Sexuality Counseling Guidebook

VOLUME III

Key Issues for Counselors and Other Mental Health Professionals

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PROLOGUE

This is the third volume of the Sexuality Counseling Guidebook, which was developed by graduate students in the Fall 2008 course, Advanced Clinical Topics in Couple and Family Counseling: Sexuality Counseling, in the Department of Counseling and Educational Development at The University of North Carolina at Greensboro.

This guidebook was written to inform counseling clinicians and clients about the experience of sexuality counseling. Sexuality counseling involves working with client couples and/or individuals about a wide range of issues related to sexuality, including sexual functioning, body image, relationship issues, attitudes and beliefs about sex, sexual development, the impact of trauma on sexuality, and positive and fulfilling aspects of sexual relationships.

The authors of this guidebook believe that sexuality is an important component of an individual's overall wellness, and that sexuality plays an important role in relationship satisfaction and one's feelings about oneself. Sexuality counseling gives clients a forum for exploration and discussion to promote growth in their sexual awareness about themselves and their relationships.

The topics in this guidebook are designed to provide information about the process of sexuality counseling, as well as to address special considerations that some clients face. In Chapter 1, Jamillah Jackson provides a critique of sexuality counseling so that clients and counselors can determine whether this approach is appropriate for them. Chapter 2 includes reviews of some commonly-used assessment instruments related to sexual functioning in males and females, prepared by Ashlee Gary. Jessica Redish's Chapter 3 covers a common experience for many clients and counselors in sexuality counseling—addressing the anxiety related to discussing such a personal aspect of life. Finally, in Chapter 4, Leslie Wilson highlights important considerations for counselors working with couples who are experiencing conflict related to their sexual relationship.

We hope that this guidebook provides a foundation for understanding expectations and concerns that may arise during the process of sexuality counseling. Volume I of this guidebook is available at the following web-site: http://www.uncg.edu/ced/bbandb/bbbguidebook.pdf. Volume II of this guidebook is available at the following web-site: http://www.uncg.edu/ced/Sexuality%20Counseling%20Guidebook--Volume%20Two--Fall%202007.pdf

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Chapter One
Critique of Sexuality Counseling
By Jamillah A. Jackson

1. Background and Introduction

a. Definitions

Sexuality counseling. Sex therapy. What is the difference, if there is one? Admittedly, Rosen and Weinstein (1988) stated that trying to distinguish between sex counseling and sex therapy has created much disagreement and confusion. In general, the term *sexuality* is preferred to *sex* to signify all aspects of the holistic person as a sexual being. This life-long process that evolves over time includes sociological, psychological, biological, cultural, and spiritual/ethical aspects (Burlew & Capuzzi, 2002). *Sex,* on the other hand, generally refers to either the various forms of intimate behavior or biological aspects of gender (Rosen & Weinstein). Oftentimes, however, many simply use *sex* to imply *sexuality* in an abbreviated form, which further contributes to the confusion.

Rosen and Weinstein (1988) assert that sex or sexuality counseling is "a process of interaction between professionals and client that allows the clients to explore and understand their sexual feelings, values, responsibilities, needs, and behavior" (p. 1). In addition, the opportunity is provided by the clinician for the client to deal with any underlying issues that manifest themselves as sexual problems. Sexuality counseling also includes an educative component, values clarification, relationship issues, self-image, reassessment of values, sexual identity, and sex-role development. Its broader spectrum allows the client to explore sexual experiences in relation to life experiences and recognize and reconcile underlying problems. Though there is much overlap between sexuality counseling and sex therapy, the latter emphasizes sexual dysfunctions and the behavioral and cognitive-behavioral approaches used to treat them (Kaplan, 1974; Masters & Johnson, 1970 as cited in Rosen & Weinstein).

b. History

According to Hartman & Fithian (1997), Robert Latou Dickinson started the scientific study of sexual dysfunctions and methods to treat them in the United States. Though he earned his medical degree in New York, he was born and educated in Germany and Switzerland. In 1890, he started gathering sex histories from his female clients, including those who were single, married, heterosexual, and lesbian. Over the course of his practice, he collected 5,200 histories from which he published reports on women's sexual difficulties (Brecher 1979; Dickinson and Beam 1931, 1934; Dickinson and Person 1925 as cited in Hartman & Fithian). Sigmund Freud's psychoanalysis no doubt had an impact on sex therapy at the beginning of the twentieth century and in 1948 and 1953, the Alfred Kinsey studies shined the light on human sexuality as a scientific study (Hartman & Fithian). This allowed sexual disorders to be treated under the umbrella of medicine and psychiatry rather than forcing them to the shadows as a personal problem subject to moral and religious scrutiny. By adapting behavioral therapy, Joseph Wolpe and Arnold Lazarus' 1966 work changed the focus of sexual therapy away from the medical and analytical model and enabled sexual dysfunctions to be seen as a product of learned responses that can be altered.

