BACKGROUND

Masters and Johnson (1970) were the founders of modern couple sex therapy. Their 2-week intensive, male–female cotherapy team model is almost extinct, but two of their concepts form the essence of contemporary sex therapy. First, sexual dysfunction is best conceptualized, assessed, and treated as a couple issue. Second, sexual comfort, skills, and functioning can be learned. A crucial third concept in modern sex therapy is the psychosocial approach to understanding, assessing, and treating sexual dysfunction (Mets & McCarthy, 2007a).

Sexual exercises are the preferred modality for helping couples develop a comfortable and functional sexual style. Sexual exercises (McCarthy & McCarthy, 2002; Wincze & Barlow, 1996) have been greatly expanded from the original sensorimotor format to include exercises involving bridges to sexual desire, non-demand pleasuring, and erotic scenarios, as well as exercises for specific male and female sexual dysfunctions.

Although the culture, especially the mass media, is saturated and obsessed with stories of great sexual performance and ultimate ecstasy, the reality is that rates of sexual dysfunction, dissatisfaction, and trauma continue to be high (Laumann, Gagnon, Michael, & Michaels, 1994). There has been significant growth in theoretical and clinical knowledge in the sexuality field, although the research base remains weak. A classification of sexual dysfunctions and disorders is included in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). However, the classification system is based on individual dysfunction and does not incorporate a relational diagnosis (Aubin & Heiman, 2004).

Models of Sexual Function and Dysfunction

Sexual dysfunctions are classified according to the triphasic model proposed by Kaplan (1974) — disorders of desire, arousal, and orgasm. The most common clinical complaints involve desire disorders, a category that was not considered in the original Masters and Johnson model. In the 1970s, "primary sexual dysfunction" predominated (i.e., a person has never been sexually functional). An example of primary sexual dysfunction is premature ejaculation, in which the man has always ejaculated prematurely. In the past 30 years, "secondary sexual dysfunction" has increased (i.e., a person was functional but is now dysfunctional). For ex-
ample, a woman was previously orgasmic during partner sex but is now nonorgasmic. For both men and women, a common sexual dysfunction is secondary hypoactive sexual desire disorder.

Traditional causes of sexual dysfunction were lack of information, repressive attitudes, high anxiety, lack of sexual skills, and rigid sexual roles. Sexuality is best understood as a multicausal, multidimensional phenomenon with psychological, biological, relational, and cultural components (Leiblum, 2007). Rates of dysfunction and dissatisfaction remain high, but their causes and types have changed significantly. With the growth of sexuality courses and self-help books, lack of knowledge has been alleviated. Unfortunately, it has been replaced by unrealistic expectations and performance demands. The importance of sexuality for couple and life satisfaction is often overemphasized, resulting in confusion, dissatisfaction, and performance anxiety. The cultural milieu has gone from one extreme (repression, rigidity, lack of information and communication) to the other (sexual overload, confusion, intimidation about one's body and sexual performance, and emphasis on medical interventions, especially for male sexuality). There have been significant cultural shifts in the frequency of premarital sex, increases in sexually transmitted diseases, the HIV/AIDS epidemic, high divorce rates, and heightened sensitivity to sexual trauma (especially childhood sexual abuse). These changes have led to a counterreaction from religious and conservative groups, especially the “family values” movement, which advocates for abstinence-only sex education, focusing on celibacy until marriage and absolute fidelity in marriage.

With the introduction of Viagra in 1998 (Goldstein et al., 1998), a paradigm shift occurred in the conceptualization of male sexuality. Tiefert (1996) warned against the “medicalization of male sexuality,” but this perspective is gaining momentum in the treatment of not only erectile dysfunction but also premature ejaculation. The movement to medicalize female sexuality (Rosen, Phillips, Gendrano, & Ferguson, 1999) is now growing although it faces a strong countermovement (Kaschak & Tiefert, 2001).

The traditional marital/couple therapy approach was to view sexual dysfunction as symptomatic of an unresolved relationship problem (e.g., poor communication, power imbalances, struggles with emotional intimacy, family-of-origin conflicts). The focus was on individual and couple dynamics, with the assumption that once these were dealt with, sexual issues would take care of themselves or be resolved with minimal intervention. There is little empirical support for this position, especially when the dysfunction is anxiety-based, with psychosocial skills deficits and a chronic avoidance pattern.

The couple therapy field has not given sufficient attention to sexuality and sexual dysfunction. Few couple training programs have courses, practica, or internships that include sex therapy as an integral component. Couple therapy, research, and practice emphasize sexual trauma, not sexual dysfunction or sex therapy. Some writers have advocated the integration of couple and sex therapy (McCarthy, Bodnar, & Handal, 2004; Weeks, 2004; Schnarch, 1991).

Couple sex therapy is best understood as a subspecialty field. The clinician—whether trained as a psychologist, social worker, psychiatrist, couple therapist, pastoral counselor, or psychiatric nurse—must possess skills in individual therapy; couple therapy; the assessment of individual, couple, and sexual factors; and the ability to develop and implement sexual interventions. Sex therapy involves comprehensive assessment and treatment, with attention to a wide range of psychological, physiological, relational, cultural, and psychosexual skills factors. Of central importance is the clinician's comfort with prescribing, processing, and individualizing sexual exercises.

