Sexuality Counseling Guidebook

Key Issues for Counselors and Other Mental Health Professionals

Volume VII

Special Theme: Intervention and Assessment

By:

Graduate Students in the
Department of Counseling and Educational Development
The University of North Carolina at Greensboro

Lauren Breedlove
Amy Craver
Samantha Edwards
Jeremy Fox
Erin Helmly
Molly Johnson
Patrick Kalaw
Nicole Kennard
Hannah Kirby
Tiffany Longjohn
Carie McElveen
Megan Murphy
Anwar Patterson
Anne Marie Roberts
Heather Teater
Alonzo Turner
Kathryn Wolfson

All students were enrolled in CED 691: Advanced Clinical Topics in Couple and Family Counseling: Sexuality Counseling, taught by Dr. Christine E. Murray, LPC, LMFT, during the Summer 2013 semester.

Copyright 2013
UNCG Department of Counseling and Educational Development
Greensboro, North Carolina

PROLOGUE

This is the seventh volume of the Sexuality Counseling Guidebook, and it was developed by students in the Summer 2013 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. Students in this course are advanced-level master's students, typically in the Couple and Family Counseling or Clinical Mental Health Counseling tracks.

The focus of this volume of the Sexuality Counseling Guidebook is on sexuality counseling interventions and assessment.

What does it mean for a client to have positive sexuality?

Positive sexual health includes different aspects of overall wellbeing – physical, emotional, spiritual, and relational. People with positive sexuality respect themselves as sexual beings, whether or not they are in a sexual relationship. They express themselves sexually in ways that are free of coercion, manipulation, violence and in ways that are consistent with their values, desires, and needs. Positive sexuality can be expressed differently depending upon the developmental level and social/cultural context of the individual.

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

A positive sexual relationship is the ability to establish a healthy intimate connection with one's partner. The most fulfilling intimate connections tend to include the following components: knowledge, caring, interdependence, mutuality, trust, and commitment (Miller & Perlman, 2008). These relationships are achieved most easily when both partners are able to maintain and nurture their sense of self while in the relationship. A positive sexual relationship encompasses each partner's sexual satisfaction through communication while also maintaining a deep connection.

How can counselors help clients move toward positive sexuality?

Counselors can play an important role in helping clients develop positive sexuality through work with individual clients or couples. Counselors can provide a nonjudgmental environment in which clients can feel comfortable exploring their own sexual needs and expectations. A healthy sexuality can take form in many different ways for each client, and counselors can help normalize and reduce anxieties around sexuality. Working with a counselor, clients can discover that there is much more to sexuality than sex.

In order to help their clients develop positive sexuality, counselors have a number of general tasks as well as ones specific to sexuality counseling. The factors influencing the success of sexuality counseling are largely the same as factors influencing success in any sort of counseling, so a counselor must prioritize building rapport, providing a safe space to be honest and explore, maintaining self-awareness of biases, and seeking supervision if necessary. A counselor also should normalize clients' thoughts and behaviors, particularly the anxieties that often accompany presenting issues in sexuality counseling. Providing education and correcting misinformation also is important, as is challenging the client's ideas and possible misconceptions about sex. It is crucial that the counselor stay in his or her role as a helper and avoid taking on the role of an expert or authority figure. A client with a counselor who is mindful of carrying out these tasks is likely to experience a good outcome in therapy.

Please see Dr. Christine Murray's faculty web-page to access previous volumes of the guidebook: http://ced.uncg.edu/people/faculty-profiles/dr-christine-murray/

Course Instructor:
Christine E. Murray, Ph.D., LPC, LMFT
E-mail: cemurray@uncg.edu

Dr. Murray's Sexuality Counseling course, Summer 2013

Table of Contents

Part One: Assessment

Chapter 1 Assessment of female sexual dysfunction Page 6
Part One: Amy Craver
Part Two: Erin Helmly

Chapter 2 Assessment of male sexual dysfunction Page 13
Heather Teater and Anwar Patterson

Chapter 3 Assessment of LGBT clients Page 16
Lauren Breedlove and Hannah Kirby

Chapter 4 Assessing sexual intimacy within couple relationships Page 19
Tiffany Longjohn and Alonzo Turner

Part Two: Interventions

Chapter 5 Interventions for female sexual dysfunction Page 23
Anne Marie Roberts and Carie McElveen

Chapter 6 Interventions for male sexual dysfunction Page 27
Kathryn Wolfson and Megan Murphy

Chapter 7 Interventions for LGBT clients Page 30
Jeremy Fox and Patrick Kalaw

Chapter 8 Interventions to enhance sexual intimacy within couple relationships Page 33
Nikki Kennard and Molly Johnson

Chapter 9 Interventions to promote individual sexual health Page 37
Samantha Edwards

Chapter 1: Assessment of Female Sexual Dysfunction
Part One: Amy Bond Craver

Background and Introduction

"Female Sexual Dysfunction is a developing multidisciplinary issue associated with biological, medical, and psychological factors and is strongly affected by the psychological and relational status of the woman" (Clegg, Towner, & Wylie, 2012 p.160). Statistics vary on the prevalence of sexual dysfunction in women due to the complicated nature of the issue, but some studies show that as many as 26%-63% are affected (Clegg et al., 2012). The issue of female sexual functioning is complicated, and there seems to be movement beyond just the physiological sexual functioning of women. In the 1960's, Masters and Johnson proposed a linear model of human sexual response including 1) desire, 2) arousal 3) orgasm, and 4) resolution. This model stresses genital response and does not address the complicated issue around female desire and arousal (Basson, 2000). Basson (2000) suggests a more circular cycle when looking at female sexuality. Research indicates that sexual desire is infrequently mentioned when asked about motivation for having sex. This motivation and the interpersonal as well as biological, cultural, psychosocial, and contextual variables are considered in this new view of female sexuality and dysfunction (Basson, 2008). Although definitions of Female Sexual Dysfunction are being reevaluated and changed on an ongoing basis there are four categories of Female Sexual Disorders as defined in diagnostic manuals such as the DSM-IV-TR. Disorders are categorized into 1) Hypoactive Sexual Desire Disorder, 2) Female Sexual Arousal Disorder, 3) Female Orgasmic Disorder, and 4) Sexual Pain Disorders – Dyspareunia and/ or Vaginismus. Marked distress in an individual or in interpersonal relationships is the differentiating factor in determining a disorder from a dysfunction or symptom (Giraldi et al., 2011). Assessing for female sexual dysfunction by a counselor or health care provider is essential in helping individuals' overall health and sense of well-being. It is important for counselors to become comfortable themselves with discussing sexuality with their clients and to take a more holistic approach in the discussion and assessment of sexuality. It is also recommended that counselors become educated in using Female Sexual Dysfunction screening tools and more specific questionnaires to help guide them in their discussion and diagnosis with clients (Giraldi et al., 2011).

Review of Relevant Research

Specific attention is given to the delicate relationship between female sexual desire and sexual arousal in Basson's Circular Model of Female Sexual Responsiveness. Research indicates that the relationship between desire and arousal is a complicated one. Spontaneous sexual desire is not reported by women as the primary motivation to engage in sexual activity, especially in longer term relationships. Sexual excitement as the driving force for sexual activity is more consistent with newer relationships (Basson, 2008). Four domains of motivation for sex as reported by women include 1) love and intimacy, 2) physical pleasure and stress relief, 3) goal attainment, and 4) protecting the relationship (Basson, 2008). Thus, the delicate dance between desire and arousal and the need for a more holistic model representing the many variables involved with desire in female sexuality and the definition of dysfunction. There appear to be many variables involved with female sexual dysfunction, and potential disorders. Studies indicate that the entire picture needs to be evaluated as possible contributors to sexual dysfunction. Biological variables such as: fatigue, depression, side effects of medications, imbalance of hormones and other possible medical conditions should be evaluated. As well, psychological variables such as: distractions in daily living, fear of negative outcomes such as pain or performance anxiety, fear of pregnancy or sexually transmitted disease, feelings of shame, embarrassment of some sort such as body image issues, and past negative sexual experiences are all considerations that can contribute to potential sexual dysfunction (Basson, Brotto, Laan, Redmond, & Utian, 2005). Given the complexity of female sexual dysfunction and the many variables involved,

both physical and psychological can cause problems in female sexual functioning and satisfaction. Issues involving vaginal lubrication primarily are associated with biological factors where complaints and issues with desire, arousal, and satisfaction are more likely linked to relationship factors (Jiann, Su, Yu, Wu, & Huang, 2009).

Questionnaires are the first choice for both clinicians and researchers in screening for specific female sexual dysfunction. Research indicates that questionnaires are an effective way to assess for Female Sexual Dysfunction when used correctly by the counselor or health care provider. It is important for administrators to be educated in the purpose of the questionnaires available as there are many to choose from with very specific intentions (Giraldi et al., 2011). Giraldi et al. (2011) offer a review of 27 available assessment questionnaires including detail in purpose and recommendations for clinicians. Acknowledging the complicated nature of the many questionnaires available to clinicians, the Sexual Complaints Screener for Women (SCS-W) is proposed. This is a simple questionnaire that can then lead to deeper exploration into more appropriate and specific direction in the area of sexual dysfunction (Giraldi et al., 2011). Clegg also supports the use of the SCS-W as a part of an overall evaluation. It is suggested that the complicated nature of some of the more detailed and specific tools may not get the overall picture necessary to help improve a patient or client's quality of life. It is noted that along with a biopsychosocial interview the SCS-W or the STEFFI can be helpful in facilitating barriers to sexual health discussion (Clegg et al., 2012). Some barriers to consider for clinicians when discussing sexual health are 1) lack of training and knowledge in the area of sexual health issues, 2) time for health care providers, 3) difficulty with sexual language, 4) cultural bias with aging and later life sex, 5)lack of referral options, and 6) lack of confidence in possible complexity of sexual issue (Clegg et al., 2012).

The question remains whether a woman's sexual complaint is biological in nature or psychosocial in nature or a combination of the two. Attitudes about female sexuality continue to evolve as do the definitions between what is normal and acceptable and what is not normal and pathological. Western society socially constructs how we think about these topics. An example is the pharmaceutical industry. The pharmaceutical companies have had an influence on the pathologizing and medicalizing female sexuality. We must be reminded that research continues to point to the fact that most sexual problems are due to cultural, social, and interpersonal issues not pathologized medical conditions. Also important is the normalization of normal body changes that take place through the life span (Canner, 2008).

Possible Counseling Issues

Assessment of female sexual dysfunction needs to be addressed with sensitivity, thoroughness, and competency. The counselor needs to have awareness around the many issues that can come up when dealing with women and sexual dysfunction of dissatisfaction. Equally important, the counselor needs to be prepared to discuss sexual health as a result of other presenting issues. As indicated, it is important to take a look at all variables in the woman's life. The clinician must assess for biological risk factors by recommending the client have a thorough physical exam and by collecting a detailed medical history. The counselor would be looking for things such as side effects from medicines, fatigue, depression, hormone changes, and illness (Basson et al., 2005). The counselor also needs to assess the psychosocial aspects of the client's life as well as contextual and situational variables. These would include but not be limited to specifics regarding the client's motivation to be sexual, any trauma, developmental history, sexual history, substance use, relationship issues, situational context, cultural and family or peer messages, and fears and anxieties (VandeCreek, Peterson, & Bley, 2007) like, fear of pain, fear of judgment due to body image or performance. As noted, the complexity of Female Sexual Dysfunction and assessment can uncover many underlying issues within in the client and within the relationship with the sexual partner or with prior relationships. "Women rate relationship difficulties as a major cause of sexual dysfunction" (Basson, 2008, p.74). It is reported that women

who receive a combination of individual, and couple therapy that includes sex therapy have more positive outcomes with sexual dysfunction. Often intimacy issues in the relationship are uncovered (Gehring, 2003). Potential other areas that might be uncovered might be past or current sexual abuse, fertility issues, parenting issues, body image, infidelity, attitudes around aging and physical changes such as menopause, pregnancy, and breastfeeding. When doing couples counseling, the counselor should be intentional and selective in what type questions are asked when interviewing the couple and when interviewing the individuals. For example, a counselor might want to save questions about self-stimulation and past sexual experience for an individual session. Questionnaires should not be intended to make diagnosis but are helpful as survey instruments (Basson, 2008). The questionnaires available to assist are numerous and can facilitate the assessment and diagnosis process but should only be used with a thorough interview as the complexity of the problem may lie deep beneath the surface. A full description of the questionnaires available can be found in Clegg's article listed below under resources. Also, available are samples of the SCS-W, STEFFI, and STEFFI-2 which are simple questionnaires recommended to be used as a starting point in assessment along with the thorough interview (Clegg et al., 2012).

Additional Guidelines for Counseling Practice

Counselors must be comfortable talking about sexual functioning with clients meet clients where they are with regard to their sexual health. Counselors must show unconditional positive regard, empathy and congruence when dealing with clients who are putting themselves in a place of vulnerability sharing their sexual issues. Building rapport and trust can be a powerful tool in helping clients open up about sexual issues. Counselors must remain mindful that patience is essential when working with women dealing with such personal topics. Assessment of sexual dysfunction should be assessed throughout the counseling relationship for this reason. Equally important, clinicians must remain as unbiased as possible and not make assumptions or push personal values regarding sexuality onto the client. This includes not placing personal judgment on sexual orientation, style or goals. The clarity of a clinical lens and personal lens might become unclear at times. Sometimes clinical judgment gets blurred with personal judgment which is why consulting and supervision would be recommended if a counselor is struggling in this area. As always, it is imperative to view the client as a whole being and not just a female with a sexual dysfunction. As research supports, this holistic view is crucial in seeing the big picture and beginning to treat the source or sources of the women's struggle. Another important piece is to attempt to develop a deeper understanding of how cultural attitudes and beliefs have impacted the client. For example, the messages from media and culture that attempt to pathologize and medicalize sexual dysfunction and sexualize culture in general. It might be necessary to help clients normalize some of their experiences due to specific life events or physical situations. Educating oneself as a counselor is key to moving forward with the comfortableness, competency, and confidence necessary to help women and their partners who are facing sexual dysfunction. Counselors also need to stay informed and knowledgeable about potential referrals and have self-awareness to know when a client might be better served with a referral.