Perhaps the most recognized names in sexual therapy are William Masters and Virginia Johnson. Their 1966 *Human Sexual Response* and 1970 *Human Sexual Inadequacy* outlined their pioneering study with nearly 700 participants, a male-female cotherapy team, and a concise and rigorous method that focused on reeducation and behavioral techniques such as sensate focus

(Hartman & Fithian, 1997). Their use of a 20% failure rate that implied, but did not mean an 80% success rate sparked confusion in the field after other therapists attempted their methods yielding less than impressive results (Hyde, 1982). Joseph LoPiccolo promoted the use of additional anxiety-reducing methods within the Masters and Johnson's behavioral model in the early 1970s (Hartman & Fithian). In 1973, more contributions came from John Gagnon and William Simon who emphasized the role of social scripting in sex therapy while family therapist and physician Harold Lief stressed how important communication difficulties and nonsexual interpersonal issues are in sexual problems. He was also a proponent of integrating the tenets of marital therapy into sex therapy at a time when so many other therapists were blending various modalities and no *one* distinguishable sex therapy existed. Cultural factors and values also came into play as their influence on sexual issues were considered (Hartman & Fithian).

Another major contribution to sex therapy was made by psychiatrist Helen Singer Kaplan when she combined cognitive psychology and behavioral therapy with traditional psychoanalysis and psychotherapy tenets (Hartman & Fithian, 1997). Other, more specific contributions have been made to the field of sex therapy by Lonnie Barbach, Betty Dodson, Bernard Apfelbaum and Dean Dauw, William Hartman and Marilyn Fithian, and Bernie Zilbergeld during the 1970s, 1980s, and 1990s.

c. Strengths

Despite its controversies and lack of cohesion at times, an asset of sex therapy is its ability to successfully and quickly treat sexual problems. Kleinplatz (2001) suggested that sex therapy's track record of successes with sexual dysfunctions actually outshines that of traditional psychotherapy in treating depression and anxiety. Over the years the face of sex therapy has improved from suspicious to respectable, as a result of professional associations, accreditation standards, journals, conferences, and certification boards.

2. Summary of Available Critiques of Sexuality Counseling

a. Psychiatrist Thomas Szasz

According to Hyde (1982), Thomas Szasz is not only a critic of sex therapy, but of psychotherapy in general. His 1980 *Sex by Prescription* revealed his disagreement with the philosophical basis of sex therapy and the application of the medical model to problems with a psychological basis. His belief that mental health professionals may do more harm than good due to labeling and thereby stigmatizing people who are having problems with life and are not "sick" is a major component of his critique (Hyde). Szasz also asserted that sex therapy, specifically, creates a host of illnesses by diagnosing sexual dysfunctions. His solution to this is not viewing sexual problems as diseases, but rather as one's solutions to life's various situations.

b. Psychologist David Schnarch

David Schnarch is another critic of sex therapy, but only in the traditional sense as he claims it overlooks essential elements in sexual relationship, such as intimacy, which are the foundations for his approach. Christensen (1995) commented that while most sex therapists see intimacy as an added bonus of sexuality, Schnarch views it as a precursor. A specific critique he has of earlier sex therapy is Masters and Johnson's sensate focus, which he argues sends the underlying message to tune out your partner in order to turn yourself on (Christensen). His 1991 *Constructing the Sexual Crucible: An Integration of Sexual and Marital Therapy* and 1998 *Passionate Marriage: Sex, Love, and Intimacy in Emotionally Committed Relationships* both explore his sexual crucible approach that encourages differentiation of self in order to better relate to one's partner.

c. Feminist critique

In Kleinplatz's *New Directions in Sex Therapy: Innovations and Alternatives* (2001), Tiefer recaps the faults of sex therapy through the feminist lens. For beginners, sex therapy focuses too much on genitals and achieving goals, sacrifices enjoyment for performance, and is infiltrated with sexist language, research, theory, even down to the taxonomy of sexual disorders. Furthermore, it is perceived that sex therapy ignores power differences between genders and may unintentionally support sexual double standards and patriarchal concerns (Klienplatz). These criticisms and more have developed in response to feminists asking how mainstream sex therapy affects, treats, or acknowledges issues and interests pertaining to women.