Unfortunately, the sex therapy field is not growing. Among young clinicians it is shrinking, especially in comparison to couple therapy. Few clinicians choose sex therapy as their primary professional identity. There are a number of reasons for this: National sexuality organizations are struggling in terms of membership and resources; there is no licensing for sex therapists; few insurance companies reimburse for sex therapy; there are few graduate sex therapy programs; and there are few funding organizations or financial resources for sex research (with the exception of drug companies). In addition, the controversy surrounding sexual trauma (Rind, Tromovitch, & Bauserman, 1998), especially recovered memories of sexual abuse, has made the field suspect, and less scientifically and professionally respected. Both the professional and the public look to medical interventions as a first-line therapy, particularly for erectile dysfunction and premature ejaculation.

The number of couples with sexual dysfunction or dissatisfaction has not decreased; if anything, it has increased. Of special concern is the nonsexual relationship. According to the criterion...
of being sexual fewer than 10 times a year, approximately 20% of married couples and 30% of unmarried couples who have been together at least 2 years have nonsexual relationships (Michael, Gagnon, Laumann, & Kolata, 1994).

Couples often find motivating a perspective that when sexuality goes well, it is a positive, integral component of a relationship, but not a major factor. A common clinical adage is that sexuality contributes 15–20% to a marriage, serving as a shared pleasure, a means to reinforce intimacy, and a tension reducer to deal with the stresses of life and marriage. Sexuality energizes the marital bond, facilitates special couple feelings, and allows each spouse to feel desired and desirable. When sexuality is dysfunctional or nonexistent, it plays an inordinately powerful role, perhaps 50–75%, draining the marriage of vitality and intimacy (McCarthy, 1997). Paradoxically, bad sex plays a more powerful negative role than good sex plays a positive role in a marriage. The most commonly cited reasons couples separate within the first 2 years of marriage (whether a first or second marriage) are fertility issues (e.g., unwanted pregnancy or infertility), an extramarital affair, or a sexual dysfunction—especially hypoactive sexual desire disorder.

ASSESSMENT IN COUPLE SEX THERAPY

History Taking

The primary assessment method in couple sex therapy is the semistructured sexual history (Risen, 2007). The protocol is a conjoint initial session that enables the therapist to assess the couple's motivation and appropriateness for sex therapy; to explore the sexual problem in the context of the relationship; to understand past attempts at resolution of the sexual problem and coexisting problems; to decide whether to conduct individual, couple, or sex therapy; to opt whether to use sex-enhancing medications; to explore medical problems (including side effects of medications); to decide whether there is a need to consult a urologist, gynecologist, psychiatrist, or endocrinologist; and to answer questions about the process of sex therapy. Sexual histories are conducted individually to obtain a clear, uncensored review of each partner's psychological, relational, and sexual development, as well as his or her attitudes toward, feelings about, and experiences with the partner. At the beginning of the session, the therapist tells the client, "I want to know as much as possible about both the strengths and vulnerabilities in your sexual development and in this relationship. I ask you to be as frank and forthcoming as possible. At the end, I will ask whether there are sensitive or secret areas you do not want to share with your partner. I will respect your decision and not share information without your permission, but I need to understand as much as possible about you and your relationship if I'm going to be helpful."

The rationale for this format is that at least 50% of individuals (probably as many as 75–80%) have sensitive or secret material, either about the past or the present, that they would not have the courage to disclose in front of their partner. Without access to this material, the clinician might inadvertently enter into a sham therapy contract. The ideal scenario is for the client to give the clinician permission to share the material in the couple feedback session. It is then therapeutically integrated into a new, genuine individual and couple narrative. This is the most common outcome. If the sensitive/secret material would substantively undermine couple therapy and permission to disclose was not given, the clinician might suggest a therapeutic approach other than couple sex therapy.

The history taking follows a semistructured, chronological format, moving from general, less anxiety-provoking material to sensitive and anxiety-provoking issues. Open-ended questions are utilized. The clinician is supportive and nonjudgmental; he or she follows up and probes to elicit attitudes, experiences, feelings, and values. The goal is to understand fully the person's psychological, relational, and sexual history, including both strengths and vulnerabilities.

The first question—"How did you learn about sex and sexuality?"—allows exploration of formal education; religious background; parents as sex educators, and as marital and sexual models; as well as sexual experiences with siblings, neighborhood children, friends, and others. Social and sexual experiences as a child are addressed, including self-exploration/masturbation, comfort with body and gender, and sexual experimentation. Age and reaction to the first orgasmic experience (by oneself or with a partner) is explored.

The format of the questions facilitates disclosure. Yes—no questions are not used. Open-ended questions with the expectation of "yes" responses are utilized (e.g., "How and when did you begin self-exploration/masturbation—what were your
feelings and reactions"). This format is used to explore sexual experiences with members of the same sex, as well as extramarital affairs (e.g., “People often have sexual feelings, fantasies, and experiences with someone of the same sex. What have been your experiences?”). If the person has not masturbated, had same-sex experiences, or had extramarital affairs, it is easy to say “no.”