What resources (e.g. books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

*Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy, 26*(1), 51-65. doi: 10.1080/009262300278641 – (See Figures 1,2, & 3)

*Basson, R. (2008). Women's sexual desire and arousal disorders. *Primary Psychiatry, 15*(9), 72-81

*Giraldi, A., Rellini, A., Pfaus, J. G., Bitzer, J., Laan, E., Jannini, E. A., & Fugl-Meyer, A. R. (2011). Questionnaires for assessment of female sexual dysfunction: A review and proposal for a standardized screener. *Journal of Sexual Medicine, 8*(10), 2681-2706. doi: 10.1111/j.1743-6109.2011.02395.x

*Clegg, M., Towner, A., & Wylie, K. (2012). Should questionnaires of female sexual dysfunction be

used in routine clinical practice? *Maturitas, 72*(2), 160-164. doi: 10.1016/j.maturitas.2012.03.009 – (See Tables 1, 2, & 3)

*Journal of Sexual Medicine

*Journal of Sex and Marital Therapy

*American Association of Sexuality Educators, Counselors, and Therapists: www.aasect.org/

*National Health and Sex Survey: http://www.nationalsexstudy.indiana.edu/

List of references used to prepare this chapter

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy, 26*(1), 51-65. doi: 10.1080/009262300278641

Basson, R. (2008). Women's sexual desire and arousal disorders. *Primary Psychiatry, 15*(9), 72-81.

Basson, R., Brotto, L. A., Laan, E., Redmond, G., & Utian, W. H. (2005). Assessment and Management of Women's Sexual Dysfunctions: Problematic Desire and Arousal. *Journal of Sexual Medicine, 2*(3), 291-300. doi: 10.1111/j.1743-6109.2005.20346.x

Canner, E. (2008). Sex, lies and pharmaceuticals: The making of an investigative documentary about 'female sexual dysfunction.'. *Feminism & Psychology, 18*(4), 488-494. doi: 10.1177/0959353508095531

Clegg, M., Towner, A., & Wylie, K. (2012). Should questionnaires of female sexual dysfunction be used in routine clinical practice? *Maturitas, 72*(2), 160-164. doi: 10.1016/j.maturitas.2012.03.009

Gehring, D. (2003). Couple therapy for low sexual desire: A systematic approach. *Journal of Sex & Marital Therapy, 29*(1), 25-38. doi: 10.1080/713847099

Giraldi, A., Rellini, A., Pfaus, J. G., Bitzer, J., Laan, E., Jannini, E. A., & Fugl-Meyer, A. R. (2011). Questionnaires for assessment of female sexual dysfunction: A review and proposal for a standardized screener. *Journal of Sexual Medicine, 8*(10), 2681-2706. doi: 10.1111/j.1743-6109.2011.02395.x

Jiann, B.-P., Su, C.-C., Yu, C.-C., Wu, T. T., & Huang, J.-K. (2009). Risk factors for individual domains of female sexual function. *Journal of Sexual Medicine, 6*(12), 3364-3375. doi: 10.1111/j.1743-6109.2009.01494.x

VandeCreek, L., Peterson, F. L., Jr., & Bley, J. W. (2007). *Innovations in clinical practice: Focus on sexual health*. Sarasota, FL US: Professional Resource Press/Professional Resource Exchange.

Chapter 1: Assessment of Female Sexual Dysfunction
Part Two: Erin Helmly

Background and Introduction

Assessment of any clinical sexual issue is of interest to practitioners and researchers in the fields of medicine, psychiatry, pharmacology, epidemiology, counseling, and psychology and also to clients/patients (and their partners) who want to understand their problem and to know whether treatment is working. Getting a "good assessment" requires a clear definition of the problem and a reliable method for determining whether or not the problem applies. A good assessment also should lead to an accurate diagnosis and establish a baseline for monitoring change over time (Althof, Dean, Derogatis, Rosen, & Sisson 2005).

The assessment process of sexual dysfunction for either sex is complicated: getting a thorough sexual history when clients are not comfortable talking about sex is difficult, there is no clear line between normal and abnormal or between a sexual problem and a sexual disorder, and integrating subjective experience, objective behaviors, and contextual factors is complex (Althof, et al., 2005). Assessing female sexual dysfunction (FSD) is further complicated by several factors. Females' sexual response is less linear and less understood than that of males. Additionally, shifting definitions and ways of understanding of FSD have contributed to an unstable research climate and lack of empirical data related to FSD (Althof, et al., 2005; Leiblum 2001; Quick, Haughie, & Symonds, 2005).

Review of Relevant Research

The history of how definitions and concepts of FSD have shifted is somewhat confusing and provides the background for debates and difficulties related to assessment. In 1999, the International Consensus Development Conference on Female Sexual Dysfunction sought to bridge gaps between DSM and ICD-10 definitions and to establish a classification/diagnostic system for FSD that could work across fields. The agreed-upon system retained DSM language and broke FSD in sexual issues of desire (hypoactive sexual desire disorder and sexual aversion disorder), arousal (sexual arousal disorder), orgasm (orgasmic disorder), and pain (dyspareunia, vaginismus, and other pain disorders) with specifiers for course (lifelong vs. acquired), context (general vs. situational), and origin (organic, psychological, mixed, or unknown). Personal distress (rather than interpersonal distress) was required for a diagnosis (Basson, Berman, Burnett…et al., 2001). In 2003 the Consensus Conference adjusted the concept of arousal to include four subtypes of disorder (subjective, genital, combined, and persistent) (Quirk, et al. 2005). Proposed changes to the DSM-V were released in 2010 with the final manual being published in 2013. Most controversially, the DSM-V combined desire and arousal disorders into sexual interest/arousal disorder and merged the pain disorders (APA 2013; Responses to the proposed DSM-V changes 2010).

A brief overview of debates produced by and related to changing definitions and clinical understanding is provided to demonstrate FSD assessment issues. One issue is the lack of empirical grounding for FSD constructs and female sexual response, which makes clear and consistent assessment problematic. To this point, Basson, et al. (2001) state: "female sexual dysfunction is an under researched and poorly understood area." Segraves (2006) notes that the evolution of the classification/diagnostic system has proceeded according to expert opinion rather than empirical data. There is simply less research relative to male issues, which gives little grounding for assessment or the development of clear definitions. Also, Davis (2001) critiques the current personal distress requirement and states that this requirement makes a subjective measure to be the determiner of a medical disorder. Leiblum (2001) points to the inherent difficulty in studying female sexual response; female responses are less empirically obvious than that of men (i.e., consider erectile dysfunction) and more heavily influenced by contextual, relational, and cultural factors (Kameya 2001).

Another issue is that the concepts of arousal, desire, and behavior and how they are interrelated are poorly understood. Researchers find that disorders of arousal and desire are often comorbid (Segraves, 2006); however, there are significant debates as to whether arousal problems and desire problems can be considered as separate syndromes (Responses to proposed DSM-V changes, 2010). Desire may be both medical and psychological, or it may be one or the other. Segraves (2006) points out that desire discrepancy between partners and low desire due to relationship issues need no medical treatment, even though the symptoms may be identical to a medically rooted problem. Accurate assessment in these cases is both crucial and difficult. Additionally, FDA guidelines use increased sex events as a mark of treatment efficacy, which does not take into account more complex, non-linear relationships between desire and behavior. Since more sex can happen while low desire persists, increased sex events cannot be a measure of efficacy for treatment of desire (Althof, et al. 2005; Segraves 2006). Although is acknowledged that the FDA guidelines are flawed, much research is driven by clinical trials, which must proceed according to those guidelines (Giraldi, et al. 2011).

Regarding specific assessment instruments, FDA guidelines for clinical trials and the desire for more research data have driven the development and implementation of a variety of questionnaires (Giraldi, et al. 2011). Giraldi, et al. (2011) and Quick, et al. (2005) found the Sexual Function Questionnaire (SFQ) to be a helpful and empirically validated instrument, suitable for standardized use. In accordance with current definitions, Hayes, et al. (2008) used the SFQ in conjunction with the Female Sexual Distress Scale (FSDS) in order to investigate the prevalence of FSD. Prevalence estimates were found to be lowest when functioning and distress were both considered.

Possible Counseling Issues

In working with clients individually, it is important to get as clear a picture as possible of the presenting complaint in order to move from assessment to the best interventions. A pain disorder caused by a sexually transmitted infection will not be helped by psychotherapy any more than desire complaints related to problems in the couple relationship will be helped by medicine.

In working with couples, it seems important to conduct separate interviews in order to gain a clear view of the dysfunction from both perspectives. Consider a couple coming to counseling with a sexual desire complaint. In a joint interview a female partner may omit previous sexual experiences in which desire was not a problem only to disclose them in an individual session. This information may indicate acquired and/or situational rather than lifelong and/or generalized difficulty and provides direction for further assessment and treatment. Furthermore, the personal distress requirement is important in the context of couple's counseling. Leiblum (2001) remarks that this requirement is intended to empower females and to encourage ownership of sexuality. While this may be true, it may also be a point of contention between partners when one partner complains of something that the other partner thinks is a non-issue.

Additional Guidelines for Counseling Practice

Understand FSD as a multi-disciplinary issue. Farrell & Cacchioni (2012) and van Lankveld, Granot, Weijmar Schultz…et al. (2010) suggest that multi- and interdisciplinary approaches ought to be used in treating pain disorders. The recommendation easily extends to all types of FSD since physical, relational, and psychological factors are involved. Counselors should draw on the expertise and perspective of other fields in order to gain the fullest understanding of a client's complaint. Building relationships with primary care doctors, psychiatrists, gynecologists, and endocrinologists can provide a base for referral and consultation.

Use assessment instruments well. Giraldi, et al. (2011) and Quick, et al. (2005) state that assessment instruments are meant to be a start for gaining an adequate clinical assessment. Counselors can use questionnaires as screening tools, to provide a starting place for dialogue with clients, and as a way to structure a thorough sexual history interview. It is important to be sure that the instrument being used is consistent with current definitions and is empirically validated in accordance with those

definitions. The SFQ with FSDS can be used to screen clients for FSD and to suggest the domain of the sexual complaint (Hayes, et al. 2011).

Know the complexity and follow the client. As has been mentioned, females' sexual response is highly contextual and non-linear; therefore, finding out what bothers the client, how she feels about the problem, and what changes she desires to see are crucial to gaining a clear assessment and treatment direction.

What resources are available to help professionals learn more about this topic?

For those interested in using a questionnaire to assess for FSD, Giraldi, et al. (2011) conducted a review of over twenty questionnaires with suggestions for clinical use. Related to the complexity of assessment, Basson, et al. (2001) provided an overview of the history of changes language and definitions for FSD in their report of the Consensus Conference.

The *Journal of Sexual Medicine* is put out by the International Society for Sexual Medicine (ISSH) and the International Society for the Study of Women's Sexual Health (ISSWSH). It is primarily medical, rooted in empirical, scientific study of human sexuality. It would be of interest to counselors wanting to be familiar with medical perspectives and to stay abreast of continuing research developments. The *Journal of Sex and Marital Therapy* takes more of a counseling perspective related to issues of FSD.

List of References

American Psychiatric Association (2013). Highlights of Changes from DSM-IV-TR to DSM-V. http://www.psychiatry.org/DSM5.

Althof, S. E., Dean, J., Derogatis, L. R., Rosen, R. C., & Sisson, M. (2005). Current Perspectives on the Clinical Assessment and Diagnosis of Female Sexual Dysfunction and Clinical Studies of Potential Therapies: A Statement of Concern. Journal Of Sexual Medicine, 2(Suppl3), 146-153. doi:10.1111/j.1743-6109.2005.00130.x

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., & ... Whipple, B. (2001). Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications. Journal Of Sex & Marital Therapy, 27(2), 83-94. doi:10.1080/00926230152051707

Davis, S. R. (2001). An external perspective on the report of the International Consensus Development Conference on Female Sexual Dysfunction: More work to be done. Journal Of Sex & Marital Therapy, 27(2), 131-133. doi:10.1080/00926230152051789

Farrell, J., & Cacchioni, T. (2012). The medicalization of women's sexual pain. Journal Of Sex Research, 49(4), 328-336. doi:10.1080/00224499.2012.688227

Giraldi, A., Rellini, A., Pfaus, J. G., Bitzer, J., Laan, E., Jannini, E. A., & Fugl-Meyer, A. R. (2011). Questionnaires for assessment of female sexual dysfunction: A review and proposal for a standardized screener. Journal Of Sexual Medicine, 8(10), 2681-2706. doi:10.1111/j.1743-6109.2011.02395.x

Hayes, R. D., Dennerstein, L., Bennett, C. M., & Fairley, C. K. (2008). What is the 'true' prevalence of female sexual dysfunctions and does the way we assess these conditions have an impact?. Journal Of Sexual Medicine, 5(4), 777-787. doi:10.1111/j.1743-6109.2007.00768.x

Kameya, Y. (2001). How Japanese culture affects the sexual functions of normal females. Journal Of Sex & Marital Therapy, 27(2), 151-152. doi:10.1080/00926230152051842

Leiblum, S. R. (2001). Critical overview of the new consensus-based definitions and classification of female sexual dysfunction. Journal Of Sex & Marital Therapy, 27(2), 159-168.

Quirk, F., Haughie, S., & Symonds, T. (2005). The Use of the Sexual Function Questionnaire as a Screening Tool for Women with Sexual Dysfunction. Journal Of Sexual Medicine, 2(4), 469-477. doi:10.1111/j.1743-6109.2005.00076.x.

Responses to the proposed DSM-V changes. (2010). Journal of Sexual Medicine, 7(6), 1998-2014. doi:10.1111/j.1743-6109.2010.01865.x

Segraves, R., & Woodard, T. (2006). Female Hypoactive Sexual Desire Disorder: History and Current Status. Journal Of Sexual Medicine, 3(3), 408-418. doi:10.1111/j.1743-6109.2006.00246.x

van Lankveld, J. M., Granot, M., Weijmar Schultz, W. M., Binik, Y. M., Wesselmann, U., Pukall, C. F., & ... Achtrari, C. (2010). Women's sexual pain disorders. Journal Of Sexual Medicine, 7(1, Pt. 2), 615-631. doi:10.1111/j.1743-6109.2009.01631.x

Chapter 2: Assessment of Male Sexual Dysfunction

By Anwar Patterson and Heather Teater

Background and Introduction

A client's sexual functioning can often go unexplored in counseling if the client's presenting concern is not directly related to his sexuality. Assessment of sexual health should be a component of the regular intake process for all clients for several reasons. For example, clients/couples are often uncomfortable talking about sexuality and therefore, may never initiate a conversation about sex, even if they have particular concerns about their own sexuality. Clients may also be embarrassed to admit that they may have a sexual dysfunction, especially if the counselor never brings up the topic of sexual health to begin with.

