Addressing Sexual Dysfunction in Couples Counseling

A graduate project submitted in partial fulfillment of the requirements

For the Degree of Master of Science in Counseling

Marriage and Family Therapy

By

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May 2015
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Abstract

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As prevalent as sex in society is, there is still a negative connotation to the subject of sex. Many marriage therapists seem to lack adequate training in the area of sexual dysfunction. This project reviews literature from studies that look at education programs for mental health professionals, the importance of a sexual relationship on intimacy in couples, possible reasons for sexual dysfunction, and some tools to use in working with sexual dysfunction. The handbook then gives a basic overview on how to approach sexual dysfunction in couples for the beginning therapist.
Chapter 1

Introduction

Background

Sex is a part of every culture, whether it is for reproduction, a way to communicate intimacy, to sell products, or just for pleasure purposes (Goodwach, 2005). We are flooded with sexual stimuli at the start of our exposure to the media, as it is filled with sexual images and advice (Byers, 2011). It surrounds people every day, yet most people are uncomfortable with talking about sex and have little knowledge about it. Wiederman and Sansone (1990), summarizing Risen (1995), states, “that sexuality is a deeply personal, and often taboo, topic in the Western culture, and is liable to engender anxiety and uncertainty on the part of both the client and psychologist.”

Regardless of how sex is looked at in the different cultures, it is an essential part of a marriage. It has been stated that sex when it is working well it makes up 5 percent of the marriage, but when it is not, it becomes 95 percent of the marriage (McCarthy & McDonald, 2009; Timm, 2009; McCarthy, 1997). When couples were asked the main difference between a marriage and a close friendship in a study done by Hinchliff & Gott (2004), they would point to the sexual relationship (Timm, 2009). A study done by Reissing and De Giulio (2010) found that many clinical psychologists were comfortable with the discussion of sexuality, but noted the lack of training in the area. In the study, over 50% of their participants lacked training in the graduate or post-graduate programs. With a lack of education and training behind the therapist, the counseling relationship is hindered, as this may sway therapist from discussing possible sexual related problems.
Freud, Ellis, and Kinsey all had theories about how sex intertwined into our lives and how sex is a natural behavior (Goodwach, 2005). Common Freudian knowledge would suggest that he believed sexual impulses started at birth and not puberty. Ellis believed that sex itself was not abnormal, but the manner in which we carry out our sexual desires may be abnormal (Ellis, 1975).

Marriage therapy developed in the post-World War 1 era, by many professionals, including those of medicine, psychology, social work, law, education, and ministry, in response to an increasing number of marital and sexual problems (Broderick & Schrader, 1991). Sex therapy is a younger movement, said to be brought to the forefront by William Masters and Virginia Johnson (Broderick & Schrader, 1991). Masters and Johnson (1976) believe that therapists who deal with sexual dysfunctions must be well versed in many professions that ultimately directly or indirectly attribute information to the understanding of and the adequate treatment of sexual dysfunction.

Sex is a beneficial aspect of a relationship, but it can also cause harm to the relationship (Lieser, Tambling, Bischof & Murry, 2007). Issues that arise need to be discussed openly and freely in a therapeutic setting. Unfortunately, marriage therapists are not always properly trained to deal with these issues within marital therapy and that is what will be discussed throughout the handbook.

Statement of Need

“Sexuality is a central binding and organizing force in life of a couple, enabling them to break from their family of origin to form a dyad” (Berman & Hof, 1987).
There are several subsystems in a person’s life, such as marital, individual, biological, and social, all of which intertwine with each other, having an effect on each other. The marital relationship influences the sexual relationship and vice versa, problems in either area will impact the other (Hof, 1987). This requires a marriage and family therapist to have an understanding in the treatment of sexual dysfunctions within a couple. (Hof, 1987). This understanding comes from receiving proper education and training in the area of sexual relationships, as well as acquiring knowledge through continued readings in books, peer-reviewed articles, and continued education.

Sex therapy was first introduced by Masters and Johnson in the late 1950’s in a research proposal, it became a more public notation and developed in the 1970’s (Binik & Meana, 2009). Sex therapy quickly became a specialized form of therapy, rather than be integrated into marital therapy. Binik and Meana (2009), state they believe sex therapy is not much different than other psychotherapies to warrant the specialization of it. Binik and Meana (2009) believe that a specialization can breed expertise, but can also continue to allow those who are not willing to work with sexually related problems to refer out clients. The relinquishing of responsibility will continue to enable a lack of education for some professionals. In a review of Binik and Meana’s article on sex therapy done by Nasserzadeh (2009), she states that people already know of the lack of specific training in place for those of medical and psychology studies in the area of treating sexual dysfunction.