A particularly important issue to explore is negative sexual experiences, including trauma. Once the client’s age when he or she left home is established, the therapist asks, “As you review your childhood and adolescence, what was your most negative, confusing, guilt-inducing, or traumatic experience?” Toward the end of the history taking, the therapist asks about the most negative or traumatic sexual experience in the client’s life. Although the therapist has spent 50–90 minutes reviewing the entire sexual history, as many as 25% of clients disclose significant new information. The therapist explores the client’s cognitions and feelings both at the time of the traumatic incident and in retrospect. Especially crucial is whether traumatized clients see themselves as survivors or as victims (McCarty & Sypeck, 2003).

A crucial assessment topic is that of past or current medical illnesses and medications. Sexuality involves physiological, as well as psychological and relational, factors. Ideally, the nonmedical therapist will have a consultative relationship with a sexual medicine subspecialist. Often one or both members of a couple have consulted a family practitioner, internist, gynecologist, urologist, psychiatrist, or endocrinologist. It is important to be aware of both partners’ health and illness status, especially side effects of medications. There is substantial literature on the sexual side effects of antidepressant medications and strategies to reduce side effects (Ashton, 2007). Other psychiatric drugs, antihypertensive medications, and a number of other medications have been implicated in sexual dysfunction (Segreaves & Balon, 2003). With the introduction of Viagra in 1998, the use of sexual pharmacology for the treatment of male sexual dysfunction has dramatically increased. The potential benefits and pitfalls of medical interventions are discussed later in this chapter.

**Couple Feedback Session:**

**The Core Sex Therapy Intervention**

The couple feedback session is a powerful method to promote understanding, increase motivation, and set the stage for change. It is scheduled as a 90-minute, or double, session with a threefold focus: (1) establishing a new understanding of the problem, with a new individual and couple narrative that includes positive, realistic expectations; (2) outlining a change strategy that involves individual, couple, and sexual components; and (3) assigning the first exercise, with a specific plan for its implementation. The clinician gives feedback about each person’s sexual development, noting strengths and vulnerabilities. The fundamental concept—each person is responsible for his or her sexuality, and the couple is an intimate team—is made personal and concrete.

The feedback session focuses and motivates the couple. It sets the stage for thinking of therapy as an integrated assessment/intervention program. Reactions to exercises, both positive and negative, provide crucial diagnostic information. For example, if nongenital pleasing builds comfort with sensual touching and initiates turn taking, openness to the giver–recipient format, and utilization of feedback, but the process falls apart with the addition of genital pleasing, the clinician becomes aware of one type of vulnerability (trap). If another couple does well as long as the woman is the initiator of the exercise and recipient of pleasure, but cannot function when the man is the recipient or the man is too passive to be the initiator, the clinician explores a different type of vulnerability. Sexual exercises have both a diagnostic and an intervention function. Exercises provide feedback to address anxieties and inhibitions. Processing exercises allows the clinician and couple to individualize and refine subsequent interventions and exercises. Anxieties and vulnerabilities are addressed with a focus on increasing sexual awareness, comfort, and psychosexual skills.

Many couples find the metaphor of building a sexual house helpful. The foundation of the house comprises trust, intimacy, awareness, and comfort. With nongenital and genital pleasing, and the addition of erotic scenarios and techniques, they build on this foundation to establish a functional, satisfying couple sexual style.

**THE PROCESS OF SEX THERAPY**

The sex therapy format begins with weekly sessions, with the couple engaging in two to three homework exercises between sessions. The primary focus is on psychosexual skills exercises but may also include reading, discussion, and watching psychoeducational videos involving pleasing, eroticism, or a specific dysfunction. The exercises follow a semistructured format (McCarty & Mc...
Carthy, 2002) that is modified and individualized as the couple progresses. This format continues with exercises for the specific dysfunction. Exercises are refined and individualized as a result of the partners’ experiences and their feedback to the therapist.

A core theme of sex therapy, in contrast to general couple therapy, is the focus on sexual attitudes, behavior, and feelings. Unlike other problems (e.g., dealing with emotional conflict, parenting, money), the therapist never directly observes the behavior; the partners never do anything sexual in the therapist’s office or in front of the therapist. The code of ethics of the American Association of Sex Educators, Counselors, and Therapists (2004) specifically prohibits sexual interaction between a therapist and client.

Assigning, processing, and designing sexual exercises are core skills in sex therapy. Marital/couple therapists are usually more comfortable exploring feelings, family-of-origin dynamics, attitudes and values, and the context of couple intimacy than focusing on sexual behavior, with attendant feelings of anxiety, aversion, or eroticism. The primary goal of sex therapy is to establish a comfortable, functional couple sexual style, which means that each person is capable of experiencing desire, arousal, orgasm, and emotional satisfaction. Unless the clinician is willing and able to structure therapy to confront sexual problems directly and deal with anxieties, inhibitions, and/or skills deficits, the goal of developing a couple sexual style will probably not be achieved.

