have cited the inadvertent negative relational consequences of online communication including miscommunication and misunderstandings, inability to manage relational anxiety in the dyad, impaired commitment and relationship satisfaction via increased accessibility, and an imbalance between autonomy and independence with relational connection (Duran, Kelly, & Rotandu, 2011; Fox, Osborn, & Warber, 2014; Hertlein & Ancheta, 2014; Hertlein et al., in review).

The Couple and Family Technology Framework

According to the Couple and Family Technology Framework (Hertlein 2012; Hertlein & Blumer, 2013), there are several aspects of technology and new media that impact one's relationship processes including effects to relationship initiation, maintenance, and termination. For example, the accessibility of technology and the Internet can contribute positively to relationship initiation in providing an easily accessible way to meet new people. The affordability of such technologies makes it easier to access sexual material. The anonymity provided by communication behind a screen makes it easier to search for these materials and watch them without judgment from others. The way in which the Internet can approximate real-world situations allows a certain flexibility in sexual gratification, both in primary relationships and outside of them. In addition, the Internet is used to accommodate behavior that people would not normally do offline – for example, there are certain cases where men identify as heterosexual, but seek male partners online (Cooper et al., 2004). There is also a significant amount of material via the Internet that is ambiguous in nature – meaning there may be sexual undertones or not, depending on how the message is interpreted.

While the Couple and Family Technology Framework speaks more generally to the way in which technology affects many aspects of our interpersonal relationships, the main goal here is to focus on the ways in which these elements of technology and media will affect the sexual portion of our relationships. Consistent with the underpinnings of the Intersystem Approach (Weeks & Cross, 2004), we will also demonstrate how sides of the Sternberg's triangle and the theory or interaction by Strong and Claiborn (1982) also can be applied to understanding the impact of technology on the sexual and intimate life of a couple. Each of these will be discussed across the three process phases of the Couple and Family Technology Framework – relationship initiation, relationship maintenance, and relationship termination.

Relationship Initiation

Technology is used to connect with others and develop interpersonal (and romantic) relationships (Rosenfeld, 2018; Rosenfeld & Thomas, 2012). Throughout history, people have pursued assistance in meeting romantic and sexual partners. Today, online dating websites and applications one way to find and expand their relationships (Greenwood, Perrin, & Duggan, 2016; Sharabi & Caughlin, 2017; Statistics and Facts, 2015), despite the continued potential for deception on those sites that still exists (Lo, Hsieh, & Chiu, 2013). Since 2005, over a third of marriages in the U.S. happened after meeting online (Cacioppo, Cacioppo,

Gonzaga, Ogburn, & Vander Weele, 2013). People who meet online are likely to face a number of transitions, which may start with a significant milestone when partners decide to meet offline or face-to-face for the first time (Sharabi, & Caughlin, 2017).

Common reasons for using online dating includes 84% of users searching for a romantic relationship, 43% of users for friendly contact and 25% of users for sexual meetings (Statista, 2017). These sites also tend to orient more toward a male population and tend to be most popular for those aged 18 to 29. Another national survey among 1,001 adults by Pew Research Center pointed out that 12% of American adults have ever used an online dating site, which was more than 9% in 2013; and 9% of American adults have ever used a dating app on their smartphone (Greenwood, Perrin, & Duggan, 2016).

Approximately one in ten Americans have used an online dating site or mobile dating app themselves, and many people know someone else who uses online dating or who has found a partner through online dating (Greenwood, Perrin, & Duggan, 2016). The 2017 online dating site users expressed that online dating websites/apps help them find someone for a long-term relationship, marriage, and provide the opportunity to meet people who just want to have fun; also, they were able to pre-screen their dates as well as experience ease in conversations (Statista, 2017). Another survey in 2017 discovered that 66% of U.S. singles have used online dating to grow their dating pool (Statista, 2017).