The lack of education and the specialization of sex therapy can cause a continued uneasiness with the topic of sex within the realm of health professionals. The specialization of sex therapy helps perpetuate the belief that sexually related problems are
removed and not in the same realm with all other life problems. (Binik, Y. M. & Meana, M. 2009). During Binik and Meana’s (2009) journey into the review of sex therapy, they discovered that there were no journal titles with sex in the name sponsored by the American Psychology Association (APA), as well as no interest groups with the topic of sexuality in the over 50 divisions in the APA. Customarily, marital therapists do not have a focus on sexuality or sexual dysfunction in their training, research, or practice. Sexually related problems are generally dealt with indirectly (McCarthy, 2001).

McCarthy (2001), cites from the *Sex in America* 1994 study, in that there is a high rate of sexual dysfunction in couples, both married and unmarried.

A general knowledge of sexual dysfunction is needed in order to adequately guide and counsel couples. With that said, it is necessary for marital counselors/therapists to have some training or understanding in the area of sexual dysfunction.

**Purpose of the Project**

There are several aspects to a marriage. Many of those aspects are covered when couples go to counseling, such as communication, parenting, financial, and family. In 1985, Alvin Cooper did a review of marital programs for therapist on non-dysfunctional couples who want to enhance their sexuality; it was found that there were few programs available (Cooper, 1985, Lieser, Tamblin, Bischof & Murry, 2007). Fyfe (1980) also state that there are few programs or workshops that provide counselors with the basic knowledge of human sexuality. In recent times, there have been improvements to sexuality education for counselors; however, there is still limited literature on the topic.
(Lieser, Tamblin, Bischof & Murry, 2007). In a review of several relationship programs, Lieser and colleagues (2007) found that many programs do not directly or routinely address matters of sex or sexuality.

A marriage therapist should be trained in all possible facets of a marriage, including the sexual component. A couple should be able to work through all problems they have with one therapist, rather than seeing a different therapist for each individual aspect of their marriage. This workbook was written with a few purposes at mind. One main reason is to highlight the need for more education and study in the area of sexual dysfunction within marital counseling programs. This workbook, created from knowledge gained from research of studies and articles, is aimed at developing six steps that a marital therapist may use when counseling a couple having sexual dysfunction within the relationship. It will also add to the already fast developing idea of sex being an important topic of therapy for a couple, and the need for those counseling couples to be knowledgeable and comfortable in the area of sexuality. Being comfortable with the topic of sex is something a therapist needs in order to be able to address these issues in session (Harris, & Hays, 2008).

With this project, it is hoped that a therapist will gain some general knowledge of the issues couples have in regards to sex and/or guide the therapist to more training if necessary or desired. Marriage is made up of many things, sex is the physical communication of the intimacy the couple shares. With that lacking, the characteristic that puts a marriage above a close friendship is no longer there.
Terminology

**Dysfunction:** when there is an obvious disconnect in the interaction and functioning of a relationship.

**Foreplay:** any act leading up to sex.

**Intimacy:**

- **Emotional:** having the ability to be vulnerable with another person.
- **Sexual:** trusting another with your body.

**Penetrative sex:** any act that includes the insertion of one’s body part into another person, or vice versa.

**Sex:** any act that includes physical arousal of genital areas.

**Sexual touching:** any act that is considered foreplay such as massages, fondling, kissing, arousal of breasts, etc.
**Organization**

The first chapter of this project gives a modest background of sex in society, how it impacts marriages, and the lack of education for marital therapists. It reviews the reasons behind the workbook and defines some terminology that might have broad or varying meanings. The following chapter, chapter 2, will consist of a literature review of studies on the relevance of sex in marriages and the impact it has on intimacy, the significance of communication on and about the subject of sex, and the integration of sex into marital therapy. Chapter 3 will be the project, followed by the conclusion in Chapter 4. The workbook is located in the appendix, which is after the references.
Chapter 2