d. Critique of sex therapy goals

Another method of evaluating sex therapy is by analyzing its goals, a major element of any modality or treatment approach. According to Kleinplatz (2001), the goals of sex therapy are flawed due to the following reasons: performance is stressed instead of subjective meaning and experience, promotion of generalized goals to the detriment of recognizing individuality, marginalization of diversity instead of welcoming it, promotion of conformity rather than social change, aim of reining in paraphilias instead of promoting underlying changes in desire, support of "a priori" solutions as opposed to change from within, and that sex therapy does not last long enough while settling for the minimal results.

e. Problems to be solved to improve sex therapy

Kleinplatz (2001) pointed out more aspects of sex therapy that are lacking in balance, such as its "gender-biased, phallocentric, and heterosexist assumptions" (p. xx) and the fact that sex therapy alleges to be a biopsychosocial science, when in fact everything it is based on is only biological. Furthermore, there is too much focus on the sexual organs and not the people who control them, desire is an important construct that is greatly underestimated, and that new approaches are not really that at all, they are more of the same (Kleinplatz). While some of these critiques may seem extreme, it appears that with the evolution of sex therapy as a science with real professional identity, many in the field now have higher expectations of it than when it was a new and curious idea.

3. Future Directions for Research and Practices

There have no doubt been many changes to the field of sex therapy over the decades and several major trends still continue from recent years. Leiblum and Rosen (2000) discussed three of them that will remain in the forefront of sex therapy. Sexual pharmacology has been very popular, especially in mainstream media, giving those with common sexual disorders such as erectile dysfunction or low desire hope for quick fixes from pills, herbs, and topical ointments. Attention to female sexuality has changed the focus of sex therapy as more disorders pertaining to women's sexual functioning have been recognized, categorized, and diagnosed. Last but not least, society's technological changes, particularly regarding the Internet, have impacted sex therapy indirectly by influencing how couples relate to each other in light of the many sexual distractions on the Internet that may help or hinder their sexual relationship.

4. What resources (e.g., books, Internet sites, and support groups) are available to help professionals learn more about sexuality counseling?

- American Association of Sexuality Educators Counselors and Therapists: www.aasect.org
- Society for the Scientific Study of Sex (SSSS): www.sexscience.org

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Chapter Two
Assessment in Sexuality Counseling
By Ashlee L. Gary

1. Background and Introduction

Assessments are used throughout the counseling process in order to effectively conceptualize the client's problem, implement an effective treatment plan, and later to evaluate the process (Whiston, 2000). The recognition of a high prevalence of sexual disorders in today's society has resulted in an increase in research on pharmacologic treatments for sexual dysfunctions (DeRogatis, 2008). Increased development of new measures of sexual functioning has paralleled the expansion of research on effective medication for sexual dysfunctions. The Food and Drug Administration (FDA) Center for Drug Evaluation and Research drafted guidelines for the pharmaceutical industry and mental health profession regarding development of products for sexual dysfunctions. These guidelines included requirements for scales, questionnaires, and other assessment instruments designed to diagnose sexual dysfunctions (Meston, & DeRogatis, 2002). Under these requirements assessments must be reliable, valid, brief, relevant, and easy to use. As with any other psychological measurement the primary focus is to provide an operational definition for a hypothetical construct in this case, sexual functioning. Consequently, a single measure of sexual functioning is not always as accurate in conceptualizing the client's presenting problem because psychological measures are not as valid and reliable as measures of physical variables (DeRogatis, 2008). There are primarily two areas of application for assessments of sexual functioning: screening and outcome measures. In assessments designed for screening purposes a brief test or inventory is used to screen for presumptive evidence of sexual dysfunction and/ or its level of severity. In contrast primary and secondary outcome measure assessments are used to evaluate the efficacy of one or another form of treatment intervention (DeRogatis, 2008).

2. Summary of Available Information on This Topic

The following includes information regarding ten instruments designed to measure the quality of sexual functioning. These instruments vary in terms of their level of comprehensiveness, but all have evidence of reliability and validity.

- The Arizona Sexual Experience Scale (ASEX) is a five-item self-report inventory using a six-point Likert scale method. The instrument is primarily designed to evaluate sexual dysfunction and changes in sexual function in individuals taking psychotropic drugs. The inventory measures quality of functioning in five domains: drive, arousal, penile erection/vaginal lubrication, ability to reach orgasm and satisfaction from orgasm (DeRogatis, 2008).
- The Center for Marital and Sexual Health Sexual Functioning Questionnaire (CMASH-SFQ) is a self-report inventory that consists of 21 specific items assessing sexual behavior in men. The inventory has scales for four domains related to sexual functioning*:* frequency of sexual activity, quality of erections, quality of orgasm and sexual satisfaction. It features

concurrent administration to the partner as well as the male subject in order to assess the partner and the client's perspectives (DeRogatis, 2008).