In the emergence of social activity, people are shaping relationships with individuals whom they meet online (Bergdall et al., 2012). Some popular online platforms such as social network sites connect people who have been friends before (Ellison et al., 2007); on the other hand, there are other online dating sites, which bring together visitors who have no initial relationship with one another (Gibbs, Ellison, & Lai, 2010). Using online dating can lead to the lack of shared physical context and nonverbal cues, which creates uncertainty, ambiguity, and complications around the process of forming relationships (Gibbs et al., 2010). Therefore, development of Internet and online social activity in relationship formation involves concerns about participants' privacy and security, potential threats of identity theft, sexual predators, cyber stalking (Spitzberg & Hoobler, 2002), and misrepresentation (della Cava, 2004; Fischler, 2007).

Dating application (apps) use has increased in recent years, appealing to both same sex and heterosexual populations. There is no doubt that the popularity of online dating apps has increased significantly since its beginning. Dating apps, once stigmatized, are cited as a good way to meet people (Smith & Anderson, 2016). Tinder, for example, was among the first to come into the established heterosexual market (Duguay, 2016). In 2015, 15% of Americans reported having used a dating app or website, and it was threefold increased since 2013 (Smith, 2016). Further, an estimated 1.5 million using Grindr every day (Grindr Team, 2014). Mobile forms of identifying sexual or romantic partners have been popular among men who have sex with men as early as 2005. Uses include Bluetooth technology to cruise on public transport (Mowlabocus, 2010), which helps to promote the success of dating apps, thus fueling further use of such apps (Gudelunas, 2012).

Many factors play a role in the growth of online dating apps including advancement of technology and the number of available options (Johnson, Vilceanu, & Pontes, 2017). These apps usually provide search results based on location, which make them very popular (Bilton, 2014). Today, we have access to massive specialized digital dating resources such as, Grinder for Her (for lesbian population), Gluten-free Singles, a dating site for health-conscience people, and Ashley Madison (for those seeking extramarital affairs) and this goes up to over 500 dating-related applications on iTunes (Wells, 2015).

These apps are designed to provide a space for users to create individualized profiles with pictures and brief descriptions of themselves, locate other users in their area, and message potential partners (Holloway et al., 2014; Phillips et al., 2014; Rice et al., 2012). Although mobile dating arises concerns about misrepresenting of self to potential partners and introduce safety issues (Guadagno, Okdie, & Kruse, 2012; Lo, Hsieh, & Chiu, 2013), some apps' success such as Tinder shows they could moderate those problems (Duguay, 2016).

Relationship initiation online is certainly fueled by the last area, sociodemographic factors. The commonplace nature of online dating and meeting would certainly affect how one uses dating apps or online dating sites in the early stages of the relationship. There may also be individual psychological factors that contribute to using dating apps and dating sites in the early stages of relationship seeking or seeking of a sexual partner. For example, early research in technology focused heavily on the type of people who were using such technologies, with a great deal of the findings centered around those who are more anxious interpersonally are more likely to text (Reid & Reid, 2007); further, those who are more shy feel more comfortable when their conversations are online versus face-to-face (Hammick & Lee, 2014).

Relationship Maintenance

Unfortunately, the beginning of a relationship is not the only time that apps are used. Instead, there are still a fair number of individuals in committed relationships who still maintain dating apps on their phones once they enter a relationship. Hertlein et al. (in review) conducted a study evaluating the presence of dating apps on cell phones and their connection to relationship outcomes. The data revealed that those who maintained dating apps on their phones after becoming involved in a committed relationship reported less trust in their relationship, lower levels of commitment, and lower levels of relationship satisfaction. They also noted higher levels of technology interfering in their relationships. Such findings correspond with the underpinnings of the Intersystems model – Sternberg's (1986) triangle – in that commitment is one of those core elements of a relationship that contribute to its overall success. There are certainly ways to improve commitment and intimacy in one's relationship using a phone – but it seems that maintaining dating apps on one's phone after a relationship has been formed is not one of them.

