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A treatment model for anxiety-related sexual dysfunctions using mindfulness meditation within a sex-positive framework

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In this article, we propose a clinical model for treating anxiety-related sexual dysfunctions that hinges on the use of mindfulness meditation practices. First, theoretical and empirical evidence for anxiety as either a cause or condition of several different sexual dysfunctions is provided. Next, the concept of mindfulness and the research that supports the use of mindfulness meditation practices in addressing anxiety are explained. The inherent link between mindfulness and sex-positivity is also addressed while acknowledging the need to emphasize both mindfulness and sex-positivity in therapy. The proposed model for the treatment of anxiety-related sexual dysfunctions using mindfulness practices within a sex-positive framework is outlined. It utilizes mindfulness-based practices such as body scan meditation and sitting meditation as well as several preexisting sex therapy interventions, including directed masturbation and sensate focus assignments. A case study is provided as an example of the progression of therapy and as a demonstration of the clinical viability of the model. Ultimately, this model illustrates a potential way in which mindfulness practices can be utilized within a sex-positive approach to sex therapy.

Keywords: sex therapy; sex-positive; mindfulness; erectile dysfunction; premature ejaculation; vaginismus; dyspareunia

Introduction

The link between anxiety and sexual dysfunctions has been identified and become well established over time (Bancroft & Vukadinovic, 2004; Bradford & Meston, 2006; Heiman, 2007; Masters & Johnson, 1970), and it is clear that the way in which a person relates to their experience of anxiety can dictate the degree to which it affects their sexual functioning. When confronted with anxiety, many people attempt to avoid the thoughts, feelings, and physical sensations associated with it. Unfortunately, the strategies that many people adopt to avoid their anxiety often exacerbate it (Chambers, Gullone, & Allen, 2009). Masters and Johnson (1970) believed that assuaging anxiety would result in the “natural” unfolding of satisfactory sexual response. Masters and Johnson’s sensate focus techniques and mindfulness meditation are conceptually similar even though Masters and Johnson likely had no knowledge of mindfulness (Weiner & Avery-Clark, 2014). It may be possible, however, to build on Masters and Johnson’s techniques by creating treatment models that are informed by the recent surge of theoretical and empirical research involving mindfulness. By developing hybrid treatment models, clinicians who treat anxiety-related sexual dysfunctions may more effectively facilitate clients’ management of anxiety.

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By cultivating a mindful state, a quality of consciousness characterized nonjudgmental awareness of one’s experiences in the present moment (Brown & Ryan, 2003), individuals learn to loosen the grip of anxiety by allowing oneself to “be with” the thoughts, emotions, and physiological symptoms with which anxiety associated. It is important to note that being mindful leading up to and during sexual experiences can be difficult for people in a culture that leads both men and women to feel anxious, shameful, and secretive about their desires as they chase after “normal” sexuality. In helping clients cultivate a sexual experience grounded in mindfulness, we advocate for a sex-positive lens when using this proposed model.

In this article, we explain the role of anxiety in sexual dysfunctions for both men and women and provide a rationale for the use of mindfulness techniques in treating anxiety-related sexual problems. We also propose a hybrid systemic sex therapy treatment modality for anxiety-related sexual dysfunctions involving several mindfulness exercises and sensate focus techniques designed for use with individuals and couples. Ultimately, this model represents a concerted effort to create an approach mindfulness-based treatment within an overtly sex-positive framework specifically designed for sexual dysfunctions that are rooted in and exacerbated by anxiety.

Sexual dysfunction and anxiety

Researchers often make a distinction between state and trait anxiety, both of which have been tied to sexual dysfunction (Bradford & Meston, 2006; Desrochers, Bergeron, Khalifé, Dupuis, & Jodoin, 2009; Watts & Nettle, 2010). Bradford and Meston (2006, p. 1068) describe state anxiety as “an acute emotional response characterized by subjective feelings of apprehension” and trait anxiety as “a stable measure that reflects an individual’s dispositional tendency to experience state anxiety.” Erectile dysfunction (ED) (Laurent & Simons, 2009; McCabe & Connaughton, 2014), premature ejaculation (PE) (McCabe & Connaughton, 2014), vaginismus (Watts & Nettle, 2010), female orgasm disorder (de Lucena & Abdo, 2014; Graham, 2010), and dyspareunia (Schnatz, Whitehurst, & O’Sullivan, 2010) have been found to either be exacerbated or maintained when a person has higher levels of state anxiety or anxiety sensitivity but less often for people with trait anxiety. The experience of anxiety affects four domains of sexual dysfunction arousal, pain, desire, and orgasm, and effects how therapist may treat a dysfunction (Laurent & Simons, 2009).