Review of Literature

Sex and Intimacy

An essential part of a person is their sexuality; it can be a cause or a consequence to many differences aspects of a person if there are problems within sexuality (Wierderman & Sasone, 1999; Charlton, 1996, Leiblum & Rosen, 1989; Wincze & Carey, 1991). “Elis believed that sex is a natural human instinct (Goodwach, 2005).” McCarthy (1997) states that a nonsexual marriage is a major threat to marital satisfaction and viability, especially for couples married less than three years. Sex plays a major role within a marriage; its main purposes are to help deal with the hassles of life, reduce the stress, develop the intimacy within the relationship, and pleasure (McCarthy, 1997). Sex is a vital part of a marriage. When there are no complaints in the sexual relationship and it is working well, sex does not play much of a factor in the marriage satisfaction; however, when not, it then becomes a major role in the satisfaction of the marriage (McCarthy, 1997). DeLamater and Moorman (2007) found in a study on the influence of age, biological factors, and psychosocial factors on sexual expression in later life that a positive outlook on the sexual relationship and physical contact is strongly related with a higher amount of sexual encounters. Many people believe that a couple needs to test their sexual compatibility early on in a relationship. While knowing if a couple is sexually compatible is an important inquiry, being physical can be put on the backburner. Busby, Carroll, and Willoughby (2010) found in a study on the influence of sexual timing in a marriage, should a couple wait or not in regards to sex, they found that marriages were
more sustainable when the sexual relationship was not sought immediately in the early developments of a relationship. They highlighted that this may be attributed to the couple’s ability to focus more on the communication and intimacy of a relationship, building a foundation, rather than focusing solely on the physical relationship, which later on can translate to a lack of communication and togetherness. In a slight contradiction, one study suggests that a person’s perceived sexual satisfaction in a relationship can guide the person’s perceived level of intimacy. Meaning, if a partner feels that he/she is sexually satisfied it would have positive impact on the level of intimacy he/she feels towards his/her partner. However, the study also pointed out that it does not go the other way, a close bond or intimacy does not dictate for a sexual satisfied relationship (Yoo, Bartle-Haring, Day, & Gangamma, 2014). This can point to a connection of the need for a sexual relationship for intimacy growth in relationships.

Many studies and literature give different definitions of intimacy. Much of the literature agrees that there is a level of vulnerability that comes from being intimate. One study done by Shawn Patrick and John Beckenbach in 2009 on the male perceptions of intimacy found that men described being intimate as sharing emotions, words, thoughts, and physical expression. It was also found that it was easier to describe acts of intimacy rather than the feeling of being intimate. Gaia (2002) brings to light the difference in type of intimacy, such as emotional intimacy as well as the more thought of sexual intimacy in a study of understanding emotional intimacy. Emotional intimacy is a closeness found in most adult relationships, those of a platonic nature as well, or what some identify as the glue of all relationships (Gaia, 2002). Intimacy levels have an effect on the marital satisfaction in couples. The inexact understanding and definition of
intimacy does not discount the knowledge that positive levels of intimacy are found with a higher rate of marital satisfaction. (Dandeneau & Johnson, 1994; Greeff & Malherbe, 2001; Papp, Goeke-Morey, & Cummings, 2013; Patrick & Beckenbach, 2009)

Gender differences have been found to play a small role in the interpretation of intimacy and the interplay of sex and intimacy (Patrick & Beckenbach, 2009). Though, it is found that both genders have a desire for and experience intimacy (Patrick & Beckenbach, 2009; Greeff & Malherbe, 2001). Patrick and Beckenbach (2009) found that the concept of masculinity influenced intimacy for the male partner. The participants in the study disclosed how masculinity taught them that they were to be the more dominant partner in the relationship, the one to be the protector, anchor, above the feminine. Nonetheless, it was found men still had the desire to be intimate, but to not be a “girl” about it. The desire and view on sex is found to have a small difference in the genders. Women have a desire for sex, but on a larger scale, women do not see penetrative sex as a necessary end goal in intimacy (Goodwach, 2005). Men were found to indicate an intimate relationship had a sexual component; however they varied in the magnitude it had on intimacy (Patrick & Beckenbach, 2009)