- The Derogatis Interview for Sexual Functioning (DISF/DISF-SR) is a set of brief matched instruments designed to provide an estimate of the quality of an individual's current sexual functioning. The DISF is semi-structured interview made up of 25 items and reflects quality of sexual functioning in multi-domains including: sexual cognition/fantasy, sexual arousal, sexual behavior/experience, orgasm and sexual drive/relationship (DeRogatis, 2008).
- The Female Sexual Functioning Index (FSFI) is a 19 item self-report inventory designed to measure the quality of female sexual functioning on five primary dimensions of sexuality (DeRogatis, 2008).
- The Index of Premature Ejaculation (IPE) is a self-report inventory that focuses on the subjective aspects of the premature ejaculation experience (DeRogatis, 2008).
- The International Index of Erectile Function (IIEF) is a 15-item self-report inventory used to provide a brief measure of erectile function and capacity. It has been frequently recommended as a standard when diagnosing erectile dysfunction (DeRogatis, 2008).
- The Personal Experiences Questionnaire (PEQ) is a questionnaire focusing on assessing the sexual functioning of middle-aged and older women in six major domains: feelings for partner, sexual responsivity, sexual frequency, libido, vaginal distress/dyspareunia and partner problems (DeRogatis, 2008).
- The Sexual Function Questionnaire (SFQ) is a self-report questionnaire designed as an outcomes measure of female sexual function. It is comprised of 26 items reflecting seven domains of female sexual function: desire, physical arousal-sensation, physical arousal-lubrication, enjoyment, orgasm, dyspareunia and partner relationship (DeRogatis, 2008).
- The Sexual Interest and Desire Inventory (SIDI) is a brief rating scale focused on measuring severity and change in response to treatment of HSDD or Inhibited Female Orgasm Disorder (DeRogatis, 2008).
- The FSDS was developed in an attempt to measure sexually related personal distress. This inventory has become a standard in assessing sexually related personal distress among women (DeRogatis, 2008).

Current research focuses heavily on sexual dysfunction and thus much of the research on sexuality assessments center around diagnosis. In contrast there are assessment tools that could also be incorporated in the counseling session that focus more on wellness and satisfaction, as opposed to dysfunction including (Pinney, Gerrard, & Denney, 1987):

- Eysenck's Inventory on attitudes towards sex
- Hudson's Index of Sexual Satisfaction
- Sexual Interaction Inventory
- Pinney Sexual Satisfaction Inventory
- Sexual genograms are also utilized often times by counselors in order to explore sexual functioning within the intergenerational family complex (Magnuson & Shaw, 2003).

3. Future Directions for Research and Practice

Consistent with the entire counseling movement towards evidenced based practices, assessment in the realm of sexuality counseling is on the rise. Most of our measures of sexual functioning are designed around diagnostic models including, the World Health Organization's International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders-IV-TR of the American Psychiatric Association (DeRogitis, 2008). With the prominence of sexual disorders in American society, there has been an increase in the use of assessments, primarily for diagnosis. Contrary to the findings of Master's and Johnson's *Kinsey Reports*, which isolated "performance anxiety" as a root of most sexual disorders, Helen Kaplan's research focused on a biological approach to sexuality. Consistent with these findings, contemporary studies view majority of sexual dysfunction cases as having an organic etiology or comorbid with a psychological disturbance (Harding) For example, 80% of erectile dysfunction in men is a result of a physical condition which affects the nerves and blood vessels in the penis. Consequently, the lack of the ability to maintain an erect penis can lead to psychological distress and performance anxiety (Harding). As a result of sexual functioning viewed from a biological basis, majority of information on assessments of sexual functioning focus on diagnosis for the use of medication. Majority of the reliable and valid assessments were designed to substantiate the use of medication to treat sexual dysfunctions. In contrast to this theory there are a number of researchers who believe that sexual dysfunctions are primarily psychological in origin, and may possibly have a secondary physiological basis (Seligman, 1998). It would appear that both theories subscribe to the fact that there is some psychological component either primary or secondary. Although the use of sexual assessments were designed for diagnosis the counselors could use these formal and informal assessments to gather more information about the client and their presenting concern, in order to develop a more accurate conceptualization and treatment plan. It appears that there are gaps in research regarding the effectiveness of sexual assessments in the counseling field that are strength oriented, nor do there appear to be a great amount of research on utilizing these assessments in a setting focusing on wellness.