This chapter briefly describes different ways that counselors may assess male sexual dysfunction in particular. Although erectile dysfunction is often the first issue that comes to mind when one mentions sexual dysfunction in males, sexual dysfunction can occur in any stage of sexual functioning: desire, excitement, plateau, orgasm, or resolution. There are four particular subtypes of sexual dysfunction, which are related to the stage in which the problem occurs. Males may struggle with low sexual desire, sexual aversion, erectile dysfunction, premature ejaculation, ejaculatory inhibition, pain with intercourse, or paraphilias.

Reviews of the literature suggest that the majority of the work around assessment for sexual dysfunction was developed in the 1980's. Not much has changed other than the creation of subjective tests with higher validity and greater versatility. There is a wide variety of resources available for the assessment of male sexual dysfunction. Conte (1986) suggests there are three general categories of assessments; self-report techniques, behavioral ratings, and physiological assessment. Conte (1986) recommends that, "the conceptualization of sexual dysfunction should include psychological, behavioral, and physiological components" (p.149). As behavioral ratings require the client be directly observed during sexual arousal and activity, and a medical doctor should perform physiological assessment, most counseling practices rely upon various self-report techniques. However, for a holistic report of sexual functioning, behavioral ratings and physiological assessments completed by other clinicians can be helpful when available.

Review of Relevant Research

Conte (1986) breaks down the category of self-report techniques into three types: interviews, questionnaires, and self-report behavioral records. The most commonly used form of self-report is the interview. Reading and Wiest (1984) cite The World Health Organization as developer of a 54-question interview that addresses sexual behaviors. Modalities included frequency estimates, overt and covert sexual behaviors and experiences, judgment of performance, beliefs surrounding the nature of dysfunction, and various questions surrounding environmental and non-sexual personal events that may have influenced sexual behavior. In 1983, Kaplan developed a diagnostic interview to assess couples. It takes into consideration the symptoms of the identified client, their onset and progression, and a sexual status exam that evaluates a couple's subjective sexual experience. This interview also examines health, drug use, and psychiatric status in order to look into different factors that may cause or contribute to sexual dysfunction. The final sections of the interview examine family and psychosocial histories. More specific information regarding this interview can be found in Kaplan's book titled *The Evaluation of Sexual Disorders* (1983).

Counselors have easy access to a wide range of questionnaires, which can provide more quantifiable data when assessing sexual functioning. Conte (1986), describes two different styles of questionnaires: one-dimensional scales and multidimensional scales. Multidimensional scales provide a more holistic view of an individual's sexual functioning, and are therefore more useful in counseling. The Golombok Rust Inventory of Sexual Satisfaction, or GRISS, which was developed for use with

heterosexual couples or individuals in a current heterosexual relationship, is a 28-item questionnaire that assesses the existence and severity of sexual problems (Rust & Golombok, 1986). Rust and Golombok developed the GRISS to investigate seven major areas of interest regarding the client's sexual experiences: frequency, satisfaction, interest, dysfunctions, anxiety, communication, and touching. Another questionnaire, the Center for Marriage and Sexual Health Function Questionnaire (CMSH-SFQ or SFQ), is a 40-question assessment with one section used for gathering baseline information and a second section which can be used to measure change in sexual functioning as treatment progresses (Corty, Althof, & Kurit, 1996). This questionnaire is used with both the identified patient and their partner, though it is unknown whether it would be as useful with non-heterosexual couples (Corty et al., 1996).

Behavioral records, the third form of self-report techniques, can be assigned to clients as a type of journal to keep track of sexual experiences in between sessions. According to Conte (1986), there is little research available regarding this type of assessment. Conte provides a few examples of what these records may look like. A counselor may provide couples with a definition of what constitutes a satisfactory versus an unsatisfactory sexual experience and then keep a record of each kind of sexual experience throughout the span of treatment, tracking changes and sparking discussions in session. One may also provide a checklist of various sexual behaviors (masturbation, intercourse, etc.), that clients would work through over the course of the week.

More recently, researchers devoted to diagnosing and treating disorders such as erectile dysfunction (ED) and premature ejaculation (PE) seek to develop and validate assessments of arousal and functioning. In 1997, Rosen et al., created the "gold standard" assessment of erectile function, the International Index of Erectile Function (IIEF). Fifteen items assessed erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. In 2007, Symonds et al., developed a nine-item assessment of PE, measuring control, frequency, minimal stimulation, distress, and interpersonal difficulty. Althof, Perelman, and Rosen (2011), went on to develop the first multidimensional subjective measure of male sexual arousal named the Subjective Sexual Arousal Scale for Men (SSASM). Looking to capture more than a physiological report, this 20 item scale measures aspects related to ED and PE such as sexual performance, mental satisfaction, sexual assertiveness, partner communication, and partner relationship.

This is not an exhaustive list of resources available for the assessment of male sexual dysfunction, and professionals are advised to look into other options and determine which assessments would be most useful for an individual client. Additional resources can be found in a later section of this chapter.

Possible Counseling Issues

The authors have found that although useful, the literature surrounding the assessment of sexual dysfunction is primarily based on heterosexual relationships. In their review of the literature, Carson and Gunn (2006) found that 44% of homosexual males report a lifetime problem of ejaculating too soon, where the national average at the time was half that. Carson and Gunn suggest that the definition of "premature" may differ between heterosexual and homosexual individuals. We would like to suggest this holds true between individuals as well, regardless of sexual identity.

In conducting a full biopsychosocial assessment, the professional may find a multitude of external factors that underlie the presenting concern. A small study by Tondo, Cantone, Carta, and Laddomada (1991), in which they conducted an MMPI evaluation of those suffering from sexual dysfunctions, found that those dealing with ED score high on the modalities of depression and anxiety. Those struggling with PE scored higher on the changeability, restlessness, and dysphoric modalities. Many health conditions may contribute to sexual dysfunctions, as well.

Additional Guidelines for Counseling Practice

Specific interventions for working with men struggling with sexual dysfunction will be covered in a later chapter. However, the authors would like to reiterate that counselors should remember that sexual dysfunction could be a very difficult topic for clients to discuss. Counselors should approach the topic with sensitivity and be patient with clients who may have a hard time putting words to their experience. Counselors should provide a warm and caring environment in which the client can share his story without judgment and be sure to give the client enough time to tell his entire story.

What resources are available to help professionals learn more about this topic?

Books

Kandeel, F. R. (2007). Male sexual dysfunction: pathophysiology and treatment. CRC Press.

Kaplan, H. S. (1983). The evaluation of sexual disorders. New York: Brunner/Mazel.

Rust, J., and Golombok, S. (1985). The Handbook of the Golombok Rust Inventory of Sexual Satisfaction (2nd ed.). N.F.E.R., Winsor, England.

Wincze, J. P., & Carey, M. P. (2012). Sexual dysfunction: A guide for assessment and treatment. Guilford Press.

Journal Articles

Conte, H. R. (1983). Development and use of self-report techniques for assessing sexual functioning: A review and critique. Archives of Sexual Behavior, 12. 555-576.

List of references used to prepare this chapter

Althof, S. E., Perelman, M. A., & Rosen, R. C. (2011). The Subjective Sexual Arousal Scale for Men (SSASM): Preliminary development and psychometric validation of a multidimensional measure of subjective male sexual arousal. *Journal of Sexual Medicine*, 8(8), 2255–2268. Retrieved from 10.1111/j.1743-6109.2011.02319.x

Conte, H.R. (1986). Multivariate assessment of sexual dysfunction. *Journal of Consulting and Clinical Psychology, 54*(2), 149-157. doi:10.1037/0022006X.54.2.149

Corty, E.W., Althof, S.E., & Kurit, D.M. (1996). The reliability and validity of a sexual functioning questionnaire. *Journal of Sex and Marital Therapy, 22*(1), 27-34. doi: 10.1080/00926239608405303

Kaplan, H. S. (1983). The Evaluation of Sexual Disorders. New York: Brunner/Mazel.

Tondo, L., Cantone, M., Carta, M., & Laddomada, A. (1991). An MMPI evaluation of male sexual dysfunction. Journal of Clinical Psychology, 47(3), 391–396. doi: 10.1002/1097-4679(199105)47:3<391::AID-JCLP2270470310>3.0.CO;2-1

Reading, A., & Wiest, W. (1984). An analysis of self-reported sexual behavior in a sample of normal males. Archives of Sexual Behavior, 13(1), 69–83. doi:10.1007/BF01542979

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. *Urology*, 49(6), 822–830. doi: 10.1016/S0090-4295(97)00238-0

Rust, J. & Golombok, S. (1986). The GRISS: A psychometric instrument for the assessment of sexual dysfunction. *Archives of Sexual Behavior, 15*(2), 157-165. doi: 10.1007/BF01542223

Symonds, T., Perelman, M. A., Althof, S., Giuliano, F., Martin, M., May, K., … Morris, M. (2007). Development and Validation of a Premature Ejaculation Diagnostic Tool. European *Urology*, 52(2), 565–573. doi: 10.1016/j.eururo.2007.01.028

Chapter 3: Assessment of LGBTQ Clients

By: Lauren Breedlove and Hannah Kirby

Background and Introduction

In counselor training programs, there is a growing interest in developing multicultural competency; however, there is very limited training in developing competence with sexual minority clients, including those who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ). Since there is such a lack of training in this area, it is not surprising that there is very little research on counselor competency and assessment of LGBTQ clients. In surveying the available research literature, the bulk of the limited research is focused on cultural competency related to working with LGBTQ clients.

The American Counseling Association and Council for Accreditation of Counseling and Related Educational Programs both require adequate preparation to work with LGBTQ clients in order to follow the ethical standard of prohibiting unfair discrimination based on sexual orientation (Israel, Ketz, Detrie, Burke, & Shulman, 4). What actually qualifies as adequate preparation is a question that can start to be answered by looking at existing frameworks for multicultural counselor competency. Israel and Selvidge outline three areas of contribution of multicultural counseling: conceptualization, training, and assessment (85). In conceptualizing multicultural competence the three areas of knowledge, attitudes, and skills are addressed. Some examples of the necessary knowledge base are the diversity within LGBTQ clients, sexual identity development, family of origin, the coming out process, and the bias in mental health services. Expanding counselor knowledge of LGBTQ individuals leads into examining a counselor's personal attitudes and stereotypes about individuals who identify as LGBTQ. This level of awareness should also be accompanied by awareness of any countertransference or reactions to clients. Counselors also must be skilled in assessing LGBTQ clients within their cultural context, as in multicultural counseling (Israel & Selvidge, 87-89). The second contribution from multicultural counseling is to have the appropriate content and form of training to work with diverse clients, including LGBTQ clients. This training should focus on identity formation, skill development, and attitude exploration. One important concept to discuss is the different types of oppression experienced by LGBTQ clients based on gender, class, ethnicity, sexual orientation, and other perceived differences (Israel & Selvidge, 91). After a counselor receives training and spends time increasing his/her competence to work, there really is not a comprehensive template or measure to assess for counselor competence. This lack of assessment in counselor competence in pen-and-paper format gives way to alternative approaches such as using a portfolio of a clinician's work to assess for counselor competence in working with LGBTQ clients (Israel & Selvidge, 93).

Review of Relevant Research

In training and educating counselors about how to assess and work with LGBTQ clients, developing cultural competency is an essential, ongoing task. The Sexual Orientation Counselor Competency Scale (SOCCS) is "an instrument that measures the attitudes, skills, and knowledge of counselors who work with lesbian, gay, and bisexual individuals" (Bidell, 267). This is based on the idea that "sexual orientation counselor competency is defined as the attitude, knowledge, and skill competencies" a counselor needs to provide proficient services to LGBTQ clients. Bidell took a sample of students, counselor supervisors, and counselor educators from university counseling programs across the United States to participate in a research study. All participants had a survey packet including informed consent, demographic questionnaire, three instruments (Attitudes Toward Lesbians and Gay Men Scale, Multicultural Counseling Knowledge and Awareness Scale, and Counselor Self-Efficacy Scale), and the SOCCS. The purpose of having participants take each of these instruments was to test the validity and reliability of the SOCCS in response to the gap of LGBTQ theory-based research and assessments. The results of the study show the SOCCA is a

"psychometrically valid and reliable instrument" that can be used by both counselor educators and supervisors to assess counselor competencies concerning LGBTQ clients (Bidell, 276). The study also showed that counseling students overall reported feeling unprepared to work with LGBTQ clients competently after completing their training. While there is still much future research needed around developing and measuring counselor competency in working with LGBTQ clients, the development of the SOCCS demonstrates how we can build on multicultural counselor competence theory to enhance counselor competence in working with LGBTQ clients.

Part of cultural competency in working with lesbian/gay/bi-sexual/questioning clients is understanding identity development around sexual orientation. Each person has a different "coming out" process. One client may feel comfortable telling their family when they are a teenager; other clients may choose never to disclose their orientation to their family. It is important for the counselor to understand where the client is, and support them in their decision. For some clients, coming out at work, home, or school could result in discrimination, financial or emotional cut off from family that the client does not want. The Gay Identity Questionnaire and Homosexual Identity Questionnaire are both assessments developed from the Homosexual Identity Formation Model that was developed in 1979 based on clinical observations (Brady & Busse, 2010). These assessments can be used by the counselor to get an understanding their client's identity, as well as provide ways for a counselor to begin having a discussion about identity development if they are unsure how to do so. The Homosexual Identity Formation Model has six distinct stages of development: Identity Confusion, Identity Comparison, Identity Tolerance, Identity Acceptance, Identity Pride and Identity Synthesis. The HIQ is a 210 item questionnaire based off of this model; the GIQ is a shorter assessment with 48 items. The GIQ was developed as a shorter alternative to the HIQ.