Therapy sessions are structured, especially at the beginning. The first agenda item is to discuss the previous week’s experiences and exercises. The therapist emphasizes detailed processing, rather than asking whether the behavior occurred and accepting an overall evaluation. The therapy discussion involves a fine-grained analysis of initiation patterns, comfort levels, receptivity and responsibility to specific pleasuring techniques, interfering anxieties or inhibitions, and subjective and objective feelings of arousal. The therapist’s own anxieties may center around a fear of appearing invasive or voyeuristic, eliciting erotic feelings or fantasies in the clients (or in him- or herself), and crossing ethical boundaries. Although these reactions do occur, there is no evidence that they are more likely to occur in sex therapy. Because of the therapist’s heightened awareness of such matters, they may actually be less likely to occur. In processing sexual exercises, the clinician uses his or her best clinical judgment in eliciting a clear picture of progress and difficulties, so that therapy is maximally effective. Therapist issues of boundaries, personal discomfort, or values are best dealt with in supervision with an experienced sex therapist.

Discussion of the coming week’s exercises should not be left for the last 5 minutes, but should be integrated throughout the session. Individualizing exercises promotes sexual comfort, receptivity to sexual and erotic touching, and psychosexual skills and responsibility.

This process reinforces the one—two combination of personal responsibility for sexuality and being part of an intimate team. Each person is responsible for his or her desire, arousal, and orgasm; it is not the other partner’s role to give him or her an orgasm. Sexuality is an interpersonal process. Ideally, the partners view each other as sexual friends, and one partner’s arousal facilitates the other’s arousal.

The sex therapist is active, especially in the early stages of therapy, and serves as a permission giver, sex educator, and advocate for intimate, erotic sexuality. As therapy progresses, structure and therapist activity decrease. The partners take increasing responsibility for processing experiences and feelings, creating their own agenda, moving to individualized and free-form sexual exercises, exploring personal and relational anxieties and vulnerabilities, and acknowledging strengths and valued characteristics. Therapy becomes less focused on psychosexual skills and focuses more on intimacy. The meanings of “intimacy” and “sexuality” are discussed, along with positive, realistic expectations. The challenge for couples, married or unmarried, straight or gay, is to integrate intimacy and eroticism into their relationship (Perel, 2006). The couple and the therapist collaborate in designing a relapse prevention program to maintain and generalize sexual gains.

The two most significant mistakes therapists make are (1) diverting the sexual focus and (2) prematurely terminating treatment when sex becomes functional. The therapist and couple may collude in avoidance because sexuality can be a sensitive and anxiety-provoking area, especially talking about erotic scenarios and techniques. Permission giving and providing relevant sexual information and sexual suggestions are helpful. However, dealing with specific inhibitions or avoidance—for instance, a man’s fear of the “wax-and-wane” erection exercise (i.e., allowing the erection to subside, then resuming erotic stimulation to arousal and erection), or a woman’s intimidation by the exercise to guide her partner’s hand or mouth to increase eroticism—is therapeutically challenging.
It is essential that the clinician stay with the therapeutic strategy, process exercises, and maintain focus, without being invasive or voyeuristic. The line between facilitating sexual awareness/comfort and making the sexual situation clinical and self-conscious requires that the therapist be sensitive and skillful. Many clinicians and most clients would rather talk about nonsexual issues, such as conflicts with families of origin or the meaning of intimacy, than stay focused on sexual function and dysfunction. It requires clinical skill and judgment to decide when to stay sexually focused and when to switch the focus to other psychological or relational issues.

Learning to be sexually functional is easier than integrating sexual expression into the couple’s life, particularly the ability to maintain gains and prevent relapse. Jacobson and Adlis (1993) have reported high levels of relapse among couples in conjoint therapy, and there is every reason to believe that this applies to sexual dysfunction as well.

Ending therapy after the first sexually functional experience is not only premature, but it may also be iatrogenic. Even sexually functional couples occasionally have problems (about 5–15% of encounters) of dysfunction and dissatisfaction (Frank, Anderson, & Rubinstein, 1978). By its nature, couple sexuality involves variability in both function and satisfaction. The unrealistic expectation that each experience must include equal desire, arousal, orgasm, and satisfaction for both partners sets a performance demand that will inevitably lead to relapse.

An integral component of high-quality, comprehensive sex therapy is a relapse prevention program (McCarthy, 1999). Integration and relapse prevention involve acceptance of the role of touch and sexuality in the couple’s everyday life. For example, how frequently do the partners express affection and sensuality, and is this valued in of itself or as a bridge to sexual arousal and intercourse? How important is sexual frequency, or is quality more important? How do they ensure that sexuality continues to play a 15–20% role in couple vitality and satisfaction? The key to maintaining therapeutic gains is positive, realistic (nonperfectionistic) expectations. Partners who accept a variable, flexible sexual style, and who realize it is normal to have occasional dysfunctional, unsatisfying, or mediocre experiences, will be inoculated against sexual problems associated with their own aging and that of the relationship. This is the focus of the “good enough sex” model (Meza & McCarthy, 2007a), in which intimacy is the ultimate focus, pleasure is as important as function, and mutual emotional acceptance serves as the couple context. Valuing variable, flexible sexual experiences (the “85% approach”) and abandoning the “need” for perfect intercourse performance inoculates the couple against sexual dysfunction by overcoming performance pressure, fears of failure, and rejection. Good enough sex is congruent with the couple’s genuine lifestyle and the couple values multiple purposes for sex and different desire and arousal styles.