Communication technologies can also allow positive connection to others in a variety of ways (Jin & Park, 2010). One important aspect of maintaining relationships is developing rituals (Campbell, Silva, & Wright, 2011) and computer-mediated communication is used as a supplement to face-to-face communication to maintain rituals and relationships (Billedo, Kerkhof, & Finkenauer, 2015). Social networking sites play an important role in maintaining relationships among the different forms of computer-mediated communication (Papp, Danielewicz, & Cayemberg, 2012). The chance to communicate everyday through social network sites makes this option helpful in relationship maintenance (Billedo, Kerkhof, & Finkenauer, 2015; Tong, & Walther, 2011). The public platform of social network sites provides opportunities for public affections and mutual belonging (Tong & Walther, 2011; Utz & Beukeboom, 2011). Further, one can see their partner's social interactions with others with relative ease (Tokunaga, 2011; Tong & Walther, 2011). There are, however, contradictory arguments about the influence of technology on maintaining relationships; for example, Fox, Osborn, and Warber (2014) noted people disagree about what would be considered acceptable maintenance behavior for couples on

Facebook. Some participants did not agree that conversations over social networks were the same as having a face-to-face conversation. In such cases, thoughts of what is acceptable to express on social network sites varies, and couples may struggle with different discourses of expression. Studies around conflicting perceptions point out that in the maintenance area, sociocultural discourses are still growing, and interpersonal-level discourses may dominate (Clayton, Nagurney, & Smith, 2013; Fox, Osborn, & Warber, 2014).

This information suggests that there may be dyadic factors that contribute to the way in which phones may be used in relationships. With or without phones, couples struggle with both expressed and implied expectations, live under rule systems of which they may not be aware, have particular power dynamics in relationships that play out in the bedroom and rules around phones, etc. In fact, many couples report that they do not have rules in their relationship regarding phone usage, but agree that rules should be provided to other couples (Duran, Kelly, & Rotaru, 2011), despite that cell phone rules in relationships do make for improved satisfaction (Miller-Ott, Kelly, & Duran, 2012). Intimacy and commitment in the relationships can be enhanced through using phones in appropriate and supportive ways.

Relationship Termination

There is little known about the overlaps between online and offline behaviors in ending relationships (Elphinston & Noller, 2011). Gershon (2010) discussed the complexities of ending relationships in the world of digital technologies. Gershon (2010) stated media usage during a breakup is created by media ideologies, or "a set of beliefs about communicative technologies with which users and designers explain perceived media structure and meaning" (p. 3). These media and technology ideologies affect how people react to breakups on online platforms such as Facebook, or Instagram. In fact, the more people view Facebook, the greater distress, negative feelings, sexual desire, and longing for the ex-partner, and lower personal growth after the breakup occurs (Marshall, 2012). In other words, on social network sites, people leave behind digital footprints in various ways such as, text exchanges, photos, posts, and likes, which will increase their sadness when they review them during breakups since they remind people of a happier time in the relationship or the painful breakup (Marshall, 2012; Van Dijck, 2007).

Therapeutic focus might be on the individual psychology of each couple in how they are responding to the termination. For example, someone suffering from a personality disorder might opt for "ghosting" (not responding to another's communications toward you) whereas someone else might opt for an extended communication and electronic boundary setting as a way to manage the termination. What is not clear, however, is how graphic information such as the exchange of nude photos might be used after a termination. As aforementioned, the accessibility of the Internet to have such materials available for use at a later time, even after the relationship has been terminated, impacts how they respond to the termination. This accessibility might create an electronic memento of the relationship potentially making it more difficult to move past the termination for either party.

Sexuality and Technology in Couples

Sexting

In addition to invading our private lives, technology has also invaded the bedroom and in particular, our sexual relationships. The literature supports the positive impact texting can

have on a romantic relationship in terms of communication (Coyne et al., 2011; Luo, 2014; Luo & Tuney, 2015). Sexually-explicit or suggestive texts (or sexts; Lenhart, 2009), might also hold some benefits for relationships. Some notable benefits include the ability to be able to maintain the physical portion of a long-distance relationship (Hertlein & Ancheta, 2014). Sexting would also allow established couples to be able to enhance or "spice up" their sexual relationship be allowing them to electronically imagine and electronically experience activities via the Internet they would not typically do in their offline lives (Hertlein & Ancheta, 2014; Parker, Blackburn, Perry, & Hawks, 2012).