A common belief is that women have a lower sex drive than that of their male counterpart; studies have shown that to be a skewed understanding of sexual desire as a whole. Leiblum (2002), referencing Wallen (2000), notes that women experience sexual desires as strong as men, maybe more so as women can experience multiple orgasm, but that the frequency of desire may be less than that of men. Meaning, men may desire sex on a more regular basis, but when women do desire sex, they can derive the same kind of pleasure from it. Leiblum (2002) also goes on to state that not only do biological
differences in the genders, i.e. hormone differences such as testosterone levels, but that culture and social factors play a role in sexual desire (McCarthy, 1997). In some cultures the woman is taught to suppress her sexuality for fear of consequences (Leiblum, 2002). Additionally, both genders agree that more experimentation, more conversations on the sexual relationship, more kissing, and oral sex is related to more satisfaction in the sex life. However, it was found that each gender puts a stronger emphasis on different sexual behaviors (Ashdown, Hackathorn, & Clark, 2011). Ashdown, Hackathorn, & Clark (2011) found in a study where they examined both sexual and non-sexual variables associated with sexual satisfaction, that men and women both put a strong relation on sexual satisfaction and communication of sexual desires. This goes along with previous studies where it was shown that open communication about sexual desires have a positive effect on sexual satisfaction (MacNeil, & Byers, 2009; Barrientos & Paez, 2006).

**Sexual Dysfunction or Decline**

Studies suggest that there is an inevitable decline in the sexual relationship and highlight the commonality of sexual issues or concerns in couples (Timm, 2009; McCarthy, 1997; Call, Sprecher, & Schwartz, 1995; Donnelly, 1993). The possible causes behind the concerns are vast. In a study done by Call, Sprecher, and Schwartz in 1995 on the frequency of marital sex, it was found that an increase in age had a negative effect on the frequency of sex. While most people would find this likely as the biological factors of aging such as decline of health affect sexual function they also note that the decline could also be due to psychological factors such as society’s negative views of the aging population and sex. Donnelly (1993) also found that there was a decline in sexual relations as a couple aged, highlighting their health as well as society’s
negative view as possible causes. In the study of sexually inactive marriages, Donnelly controlled for health, and still found a decline in sexual activity in older couples, prompting the inquiry of the societal views. In Call, Sprecher, & Schwartz’s study of frequency of marital sex (1995) it was also found that sexual activity had a sudden drop after the honeymoon stage of marriage, which they identified as the first year, then continued with a steady decline. They note that there appears to be two components to the sudden decline in the sexual relationship, the lessening of the novelty of physical pleasure by one partner and the decline in the perceived need to maintain the elevated level of sexual behaviors. Timm (2009) highlights the side-effects that medications have on sexual desire or function of a person, as well as the effect on sexual desire from illnesses such as depression or diabetes. Many factors can cause a glitch in the sexual relationship. McCarthy (1997) states that these factors such as alcohol abuse, arguments over money or fertility, or affairs, may create the opening for dysfunction, but that they do not continue the dysfunction. She goes on to state that the sexual problems tend to get more severe or chronic in that the problem now lies in a cycle of anxiety, failed experiences, guilt and blaming, and sexual avoidance.

Becoming parents is a milestone in a relationship; it can mark the couple’s investment in the relationship. Having children bring a kind of joy that only they could bring, however they also bring stressors of their own. Infants and young children require an abundance of attention and care, which causes fatigue on the part of the parents, as well as takes time away from the couple themselves (Call, Sprecher, & Schwartz, 1995). As the children grow and they have reached an age of more independence, the sexual relationship in the couple fare a bit better. This can be due in part to less time needed to
devote to a child as older children are more able to care for themselves and more opportunities for sexual behaviors as the teenage children are not occupying the home as frequently (Call, Sprecher, & Schwartz, 1995). Donnelly (1995) had conflicting results with previous studies that state children have a negative effect on the sexual relationship. She found that couples with children were more likely to report a higher rate of sexual active than those with no children. She found this may be due to unhappy couples are less likely to have children, whereas happy couples do have children.

**Communication, Problem Solving and Sexual Intimacy**

Communication is a key to any relationship. Poor communication can result in a decrease of satisfaction in many areas of a relationship; including the sexual relationship (Byers, 2005). In a study by Hana Yoo in 2014 on communication and sexual and emotional intimacy in a relationship; it was found that a couple has a higher satisfaction rate if the communication within the relationship is viewed as positive. It was also found that this may have indirect effect on sexual and emotional intimacy. If the communication and relationship are viewed positively, couples report a higher rate in intimacy (Yoo, Bartle-Haring, Day, Gangamma, 2014). Discussion about sex and the sexual relationship in the couple is a necessary tool to help maintain sexual satisfaction in the relationship (Cupach & Comstock, 1990; Træen & Skogerbø, 2009). A study done by MacNeil and Byers in 2009 on the role of sexual self-disclosure in the sexual satisfaction on long term heterosexual couples shows that in long-term relationships, couples report high sexual satisfaction when they have higher communication of sexual desire rates. They point out that this could be due to the disclosure allowing each partner to better understand the partner’s sexual desires, what he/she may like or dislike. Readings also suggest that even
as perfectly matched that two people may be, their individual wants and desires will
differ and that these can and do change for a person on a day to day, week by week, or
month by month basis and that couples need to keep a constant open line of
communication for these desires to be discussed (Byers, 2011).