4. What resources (e.g., books, Internet sites, and support groups) are available to help professionals learn more?

- Mental measures yearbook includes a comprehensive list of available assessments http://www.unl.edu/buros/
- The assessment instruction manual accompanied by each inventory will provide qualification information, as well as information regarding reliability and validity of each instrument
- DSM-IV provides information regarding criteria for sexual disorders which can be an used as an informal checklist in order to diagnosis, rule out a diagnosis, or for exploration of the presenting problem

- *Principles and Applications of Assessment in Counseling* by Susan Whiston provides information regarding the most effective ways of administering any assessment in the counseling setting
- *Innovations in Clinical Practice: Focus on Sexual Health* by VandeCreeke, Peterson, and Bley provides information on issues of sexual health and includes pertinent information to the clinician regarding the use of assessments in sexuality counseling
- *Sexuality Counseling: An Integrative Approach* by Long, Burrnett, and Thomas provides information from a strength base approach to sexuality counseling and outlines assessment methods within the process

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Chapter Three
Addressing Client and Counselor Anxiety in Sexuality Counseling
By Jessica Redish

1. Background and Introduction

The term anxiety is defined by the Merriam-Webster Dictionary as "an abnormal and overwhelming sense of apprehension and fear often marked by physiological signs (i.e. sweating, tension, and increased pulse), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it." For the purposes of relating this to sexuality counseling, anxiety is seen as having this reaction when entering into this type of therapy. As one can imagine, discussing the personal aspects of your sexual relationship does not come easy to many people, including both the clients and the counselors involved. "Most clients approach counseling with mixed feelings. They want to improve their life [and sexual] situation, and yet they are reluctant to become involved in the counseling process" (Hackney & Cormier, 2005, p. 36). Further, "inexperienced clients enter counseling without knowing exactly what to expect or what will be expected of them, because of this…they may feel uncertain, vulnerable, or guarded and doubtful" (Hackney & Cormier, 2005, p. 36).

There are many reasons why a person would enter into sexuality counseling, but regardless of the reason, there will likely be some anxiety about beginning the sessions. By entering into treatment, clients are taking the risk of opening up to a stranger about their sexual issues. Kottler, 2003, states, "there is a risk (or perhaps even a certainty) that some destabilization will occur. In order for real growth to be attained, the client must be willing to experience intense confusion, disorientation and discomfort…she[or he] risks all of this for the possibility of a better existence" (p. 14). It is also important to remark on the counselor's anxiety surrounding sexuality counseling. The counselor may feel uncomfortable or embarrassed about discussing certain sexual issues that may arise. The counselor may also feel pressure to help the client "fix" some particular sexual problem and not want to go much further into the issue. VandeCreek, Peterson & Bley, 2007, stated that "clinicians are often embarrassed to admit how anxious they feel about actually saying out loud sexual terms…nevertheless, it is up to us [clinicians] to go first" (p. 20) and that "beyond the awkwardness of sexual language, the many concerns about being perceived as nosy or intrusive may be more or less present." (p. 21).

2. Summary of Available Information about Client and Counselor Anxiety in Sexuality Counseling

a. Sexual information and communication

When discussing a topic such as sexuality, one must consider the source of where individuals get their original information from and how they were taught to communicate about it. Recognizing this can help clients better understand the potential anxiety they may face when entering into counseling. According to Sprecher, Harris & Meyers, 2008, "in the literature on sex education from parents to teens, sex education often is referred to interchangeably with sex communication. It is assumed that if parents communicate about sex with their children, they are providing sex education. Sprecher et al., 2008, reported on sexual communication as it relates to family and social influences, ethnicity and gender. They found that "the higher the participants' family social class, the more sex education the participants reported from their parents. In addition, the higher the index of social class, the greater sex communication with parents." In terms of ethnicity they found that "Blacks reported a significantly higher level of sex education from parents than did Whites and Hispanics/Latinos, and Hispanics/Latinos reported the lowest

level. Conversely, Whites and Hispanics/Latinos reported a higher level of sex education from peers than did Blacks." Moreover, Whites reported the lowest level of influence from media and the lowest level on gaining sex education based on reading about it. In terms of gender, "compared with women, men reported receiving less information about sex from a number of sources, including same-sex friends, dating partners, various professionals, and reading on their own."