**COMMON SEXUAL DYSFUNCTIONS**

Sexual dysfunction is more common among women than among men. The most common female dysfunctions are (1) hypoactive sexual desire disorder (HSDD), (2) nonorgasmic response during partner sex, (3) painful intercourse (dyspareunia), (4) female arousal dysfunction, (5) and primary nonorgasmic response. The most common male sexual dysfunctions are (1) premature ejaculation, (2) erectile dysfunction, (3) HSDD, and (4) ejaculatory inhibition.

The definition of “sexual function” is the ability to experience “desire” (positive anticipation and feel deserving of sexual pleasure), “arousal” (receptivity and responsiveness to erotic touch, resulting in subjective arousal and lubrication for the woman and erection for the man), “orgasm” (a voluntary response that is a natural culmination of high arousal), and “satisfaction” (feeling emotionally and sexually fulfilled and bonded).

Sexual dysfunction often involves more than one problem and may be comorbid with a partner’s dysfunction. The most common example of partner comorbidity is a male with secondary erectile dysfunction and hypoactive desire, and a female with primary hypoactive desire, and secondary arousal and orgasmic dysfunction. Dysfunction might not be constant, but it is predominant. For example, a woman with painful intercourse may have occasional comfortable experiences, or a male with ejaculatory inhibition may ejaculate intravaginally 30% of the time.

**Female Sexual Dysfunction**

**Hypoactive Sexual Desire Disorder**

Despite the number of books, chapters, and articles on HSDD (e.g., Basson, 2007; Hertlein, Weeks, & Gambescia, 2007; Kaplan, 1993), assessment and
intervention strategies are not clear, and the outcome is often disappointing.

It had previously been assumed that if a woman has an orgasm, then everything is functional. However, a fine-grained analysis reveals that some women, though aroused and orgasmic once they are involved sexually, continue to experience low desire. The core components of desire are positive anticipation and a sense of deserving pleasure. Anticipation involves a number of factors—openness to touch, the presence of romantic or erotic thoughts and fantasies, emotional connection with her partner, a desire for orgasm, and responsiveness to the partner's desire. Contextual factors, such as an inviting milieu, a weekend away without children, or a romantic or fun night out, can facilitate anticipation.

The organizing therapeutic concept in dealing with HSDD is to have "his, her, and our bridge to sexual desire" (McCarthy, 1995). The initial romantic love/passionate sex desire found in premarital and extramarital sex does not maintain desire in ongoing relationships. Basson's (2000) breakthrough concept is "responsive female sexual desire" rather than the male model of desire—erotic fantasies and spontaneous erection. The responsive female sexual desire model posits that women are often neutral at first, but if open and receptive to touch and responsive either emotionally or physically to pleasure and sensuality (a subjective arousal level of 2 or 3), they then choose whether to experience desire and arousal.

Schnarch (1997) has challenged common therapy concepts regarding desire. He emphasizes the crucial role of individuation and autonomy in maintaining sexual desire. Schnarch also challenged the use of sexual exercises, believing that they promote an other-centered need for sexual validation, which subverts desire. Lobitz and Lobitz (1996) acknowledge the value of Schnarch's emphasis on autonomy but take this to the critical next step of being open to the partner's sexual feelings and preferences, and integrating these into the couple's sexual style. With integrated sexuality, each person's desire and arousal plays off that of the other. The major aphrodisiac is an involved, aroused partner. Use of sexual exercises in a mechanistic manner can be self-defeating. However, if the exercises are used in a manner that confronts avoidance and inhibitions, while facilitating the involvement of both partners in the process of giving and receiving pleasure, then they can be invaluable in the development of a positive, resilient couple sexual style. The desire exercises focus on comfort, attraction, trust, and on partners designing their own sexual scenario (McCarthy & McCarthy, 2003).

Our culture idealizes spontaneous, nonverbal, intense erotic scenarios (the movie model). Such idealization creates unrealistic performance demands and expectations. Not surprisingly, marital sex is rarely shown in movies. Another unrealistic media theme is that both people are very turned on before touching. These scenarios make good entertainment but are poisonous for real-life couples.

One in three women complain of HSDD (Laumann, Rosen, & Paik, 1999): more than half of these complaints are secondary desire problems. With primary HSDD, the woman does not experience sexuality as a positive, integral part of her personhood. Primary desire problems can be caused by a number of factors—antisexual family learnings, poor body image, lack of experience with self-exploration/masturbation, childhood sexual trauma, fear of pregnancy or HIV/AIDS, a history of sexual humiliation or rejection, a fundamentalist religious background, or an antisexual value system.

The sexual history taking and processing of sexual exercises help to identify factors that inhibit desire. Common causes of secondary HSDD are disappointment or anger with the partner and negative sexual experiences (e.g., rape, unwanted pregnancy, painful intercourse, or being blamed for the partner's sexual dysfunction). Other possible causes include insufficient couple time, exhaustion due to child care, devaluation of marital sexuality, a belief that only intercourse counts as "sex," feeling pressured or coerced by her partner, feeling trapped in a boring sexual routine, fear of another pregnancy, and comparison of present sexual experiences with earlier experiences.