It is shown in literature that the problem of sexual dysfunction is a couple issue,
not necessarily an individual issue and should be treated as such (McCarthy, 1997;
Seider, Hirschberger, Nelson, & Levenson, 2009). The communication within the couple
can dictate how they view problems within the relationship (Seider, Hirschberger,
Nelson, & Levenson, 2009). Communicating in terms of togetherness instead of
individualism is also an indication of how the couple views problems in the marriage. If a
couple’s communication style is individualistic, each will point fingers at one another and
state what the other needs to change in order to solve problems (Seider, Hirschberger,
Nelson, & Levenson, 2009). If a couple’s communication style is togetherness, each will
talk about what they both can do to solve the problems together. Problems that occur in a
relationship are best dealt with when both partners are putting effort into fixing them.
Each person plays a role in the problems and each person has to compromise in order for
them to be solved. (Seider, Hirschberger, Nelson, & Levenson, 2009)

**Education and Therapy Techniques**

The education behind a therapist is a most important thing. Studies have shown
how the education of a therapist aids in the level of comfort he/she has with discussing
sexuality in sessions (Harris & Hays, 2008). A study done by Harris and Hays in 2008
on therapist comfort with sexually related topics and the willingness to discuss with
clients reports that through sexuality education and supervision experience, beginning therapists report a more perceived knowledge of sexuality and are more likely to engage in discussions of it with clients. They also noted that for their sample it was noticed that comfort with the topic of sex did not improve solely with experience, but that a level of education about it is needed along with experience. Byers’s (2011) study in where clinical and counseling psychology students were asked about their levels of training of sexually related issues in their programs, she found that a majority of them did not have any training in sexually related issues, whether through their coursework or practicums. They were asked about training in nine different topics some of which were conflict over sexual issues within relationships, sexually transmitted infections, sexual problems and dysfunctions, and sexual guilt and anxiety. She also noted that many of them were aware of the lack of training and showed an interest in receiving training in the area. Byers went on to state that a reported 95% of the respondents believed that it was important that graduate students receive education on sexually related topics.

Customarily, marriage therapists do not directly deal with sexuality or sexual dysfunction in couples (McCarthy, 2001). McCarthy in a peer-reviewed article in 2001 on integrating sex therapy strategies and techniques into marital therapy states that the sexual problems in a marriage are traditionally dealt with indirectly as symptoms of power issues, poor communication, reflection of emotionally intimacy, and a barometer of commitment. It is also pointed out that many therapists may avoid asking direct questions about the sexual relationship because of fear of invasiveness, boundary violations, and eliciting sexual feelings in the therapist or client (McCarthy, 2001).
In an ideal world, marriage therapists would integrate a level of sex therapy into the marriage therapy. McCarthy (2001) goes on to state that marriage therapists should adopt the first two steps of the Plissit model into counseling couples. The Plissit Model was created by Annon in 1976 (McCarthy, 2001; Parkin, 2009) as a model to aid therapists in assessments and treatment of sexual dysfunction. The first step is permission giving, where the therapist gives the client or couple permission to talk about sexually related issues, to have or not have feelings of a sexual nature, to want or not want behaviors of a sexual nature (Parkin, 2009). Adopting the permission giving in all therapeutic settings will allow for a more open place to discuss concerns. The second level of the Plissit model is the limited information. This is when the therapist gives simple information regarding the sexual relationship (McCarthy, 2009). McCarthy also discusses the therapist’s need to confront the client on any myths they might have in regards to a sexual relationship. The third level in the Plissit model is for specific suggestions. This can be in the form of using non-demand pleasure techniques, the use of masturbation in self-discovery, start-stop techniques for ejaculatory control, etc. (McCarthy, 2009). The use of these interventions used by marriage therapists suggest that recognition of the importance of sexuality in a relationship is made (McCarthy, 2009). The final level is intensive therapy. If the couple does not report an increase of sexual or marital satisfaction within the first three levels than there are deeper concerns that need to be dealt with in more therapy and a referral to a sex therapist may be required (McCarthy, 2009).

Research emphasizes the importance of marriage therapist addressing sexual dysfunction in couples (Harris & Hays, 2008; Parkin, 2009; Wiederman & Sansone,
1999; McCarthy, 2001), however, Harris and Hays (2008) point out that little data has been published on how to effectively address the sexual concerns of clients as well as noting that previous researchers note the lack of training of mental health professionals in the areas of sexual concerns. The need for marriage therapist to have a base in sexual knowledge is due in part to the lack of therapists who specialize in sexual dysfunction, the lack of insurance reimbursement for sex therapy, and the more “acceptable” form of couples counseling is marriage therapy since there are more of them and they are licensed (McCarthy, 2001). In a course developed by Wayne Anderson in 1986, he discussed the lack of education and training behind beginning therapist in areas of sexual dysfunction and how to treat it. He mentions studies done by Richards in 1978 where it was found that students who had at least one class in human sexuality in their graduate program were more effective and helpful with clients who had issues within the sexual relationship than those who did not take a course in human sexuality. In a review of Sex therapy by Binik and Meana in 2008, they comment on a common belief in that what separates sex therapists from the rest is their level of comfort with and willingness to discuss sexual matters, but that they believe that all mental health professionals need to become comfortable with and willing to work with sexually related issues. They also continue to point out the misconception that there is one specialization that has the absolute competence to deal with sexual dysfunction is contradictory to research that supports a multidisciplinary approach to sexual dysfunction. In a review of sex therapy and the specialization or marginalization of it by Binik and Meana in 2009, they believe that sex therapy practiced at that time was not much different than any other psychotherapy practiced at that time to warrant a specialization of it. They go on to
highlight how most techniques used by sex therapists have roots in other schools of therapy, such as cognitive-behavioral therapy.

Masters and Johnson (1976) brought forth the idea that an adequately trained sex therapist is one who has been educated in a wide range of areas dedicated to the health care of people. It suggests that sexual dysfunction has roots of all kinds, biological, chemical, emotional, organic issues (Parkin, 2009; Binik & Meana, 2009). Binik & Meana (2009) discuss the idea that instead of treating sex therapy as a special type of therapy we focus on the special type of problem, sexual dysfunction, in order to integrate sex therapy into more disciplines making sexual dysfunction an everyone-problem rather than a sex therapy problem. They also discuss the licensing of mental health practitioners in that they get certified on a general level and it is up to each individual in what kind of therapy to specialize in. They highlight the lack of certification for eating or anxiety disorders, but how sex therapists have certifications for their type of therapy.

Some literature (Binik & Meana, 2009; McCarthy 1997) points to a more cognitive-behavioral approach to dealing with sexually related problems. Binik and Meana (2009) asserts that most therapist who practice sex therapy adopt a more cognitive-behavioral technique when dealing with sexual dysfunction. McCarthy in 1997 created a set of techniques and strategies for a nonsexual marriage using cognitive-behavioral techniques. He felt that the focus of treatment needed to be on desire and satisfaction rather than arousal and orgasm, which he states can be successfully addressed using the concepts, assessments and interventions cognitive-behavioral therapy.
Chapter 3

The Project

Introduction

Literature has highlighted a lack of education behind therapist for sexual dysfunction in marriage. Marriage and family therapist do not always get formal training in treating sexual dysfunction. In the reading of many studies, it was seen that in order to treat sexual dysfunction within couples the therapist needs to be open about, comfortable with, have a multifaceted therapeutic understanding of sexuality. It was also noticed that the therapist is, in a way, the catalyst of permission for the client to talk about sexual desires or concerns.

This graduate project was developed to aid a beginning therapist in gaining knowledge on the sexual component of a relationship. It is also hoped that it can be used to guide a beginning therapist in the aiding of a couple’s sexual relationship, whether it be to enhance or to repair it.

While researching for this project, it was interesting to discover the multiple views on sexuality as a whole, the broad, yet specific definitions of intimacy and how the two relate together. Much literature points to the importance of the two in a relationship and in a person, but also the lack of understanding of them. This handbook is meant to give a therapist a guide on how to rebuild the sexual relationship or sexual intimacy.

The handbook, that is located in the Appendix, outlines possible strategies and interventions to use when counseling a couple with sexual dysfunction in the relationship.
Chapter 4

Conclusion

In a society where sex is prevalent, it is surprising that discussions of a sexual nature can cause many to shy away. Various literatures indicate a lack of comfort therapists have with bringing up discussions of a sexual nature in sessions with couples (Harris & Hays, 2008; Binik & Meana, 2009). Studies have also pointed to the idea that education breeds comfort (Harris & Hays, 2008), which signifies the need for counseling programs to integrate classes on human sexuality and how to address sexual dysfunction into student’s coursework (Wiederman & Sansone, 1999). Readings have indicated an importance of marital therapists to have a basic understanding of sexual dysfunction (Nazzerzadeh, 2009; Fyfe, 1980). It is widely understood that sexual relationship is an important part of a marriage. It is also understood that the sexual relationship has its dysfunctions and concerns as much as other aspects of a relationship. Nonetheless, some mental health professionals shy away from discussing it with clients and some education programs do not cover it in their programs.

The objective of this project has been to give an initial understanding and a guide for the beginning therapist on how to approach possible sexual dysfunction in a marriage. As discussed there are many issues to sexual dysfunction in a marriage. The literature review gives the beginning therapist needed background and knowledge into sexual dysfunction. This workbook then helps provide questions to ask, rapport building tools and possible directions to aid the couple in healing.
References


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APPENDIX

Handbook on Addressing the Dysfunction of the Sexual Relationship

Developed by Desiree Joslyn

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May 2015
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Building rapport and learning history  

Goals and outcomes  

Individual Sessions and Hearing Partner’s Views  

Trust, Boundaries, and Responsibility  

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Building Rapport and Learning History

A majority of people have a hard time with discussions of a sexual nature. Patients take cues from the therapist, if the therapist shows anxiety over a topic, the patient will not feel comfortable talking about the topic. When building the rapport, discuss the concerns that brought the couple into counseling, it will allow for a better understanding of where take the sessions

- Create a safe and open environment for the couple to feel comfortable with discussing the sexual relationship by giving the client the go-ahead or telling them it is ok to discuss sex.
  - Aids the couple to become comfortable with being able to discuss sex outside of therapy.
  - Lifting any taboo that may be there and laying a foundation to openly discuss sex and sexuality may help the couple in creating a more comfortable arena to building sexual intimacy.
The views a person was raised with can dictate the behavior of a person and the beliefs he/she has towards certain topics. To have an understanding of the couple; one would want to take a history of the couple.

- Explore if the parents were open or closed about sex.
  - Ask how sex was discussed in the family.
    - Was it treated as a taboo topic or were questions about sex allowed?
    - Was sex taught to be an act that was dirty and shameful?
    - Was sex taught to be a natural and/or beautiful act between those who love each other?
    - Was sex taught to be just a mere physical act that occurs between two adults?
    - Was sex taught to only be used for procreation?
      - This will allow for the knowledge of a possible level of comfort that each partner has with discussing sex.
      - It will also aid in knowing if each partner was taught shame or acceptance of sex and the boundaries to put on sex.
        - A negative view on sex can hinder the growth of a sexual relationship.
        - A partner can feel bullied if the other partner has a more open view of sexuality and pushes the other to meet his/her view on it.
  - Explore the level of affection demonstrated to each partner in the childhood home.
• Enquire about how affection was shown within the family
  • Did the parents show affection to one another in front of the kids?
  • Did the parents show affection to the children within the home?
  • How was affection shown; i.e. hugs or kisses or high fives?
  • How often was affection shown?
  • Was it more verbal, saying “I love you” or more physical, giving hugs?
  o Intimacy has been described as an act of sharing the physical representation of love. This is demonstrated as being affectionate, i.e. hugs, and kisses, etc. to those you love. Children learn these behaviors in their families
  o It may also give the therapist and the couple an understanding of what each person feels is the necessary amount affection.

- Explore the couple’s sexual relationship.
  • Did the couple wait to be sexually active with each other? If so, how long?
  • How was sex discussed throughout the relationship?
  • Who was more likely to initiate sex?
  • Have them describe a typical encounter.
  o Knowledge of the couple’s sexual history allows for the insight into possible patterns.
- Discussing past sexual behaviors within the relationship may help indicate when a change in the sexual relationship took place.

- Explore if there is a history of sexual trauma for either partner.
  - Any trauma could hinder the growth or desire of a sexual relationship.
  - If there is untreated trauma it will take precedent and referral for individual counseling would be necessary.
**Goals and Outcomes**

Setting goals at the beginning of therapy will allow you to have a direction in the therapy.

Having both short-term and long-term goals set will allow for more attainable outcomes.

- Short-term goals will give the clients stepping stones to meet throughout therapy.
- Long-term goals will give the clients goals to continue working on after therapy is complete or when the couple feels therapy is no longer needed.

Goals can be changed as well as added as the therapy progresses. If the couple is hesitant in the beginning of the therapy, then starting off with small short term goals will allow them to ease into therapy.

- Goal Setting:
  - What is it that both clients would like out of therapy?
  - What in the sexual relationship does the couple feels needs the most amount of work?
  - Have a minimum of 2 short-term goals and 2 long-terms agreed upon with both partners.

Throughout therapy, it is important to continue to check in with the couple to know if there is a change or not with the desired outcome of therapy. If one or both do not have a desire to rebuild the relationship, no amount of intervention will aid the relationship.
Possible goals to set:

- Being able to communicate about sexual desires or problems that may arise within the sexual relationship.
- Feeling comfortable to try new sexual acts within the safety of the relationship, experimenting.
- Having monthly, bi monthly date nights.
- Being comfortable with oneself to explore possible pleasures.
Individual Sessions and Hearing Partner’s View

Having an individual session with each client gives each partner time to express their feelings without their partner looking over their shoulder. However, it is important that each partner knows that what is discussed within the individual sessions will be processed in the next couple session.

- Within the individual sessions the therapist will be able to get a clearer picture of each partner’s view. It may be hard for clients to speak openly about his/her feelings in front of his/her partner, the individual sessions will allow for the client to speak his/her own mind without feeling like he/she will be attacked by the spouse.

Possible questions to ask within individual sessions:

- Ask about the individual’s views on sex.
  - What does he/she define as sex and foreplay?
  - What does he/she feels is the appropriate level of sex within the relationship?
  - Is masturbation an appropriate activity in a marriage?

- Ask about the individual’s view on the problem of the relationship.
  - What does he/she define as the core issue in the sexual relationship?
  - What does he/she feel is his/her part in the problem is?
  - What does he/she feel the partner brings to the dysfunction?
Views on one’s own sexuality and that of his/her partner can play a role in the sexual relationship. Being comfortable with one’s own body and that of his/her partner will enhance the person willingness to be open with sex.
Trust, Boundaries, and Responsibility

The ability to have an open conversation about the wants and needs of sexual relationship can aid in the development of a more cohesive bond. Each partner has his/her own likes and dislikes in the sexual arena, all of which need to be recognized and accepted by both partners. Understanding the boundaries, likes and dislikes, of each partner will allow for the development of additional outlets for sexual desires.

Within sessions, have partners discuss their likes and dislikes with each other.

- What are turn ons and offs of each partner?
- What are behaviors that make each feel comfortable or uncomfortable?

Being aware of one’s own actions and reactions can aid in changing behaviors. Working with the couple on distinguishing who is responsible for what behavior will enable them to take responsibility for any negative actions. Discuss ways in which each partner has gone about getting desired outcome and if he/she was successful or not. This may allow for a change in the expectations of each partner within the relationship.

A willingness to step out of one’s comfort zone may be developed through the trusting of one’s partner.
Activities and Journaling

Journaling can support the couple in processing feelings that occur outside of therapy, in therapy. Having the couple keep an individual journal of his/her interactions may aid in highlighting behaviors he/she is unaware of as well as feelings he/she is unaware of.

- When journaling discuss how one felt during the interaction, what each feels is an area of need, possible behavior changes for the interaction.

People change over time, couples may have to get reacquainted. Creating activities for the couple will allow for the reinventing of the relationship as well as aid in the task of learning about one’s partner.

- Have the couple discuss activities of both sexual and non-sexual in nature.

  - Creating non-sexual activities will allow the couple to develop additional channels for intimacy.
    - Movie night
    - Cooking classes
    - Role play nights; attend a bar or coffee place and meet as strangers.
  
  - Creating sexual activities that do not end in penetrative sex can facilitate the creation of many other sexual acts that bring the same desired outcome.
    - Sexual massages
    - Oral sex
Creating activities that focus each individual’s interests will allow for more insight to each other.

- One night do something one partner wants, next night do something the other partner wants.

This will also help create an environment that allows for the trying of new activities.

Discuss in sessions possible fantasies of each partner and ways for them to explore those fantasies, such as role play.
After Therapy

Key to success of any relationship is constant effort; the sexual relationship is no exception. Couples will have to continue with the goals and activities that were set up in therapy, along with problem-solving skill that were developed over the course of therapy. Assure the couple that they are able to resume therapy at any time.

Discuss permanent activities for the couple. These activities can be looked at as a way to continue dating your partner and continue to learn and grow with one another.