Some assessments have been developed and adapted to use when working with LGBT clients. In working with LGBT clients on the issue of substance abuse, Susan Anderson includes items in her assessments that would not be included for heterosexual clients (Karoll, 2012). Her assessments take into consideration internalized homophobia, gay meeting places, and the impact of heterosexism on the client. She also acknowledges that a "one size fits all" does not work, and that alternative treatment problems to things like 12-step may be particularly helpful for this population. Although this is just one of example of taking a different approach to an issue (substance abuse) when working with LGBT clients, it draws to attention that to be a cultural competent counselor, it is important to look at issues through the lens of your client. Although no two people with in a specific population will have the same experience, it is important to acknowledge and be aware of the sub-culture clients may be a part of, and to incorporate their experience into assessment and treatment of the issue they bring to counseling.

Possible Counseling Issues

When working with LGBTQ clients, it is important to recognize that they may not be coming in for issues directly related to their sexual orientation. Clients may be comfortable with their sexual orientation and not want to discuss their coming out process. It is always important for the counselor to meet the client where they are. This is where assessment of homosexual identity development can be very helpful. A friend of mine went to see a counselor when an undergraduate. The counselor told him he either needed to come out or start taking anti-depressants. At the time, coming out was not even something he was considering, he was just starting to accept his sexual orientation to himself. He never went back to the counselor. Rather than listening and paying attention to what he needed as the client, she assumed she knew and pushed him to a place he was not ready to go, which ended up damaging the therapeutic relationship.

In addition to avoiding the assumption that an LGBTQ client is coming in to talk about their sexual orientation, there are some other ethical concerns that are specific to counseling LGBTQ clients. One such consideration is the idea of conversion therapy to change a client's sexual orientation,

whether the client desires to do so or not. This requires an emphasis on informed consent and providing unbiased services. There has been much controversy around the idea of conversion therapy and counselors who are competent with LGBTQ clients must be aware of how internalized homophobia, self-acceptance, and self-esteem might be affecting a client, especially in how these interact with a client's belief system. A counselor must also be aware of the added level of confidentiality desired by some LGBTQ clients in order to protect them form any unwanted disclosure of their sexual orientation, or any other issues discussed in counseling (Israel & Selvidge, 90).

Additional Guidelines for Counseling Practice

There are training programs available for counselors and the general community to increase awareness about the LGBTQ community and providing a safe space for them. One article points out the importance of mental health professionals increasing their understanding of the LGBTQ community as they are larger consumers of psychotherapy than heterosexual counterparts (Finkel, M. et al., 556). Also the number of LGBTQ households is growing in the United States. In 2000 the Census estimated around 600,000 same-sex households, which does not include those who chose not to be counted. Many college campuses have developed a SafeZone training program for students, staff, and faculty at universities, which are helpful in educating people about the LGBTQ community. These programs focus on inclusion, acceptance of the LGBTQ community, and how people can work towards a safer community at their school or workplace. To attend a SafeZone program, look to see if a local university has trainings. Leaders of the training can also connect counselors with other resources specific to the community that can provide more information about the LGBTQ or resources for clients.

Resources for professional working with this population

American Psychological Association Div. 44: Society for the Psychological Study of Lesbian, Gay and Bisexual Issues
Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC)
Gay and Lesbian Alliance Against Defamation (GLAAD)
Journal of LGBT Issues in Counseling
National Alliance on Mental Illness (NAMI) Multicultural Action Center
National Coalition for LGBT Health
Parents, Families and Friends of Lesbians and Gays (PFLAG)
SafeZone at UNC-Greensboro: http://oma.uncg.edu/safezone

References

Bidell, M. P. (2005). The Sexual Orientation Counselor Competency Scale: Assessing Attitudes, Skills, and Knowledge of Counselors Working With Lesbian, Gay, and Bisexual Clients. *Counselor Education And Supervision, 44*(4), 267-279. doi:10.1002/j.1556-6978.2005.tb01755.x

Brady, S. & Busse, W. (1994). The Gay Identity Questionnaire. *Journal of Homosexuality*, 26:4, 1-22, DOI: 10.1300/J082v26n04_01.

Finkel, M. J., Storaasli, R. D., Bandele, A., & Schaefer, V. (2003). Diversity training in graduate school: An exploratory evaluation of the Safe Zone project. *Professional Psychology: Research And Practice, 34*(5), 555-561. doi:10.1037/0735-7028.34.5.555

Israel, T., Ketz, K., Detrie, P. M., Burke, M. C., & Shulman, J. L. (2003). Identifying Counselor Competencies for Working with Lesbian, Gay, and Bisexual Clients. *Journal Of Gay & Lesbian Psychotherapy, 7*(4), 3-21. DOI:10.1300/J236v07n04_02

Israel, T., & Selvidge, M. D. (2003). Contributions of multicultural counseling to counselor competence with lesbian, gay and bisexual clients. *Journal Of Multicultural Counseling And Development, 31*(2), 84-98. doi:10.1002/j.2161-1912.2003.tb00535.x

Karoll, B. (2012). Sandra C. Anderson, Substance use disorders in lesbian, gay, bisexual, and transgender clients: Assessment and treatment. *Journal of Social Work, 12*:29. DOI: 10.1177/1468017311403961f.

Chapter 4: Assessing Sexual Intimacy within Couple Relationships

By Tiffany Longjohn and Alonzo Turner

Background and Introduction

In life, each individual is born with an innate desire to love and be loved by others. The fulfillment of such a connection is better known as intimacy and is expressed mentally, emotionally, and physically. Intimacy can be expressed and seen in various relational interactions including socially, emotionally, intellectually, recreationally, and sexually (Moore, et.al, 2008). Sexual intimacy in couple relationships encompasses more than the act of sexual intercourse but also involves a deeper connection between participating individuals. Schaefer & Olson (1981) define the term sexual intimacy as engaging in mutual emotional, physical, and mental sensation through sexual behavior.

Sexual intimacy holds a mirror to the depths or superficial connection and overall satisfaction in a relationship—both individually and collectively. The expression of sexual intimacy by each partner serves as a direct link to the connection established. The importance of sexual intimacy in a relationship is determined by the experience that each partner seeks from being intimate with one another. Greeff & Malherbe (2001) assert that "men use sexual interaction to increase emotional intimacy, whereas women need emotional intimacy to be sexually intimate." Therefore, when it comes to talking about the topic of sexual intimacy the discussion goes far beyond the bedroom.

Although intimacy encompasses many different outlets of expression our chapter will focus specifically on sexual intimacy. This chapter will discuss relevant research on assessing sexual intimacy, counseling implications, guidelines for counseling practice, and provide additional resources for professionals seeking to learn more about the topic.

Review of Relevant Research

While it is beyond the scope of this chapter to provide all research regarding sexual intimacy, the studies that are listed here serve as a review of how research defines intimacy and examples of how men and women of various backgrounds define and express sexual intimacy while also exploring the effect on relationship satisfaction.

Vohs and Baumeister (2004) describe intimacy as being a condition of a relationship having three separate parts. Intimacy involves mutual understanding, positive feelings about one another, and effective communication. When there is a mutual understanding between spouses, they both feel understood by the other individual and in turn offer complete understanding to their partner. Intimate partners have positive feelings about each other, genuinely care about their spouse's well-being, and demonstrate positive feelings in the forms of affection, warmth, and care. These components combined can foster a positive intimate connection in couple relationships and may have positive effects on the overall satisfaction in the relationship.

The Journal of Sex and Marital Therapy issued a report in 2001 which revealed the levels of satisfaction and experiences within sexually intimate relationships. The aforementioned study shows correlation between experienced levels of sexual intimacy, feelings of closeness in couple relationships and overall relationship satisfaction. Conducted with 57 couples, the study revealed significant differences between men and women in two areas of experienced intimacy as well as social/sexual incongruences (Greeff & Malherbe, 2001). Based on the results of the study, men experienced significantly less sexual intimacy than women which could also indicate men being more dissatisfied with their sexual experiences than their female counterparts. Furthermore, it was discovered that the levels of sexual intimacy is desired by women are much higher than the level that they actually experience with their spouse. Brehm (1992) highlights that spousal satisfaction is higher when the sexual activity experienced together closely resembles the sexual activity desired. All in all, this study shows a positive correlation between experience of sexual intimacy and relationship satisfaction.

To further support the notion that relationship satisfaction is determined by the intimacy in the relationship, Merves-okin (1991) stated "the best predictors of satisfaction in marriage were specific attitudes toward intimacy in marriage." In this particular study which focused on heterosexual relationships, 75 married couples were administered instruments measuring levels of intimacy and intimacy attitudes reflected in satisfaction and self-disclosure. The results revealed that partners identify verbal expression of feelings and support and encouragement as valid indicators of expectations being met in marital relationships. Based on the responses from the couples in the study, in can be implied that intimacy encompasses verbal, emotional, and physical expression of feelings while receiving validation from their partner through support and encouragement.

All in all, intimacy is a very pivotal part in a couples' level of marital satisfaction. Intimacy encompasses the ability to share desired expectations and actual experiences with one another. In addition, it also includes one's ability to freely self-disclose verbal, emotional and spiritual feelings while receiving affirmations of support and encouragement from their partner. The level of satisfaction varies based upon the congruence level of desired vs. experienced intimacy. When it comes to being sexually intimate and satisfied in relationships, it's much more than just what you say—it's about the experience of what you do.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

The concept of intimacy is a difficult idea to define particularly when it comes to gender differences. Men and women both believe that intimacy is a vital part of marital satisfaction, but have different viewpoints of what intimacy is. Miscommunicated expectations of intimacy may surface as an issue in a counseling setting. If there is a lack of sexual intimacy in a relationship that stems from differences in expectations, counselors should provide a safe space for the couple to verbally express their needs for sexual intimacy and how they define intimacy themselves. Fear of expression is also a possible counseling issue as many couples may feel hesitant to verbally express feelings of satisfaction and desired intimacy with their partner. As a result, it would be imperative for clinicians to cultivate an atmosphere that allows both partners to express and hear each other's desired level of intimacy and experience. Through couples counseling, couples can work to establish a collaborative definition of intimacy that will effectively meet both individuals' expectations. When this is done couples are able to better define expectations and desired intimacy while increasing comfort levels of verbal expression and self-disclosure (Merves-okin, et. al., 1991).

Research shows that both support and encouragement were the most important components contributing to marital satisfaction (Greeff & Malherbe, 2001). Couples who have higher levels of relationship satisfaction are more likely to be sexually intimate. If a spouse reports low feelings of support or encouragement in the relationship this might present another counseling issue. Clinicians must be able to create a setting that allows couples to support, encourage, and accept one another while remaining differentiated. This may be done through affirmations and more intimate interactions including holding hands and looking at each other while disclosing.

Additional Guidelines for Counseling Practice

- Clinicians should be prepared to deal with issues that may be more appropriate in individual counseling. For instance, counselor and client may need to restructure cognitions stemming from childhood that have shaped the individual's level of comfort being sexually intimate. Counselors should take into consideration client narratives of shame and guilt centered on their sexuality.
- Clinicians should also be aware of both formal and informal assessments available to assess intimacy and closeness in couple relationships. Some are listed below:
    - Relationship Intimacy Assessment (Metz, 2008): The RIA is used to measure different facets of the relationship. Using rank order, couples explore levels of importance in

areas that include but are not limited to the following: recreation, work, spirituality, creativity, commitment and sexual intimacy.
  - Personal Assessment of Intimacy in Relationships (Schaefer & Olson, 1981): The PAIR assessment is used to measure actual and ideal levels in relationships. The PAIR uses the three focus areas of engagement, communication and shared relationships in order to measure levels of satisfaction in relationships.
  - Intimacy Assessment Interview (Prager, 2013): The IAI is used to raise couples' awareness of what is lacking in their relationships. The interview consists of asking open ended questions regarding closeness, time spent, verbal and emotional intimacy, fun, compassion and sexual intimacy.
  - Relationship Closeness Inventory (Berscheid et. al, 1989): The RCI assessment is used to measure how different relationships can impact levels of intimacy within couples. These relationships are measured on frequency, diversity and strength to illustrate the connection that is established.
  - Unidimensional Relationship Closeness Scale (Dibble et. al., 2011): This scale measure the level of closeness in social and personal relationships. Using a 12 item self report scale, the scale measures the levels of closeness in friendships, family and significant others.

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

Books:

Harvey, J. H., Wenzel, A., & Sprecher, S. (2004). *The handbook of sexuality in close relationships.* Mahwah, NJ: Lawrence Erlbaum Associates.

- This book written specifically for professionals in the fields of psychology, health sciences, and counseling provides a broad look into sexuality and its effects on close relationships. This book explores topics related to life stages and sexuality, as well as, the effect of external factors on the level of satisfaction with closeness and sexual intimacy.

Mashek, D. J., & Aron, A. (2004). *Handbook of closeness and intimacy.* Mahwah, New Jersey: L.E. Associates, Publishers.

- This book written specifically for professionals and students in the fields of counseling, psychology and family studies explores common definitions of intimacy and closeness and reviews research in the field while also providing some situational and individual factors that may affect both partner and/or family closeness and intimacy.

Schnarch, D. (1998). *Passionate Marriage: Keeping love and intimacy alive in committed relationships.* New York: Owl Books.

- In this book, Schnarch provides a framework for couples who seek a higher level of intimacy by describing several cases of couples working towards sustaining intimacy in their relationships and describing realistic strategies that can be used to increase relationship and sexual satisfaction within marriages.

Websites:

American Association of Sexuality Educators, Counselors, and Therapists (AASECT) – www.aasect.org

International Association of Marriage and Family Counselors (IAMFC) – www.iamfconline.com

The Sexuality Information and Education Council of the United States – www.siecus.org

List of references used in this chapter:

Brehm, S. S. (1992). *Intimate Relationships*. McGraw-Hill: New York.

Bersceid, E., Snyder, M., & Omoto, A.M. (1989). The relationship closeness inventory: Assessing the closeness of interpersonal relationships. *Journal of Personality and Social Psychology,* 57, 792-807.