The engagement of sexting in a relationship, however, has a different impact based on sociodemographic and cultural characteristics. Specifically, there is a tendency for those who identify as heterosexual women to experience negative consequences if they do not return a sexually-explicit text message; the same is not true, however, for men and non-heterosexual women, who do not experience negative consequences (Currin, Jayne, Hammer, Brim, & Hubach, 2016). Sexting also has some associations to attachment: those who are anxiously attached may initiate sexting as a way to obtain reassurance (Weisskirch & Delevi, 2011). Specifically, they may reach out to have their partner to solicit nude photos or sexually-explicit material, as a way to feel that their partner is thinking about them, as well as believing that sexting will improve their relationship (Weisskirch & Delevi, 2011).

Outside of sexting there are other ways that technology and sexuality can augment a couple's relationship. Technologies such as Real Sex and other software programs can assist a couple with achieving sexual pleasure through downloading videos and stimulating the user in time with what is occurring in the clip. Realbotix, for example, is one such company that advertises that the user can have a real artificial intelligent experience (Realbotix, 2018). Artificial intelligence companies develop programs that facilitate interaction between men and machine. Artificial intelligence has countless applications, included among them: conversational skills, teaching and learning activities, problem solving, information database and much more (including sexual gratification).

Finally, technology and the Internet may also fuel sexual initiation in non-established couples. A number of websites and apps are designed to promote and facilitate "hook ups." Individuals who meet one another offline are more likely to marry than those who meet online (Paul, 2014). A primary characteristic of the relationships developed via technology and media is the fact that relationships develop more quickly, whereas relationships that develop offline do so over longer periods of time, thus making the relationships more stable. In addition to online relationships being subject to breakup, there may also be significant consequences to one's physical health. Specifically, the more people engaged in online interactions to meet another, the more likely they were to increase their risk to STIs and the riskier their sexual behavior was generally (Cabecinha et al., 2017).

Sexuality with Couples of Diverse Backgrounds

As mentioned earlier, meeting online as a key strategy to obtain a partner is becoming very commonplace. In fact, it is the most common way to meet a partner in the lesbian, gay, and bisexual community (Cabecinha et al., 2017; Rosenfeld & Thomas, 2012). Such apps may also be an important mechanism for those in polyamorous relationships to find additional potential partners. In same sex-oriented individuals, sexting is a more accepted practice in their relationships as compared to bisexual individuals and heterosexual individuals within their relationships (Hertlein, Shadid, & Steelman, 2015; Twist, Belous,

Maier, & Bergdall, 2017). Sexting is also used among youth as a space to begin to establish their identity (Albury & Byron, 2014).

Therapeutic Dilemmas

As much as therapists also live in a society with cell phones, Internet, etc., couple and family therapists tend to be woefully uninformed about the role of technology both in the business end of their practices (Blumer, Hertlein, & VandenBosch, 2015) as well as the ways in which their clients are using technology in their personal lives and relationships. Therapists need to be clear about what their clients are actually doing and know what questions they need to ask to get the information they need. The field of couple and family therapy is harangued by the mandate that therapy only counts if in person (an accreditation standard in place in training programs). In addition, the American Association for Marriage and Family Therapy's attempt to outline best practices for MFTs regarding online practice (Caldwell, Bischoff, Derrig-Palumbo, & Liebert, 2017) is insufficient in describing the way that technology is changing our practices, especially when compared with standards and competencies drawn up by similar professions such as social work and counseling (Hertlein & Earl, in preparation). As a consequence of devaluing technology in their practice, the profession may be communicating the message that technology does not matter at all. Such a position may lead therapists away from asking critical details about phone and technology usage.

There is also a potential for countertransference in these cases. Therapists, like the rest of the world, are connected to the world through their phones. To ask an individual to alter their phone usage may prevent therapists from acknowledging the behaviors they may be doing on their own with their phones or their partners. In addition, therapists have an implicit bias when technology enters the clinical pictures – research has shown, for example, that therapists who are younger and those who are more religious tend to treat Internet infidelity with first-order as opposed to second-changes. For example, common first-order change strategies include moving the computer to the other room and proscribing individual therapy, as compared to second-order interventions (such as couple therapy to address dissatisfaction and neglect) which may be more appropriate (Hertlein & Piercy, 2008). These are classic examples of countertransference related to the machine – not the client – interfering with treatment.