Couple exercises that can facilitate desire include building comfort with nudity and body image, taking turns initiating, identifying characteristics of the partner that the woman finds attractive, making one to three requests for change that increase attraction, establishing a trust/vulnerability position, identifying and playing out erotic scenarios, initiating erotic touching on a weekly basis, identifying external stimuli as turn-ons, utilizing role enactment arousal, and using a "veto" to stop an uncomfortable sexual experience (this is a crucial technique for persons with a history of sexual trauma).

A key concept in dealing with HSDD is that unless a woman feels she has the right to say "no"
to sex, she is not able to say "yes" to sex. The therapy focuses on helping the woman learn to view her partner as an intimate, erotic friend who is aware of her needs and open to her requests. She needs to establish her “sexual voice.” Female sexuality groups (Barbach, 1975), originally focused on teaching women to be orgasmic, have been expanded to deal with desire, arousal, and pain issues. The successful resolution of sexual dysfunction (e.g., learning to become aroused, orgasmic, or to eliminate pain) is of great value, but it is not enough. Orgasm alone does not build desire. Desire involves a complex interplay among cognitive, behavioral, emotional, and relational phenomena. Basson's (2007) integrative model of female sexual function and dysfunction, with its emphasis on responsive sexual desire, is of great value. Responsive sexual desire is equally important and valuable for male HSDD, especially for men over 50. The list of guidelines in Table 21.1, used for both males and females, is given to the couple as a handout.

**Orgasmic Dysfunction**

A common sexual complaint is that the woman is not orgasmic during intercourse. Typically, the man is more upset than the woman. He wants her to function the way he functions—to have one orgasm during intercourse without needing additional stimulation. This has traditionally been considered the “right” way to be orgasmic. In fact, one in three women who are regularly orgasmic with couple sex are not orgasmic during intercourse. This is not a dysfunction, but a normal variation in female sexual response. Female sexual response is more variable and complex than male sexual response. In truth, the majority of women who are orgasmic during intercourse use multiple stimulation, especially manual clitoral stimulation with the partner's fingers, her own fingers, or vibrator stimulation. A woman may be nonorgasmic, singly orgasmic, or multiorgasmic. Orgasms can occur with pleasing/foreplay, during intercourse, or in afterplay. Feminist sexologists (e.g., Tiefen, 2004) have noted that concepts of sexual function and dysfunction are heavily influenced by the traditional male model, with a phallocentric obsession with intercourse as "real sex." The feminist sexual response model honors flexibility, variability, and individual differences in the meaning and experience of sexuality. Intimacy, pleasing, playfulness, eroticism, manual—oral—rubbing stimulation, and erotic scenarios and techniques are in the normal range. Self-stimulation is encouraged during partner sex (Heiman & LoPiccolo, 1988). An example of the variability of female sexual response is that 15–20% of women have a multiorgasmic response pattern, most commonly with cumminguis or manual stimulation.

As noted, being nonorgasmic during intercourse is a normal variation, not a dysfunction. Not being orgasmic at each sexual experience is also a normal variation. The therapist can set positive, realistic expectations about orgasmic response. An unrealistic performance demand of simultaneous orgasm during intercourse is self-defeating, as is belief that achieving orgasm during intercourse is the only “right” way to be sexual.

A positive, realistic expectation is that the woman develops a regular pattern of arousal and orgasm, with recognition of flexibility and variability. Dysfunction is the absence of orgasm by any means (primary nonorgasmic response), orgasmic response with self-stimulation but not partner sex, or infrequent orgasmic response (orgasm in fewer than 25% of experiences). Since the 1970s, there has been a decrease in primary nonorgasmic response due to increased awareness of female sexuality; the availability of female sexuality therapy groups and self-help books; increased use of vibrators, manual, and oral stimulation; and women taking a more active role in the sexual scenario. However, there has been an increase in secondary nonorgasmic response, partly due to performance demands and failure to incorporate the meaning and value of intimacy and eroticism in an ongoing relationship.

In assessing nonorgasmic response, several factors are crucial: the woman's attitudes toward sexuality and her body; awareness of her arousal—orgasm pattern; development of her "sexual voice"; awareness of what facilitates and inhibits desire and receptivity; inhibitions or resentments that interfere with responsibility and arousal; passivity; a history of sexual trauma; guilt over sexual secrets; and emotional and practical factors that block sexual expression. Orgasmic response is the natural culmination of comfort, pleasure, arousal, and erotic flow.

With secondary nonorgasmic response, it is crucial to assess carefully a wide range of personal, relational, physical, and situational factors that inhibit sexuality. Factors include side effects of medications (especially antidepressants); resentment toward or disappointment in the partner or the relationship; lack of time and energy due to competing demands from children, extended family, job, and house; feeling bored with a mechanical sexual
TABLE 21.1. Guidelines for Revitalizing and Maintaining Sexual Desire

1. The essential keys to sexual desire are positive anticipation and feeling that you deserve sexual pleasure in this relationship.