Dibble, J. L., Levine, T. T., & Park, H. S. (2011). The unidimensional relationship closeness scale (URCS): Reliability and validity evidence for a new measure of relationship closeness. *Psychological Assessment.*

Greeff, A. P., & Malherbe, H. L. (2001). Intimacy and marital satisfaction in spouses. *Journal of Sex & Marital Therapy,* 27, 3.
Metz, M. (2008). *Relationship Intimacy Assessment.* Retrieved from http://www.michaelmetzphd.com/20071112/INCLUDES/!!RIA-ORIG-rev%2008.pdf
Merves-Okin, L., Amidon, E., & Bernt, F. (1991). Perceptions of intimacy in marriage: A study of married couples. *The American Journal of Family Therapy*, 19, 2, 110.
Moore, K. A. M. P. M. C. J. E. S. (1999). Factor analysis of the personal assessment of intimacy in relationships scale (PAIR): Engagement, communication and shared friendships. *Sage Family Studies Abstracts*, 21, 3.
Prager, K. J. (2013). *The dilemmas of intimacy: conceptualization, assessment, and treatment.* Routledge.
Schaefer, M. & Olson, D. (1981). Assessing intimacy: The pair inventory. *Journal of Marital and Family Therapy, 7 (1), 47-60*
Vohs, K. D., & Baumeister, R. F. (2004). Sexual passion, intimacy, and gender. In D.J. Mashek & A. Aron (Ed.), *Handbook of closeness and intimacy* (pp. 189-199). Mahwah, N.J.: L. E. Associates, Publishers.

Chapter 5: Treatment for Female Sexual Dysfunction

By Carie McElveen and Anne Marie Roberts

Background and Introduction

Sexual dysfunction among the female population has historically been a repressed and taboo topic. It has often been glossed over in favor of focus on the male orgasm and the female fulfilling traditional tasks such as "pleasing her man." Thus, sexual dysfunction among women is under-diagnosed and underreported (Adegunloye & Ezeoke, 2011). It is estimated that 43 percent of women experience some type of sexual dysfunction at some point in their lives. Of that percentage, 20 percent report some type of childhood sexual trauma in their histories (Brotto, Seal, & Rellini, 2012). Other studies indicate that 53 percent of women experiencing sexual dysfunction due not seek help due to stigma, shame and a lack of awareness of what help is available (Adegunloye & Ezeoke, 2011).

Dysfunction can be classified in several areas of sexuality, including difficulties around orgasm, pleasure, arousal, desire and pain. Clinicians may also work with clients struggling with their sexual satisfaction (Brotto, Seal, & Rellini, 2012). It is important to note that a client should only be diagnosed with a sexual dysfunction if it is causing considerable stress and difficulties within her life and relationships. Along those lines, it is important to normalize and define with clients sexual expectations, and what may seem abnormal to them compared with society's portrayal of sexuality, may actually be quite typical of the average population.

Normalizing sexual experiences, particularly sexual experiences that involve dysfunction, is an important task for a clinician in establishing a treatment plan with a client. Clients may feel hesitant and embarrassed to discuss such issues, and may also feel defective and that something is wrong with them on a personal level if they experience any type of sexual dysfunction. A clinician who provides a safe place to discuss this sensitive and important issue creates a supportive foundation of rapport, trust and safety.

Review of Relevant Research

The research that exists around the treatment of female sexual dysfunction is limited and sparse. Much of the studies focus on biological treatment perspectives, and are often pharmacologically-based (Heiman, 2002). While initial treatment of female sexual dysfunction should include a thorough examination by a medical professional, with prescribed medications as necessary, studies are surfacing that indicate a psychological component is often associated with female sexual issues (Adegunloye & Ezeoke, 2011).

Treatment for female sexual dysfunction has historically employed Masters and Johnson's sensation-focused techniques, in conjunction with medicinal treatment and counseling. Masters and Johnson were among the first to develop a treatment approach to addressing female sexual dysfunction, one focused mainly on sensations and technique (Masters & Johnson, 1970). Another study suggests that female orgasmic dysfunction can often be treated successfully simply by teaching new skills and techniques (Morokoff & LoPiccolo, 1986). While past research shows high success rates following such technique-based treatment, new research is shifting the focus to cognitive-behavioral therapy approaches in an attempt to capture the psychological and relational components that sensation-focused therapies miss.

There are a few studies indicating that CBT and cognitive restructuring methods may be helpful in addressing clients' maladaptive beliefs and fears around sex (Van Lankveld, Everaerd, and Grotjohann, 2001). In a study by McCabe (2001), almost half of the participants identifying as having a sexual dysfunction at the beginning of treatment reported no longer qualifying for diagnosis of a sexual disorder after participating in a CBT treatment that addressed anxiety and negative cognitions around sex. Another article, this one focused on comprehensive treatment methods for hypoactive sexual desire disorder, endorses a multifaceted approach that includes psychoeducation, couples

therapy and individual counseling that seeks to challenge expectations, examine cultural and familial beliefs about sex, lower anxiety, and various other tasks (Weeks, Hertlein,and Gambescia, 2009). Though many mental health professionals offer guidelines for treating various types of female sexual dysfunction based on their own clinical expertise, hypoactive sexual desire disorder and some other female sexual dysfunctions lack standard methods of treatment at this point in time, indicating the need for further research (Ullery, Millner, & Willingham, 2002).

Practitioners are publishing more studies that reflect the efficacy of mindfulness approaches to address sexual dysfunction issues, indicating that teaching clients how to be aware and accepting of their present moment experiences can enhance their sexual satisfaction and address common sexual dysfunction issues. Brotto, Basson, and Luria (2008) reported that mindfulness interventions were successful in treating female sexual desire disorder. Mindfulness was also used as a treatment approach in helping women reporting sexual dysfunction with a history of childhood sexual abuse. This study found that the women in the mindfulness group experienced greater sexual arousal post-treatment and reported they were better able to be present and accepting of their sexual experiences, which in turn addressed their sexual dysfunction (Brotto, Seal, & Rellini, 2012).

Research also shows that some specific therapies are actually more successful in treating specific sexual dysfunction issues. For example, directed masturbation has been found to be the most effective treatment for female orgasm disorder (Jones & McCabe, 2011). Jones and McCabe's research also indicates that medicine alone is not always completely effective in helping women with sexual dysfunction issues, and treatment works best when combined with other types of counseling, such as couple and sex therapy.

Overall, research on female sexual dysfunction is beginning to point to a more integrated, multi-faceted approach to treating sexual dysfunction, and it is important to take into account the physiological, psychological, and relational aspects around these disorders.

Possible Counseling Issues

As part of clinical work with women identifying as experiencing sexual dysfunction, it is important to be aware of specific counseling issues that may surface with these clients. Sexual dysfunction can be a result of childhood sexual abuse. Research indicates that survivors of childhood sexual trauma often struggle with a disconnect between their physical experience in their bodies and their subjective psychological experience that helps give meaning to their lives (Brotto, Seal, & Rellini, 2012). It may be important to assess for childhood sexual abuse when working with women with sexual dysfunction, as this disorder can often (but not always) be a coping mechanism for their traumatic past experiences.

Other issues for clinicians to consider include comorbid conditions and relationship concerns. Comorbidity with other psychiatric disorders is often common with female sexual dysfunction (Adegunloye & Ezeoke, 2011). A clinician may see clients with self-esteem issues playing into their relationship and sexual experiences, and, on the more clinical end, variations of eating disorders. As such, it is important for a clinician to keep in mind that if a client’s issues fall out of his or her scope of practice (sex therapy, couple therapy, eating disorders, physical exams), the clinician should consult and seek appropriate supervision, with referrals and community resources easily accessible. Furthermore, although a clinician may be treating the individual client with the sexual dysfunction, it is certainly important to keep in mind that sex is an act typical within a partnership, so relational issues should be explored and discussed, with a referral to couple counseling or sex therapy if necessary.

Additional Guidelines for Counseling Practice

Guidelines for counseling women with sexual dysfunction include first sending the client for a full medical examination with medication prescribed as necessary. Counseling strategies include normalizing and educating the client around sexual issues and defining sexual goals and expectations that are realistic for them in their intimate partnerships (Graziottin, Castoldi, Montorsi, Salonia, &

Maga, 2001). Cognitive-behavioral therapies are helpful in challenging and teaching new thoughts around the client's perception of self and sexuality. Sometimes teaching skills and providing education around sexuality, though seemingly basic interventions, can provide realistic expectations of sexuality, as well as concrete behaviors to implement. It is important to emphasize, even in teaching sensate-focused techniques, that satisfying sexual experiences are often less about skill and technique and more about addressing underlying cognitive and emotional issues (Leiblum & Wiegel, 2002).

While sensate-focused therapies are often the most "popular" and most well-researched, it is important to emphasize to clients that techniques can actually increase anxiety and get in the way of being present in the moment. That is why mindfulness-based therapies are becoming increasingly popular in treating sexual dysfunction in females. This type of treatment emphasizes present moment awareness and acceptance. Clinicians teach clients to focus on the moment at hand while also acknowledging thoughts and feelings without putting labels (negative/positive) on their experience. This type of therapy helps clients be with what is and more fully immerse themselves in the sexual experience (Brotto, Seal, & Rellini, 2012). Couples therapy can also be helpful if the client indicates communication and relational issues.

General guidelines for treating female sexual dysfunction should ideally include an integrated treatment team that consults with physicians and other health professionals such as marriage and sex therapists and psychiatrists (Leiblum and Wiegel, 2002).

What resources are available to help professionals learn more about this topic?

Professionals and clinicians can visit several valid websites hosted by government and professional organizations with experience in treating female sexual dysfunction.

- *The American Family Physician (http://www.aafp.org/afp/2011/0915/p705.html):* American Family Physician provides statistics on female sexual dysfunction and provides a treatment overview for each clinical disorder
- The Association of Reproductive Health Professionals provides an outline of how to approach female sexual dysfunction from a medical perspective, while also discussing psychological and sociological aspects of normalizing expectations and redefining sexuality for the client: (http://www.arhp.org/Publications-and-Resources/Clinical-Practice-Tools/Handbook-On-Female-Sexual-Health-And-Wellness/Treating-Female-Sexual-Dysfuntion)
- *The Journal of Sexuality and Gender Studies* and *The Journal of Sex Research* are two resources for health professionals working with clients with sexual issues.
- International Association of Marriage and Family Counselors (IAMFC): www.iamfconline.org/

List of references used to prepare this chapter

Adegunloye, O., & Ezeoke, G. (2011). Sexual dysfunction—A silent hurt: Issues on treatment awareness. *Journal Of Sexual Medicine*, *8*(5), 1322-1329. doi:10.1111/j.1743-6109.2010.02090.x

Brotto, L. A., Seal, B. N., & Rellini, A. (2012). Pilot study of a brief cognitive behavioral versus mindfulness-based intervention for women with sexual distress and a history of childhood sexual abuse. *Journal Of Sex & Marital Therapy*, *38*(1), 1-27. doi:10.1080/0092623X.2011.569636

Brotto, L., Basson, R., & Luria, M. (2008). A mindfulness-based group psychoeducational intervention targeting sexual arousal disorder in women. *Journal of Sexual Medicine*, *5*, 1646-59.

Graziottin, A., Castoldi, E., Montorsi, F., Salonia, A., & Maga, T. (2001). Vulvodynia: The challenge of 'unexplained' genital pain. *Journal Of Sex & Marital Therapy*, *27*(5), 503-512. doi:10.1080/713846809

Heiman, J. R. (2002). Psychologic treatments for female sexual dysfunction: Are they effective and do we need them? *Archives of Sexual Behavior, 31*(5), 445-450.

Jones, L. M., & McCabe, M. P. (2011). The effectiveness of an Internet-based psychological treatment program for female sexual dysfunction. *Journal Of Sexual Medicine*, *8*(10), 2781-2792. doi:10.1111/j.1743-6109.2011.02381.x

Leiblum, S. R., Wiegel, M. (2002). Psychotherapeutic interventions for treating female sexual dysfunction. *World Journal of Urology, 20*(2), 127-136.

Masters, W.H, & Johnson, V.G (1970). *Human sexual inadequacy*. London: J&A Churchill.

McCabe , M. (2001). Evaluation of a cognitive behaviour therapy program for people with sexual dysfunction. *Journal of Sex and Marital Therapy*, *27*, 259-71.

Morokoff, P. J., LoPiccolo, J. (1986). A comparative evaluation of minimal therapist contact and 15-session treatment for female orgasmic dysfunction. *Journal of Consulting and Clinical Psychology, 54*(3), 294-300.

Ullery, E. K., Millner, V. S., Willingham, H. A. (2002). The emergent care and treatment of women with hypoactive sexual desire disorder. *The Family Journal, 10*(3), 346-350.

Van Lankveld, J., Everaerd, W., & Grotjohann, Y. (2001). Cognitive behavioral bibliotherapy for sexual dysfunctions in heterosexual couples: A randomized waiting-list controlled clinical trial in the Netherlands. *Journal of Sex Research*, *38*, 51-67.

Weeks, G. R., Hertlein, K. M., Gambescia, N. (2009). The treatment of hypoactive sexual desire disorder. *Journal of Family Psychotherapy, 20*(2-3), 129-149. DOI: 10.1080/08975350902967358

Chapter 6: Houston, We Have a Problem: Interventions for Male Sexual Dysfunction

By Megan Murphy and Kathryn Wolfson

Background and Introduction

Since the beginning of psychology, our sexual urges have been under a microscope. Freud believed that the basis of development was grounded on our sexuality. While most people may be able to identify Freud's beliefs about healthy functioning of sexuality, not many would be able to tell you what he believed about dysfunctions in sexuality. Freud did, however, look into the psychological reasons behind male sexual dysfunction; in particular impotence (Hartmann, 2009). Since then, however, most of the research surrounding male sexual dysfunction has focused on a biological reason, and a pharmacological fix to the problem. With the vast array of medications that may help a man alleviate the physical symptoms of sexual dysfunction, there also exists the larger implication of the psychological reasons behind sexual dysfunction for a man, as well as the consequences for the couple that he may be a part of. This chapter looks specifically at the interventions that can be used within counseling.