The main source of information for respondents in Sprecher et al., 2008, were peers, especially same-sex peers, more than any other source. However, other sources noted were dating partners, opposite-sex friends, the media, reading on one's own, mothers and teachers provided only a small amount of information, and reportedly fathers even less.

b. Client anxiety

There could be many reasons that clients may feel anxious when entering into sexuality counseling, and even continue to feel it throughout the counseling experience. These may include feeling uncomfortable sharing intimate details of personal experiences, fear of being judged by the counselor, not wanting to share negative thoughts about one's partner while the partner is present, discomfort in using sexual terms/language, and/or preconceived perceptions of having to "act out" sexual experiences in session. Additionally, "clients are shy about revealing their sexual issues. It feels so private, so awkward, so potentially embarrassing" (VandeCreek, Peterson & Bley, 2007, p. 20) and these can certainly create anxiety within a client.

"Clients' in-session feelings can be an extension into the therapy session of the client's…related distress such as anxiety [about coming into the session]" (Elliott, R., & James, E., 1989). It is also not uncommon for clients to feel anxious while in session and throughout the process due to the nature of the counseling. Clients are expected to talk to the counselor about both sexual and relationship issues that may be uncomfortable to discuss. They are also expected to explore new avenues that may seem foreign and scary at first. Clients sometimes "complain of too much anxiety when they venture into the unknown of "going somewhere new" (Schnarch, 1991, p. 528-529).

c. Counselor anxiety and Counselor addressing client anxiety

Several areas can be considered for sexuality counselors to help alleviate the anxiety felt by the clients and by themselves when beginning sessions. For the counselor, it is important to recognize what it is that they may feel embarrassed or anxious about when talking about sexuality related issues. If a clinician has significant anxiety surrounding using sexual terms and language, then the counselor may need to practice saying the terms out loud to become more comfortable doing so and just see how it feels (VandeCreek, Peterson & Bley, 2007, p. 20).

To alleviate anxiety for the client, the counselor has many options. It may prove beneficial to return to the basics of building rapport and showing empathy. This may be new territory for you and the client, and building rapport is essential in making a foundational relationship in sexuality counseling and gaining a client's trust. It is up to the counselor to create a safe and comfortable atmosphere. To ease some of the initial anxiety, the counselor can give simple initial direction to the client, such as how long the session will be and a description of what typically takes place during session, the counselor can build upon trust, respect and safety, and the counselor can check in on what the client's impressions are of what they expect in counseling (Hackney & Cormier, 2005, p. 36-37). Additionally, "conditions that have been identified as important in the

establishment of an effective counselor-client relationship include accurate empathy, counselor genuineness, and an unconditional caring or positive regard for the client" (Hackney & Cormier, 2005, p. 46). Elliot, 2008 found that clients reported similar aspects that they found helpful in their counseling relationship, "the therapeutic relationship, the therapist listening or being empathetic, affirming or validating, and the therapist offering specific techniques for dealing with problems." He also found that clients reported "common findings on hindering processes includ[ing] therapists imposing their views on clients or being judgmental or invalidating."

Another study by Hodgetts & Wright, 2007, established that "clients found the most helpful element to be a therapist who listens and shows understanding. Clients also value a collaborative relationship where the therapist sees beyond a diagnosis to the whole person. Interestingly, specific interventions were not identified; rather, clients referred to the value of therapists' ability to deal with difficult and strong emotions while showing a willingness to explore and provide comfort. Problem-solving skills and encouragement were also seen as helpful." They also looked at qualities in a counselor that were seen as unhelpful to the therapeutic process by clients including, "therapists' superiority, being judgmental and making assumptions as well as showing a lack of respect to the client, and the therapist's reluctance to explore difficult areas, e.g., abuse, or to communicate disbelief about the client's experiences hindered therapy."

3. Future Directions for Research and Practice

Further research needs to be conducted on client's preconceptions and anxieties about entering into sexuality counseling as there was little research to be found in this direct area. This could be accomplished by conducting surveys, questionnaires, or interviews before the clients enter into the counseling sessions. Additionally, more research is needed to address the counselor's anxiety about discussing sexuality issues in a counseling setting. This could be conducted in the same nature with surveys and interviews. Moreover, counselors need more adept training in the field of sexuality counseling in general and in addressing the anxieties that come with it.

4. Available Resources

There are several professional journals that cover the topic of sexuality counseling, specifically: Clinical Psychology & Psychotherapy; Journal of Sex Research; Journal of Human Sexuality; Journal of Child Sexual Abuse; Journal of Homosexuality; Journal of Lesbian Studies; and the Journal of Sex & Marital Therapy. Some available internet sources: http://www.sexaa.org/; http://www.slaafws.org; http://www.sa.org/; http://www.sca-recovery.org; and http://www.aasect.org/profession.asp.