2. The change process is a one-two combination of personal responsibility and being an intimate team. Each person is responsible for his or her desire, with the couple functioning as an intimate team to nurture and enhance desire. Revitalizing sexual desire is a couple task. Out, blame, and pressure subvert the change process.

3. Inhibited desire is the most common sexual dysfunction, affecting two in five couples. Sexual power struggles and avoidance drain intimacy and vitalism from the marital bond.

4. One in five married couples has a nonsexual relationship (being sexual less than 10 times a year). One in three nonmarried couples who have been together longer than 2 years has a nonsexual relationship.

5. The average frequency of sexual intercourse ranges from three times per week to once every 2 weeks. For couples in their 20s, the average sexual frequency is two to three times a week for couples in their 50s, once a week.

6. The idealized romantic love/passionate sex type of desire lasts less than 2 years, and usually less than 6 months. Desire is facilitated by an intimate, interactive relationship.

7. Contrary to the myth that “horniness” occurs after not being sexual for weeks, desire is facilitated by a regular rhythm of sexual activity. When sex occurs less than twice a month, couples become self-conscious and fall into a cycle of anticipatory anxiety, tenseness and performance-oriented sex, and avoidance.

8. A key strategy is to develop “her,” “his,” and “our” bridges to sexual desire. This involves ways of thinking, talking, anticipating, and feeling that invite sexual encounters.

9. The essence of sexuality is giving and receiving pleasure-oriented touching. The prescription to maintaining desire is to integrate intimacy, pleasing, and eroticism.

10. Touching occurs both inside and outside the bedroom. Touching is valued for itself. Both the man and woman are comfortable initiating. Touching should not always lead to intercourse. Both partners feel free to say “no” and to suggest an alternative way to connect and to share pleasure.

11. Couples who maintain a vital sexual relationship can use the touching metaphor that involves “five gears.” First gear is clothes on, affectionate touch (hugging, kissing, hugging). Second gear is nonsexual, touch, which can be clothed, semiclothed, or nude (whole-body massage, cuddling on the couch, touching while going to sleep or on awakening). Third gear is playful touch with competent genital and nonsexual touching, clothed or unclothed, and may take place in bed, while dancing, in the shower, or on the couch. Four gear is erotic touch (manual, oral, or rubbing) to high arousal and orgasm for one or both partners. Fifth gear integrates pleasurable and erotic touch that flows into intercourse.

12. Personal turn-ons facilitate sexual anticipation and desire. These include the use of fantasy and favorite erotic scenarios, as well as sex associated with special celebrations or anniversaries, sex with the goal of conception, sex when feeling caring and close, or even sex to soothe a personal disappointment or loss.

13. External turn-ons (R- or X-rated videos, music, candles, visual feedback from mirrors, locations other than the bedroom, a weekend away from the kids) can elicit sexual desire.

14. Males and females with hormonal deficits may use testosterone injections, patches, or creams to enhance sexual desire, but only under medical supervision. Hormone replacement can be a positive resource but not an “stand-alone” intervention. The medical intervention needs to be integrated into the couple’s sexual style of intimacy, pleasing, and eroticism.

15. Medical problems and side effects of medication are a major cause of inhibited sexual desire. As a couple, consult your physician about medications and health behaviors.

16. Sexual desire is a psychosocial process. You need to use all of your psychological, physical, and emotional resources to promote openness to intimacy and sexuality.

17. Sexuality has a number of positive functions—a shared pleasure, a means to reinforce and deepen intimacy, and a tension reducer to deal with the stresses of life and marriage.

18. “Intimacy coercion” is not acceptable. Sexuality is neither a reward nor a punishment. Healthy sexuality is voluntary, mutual, and pleasure-oriented.

19. Realistic expectations are crucial for maintaining a healthy sexual relationship. It is self-defeating to demand equal desire, orgasm, and satisfaction each time. A positive, realistic expectation is that 40–50% of experiences are very good for both partners; 20–25% are very good for one partner (usually the man) and fine for the other; 20–25% are acceptable but not remarkable; 5–15% of sexual experiences are dissatisfying or dysfunctional. Couples who accept occasional dissatisfaction or dysfunction without guilt or blaming and try again when they are receptive and responsive will have a vital, resilient sexual relationship. Satisfied couples use the guideline of “good enough” sex with positive, realistic expectations.

20. If the couple has gone 2 weeks without any sexual contact, the partner with the higher desire takes the initiative to set up a planned or spontaneous sexual date. If that does not occur, the other partner initiates a sexual or play date during the following week. If that does not occur and they have gone 1 month without sexual contact, they schedule a “booster” therapy session.

21. Healthy sexuality plays a positive, integral role in a relationship, with the main function to energize the bond and generate feelings of desirability and being desired. Paradoxically, bad or nonexistent sex plays a more powerful negative role in a relationship than the positive role of good sex.
pattern; or partner sexual dysfunction. Assessment continues in the treatment phase in response to exercises, processing during therapy, and exploring the meaning of “sexuality” and “sexual dysfunction” for the woman and relationship.