Review of Relevant Research

Since former presidential candidate Bob Dole appeared on television advertising the "Blue Pill" in 1998, the conversation surrounding male sexual dysfunction was brought to the foreground in the United States. Before that, however, male sexual dysfunction was not a topic that was readily discussed, even within the mental health field. While research about the male erection dates back to the 19th century, it was not until the 20th century that research moved from animals to humans along with studying the possible psychological reasons contributing to the dysfunction (Giuliano et al., 2010).

In the new Diagnostics and Statistical Manual of Mental Disorders, version five (DSM-V), there have been some changes regarding sexual dysfunction (2013). According to the DSM-V, there are seven types of diagnosable male sexual dysfunctions (2013). While all seven disorders can cause equal amounts of shame and distress for a client, most of the research has been conducted on erectile disorder (ED). This is most likely due to the fact that many people associate male sexual dysfunction with ED, and we now have mainstream medications that address ED; such as Viagra, Cialis, and Levitra. For this reason, the relevant research that is addressed in this chapter will focus on ED.

While most research, and popular belief, is that ED always affects older men, some research suggests that as age increases, satisfaction in sexual experiences also increases (Potts, Grace, Vares & Gavey, 2006). Potts, Grace, Vares & Gavey indicate that many men feel more competent in giving pleasure and may be able to experiment with new sexual lifestyles, which also increases their satisfaction with their sexual experiences (2006). Some difficulty in achieving and sustaining an erection to ejaculation is normal with age, but ED is not necessarily an older man's disorder. A study by Mialon, Berchtold, Michaud, Gmel & Suris indicated that ED can also affect the younger (ages 18-25) male population by almost 30% (2012). In this particular study, poor mental health was the only factor to have a direct association with sexual dysfunction (2012).

According to the Massachusetts Male Aging Study, by age 40 up to 40% of men are affected with some degree of ED (Feldman et al., 1994). Some of the research surrounding ED briefly talks about contributing factors, like smoking, but not many studies search for answers outside of the physiological aspect. Understanding the mental health factors that may be contributing to all sexual dysfunctions is crucial. Having knowledge of how counselors can work with this population without prescribing medication as a salve to a larger problem is also very important. Medication is not a cure all for this problem. According to Emedicinehealth.com, Viagra works successfully for only 60-75% of men, which means that there exists a large population of men with ED who, even with medication, are in need of an alternate intervention (2013). In those cases, counseling may be just what the doctor ordered.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

From a biopsychosocial perspective, male sexual dysfunction is viewed as multidimensional and multicausal, and is thought to best be treated by using interventions and relapse prevention plans that take into account the biological, psychological, and relational consequences that males experience as a result of their sexual dysfunction. A male may experience a variety of psychological stressors related to his sexual dysfunction. For example, anxiety is commonly associated with male sexual dysfunction. More specifically, anticipatory and performance anxiety have shown to play a significant role in the development and maintenance of sexual dysfunction in men (McCabe, 2005). Sexual dysfunction is also associated with depression, embarrassment, and low levels of self-esteem and self-confidence (Rosen & Althof, 2008). Anxiety, depression, embarrassment, and/or decreased self-esteem and self-confidence can contribute to a man's avoidance of sexual interactions and/or feelings of reluctance in developing new partner relationships (Rosen & Althof, 2008).

As well as individual psychological issues, sexual dysfunction in males is also often linked to relational distress. A man's sexual dysfunction may impact his partner's sex life by limiting the frequency of sexual contact or by changing the nature of their sexual relationship. One study of women with male partners complaining of ED found that female partners experience lower levels of sexual arousal, lubrication, orgasm, and satisfaction as a result of their partner's sexual dysfunction (Cayan, Bozlu, Canpolat, & Akbay, 2004). Furthermore, an analysis of multiple studies on premature ejaculation found that premature ejaculation had a significant negative impact on relationships by contributing to greater levels of distress and interpersonal difficulty, lower levels of intimacy, and lower levels of confidence in the relationship (Rosen & Althof, 2008). As a result, couples where sexual dysfunction is a concern are vulnerable for divorce.

Additional Guidelines for Counseling Practice

Clinicians should be aware that males typically feel reluctant about seeking treatment for sexual dysfunction due to embarrassment or belief that treatment does not exist (Rosen & Althof, 2008); therefore, counselors should focus on developing a strong therapeutic alliance and promote acceptance and normalization of male sexual dysfunction. Also, clinicians should employ a comprehensive approach to treating male sexual dysfunction by referring to a physician as a first step in the client's treatment to determine comorbid disorders and the appropriateness of employing a medical intervention. Medical interventions are common in treating sexual dysfunction and may include prescribing oral medications such as Viagra or antidepressants, hormonal therapy, or penile implants. Counselors can enhance the effectiveness of such medical interventions by working with individuals or couples to implement the intervention into their sexual script, develop positive and realistic goals, explore issues of intimacy, and address comorbid psychological disorders (McCarthy & Fucito, 2005). Counselors can also help clients by helping them make lifestyle changes, providing them with education about sexual technique, teaching them communication skills, and providing them with community resources. A popular intervention that counselors may choose to use is Masters and Johnson's approach, sensate focus. With a sensate focus approach, clients learn to pay more attention to the physical sensations rather than their performance during sex through a graduated process that includes homework assignments, clothed non-genital touching, genital touching, and then intercourse. Clinicians may also use David Schnarch's Crucible Approach when treating males with sexual dysfunction. The Crucible Approach treats sexual dysfunction through a focus on increasing intimacy and passion and fostering personal growth and differentiation (Schnarch, 1998). Whether working with the male experiencing sexual dysfunction individually or with his partner, counselors can help clients alleviate the distress associated with the psychological and social consequences of their sexual dysfunction.

What resources (e.g. books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

- American Association of Sex Educators, Counselors, and Therapists: www.aasect.org
- Kingsberg, S., Althof, S. E., & Leiblum, S. (2002). Books helpful to patients with sexual and marital problems. *Journal Of Sex & Marital Therapy*, *28*(3), 219-228. doi:10.1080/009262302760328262
- Schnarch, D. (2010). Using crucible therapy to treat sexual desire disorders. In S. R. Leiblum (Ed.) , *Treating sexual desire disorders: A clinical casebook* (pp. 44-60). New York, NY US: Guilford Press.
- Urology Care Foundation: www.urologyhealth.org
- Weeks, G. R., & Gambescia, N. (2009). A systemic approach to sensate focus. In K. M. Hertlein, G. R. Weeks, N. Gambescia (Eds.), *Systemic sex therapy* (pp. 341-362). New York, NY US: Routledge/Taylor & Francis Group
- Winton, M. (2000). The medicalization of male sexual dysfunctions: An analysis of sex therapy journals. *Journal Of Sex Education & Therapy*, *25*(4), 231-239

References

According to Emedicinehealth.com. (2013). Retrieved on July 24, 2013, from http://www.emedicinehealth.com/impotenceerectile_dysfunction/page5_em.htm.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental health disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Çayan, S., Bozlu, M., Canpolat, B., & Akbay, E. (2004). The assessment of sexual functions in women with male partners complaining of erectile dysfunction: Does treatment of male sexual dysfunction improve female partner's sexual functions?. *Journal Of Sex & Marital Therapy*, *30*(5), 333-341. doi:10.1080/00926230490465091

Feldman H. A., Goldstein I, Hatzichristou D.G. & et al. (1994). Impotence and its medical and psychosocial correlates: Results of the massachusetts male aging study. *Journal of Urology*,151:54–61.

Giuliano, F., Pfaus, J., Balasubramanian, S., Hedlund, P., Hisasue, S., Marson, L., & Wallen, K. (2010). Experimental models for the study of female and male sexual function. *Journal of Sexual Medicine*, 7(9), 2970-2995. doi:10.1111/j.1743-6109.2010.01960.x

Hartmann, U. (2009). Sigmund freud and his impact on our understanding of male sexual dysfunction. *Journal of Sexual Medicine*, 6(8), 2332-2339. doi:10.1111/j.1743-6109.2009.01332.x

McCabe, M. P. (2005). The role of performance anxiety in the development and maintenance of sexual dysfunction in men and women. *International Journal Of Stress Management*, *12*(4), 379-388. doi:10.1037/1072-5245.12.4.379

McCarthy, B. W., & Fucito, L. M. (2005). Integrating Medication, Realistic Expectations, and Therapeutic Interventions in the Treatment of Male Sexual Dysfunction. *Journal Of Sex & Marital Therapy*, *31*(4), 319-328. doi:10.1080/00926230590950226

Mialon, A., Berchtold, A., Michaud, P., Gmel, G., & Suris, J. (2012). Sexual dysfunctions among young men: Prevalence and associated factors. *Journal of Adolescent Health*, 51(1), 25-31. doi:10.1016/j.jadohealth.2012.01.008

Potts, A., Grace, V. M., Vares, T., & Gavey, N. (2006). 'Sex for life'? Men's counter-stories on 'erectile dysfunction', male sexuality and ageing. *Sociology of Health & Illness*, 28(3), 306-329.

Rosen, R. C., & Althof, S. (2008). Impact of premature ejaculation: The psychological, quality of life, and sexual relationship consequences. *Journal Of Sexual Medicine*, *5*(6), 1296-1307. doi:10.1111/j.1743-6109.2008.00825.x

Schnarch, D. (1998). *Passionate marriage: Keeping love and intimacy alive in committed relationships.* New York: Owl Books. ISBN: 0805058265.

Chapter 7: Interventions for LGBT Clients
By Patrick Kalaw and Jeremy Fox

Background and Introduction

Just 40 years ago, the American Psychiatric Association had homosexuality as a diagnostic category from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1968). This created some tension between the LGBT community and clinicians as clients were pathologized for their sexual orientation. It wasn't until 1973 that the *DSM* removed homosexuality as a mental illness. This signified a momentous victory for gay rights and was in large part due to the LGBT civil rights movement in the 1970's and 1980's (Landridge, 2007). As the world started to shift its views of homosexuality, Gay and Lesbian Affirmative Psychotherapy emerged. Due to the historical relevance of its origin, we have chosen to focus on Gay and Lesbian Affirmative Therapy interventions that would provide therapists with a starting point in working with LGBT clients.

Review of Relevant Research

With this being a fairly new approach in the therapy world, there is some dispute as to what actually constitutes Affirmative Therapy. Most practitioners adopt the belief that a Gay and Lesbian Affirmative Psychotherapy approach is adaptable to any therapist's preferred style (Falco, 1996 as cited in Ritter & Terndrup, 2002). The important thing to highlight is the modification of therapy in order to incorporate stressors of being an LGBT person in a heterocentric world. A review of the literature from Coyle and Kitzinger (2002) found that there are several "qualities" that are common among the varying perspectives of Affirmative Therapy. One of these qualities states that therapists should not pathologize the sexuality of an LGBT client, rather view it as normal and natural. Another common quality among therapists is the notion that sexuality is not necessarily the source of a client's distress. Instead, societal and interpersonal reactions towards the client's sexuality should be taken into consideration. A contextual focus is suggested in order to understand where the problem arises; interpersonal dynamics, prejudice, internalized homophobia, etc. In essence, Gay and Lesbian Affirmative Psychotherapy is an approach to get client's to accept who they are rather than change or fix a problem.

Although Gay and Lesbian Affirmative Psychotherapy can be used in conjunction with other approaches, it has specific interventions that we will briefly mention. Early on when an LGBT client is starting to realize that they may not be heterosexual, a powerful intervention that can be used is Empathetic Exploration (Ritter & Terndrup, 2002). During this phase of questioning, the therapist must navigate empathizing the clients confusion of their sexual orientation, rather than highlight and possibly increase fears that they are no longer heterosexual. It is natural for clients to show anxiety in this phase, as it is natural for clinicians to want to alleviate this anxiety. A common mistake by clinicians is to try and move the client to acceptance before they are ready. Clinicians are encouraged to go slow and to keep a check on their pacing.

As clients start to move away from their heterosexual identity, there is a certain amount of grief and loss that comes from abandoning that identity. This usually happens because LGBT clients are socialized from a heterocentric worldview so they abandon their pre-established way of life for a new LGBT way of life. Using a Gay and Lesbian Affirmative Psychotherapy approach, clinicians help facilitate the process of grief and loss with their clients (Ritter & Terndrup, 2002). After acceptance of the loss of their heterosexual identity, then clients can explore a new identity.

Further along in the coming out process, clients inevitably have to deal with disclosure of their new sexual identity. One of the biggest issues that clients face is who and how to tell their friends and families about their sexual orientation. Often times, parents are the most difficult to disclose to. Instead of going straight to the parents, it is encouraged to build up comfort with disclosure and

slowly move up to the parents. One strategy is to create a support system of other LGBT people in order to establish a sense of belonging and acceptance. Being surrounded by like-minded people can ease a client into their new identity. Clinicians can help navigate this process in a variety of ways. Role plays are often used to enact what a coming out conversation would look like. This strategy is a safe, contained building block for actually disclosing to friends and family. Using therapeutic core conditions of simply meeting the client where they are at works well the Affirmative Therapy approach.

Possible Counseling Issues

While Gay and Lesbian Affirmative Therapy is the primary intervention focus of this chapter, there are other possible counseling issues that a client may bring in a session. Many clients may be experiencing problems concerning the intersection of sexuality and culture. LGBT clients may experience additional stress in integrating sexual identity in their personal or social contexts. This can include implicit messages received from a hetero-sexualized society or explicit message from one's own religious tradition. A client may be receiving conflicting messages from various social contexts regarding sexual identity and may not know what to do with the messages. For these issues, Affirmative Therapy can be a starting point, and other approaches may be necessary.

Family issues can come up with a LGBT client. A client may be deciding on whether or not to disclose their sexuality to friends or family. This process can lead to increased anxiety for a client and it is important that a therapist be open to discussing what this means for an individual. Another issue that may surface in sessions is the possibility if a client in a same-sex relationship pursuing adoption. While there may not be laws preventing single individuals from adopting based on sexual identity, many states have laws prohibiting same-sex couples from adopting as a couple. The concerns and stresses that this places on a relationship could surface in conversations with LGBT clients.

For therapists who incorporate couples counseling into their practice, it is possible that a therapist will see a same-sex couple. While there are several different theories in how to approach couples counseling, one that can work with many couples regardless of sexual identity is Emotionally Focused Couples Therapy (EFT). The bonds of attachment lie deep within, no matter what sexual identification one embraces. In intimate relationships, people attempt to find partners who are emotionally available and responsive enough to ease anxiety and distress.