Anxiety has been associated with both an inhibiting (Bancroft & Vukadinovic, 2004) and excitatory effects (Bancroft & Vukadinovic, 2004) on arousal. Desire and arousal capture different aspects of anxiety, but both can be measured subjectively and as an objective physiological response and subjectively and can occur independently of one another (Toledano & Pfaus, 2006). Research on dyspareunia has shown that women with the disorder have lower levels of physiological arousal than controls but are not different in terms of subjective arousal in response to erotic stimuli (Boyer, Pukall, & Chamberlain, 2013). With arousal, state anxiety has been shown to be related to negative affective response to subjective arousal in women (Bradford & Metson, 2006). Regarding desire, Beck and Bozman (1995) found that subjective reports of anxiety decreased subjective reports of desire for both men and women. Similarly, de Lucena and Abdo (2014) found that increased levels of anxiety increased women’s difficulty reaching orgasm. Finally, anxiety about pain may come from fear about experiencing pain during sexual activity, which might be due to a number of negative past experiences or a generally high sensitivity to pain (Basson, 2012).

While discussing the role of anxiety in sexual dysfunction related to pain, the most prominent model is the fear-avoidance model (Norton & Asmundson, 2004). The fear-
avoidance model predicts chronicity, maintenance, intensity, perceived and objective
disability of pain, as well as catastrophizing, hypervigilance, and elevated levels of
fear in anticipation of pain (Norton & Asmundson, 2004). These factors have also
been linked with vulvo-vaginal pain (Desrochers et al., 2009). Anxiety exacerbates
the fear of what may or may not happen during sexual activity; this may help to main-
tain dysfunction through avoidance of any sexual activity at all, ultimately resulting in
more anxiety (Basson, 2012). This circular model depicted by Basson (2012) specifically
addresses provoked vestibulodynia (PVD) but suggests that other chronic pain
fits as well. The concept of central sensitization in genital pain (Pukall & Cahill,
2014) also helps to explain how lower thresholds of sensation may induce pain and
also increase anxiety and contribute to the fear-avoidance response. These two con-
cepts explain the difficulty differentiating between vaginismus and PVD. A number
of authors have addressed this debate about distinctions between genital pain disorders
(e.g. Lahaie et al., 2014; Reissing et al., 2014) and what factors help differentiate.
Lahaie and colleagues (2014) findings support that fear and vaginal tension better
describe vaginismus than PVD. This is an important consideration for our proposed
model because a mindfulness-based approach has been shown to effectively relieve
symptoms of sexual dysfunctions related to pain (Basson, 2012).

Mindfulness

Although implementation of treatments for these sexual dysfunctions may differ, non-
pharmalogical treatments generally consist of helping clients develop attentiveness to
and normalization of their sexual experience though variations of sensate focus, cognitive
and behavioral therapy techniques (Basson, 2012), and education (see Hertlein, Weeks,
& Gambescia, 2009 for descriptions of treatment for each dysfunction). These character-
istics of treatment are similar to the principles of mindfulness. In fact, Weiner and Avery-
Clark (2014) stated that “the attitude of Sensate Focus Phase 1 is what is currently
referred to as mindfulness” (p. 310). Even though its principles are found in typical treat-
ments for sexual dysfunction, mindfulness has not received sufficient attention as a sex
therapy modality. A mindfulness-based sex therapy offers both a short- and long-term
effect that can assuage sexual anxiety and, especially when used within a sex-positive
framework, mindfulness interventions can decrease state anxiety, trait anxiety, and offer
clients a new lens to view their sexuality.

Mindfulness is a way of being focused on “cultivating constant awareness of our
experiences moment-by-moment, nonjudgmentally” (Khong & Mruk, 2009, p. 112), and
it may be a key tool in addressing anxiety-related sexual dysfunctions. Buddhism is often
credited for the development of mindfulness as a practice, but mindfulness has been an
integral facet of other spiritual traditions for centuries (Kumar, 2003). However, over the
past few decades, the popularity of mindfulness has grown exponentially and the practice
of mindfulness has been incorporated into Western psychological treatments. Sitting
meditation, eating meditation, and body scan are a few of the mindfulness-based techni-
ques adopted by Western psychologists that have been purported to alleviate a variety of
stress-related symptoms (Kabat-Zinn, 2004).