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http://www.merriam-webster.com/dictionary/anxiety

Chapter Four
Counseling Guidelines for Couples who Have Conflict about their Sexual Relationship
By Leslie Wilson

1. What is the definition of conflict within couples about their sexual relationship?

Couples have a conflict with their sexual relationship when one or both partners are dissatisfied with their sex life. This then leads to conflict within the couple because sex is an integral part of the couple's relationship and the overall health of each partner (Metz & McCarthy, 2007).

Sexual conflict can happen for many different reasons and sexual difficulties often have multiple influences; the causes are not often simple (Metz & McCarthy, 2007). There can be conflict within the couple relationship that spills over into the sexual relationship. Many theorists argue that a couple's sex life is often a manifestation of their relationship, so if the couple is having problems remaining close and intimate in daily life, they are likely to experience those same issues in the bedroom. Anger, lack of trust, and hurt, and frustration with each other all influence sexuality. Sexual conflict and relationship conflict have a positive relationship; each one builds conflict in the other area; sex cannot be separated from the couple (McKay, 2006).

Others argue that sexual problems indicate a conflict within the individual. There can be fears, anxiety, traumas, and unrealistic expectations that come into play and negatively impact sex. Usually, within couples, there is one partner that desires more sex than the other partner. This can create a lot of conflict between the couple, as both are trying to get their needs met with different goals in mind (Scnarch, 1998). Also, within the individual, there can be medical issues that are impacting sexual function and satisfaction (Kingsburg, 2008)

Sexual conflict is the main reason that couples enter sexuality counseling. In recent years, there has been a medicalization of sexual problems and many drugs have been developed to help. However, these drugs are mostly helpful for men; there have been few drug developments to help with sexual issues that women deal with. Additionally, medical treatment of sexual issues does not treat the psychological aspects that many of these issues stem from (Graham, 2007). This is why sexual counseling can be so helpful.

2. How common are couples with a sexual conflict?

"Approximately 45 percent of couples at a given time suffer a male, female or couple sex problem" (Metz & McCarthy, 2007). This is a very widespread problem and in fact, is very normal for most couples. Sex therapist, Scnarch, insists that all couples reach points in their relationship where they are having conflicts about their sexual relationship. He says that it is then that the couple can grow or stagnate (Schnarch, 1998). Sexual conflict is normal, but it is not something that is easy for people to talk about or search out help for.

3. What is the typical developmental course of conflict within the couple relationship concerning the sexual relationship?

Every couple is unique and the conflict over their sexual relationship also developed in a unique way; therefore there is no way that there can be outlined a course that would fit every couple. A counselor must look at the specific issues that the couple is experiencing and also the specific issues that each individual brings in with them. Some couples have been through extraordinary events that have had a negative impact on their sexual relationship, like trauma.

There could be a history of sexual abuse or assault for a partner, or a partner could have been through events like those of a war. Currently, it has been found that many soldiers returning from the wars in Iraq and Afghanistan have been experiencing many sexual problems which are leading to conflicts within their relationships. So, experiences like these must be taken into consideration when examining the development of the conflict (Goff, Crow, Reisbig, & Hamilton, 2007).

In couples that have not had traumatic experiences like these, the course of their conflict may be more typical. Scharch theorizes that sex is usually very satisfying and exciting at the beginning of a relationship, but as couples grow closer over time, their sex life stagnates and becomes boring because the couple is not connecting and increasing their intimacy. Sex then becomes perfunctory and conflicts arise. Many times, the couple does not know what to do to improve their sexual relationship or how to work through the conflict because they bring their own issues and insecurities. Many couples have trouble being honest and open when it comes to sex; there seems to be much miscommunication involved (Scnarch, 1998). In general, as conflict within the couple rises, so does sexual conflict (McKay, 2006).

4. What impact does this conflict have on the individual involved?

There is a huge negative impact on the individuals involved when there is sexual dissatisfaction and conflict. Since sexual satisfaction is an important component of wellness, sexual dissatisfaction means that there is an important aspect of health and wellness that is not being met for the individual (Metz & McCarthy, 2007).

Also, the individual is likely to feel that they are not satisfied with their relationship as a whole. They may not feel connected to their partner or understood. There can be many negative feelings involved such as anger, frustration, shame and sadness. Eventually, the sexual conflict may even lead to a break-up or divorce if not resolved. A healthy sexuality is vital for health of the individual and the couple (Metz & McCarthy).