EFT views attachment insecurity and continual separation distress as the primary source of conflict and relational unhappiness. Due to internal and external pressures, LGBT clients could face sexual identity related stress that can interfere with a positive sexual development and the establishment of a strong bond with a partner (Zuccarini & Karos, 2011). Before a therapist were to begin using EFT to help clients establish a secure attachment, it is important to address whether or not each partner has developed a positive sense of sexual identity. The contextual influences listed above can have a great influence on the positive sexual development of a client and should discussed without making assumptions regarding the influences.

Additional Guidelines for Counseling Practice

It is important for a therapist to stay current in the constant changing public policy landscape. The changes in public policy can impact the resources accessible for a client. This can also impact the possibility of a client having access to health insurance, possibly creating a financial strain and reason to discontinue therapy. Some public policies can determine a person's ability to adopt a child based on sexual identity. A therapist can also use this awareness to advocate for LGBT clients concerning public policy.

It is also important that a therapist not make assumptions about a client's identity, this includes assuming the client is heterosexual. Even if a client were to not specifically state his or her sexual identity, assuming silence equates to heterosexuality can discourage a client to be honest about her or his identity and may damage the therapeutic alliance. This can be especially harmful if sexuality is a

primary concern for a client's visit. A therapist should use open ended questions when asking about sexuality and not limit the ways in which a client can identify him or herself. For instance, asking if a client is homosexual or heterosexual neglects the other identities a client may hold and makes an assumption that sexuality can be limited to such a dichotomy. Any therapist would benefit from reviewing and adhering to the Association for Lesbian, Gay, Bisexual, & Transgender Issues in Counseling's competencies for counseling found at the site below.

One issue that may come up for the therapist is the role a therapist has during sessions with a LGBT client. This is a concern that needs to be addressed at the beginning of a therapeutic relationship with utmost clarity. There is a distinction between a therapist whose role is to change a client and one who is providing a relationship that clients can use, if they choose, to enhance their own self-understanding (Mair, 2006). A lack of clarity can cause many difficulties during sessions, including seducing a counselor into believing that it is his or her role to bring about change in a client. This belief can damage the relationship and the increase the potential for unhelpful sessions. When a therapist takes the time to reflect on the role used in counseling, it is also a good chance to reflect and engage with a therapist's own homophobia. Engaging one's own homophobia is ultimately helpful for the growth of the therapist and clients.

What resources are available to help professionals learn more about this topic?

Websites:

- Association for Lesbian, Gay, Bisexual, & Transgender Issues in Counseling
  http://www.algbtic.org/
- Gay and Lesbian Affirmative Psychotherapy: A Division of the Institute for Contemporary Psychotherapy
  http://www.glapnyc.org/
- Association of Lesbian & Gay Affirmative Psychotherapists
  http://algap.org/

Books:

- Handbook of Psychotherapy with LGBT Clients
  Bieschke, K., Perez, R., & DeBord, K. (Eds.). (2007). *Handbook of Counseling and Psychotherapy With Lesbian, Gay, Bisexual, and Transgender Clients* (2nd ed.). Washington, D.C.: American Psychological Association.
- Handbook of Affirmative Psychotherapy
  Ritter, K., & Terndrup, A. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: The Guilford Press.
- Gay Affirmative Therapy for the Straight Clinician: The Essential Guide
  Kort, J (2008). *Gay affirmative therapy for the straight clinician: The essential guide.* New York, NY: W. W. Norton & Company, Inc.

List of References

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

Coyle, A., & Kitzinger, C. (2002). *Lesbian & gay psychology: New perspectives*. (1 ed.). London: Blackwell Publishers Ltd.

Falco, K.L. (1996). Psychotherapy with women who love women. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 397-412). Washington, DC: American Psychiatric Press.

Landridge, D. (2007). Gay affirmative therapy: A theoretical framework and defense. *Journal of gay & lesbian psychotherapy,* 11(1/2), 27-43

Mair, D. (2006). Psychodynamic counselling and sexual orientation. In S. Wheeler (Ed.), *Difference and diversity in counselling: Contemporary psychodynamic perspectives* (pp. 57-73). New York: Palgrave.

Ritter, K., & Terndrup, A. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: The Guilford Press.

Zuccarini, D., & Karos, L. (2011). Emotionally focused therapy for gay and lesbian couples: Strong identities, strong bonds. In J. L. Furrow, S. M. Johnson & B. A. Bradley (Eds.), *The emotionally focused casebook: New directions in treating couples* (pp. 317-342). New York: Routledge.

Chapter 8: Interventions to Enhance Sexual Intimacy within Couple Relationships
By Nikki Kennard and Molly Johnson

Background and Introduction

Most sex therapy interventions are specifically designed to address sexual dysfunction, rather than to enhance sexual intimacy. Some may think "Aren't these just different approaches to address the same problem?" The simple answer is no. In order to understand the difference, one must first understand intimacy.

The concept of intimacy is complex and difficult to define, as it consists of many different elements (Miller & Perlman, 2008). Some findings suggests that both researchers and the general public agree that "intimate relationships differ from more casual associations in at least six specific ways: knowledge, caring, interdependence, mutuality, trust, and commitment" (Miller & Perlman, 2008, p. 2). While these are not necessary for intimacy to be present, the most profound and fulfilling intimate relationships tend to include all six elements.

Intimacy not only affects relationship well-being, but it also impacts personal well-being. Intimacy is a fundamental human need, and the desire to establish intimate relationships is both potent and pervasive. Loss of intimate connections has been associated with higher blood pressure, weakened immune functioning, and higher mortality rates (Miller & Perlman, 2008).

Where does sexual intimacy fit in with our need for intimacy? Birnie-Porter & Lydon (2013) stated it very clearly, "sexual intimacy is very much an experience of intimacy, but it may be helpful to think of it as a sexual experience that is intimate" (p. 256). These researchers conducted four separate studies into the nature of sexual intimacy, and concluded that sexual intimacy is a distinct subtype of intimacy. While it involves characteristics that are commonly correlated with sexual activity, such as sexual arousal and orgasms, it extends to include the following elements: consensual, having a connection, eye contact, senses, natural, and seduction.

In contemporary society, it is assumed that in order to be intimate with a person, a sexual act must be involved - when in reality, intimacy consists of many more dimensions than just sex alone. It is possible to be intimate with another person without sexual contact; and conversely, it is also possible to have sexual contact without intimacy. By uniting the experience of intimacy with sexual activity, couples are able to move toward sexual fulfillment.

While interventions that address sexual dysfunction may be more focused on enhancing desire and arousal *within* each partner, interventions aimed at enhancing sexual intimacy address the meaning and connections made *between* the couple (Armstrong, 2006). By centering on behavioral or sensation-focused interventions to address dysfunction, sex therapy often overlooks the intimacy issues underlying the dysfunction, which may intensify the problem. Enhanced sexual performance, alone, will not allow couples to reach their sexual potential. This signifies the need for interventions to enhance sexual intimacy within couple relationships.

Review of Relevant Research

One method that is used to increase intimacy and marital satisfaction are Marriage Enrichment Programs. There are many different variations of these programs available, depending on the comfort level of the couple; some even use an adventure component. There are hope-focused marital enrichment programs and even empathy-centered forgiveness-based marital enrichment programs. Marriage Enrichment Programs work through an educational model, teaching skills of communication, conflict resolution, and decision making (Hickmon, Protinsky & Singh, 1997). Although some research has found that some of these programs are beneficial in increasing positive behaviors within couples (Ripley & Worthington, 2002), others had dissimilar findings. Dixon, Gordon, Frousakis, and Schumm (2012) found that "the greater the disparity between participants' expectations of effort toward implementing what they learned in the seminar and their

perceived amounts of effort toward actually doing the same, the greater the dissatisfaction, in the amount of effort exerted" (p. 84). In other words, expectations play a role in our perceived "effectiveness" of these programs. The expectations that one has could be for themselves, their partner or for the program.

Timmers, Sinclair, and James (1976) discuss the importance of enhancing sexual intimacy through a non-goal-directed approach to sexual interaction. They posit that a linear, goal-directed approach to sexual interactions (e.g. touching, kissing, caressing, vagina-penis contact, followed by intercourse and orgasm) limits the couples' ability to connect and experience joy and pleasure, and leads to boredom and frustration. They encourage couples to create their own repertoire of intimate sexual behaviors that do not focus on intercourse and orgasm as the end goal. Helping professionals can aid clients in enhancing sexual intimacy by shifting their focus to a non-goal directed approach, which allows them to be more in the moment with their partner, rather than distracted by focusing on orgasms (either their own or their partner's).

Armstrong (2006) takes a humanistic approach in considering interventions to enhance sexual intimacy. He believes that "the ultimate goal of sex therapy should be to work toward a client's ideal notion of the sexual encounter" (Armstrong, 2006, p. 294). This may be different for each partner, and it is important to explore these differences. As a way to strengthen intimacy, Armstrong suggest an intervention called "ask anything nights," in which the couple takes turns asking each other any question, and they are expected to answer truthfully. This experience of cooperative sharing is meant to enhance intimacy, and thereby, sexual intimacy.

Emotionally-focused therapy (EFT) is yet another approach to enhancing sexual intimacy in couple relationships. Counselors who employ an attachment-based, EFT perspective have been successful in addressing issues with sexual intimacy (Honarparvaran, Tabrizy, Navabinejad, & Shafiabady, 2010; Johnson & Zuccarini, 2010). From this viewpoint, sexual difficulties stem from real or perceived threats to the partners' attachment to each other (Honarparvaran, Tabrizy, Navabinejad, & Shafiabady, 2010). Through the process of EFT, counselors help clients to create a secure and trusting attachment, which by proxy enhances sexual intimacy. Often, couples in distressed relationships are hooked in a cycle in which one partner is critical and pursuing, while the other is withdrawing and defensive (Johnson & Zuccarini, 2010). This cycle can extend to the bedroom, which has a major impact on sexual intimacy. The counselor works to help the couple to deescalate their negative cycle and restructure their bond and, through this process, they become more emotionally responsive and accessible to themselves and each other. This allows the couple to feel a stronger connection and security in their relationship, which then promotes an enhanced experience of sexual intimacy.

Possible Counseling Issues

Although there is some consensus as to the general idea of what intimacy is (Miller & Perlman, 2008) the definition varies depending on who is asked. There are many different variations of what constitutes an intimate act, what intimacy looks like, and how it feels. There are even cultural differences when it comes to views on intimacy. It has been found that in a study of Chinese college students, there were high levels of fear of intimacy and sexual anxiety (Ingersoll, 2012).

To complicate matters further, there are varying levels of comfort in willingness to discuss one's ability to be intimate or the level of intimacy in a relationship. Although this could be a result of many different factors, a person's family of origin plays a crucial role in this. Dornak (2013) discussed the differing perceptions of intimacy and marriage in adult children of divorce compared to adult children from intact families. This study found that those adult children of divorce were not only more likely to fear rejection, but they were also more likely to need attention and emotional connection; which can be conflicting for the individual. Schnarch (1997) discusses the importance of increasing each individual's differentiation in order for them to be able to truly be intimate with a partner. One is not able to fully be with another person if they are not sufficiently differentiated.

With so many different variables to consider, it is no wonder that some couples have difficulties when it comes to developing and expressing intimacy. As a counselor, it is important to also consider alternative factors that may be affecting the level of intimacy between couples. Some of these factors could be medical conditions, substance use, medications, previous trauma, medications or mental health concerns. Individually, each of these factors could potentially affect many of the different aspects of intimacy between couples. It is essential to conduct a thorough intake with couples to try to identify if any of these factors are present.

Additional Guidelines for Counseling Practice

As previously stated, intimacy is an extremely complex concept. There are many components that make up what we define as intimacy - and each of those can look very different for each and every individual and couple relationship. Schnarch (1997) discusses intimacy as a developmental process that ebbs and flows throughout our lifespan. The flexibility and developmental process of this concept allows clients to personally grow in their capacity to be intimate and increase intimacy within their relationships.

A benefit of this flexibility for counseling professionals is that there are many different approaches that can be taken when working on increasing intimacy in clients' couple relationships. Wubbolding (1999) views intimacy through the lens of reality therapy. He suggests that an intimate relationship involves an overlap in the couples specific wants, goals, and desires, as they relate to the sources of human motivation and needs. Wubbolding agrees that intimacy is developmental in nature and focuses on different levels of interaction to help clients explore and develop each level, as a way to increase intimacy. Counselors can take different approaches with each different couple to explore what intimacy means, and how to develop and maintain it.

What resources are available to help professionals learn more about this topic?

Books

- Corwin, G. (2012). *Sexual intimacy for women*. Berkeley: Seal Press.
- Miller , R., & Perlman, D. (2008). *Intimate relationships*. (5 ed.). New York, NY: McGraw-Hill.
- Schnarch, D. (1997). *Passionate marriage: Keeping love & intimacy alive in committed relationships*. New York: Henry Holt and Company.