Anxiety and mindfulness in sex therapy

Anxiety may marshal one’s automatic thoughts and perceptions that engender and main-
tain sexual dysfunctions involving anxiety and, by extension, arousal, pain, desire, and
orgasm. Consequently, anxiety-related processes often reify unhelpful beliefs about the self and sexuality that are implicitly or explicitly. Fortunately, mindfulness can be a catalyst for change in terms of the relationship one has to his or her experiences by attenuating the fusion between the self and anxiety-related thoughts, which allows for more effective regulation of emotion.

Recent studies providing evidence that mindfulness meditation may be helpful in treating anxiety, pain, and other negative psychological and physiological states have led researchers to explore mindfulness meditation as a way of addressing sexual problems. Brotto, Basson, Carlson, and Zhu (2013), for example, reviewed literature from a variety of disciplines in constructing a model of PVD and averred that mindfulness-based cognitive behavioral therapy (CBT) would be a promising form of treatment in addressing key PVD symptoms. In addition, two studies have been conducted inquiring about the use of mindfulness in the treatment of several sexual disorders among women (Brotto & Heiman, 2007; Brotto, Basson, & Luria, 2008). Mindfulness training has been shown to mitigate psychological barriers to sexual functioning (Silverstein, Brown, Roth, & Britton, 2011), and Rosenbaum (2013) presented a mindfulness-based treatment for women with sexual pain and anxiety that included couple-level interventions. We seek to extend previous research and clinical approaches by presenting a mindfulness-based model that utilizes sex-positivity and is tailored to treat anxiety-related sexual dysfunctions in men and women.

**Sex-positivity**

Sex-positivity continues to be an assumption underlying sex therapy; however, as Kleinplatz (2012) elaborates, the field of sex therapy has in many ways simply, “dressed up old assumptions” (pp. xx—xxi). Acknowledging that research is about averages and that the meaning people attribute to sexuality requires a commitment to studying sex such that we liberate rather than constrict human sexuality. Overtly integrating sex-positivity into this model is necessary because it is a concept in line with mindfulness and is a mindset needed to combat the still prevalent unidimensional approach to sex in our culture.

Pulling from previously used definitions of sex-positivity (e.g. Glickman, 2000; Heilakka, 1993; Williams, Prior, & Wegner, 2013), we define sex-positivity as the belief that all consensual expressions of sexuality are valid and argue that a sex-positive attitude calls for a deliberate focus on the client’s personal meaning of their sexuality and its relationship with their well-being. The sex-positive framework inherently advocates for acceptance of and attention to one’s unique sexual experience, making it fit well with mindfulness-based approaches.

**Rationale**

Several different components of anxiety are related to sexual dysfunctions, including state anxiety, trait anxiety, and a physical response to anxiety, all of which can be associated with sexual dysfunctions. Researchers argue that mindfulness meditation strengthens ability to witness thoughts, emotions, and experiences in a receptive way rather than avoiding anxiety (Vago & Silbersweig, 2012) suggest that, during assessment, clinicians should normalize sex talk, use the client’s language, promote the clients comfort and ease in disclosing, and avoid shaming. These guidelines parallel a sex-positive lens and help validate clients’ unique sexual experience and set the tone for future discussions. Two assessment tools that help contextualize client’s developed meanings of sexuality are a
focused genogram or gender genogram (see Hertlein, Weeks, & Sendak, 2009 for descriptions). The treatment model is comprised of three “stages”: initial, middle, and end sessions. The mindfulness exercises include techniques from Becoming Orgasmic (Heiman & LoPiccolo, 1988) and from several of Kabat-Zinn’s (2003, 2004) versions of ancient mindfulness practices. The five primary mindfulness interventions include a focusing exercise, a self-observation exercise, a self-observation and touch exercise, body scan meditation, and sitting meditation.

**Initial sessions**

The initial sessions include three major components: (1) psychoeducation regarding mindfulness practices, (2) body scan meditations, and (3) sitting meditation. The first session includes meeting with the clients together as a couple, completing a sex history, a focused and/or gender genogram, and introducing the clients to the practice of mindfulness, including a brief explanation of the practice, information regarding the strengths of mindfulness as cited in the literature, and an overview of how mindfulness can be practiced on a daily basis (as described below). There are two mindfulness practices utilized in the initial phase of treatment: body scan and sitting meditation. One of these exercises is practiced briefly during the session, and the therapist provides the clients with an opportunity discuss the experience. The therapist also validates the client’s efforts and encourages each person to recognize his or her own power to focus the mind on the present moment.

Following the first session, the therapist meets with the couple to help them practice body scan meditation. Body scan meditation is a technique aimed at bringing a concentrated awareness to various body parts (Kabat-Zinn, 2003, 2004). By practicing body scan meditation, the client develops a newfound intimacy with his or her own body. During this process, the therapist encourages the client to cultivate an acute, nonjudgmental awareness of a specific body part, such as the heel of the right foot, and then the therapist tells the client to move the awareness of that body part to another part of the body. The client is also instructed to maintain awareness of the sensation of each breath (Kabat-Zinn, 2003, 2004). Clients are reminded that getting lost in thought will happen often, and that, when they notice this, they should take a moment to nonjudgmentally notice the contents of the mind for a moment before gently refocusing their attention on the various body parts.

The therapist will work with the clients on body scan meditation for 10 to 15 minutes during the second and third session. The therapist instructs the client to continue the body scan meditation at home on a daily basis. Body scan meditation is a technique that can enhance the effects of subsequent sensate focus exercises (see Masters & Johnson, 1970); having an awareness of one’s body without being touched may lead to a greater awareness of one’s bodily sensations during the sensate focused exercises.

During the subsequent couple sessions, the therapist works with the clients on sitting meditation; more specifically, the therapist helps the client to meditate on the physical sensations of the body while also observing one’s thoughts and feelings in a nonjudgmental manner (Kabat-Zinn, 2004). At first, the therapist facilitates sitting meditation in sessions, but the couple is also told to practice sitting meditation for 10 to 15 minutes per day at a time that is convenient for them. The clients are encouraged to gradually practice sitting meditation for longer periods of time each day. Ideally, the nonjudgmental awareness cultivated through mindfulness should extend beyond the practice of sitting meditation over time (Kabat-Zinn, 2004); for example, the partners may report experiencing...
awareness associated with mindfulness while getting ready in the morning or while washing dishes.

**Middle sessions**

After the clients have begun to feel more comfortable with body scan and sitting meditation, the clinician schedules individual sessions with each member of the couple to expand mindfulness practices to incorporate sexual experiences. The therapist meets with the client one time per week for one-hour (each). Several self-focused sexual practices will be the focus of the middle phase of treatment; first, Heiman and LoPiccolo’s (1988) sexual mindfulness exercises will be utilized, and, second, directed masturbation techniques taken from Heiman (2007) are explained by the therapist and are given to the clients as homework to complete separately. Over time, the client is encouraged to integrate the mindfulness techniques acquired during the initial phase of treatment with the self-focused sexual practices engaged in this phase.

*Becoming Orgasmic* (Heiman & LoPiccolo, 1988) provides sexual mindfulness exercises for women, but the authors have adapted the practices in order to apply them to both men and women. The first assignment includes a “focusing exercise” in which the client is instructed to look at his/her naked body after showering. The second exercise, a “self-observation” exercise, invites the client to observe his/her genitals with a hand mirror. The third exercise, “self-observation and touch” involves clients gently touching their genitals while observing themselves with a hand mirror. Each exercise will be assigned on separate sessions to allow time for attempts and processing the assignments. These three exercises build on the mindfulness exercises and also provide a foundation for future exercises. It is important that clinicians remain sex-positive and validate the clients experience during these first sex therapy assignments by emphasizing that there is no “right” way to proceed and encourage clients to mindfully observe their bodies and the sensations that the touch creates.

At this point in the therapeutic process, the therapist introduces the directed masturbation technique (as presented in Heiman, 2007, pp. 96–98). The *Directed Masturbation Treatment* provides step-by-step directions for exploring the genitals, becoming comfortable with one’s own genitals, exploring sexual desire and fantasies, and practicing masturbation. These detailed instructions will provide clients with useful directions to discover (or rediscover) their own sexual appetite while integrating the mindfulness practices from the initial sessions to remain calm and increase awareness of physical sensations. In maintaining sex-positive lens, the therapist will continue to emphasize that, as clients observe and become aware of their sexual appetite, the content of these phenomenon are valid expressions of sexuality. The therapist continues to meet with clients individually to discuss experiences during homework assignments and build mindfulness skills until the therapist and client both feel confident that the client is prepared to progress to couple-based sexual mindfulness.

**Final sessions**

After completing the individual sessions and fortifying the couple’s confidence to progress to couple-based sexual mindfulness, the therapist returns to couple sessions. The couple is encouraged to continue employing the mindfulness techniques taught during the initial stages to reduce anxiety prior to, during, and after sexual interactions. As previously stated, successful mindfulness during self-stimulation allows for more sexually oriented homework for the couple. The therapist provides the couple with information that
allows them to engage in the sensate focus exercises that were originally developed by Masters and Johnson (1970).

The next task is to practice the sensate focus techniques during sexual contact. Before giving the written prompt for the mindfulness practice, the therapist clarifies that there is no “goal” of the exercise. The instruction is be written as

Find a quiet area and negotiate with your partner about the place where sex is less distracted and more joyful. During the sexual contact, engage in a nonjudgmental awareness of your sensual experience. If you find yourself judging your body’s response, allow yourself to observe this process before bringing yourself back into a broader awareness of the experience. Focus on your breath and bodily reactions to the present sexual intimacy. Continue being mindful and nonjudgmental about the sensations that you experience. Allow the experience to be what it is. When you notice that your mind has strayed, acknowledge the thought that your mind brought into awareness, and then, gently but firmly, guide your mind back to the present. Try to practice this exercise at least 3 times in a week.

The therapist also assigns the couple to reward each other after these mindfulness practices by having them do something together that they both enjoy, such as cooking a meal or playing a game. By doing so, the partners reinforce the nonjudgmental attitude toward each other.

**Contraindications**

This model need not be followed rigidly; rather, it should be adapted to fit the needs of the client. However, in adopting the overall model for clinical work, there are several contraindications that are important to consider. First, because mindfulness meditation may allow traumatic memories to come the forefront of conscious experience, potentially causing great psychological discomfort, individuals who have destabilizing traumatic memories should not be treated with our proposed model. Second, cases involving extreme marital discord should be treated with another form of couples therapy before mindfulness practices are incorporated into treatment. Third, some individuals will be skeptical about how mindfulness practices can influence anxiety-related sexual dysfunctions. Psychoeducation regarding the theoretical and empirical foundations of mindfulness practices can be used in this situation, but, if the couple is still doubtful about the mindfulness practices, another approach to therapy may be necessary.

Mindfulness practices have the effect of breaking down shields that people have erected in order to avoid painful thoughts and emotions, so beginning mindfulness meditation may temporarily exacerbate anxiety. The therapist should mention this to clients prior to teaching meditation practices so that the clients are less likely to be surprised by initial experiences of anxiety. If clients report irritability, insomnia, or “out-of-body” experiences, however, a break from meditation practice may be necessary (Atkins, 2013).

Although formal training is not required to use the proposed model, the authors suggest that extensive, consistent personal mindfulness practice is needed to have an appropriate understanding of mindfulness before using it with clients. Attempts to utilize a mindfulness-based approach to sex therapy without immersing oneself in mindfulness practices may result in a lack of therapeutic progress.

**Case study**

Thomas and Emily, both 25 years old, had been together for over a year and a half. They had not attempted to have intercourse until they were together for a year, and they entered
therapy because Emily was experiencing pain and anxiety with any attempts to engage in intercourse with Thomas over the course of the previous six months. Emily did not have any traumatic childhood or adolescent experiences that would have contributed to vaginismus, but Thomas was her first sexual partner. Emily reported feeling “defective” because of her inability to engage in intercourse. Thomas had had sexual partners in the past, but he reported experiencing some stress, impatience, and anxiety with sexual interactions since attempting and failing to have intercourse with Emily. Thomas and Emily had been cohabitating for two-months and, aside from the issue involving pain and anxiety with intercourse, they did not report any other major relationship issues to the therapist.

The initial stage of therapy included psychoeducation regarding mindfulness followed by body scan meditation and sitting meditation and occurred over the course of the first four sessions. Emily reported that being deliberate about bringing her attention back to the present moment assuaged ruminative thoughts about physical intimacy. Thomas said that he was able to be more empathic toward Emily and patient in regard to his desire to engage in intercourse with her. The therapist then held individual sessions with Thomas and Emily to advance to the sensate focus exercises and the masturbation techniques. During the middle sessions, Thomas and Emily reported several positive sexual experiences with a significant reduction in anxiety, though they had not attempted intercourse since therapy began. The eighth sessions marked entrance into the final stage of the model. The therapist prescribed sensate focus exercises during sexual interaction for Thomas and Emily. The next session, they reported successfully having intercourse with only minor pain. Furthermore, two sessions later, Emily reported having almost no pain or anxiety with intercourse.

Discussion

One of the primary limitations for this model is the lack of quantitative empirical support, so future research involving both quantitative and qualitative methodology is needed to evaluate the presented model. In addition, the number of sessions that are required to move through the necessary steps in this model may vary greatly because of the nature of the sexual dysfunction and a host of other moderating factors. Most mindfulness-based treatments were designed to span 8 or 12 weeks, but there is evidence that supports the effectiveness of briefer mindfulness interventions (e.g. Zeidan, Johnson, Gordon, & Goolkasian, 2010). In utilizing mindfulness-based treatments in sex therapy, therapists must be willing to be prudent and use their clinical judgment in adapting the nature and length of treatment to best fit the clients.

Undoubtedly, many individuals and couples experience anxiety during sexual activity, which can have enduring negative personal and relational consequences. The mindfulness-based treatment we propose represents an attempt to use existing knowledge about mindfulness to establish a theoretical foundation for future empirical investigations regarding mindfulness and the treatment of anxiety-related sexual problems in couples. Furthermore, the sex-positive lens is easily incorporated into this model and supplements the gains made by practicing mindfulness. The sex-positive framework orients the therapist to acknowledging the clients unique process in learning mindfulness, incorporating it into their sexuality, and provides space for clients to accept their sexual expression. The concept of sex-positivity needs further operationalization backed by empirical research in the sex therapy literature, but this mindfulness-based model serves as an example of how a sex-positive framework can be incorporated into treatment models in sex therapy.
Mindfulness is inextricably linked to a sex-positive attitude. Mindfulness practices hinge on cultivating a form of awareness that is nonjudgmental in nature, so firm appraisals regarding what is acceptable sexually are antithetical to such practices. Sex-positivity is distinct from mindfulness, but we argue that sex-positivity should be something that is built into mindfulness models rather than something that is added onto it. Our model makes the connection between mindfulness and sex-positivity overt, and we believe that by being more deliberate in joining a sex-positive lens with mindfulness interventions, therapists may be more able to fully embrace the core ideas of mindfulness in treating couples.

Disclosure statement
No potential conflict of interest was reported by the authors.

Notes on contributors
Jonathan Kimmes is a licensed marriage and family therapist. He earned his Master’s degree in marriage and family therapy at Purdue University Calumet. He is currently a PhD student in Kansas State University’s marriage and family therapy program, and an AAMFT/SAMHSA minority fellow and a research assistant at Kansas State University. His research interests include mindfulness, attributions, and empathy, especially as they relate to processes in romantic relationships.

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Charlotte Cameron is a marriage and family therapist currently practicing in North Carolina. She received her Bachelor’s degree in human development and family studies at Michigan State University. She holds a MSc degree in marriage and family therapy from Purdue University Calumet. Her research and practice focuses on assisting families transitioning through the divorce process and integrating narrative and solution focused therapy to achieve clinical progress with children, adolescents, and adults.

Özlem Köse is a marriage and family therapist currently working in a private practice clinic and an employee assistance program (EAP) in Istanbul, Turkey. In 2013, she received her Master’s degree in marriage and family therapy at Purdue University Calumet. Her recent clinical work includes couples therapy, sex therapy, systemic child therapy, addiction therapy, and individual therapy. Her research interests are dyadic coping, trauma, addiction, long-distance dating relationships, and power dynamics and gender issues in couple relationships. She is currently doing research with a professor at Middle East Technical University. The research is a longitudinal study that focuses on dyadic coping, sexual satisfaction, and relationship satisfaction in couples.

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