Therapeutic interventions for orgasmic dysfunction include encouraging the woman to develop her “sexual voice”; to use multiple stimulation during nonintercourse and intercourse sex; to identify “orgasm triggers” from masturbation and transfer these to partner sex; to increase comfort, emotional intimacy, and trust; to identify and play out erotic scenarios; to request and guide stimulation; to make the transition to intercourse at her initiation; and to give herself permission to let go and be orgasmic with manual, oral, or rubbing stimulation. When a woman’s orgasm is viewed as a sign of a man’s expertise, this creates performance anxiety. Women are not autonomous sexual responders; both female socialization and physiology support intimate, interactive sexuality. The man is viewed as her intimate, erotic friend. The optimal prescription for female orgasmic response is to integrate intimacy, pleasurizing, and eroticism.

Traditionally, eroticism has been underplayed in female sexuality. Without a solid base of receptivity and responsiveness, erotic techniques cannot “force” orgasm. Orgasm is the natural culmination of pleasure, arousal, erotic flow, and letting go. Her partner’s attitudes, behavior, and feelings are integral to a woman’s arousal. Often a man, under the guise of being a “sophisticated lover,” is in fact manipulating the woman (i.e., her orgasm is to prove something for him). The woman is responsible for her orgasm, and the man respects her sexual voice and autonomy. Sex is about awareness and sharing pleasure, not a performance to satisfy an arbitrary criterion. As noted, a crucial therapeutic strategy is to reinforce the one–two combination of each person taking responsibility for sexuality, with the couple functioning as an intimate team.

Sex therapy strategies and techniques are most effective with anxiety-based dysfunctions, lack of awareness, and inhibitions. Therapeutic techniques include self-stimulation (with or without a vibrator), increased awareness, guiding a supportive partner, using multiple erotic stimulation, gaining confidence in one’s arousal–orgasm pattern, and freedom to decide when and how to integrate intercourse into the couple’s lovemaking style.

When dysfunction (especially secondary arousal dysfunction and/or nonorgasmic response) is confounded with negative emotions (disappointment, anger, alienation, distrust), treatment is more complex. Attention is focused on assessment/intervention at the systemic and meaning levels. An important technique is to help each person recognize the function of the sexual problem and do a cost–benefit assessment of the emotional and relational consequences of resolving the problem. Therapy sessions help clarify the functions and meaning of sexuality for the woman and the relationship (Heiman, 2007).

Female Arousal Dysfunction

Although much attention has been paid to male arousal dysfunction (erection), relatively little clinical or research attention has focused on female arousal dysfunction. The objective (physiological) measures of arousal are ease and amount of vaginal lubrication. The subjective measure is feeling “turned on.” Both are variable and difficult to quantify (Basson, 2007). The introduction of Viagra has led to renewed interest in female arousal for researchers and clinicians.

When a woman enters therapy with the complaint of painful intercourse or nonorgasmic response, a careful analysis often reveals that the primary problem is lack of arousal. It is possible for a woman to have high desire and low arousal, or to be orgasmic but still have arousal dysfunction. The therapeutic focus is usually on desire or orgasm, but in fact arousal is a crucial component deserving assessment and intervention.

The key to understanding arousal is a careful assessment of the woman’s receptivity–responsivity pattern. To what pleasurizing scenarios and techniques is she most receptive? When is she open and responsive to erotic touch? What is the optimal timing and sequencing of erotic techniques? It is useful to think of sexual response on a 0–10-point scale (10 is orgasm): 1–3 refers to comfort and sensuality; 3–5 refers to pleasure; and 6–9 refers to arousal/erotic flow.

Traditionally, it is the male who controls “foreplay.” The man stimulates the woman until he judges that she is ready for intercourse, then initiates intromission. In the treatment program for female arousal dysfunction, it is the woman who controls the type of stimulation and timing of transitions. For example, many women prefer prolonged nongenital pleasuring. Some women prefer taking turns in the pleasurer–recipient format, whereas others prefer mutual pleasuring. Attitudinally, the focus is on “pleasuring,” not “foreplay.” Intercourse is not necessarily the centerpiece of the pleasuring–eroticism process. In designing and processing exercises, the woman is encouraged to experiment with
single versus multiple stimulation; taking turns versus mutual pleasuring; utilizing manual, oral, or rubbing stimulation versus intercourse; and using lubricants such as Astroglide, nonallergenic water-based lotions, or K-Y Jelly. She is actively involved in the pleasuring-arousal-eroticism process.

For those women who feel subjectively aroused but do not lubricate sufficiently, the preferred intervention is to use lubricants. This can be done in a comfortable, sensual manner, either using the lubricant prophylactically or as part of the pleasuring process. Being self-conscious or apologetic blocks erotic flow. A rhythm of comfort, pleasure, and eroticism is integral to overcoming female arousal dysfunction and orgasm dysfunction. The guidelines (in Table 21.2) to enhance female arousal and orgasm are given as a handout to women and couples.

### TABLE 21.2. Guidelines for Female Arousal and Orgasm

<table>
<thead>
<tr>
<th>1. You are responsible for your desire, arousal, and orgasm. Developing your &quot;sexual voice&quot; is a positive challenge. It is not the man’s responsibility to &quot;give you&quot; an orgasm.</th>
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</thead>
<tbody>
<tr>
<td>2. