Sexuality Counseling Guidebook

Key Issues for Counselors and Other Mental Health Professionals

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PROLOGUE

This guidebook was written by graduate students in the Department of Counseling and Educational Development at The University of North Carolina at Greensboro. All of the students involved were enrolled in an advanced couple and family counseling course on sexuality counseling at the time of the project. Each chapter reflects the independent work and ideas of each contributor based on his or her review of relevant research. As such, the ideas contained within each chapter do not necessarily reflect the opinions and beliefs of the other contributors, the course instructor, or the Department of Counseling and Educational Development.

The purpose of this guidebook is to serve as a resource for counseling students and professional counselors when they provide counseling related to a wide range of sexuality-related issues. The general theme of this guidebook is to help counselors promote positive sexual health and positive sexual relationships through their work with clients. To that end, the contributors to this guidebook provided reflections to the following questions:

What does it mean for an individual to have positive sexual health?

There are many different aspects of positive sexual health. It includes a person viewing their sexuality as more than just physiology, including emotional and mental aspects as well. A person with positive sexual health stays well-educated regarding issues such as safe sex practices, regular STD testing, and recommended physical health exams. A person with positive sexual health has positive self-esteem, a positive view of their sexuality, and well-defined personal boundaries that have been established through self-exploration. Having a person with whom to talk about sexuality can foster positive sexual health for individuals.

--Angel Coldiron, Christine Mulcahy, and Thea Vondracek

What does it mean for a couple to have a positive sexual relationship?

Couples can establish and maintain positive sexual relationships by engaging in open communication about sex and by developing a willingness to grow and to change. The couple's sexuality is expressed in an environment infused with trust, respect, safety, and security. Both individuals are working toward understanding, accepting, and appreciating their own and their partner's sexuality.

--Anne Buford, Sarah Moxley, and Eric Spencer

What are the most fundamental strategies counselors can use to help clients develop positive sexual health?

Clients present with a variety of sexual issues. However, the following list provides counselors with basic counseling goals to assist clients in fostering positive sexual health:

- *Developing a positive self-image*
- *Increasing self-esteem*
- *Providing education that highlights the emotional qualities of sexuality*
- *Promoting self-respect*
- *Offering a safe environment for clients to discuss their sexuality*

--Jennie Gouker, Ebony Smith, and Mario Sacasa

What are the most fundamental strategies counselors can use to help couples develop more positive sexual relationships?

The following are strategies counselors can employ to facilitate healthy sexual relationship. A non-threatening, non-judgmental environment with a neutral therapist is necessary for openness to discuss sexual issues. A complete biopsychosocial history for each individual aids the counselor's holistic understanding of the couple's issues. Counselors view sexuality as one factor of a healthy and intimate relationship, not merely a dysfunction, and emphasize all aspects of intimacy within the partnership. Normalizing the changing sexual relationship validates the couple's experience.

--Laura Harbeson, Melissa Mekita, Caren Miller, and Elizabeth Trump

We hope that this guidebook is useful to you in your work!

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Chapter One

Sexuality Counseling with Sexually Promiscuous Adolescents

By Angel Coldiron

1. What is the definition of adolescent sexual promiscuity?

Adolescent sexual promiscuity is defined as individuals who are between the ages of 13 and 19 who are sexually active with more than one person (Kotchik, Shaffer, Forehand, & Miller, 2001). Promiscuity is further defined as being indiscriminate in the choice of sexual partners. Sexually promiscuous adolescents can be very casual and random in the people they choose to have sex with, when and where they have sex, and the number of sexual experiences they have (Kotchik et al., 2001).

There is a negative correlation between sexual promiscuity and contraceptive use (Davies et al., 2006). Therefore, adolescents who are sexually promiscuous tend to have a greater number of teenage pregnancies and sexually transmitted infections (STIs). The Guttmacher Institute (2006) related that most adolescents have sex for the first time at the age of 17 but do not marry until their middle or late 20s. Subsequently, adolescents and young adults are at risk of STIs and unwanted pregnancy for a decade.

2. How widespread is adolescent sexual promiscuity?

Researchers (Kotchik et al., 2001) have gathered data that stated in the United States, 46% of 15- to 19-year-olds have had sex at least once. While having sex at least once is not technically considered sexual promiscuity, having sex for the first time typically results in having multiple partners. In fact, the earlier the age of first sexual intercourse, the more partners one will have during adolescence (The Guttmacher Institute, 2006). By the time adolescents graduate from high school, half of them will have begun having sex (Futris & McDowell, 2002).

3. What is the typical developmental course of adolescent sexual promiscuity?

When individuals enter puberty, they experience physical growth and hormone changes that initiate sexual feelings. Their sex organs are maturing in preparation to be able to procreate and generate new life. Typically, adolescents' first sexual experiences primarily involve foreplay; however, after some time, the adolescents go beyond foreplay to having sexual intercourse. The Guttmacher Institute (2006) related that females participate in sexual intercourse to express feelings related to love while males are inclined to have sex for pleasure. More than 75% of adolescent females reported that their first sexual experience was with a "steady boyfriend, a fiancé, a husband or a cohabiting partner" (The Guttmacher Institute, 2006). The females reported that they became sexually promiscuous after these relationships dissolved.

Certain factors place adolescents at a higher risk of engaging in sexual activity (Futris & McDowell, 2002). If the adolescents perceive their peers to be sexually active, they are more likely to engage in sexual activity, especially at earlier ages (Upadhyay & Hindin, 2006). Adolescents who have older siblings who engage in sexual activity are more likely to be sexually active because they see their sibling having sex as giving them permission to do so (Futris & McDowell, 2002). Adolescents who live in a single-parent home are more likely to engage in sexual activity than those with two-parent homes. This is due to lack of supervision in a single-parent home as well as added stress of living in a home without two parents. The time of pubertal development also affects the risk of engaging in sexual activity. The earlier the development, the more likely the adolescent will hang around an older crowd and be influenced to participate in sexual activity. If friends are part of a deviant group of peers in that they use substances and/or are delinquent, they are more likely to engage in risky sexual activity. If the adolescents use alcohol and drugs, they are at a greater risk for promiscuous sexual activity that is unsafe. Sexual abuse is a key predictor of adolescents participating in sexual promiscuity. If they have experienced involuntary sexual activity such as sexual abuse as children, they are more likely to begin

having sex at an early age, usually have more sexual partners, and are less inclined to use protection when having sex (Futris & McDowell, 2002).

4. What impact does being sexually promiscuous have on the adolescents involved?

Being sexually promiscuous can have many consequences for the adolescent. Because of multiple partners and the lack of protection, adolescents are at a high risk for STIs and pregnancy. Futris and McDowell (2002) found that a staggering 8 million cases of STIs are reported each year for individuals under the age of 25, and the highest rates of chlamydia, syphilis, and gonorrhea are found among adolescents aged 15-19. They also found that in the United States, nearly 20% of sexually active adolescents become pregnant each year which results in nearly one million 15-19-year-old pregnant females each year.

There are many emotional and mental issues that surface when adolescents become sexually promiscuous. Depending on the particular adolescents, they may experience low self-esteem, depression, feelings of worthlessness, and feelings of being unlovable among other feelings. Typically, there is a lot of guilt and shame that surrounds being sexually promiscuous. There is often an underlying fear of becoming pregnant or infected. Adolescents often feel alone in their attempts to deal with these issues that surface.

5. What impact does being sexually promiscuous have on the adolescents' family system?

Adolescents in general can have a rough time finding their place in the family system due to all of the changes they are experiencing physically and emotionally. Adolescents who are sexually promiscuous tend to struggle even more due to the added sexual issues (Futris & McDowell, 2002). Adolescents who have parents who are involved usually experience a power struggle relating to the issues around sex, peers, and school. Usually parents will struggle with their adolescents for a long period of time before giving up either by letting the adolescents do whatever they want or by seeking help from a counselor. Adolescents who do not have parents involved typically do not see a change in their family system when they become sexually promiscuous (Futris & McDowell, 2002).

A major change that can take place in the adolescents' family system is adolescents having children of their own due to being sexually promiscuous. The family system may embrace the adolescent and try to help him/her through this process, or they may disown the adolescent from the family. The subsequent results depend on the initial family system. Similar things can happen in the family system when the adolescent gets an STI such as HIV.

6. What impact does being sexually promiscuous have on the adolescents' social functioning (e.g., career, friendships, and community involvement)?

These adolescents typically do not care as much as others about succeeding in school or sports (Futris & McDowell, 2002). They tend not to be involved in school or community activities except that they may hold a part time job. As mentioned previously, being sexually promiscuous is correlated with high-risk activity such as alcohol and drug use. They are often involved with peers who use alcohol and drugs and often participate in delinquent behavior. If the females become pregnant, they have a higher rate of dropping out of high school. Therefore, the career outlook for sexually promiscuous adolescents is not as high as those who are not sexually promiscuous (Futris & McDowell, 2002).

7. Are there any legal issues related to adolescent sexual promiscuity? If so, what are they?

The two main legal issues concerning sexually promiscuous adolescents are sexual assault and statutory rape. Researchers (The Guttmacher Institute, 2006) found that ten percent of young women aged 18-24 who had sex before the age of 20 reported that their first sexual intercourse was involuntary. The younger they were at first intercourse, the higher the proportion. Any involuntary sexual act is illegal. Even when an adolescent consents to having sexual intercourse and is either 13, 14, or 15 years old, and the partner is six years older, this is considered statutory rape—class B1 felony. If the adolescent is 13, 14, or 15 and the partner is more than four years but less than six years

older, this is considered statutory rape—class C felony (North Carolina General Statutes, 2005-06). Researchers found that 59% of sexual promiscuous adolescent females had a first sexual partner who was 1-3 years older than them. Eight percent had first partners who were six or more years older (The Guttmacher Institute, 2006).

8. **What assessment strategies should a counselor use when working with an adolescent client who is sexually promiscuous?**

Researchers (Buckelew, Ozer, & Adams, 2006) related that assessing and counseling adolescent clients about risky health behaviors is a critical part of adolescent preventive care. They found that counselor perceived self-efficacy is a very important predictor of whether a counselor adequately screens for and counsels clients on risky sexual behavior. Therefore, counselors must be comfortable with their own sexual issues and comfortable in talking with clients about theirs. If the counselors are not comfortable in doing so, adolescents may not receive the necessary assessment and counseling. Researchers (Buckelew et al., 2006) suggested that the basic assessment technique of asking the clients about their sexual behavior and experience can be an effective assessment if proper rapport has been established.

Another assessment piece that is important when working with sexually promiscuous adolescents is to encourage them to get a physical exam and to get tested for STIs. The counselor should explain the risks of being infected and should give them information about the exams and tests. Counselors can be invaluable to adolescent clients in this way because the counselor can dispel myths about exams and testing.

9. **What are some effective counseling strategies to use when working with an adolescent client who is sexually promiscuous?**

Crockett, Moilanen, Raffaelli, & Randall (2006) suggested that using a person-centered approach is an effective way to work with adolescents who need self-regulation in areas such as sexual promiscuity. Researchers (Raffaelli & Crockett, 2003) found a connection between self-regulation in early adolescence and risky sexual behavior in midadolescence.

The person-centered approach views the adolescent as an "organized whole, functioning and developing as a totality" wherein "each aspect of the various structures and processes…takes on meaning from the role it plays in the total functioning of the individual (Bergman & Magnusson, 1997, p. 291). Therefore, rather than seeing the adolescent primarily as a sexually promiscuous being, the counselor looks at the entire adolescent as a whole and treats the sexual issues as only a part of the adolescent. Researchers (Allen et al., 2007; Raffelli & Crocket, 2003) have found that adults who are preoccupied with adolescents' sexuality to the exclusion of a thoughtful focus on the developing adolescent as a whole person are not effective in working with them. The adolescents tend to not open up to counselors who take the position of being an expert on sexuality issues. The counselor can be more effective if they treat the adolescent clients as if they are the experts on their bodies. The counselor can then provide education and motivation where it is lacking in the adolescents' lives (Raffaelli & Crockett, 2003).

10. **What resources (e.g., books, Internet sites, and support groups) are available to help support adolescents who are sexually promiscuous?**

www.teenpregnancy.org
www.mvparents.com
www.teenhelp.com
www.focusas.com
www.iwannaknow.org.
www.parentingteens.about.com
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Chapter Two

Sexuality Counseling During Pregnancy

By: Laura Harbeson

1. What is the definition of sex during pregnancy?

Sex during pregnancy will be defined in this chapter as the sexual actions, sometimes but not always, resulting in sexual intercourse between a man and his pregnant partner.

2. How widespread is the act of sex during pregnancy?

Research has been conducted in the area of the frequency of sexual intercourse during pregnancy (Dahlen, 2002; Rothnie-Jones, 2001). The results of these studies have indicated that approximately 85 percent of women were sexually active during the first three months of their pregnancy, with a decline to approximately 23 percent during the last four weeks prior to delivery. The reasons for this decline were reported to be due to the increasing physical discomfort, a loss of interest, and the fear of harming the mother or baby during sexual intercourse. However, some of the research participants suggested that for them, the state of pregnancy induced an exaggerated sense of attraction and a heightened level of intimacy in their lovemaking.

3. What is the typical developmental course of sex during pregnancy?

Obstetricians have been being asked questions concerning the safety issues related to sex during pregnancy for years (Rothnie-Jones, 2001). The consensus is that in most cases, it is safe to have intercourse while pregnant, until the last four to six weeks. Research has supported this perspective and has actually further concluded that sex during pregnancy has many benefits. One study found that healthy women who were between 23 and 26 weeks pregnant, and had sexual intercourse at least once a week, had a lower rate of pre-term deliveries than women that had sex less often (Klitsch, 1993). Another study found that women that masturbate to orgasm also tend to have lower rates of premature delivery (Dahlen, 2001).

4. What impact does sex during pregnancy have on the individual involved?

The concept of sexual activity during pregnancy can bring up a variety of feelings for everyone involved (Little, 1996). In most cases, the common concerns revolve around the safety for mom and unborn baby. Other concerns that are common to an individual or an expecting couple include self-esteem issues, possible risks of infection, physical and emotional comfort, communication issues, common myths, and pros vs. cons of various sexual positions.

Anticipated levels of attractiveness are reported to be a problem for men and women during pregnancy (Little, 1996). Women tend to have concerns of not being attractive with their bodily changes. During pregnancy most women report to feel fat and disproportioned, clumsy, and etc. The level of confidence in their body image declines rapidly as the due date comes closer and closer. Sometimes women may put higher stakes in their partner's response to them, being more sensitive toward their partners' comments or lack of show of affection. Pregnancy tends to be a time when women want to feel appreciated and doubts often surface which surrounds what their partner might be thinking or feeling.

5. What impact does sex during pregnancy have on the individual's family system?

Men tend to also have concerns related to levels of attractiveness toward their partner (Little, 1996). Some common problems include not wanting to instigate sexual intercourse due to a perceived denial, fear of harming their partner and/ or the unborn child, and uncertainty of new grounds to be explored requiring possibly new positions, and new ways of touching one another. At times, the lack of communication about these issues can lead to depression or anxiety. This may be due to the fact that men are not as likely, as women, to bring up their concerns to their wife, or to others. This may mean that it might be something to be brought up by the therapist.

6. What impact does sex during pregnancy have on the individual's social functioning (e.g., career, friendships, and community involvement)?

Often times, couples or individuals that are pregnant have many questions about their sexual relationships during pregnancy. *When I have sex with my husband, can my unborn child see him? Will I go into labor too early if I have sex with my husband? Will my husband be turned off by me if he sees my rounded middle? How do I have sex with my wife without hurting her when she is pregnant? Will we hurt our baby if we have sex?* All of these questions are examples of the common concerns that individuals and couples can be consumed by during the sensitive time of pregnancy. It is difficult for those with such questions to feel comfortable asking for the answers from the people in their social network. Society does not support sexual relations during pregnancy, and therefore it is more difficult for those in this life stage to know who to turn to for the answers to their questions. As a professional counselor working with individuals and couples, it is imperative that not only do you know how to answer some of these questions, but also it is key to understand the dynamics that are brought into a relationship when an individual or a couple is pregnant.

7. Are there any legal issues related to sex during pregnancy?

There are no known legal issues related to this issue..

8. What assessment strategies should a counselor use when working with a client facing sexual relations during pregnancy?

Due to the fact that the majority of the anxieties of sexuality during pregnancy revolve around medical concerns, it is key that the therapist verify that the couple or individual has consulted with an obstetrician. This doctor would have had to have given the authorization for the couple to participate in sexual activities and would have announced any restrictions to their activities. The counselor's role is not to give the approval of any sexual action, but instead is acting as a sounding board and a tool for processing the thoughts and emotions revolving around the presenting concerns.

9. What are some effective counseling strategies to use when working with a client facing sexual issues during pregnancy?

As mentioned throughout this chapter, the role of the counselor is greatly dependent on the specific situation that is presented by the client(s). If the clients are a married couple that is concerned about their sexual relationship since they have become pregnant, the role of the counselor might be different than if the client were a 16-year-old girl that is pregnant. The qualities that a counselor must be present in the therapeutic relationship across the board are empathy, understanding, positive unconditional regard, active listening, and compassion. However, dependent on the situation, the therapist may have to act as more of an informant and provide psychoeducation on the topic of sexuality during pregnancy.

Studies have also evaluated sexual intercourse positions to determine their effects on safety issues during pregnancy (McBurney & McBurney, 2004). The only position that was found to increase the risk of pre-term delivery was the missionary position. Positions that women have reported to find more comfortable, and are not seen as generally harmful to the mother or baby, are when the wife is on top, or rear entry approaches. Forceful penetration, in any position, is an act to avoid. Although the baby has natural protectors, which include the cervix, the cervical plug, and the amniotic sac, physicians advise couples to exercise caution with care during sexual activities.

Some doctors may even suggest that women attempt having sexual relations with their spouse to induce labor (Rothnie-Jones, 2001). The prostaglandin that is naturally in semen has been proven to ripen the cervix during orgasm. The mechanics of sexual intercourse, such as stimulation to the nipples, can also ripen the cervix to induce labor. However, it is very important that women are evaluated by their obstetrician, to be properly evaluated, prior to following this method of labor induction.

Sex during the last month prior to delivery has been found to be more risky (Naeye, 1996). It has been found that sex in the later parts of pregnancy can lead to an increase in amniotic fluid infection. Obstetricians warn that such an infection is the most frequent underlying cause of neonatal and fetal deaths in the United States. Other physical reasons that a doctor may warn a couple to abstain from sexual relations are vaginal bleeding, premature rupture of the amniotic membrane, placenta previa (placenta positioned at bottom of the uterus), and pain during sexual intercourse. Furthermore, other risks associated with late pregnancy sex are infants having lower Apgar scores and more trouble breathing than infants born to parents not engaging in late pregnancy sexual intercourse.

Teenage pregnancies bring arise other concerns. Studies with pregnant teens have demonstrated the concern of high risk sexual activity related to unprotected sex with multiple partners (Klitsch, 1993). Two hundred and sixty-seven teens between the ages of 13 and 17 were tested for STIs at the initial maternity care appointment and then again at the start of their third trimester. While 28 percent had tested positive for an STI at the start of their pregnancy, and 39 percent of the teens tested positive for an STI at the beginning of their third trimester. This research alerts professionals of the probability of STIs among this population. Multiple screenings for STIs are suggested throughout the pregnancies of teens due to this concern.

Although testing for STIs is not the responsibility of professional counselors, it is a topic that might be important to bring up in counseling, particularly if the client admits to participating in risky sexual behaviors. Also, a therapist should be prepared to have conversations about STIs, and the dynamics surrounding the diagnosis of an STI, with clients. The dynamics created by such diagnoses are very diverse, depending on the circumstance; however, in combination with the state of pregnancy, this can bring up many other issues.

In addition to sexual intercourse, couples should be reminded that there are many other ways to communicate intimacy within a relationship. Massages, sending cards, kissing, hugging, and etc. are all alternatives to intercourse and can be just as meaningful as sexual intercourse in the expression of intimate feelings for one another. These suggestions may be of particular importance to a couple that is unable to have sexual intercourse during pregnancy for medical reasons. They may also be used to communicate affection in addition to sexual intercourse. Many times, couples take the more subtle forms of expression for granted, and it may be up to the therapist to remind them that these tools of affection still exist and can still be utilized within their relationship.

In summary, a counselor working with individuals or couples that are expecting, must consider many of the common issues that often present themselves during this sensitive state. Sexuality is a common theme for pregnant women and couples to struggle through, and it is the role of the counselor to be informed of the issues that may interrupt, heighten, or confuse the sexual intercourse that a couple experiences. With the understanding that some of the common concerns might not be introduced in the session by the client(s), it is sometimes up to the therapist to introduce the topic of sexuality issues during pregnancy. From that point on, it is the counselor's role to facilitate the natural processing of thoughts and emotions that are presented by the client(s).

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by concerns related to sex during pregnancy?

In addition to the references listed at the end of this chapter, a client looking for more information about sex during pregnancy, or to be referred to a local support group of others who have similar concerns, can go to their regular obstetrician. The following websites are also available for further information:

- www.kidshealth.org/parent/pregnancy_newborn/pregnancy/sex_pregnancy.html
- www.babycenter.com/refcap/pregnancy/pregnancysex/390.html
- www.babyworld.co.uk/information/pregnancy/sex_pregnancy/sex_during_pregnancy.asp

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Chapter Three

Sexuality Counseling with Menopausal Women

By Thea E. Vondracek

1. What is the definition of menopause?

The word menopause comes from the Greek roots of "meno", meaning month, and "pause", meaning to stop. The cessation of menses is a physical result of aging, or can be surgically induced by hysterectomy (Wikipedia, 2006). The terms *menopause* and *climacteric* are used interchangeably (Patterson & Lynch, 1988; Huffman & Myers, 1999). Menopause can only be diagnosed in retrospect when a woman has gone 12 months without her monthly period due to the loss of ovarian function (Robinson, 2001).

2. How widespread is menopause?

All women, regardless of race or ethnicity, will experience menopause (Baldo, Schneider, & Slyter, 2003). By 2010, an estimated 41,510,000 women will be in the menopausal age group of 45 to 64 years old. Women in this age group will comprise approximately 26.4% of the total population of the United States (United States Census Bureau, 2004).

3. What is the typical developmental course of menopause?

Perimenopause (the period from the beginning of menopausal symptoms to cessation of menstrual periods) usually begins in the late 30s and can last from five to 15 years, or longer, with full menopause achieved at the average age of 52 (Mills, 2006).

4. What impact does menopause have on the individual involved?

The most common physical symptom is sudden, intense waves of heat called a *hot flash*. Other symptoms include: insomnia, mood swings, fatigue, weight gain, depression, irritability, racing heart, headaches, joint and muscle aches and pains, changes in libido, vaginal dryness, and bladder control problems (Hotze, 2006). Menopausal and post-menopausal women are at risk for osteoporosis, coronary heart disease, and breast cancer (Huffman & Myers, 1999).

Perimenopausal women are three times more likely to develop depression for the first time than premenopausal women (Elias, 2004); however, the depression may be related to other life events that may be overlooked if the therapist assumes the cause is menopause ("New Ideas", 1994). Depression that occurs during the perimenopausal period is likely to decrease once the woman becomes post-menopausal (Huffman & Myers, 1999).

Many women demonstrate difficulty describing their feelings about their changing bodies. Menopausal women face numerous changes in their lives during this time: physical, emotional, and social. For many, the loss of youthful appearance and reproductive ability can impact a woman's sense of identity and self-esteem. The lack of relevant, accurate, and conflicting information, and the negative biomedical model of menopause as a degenerative process, may lead to frustration and anger (Bannister, 2000).

Contrary to the abundance of literature discussing the negative aspects of the menopausal transition, some women discover increased well-being, independence, and sexual initiative when they are free of monthly menstruation and possible pregnancy (Robinson, 2001; Burlew & Capuzzi, 2002).

5. What impact does menopause have on the individual's family system?

The Midlife Women's Health Survey (2003) results indicated that approximately two-thirds of husbands had insufficient knowledge about menopause to be an adequate source of support for their wives. One-fourth of the men indicated that their partner's menopausal transition was a negative experience for them as well as their partner (Koch & Mansfield, 2004).

Intimate relationships may be impacted by women who experience reduction in desire and arousal, difficulty in achieving orgasm, and pain during intercourse (Koch & Mansfield, 2004).

6. What impact does menopause have on the individual's social functioning?

Studies have shown a positive correlation between the existence of a strong support system and a woman's emotional health. During the transition to midlife, women can develop a stronger sense of self by tapping into their existing social networks, developing new social networks, and engaging professional helpers (Koch & Mansfield, 2004). Finding a formal midlife support group, walking with a friend, or finding a mentor are possible ways to increase female socialization ("New Ideas", 1994).

7. Are there any legal issues related to menopause?

None known.

8. What assessment strategies should a counselor use when working with a client facing menopause?

Mental health concerns should be viewed within the context of the client's social, cultural, and economic life (Bannister, 2000). Use in-depth interview process to determine if emotional distress is related to physical changes (Derry, 2004). Refer to physician as needed (Patterson & Lynch, 1988).

9. What are some effective counseling strategies to use when working with a client facing menopause?

The seven-phase integrative and personal approach designed by Huffman and Myers (1999) addresses the many facets of the impact menopause can have on a woman: education; recognize the importance of the physical issues; facilitate self-assessment; communication with others and determination of personal meaning of client's experience; develop resources and create a plan for positive, empowering choices; implement the plan; and, reevaluate and make adjustments as needed.

In a culture where there is no formal rite of passage into midlife, some women may need to mourn the loss of their reproductive status. Emphasize the knowledge gained through life experience. Reframe the "loss" as an opportunity for growth and the expression of personal creativity (Patterson & Lynch, 1988). Encourage clients to challenge negative attitudes about midlife changes and develop coping strategies to mitigate their physical and emotional discomfort (Derry, 2004).

Support groups are effective in normalizing the menopausal experience, developing coping strategies, and gaining accurate information (Patterson & Lynch, 1988).

Assertiveness training can counter cultural bias towards aging and irrational thoughts of reduced value to society. Clients can benefit from cognitive-behavioral approaches to reframe negative feelings about body image as well as feelings of inferiority and depression. *Values clarification* helps women identify incongruence of behavior and environment which creates conflicting feelings about their identity (Saucier, 2004).

According to the The North American Menopause Society website, incorporating the following into a woman's lifestyle can make menopause a positive experience: cultivate positive thoughts; laugh; make time for self-care; connect with social support; and, stay in the moment to avoid worrying about the future or dwelling on the past (Kegan, 2006).

10. What resources are available to help support individuals affected by menopause?

The Internet is full of helpful sites that provide information on menopause. Be aware that some sites are sponsored by pharmaceutical companies and may provided information skewed to support the use of their products.

A Friend Indeed (www.afriendindeed.ca)

Menopause Online (www.menopause-online.com)

The North American Menopause Society (www.menopause.org) Has guidelines for menopause discussion groups and a list of existing groups in North America.

Power Surge (www.power-surge.com)

The Agency for Healthcare Research and Quality (www.ahcpr.gov) (Koch & Mansfield, 2004)

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Chapter Four

Sexuality Counseling for Parents of Children who are "Coming Out" as Being Gay or Lesbian

By: Melissa Mekita

1. What is the definition of the "coming out" process?

The definition of the "coming out" is "when an individual begins to associate her or himself personally and publicly with other gay, lesbian, or bisexual (GLB) persons, or discloses her or his sexual identity to non-GLB persons" (Grov, Bimbi, Nanin & Parsons, 2006). The individual is looking for "affirmation for this contested identity" from others, which includes the parents of the individual (Galatzer-Levy & Cohler, 2002). This process also includes a change in how the individual changes how they see themselves, because he or she accepts the same sex gender desire as part of their own identity.

2. How widespread is "coming out"?

Statistics indicate that in terms of disclosure to parents, the trend is that more and more youth are disclosing to their parents at a younger and younger age. The average age is around 18, but the range of ages is from 13-24 typically (Grov et. al, 2006). The percentages of who youth are disclosing to, in terms of gender of the parent are as follows. The number of mothers that youth have disclosed to is between 40 and 75% (Savin-Williams, 2001). For fathers, the numbers are only 30 to 55%. There is a difference in these numbers when looking at difference in ethnicity however. However the order in whom a person discloses to is usually a close friend first, then a sibling, and the youth's mother, then the father. Those who are non-Caucasian tend to disclose to another family member (Grov et al. 2006). For example, when looking at the Chinese culture 80% disclose to a family member but usually a sibling, more likely a sister (Savin-Williams & Esterberg, 2000). Only 25% of Chinese adolescents disclose to their parents.

3. What is the typical developmental course of "coming out"?

There are two typical developmental courses of "coming out", one for the youth and another for the parents. For the youth "coming out" starts as a fight between an inner self and an outer self which are not always congruent (Galatzer-Levy & Cohler, 2002). **"**Coming out" then signifies a process in which the individual tells others about their identity, and therefore becomes congruent with the self (Schope, 2004). There is debate when this process starts, but commonly it is said to start in adolescence where youth are coming to terms with sexuality in the context of their family, school and community (Galatzer-Levy & Cohler, 2002). So in early adolescence, the individual is aware of same sex attractions (Savin-Williams, 2001). Then there is the process of testing and exploration. During this time youth usually are going through an overwhelming fear of being "detected" or found out and so they hide their identity (Schope, 2004). Also the youth tend to have scapegoat behaviors on others, in which they ridicule others who may be gay just because they are trying to hide their secret. When the youth is ready to adopt the "label", they will start disclosing to others, known as "coming out" (Savin-Williams, 2001). They will then disclose to others and integrate their sexual identity into their life. This may include figuring out how to date and have a relationship with those of the same sex as they are (Schope, 2004). It is argued that nobody ever "stops" coming out, in every new situation they will have to disclose or deal with it, so that coming out is a life long process (Galatzer-Levy & Cohler, 2002).

Parents also go through a developmental process when finding out that their offspring is gay or lesbian. First some parents already know that their child is gay before the coming out process even happens. In fact 25% of parents know before their child states it to them (Savin-Williams, 2001). A reason for this may be that atypical gender behavior also leads parents to have "clues" about their child's sexuality (D' Augelli, 2005). Or it may be the opposite where parental victimization may have

an effect on parents finding out whether their child is gay or not. For example, past anti-gay comments may lead to reactions from the youth that led to suspicions by his or her parents.

But when the youth discloses the typical process in which parents go through is that of grief. The parents first go through a shock/denial, phase followed in which the parents usually feel some sort of shame and guilt associated with it (Savin-Williams & Esterberg, 2000). Also there are parents have no understanding of homosexuality, had stereotypes, never thought about it and now this forces them into thinking about it (Savin-Williams, 2001). Then the parents go through anger and bargaining in which they hope that this disclosure is "just a phase" (Galatzer-Levy & Cohler, 2002). This is because having alternative lifestyle threatens the traditions of becoming a grandparent, marriage, and continuation of the family line, along with any type of religious/spiritual beliefs the family may have. Coming out led the parents to do self evaluation and reorganizing of priorities and expectations. Eventually many parents with acceptance will integrate their children's sexuality into their family life (Savin-Williams & Esterberg, 2000). It is said that the longer that the parents had to internalize and understand their child's sexuality then the more apt they are to be supportive (D'Augeilli, 2005)

4. **What impact does "coming out" have on the individual involved?**

There is research showing how the youth feel that their parents will react to their disclosure. There are youth who think that their parents will respond negatively to coming out, around half expect mothers and two thirds of fathers to be intolerant/rejecting, when in actuality only twenty percent of mothers and twenty eight percent of fathers are (Savin-Williams, 2001). This makes the individual hide their sexuality from their parents, causing them to feel alone and isolated from others. This may be a reason why there is such a high suicide rate in this particular population. But in later adolescence having same sex relationships is harder to hide in that one may want to bring a partner home for the holidays, or there is increasing pressure to when one is going to marry and have kids. (Galatzer-Levy & Cohler, 2002). Racial and ethnic minorities who are from multigenerational family system may not want to disclose to their parents because they do not want this extended family to know about what is going on (Savin-Williams, 2001).

5. What impact does "coming out" have on the individual's family system?

The greatest fear of the youth is being detected by family and then rejected by the family, which will then reaffirm their internal homophobia (Schope, 2004). In terms of coming out family is again usually not the first told, but mothers are usually told before fathers, and the relationship with mothers are usually more positive than with fathers after disclosure (Savin-Williams, 2001). In terms of what happens after disclosure with youth surveyed in support groups, sixty percent had had some type of verbal/physical harassment from a family member. In this same study 11% of mothers, 3% of fathers, 2% siblings reacted with threats of rejection, uncontrolled emotional outbursts, or other severely negative reactions. In terms of physical assault by a family member, girls tended to have more physical assault than boys and the percentages by family members: mothers (22%), brothers (15%), fathers (14%), and sisters (9%). Another study cited that half of mothers and fathers responded with disbelief, silence, denial, or negative comments such as "it won't last" (Savin-Williams & Esterberg, 2000). Many parents don't react positively or negatively, rather they are ambivalent about the situation (Galatzer-Levy & Cohler, 2002). What is important to remember is that presentation of sexual identity (as a good thing or as a problem) also led to how the parent saw it as, and also that there were a good percentage of families that were ok with the coming out process as well

6. What impact does "coming out" have on the individual's social functioning?

There is not as much research about how parents deal with their social functioning after hearing of disclosure from their youth. The consensus is that either the parents hide the fact of their child coming out to everyone, are selective about who they tell, or are very socially active in the gay and lesbian community (Galatzer-Levy & Cohler, 2002). In terms of the youth, they tend to have more gay

friends than heterosexual friends, because they feel that they understand them better and will not judge them for what they have been through (D' Augelli, 2004). There are also new rules that the youth may have to face when it comes to finding partners to date, and how to go about dating them as well. This was also sited as a concern of the parents who were accepting of their youth's sexuality. The most major concern though was that the youth may also face discrimination both in school and also in the work place. So many parents worry about these two things and how their child will function in the world being a minority.

7. Are there any legal issues related to "coming out"? If so what are they?

There are several legal issues related to "coming out" or having same sex gender preference in general (Savin-Williams & Esterberg, 2000). One of the major issues is same sex marriages and domestic partnerships. In most states in the United States same sex marriages are illegal, and there are even some states trying to make a constitutional amendment to ban same sex marriages. There are however a few states where there are legal civil unions (Connecticut and Vermont), and several more that are putting forth legislation to go towards legal civil unions. What that means is that there are governmental issues of what constitutes a marriage, and the legal benefits of a marriage which those who are gay at this time do not have. This would include the privledges with filing for taxes as a couple, all types of insurance and benefits of any sort, joint property that the couple may share, who can visit and considered "family" when a partner is in the hospital, and what can be put in wills since the partner is usually not considered a spouse and is not given those rights. This also is a problem for those seeking to have children in which some states do not allow adoption and the courts look at look the person's ability to parent, and the "intentionality" of having a family a lot more closely than they would with heterosexual couples. These are some of the issues that need to be discussed in counseling so that the client has a better idea of the barriers they are up against.

8. What assessment strategies should a counselor use when working with a client facing the "coming out" process?

The assessment strategies that a counselor should use with the youth should be looking at where in the process of coming out they are in, and also looking at a suicide assessment because of the fact that it is so prevelant in this population. There is also a risk of depression, anxiety, low self esteem, and identity issues that need to be assessed.

In terms of counseling, the assessment that should be looked at when dealing with parents who have youth that are "coming out" are six dimensions that are affected when youth come out (Galatzer-Levy & Cohler, 2002). The first three deal with emotions and reactions of the disclosure. One of these is whether parents felt shame and guilt with offspring disclosure and whether the parents decided to inform friends and relatives of the disclosure which might hint at this shame and guilt. Secondly is to look at the extent to which the disclosure affected the closeness of the relationship between the parents and the youth. Has the relationship become more distant since the disclosure? If so, does the family want to work on making the connections closer again? How can everybody be on the same page? Thirdly, is the extent to which parents were empathic with disclosure and if the parents have made efforts to help the youth become more comfortable in their gay or lesbian identity. What were their reactions to the disclosure and afterward? Were they warm and embracing or ambivalent or even abusive?

The next three deal with the future after the disclosure and how parents integrate their child's new identity into their life. So it is asked the extent of parental contact with resources that deal with gay and lesbian issues to educate themselves about the issue and for support, such as Parents, Family, and Friends of Lesbians and Gays (PFLAG). This is to see what level of social action they are taking on behalf of their youth. Another thing to look at is extent to which parents were inclusive of offspring's lover or partner as part of the family. Do they even accept the partner? Do they include

them in family functions? The final assessment is to look at the extent to which parents were able to see a future for their gay or lesbian offspring. Have parents let go of traditional wedding and childbearing ideas? Are they going to be happy for their child and not worry all the time? These are things to look at with a family in terms of assessing where they are in the process of their children "coming out".

9. What are some effective counseling strategies to use when working with a client facing "coming out"?

It is important to note that usually those coming into counseling who are gay are seeking counseling for different reasons such as help with relationships, finances, career, etc. Or may be seeking help for depression or anxiety. So helping the parents also see these different struggles instead of having everything be focused on sexuality is important (Schope, 2004). Also with youth it is important to look at the fact that identity formation is going on and that the stigma of their new identity needs to be handled. So with this in mind it is important to make sure that the counselor shows that they are "gay friendly" to the community either by saying so in their professional disclosure, talking about it with the client, or by having some sort of symbol (rainbow, flag) in the office. The counselor should also make sure she/he uses strategies and also language that is comfortable for the client, and to be aware of the heterosexual bias that can come along with counseling.

It is also important to look at how the parent is dealing with the situation. It is seen that the interaction between parents and youth is mutually exclusive in that both rely on each other for their sense of self and purpose at times. Parents often measure their own worth by looking at their children (Parental self). They also may see their dreams come true through their children as well (Galatzer-Levy & Cohler, 2002). So it is important to look at the losses that come with the disclosure and allow the parents room to grieve for these losses and be able come to a fuller acceptance of their child, and reintegration of the youth within the new type of family.

Some effective counseling strategies include turning to feminist theory in which looking at the messages sent to both the youth and the parents needs to be evaluated. For example, parents may teach their children to see homosexuals as inferior, immoral, or sick (Schope, 2004). This can lead the youth to identity confusion, low self esteem, social role conflict, or cognitive dissonance. Parents need to understand the "self-shaming" scripts that their son or daughter may have in that heterosexuality is morally preferable and that those who are homosexual will lead a lonely and miserable life. It is seen that the youth who are not out, or just came out tend to have a higher external locus of control and focus on what others think rather than what they think themselves, so their family influence is very important at this time. So there becomes a need to "unlearn" those powerful homophobic messages that may be strong within the family ties (Schope, 2004)

9. What resources are available to help support individuals affected by "coming out"?

There are many resources available to help support individuals affected by coming out along with their families. If looking for a therapist, be sure to be upfront about whether they are comfortable working with the gay or lesbian population. Most of these resources are either based here in Greensboro, NC or have chapters here in the area. Their titles and respected websites are listed here:

Parents, Family, and Friends of Lesbians and Gays: http://www.pflag.org/
GLBT National Hotline: http://www.glnh.org/
UNCG Pride: http://pride.uncg.edu/
Out Greensboro: http://www.outgreensboro.com/index.html
Safe Schools NC: http://www.safeschoolsnc.com/
Project Rainbow Net: http://www.projectrainbownet.org/
Triangle Families: www.trianglefamilies.org

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Chapter Five

Sexuality Counseling with a Client Considering Sex Reassignment Surgery

By Elizabeth E. Trump

1. What are the definitions for gender identity disorder and sex reassignment?

Gender identity disorder is defined as (a) evidence of the individual's strong persistent cross-gender identification and (b) persistent discomfort with one's biological sex or a sense of inappropriateness about one's associated gender role (American Psychiatric Association, 2000). These criteria must be present without concurrent physical intersex conditions and cause marked distress or impairment in the social, occupational, and other areas of functioning. Children with gender identity disorder express a desire to grow up as the opposite gender. Adults express a desire to live as a member of the opposite sex. Adolescents may present desires that resemble those of children or adults depending on the individual's developmental level (APA, 2000). Individuals with gender identity disorder are also referred to as transgendered.

Sex reassignment includes three levels of physical intervention—fully reversible, partially reversible, and irreversible (Harry Benjamin International Gender Dysphoria Association, 2001). A staged process of sex reassignment is recommended to allow for flexibility within the first two stages. Fully reversible interventions include the use of hormones which suppress hormone production and delay the onset of puberty. Partially reversible interventions are hormonal therapies which feminize or masculinize the physical body. Irreversible interventions involve surgical procedures to alter the primary and secondary sexual characteristics of the body (HBIGD, 2001).

2. How widespread is gender identity disorder?

Though considered rare, there are no statistics to indicate the prevalence of gender identity disorder in the United States (APA, 2000; Coolidge, Thede, & Young, 2002). Data from European countries suggests prevalence in the Netherlands of 1:18,000 for men and 1:54,000 for women and in the UK 1:4,000 for men and 1:11,000 for women (Midence & Hargreaves, 1997). In clinical studies of children there is a ratio of 5:1, with many more boys being treated for gender identity disorder (GID); though this may be due to a greater acceptance of cross-gender behavior from girls that lead to a clinical intervention (Coolidge, Thede, & Young, 2002). European statistics also suggest that approximately 1 in 30,000 males and 1 in 100,000 females seek sex-reassignment surgery (APA, 2000).

3. What is the typical developmental course of gender identity disorder?

There are two courses of gender identity disorder—one with childhood onset and the other with onset in early to mid-adulthood (APA, 2000). Childhood onset does not necessitate a lifetime diagnosis. Children begin to display cross-gender interests and behaviors between the ages of two and four years old (APA, 2000). These interests are apparent in cross dressing, play usually identified with the opposite sex, association with children from the sex and gender with which the child associates, and statements of dislike toward genitalia and intent to grow up as the opposite sex (Bower, 2001; HBIGDA, 2001).

By late adolescence, over 90% of the children diagnosed with GID no longer meet the criteria of the disorder (APA, 2000). The small number of children who continue to meet the criteria for GID experience considerable stress at the onset of puberty, which is experienced as a betrayal of the physical body (Bower, 2001). These adolescents generally develop a stronger cross-gender identity and pursue physical interventions into adulthood (APA, 2000). Those individuals who develop late onset GID in early and mid-adulthood experience more fluctuation about their gender identity, have more ambivalence about sex-reassignment surgery, and are more likely to be aroused by cross dressing (APA, 2000; Bower, 2001).

4. What impact does gender identity disorder and sex reassignment have on the individual involved?

One of the secondary criteria for a diagnosis of gender identity disorder is marked distress or impairment caused by a discomfort with one's biological sex. The individual can have a very confusing and difficult battle for personal and social acceptance of a transgender identity. Individuals with gender identity disorder have a higher risk of behavioral problems, anxiety, and depressive disorders (APA, 2000; Coolidge, Thede, & Young, 2002). They are at increased risk of suicide attempts and substance abuse (APA, 2000). One study states that more that one third of the transsexual research population had previously attempted suicide (Midence & Hargreaves, 1997).

According to two literature reviews on male patients, individuals who are approved for and follow through with sex reassignment surgery have between a 71-88% rate of satisfactory physical outcome and a rate of 60-85% psychological improvement (Midence & Hargreaves, 1997). Improvements were most pronounced in cosmetic satisfaction, interpersonal relationships, and psychological well-being and less pronounced in work, finances, and sexual relations (Midence & Hargreaves, 1997). Thus for a majority of people who have sex reassignment surgery, there is a marked improvement in functioning and satisfaction with oneself. There is a significant financial burden associated with sex reassignment, ranging from $5000 to $150,000, depending on the physical procedures which are excluded from most health care plans (PFLAG, n.d.b).

5. What impact does gender identity disorder and sex reassignment have on the individual's family system?

There is no direct research available on the impact of gender identity disorder and sex reassignment surgery on the individual's family system. Family members are certainly affected by the psychological issues of the transgendered individual. Personal stories posted on the PFLAG website by family members show concern for the welfare of the child as a major concern (PFLAG, n.d.a). Family members try to understand an alternate view of gender and complex religious beliefs. They report going through their own "coming out processes" as they decide who and how to tell extended family and friends. There are feelings of shock, denial, anger, guilt, grief and loss. They must learn to address the cross-gender by a new name and pronoun (PFLAG, n.d.a). It must be noted that these are posting from family members who were eventually accepting of the child's gender dysphoria. Therefore, the other end of the spectrum for family members may include grief over the loss of the child in the family life for these families which do not accept the cross-gender individual.

6. What impact does gender identity disorder and sex reassignment have on the individual's social functioning (e.g., career, friendships, and community involvement)?

Society's discomfort with alternative gender roles often results isolation and social ostracism, low self-esteem, and difficulty in relationships and social situations (APA, 2000; Bower, 2001; Midence & Hargreaves, 1997). Individuals with GID have been denied service by restaurants, stores and public facilities, making community involvement challenging and threatening (PFLAG, n.d.b). Due to limitations in the law, which will be discussed in more detail, individuals with gender identity disorder are often unable to find employment, housing, or health care and are the victims of verbal and physical violence that is unreported (Parents and Friends of Lesbians and Gays, n.d.b.).

7. Are there any legal issues related to gender identity disorder and sex reassignment? If so, what are they?

Existing law does not protect transgendered people from discrimination, despite protection for individuals on the basis of sex and sexual orientation (PFLAG, n.d.b). In fact, transgendered individuals are specifically excluded in the Americans with Disabilities Act of 1991 (PFLAG, n.d.b). At this time Minnesota and Oregon are the only two states which offer anti-discrimination protection to individuals with GID (PFLAG, n.d.b). Therefore, when these individuals are fired from their jobs,

denied or evicted from housing, there is no basis for a report or justice. Individuals with GID are often targets of physical and verbal assault, often because they are assumed to be homosexual. Too often these crimes are not prosecuted due to the victim's shame in reporting and police unwillingness to investigate (PFLAG, n.d.b).

Once a transgender person follows through with sex reassignment surgery, he or she must obtain new legal documentation showing the new name and sex. Rules for changing documentation vary widely between states and are often determined by the administrator who handles the case (PFLAG, n.d.b). Thus, a transgender person may exhibit one gender through body and spirit and display another through legal identification.

8. What assessment strategies should a counselor use when working with a client facing gender identity disorder and sex reassignment?

Though some researchers demonstrate a relationship between assessments, including the Draw-a-Person test, the Brown I.T. Scale for Children, the Schneidman Make-a-Picture Story Test, the Coolidge Personality and Neuropsychological Inventory for Children, the MMPI, and the WAIS, there is no diagnostic test specific for gender identity disorder (APA, 2000; Bower, 2001 Coolidge, Thede, & Young, 2002; Midence & Hargreaves, 1997; Sugar, 1995). A diagnosis of gender identity disorder is subjective based on the judgment of the clinician (Bower, 2001). The task of the mental health professional is to assess the nature and characteristics of the individual's gender identity, provide counseling for any therapeutic issues and determine eligibility and readiness to proceed with sex reassignment (HBIGDA, 2001). A complete psychiatric assessment should be performed to assess for co-morbid psychiatric conditions that may interfere with gender identity or with sex reassignment procedures. One research study showed that group therapy is an effective method of collecting accurate information that may have been falsified in the initial assessment (Keller, Althof, & Lothstein, 1982). Due to the complexity of gender identity disorder, especially in children and adolescents, it is imperative that diagnosis and decisions about treatment are based on long-term evaluation and psychotherapy (Keller, Althof, & Lothstein, 1982).

9. What are some effective counseling strategies to use when working with a client facing gender identity disorder and sex reassignment?

Determining which counseling strategies are effective in working with clients with gender identity disorder depends on the goal of therapy. The Harry Benjamin International Gender Dysphoria Association (2001, pg.1) states in their standards of care that the goal of psychotherapy for persons with GID is "to provide lasting comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment." The only available research on effective counseling strategies involves a research study on the use of group therapy which does show improvement in the individuals' acceptance of their gender through different avenues, including a decision to abandon the trans-gender search, to cross-dress, to live as a homosexual, or to have sex reassignment surgery (Keller, Althof, & Lothstein, 1982).

For those who have lasting discomfort with their physical sex, it has been suggested that sex reassignment surgery is the only effective treatment (Bower, 2001). However, due to the vast array of gender experiences and outcomes of children who were diagnosed with gender identity disorder, sex reassignment is only considered seriously after the individual follows a series of steps: psychotherapy must be conducted for at least six months, the individual must complete a real life test living as the other gender for one year, and two mental health professionals must recommend the individual for surgery before serious plans for surgery are considered (Meyenburg, 1999).

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by gender identity disorder and sex reassignment?

In spite of the isolation felt by many individuals and families who are dealing with gender identity disorders, there are resources available.

- PFLAG: www.pflag.org
- Transgender helpline: (216) 691- HELP (4357)
- For youth: www.youthresource.com
- For families: Families Like Mine; Straight Spouse Network
- For those considering sex reassignment surgery: http://marcibowers.com; www.annelawrence.com/SRS index.html; www.HBIGDA.org
- Books: *True Selves: Understanding Transsexualism* by Brown & Rounsley
  FTM: Female-to-Male Transsexuals in Society by H. Devor
  Gender Identity Disorder and Psychosexual Problems in Children and Adolescents by K.J. Zucker & S.J. Bradley

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Chapter Six

Sexuality Counseling for Intersex Clients

By Jennie Gouker

1. What is the definition of intersexuality?

Intersexuality is an inconsistency between an individual's internal and external genitals (Greene, 2006). It occurs when infants' genitalia are not definitively male or female, but rather ambiguous. "True hermaphrodites" (Slijper, Drop, Molenaar, & de Muinck Keizer-Schrama, 1998), or "true intersexed" individuals, have both ovarian and testicular tissue (Kessler, 1990). However, most intersex people's external genitalia do not form in the typical fashion in the womb. For example, a baby may have an unusually large clitoris or a small penis. Intersex individuals may also have the XY karyotype, or masculine chromosomal pattern, but female genitals (Alderson, Madill, & Balen, 2004). Likewise, male pseudohermaphrodites have the XY karyotype, but their genitalia have inadequately developed. Yet, they also do not have female gonads or a vagina (Slijper et al.). Doctors may later reassign the gender of intersex patients, often ending in surgical reconstruction of the external genitals. Typically, the medical team diagnoses certain hormonal disorders, such as congenital adrenal hyperplasia (CAH) and androgen insensitivity syndrome (AIS), as the reasons for the intersex condition.

2. How widespread is intersexuality?

Statistics vary regarding the prevalence of intersexuality. Physicians must register chromosomal abnormalities, but not all intersex individuals have these conditions (Kessler, 1990). Williams (2002) offered the estimate that 1 in 100 infants have genitals, genetics, or hormones that do not meet the male or female standard. CAH affects both genetic males and females, with an approximate incidence rate of about 1 in 5,000-15,000 live births (Zucker et al., 1996). In addition, AIS probably occurs in 1 in 41, 000 to 1 in 99,000 births (Alderson et al., 2004).

3. What is the typical developmental course of intersexuality?

The evolution of intersexuality depends greatly upon the hormonal cause of the condition. For example, CAH is common in the intersex population (Slijper et al., 1998). It is a disorder that develops from a defect in an enzyme, typically 21-hydroxylase. The enzyme assists in the production of cortisone, a stress hormone, (Zucker et al., 1996) and aldosterone, essential in electrolyte homeostasis (Servin, Nordenstrom, Larsson, & Bohlin, 2003). Overproduction of adrenal androgens then occurs while in the womb, and testing amniotic fluid can assist in diagnosing CAH. The hormonal imbalance causes the genitalia to appear more masculine, resulting in labial fusion and clitoral enlargement (Slijper et al.). Physicians may initially deem newborns with CAH as male, due to the physical appearance (Servin et al.). Yet, the babies' internal gonads remain feminine, and parents usually raise individuals with CAH as girls. Doctors typically treat CAH with surgery or cortisone-replacement therapy (Zucker, 2002).

Androgen insensitivity syndrome (AIS) is another disorder that occurs frequently in intersex individuals (Alderson et al., 2004). Two diagnoses may result from this condition, complete androgen insensitivity syndrome (CAIS) or partial androgen insensitivity syndrome (PAIS). In either group, these people usually appear to be women, but they have the XY karyotype. Although female secondary sex characteristics form, they do not have the standard feminine gonads. Women with CAIS typically develop breasts as well as the vulva, clitoris, and introitus with a short vaginia. However, the external genitalia of females with PAIS are more ambiguous, such as an enlarged clitoris. This apparent difference may result in gender assignment at birth. Thus, parents may raise PAIS children as either boys or girls. For others, diagnosis does not occur until adolescence when menstruation does not begin (Alderson et al.).

4. What impact does intersexuality have on the individual involved?

Beginning in the 1950s, the medical community treated intersexuality with much secrecy. Physicians believed that, in order for children's gender identities to form properly, parents and patients must never question the doctors' assignments of gender (Alderson et al., 2004; Slijper et al., 1998). Therefore, intersexed individuals may not even be aware of their condition, yet remember traumatic and embarrassing medical procedures. As a result, parents of intersex children and adolescents may isolate or stigmatize them. As adults, they often experience distress related to their syndrome (Alderson et al.). Some people may have negative body image and depression, believing their womanhood or manhood is compromised, and no one can relate to their experiences. In addition, they may react with rage or shame once they discover the truth about their gender (Williams, 2002). Lastly, intersex clients may seek out reconstruction surgery to medically change their gender (Zucker et al., 1996).

Despite the attempts of physicians and parents to stabilize gender identity through secrecy, many intersex people question their gender (Alderson et al., 2004; Zucker et al., 1996) and may even receive the clinical diagnosis of Gender Identity Disorder (GID). In a recent study of intersex children, Slijper et al. (1998) found that 13% of the girls had GID, while none of the boys displayed symptoms. According to the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR)* (American Psychiatric Association [APA], 2000), this syndrome occurs when the client presents with intense sadness and dissatisfaction with the assigned sex. His or her behavior is also usually appropriate for the other gender.

Slijper et al. (1998) also found that 39% of their sample of children developed severe general psychopathology and 11% had mild psychological problems. However, all of the participants in their study received their sex assignments before the age of one year. Psychological problems included the externalizing diagnoses of oppositional defiant disorder, attention deficit hyperactivity disorder, and conduct disorder. Participants also had internalizing diagnoses, including depression, anxiety disorder, selective mutism, and sexual disorder not otherwise specified (NOS).

5. What impact does intersexuality have on the individual's family system?

Intersexuality can greatly affect the family system. The nuclear family may have difficulty accepting the medical condition of the child, especially if doctors change the infant's original gender assignment (Kessler, 1990). When this situation occurs, parents must grieve the son or daughter they believed they would have. This reaction is particularly true for the father who must raise his baby as female, despite the initial determination by doctors that the infant was male (Slijper et al., 1998). In addition, some parents may agonize while waiting for test results to determine the gender of their babies, a time that can be stressful for even the most stable families. They also must make difficult decisions, especially regarding genital surgery or reconstruction (Slijper et al.). Additionally, physicians may increase stress by explaining to parents that their child's gender identification relies almost solely on their rearing (Kessler).

Not all parents accept their intersex children. In Slijper et al.'s study (1998) of intersex youngsters, three parents openly rejected their offspring. The condition of intersexuality may also highlight problems within the couple's relationship, possibly even instigating divorce. Parents must also address their own emotional responses to their baby's medical condition. They may face personal embarrassment and want to shield their child from stigma (Alderson et al., 2004). They may blame themselves and worry about possibly having other infants with the intersex condition.

Adults' intersex condition may also affect their marital or dating relationships. Kessler (1990) reported a major concern with genital surgery included distress that the reconstruction will not appear natural or normal. Likewise, parents and intersex adults worry about the physical ability to perform sexual intercourse. Most intersex women also face infertility problems, resulting directly from the

condition. However, they may choose not to reveal the whole truth behind their intersexuality to their significant others. Yet, romantic partners can be an essential support (Alderson et al., 2004).

6. What impact does intersexuality have on the individual's social functioning (career, friendships, and community involvement)?

Friendships can be another source of support, especially for intersex women (Alderson et al., 2004). However, these individuals often fear devaluation and overburdening, possibly causing difficulty in making friends. Thus, these females may become selective in the information they share about their condition. Concurrent psychological problems may also complicate social functioning (Slijper et al., 1998). For example, an intersex individual suffering from depression as a result of the syndrome may have trouble getting out of bed in the morning. As a result, he or she may not be able to maintain a job.

7. Are there any legal issues related to intersexuality? If so, what are they?

States have their own laws requiring the filing of birth certificates, which include the gender of the infant (Kessler, 1990). For example, New York residents must complete the form during the forty-eight hours following delivery. However, they have thirty days to officially file the birth certificate. Parents and counselors should familiarize themselves with their state's laws and act accordingly. Intersex adults may also have difficulties with equal opportunity laws, based on their specifications of who is covered. For example, the laws may explicitly claim that men and women have equal rights, but not mention intersex individuals. Marriage laws may discriminate against intersex adults, who are neither male nor female (ISNA, 2006).

8. What assessment strategies should a counselor use when working with a client facing intersexuality?

Only recently, counselors and psychologists became actively involved in working with intersex individuals. As a result, the field's literature generally lacks specific tools for assessing clients with this condition. However, Slijper et al. (1998) referenced the criteria in the DSM-IV to diagnose various psychological disorders, including GID, in their young intersex participants. Zucker et al. (1996) used a variety of assessments in their study of adult intersex participants, focusing mainly on dissatisfaction with gender role as well as heterosexuality and homosexuality. They utilized the Gender Dysphoria/Identification (GDI) survey to assess participants' comfort with their gender. This questionnaire may also be useful when counseling intersex clients.

9. What are some effective counseling strategies to use when working with a client facing intersexuality?

The field's literature also has a scarcity of strategies to utilize with intersex clients. Most research focuses on gaining a better understanding of the intersex condition (Alderson et al., 2004; Servin et al., 2003; Zucker et al., 1996), rather than providing counseling. However, well-timed psychotherapy can be a great benefit to intersex children or adults and their parents. Slijper et al. (1998) found that families that received counseling as soon as they received a diagnosis were less likely to have psychopathology. The authors suggested that individual psychotherapy may be preventative, but they did not offer techniques for working with this population. Few families received family counseling, with most participants attending individual sessions with therapists. They also stress the importance of grief counseling with parents.

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by intersexuality?

The Intersex Society of North America's (ISNA) website (www.isna.org) might be helpful to intersex clients (ISNA, 2006). It provides answers to frequently asked questions, including appropriate treatment options. The website also connects intersex individuals with others experiencing similar

situations. It offers an extensive list of support groups, separated by the cause of intersexuality. For example, clients could find a group for AIS or CAH.

In addition, Alan Greene's web article through Medline Plus Medical Encyclopedia (http://www.nlm.nih.gov/medlineplus/ency/article/001669.htm) provides a thorough explanation of the condition along with diagrams (Greene, 2006). The website also assists visitors in finding appropriate support groups and information on treatment. Although the Internet provides a wealth of information on intersexuality, the few books available are quite technical. Clients may have difficulty understanding all the medical jargon.

Counselors have much to offer intersex clients, assisting them as they work through a variety of issues surrounding their condition. Therapists may also become advocates, particularly in regards to genital surgery (ISNA, 2006). As the knowledge of intersexuality grows, so will counseling's assessment and intervention techniques.

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Chapter Seven

Sexuality Counseling with Individuals who Engage in Cross-Dressing

By Christine Mulcahy

1. What is the definition of Cross-Dressing?

Cross-dressing is also known as Transvestism, Transvestitism, Eonism, or Dressing in Drag. According to Dictionary.com, cross dressing is defined as the practice of adopting the clothes or the manner or the sexual role of the opposite sex. Transvestism has the same definition according to this website. The Diagnostics and Statistics Manual of Mental Disorders (DSM) defines Transvestic Fetishism as meeting the two criteria of a) Over a period of at least 6 moths, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing and b) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Despite the DSM defining cross-dressing as a disorder only if it interferes significantly with a person's life, many people would consider cross-dressing for sexual pleasure or as a habit to be indicative of disorder whether or not the person engaging in the activities finds it as problematic.

It is important to note that transvestism is not the same as transsexualism, which is defined by dictionary.com as 1) a person having a strong desire to assume the physical characteristics and gender role of the opposite sex. 2) a person who has undergone hormone treatment and surgery to attain the physical characteristics of the opposite sex or 3) of, pertaining to, or characteristic of transsexuals. While transsexuals often cross dress, transvestites are not necessarily transsexuals. For the remainder of this chapter, this phenomenon of dressing in the clothing of the opposite sex will be referred to as "cross-dressing" and those who engage in it as "cross-dressers." This terminology is more consistent with materials that are tolerant of the behavior and, as highlighted by Deidre McCloskey in her memoir, is less medicalized and 'disease' oriented in its manner than is "transvestism."

2. How widespread is Cross-Dressing?

As is stated in all of the (very few) articles that I was able to find that addressed cross-dressing, there has thus far not been very much research done with this population. As Charlotte Suthrell notes, however, there have been many accounts of cross-dressing across time and cultures. It seems to be a phenomenon that is not isolated to a certain time period or region of the globe. In some cultures the cross-dressing person or the trans-gender person is elevated to a higher status than the "normal" person. I was not able to find any statistics regarding the prevalence of cross-dressing, but I was able to find some information about people who tend to engage in cross-dressing.

Most cross-dressers are male, but as is discussed by Cindi Penor Ceglian and Nancy Lyons, this may partially be because of the fact that there is more tolerance for women to wear "masculine" clothes in today's society. Women wear pants all of the time – jeans, cargo pants, etc – and it is perfectly acceptable. Many women even wear men's sweaters or shirts regularly. It is out of the ordinary, however for a male to wear women's clothing and express femininity. Were it as unacceptable for women to dress as men, the preponderance of men who cross-dress as compared to women may not be as notable.

The prevalence of a non-heterosexual orientation in cross-dressers is similar to that of the general population. Two studies which included cross-dressers in the United States indicated rates of heterosexual orientation at 75% and 89% of the participants. There has been a reported correlation between cross-dressing and promiscuity. Cross-dressing was also associated with frequent masturbation, having had a same-sex sexual experience, use of pornography, sadism/masochism, voyeurism, and "flashing" ones genitals for others to see. Cross-dressing appeared unrelated to age,

immigrant status, family size, socioeconomic status, satisfaction with life, or physical health in this study.

3. What is the typical developmental course of Cross-Dressing?

Most cross-dressers begin to be interested in dressing as the opposite sex early in their lives. It was found in a study of cross-dressers in the U.S. and Australia that close to half of people who later identified as cross dressers first experimented with wearing the clothing of the opposite sex pre-puberty. Most of these subjects reported that by the later part of adolescence they had an established pattern of Cross-Dressing. When a person first begins to cross-dress, it is usually accompanied by sexual stimulation or arousal, but this arousal tends to wan over time, leaving the person cross-dressing for the sake of dressing alone. Cross-dressing does not seem to be something that tends to be a "phase" that a person will go through. By adolescence it is an established pattern that tends to persist through life. Even if a person does not engage actively in cross-dressing throughout their life, the desire to do so is still there. Engaging in cross-dressing may be, but is not necessarily, a precursor to identifying as transgendered. It may be easier for some people to identify themselves as "a straight man who likes to wear women's clothing sometimes" than as a transgendered individual who would rather *be* a woman.

4. What impact does Cross-Dressing have on the individual involved?

There is very little in the literature regarding this topic. I believe this to be a function of the fact that cross-dressing is a relatively unstudied topic, and it is important to further define the phenomena as a profession before one delves into more specifics. The following descriptions are based on my own opinions, memoirs, and the experiences of cross-dressers that I know personally. An individual who cross-dresses may have some of the same difficulties that a person who is identifies as non-heterosexual does. There are some similar stereotypes and beliefs held by society about both of these groups, and heterosexual persons who cross-dress may question their sexuality, as it is a common misperception that men who dress as women are mostly homosexual. This person may also have difficulty in deciding how/when/if to "come out" to their partner or spouse as a cross-dresser. Because the act of cross-dressing is little understood or accepted in our current culture, a person risks rejection by "outing" themselves. They may risk losing their relationship due to their significant other's inability to accept their behaviors. A cross-dresser may wonder "what is wrong with me?" and have difficulty in their gender and sexual identity development, as they often do not fit into pre-prescribed categories that society expects one to develop into. A cross-dresser may wonder if they will ever be able to find a life-partner who is willing to accept and understand their behaviors. If a person who cross-dresses does not become connected with transgendered or cross-dressing communities, they run a high risk of feeling socially isolated and depressed. The risk of depression is also high in persons who have the urge to cross-dress but who believe it is wrong to do so or in persons whose friends and family do not accept their behaviors.

5. What impact does Cross-Dressing have on the individual's family system?

The following description is similar to the previous in that it is based less on research and more on personal experiences of cross-dressers and myself, due to a lack of research that covers this topic fully. Many family members have difficulty in accepting that a family member cross-dresses. Many times it can bring up trust issues – if someone they are close to was able to hide cross-dressing from them, what else may this person have hidden? Family members also tend to have many questions about what implications this has for the family structure and what it really says about the cross-dresser. Does this mean that my father/husband/brother is gay? That he wants to be a girl? Will he wear a dress to the next big family gathering? To the next neighborhood picnic? Spouses and partners of cross-dressers may even question what it means about their own sexuality that they are attracted to a person who cross-dresses. Family members may often react with shock and disbelief at first. They may not know how to handle the new information that they have about their family member.

6. What impact does Cross-Dressing have on the individual's social functioning (e.g., career, friendships, and community involvement)?

Memoirs and anecdotes show that cross-dressing can have a very significant affect on a person's social functioning, both in positive and negative ways. A person may be ostracized from friends, family, work, and community if they "come out" as a cross-dresser and are not accepted or understood by those around them. A person may lose their job, be arrested for using the "wrong" bathroom, risk physical harm due to prejudice, and feel out of place in social situations – either for fear of being "found out" as a cross-dresser, or for wanting to be in drag but feeling that they need to dress as their born sex-type in public. Identifying as a cross-dresser can also have a positive impact on a person's social functioning, however, as is highlighted in several parts of Deidre McCloskey's story. She was able to find a "family" of like-minded people in the cross-dressing and transgendered communities. She was able to know people world-wide in her professional and social life, which made her travels more enjoyable and fruitful. Deidre was able to become part of a community which accepted who she was and always had been rather than being part of a social network in which she had to keep a major part of who she was a secret.

7. Are there any legal issues related to Cross-Dressing? If so, what are they?

There is some question as to whether or not cross-dressing persons should be protected under anti-discrimination law. Levi & Klein state that "The term *transgendered* is intended to cover a broad range of experiences, including transsexual people who undergo medical care and treatment to transition from their assigned sex at birth to the sex that is consistent with their gender identities, people who undergo no medical treatment but also take steps to conform their gender expressions to meet their gender identities, as well as people who take no such steps but gender non-conforming in some way." (p 80) It is my belief that the third part of this definition of transgendered could encompass people who Cross-Dress, and therefore those states who have laws protecting transgendered persons must extend those laws to persons who actively engage in Cross-Dressing. Seven or more states have laws or precedents showing that transgendered persons should be protected under disability law. Despite this protection being in place, many persons chose not to take action against discrimination under these laws because they believe that they are saying that their gender identity is a disability by doing so. Levi & Klein posit that the disability is actually in that they may be discriminated against and thus not have equal access to opportunities. I did not find any laws that prohibited cross-dressing. It would appear that dressing in drag is against only social norms or "laws/rules" as opposed to any explicitly stated laws.

8. What assessment strategies should a counselor use when working with a client facing Cross-Dressing?

I found no particular assessment strategies that should be used when working with a Cross-Dressing client. I believe that a counselor should be able to assess the extent of a persons Cross-Dressing tendencies, how much this may cause psychological or interpersonal distress, and whether a person identifies as a Cross-Dresser or a Transsexual. I believe that these things can be assessed informally as part of the rapport building process with a client and that using formal assessments may be contraindicated. Formal assessments run the risk of portraying that you are assessing for illness or for something wrong. Despite the fact that a counselor may simply be trying to learn more about the client, a formal assessment about Cross-Dressing could easily put a client on the defensive and make a client feel that the counselor is not open to their particular sexual expression. It may also be a good idea to assess for some of the characteristics that have been shown to be associated with Cross-Dressing if you are working with a client who engages in Cross-Dressing (e.g.: sadism/masochism, voyeurism).

9. What are some effective counseling strategies to use when working with a client facing Cross-Dressing?

I found no particular strategies that would be best to use when working with Cross-Dressers. I believe that when working with this population counseling strategies should be chosen on the basis of the presenting concern and client characteristics rather than the fact that the client cross-dresses. Clients who cross-dress come from a wide variety of backgrounds and can have a wide variety of personalities and presenting concerns. It is most important to address these when choosing a counseling strategy for working with a Cross-Dressing client.

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by Cross-Dressing?

Tri-Ess is a group which exists to provide support and networking for Cross-Dressers in the United States. It provides resources for Cross-Dressers, their family, and their partners/spouses. They have 30 chapters throughout the United States as well as online forums. They hold chapter and national events/conferences and publish quarterly newsletters for Cross-Dressers and their spouses.

CDS pub (http://www.cdspub.com) is a site where persons can look for books, magazines, and videos about cross-dressing. Ladylike Magazine is a quarterly magazine written by and for Cross-Dressers. http://www.cross-dress.com is a web based store that caters to male Cross-Dressers. There are many other websites that cater towards the Cross-Dressing community and a person can generally find Cross-Dresser friendly shops and services in their community. Deidre McCloskey, for example, (who Cross-Dressed as part of the process of becoming a transsexual) was able to find shops where she could buy clothing and shoes that fit her mannish frame as well as wig shops that were open to her Cross-Dressing and shops that carried larger sized shoes. For many people this is a benefit of becoming part of a community of Cross-Dressers: sharing information about cross-dresser friendly people and shops in the area.

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Chapter Eight

Sexuality Counseling with Breast Cancer Patients and Survivors

By Anne Buford

1. How are breast cancer-related sexuality issues defined?

Breast cancer-related sexuality issues are multifaceted and complex (see generally Meyerowitz, Desmond, Rowland, Wyatt, & Ganz, 1999). Here, they may be broadly defined as: (a) physical changes induced by cancer and its treatment (e.g., chemotherapy-associated early menopause), (b) psychological impacts brought on by cancer and its treatment (e.g., changes in perceived sexual attractiveness), and (c) relationship adjustments connected to cancer and its treatment (e.g., changes in partners' reactions). Although more issues may exist, exploring these three facets provides a helpful introduction into the influence of breast cancer on sexuality (for a review of these issues and other aspects of breast cancer, see Fleming & Kleinbart, 2001; Henson, 2002; Huber, Ramnarace, & McCaffrey, 2006; Marshall & Kiemle, 2005; Meyerowitz et al., 1999; Pelusi, 2006; Wilmoth, Coleman, Smith, & Davis, 2004).

2. How widespread are breast cancer-related sexuality issues?

Breast cancer is the second-most frequently diagnosed cancer in women (the first is skin cancer), and it ranks behind only lung cancer in cancer-related lethality (American Cancer Society, 2006a). It is estimated that more than 200,000 women living in the United States will be diagnosed with breast cancer in 2006 (American Cancer Society, 2006a). Overall, roughly one in eight women will be diagnosed with breast cancer across the lifespan (American Cancer Society, 2006a; Huber et al., 2006; Meyerowitz et al., 1999).

Due to the prevalence and improving survival rates associated with this disease, it is likely that counselors will work with clients affected by breast cancer (Meyerowitz et al., 1999). Moreover, there is a high probability that sexuality-related concerns will be present, as women diagnosed with breast cancer commonly experience problems with sexual health (Marshall & Kiemle, 2005). Indeed, research indicates that nearly 50% of women with breast cancer have difficulties across aspects of the sexual response spectrum (Fleming & Kleinbart, 2001, referencing Ganz et al., 1998 & Schover, 1999; Wilmoth et al., 2004).

3. What is the typical developmental course of breast cancer-related sexuality issues?

Breast cancer-related sexuality issues depend on characteristics of individual clients, disease processes, and interventions employed (Huber et al., 2006; Meyerowitz et al., 1999). However, sexual difficulties often arise quickly following diagnosis, as clients and partners shift their focus to survival (Henson, 2002; Marshall & Kiemle, 2005) and away from other concerns, like their sex lives. Additionally, sexual problems can increase in severity as a result of treatment (as described here).

Although improvements in overall health usually occur within the first two years after treatment (Fleming & Kleinbart, 2001; Meyerowitz et al., 1999), sexual dysfunction typically remains a long-term concern for breast cancer survivors (Fleming & Kleinbart; Ganz, Desmond, Belin, Meyerowitz, & Rowland, 1999; Henson, 2002; Huber et al., 2006; Meyerowitz et al.). Some research suggests that women experience sexual problems three years or more beyond cancer detection (Meyerowitz et al., referencing Ganz et al., 1996 & Schag et al., 1993). Moreover, as clients are surviving longer, breast cancer is becoming more of a chronic disease (Henson) – one that impacts women – and their sexuality – for extended periods of time.

4. What impacts do breast cancer-related sexuality issues have on the individual involved?

Breast cancer-related sexuality issues can make significant impacts at the individual level. Physically, women undergoing treatment may experience declines in sexual desire, problems with sexual excitement, and difficulties achieving orgasm (see generally Fleming & Kleinbart, 2001; Huber

et al., 2006; Wilmoth et al., 2004). They may encounter infertility, as well as early menopause, as a result of chemotherapy-related damage to ovaries (Fleming & Kleinbart; Henson, 2002; Huber et al.; Meyerowitz et al., 1999; Wilmoth et al.). Additionally, they may suffer pain from surgery, fatigue, lack of feeling in their reconstructed breast(s), dyspareunia, and they may have decreased vaginal lubrication, which may make intercourse more difficult and less enjoyable (Fleming & Kleinbart; Henson; Huber et al.; Marshall & Kiemle, 2005; Wilmoth et al.; see also Meyerowitz et al.).

Psychologically, women with breast cancer frequently experience body image and self-esteem changes (see generally Fleming & Kleinbart, 2001; Henson, 2002; Huber et al., 2006; Pelusi, 2006; Wilmoth et al., 2004). They may feel less sexually attractive because of treatment impacts – such as breast(s) missing, hair loss brought on by chemotherapy, and radiation-based skin reactions – and they may even begin to question their womanhood (Fleming & Kleinbart; Marshall & Kiemle, 2005; Wilmoth et al.). These psychological effects can vary significantly, however, depending on how women perceive their breasts, what role their breasts play in sexual encounters, as well as cultural values associated with breasts (Henson; Marshall & Kiemle; see also Huber et al.). Additionally, research points out that younger women and those given chemotherapy face more challenging psychosexual adjustments (Ganz et al., 1999; Fleming & Kleinbart; Henson; Meyerowitz et al., 1999); in a related way, it is important to be aware of and sensitive to the unique experiences of certain populations diagnosed with breast cancer – including single women and women of racial, ethnic, and/or sexual minority backgrounds (for a discussion of breast cancer among sexual minority women, see generally Boehmer, Linde, & Freund, 2005; see also Huber et al.).

5. What impacts do breast cancer-related sexuality issues have on the individual's family system?

Breast cancer affects not only individual women, but their partners and families as well (Feldman & Broussard, 2006; Marshall & Kiemle, 2005). Generally, diagnosis and treatment greatly enhance stress on relationship and family connections (Feldman & Broussard). Normal activities may be disrupted, and roles may change (e.g., partners may have more household and convalescent responsibilities; Feldman & Broussard; Fleming & Kleinbart, 2001; Marshall & Kiemle). Partners themselves frequently experience feelings of powerlessness, and they may be more vulnerable to depression (Feldman & Broussard; Marshall & Kiemle). Furthermore, the long-term consequences of breast cancer and its treatment may be questionable and indeterminate – requiring women, as well as partners and family systems, to tolerate the anxious unknown (Feldman & Broussard).

Within the sexual relationship itself, many difficulties may occur. For instance, affected clients might have some apprehension about how their partners will view them sexually, especially as they experience physical changes connected to cancer treatment (Marshall & Kiemle, 2005). This increased self-consciousness – combined with other factors – may lead to decreases in the quantity and quality of sexual activity. What is more, clients may feel badly about not engaging in sex, and they may be concerned that their partners will leave (Fleming & Kleinbart, 2001; Henson, 2002; Marshall & Kiemle). From the partners' perspectives, too, there may be concern about not causing injury during sexual interactions (Marshall & Kiemle), or there may be some hesitation to ask for sex (Henson).

6. What impacts do breast cancer-related sexuality issues have on the individual's social functioning (e.g., career, friendships, and community involvement)?

Much of the literature in this area focuses on the individual and intimate interpersonal experiences of breast cancer. Thus, information about the impacts of breast cancer-related sexuality issues on social functioning is limited. However, it may be reasonable to conclude that because breast cancer often causes global change to the individual and the family system, social behaviors are altered as well. Women undergoing treatment may be too ill to attend work or participate in outside activities,

for instance. Similarly, their partners may be consumed by increasing responsibilities, such that they cannot find the time or energy to focus on their work or other social obligations.

7. Are there any legal issues related to breast cancer and sexuality? If so, what are they?

There are a few legal issues that apply to breast cancer, its treatment, and potentially to sexual health. Perhaps most notably, doctors must secure informed consent from breast cancer patients before initiating treatment (Wynstra, 1994). As part of this process, they must make patients aware of the dangers associated with medical interventions (Wynstra). Thus, it may be considered entirely ethical, appropriate, and necessary for discussions of sexual impacts to occur before surgery, radiation, or chemotherapy begin. Additionally, clients and partners should bear in mind that the Women's Health and Cancer Rights Act of 1998 mandates that health insurance companies reimburse reconstructive surgery following mastectomy, if they already pay for mastectomy (American Cancer Society, 2005).

8. What assessment strategies should a counselor use when working with a client facing breast cancer-related sexuality issues?

With clients and partners facing breast cancer, it is best to assess sexual matters delicately. It is most often appropriate to discuss sexuality well into treatment, after the initial shock of diagnosis has diminished (Henson, 2002; Marshall & Kiemle, 2005; see also Huber et al., 2006 referencing Holmberg et al., 2001). It also is helpful for counselors to bring up sexuality issues (see generally Marshall & Kiemle), as clients and partners may be hesitant to volunteer such sensitive information. In addition, counselors should get a clear picture of exactly which facets of sexual interactions are problematic (e.g., pain during intercourse; Henson). Likewise, counselors should inquire about the quality of client-partner relationships – specifically including sexuality – prior to diagnosis and treatment, and they should ask about partners' concurrent sexual difficulties, as these factors can affect sexual health prognosis (Ganz et al., 1999; Marshall & Kiemle; Meyerowitz et al., 1999; Pelusi, 2006). Altogether, a thorough, ongoing assessment is critical (Fleming & Kleinbart, 2001; Huber et al.) because, if avoided, sexual problems can lead to relationship deterioration (Fleming & Kleinbart).

9. What are some effective counseling strategies to use when working with a client facing breast cancer-related sexuality issues?

Counseling can be a vital component of breast cancer care. It can make the diagnosis and treatment processes less frightening, and it can serve as a major source of support. As an overall rule, counseling can be particularly helpful when both clients and their partners are included in the therapeutic process (Feldman & Broussard, 2006; Fleming & Kleinbart, 2001; see also Henson, 2002 and Marshall & Kiemle, 2005).

Generally, when addressing breast cancer-related sexuality issues, it is important for counselors to provide recognition and empathy. The acknowledgement of sexual difficulties associated with cancer and its treatment can mitigate clients' and partners' distress (Henson, 2002; Pelusi, 2006). Counselors also can help normalize the breast cancer experience by offering information about the disease, medical interventions, and impacts on sexuality (it is best to consult with physicians about this; Huber et al., 2006; see also Marshall & Kiemle, 2005). Furthermore, counselors can discuss clients' and partners' thoughts regarding treatment (e.g., what will breast reconstruction look like?; Marshall & Kiemle), as well as inspire hope by highlighting survival rates and emphasizing possible improvements in sexual relationships (see generally Ganz et al., 1999 and Meyerowitz et al., 1999).

On a cognitive-behavioral level, counselors can work with clients and partners to facilitate positive thinking and enhance self-esteem, as research suggests that optimistic perspectives are important for overall well-being (presumably including sexuality; Marshall & Kiemle, 2005). Counselors also can help clients employ coping strategies (e.g., hobbies, groups; Feldman & Broussard, 2006; Marshall & Kiemle). These may provide reprieve and may reduce partnership stress.

Additionally, counselors can help clients and partners communicate more healthfully, which is

an important aspect of adjustment (Marshall & Kiemle, 2005; see also Meyerowitz et al., 1999), and something that can decrease relationship strain. To further improve sexual functioning, counselors might recommend regular exercise (Wilmoth et al., 2004). They also could suggest vaginal lubricants (Ganz et al., 1999; Fleming & Kleinbart, 2001; Henson, 2002; Meyerowitz et al.; Pelusi, 2006). Counselors also can discuss the use of sexually-charged media (e.g., movies, books) to increase excitement and responsiveness (Fleming & Kleinbart). It also might be helpful to have couples use sensate focus exercises, attempt new sexual positions, and practice systematic desensitization with the affected breast(s)/scar(s) (Fleming & Kleinbart; Henson; Meyerowitz et al.; Pelusi). Furthermore, consultation with medical personnel could help determine if localized estrogen use or testosterone injections might enhance sexual interest (Ganz et al.; Henson; see also Fleming & Kleinbart).

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by breast cancer-related sexuality issues?

Many general supportive and informational services are available to women who are undergoing treatment for, or who are recovering from, breast cancer. It is possible that engaging such mechanisms will improve the coping abilities of clients and partners, facilitating improvements in many health dimensions (potentially including sexuality). Relevant Internet resources include, but are not limited to: (a) the Susan G. Komen Breast Cancer Foundation (www.komen.org), (b) the American Cancer Society (www.cancer.org), (c) the Y-Me National Breast Cancer Foundation (www.y-me.org), (d) the Asian American Women's Breast and Cervical Cancer Project (www.nawho.org), (e) the Sisters Network, for African-American women (www.sistersnetworkinc.org), and (f) the Mautner Project – the National Lesbian Health Organization (www.mautnerproject.org).

In addition to these websites and organizations, a search of Amazon.com reveals several helpful books. Most of these books provide information about numerous aspects of breast cancer, and many specifically address sexuality issues. These books include, but are not limited to: (a) *No Less A Woman: Femininity, Sexuality, and Breast Cancer*, by Deborah Hobler Kahane (1995, Hunter House); (b) *Breast Cancer: The Complete Guide*, by Dr. Yashar Hirshaut and Dr. Peter Pressman (2000, Bantam); (c) *Dr. Susan Love's Breast Book*, by Dr. Susan Love and Karen Lindsey (2005, Da Capo Press); and (d) *Breast Cancer Husband: How to Help Your Wife (and Yourself) During Diagnosis, Treatment, and Beyond*, by Marc Silver (2004, Rodale).

To access counseling services, clients and partners can log on to three websites: (a) CounselorFind, offered by the National Board for Certified Counselors (www.nbcc.org); (b) the American Association of Sexuality Educators, Counselors and Therapists (www.aasect.org); and (c) TherapistLocator.net, offered by the American Association for Marriage and Family Therapy (www.therapistlocater.net). Additionally, counseling services may be offered by hospitals – for instance the Beth Israel Medical Center's Sexual Health and Rehabilitation Program (SHARP; Fleming & Kleinbart, 2001; see also American Cancer Society, 2006b).

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Chapter Nine

Sexuality Counseling with Couples and Individuals who have Experienced Miscarriage

By Eric Spencer

1. What is the definition of a miscarriage?

A miscarriage is defined as the termination of a pregnancy in uterus that leads to fetal death. Generally, this termination occurs between 14-16 weeks of pregnancy, or at least before the 20th week.

2. How widespread are miscarriages?

Miscarriages are a relatively common phenomenon, but the actual rate changes depending on the age of the woman. In fact, in a recent study by Klier et al. (2002) the frequency was indicated at around 14%, but women from 20-24 faced only a 9% risk, while those older than 45 faced a rate of almost 75%.

3. What is the typical developmental course of miscarriage?

A variety of things increase a woman's chance of having a miscarriage. Klier et al. (2002) indicate that these may include genetic, anatomic, immunologic, microbiologic, or endocrinologic. Further, environmental factors such as stress, caffeine or drug use, and life events may also become risk factors. Since miscarriage is a spontaneous termination, these risk factors are as close to a developmental course as we can come.

4. What impact does miscarriage have on the individual involved?

Miscarriage has a very large impact on the mother. Having psychologically bonded with the child already, the woman in certainly bound to feel a great loss. As such, miscarriage leads most often to feelings of grief and sadness. It may also, however, lead to feelings of guilt and shame. The woman may feel as though she is not a 'real' woman if she was unable to give birth. Also, a woman will experience the loss of her future plans for the child. She will have to accept the loss of all the dreams she had for her child. The miscarriage may lead to feelings of depression as well as feelings of denial and regret. Further, Klier et al. (2002) indicate that especially within the first 6 months after the loss, the woman is at an elevated risk for depression and depressive symptoms. In some women, this could lead to poor coping strategies such as substance abuse. Also, some women may indicate a desire to immediately become pregnant again during this period, which would be an excellent point of exploration with the couple.

5. What impact does miscarriage have on the individual's family system?

Miscarriage has a profound effect on the family system as well. The father involved in a miscarriage is certain to feel grief and loss just as is the mother. Further, due to societal pressure, the father may have little or no outlet for his grief. Davis (1996) indicates that this may lead to the subversion of his own feeling. She further indicates five common ways in which men channel their feelings of grief: silence, secrecy, action, anger and addiction. That being the case, counselors should be on the lookout for symptoms of these channels in men. Further, they may feel more feelings of loneliness. There is also the concern that some women, as reported above, will desire to become pregnant again immediately, and this may become a point of contention for the couple. In contrast, according to Sperry and Sperry (2004), some partners may exhibit a marked lack of sexual desire so as to prevent the opportunity for another miscarriage to occur.

Charkow (1999) indicates that other impacts may include blame of self or others, a loss of energy that inhibits relationship maintenance activities, and that different coping styles my lead to feelings of misunderstanding or distress. Also, Puddifoot and Johnson (1999), indicate that men tend to show the same level of overall distress and trouble coping as women, but that their coping is often delayed in comparison to the response times of their partners.

6. What impact does miscarriage have on the individual's social functioning?

Miscarriage may have a large impact on the mother's social functioning. Apart from the obvious issues of depression, women who have experienced a miscarriage may feel as though their friends do not understand their pain. Also, if many of their friends are parents, or expecting parents, this may be exceptionally tough. Also, if the woman has taken maternity leave she may have to explain the loss of her child to many people at her workplace, which could be exhausting. She may also face pressure to 'move on' before she is ready, or feel that her loss is invalidated by those around her (such as, 'you never got to know your child.') This may lend itself to further social isolation.

7. Are there any legal issues related to miscarriage? If so, what are they?

Not applicable.

8. What assessment strategies should a counselor use when working with a client facing a miscarriage?

Counselors working with couples facing a miscarriage will want to assess for a couple of things. Firstly, both mother and father are at an increased risk for depression, and should be assessed for such. This could be a dangerous time, so counselors will want to also assess each individual's coping skills as well. Further, the counselor will want to begin to assess the couple's level of social support and how this will affect coping. Klier et al. (2002) suggest that counselors assess for psychiatric disorders, affective disorders, as well as assessing for substance abuse and anxiety. Lastly, Davis (1996) asserts that the male partners may be more prone to substance abuse at this time, and so counselors should assess for a history of substance abuse as well as current abuse or risk of abuse. Also, as previously mentioned, subsequent pregnancy can be an important issue for couples who have experienced a miscarriage. As such, a counselor would do well to talk with both partners about their feelings about another pregnancy, and asses their current readiness levels.

9. What are some effective counseling strategies to use when working with a client facing a miscarriage?

First and foremost, counselors working with couples who have suffered a miscarriage will need to validate the couple's experience. Often times, a couple will feel invalidated by the responses of their friends and family. It may fall then to counselors to acknowledge and validate their loss. Further, counselors can help couples work through their grief reactions. It can be very important to provide the couple a safe and accepting place in which to talk about their feelings. Also, counselors can help the couple to talk with one another about the loss and their feelings associated with it. Klier et al. (2002), suggest that long-term counseling may be most effective with woman who have experienced a miscarriage. They also indicate that research has not been clear yet whether immediate subsequent pregnancy helps to resolve the psychological distress of a miscarriage, or whether this distress carries into the following pregnancy. This too would be an important point to discuss with clients who have this problem.

Counselors should also, whenever possible, work with the couple to help them begin to reconnect. Both partners may be having problems feeling connected in their relationship, and one or both may feel responsible for the miscarriage. Further, there is a high likelihood of sexual difficulty between the partners. Some people will want to avoid having sex to avoid the possibility of another miscarriage while others will seek out sexual contact as a life-affirming event. Counselors can help both partners to explain their own feelings about sex and can help each partner try and work with the other. It will also be important for counselors to work with the couple on supporting one another in times when it is very difficult to receive outside support.

10. What resources are available to help support individuals affected by miscarriage?

http://www.empty-cradles.com/miscarriage.htm A website for people struggling with miscarriages, still births, and other types of infant loss.

http://www.pamsupport.org/pam.php A website for woman who are planning to conceive again after a miscarriage.
http://www.nationalshareoffice.com/ Another site of support for parents of miscarriage, including contacts by state for local support.

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Chapter Ten

Sexuality Counseling with Men Affected by Erectile Dysfunction

By Casey Maultsby

1. What is the definition of erectile dysfunction (ED)?

Erectile dysfunction (ED), previously referred to as male impotence, is defined as the inability of a man to achieve and maintain an erection sufficient for mutually satisfactory intercourse with his partner. The DSM-IV-TR divides ED into three categories:

- *Lifelong vs. Acquired* – referring to whether the condition has been present over the lifetime or developed later in life after normal functioning.
- *Generalized vs. Situational* – pertains to whether the dysfunction was associated with a certain type of stimulation, situation, or partner.
- *Due to Psychological Factors vs. Due to Combined Factors* – refers to whether the condition was psychological in origin or resulted from either medical diagnosis or substance use that could have contributed to the condition but was not sufficient to account for the dysfunction.

2. How widespread is erectile dysfunction?

Statistics indicate that ED effects anywhere from 10 to 30 million U.S. males, and is experienced by both heterosexual and homosexual men. Researchers reported in a 1994 study that 52% of men age 40 to 70 had some degree of ED, with 10% having complete ED. These researchers found that as men age the prevalence of ED increases, with 68% of men age 60 to 70 experiencing some degree of ED. Yet, in 2004, researchers estimated that only 3 million men were treated for ED. Thus far, there have been no significant ethnic differences found in the prevalence of ED.

3. What is the typical developmental course of ED?

While researchers have detailed understanding of the structure and functioning of the male penis, the relationship between psychological mechanisms and the physiological responses involved in ED is not clear. However, there is evidence that only about half of ED originates from organic/physiological factors. Thus it is imperative that the counselor does not oversimplify a client's complaint of ED to something "purely" physiological or psychological in nature. There are some common risk-factors found in those with ED, including:

- *Physical/Medical* – Hypertension, cardiovascular disease, diabetes mellitus, dyslipidemia, sleep apnea, high cholesterol, and obesity.
- *Psychological/Emotional* – Depression, low self-esteem/confidence, anxiety, conflict and/or poor communication with partner, and low sexual desire.
- *Lifestyle* – Lack of exercise, sedentary behavior, smoking, poor diet, high stress levels, loss of income, and substance abuse (especially alcoholism).

4. What impact does ED have on the individual involved?

Problems with obtaining/maintaining erections are often reported as "highly bothersome" in men experiencing ED. Researchers have repeatedly found a positive correlation between depression and ED, leading some to ponder if this relationship is purely coincidental or causal. And while no significant findings have been published as to whether or not depression is a cause, consequence or collaborator of ED, the emotional effects on the individual are relatively characteristic. Men suffering from ED often report feelings of: frustration, performance anxiety, inadequacy, fear, embarrassment/shame, questioning manhood, and low self-esteem. While these emotional symptoms are common to most men with ED; it should be noted that among males treated for ED, many were not bothered enough by these symptoms to meet criteria for a major depressive episode, or any other mood

disturbance. Men with ED often report withdrawing from sexual behavior in general, for fear of failing to obtain/maintain an erection, and not being satisfied or content with non-intercourse related behavior.

ED takes on a unique significance when working with homosexual males. Researchers have found that gay men report higher incidences of "occasional" impotence or ED than their heterosexual counterparts. This increased rate continues to be significant when age and relationship status is taken out of the comparison. Researchers do not yet have a substantiated theory as to why there is an increased rate of ED found in gay men, however there are theories. Some have speculated that sexual inhibition due to performance anxiety, while a significant predictor of ED in both, is greater in gay males than in heterosexual males. These same individuals imply that gay men have more social pressure to be sexually potent and expressive, and erectile response is seen as having more to do with asserting masculinity than giving pleasure to the partner. Yet, while it is important to repeat that these are just speculations, the point to take home is that this may be an area of interest that counselors should pay attention to in their homosexual clients.

Furthermore, it is important for the counselor to note that one of the most common and popular treatments for depression, antidepressant medications, has also been shown to be highly associated with decreased erectile functioning. In particular, selective serotonin reuptake inhibitors (SSRIs) have proven to be the most detrimental to sexual functioning. It has been reported that up to 90% of men on antidepressant therapy may suffer sexual side effects. While, additional medications can be taken to improve sexual functioning in conjunction with antidepressant therapy, studies have shown that men who experienced these side effects were more likely to discontinue their medications than men who did not experience reduction or loss of erectile functioning. Therefore, it is easy to see how such a scenario can create a double-bind for both counselors and clients.

5. What impact does ED have on the individual's family system?

Not often is the partner of the male suffering from ED thought about, so much so that little research has been devoted to partner reactions to ED. While it is well supported in the literature that sexual avoidance is often typical in those experiencing sexual difficulties, it is important to note that a host of interpersonal responses affect the partner of the man with ED. As previously mentioned, performance anxiety, frustration, negative expectancies, embarrassment and self-focused attention experienced by the man with ED will inevitably affect his relationship and interactions with his partner. Communication may break down due to embarrassment and/or anger about the issue, continued negative experiences may cause both partners to withdraw or fall into a "pursuer/avoider" relationship. Once communication falls apart and couples fall into inflexible roles, other relationship issues flood onto the *emotional playing field* and often result in power-struggles and no-win situations. Feelings of anger, rejection, resentment and isolation may quickly develop in the partner of the male with ED. If these patterns continue unchecked, often the relationship will dissolve or the individual may look outside of their partner for sexual/emotional fulfillment.

6. What impact does ED have on the individual's social functioning (e.g., career, friendships, and community involvement)?

ED does not have any direct impact on the individual's social functioning outside of a romantic/sexual relationship. However, indirectly a man with ED may react behaviorally to the emotional consequences of experiencing sexual difficulties. For instance, as previously mentioned, embarrassment and questions of manhood are common in individuals suffering from ED. As is often the case with clients, we see patterns of withdrawing/isolating the self from friends and family due to feelings of embarrassment or shame that makes it difficult to function *normally*, often pushing the client further into self-criticism and depression. Or we may see markedly different responses; overly masculine behavior, aggression, and boisterousness in attempts to compensate for or disguise the

perceived inadequacies that the individual may be feeling. Either of these responses often precipitate losses of social contacts and/or increased conflicts with others.

7. Are there any legal issues related to ED? If so, what are they?

There are no significant legal issues related with ED or the treatment of ED. However, physicians should always check what medications their patients are taking before prescribing any of the oral treatments for ED (i.e. sildenafil [Viagra] vardenafil [Levitra], & tadalafil [Cialis]). It has been well documented that these medications are absolutely contraindicated in patients taking nitrates such as nitroglycerin or isosorbide. This is because these medications can exacerbate the effects of nitrate-based medications, with potentially dangerous consequences. Patients with serious cardiac disease, or those taking antihypertensive medications are advised to seek the advice of a cardiologist before beginning oral therapy for ED.

8. What assessment strategies should a counselor use when working with a client facing ED?

First and foremost, counselors must become comfortable with the topic of sexuality and sexual behavior. In 2004, researchers found that only 58% of men with ED had discussed the problem with their health care professional. In 1999, researchers were astounded that 71% of patients were afraid that their physicians would not consider ED a medical problem, while 68% of patients did not discuss sexuality with their physicians out of fear of embarrassing their physician. In regards to the counselor's role, as mental health professionals, any hesitancy to inquire about or discuss sexuality or sexually related issues in our clients may easily be viewed by clients as:

- Sex is something that cannot be discussed, even in this confidential helping relationship.
- No one else must have these problems, because surely my counselor would have discussed it if it were important.

Often counselors may be hesitant to address sexuality issues with clients due to embarrassment, basic lack of education in human sexuality, or downplaying the importance of sex in an individual's life. Becoming familiar and comfortable with asking questions about their past sexual experiences, current sexual beliefs and practices are great ways to initiate conversations with our clients. Often times, the client will be grateful that they didn't have to bring up the topic. It would be advisable for counselors to reflect on all of the different ways that sexuality impacts our experiences and relationships, and then consider if it is possible to holistically conceptualize our client's with this information missing or purposely avoided. Furthermore, once we obtain some general knowledge and understanding of human sexuality (perhaps by taking a course/workshop or reading special interest books), we must then learn to recognize where our competencies lie. It is very important that once we have determined that a client has or is showing signs of ED, or any other sexually related dysfunction, that they must be referred to a medical professional for medical screening. From this point on, it is extremely important that counselors take a team approach when working with clients who are seeing other professionals on a continual basis for the same issues that they are seeing you for. As a team, we are better able to provide optimal care for our clients.

9. What are some effective counseling strategies to use when working with a client facing ED?

Besides medical treatments, such as oral medications, pumps, injections, and implants, there are a host of therapeutic options as well. Individual counseling, couples counseling, conjoint sex therapy, or a combination of any of the above may be warranted for any particular client. Yet, as is the case when working with clients facing issues that may be fully or partially medically based, information giving and normalizing may be some of the first steps in counseling a client with ED. We can assume that the majority of our clients will be to some degree uncomfortable talking about ED, yet we can also assume that if we can approach the subject comfortably and professionally then that discomfort should dissipate relatively quickly. After referring the client to a physician or specialist, we can begin to learn with our client what treatment will look like for them as an individual. What, if any,

medications will they be on? Have they talked to their partner about the problem and/or the treatment? How has ED affected them emotionally or in reference to self-confidence? What are their current views about sex and the likelihood that their next experience will be a positive one? How much do they want their partner involved in their treatment? Questions like these can open up the floor for the client to decide how much focus they want to put on ED and its effects in their therapy, and how much involvement they want from their partner. It is helpful for the counselor to treat the client as though two problems exist: a *sexual dysfunction* (ED), and a *sexual disturbance* (the emotional and relational effects of ED). One task of particular importance is helping clients discover their own realistic and comfortable definition for "normal" sexual behavior. As for therapeutic techniques, cognitive-behavioral therapy may be of help for clients whose stress levels and distracting thoughts of work or relationship problems get in the way of sexual performance.

Combating irrational beliefs such as *catastrophizing*, *over-generalizing*, or *filtering* would be important in facilitating positive outcome expectancies and increasing self-esteem. Teaching couples effective communication skills, and taking focus away from "intercourse-driven sex" and helping couples discover the multitude of ways to be sexual with one another. Often counselors will advise couples to abstain from sexual intercourse for a specified period of time; thus reducing the pressure to "achieve success" during the process of therapy, and simultaneously building sexual desire and tension at the thought of being "prohibited" from it. This "prohibition" also allows room for discovering other sexual behaviors that might be pleasurable and satisfying besides intercourse. Couples are often surprised by the exciting and creative ways that they learn to "improvise" during the absence of intercourse. This process facilitates increased partner communication and individual self-esteem. Lastly, once sex is reinstated into the relationship, counselors can suggest that couples experiment with different sexual positions that may increase ease of penetration and ejaculatory control. Such positions may be assisted by placing pillows under the partner's buttocks in order to raise the vagina to be on the same level of the penis, giving full view of the partner's genitals and allowing for maximum control.

10. What resources (e.g., books, Internet sites, and support groups) are available to help support individuals affected by ED?

One can go to any general physician or urologist and ask for medical screening or tests to determine if experienced difficulties could be signs of ED. However, the most convenient and easily accessible, not to mention free, resource that individuals have available is the Internet. By going to any search engine and typing in the words "erectile dysfunction" or "erectile disorder," a plethora of materials are at your disposal. Websites based on medical research or those partnered with hospitals or pharmaceutical companies tend to be the most reliable in information displayed. Examples of such websites are: WebMD, Medscape, MedlinePlus, Wikipedia, Familydoctor.org, and Mayoclinic.com.

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Chapter Eleven

Sexuality Counseling for Sexual Addiction

By Ebony Smith

1. **What is the definition of sexual addiction?**

According to the Sex Help (2006) website, sexual addiction is "any sexual related compulsive behavior which interferes with normal living and causes severe stress on family, friends, loved ones, and one's work environment."