A final therapeutic dilemma is how to resolve the issue of defining infidelity or behaviors that would break the relationship contract. In the case of Internet infidelity, couples present in treatment with very different ideas about what constitutes infidelity, or whether the infidelity occurred at all given the ability for one to delete histories (Hertlein, Dulley, Chang, Cloud, & Leon, 2017). In the age of the Internet, the definition of what constitutes infidelity varies from person to person – and often, couples do not have the conversation of what constitutes infidelity in a digital age when they identify that they are in an established, exclusive relationship. Couples intuitively know that physical sexual contact with another person would constitute infidelity – but rarely do they have conversations around porn usage, swapping electronic messages with exes, friends, watching pornography, etc. The dilemma for the therapist is that one partner claims the other cheated; the other claims there was no physical contact and thus, no breach. If the therapist joins with the partner who felt betrayed, the therapist may not be able to join with the partner who claims they did not breach the contract. On the other hand, if the therapist joins with the individual who was claiming to be involved and suggest that since there was no physical

contact there was no breach, the partner feeling betrayed will terminate services. Resolution to this dilemma relies on the therapist looking at the big picture and getting the partner accused of being involved to, independent of the reason, acknowledge that their partner, for whatever reason, feels betrayed, and to begin work from that common point (Hertlein, Dulley, Chang, Cloud, & Leon, 2017).

Integrating Sex Therapy with Technology

Taking a Sexuality-Focused Technology History

While there are many areas of taking an inventory for therapeutic purposes, a technology inventory with a sexuality focus can greatly enhance the opportunities had to intervene. While there are many areas of taking an inventory for therapeutic purposes, a technology inventory with a sexuality focus can greatly enhance the opportunities had to intervene; for example, using a focused genogram (Weeks, Hof, & DeMaria, 1999). In addition, therapists can take a technology-focused genogram (Blumer & Hertlein, 2015). This type of genogram adopts the position that technology is an individual entity and acts like another family member in the system, and encourages family members to both acknowledge this position and make decisions with this awareness. The technology-focused genogram also looks at patterns in the relationship not just within the immediate family, but patterns among technology usage in the family more generally. For example, one member of a couple may recall that their father spent a great deal of time involved with technology and on cell phones – a pattern so entrenched in the family that it shaped this individual to operate the same way, much to the chagrin of his partner. In this case, the desire to be loyal and close to one's family might underlie the use of the cell phone rather than other factors.

Taking a Technology Inventory

The way in which an inventory is used is different than history or the genogram, where the couple evaluates how the computer is situated in the couple or family system. The technology inventory seeks to understand the way that technology is currently used in the couples' relationships. In the case of sex and sex therapy, the inventory can be around what type and frequency of usage is acceptable in each couple. In one case example, Carly and Max, a professional couple, came to therapy to discuss the problems in their marriage, including in their sex lives. As they discussed their sex lives, Max noted that Carly liked to use her phone to view pornography prior to having sex. It allowed her to, in her words, "warm up" and she was better able to achieve orgasm when paired with viewing pornography prior to having sex. Using technology in this way helped the couple to use technology as foreplay as well as to improve the quality of their sexual interaction. The couple also experienced more negotiation in their relationship as they both began to work together to select what type of videos would be viewed prior to sexual play.

In order to best assess a couple's individual use, critical elements of the inventory include:

- Number of apps downloaded
- Number of apps used (may be different than ones downloaded)
- Function of apps used

- Location of the phones and screens during bed time
- Bed time routine
- Couple's routine to stay connected – both offline and online or over text/email
- Who has access to devices and passwords
- Appropriateness of the apps on one's phone or both the person and their relationship health
- Definitions of what constitutes infidelity
- Flexibility of each member of the couple as it pertains to roles, rules, and structure in the relationship

In this inventory, the therapist is looking for the elements in the relationship that would be vulnerable to the effects of technology as well as areas where technology could be used for improvement in the couple's relationship. Some areas that speak to the way in which the couple might be able to build bridges include whether they have the same apps – for example, couples can spend time during a busy workday both engaging in a five-minute meditation offered from the same app. They may be able to share musical playlists together to listen at the same time as a way to feel connected or even create and contribute to a collaborative electronic journal. In addition, the couple may share pornography pictures online while they are together in bed rather than engage in independent screen time. These are just a few suggestions, and certainly once the therapist has the landscape of what constitutes the couple's sexual relationship and app usage, they may make recommendations to bring the couple together using technology.

In addition, the therapist is looking for the presence of any sexual dysfunction that may be ameliorated or at least improved through using media and the Internet (Hertlein, Nakamura, Arguello, & Langin, 2017). For example, Internet technologies allow us to be able to approximate real world situations. In cases where people are aversive to sexual situations the Internet can be used to work towards helping them to desensitize and reduce their anxiety in sexual situations. The Internet may also be used as a tool for increasing desire as it provides a wealth of images that one may find sexually gratifying. As in the case of the couple mentioned earlier, pornography was used as a way to better achieve orgasm with one another.

Checking for Change

Literature on technology and couple relationships primarily focused on the impact of technology on relationships (Hertlein & Ancheta, 2014; Hertlein & Webster, 2008). The studies have been split in their focus – some focus on the positive uses of technology in relationships and others focus on the negative. For the positives, as mentioned earlier, the enhancement in one's sexual relationship is a key factor in why people use technology (Hertlein & Ancheta, 2014). Checking for change means the therapist needs to revisit the app choices and connections that the couple has made to both ensure compliance with treatment as well as to see how these changes are affecting the couple's relationship.

Research studies over the past decade has shown positive aspects of using technology and Internet in relationships; for example, Pettigrew (2009), reported specific use of text messages help couples stay connected throughout the day while increasing their communication. Other scholars mentioned similar findings that partners expressed the importance of accessibility of one's spouse in an emergency situation, or if a partner was dealing with stress (Dietmar, 2005; Döring & Dietmar, 2003; Parker et al., 2012). These results

provide awareness for couples to connect to fulfill functional and emotional needs within the relationship; for example, the possibility for communicating information without other parties overhearing, or opportunity to increase flirtatious communication with the sense of secret contact with one another (Hertlein & Ancheta, 2014). A large number of researchers have mentioned the effectiveness of text messaging and email for individuals and relationships – for example, texting as a tool to maintain their relationships, whether to stay in contact or express emotions (Bauer et al., 2012; Castañno et al., 2012; Shapiro et al., 2010; Watkins, Smith, Kerber, Kuebler, & Himble, 2011).

Yet there are other concerns that occur regarding trust and transparency in using technology in relationships. With the increasing contiguity of electronic intimacy and even virtual sex, it is important to define what it means to have an affair or be unfaithful to a partner and if the effect of virtual infidelity on a relationship is the same as the usual affair of the past (Schneider, Weiss, & Samenow, 2012). The cybersex user's sexual activities could bring emotional distress to a partner, whether the user themselves deems the behavior as problematic (Schneider, Weiss, & Samenow, 2012). This is especially problematic when a couple disagrees about what actually constitutes infidelity (Hertlein, 2012; Jones & Hertlein, 2012), as that will prevent the treatment process from moving forward in a meaningful way.

One of the most challenging things about treating affairs mediated by communication technologies is the assertion by one partner that the affair is tied to the device rather than issues in the relationship or within the partner who became involved. What is equally problematic is this misconception is not held only by clients, but also by therapists (Hertlein & Piercy, 2012). The position that the problem resides in the technology rather than the use of technology is a set up for failure, again, because the Internet is accessible everywhere. In treating the affair, the therapist must continue to operate from a systemic perspective while addressing areas related to technology and phones that might fuel the issue or further the trauma. For example, it is common for the betrayed partner to set up a GPS system on their partner's phone to track their movements. While this might initially provide temporary reassurance, it is not a dynamic that will work long term for the couple: there are other ways to use technology to improve the relationship other than for surveillance.

Psychoeducation

A major advantage of the Internet is the sheer amount of information accessible at our fingertips. Due to its searchable nature, therapists and clients can identify what skills need to be honed and use the Internet as a way to find helpful and accurate information about certain processes. For example, for couples with an interest in sexual skill building, the advent of the Internet to host pornography videos on one's phone may be an important adjunct in one's sexual relationship. Specific strategies might include viewing porn while in bed with their partner as a way to be in a sexual encounter or to show one's partner your sexual preferences, likes, and dislikes.

Conclusion

As technology and the Internet continue to shift our communication and connections patterns, couples need to be one step ahead of the technologies in order to ensure these technologies can be used to their relational advantage. In the case of sex therapy, ecological

elements of the Internet and media provide avenues to emboldening couples relationships, both in areas of physical and emotional intimacy. Specifically, couples can use the Internet and smart phones can play a central role in relationship initiation, relationship maintenance, and relationship termination. Finally, these elements can assist with changes to a couple's sexual activities, intimacy level, and perceived commitment to each other.

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CONCLUSION

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The major purpose of all three editions of *Systemic Sex Therapy* is threefold. First, we want to present our theoretical approach for understanding the etiology and treatment of sexual dysfunctions. We revised some parts the formulation of the Intersystem Approach. This update stresses the need to simultaneously understand any aspect of human sexuality and dysfunction from the five domains described. Attachment styles were added as a new integrational construct. This new construct should strengthen the focus on the intergenerational domain and enhance the link between intimacy and sexuality. The second purpose is to demonstrate the utility of this approach in the assessment and treatment of all the major sexual dysfunctions. The treatment chapters clearly demonstrate how etiological factors can manifest in all domains of the Intersystem Approach and how treatment is tailored such that each of the causative factors can be dealt with most appropriately. By viewing the dysfunctions multi-causally, a variety of treatment modalities and techniques within those modalities can be combined in order to provide an integrative and systemic approach to treatment. Third, an implicit goal of this text as well as all our prior texts on sex therapy preceding it, has been to continue a paradigm shift in the field of sex therapy from one that has been predominately individualistic/cognitive behavioral to one that is systemic/relational/integrative. Because the bulk of our work has been published in books, it usually does not appear in literature reviews nor is it cited unless the authors are familiar with the field of sex therapy and the texts within the field. Although our texts are now used in many training programs in Couple and Family Therapy (CFT), they may not be acknowledged outside the field.

Binik and Meana (2009) were two of the first authors to sound the alarm about what was lacking in sex therapy. They believed the field of sex therapy did not have a unified underlying theory, a set of specific practices that were exclusive to only the field of sex therapy, or evidence-based practices. However, by 2009, Weeks and his colleagues had published three texts (Weeks & Hof, 1987; Weeks & Gambescia, 2000; 2002) advocating for the integration of sex and couple therapy and the use of the Intersystem Approach in understanding and treating erectile dysfunction, lack of sexual desire, and other problems.

Theory development in sex therapy has been lacking. Jones, Meneses da Silva & Soloski (2011) developed "sexological system theory" as a model for treating sexual problems. It was very much like the biopsychosocial approach of Engel (1977; 1980) that has been used in the field of health care, especially psychiatry and psychology. Another strictly theoretical conceptualization for doing sex therapy was developed by Derby, Peleg-Sagy, and Doron (2016). This theory stressed an in-depth and integrative understanding of the client's

difficulties and needs. Neither of these two theories gained much traction in the field of sex therapy, if we exclude sexual medicine.

Jones, Johnson, Wenglein, and Elshershaby (2018) described a 17-year content analysis of 13,919 articles published in 15 couple and family therapy journals. Only 137 focused on sexuality or sex therapy. Their review disclosed a number of themes, which we have addressed since 1987: a lack of focus on the relational etiology of sexual problems, the lack of integration of sex and couple therapy, and the lack of training and supervision of sex therapy in CFT programs. More specifically, they found only seven articles on the integration of sex and couple therapy with the earliest being published in 2008. This review did not include books such as ours, which explicitly advocated for this integration as early as 1987. It is difficult to conceive that the field of marriage and family therapy has, in the last 17 years, only given consideration to the role of sexuality and sexual dysfunction in only 0.01% of its publications. One of the main conclusions of the Jones, Johnson, Wenglein, and Elshershaby (2018) article was that CFTs are in a unique position to understand and treat sexual problems from a systemic perspective. As such, all CFTs should be trained to assess and treat problems within all client systems, especially when sexual intimacy concerns are presented. Additionally, a number of articles advocated for the use of biopsychosocial approaches, the integration of medical therapies with talk therapies, or sex therapy. For example, Kingsberg and Althof (2018) and McCarthy, Koman, and Cohn (2018) described the use of the biopsychosocial approach to treating low desire. Berry and Berry (2014) were explicit in saying an integrative biopsychosocial approach was needed in treating erectile dysfunction. In addition, Hongjun, Gao, and Wang (2016) discussed the importance of fully involving the spouse in managing erectile dysfunction. They understood that working with the couple was essential for understanding the problem and achieving the best outcome (Mobley, Khera, and Baum, 2017).

For many years there has been a debate over the medicalization of sexology. Almas (2016) conducted a literature review of this debate between 2001–2010. Two interesting themes addressed the definition of sexual medicine from its inception to its current conceptualization. There is the binary view that sexual medicine is something that a medical doctor performs, mostly through diagnosis and pharmacological intervention. A much broader definition of sexual medicine involves talk psychotherapy with medical therapies. Most importantly, there has been a trend in sexual medicine to recognize that the most successful approach to sexual problems integrates the biopsychosocial within the field of sex therapy.

Althof (2006) may have been the first author to develop a conceptual paradigm for what he called combined therapy. He believed that combining medical and psychological interventions would produce the best outcome. Since then a number of authors with a sexual medicine background have proposed a biopsychosocial approach. Brotto, et al. (2016) discussed the psychological and interpersonal dimensions of sexual function and dysfunction. The biopsychosocial approach was advocated by Berry and Berry (2013) in a review of theory within the sexual medicine field. Mark and Lasso (2018), using a biopsychosocial model performed research on how sexual desire is maintained in long-term relationships. Another surprising model for understanding women's genito-pelvic pain was published by Rosen and Bergeron (2018) who found that a woman's ability to regulate her level of pain was based on "interpersonal emotion regulation" (p. 1559). Rather than view pain from an individualistic point of view, they proposed that the couple's awareness, expression, and experience are central to how pain is experienced. Apparently, authors coming from a sexual medicine perspective have been more interested in a biopsychosocial model than those coming from a psychological perspective.

The biopsychosocial model is similar to the Intersystem Approach in that it directs our attention to the biological, psychological, and social. The Intersystem Approach, however, is more directed to understanding the couple's role in the creation, maintenance and treatment of sexual disorders. This approach underscores the necessity of integrating couple and sex therapy. The Intersystem Approach also directs us to the intergenerational understanding of sexuality and sexual dysfunctions. For example, experiences in the family-of-origin, the transmission of attachment styles and messages about sexuality passed from one generation to the next may play an important role in the expression of love, sex, and intimacy. Finally, in the IA, larger cultural, political, social, religious, and environmental systems may impact how sexuality is learned and expressed. The therapist or researcher is inspired to understand sexuality from all dimensions; thus, it is comprehensive and integrative of all domains of the human experience. Clearly, the Intersystem Approach is a more ambitious model and one with more specific foci that are directly relevant to our understanding and treatment of sexual problems.

The unfortunate reality is that most therapists are well versed in one modality such as couple therapy or individual therapy and may be familiar with a limited number of preferred treatments within that modality. This is evident to us throughout our combined years of teaching and supervising psychotherapists. With such limited training in numerous approaches, the therapist is chronically underprepared to tackle the complexities of systemic sex/relationship issues. We are fortunate to help with the expansion of the therapist's conceptual framework and clinical repertoire through our publications, teaching, and supervision of therapists who are aware of the limitations of a singular approach to psychotherapy. In one postgraduate program for CFTs in Philadelphia, Council for Relationships, all courses, including three sex therapy courses are taught using the Intersystem Approach. This program facilitates the personal development of therapists and the expansion of their knowledge base and clinical repertoire. Graduates are strong clinicians and fully prepared to perform sex and relational therapy-not one or the other. Gradually, the Intersystem Approach is being used throughout the United States and in Europe as more therapists recognize the value of a comprehensive and integrative approach to all client systems.

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