5. What impact does conflict about the sexual relationship have on the family system?

There are various subsystems within each family; each subsystem affects the others. The couple is it's own dyad and part of what makes the strength of this dyad is sexuality. As mentioned before, when there is conflict surrounding the sexual relationship, the rest of the couple's relationship is affected, and vise versa. This cannot help but to affect the other subsystems of the family (Maddock, 1989). Conflict and stress between parents always affects children, even if the children are unaware that part of the problem is sexual in nature. Conflict within the couple can cause them to be a less cohesive dyad and the other members of the family can often sense the strain and dissatisfaction within that relationship (Pacey, 2005).

Sexuality is part of the family; each member has a sexual self and there is usually awareness of this within the family system. The parents are sexual role models for their children and the way that they act towards each other formulates what the children think and expect about couple relationships. Of course, appropriate boundaries are vital in maintaining wellness within a family; they should not display inappropriate sexuality in front of other members, nor deny sexual or affectionate feelings. It is not good for children to witness only dysfunctional sexual interactions between parent figures. The parents are also the ones who teach their children about sex, what it means, and the rules that go along with it. Conflicts in their own sex life may mean that the couple is not teaching their children the things that would be beneficial (Maddock, 1989).

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

There seem to be few, if any studies that examine this specifically. However, studies have found that in victims of childhood sexual abuse, there are no differences in the amount of friends, close relationships, or social interactions for them as adults (Peleikis, Mykletun, & Dahl, 2005). This would lead to the hypothesis that sexual conflict within couples would not likely lead the individuals to have problems with friends or participating in social activities. In fact, it would be interesting to see if those individuals would be more likely to seek out connections with others, since their partner relationship is full of conflict. More research needs to be done in this area to make a conclusive argument.

7. Are there any legal issues related to conflict about the sexual relationship?

The only way that sexual conflict within a couple would become a legal issue would be if the conflict leads to physical or sexual abuse. This is extreme, but abuse is unfortunately too common in romantic relationships.

Conflict about the sexual relationship may also lead to divorce; which can become a legal battle and be very painful.

8. What assessment strategies should a counselor working with these couples use?

First, the counselor would want to get a real sense of what the issues are. As mentioned before, these issues are very complex and usually have multiple influences. The counselor would want to rule out biological problems, so if appropriate, the individual or couple may need to see a medical doctor. However, there are usually psychological components to the conflict within the couple, so this is where the counselor would focus (Metz & McCarthy, 2007). *Questions to consider*: What is the conflict about? Who is the high desire/low desire partner and why? Has there been any trauma? What family of origin issues do the individuals bring in? What are their expectations about sex and are they similar? What is their meaning for sex? When they have sex, how is it (intimate, disconnected, etc)? What other conflict is going on in the relationship (seemingly unrelated to sex)?

This may seem like a long list of things to assess for, but this is because many things effect the satisfaction of one's sexual relationships. Since every couple and person is unique, the counselor will need to explore various areas of the couple's conflict and life in order to find the sources and impacting factors. These issues should be explored with both partners because it is not likely that the conflict is the result of "one person's problem" (Scnarch, 1998).

9. What are some effective counseling strategies to use when working with a client facing conflict relating to their sexual relationship?

Try to understand where the conflict is coming from. If there is stress within the relationship, then helping the couple to build a healthier relationship through problem solving and improved communication can help the couple's sex life (McKay, 2006).

Work to build intimacy and satisfaction through sex, all the while having realistic expectations for how sex will be. Having the knowledge that sex can be very intimate and powerful, but that it will not always be mind-blowing (Metz & McCarthy, 2007).

Help the individuals within the couple to step up to challenge their own issues, instead of trying to change their partner (Scnarch, 1998).

Also, help the couple to explore what meaning they give to sex and help them to find

shared meaning. People can often become rigid in their ideas about sex and their sexuality, but those who are most sexually healthy are flexible and adapt to changes and growth within the sexual relationship (Maddock, 1989).

10. What resources are available to help individuals who are facing conflict about their sexual relationship?

Of course, sexuality counseling is helpful for couples facing conflicts about their sexual relationship. With a counselor, the couple can explore cognitive or behavioral changes with an objective professional (Fagan, 2007). However, many couples may be hesitant to enter counseling and may benefit from other types of support. On the internet, couples can find websites that offer to give them instant marriage advice about many issues. Many websites explain the warning signs of relationship problems and give advice about building a stronger sexual relationship. There are also many books, written by professionals in the field of counseling and layman that give advice for sexual health. Self-help is very popular and can be helpful for couples who can implement the ideas in their own lives or do not feel comfortable with counseling.

Individuals with sexual difficulties including sexual disorders or addictions can find a myriad of support groups that they can join. A quick search online or in the phone book will show many options.

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