2. **How widespread is sexual addiction?**

Be Broken Ministries (2006) quoted The National Council on Sexual Addiction and Compulsivity estimated statistic that between 18 and 24 millions of Americans are sex addicts, but the actual number is probably higher.

3. **What is the typical developmental course of sexual addiction?**

Nakken (1996) described addiction as a way that addicts get their emotional needs meet through objects or events. Both Carnes (1985) and Knauer (2002) believe that due to addicts not getting their emotional needs met in the family of origin or though the pain of childhood abuse, that addict may turn to sexual compulsive behavior to numb or hide from their pain. Knauer (2002) also stated that victims of sexual abuse may turn to sexual addiction as a way to try to regain the power and control that was taken away from them through sexual abuse.

Carnes (1985) list four core beliefs that many sexual addicts have. The first one related to self-image is the belief that the addict is a bad and unworthy person. The second one is related to relationships with the addict believing that no one would love them as they are. The third one states that the addicts don't believe that others will meet their needs. Lastly, sexual addicts believe that sex is their most important need.

According to Nakken (1996) the addiction begins when the addict first experience a mood change with the use of an object or event. He mentioned three different kinds of addictive highs, arousal, satiation and fantasy. The addict starts using the object or event to escape any unpleasant feelings or situations. According to the author, this leads to the addiction cycle where a person would have pain, feel the need to act out, act out the behavior, which makes them feel better, then they experience shame, remorse, or pain from the acting out behavior, which causes them to want to act out again to escape the pain. He notes that this is the beginning of the inner struggle between the person's self and their addictive personality. As the addictive personality starts winning more over the self by using more, the self slowly starts to decrease. The person then starts to become behaviorally dependent on the use in a ritualistic manner, while their behavior becomes more and more out of control. Over time the person life breaks down due to their addictive use.

4. **What impact does sexual addiction have on the individual involved?**

Nakken (1996) pointed out that as the person start meeting their emotional needs through their sexual addiction, they lose the relationship with family and friends, their spiritual higher power, self and community, which isolates the person from the outside world. Another thing that impact sexual addicts are the shame that they feel after they have after acting sexually compulsively as well as other emotional distress like anxiety and depression. Other consequences that Carnes (1985) listed were sexual transmitted diseases, pregnancy, arrests, lost of jobs and lost of relationships. There may also be financial burden from the amount of money that is spent to support the habit like pornography and prostitution.

5. **What impact does sexual addiction have on the individual's family system?**

Sexual addiction may cause the addict to physically or emotionally neglect his or her family. The family members may feel betrayed by the addict's actions as well as lose trust in the addict. The

children in the family may act out or have behavioral, emotional or school problems as a response to the addictive behavior. In cases of incest, not only does it totally change the family dynamics, it also can create severe damage for everyone involved, especially the children. The family members may also develop addictive or co-addictive behavior, which creates or continues the generational transmission of addictive behavior.

6. What impact does sexual addiction have on the individual's social function (e.g. career, friendships, and community involvement)?

As stated in both Carnes (1985) and Nakken (1996), sexual addiction can lead to loss of job due to the addict excessively missing work due to their addiction, reduced job productivity or quality or being caught accessing pornographic websites from work. Sexual addiction in of itself is very isolating. The addict usually commits the compulsive behavior alone or in secrecy, the guilt and shame that the addicts feels leads them to isolate even more, and most sexual compulsive behaviors are not socially acceptable, so they will be reject and scorn for that. Sexual addicts are less likely to be involved in the community. The addiction itself is very detrimental to a person's social function.

7. Are there any legal issues related to sexual addiction? If so, what are they?

Not all sexual compulsive behaviors have legal consequences. Carnes (1985) listed three levels of sexual addiction. The first level includes behaviors that are not illegal or are inconsistently or rarely enforced. They include masturbation, multiple heterosexual or homosexual relationships, pornography, and prostitution. Level two sexual addictions are those behaviors that are considered to be a nuisance that carry misdemeanor charges. They include exhibitionism, voyeurism, indecent phone calls and indecent liberties. Level three addictions are serious offenses and usually are a felony. They include child molestation, incest and rape.

8. What assessment strategies should a counselor use when working with a client facing sexual addiction?

One assessment suggested by Hagedorn and Juhnke (2005) was the WASTE Time Assessment in which you ask the client about Withdrawal, Adverse consequences, inability to Stop, Tolerance or intensity, Escape, Time spent and Time wasted. Other assessments they listed include the Sexual Addiction Screening Test, Sexual Dependency Inventory-Revised, Compulsive Sexual Disorders Interview, and the Sexual Compulsivity Scale.

9. What are some effective counseling strategies to use when working with a client facing sexual addiction?

Hagedorn and Juhnke (2005) suggested using cognitive behavioral counseling or psychodynamic/insight oriented counseling when working with sexually addicted clients. Some cognitive behavior techniques are identification of erotic triggers, anxiety reduction, aversion counseling, covert extinction, orgasmic reconditioning, thought stopping, cognitive restructuring, risk recognition, modification of distorted cognitions, victim empathy, social and assertive skills, and education of healthy sexuality and relationships. Psychodynamic counseling could be used to help clients resolve past and current experiences that maintain the addictive behavior. The goal of the psychodynamic approach is to help facilitate the improvement of impulse control, interpersonal skills and self-esteem so clients can work through mastering more appropriate avenues to sexual gratification.

10. What resources (e.g. books, Internet sites, and support groups) are available to help support individuals affected by sexual addiction?

There are several websites geared to help individuals who are sexually addicted. They include:

- www.sexhelp.com
- www.sexaddictionhelp.com
- www.sarr.org

- Society for the Advancement of Sexual Health (also known as The National Council on Sexual Addiction Compulsivity) www.ncsac.org
- Sexual Addicts Support Groups:
- Sexaholics Anonymous http://www.sa.org/
- Sex Addicts Anonymous http://www.sexaa.org/
- Sex and Love Anonymous http://www.slaafws.org/
- Sexual Recovery Anonymous http://www.sexualrecovery.org/
- Sexual Compulsives Anonymous http://www.sca-recovery.org/
- Partner or Family Member Support Groups:
- Codependents of Sex Addicts (COSA) http://www.cosa-recovery.org/
- Recovering Couples Anonymous (RCA) http://www.recovery-couples.org/
- S-Anon International Family Groups http://www.sanon.org

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Chapter Twelve

Sexuality Counseling for Compulsive Internet Sexual Behaviors

Mario A. Sacasa

1. What is the definition of compulsive Internet sexual behaviors?

Compulsive Internet sexual behavior is defined by an individual spending excessive amount of time on the Internet while engaging in sexual activity. There are five particular qualities that define compulsive Internet usage, which are denial, unsuccessful repeated efforts to discontinue activity, excessive amounts of time dedicated to the activity, the behavior having a negative impact on social, occupational and recreational functioning, and repetition of the behavior despite adverse consequences (Cooper, McLoughlin, & Campbell, 2004). Online activities that are used by someone a compulsive individual are not just limited to viewing pornography, but also contain sex chat rooms, making arrangements to meet with sex partners offline, using web cams for sexual gratification, purchasing sex toys, and prostitution

With the purpose of providing better understanding about what is considered excessive amounts of time on the Internet, Daneback, Ross & Mansson (2006) stated that individuals spending more than 15 hours a week on the Internet are more likely to be looking for a partner, replying to sex ads, chatting with people with similar interests, and contacting prostitutes. Finally, counselors should ascertain information from the client and his/her family concerning their information. Comparing the two sources of information could provide insight into the client's readiness for change.

2. How widespread is compulsive Internet sexual behavior?

In looking at the statistics of compulsive online sexual behaviors, some researchers have found as much as 17% of online sex users have a problem (Cooper, Delmonico, & Burg, 2000), while others stated that number to be less than 10% (Daneback, Ross, & Mansson, 2006). Comparing this to the 172 million individuals who have Internet access in the US, 20 to 33% of them visit sexual explicit websites, with the majority being males over 35 years old, in committed relationships (Cooper, Delmonico, & Burg, 2000). When looking at gender differences, guys more likely to view pornography, while women are more likely to engage in chat rooms or web cam behaviors. (Boies, Knudson, Young, 2004), but overall men are more likely to have an Internet sexual compulsion (Daneback, Ross, & Mansson, 2006).

3. What is the typical developmental course of compulsive Internet sexual behavior?

Defining the typical developmental course is difficult because the reasons for compulsive behaviors are varied. Also, online pornography has deceptive addictive qualities; therefore a problem does not begin overnight but gradually over time. It has been stated that the average age of viewing online pornography is 17.7 years old (Boies, Knudson, & Young, 2004), meaning that the average user is below the adult age limit. One of the main reasons that individuals are drawn to pornography is due to the "Triple A engine", which is Accessibility, Affordability, and Anonymity (Cooper, 1998). This is saying that main lure of Internet pornography is because it is free of the social stigma of store purchases, it is cheap and you never need to leave your home to look at it. Unfortunately, the convenience of Internet sex makes it easier for individuals to develop problems.

4. What impact does it have on the individual involved?

Compulsive online sexual behaviors have tremendous impact on the individual user. The first is that there is a high correlation between amount of time spent on Internet sexual activity and loneliness (Yoder, Virden, & Amin, 2005). One reason could be that the user spends more time online than in physical contact with other people. They tend to shun the real world for the virtual one instead. Online pornography users tend to have a decreased social functioning (Manning, 2006 and Boies, Knudson, & Young, 2004). Also, it detrimentally affects their perceptions of women, they are more likely to be

degrading of other races and accepting of the Rape myth. Another potential impact is that online compulsive sexual behaviors tend to lead an individual to engage in offline pornography usage (Daneback, Ross, & Mansson, 2006). Some individuals will meet online, engage in cybersex (otherwise in a chat room, via a webcam, or both) and setup a time to meet to have actual intercourse. This risky behavior leads to a higher chance of contracting a sexually transmitted infection. Also, if the individual is of a young age, it could affect their sexual development and perceptions of sex. They would be more likely to perceive pornographic sex as the norm for sexual behaviors, when in fact it is not.

5. What impact does it have on the individual's family system?

Even though the user believes this behavior to be a highly individual one, its effects are felt beyond the private time at the computer. One of the areas where compulsive online sexual behavior has a profound impact is on the individual's marriage or intimate relationship. When compared to men, women consider using the Internet for sexual purposes as a type of infidelity (Witty, 2003). Moreover, women were equally upset if the affair was only for the purposes of increased emotional connection. Also, married women more distressed by husband's online behaviors and believe it to be a possible cause for separation (Manning, 2006). Another area where this presents a problem is that men will take what they see online to the bedroom. They will otherwise lose interest in sex with spouse because the spouse no longer can compete with what he sees online, or the husband will want the spouse to perform behaviors found online. Moreover, most of these behaviors are considered degrading and objectifying of women. I believe that affects that compulsive online sexual behaviors are only just beginning to be felt. We will see more serious effects when the Internet has been established for a longer time.

6. What impact does it have on the individual's social functioning (e.g., career, friendships, and community involvement)?

As stated earlier, the most serious impact of compulsive online sexual behavior is its effect on the user's social functioning (Manning, 2006 and Boies, Knudson, & Young, 2004). Since this behavior can be characterized as an addictive one, the impact in endless. People have lost jobs for spending too much time looking at pornography. They can spend excessive amounts of money on sexual activities. Also, they become more isolated and confined due to the amount of time dedicated to the Internet. They lose friendships and divorces occur because of their inability to stop their compulsions and cease engaging in this behavior.

7. Are there any legal issues related to it? If so, what are they?

For the majority of individuals who are compulsive online sexual users, they are not breaking any laws in our country, since it is perfectly legal to do so. Also, even in the event that the user was underage, the chances that they would be prosecuted are minimal. Due to the anonymity of the Internet it is difficult to know someone's true age and identity. Still, there are certain instances where a compulsive online sex user could encounter legal difficulties. The most obvious is if the person is viewing child pornography or engaging in any sort of sexual activity with a minor. There have been cases where a person will set up a time and date to meet with a minor to partake in a sexual experience. This issue is both a legal problem and a relational problem.

8. What assessment strategies should a counselor use when working with a client struggling with compulsive Internet sexual behaviors?

A simple and direct assessment strategy is to ask the user a series of questions detailing their current online usage and perceptions of that use. Counselors should ask about the amount of time spent online and if they are neglecting social and familial responsibilities. To see if there is a history of compulsive behaviors, the counselor could implore the use of a genogram to aid in the assessment process. It would also be important for the counselor to understand the client's values attached to their

behavior and if they are feeling a sense of shame or guilt. Moreover, the counselor should understand their personal beliefs surrounding sexuality.

In the context of a relationship, the counselor should incorporate the spouse to hear her reactions to the user's online sexual activity. Certain qualities to assess for are, seeing if the user has lost interest in sex with the spouse. Also, check to see if they are having difficulty maintaining an erection or achieving orgasm during intercourse but are still able to climax while masturbating to pornographic images. This will help the counselor to properly assess the scope of the problem.

9. What are some effective counseling strategies to use when working with a client with compulsive Internet sexual behaviors?

The two most common treatment modalities that have been cited to help individuals overcome their compulsive Internet sexual behaviors are cognitive behavioral therapy and emotionally focused couples therapy (Corley, 2006). Cognitive behavioral will help the user to develop concrete strategies to change their behavior and learn to master their desires to seek online sexual activity. Emotionally focused therapy would be helpful in the context of the relationship, to uncover hidden meanings attached to the Internet sexual activity and help find healing for the wounds created by this form of infidelity.

Corley (2006) provided suggestions to reduce the amount of temptation for an individual struggling with compulsive Internet sexual behaviors. One suggestion was to make sure that the computer is in a central location (such as the living room or dining room) as opposed to an office or bedroom. Another was to make sure the individual has an accountability partner, someone that they could talk to when they feel the urge to engage in online sexual activity. Also, the individual is discouraged from using the Internet when no one else is in the house. In order to keep the person aware that his/her behaviors are affecting the family, the computer should have pictures of the family as the wallpaper on the desktop and/or as the screensaver. These were just a few suggestions made to diminish the possibility of a relapse.

Finally, in the case that an individual is in need of more corrective therapy there does exist a 12-step process for overcoming the hurt caused by online sexual behaviors (Corley, 2006). In order, they are clarity of impact, keep user engaged and committed to counseling, uncover emotions, help user accept responsibility, help user find hidden meaning to behavior, offer apology, give spouse the space to seek more information about the behavior, spouse accepts apology, summarize the process, help the couple to re-establish their sexual relationship, and develop a plan should the user relapse. These steps are guidelines for counselors to implement when working with families where a member has an Internet sexual problem.

10. What resources are available to help support individuals affected by compulsive Internet sexual behaviors?

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Recovering Couples Anonymous www.recovering-couples.org

Sex Addict Anonymous www.sexaa.org

Society for the Advancement of Sexual Health (SASH) www.sash.net or www.ncsac.org

Pure Intimacy www.pureintimacy.com

Theology of the Body Institute www.tobinstitute.org

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Chapter Thirteen

Sexuality Counseling with Current and Former Prostitutes

By Sarah Moxley

1. What is the definition of prostitution?

Prostitution is defined as exchanging sexual acts for monetary or material gain.

2. How widespread is prostitution?

Statistics indicate that roughly 5% of women engage in some form of prostitution for some length of time at some point in their life (Bullough & Bullough, 1996). Accurate statistics on this population are difficult to surmise because it is largely unreported. Those statistics gathered from arrest records are non-representative of this population because they do not take into account those individuals who are not arrested but who are engaging in acts of prostitution. While the majority of prostitutes are women, there is also a significant male and transgendered segment of this population found more often in urban, less rural locations.

For those individuals who have been involved with prostitution for more than a few months, they are likely to float among different venues of prostitution. Some of these include street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult pornography, trafficking and prostitution tourism. (Farley, Cotton, Lynne, Zumbeck, Spiwak, Reyes, Alvarez and Sezgin, 2003)

3. What is the typical developmental course of prostitution?

Research tends to support the idea that a majority of those individuals engaging in acts of prostitution were at some point in their lives sexually abused. It is increasingly accepted among mental health professionals that experiences of sexual trauma, particularly by family members, as a child has a direct link to prostituting behaviors as an adult (Napoli, Gerdes & DeSouza-Rowland, 2001). Conservative estimates indicate that 13-14 years of age is the time at which most individuals are recruited into prostituting, or "turning tricks" (Farley, et. al., 2003). There was little information found on the age at which individuals stop prostituting themselves or those factors that lead to exiting this lifestyle.