Websites

- American Association of Sex Educators, Counselors, and Therapists: http://www.aasect.org/
- Society for the Scientific Study of Sexuality: http://www.sexscience.org/
- American Association for Marriage and Family Therapy: http://www.aamft.org

Online Journal Articles

- Couples Exercises for Building Intimacy: https://www.mylifestages.org/health/sexual_health/couples_exercise_for_intimacy.page
- Exercises to Enhance Your Sexual Desire and Satisfaction: www.psychologytoday.com/blog/whats-your-sexual-style/201203/exercises-enhance-your-sexual-desire-and-satisfaction
- Sexuality and Marital Intimacy: http://psychcentral.com/lib/sexuality-and-marital-intimacy/00012148
- Tantric Sex Techniques to Reinvigorate Lovemaking: http://health.howstuffworks.com/sexual-health/sexuality/tantric-sex-dictionary.htm

References

Armstrong, L. (2006). Barriers to Intimate Sexuality: Concerns and Meaning-Based Therapy Approaches. *Humanistic Psychologist*, *34*(3),281-298. doi:10.1207/s15473333thp3403_5

Birnie-Porter, C., & Lydon, J. E. (2013). A prototype approach to understanding sexual intimacy through its relationship to intimacy.*Personal Relationships*, *20*(2), 236-258. doi:10.1111/j.1475-6811.2012.01402.x

Dixon, L. J., Gordon, K., Frousakis, N. N., & Schumm, J. A. (2012). A study of expectations and the marital quality of participants of amarital enrichment seminar. *Family Relations: An Interdisciplinary Journal Of Applied Family Studies*,*61*(1), 75-89. doi:10.1111/j.1741-3729.2011.00681.x

Dornak, T. (2013). Adult children of divorce and their views of their parents' divorce and intimacy. *Dissertation Abstracts International*, *73*
Hickmon, W. r., Protinsky, H. O., & Singh, K. (1997). Increasing marital intimacy: Lessons from marital enrichment. *Contemporary Family Therapy: An International Journal*, *19*(4), 581-589. doi:10.1023/A:1026191223476
Honarparvaran, N. N., Tabrizy, M. M., Navabinejad, S. h., & Shafiabady, A. A. (2010). The Efficacy of Emotionally Focused Couple Therapy (EFT-C) Training with Regard to Reducing Sexual Dissatisfaction among Couples. *European Journal Of Scientific Research*, *43*(4), 538-545.
Ingersoll, T. (2012). Examining the relationship between fear of intimacy and sexual anxiety among Chinese college students. *Dissertation Abstracts International Section A*, *73*,
Johnson, S., & Zuccarini, D. (2010). Integrating Sex and Attachment in Emotionally Focused Couple Therapy. *Journal Of Marital & Family Therapy*, *36*(4), 431-445. doi:10.1111/j.1752-0606.2009.00155.x
Miller , R., & Perlman, D. (2008). *Intimate relationships*. (5 ed.). New York, NY: McGraw-Hill.
Ripley, J. S., & Worthington, E. R. (2002). Hope-focused and forgiveness-based group interventions to promote marital enrichment. *Journal Of Counseling & Development*,*80*(4), 452-463. doi:10.1002/j.1556-6678.2002.tb00212.x
Schnarch, D. (1997). *Passionate marriage: Keeping love & intimacy alive in committed relationships*. New York: Henry Holt and Company.
Timmers, R. L., Sinclair, L. G., & James, J. (1976). Treating Goal-directed Intimacy. *Social Work*, *21*(5), 401.
Wubbolding, R. E. (1999). Creating intimacy through reality therapy. In J. Carlson, L. Sperry (Eds.) , *The intimate couple* (pp. 227-246). Philadelphia, PA US: Brunner/Mazel.

Chapter 9: Interventions to Promote Individual Sexual Health
By Samantha Edwards

Background and Introduction

Counselors may typically assume that client sexuality may only be a topic for discussion when the client describes a particular issue that is causing discomfort or distress. However, it is important that counselors recognize that a client's sexual health is an important component in their wellness as a whole. The World Health Organization (WHO) defines sexual health as "…a state of physical, emotional, mental and social wellbeing related to sexuality…sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence" (2013).

Sexual health is multifaceted and involves biological, psychosocial, behavioral, moral and cultural aspects of consideration. Interventions similarly may be multidimensional in nature and attend to multiple aspects of a client's sexuality. Clients may not enter counseling with specific sexual health concerns, but counselors have the opportunity to explore sexual health as an important component to overall personal wellbeing.

Review of Relevant Research

Because sexual health is a broad concept, there is a wide range of literature regarding what constitutes sexual health, though more limited literature regarding specific interventions to promote sexual health outside of when dysfunction or specific concerns are not present.

Sexual health and sexuality appear to be used somewhat interchangeably in the existing literature. However, Sharpe notes that it is important for clinicians to be able to differentiate sexual terminology, particularly with regard to understanding the differences between sexuality, sexual behavior, and sexual desire (2003). Sharpe describes sexuality as a dimension of being human that includes feelings of individuality, intimacy, love and desire for emotional connection with another human being, whereas sexual behaviors are the verbal and nonverbal expressions of sexuality. Sexual desire, according to Sharpe, is motivation to engage in sexual acts, either in initiation or reception.

Some research does appear to provide opportunities to improve sexual health when dysfunction is not present. Mindfulness, in which one's attention is brought to the present experience in the moment, has shown some promise for general improvement to sexual health. A 2013 study by Lazaridou and Kalogianni specifically explored the relationship between mindfulness and sexuality in healthy individuals, looking specifically at control measures of sexual consciousness, sexual monitoring, sexual depression and anxiety and sexual motivation. Their results indicate that mindfulness when viewed as an openness to novelty functions as a sexual stimulant, particularly in partnered relationships (2013). Mindfulness has also been shown improve sexual functioning by increasing body awareness and creating an increased capacity for self compassion and kindness (Mize & Iantaffi, 2013).

Existing literature concerning sexual health interventions also highlights the importance of counselor knowledge and particularly acknowledgement of counselor beliefs and biases regarding sexual health. Russell (2012) found that counselors were more likely to utilize sexual health interventions based on their own attitudes toward sexual health, rather than simply their sexual health knowledge. Russell states that it is unclear what perceived barriers might prevent clinicians from discussing sexual health topics with clients, but suggested that increasing counselors' knowledge of basic sexual health competencies may potentially impact perception of barriers.

Possible Counseling Issues

Sexual health concerns may be general, though specific concerns may also be present. WHO cites six areas of sexual health concerns for individuals that may serve here as a basis for counselor interventions. These include (a) sexual health concerns related to body integrity and to sexual safety,

(b) sexual health concerns related to eroticism, (c) sexual health concerns related to gender, (d) sexual health concerns related to sexual orientation, (e) sexual health concerns related to emotional attachment, and (f) sexual health concerns related to reproduction (2013). While such concerns may not be inherently present when clients enter counseling, they nonetheless provide an excellent guideline for consideration in how counselors approach sexual health interventions.

Concerns related to body integrity and to sexual safety may include client concerns about STIs including HIV/AIDS, the impact of medical or surgical conditions, or sexual health as related to physical or mental disabilities. Counselors can ensure they best serve their clients by conducting a thorough biopsychosocial assessment to explore any client medical concerns, including specific concerns about sexual health. Counselors can also use this as an opportunity to ask clients whether they regularly see a doctor, as well as provide information and education about how health and medical concerns may impact sexuality and sexual health. Counselors can also help clients develop realistic and appropriate goals for approaching sex in the face of possible body limitations. It is important that clients have an opportunity to discuss sexual health, and clinicians should be responsible for introducing sexuality as an important component in wellness when clients do not directly present with sexuality-related concerns. Counselors should also thoroughly assess for possible domestic or sexual violence and sexual coercion, particularly when working with couples.

Sexual health concerns as related to eroticism may include discussions with clients concerning sexual response and pleasure, as well as client values and self-concepts as sexual beings. Counselors can help facilitate meaningful discussion with clients around eroticism and sexual pleasure by ensuring they provide a nonjudgmental environment that encourages clients to freely discuss their sexuality, as well as validating the client for taking risks by sharing private and personal information. Counselors may help clients explore sexual fantasies, as well as help clients practice sharing sexual fantasies with partners as a way to increase mutual sexual pleasure and intimacy (Southern, 1999). This also may involve normalizing fantasy for clients, particularly as related to client value systems. Counselors may also help clients explore and recognize personal sexual preferences. Masters, Johnson and Kolodny suggest that when clients are able to focus on and share their sexual preferences, clients take responsibility for their own sexual pleasure, rather than placing responsibility solely on partners (1995). Counselors also have an opportunity to discuss exploration of alternate forms of sexual expression with clients, particularly if clients' sexual expression is generally limited to intercourse or other "normalized" sexual behaviors (Russell, 2012). Most importantly, counselors have the opportunity to normalize client desires and frame them within both a natural and evolving context.

Sexual health concerns related to gender and sexual identity may deal with clients' value frameworks by examining client expressions of gender and sexuality identity, as well as the impact of possible discrimination or perceived differences that have impacted sexual health. It is important for counselors to examine stereotypes about sexuality that they may hold or have been subjected to, as well as asking clients about messages they may have received about sex. Counselors may pay particular attention to clients' sexual self-concepts and identify both positive and negative self evaluations that inform a client's sexuality, particularly as research suggests that a positive view of the self increases confidence concerning sexual health (Rostosky, Dekhtyar, Cupp & Andermann, 2008; Masters, Johnson & Kolodny, 1995).

Emotional attachment as it relates to sexual health involves clients and their desire to connect with another human being, as in a committed couple or otherwise. Sensate focus exercises, in which couples are encouraged to focus on subtle sensations involved in intimate, nonsexual contact while gradually moving from nongenital exploration to nondemanding sexual touch, have generally been the guiding conceptual paradigm for sex therapy intervention (Southern, 1999). More recent research has indicated that teaching clients to practice mindfulness, which teaches clients to focus on the present moment and related sensations, presents an opportunity to improve sexual health and improve levels of

intimacy for individual clients and couples without sexual dysfunction. Mindfulness has been shown to improve relationship satisfaction and decrease distress and anxiety within relationships, allowing couples to focus on connection and awareness of sensations (Mize & Iantaffi, 2013). Additionally, counselors can also help clients explore underlying intimacy issues, such as fears or anxieties related to a partnered relationship, which may negatively impact sex and sexuality. Counselors may teach clients communication and assertiveness skills as a way to enhance relationships and increase intimacy. Masters, Johnson and Kolodny (1995) suggest teaching clients to use "I" language, in which each partner takes responsibility for their self through their language, as one specific type of intervention.

Finally, with regard to sexual health and reproduction, counselors should assist clients in identifying supports and reviewing all options as related to pregnancy, both wanted and unwanted, and with regard to infertility. Counselors may view pregnancy as a specific developmental period in the lifespan of an individual's sexuality and address that one's sexual self-concept will likely change and adapt as a result of pregnancy (Sharpe, 2003). This may also include exploring client expectations for sexuality following childbirth or abortion. With regard to LGBTQ clients, counselors may also be mindful that it may be more difficult for individuals to have children, and should explore any impact this may have on sexual health. Counselors should offer clients an opportunity to discuss specific fears and anxieties while validating and normalizing the client's experience.

Additional Guidelines for Counseling Practice

Sexuality and sexual health are topics that are relevant across the lifespan; therefore, counselors must be knowledgeable about addressing sexual health at different developmental stages. Counselors should be aware that healthy sexuality for adolescents looks differently than it does for adults, though there is limited research that focuses on promoting adolescent sexual health rather than focusing specifically on risk reduction (Rostosky, Dekhtyar, Cupp & Andermann, 2008). Thus, clinicians working with children and adolescents should actively seek information on addressing healthy sexuality in an open and sensitive way with clients and parents.

Clinicians should not only be comfortable discussing sexuality and sexual health with their clients, but also understand their own feelings around sex and be willing to respond honestly and clearly to client concerns. Acknowledgement of client feelings, attitudes, and cultural norms that may be both beneficial and obstacles to individual sexual health can assist clients in developing greater insight into their sexual health. It is important to be aware and respectful of clients' sexual values and lifestyles, while also providing validating and objective clinical information regarding sexual health. The Association for Reproductive Health (2010) suggests some ways which counselors can do this are:

- Participating in continuing education activities focused on sexual health: counselors can continue to obtain up-to-date information, and research informed approaches to practice
- Providing clients with current information, including research and education, around sexual health
- Helping clients develop skills and strategies for achieving personal goals related to sexual health, such as communication skills or intimacy building activities
- Recognizing limitations of practice and providing referrals as needed

What resources (e.g. books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

Books:

Chirban, J.T. & McGraw, P. (2012). *How to talk with your kids about sex: Help your children develop a positive, healthy attitude toward sex and relationships.* Nashville, TN: Thomas Nelson.

McCarthy, B. & McCarthy, E. (2012). *Sexual awareness: Your guide to healthy couple sexuality* (5th ed.). New York, NY: Taylor & Francis Group.

Journals:

The Family Journal, The Journal of Sex Research, Sexual and Relationship Therapy

Websites:
The American Association of Sexuality Educators, Counselors and Therapists (AASECT)
http://www.aasect.org/
The Society for Sex Therapy and Research (SSTAR)
http://www.sstarnet.org/
The Society for the Scientific Study of Sexuality (SSSS)
http://www.sexscience.org/
Association of Reproductive Health Professionals
http://www.arhp.org/
World Association for Sexual Health
http://www.worldsexology.org
World Health Organization
http://www.who.int/topics/sexual_health/en/

List of references used to prepare this chapter

Association of Reproductive Health Professionals (2010). *Sex Therapy for Non-Sex Therapists*. Retrieved from http://www.arhp.org/Publications-and-Resources/Clinical-Fact-Sheets/SHF-Therapy

Lazaridou, A. & Kalogianni, C. (2013). Mindfulness and sexuality. *Sexual and Relationship Therapy, 28(1)*, 29-38. doi: 10.1080/14681994.2013.773398

Masters, W.H., Johnson, V.E. & Kolodny, R.C. (1995) *Human sexuality* (5th ed.). New York, NY: HarperCollins College Publishers.

Mize, S.J.S. & Iantaffi, A. (2013). The place of mindfulness in a sensorimotor psychotherapy intervention to improve women's sexual health. *Sexual and Relationship Therapy, 28*(1), 63-76. doi: 10.1080/14681994.2013.770144

Rostosky, S.S., Dekhtyar, O., Cupp, P.K., Andermann, E.M. (2008). Sexual self-concept and sexual self-efficacy in adolescents: A possible clue to promoting sexual health? *Journal of Sex Research, 45*(3), 277-286. doi: 10.1080/00224490802204480

Russell, E.B. (2012). Sexual health attitudes, knowledge, and clinical behaviors: Implications for counseling. *The Family Journal, 20*(1), 94-101. doi: 10.1177/1066480711430196

Sharpe, T.H. (2003). Adult sexuality. *The Family Journal*, *11*(4), 420-426. doi: 10.1177/1066480703255386

Southern, S. (1999). Facilitating sexual health: Intimacy enhancement techniques for sexual dysfunction. *Journal of Mental Health Counseling, 21*(1), 15-33.

World Health Organization (2013) *Sexual and reproductive health*. Retrieved from http://www.who.int/reproductivehealth/en/