4. What impact does prostitution have on the individual involved?

Individuals engaging in acts of prostitution are often at great risk of being repetitively humiliated and left vulnerable to physical (Valera, Sawyer, & Schiraldi, 2001) and sexual attack. Because the highest percentage of physical, sexual and verbal attacks of prostitutes come from the customers themselves, the job itself is detrimental in its own right, risk factors and after-effects notwithstanding. This population also tends to suffer from a rather significant rate of alcohol and drug use and abuse (Valera, Sawyer, & Schiraldi, 2001). Other risks include contracting sexually transmitted diseases and unwanted pregnancy. Mentally and emotionally, there is a great toll exacted upon this population. Many prostitutes suffer from low self-esteem, post-traumatic stress disorder (PTSD), and "psychic numbing" or dissociation from their body sensations and from their emotions. (Napoli, Gerdes & DeSouza-Rowland, 2001)

5. What impact does prostitution have on the individual's family system?

Systems theory posits that if one component of a system impacts all other components of the system. So it is with individuals who are prostituting. If the individual who is prostituting themselves has a childhood history of abuse, it is likely that the family-of-origin relationship patterns will be repeated in future generations (Dalla, 2004). Thus, whatever effect of prostitution the individual is experiencing, the family system will also be affected. For instance, if the individual experiences life as a prostitute in an emotionally disconnected way, it is likely that this emotional disconnect also manifests itself in the family system with other family members. If the individual has children, it is likely that their faulty self-perceptions and beliefs about the world will in some way be passed to the next generation continuing a cycle of psychological issues at the hand of prostitution. So, the

importance of intervention and psychological health of individuals in this population has far-reaching implications.

6. What impact does prostitution have on the individual's social functioning?

Social functioning of individuals within this population is often blunted because of the fear of being "found out" and the fear of rejection among peers in a society that looks down upon this lifestyle (Dalla, 2004). So, many prostitutes keep this part of their lives, as much as possible, a secret from those outside the world of prostitution. There is typically a sense of shame and debasement associated with prostitution that inhibits taking initiative in "healthy" social interactions.

Because prostitution is an illegal activity, it must be kept secret from any other forms of employment the individual may have. This seems to increase the likelihood of isolating behaviors in which help, or a "way out" is not sought.

7. Are there any legal issues related to prostitution? If so, what are they?

Prostitution is illegal in the U.S., and so some members within this population may be facing counseling as a court mandated directive. Because of the often-present distorted self-perceptions and perceptions of society, prostitutes may exhibit little concern for being incarcerated. Incarceration as a form of corrective action also has proven to be largely ineffective because it does not address the underlying psychological issues often present in these individuals. (Napoli, Gerdes & DeSouza-Rowland, 2001)

8. What assessment strategies should a counselor use when working with a client facing prostitution?

It is important for counselors working with this population to understand the role that the prostituting behaviors play in the client's life. That is, it is important to ascertain the functions these behaviors serve. Once prostitution is understood in the larger context of the client's life, a working "map" of the areas needing attention in counseling can be developed (Wolfe, 2000). For instance, the prostituting behaviors could be a result of trauma experienced in childhood. Thus, the counselor would want to assess for PTSD issues and "repetition compulsion" in which the client is re-experiencing the childhood trauma within the context of current prostitution. Because not all prostituting behaviors are a result of childhood trauma, it is important to understand from the client the function of the behaviors in order to address the root domains (i.e. physical, emotional, mental, spiritual) from which the prostitution stems.

9. What are some effective counseling strategies to use when working with a client facing prostitution?

One of the most effective counseling strategies with this population involves an integrative approach that seeks to focus clients on reconnecting their cognitions with their physical and emotional sensations. A simplified framework for this approach includes four primary stages. The first stage involves establishing a safe environment for the client. Because authority figures have often been associated with "perpetrators" in clients' experiences, an awareness of this dynamic in the relationship is necessary to process with the client. Oftentimes, male counselors will have a more difficult time gaining the trust of their client because of the predominantly male/female aggressor/victim dynamic. Also, male counselors may also encounter female clients who behave in a very sexualized manner toward the counselor. While these are hurdles that must be dealt with in a delicate and forthright manner, this dynamic also can provide a powerful opportunity for corrective experience.

The second stage involves regaining a sense of connection to the physical body. This is often aided by using breath work, muscle relaxation, and guided imagery. These strategies help the client to remember and experience their physical and emotional reactions to past trauma. The third stage flows from the second in that it helps the client to articulate their own psychological history by exploring their full range of emotions regarding past abuse. Guided imagery and visualization techniques can be helpful throughout this process. This moves clients into the next stage where they begin to understand and articulate the way their history of abuse influences their choices as a prostitute. This stage is

similar to cognitive therapy but may be augmented with body work, guided imagery and visualization exercises. Over time, the client builds the confidence to perceive themselves and their world differently. They learn to "re-parent" themselves giving their inner child the nurture and care that was lacking in their formative years and that are pivotal in making day-to-day choices regarding prostitution.

Within this framework, other techniques and strategies may be helpful in aiding the client to get in touch with their emotions. These include but are not limited to: letter writing, journaling, genogram, guided storytelling, script-changing, "re-parenting", role-playing, and dance/movement therapy. (Napoli, Gerdes & DeSouza-Rowland, 2001)

10. What resources are available to help support individuals affected by prostitution?

- www.prostitutionresearch.com
- MASIE (Minorities and Survivors Improving Empowerment)
- www.endslavery.org
- Sex Industry Survivors Anonymous: http://www.sexindustrysurvivors.com; 888-702-7273
- Women's Resource Center of Greensboro; 336-275-6090; 628 Summit Avenue/Greensboro, NC/27405

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Chapter Fourteen

Sexuality Counseling with Sexual Predators

By Caren Miller

1. What is the definition of a sexual predator?

A sexual predator is someone who seeks out and attempts to obtain sexual contact with another individual in a predatory manner (Sexual Predator, 2006). The title of sexual predator is used to refer individuals who engage in a number of different criminal activities including but not limited to soliciting sex from a minor, sexual abuse, molestation, statutory rape, exhibitionism, voyeurism, rape, penetration of any part of the victim's body using any part of the offender's body or other objects, and sexual assault. Different states have different definitions of sexual predator, which can confuse which crimes are considered acts of a sexual predator. The term sexual predator is distinct from the term sex offender. Generally, a sex offender has committed a sexual offense against one other individual. The term sexual predator typically refers to an individual with multiple victims. However, an individual who has only committed an offense against one individual who is a minor is still considered a sexual predator (Sexual Predator). Sexual predators are typically, but not always, male. In the majority of cases, the sexual predator knew the victim prior to engaging in the criminal behavior (Briggs, 1995).

2. How widespread is sexual predation?

Statistics indicate that there are 579,974 registered sex offenders in the United States as of 2006 (National Center for Missing and Exploited Children, 2006). According to this source, North Carolina had 9,704 registered sex offenders as of February, 2006. Guilford County had the highest number of registered sex offenders in all of North Carolina at a total of 68, with Forsyth close behind at 50 registered sex offenders, according to the most recent available statistics (North Carolina Sex Offender and Sexual Predator Statistics, 2003). These statistics only reflect the number of sexual predators who have been caught, found guilty, and registered. Numbers of actual sexual predators are estimated to be much higher, due to underreporting of sexual crimes. According to research and estimated 34 to 60 percent of all sexual offenses are perpetrated by adolescents, and that 70 percent of this population receives no counseling or incarceration for these crimes (Cashwell & Caruso, 1997). It has been estimated that without treatment or incarceration, sexual predators on average will have 350 victims, and commit an average of 581 total acts (Cashwell & Caruso).

3. What is the typical developmental course of sexual predators?

Due to the fact that the term sexual predator can refer to an individual who has committed any number of crimes of a sexual nature, it is impossible to describe a typical developmental course that applies to all sexual predators. There are multiple levels of severity within the title of sexual predator, and very little is known about the causes and developmental processes which lead to sex offending. Within the category of sexual predator, there are a few subgroups whose developmental course is better understood. One of these subgroups is sex offenders with developmental disabilities. For this population, it is typical for the perpetrator to have come from a family characterized by multiple pathologies, marital discord, parental separation, violence and neglect (Lindsay, 2004). Certain indicators may be present from a young age including poor relationships with peers, lack of social sexual knowledge, feelings of powerlessness, distorted self-concept, a history of difficulty adjusting to school, and delinquent behaviors (Lindsay). It is possible that these indicators may also be evident in the early childhood development of sexual predators who are not developmentally disabled.

However, many children who display these behaviors will not grow up to become sexual predators, and these indicators should not be used to predict probable occurrence of sexual offenses. Another population which may have a typical developmental course are sexual predators who were themselves sexually abused as children. It is unclear what percentages of sexual predators were sexually abused as children. Estimates as low as ten percent and as high as eighty percent have been reported (Cashwell & Caruso, 1997). For children who have been sexually abused, many begin to equate the

sexual acts with intimacy and caregiving. Many come from a home environment which may include rejection, neglect, or physical abuse. This may open the door for sexual predators, who show the child affection and give attention. Once sexual abuse has occurred, it is not atypical for victims to begin to identify with the perpetrator. Many may begin to reenact the abuse with friends and children who are younger than themselves (Cashwell & Caruso). The abuse itself distorts the child's sexual development. All of these factors may contribute to the individual becoming a perpetrator of sexual offenses. It is important to note that not all victims of sexual abuse will become perpetrators. In addition, not all perpetrators were victims. More information is needed regarding the developmental course of perpetrators who were not childhood victims of sexual abuse.

4. What impact does being a sexual predator have on the individual?

The general population has a very negative view towards sex offenses and sexual predators. However, before the discovery than an individual has committed a sexual offense, sexual predators are typically viewed as normal or even good individuals (Briggs, 1995). Once the predator has been discovered, he or she is typically shunned by the general population who look upon this individual with horror and disgust. The individual may lose friends, a career, and opportunities for the future. The individual may experience humiliation, guilt, or shame. Due to relevant laws, the individual may serve prison time for the offenses. If the individual is imprisoned, it is not unlikely that he or she will be assaulted by other inmates, due to the attitudes that other inmates have about sexual predators (Briggs). In addition, the majority of sex offenders are required to register with both the state and the national government (LaFond, 2005). Personal information, such as sex offender status, name, and address are all available to the general public. The individual faces many losses including social standing, social support, career aspirations, and personal freedom.

5. What impact do sexual predators have on the individual's family system?

Currently, little to no research has been conducted in order to investigate the impact of being in close relationship to a sexual predator. Briggs reports that in situations where a family is labeled as dysfunctional, blame may be placed on the spouse or other family members for the sexual offender's behavior (1995). In addition, it is not uncommon for parents of adolescent sex offenders to feel as though they are responsible in some way (Cashwell & Caruso, 1997). This may lead to feelings of guilt and shame for member of a sexual predator's family. In some cases, the victim of the offense may also be a family member. This may lead to feeling torn between two family members, feeling as though the victim should have been better protected, guilt, and sadness. Despite the fact that sexual predators are not visibly any different than other members of society, individuals who knew the perpetrator well may feel as though they should have been able to tell that the individual was committing sexual offenses. These individuals may question their ability to judge others' characters, may create trust issues, and may create a feeling of betrayal. Individuals whose family members are tried and convicted of sexual offenses may have to endure years of separation in which the loved one is incarcerated. These individuals may feel abandoned and angry at the loved one for creating the situation which led to the separation. Counselors need to be aware of the potential impact that finding out that a love one has committed sexual offenses has on the family itself, as family members may seek therapy in order to resolve feelings and conflicts associated with the sexual predator.

6. What impact does being a sexual predator have on the individual's social functioning?

Being a sexual predator in and of itself does not affect an individual's social functioning. However, if the individual is discovered as being a sexual predator, the individual's social functioning is effected dramatically. In many cases, the individual will be tried, convicted, and ultimately incarcerated. Being imprisoned separates the individual from society, and completely disrupts all areas of the individual's social functioning. If the individual is not incarcerated or after the period of incarceration, the individual is still required by law to register with the state and national government. Being registered as a sex offender makes it very difficult to acquire many different types of jobs. Many careers will no longer be an option for the individual. The status as sex offender would also limit the

individual's opportunity for community involvement, as the population at large views sex offenders negatively. Due to the stigma associated with being a sexual predator, the individual may lose friendships and find it difficult to make new friends.

7. Are there legal issues related to sexual predators? If so, what are they?

There are laws in every state which require the registration of known sex offenders (LaFond, 2005). In addition to these state registries, there is also a national registry for sex offenders. Individuals who are required to register are mandated to report their current address and any address changes for the remainder of their life. In addition, they may be required to submit current photographs of themselves, DNA samples, and fingerprints in some states (LaFond). Megan's law was created in order to ensure that children are better protected from sexual predators by requiring law enforcement to notify neighbors when dangerous sex offenders move into a neighborhood. In addition to the requirements for registry, many states have passed chemical castration laws. These laws require sex offenders to take certain drugs which are known to reduce sexual drive as a condition of parole. If the individual refuses or stops taking the drugs, they must serve the full sentence. The rationale behind these laws is that sex offenses are sexual in nature and will not occur if the perpetrator does not have an active sex drive (LaFond).

Beginning in 1990, fifteen states have passed Sexually Violent Predator (SVP) statues. The purpose of these statutes is to keep dangerous sexual predators from being able to commit more crimes. These statutes allow the state to continue to confine sexual predators who have met certain requirements after they have served their prison terms. The prosecutor must be able to prove that the individual has committed a qualifying sex crime, has either a mental disorder or personality disorder, and is likely to commit another serious offense. If these conditions are met, the individual can be confined in institutions established for this purpose until they are no longer a threat to society. These institutions provide psychological treatment, but many refuse to participate. Once confined to these institutions, few have been released back into society (LaFond).

8. What assessment strategies should a counselor use when working with a sexual predator?

When assessing clients who are sexual predators, it is important to obtain information such as prior history of sex offending behaviors, criminal record, and psychosexual history (LaFond, 2005). In addition, it is important to assess the client's history of childhood abuse, if a history exists. This is important, as it will impact the direction of therapy. Interviews with others who are familiar with the offender may be beneficial, as sexual predators often give false or misleading information (LaFond). One important element for assessment is level of dangerousness and likelihood to commit other sexual crimes.

A few instruments have been created in an effort to predict risk of re-offending. Examples of such instruments include the Static-99 and the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR). Unfortunately neither assessment instruments nor counselor interviews have high predictive validity when it comes to recidivism (LaFond). When working with sexual predators with developmental disabilities, Lindsay suggests the use of the Socio-sexual Knowledge and Attitudes Test (SSKAT), the Abel and Becker Cognition Scale, and the Questionnaire on Attitudes Consistent with Sex Offending (QACSO)(2004). Impulse control is an area which will need to be explored, especially for adolescents. In addition, it is important to distinguish between typical sexual behaviors and deviant behaviors in the adolescent population (Cashwell & Caruso, 1997). It may also be appropriate to assess for specific mental or personality disorders, depending on the individual.

9. What are some effective counseling strategies to use when working with sexual predators?

When counseling sexual predators, it is important for the counselor to begin by exploring her/his own biases, feelings, and opinions regarding sexual predators (Nelson, Herlihy, & Oescher, 2002). Without unconditional positive regard and the ability to be genuine, the counseling process is unlikely to be beneficial to the client. Some skills that are necessary for counselors to posses in order to be effective with this population include confrontation skills, concern for community safety, ability to

handle stress, ability to discuss sexual matters openly, ability to maintain objectivity, and the ability to remain realistic about sexual offenders potential to commit further crimes (Nelson, Herlihy & Oescher). Cognitive-behavioral techniques have been proven effective with sexual predators. In order for treatment to be successful, the offender must be willing to participate in treatment, show a desire to stop the offending behavior, and be able to identify thoughts, feelings, and situations which contribute to the offending behavior (McGrath & Purdy, 1999).

If the individual is unwilling to admit to the offenses, or that the offenses harmed the victim, certain techniques can be utilized. These techniques include psychoeducation about the nature of sexual offenses and the impact of the sexual offense on the victim and group counseling with other offenders in an effort to increase peer pressure and provide positive reinforcement (McGrath & Purdy). Briggs acknowledges that it is the counselor's responsibility to counter offender's efforts to minimize or rationalize offenses (1995). Once the offender is willing to engage in treatment, several goals should be established. These goals include accepting responsibility for behavior, modifying cognitive distortions which support the offending behavior, developing victim empathy, controlling sexual arousal, improving social competencies and skills, and developing relapse prevention skills (McGrath & Purdy). In terms of reducing inappropriate arousal, behavioral techniques such as aversion therapy and masturbatory retraining techniques are often used (Cashwell & Caruso, 1997; LaFond, 2005). In addition to these goals, it is important for counselors to help sexual predators who have been abused themselves to deal with their own victimization (Cashwell & Caruso).

10. What resources are available to help support recovering sexual predators and those who are affected by them?

Sex Addicts Anonymous is a 12-step program which can provide support for sexual predators. There are over 750 meetings around the world. In addition, the organization's website can provide information concerning resources, meeting locations, and information about sex addiction. For more information, please visit the organization's website at http://www.sexaa.org. In addition to Sex Addicts Anonymous, Sex and Love Addicts Anonymous is another 12-step program designed to help individuals who are trying to recover from sex addictions. The Sex and Love Addicts Anonymous website can be found at http://www.slaafws.org.

One other 12-step program which can provide support to sex offenders is Sexual Compulsives Anonymous, and can be found at http://www.sca-recovery.org.

For individual's who have been affected by sexual predators, S-Anon International and COSA are both 12-step support groups which may provide help. They can be found at http://www.sanon.org, and http://www.sca-recovery.org respectively.

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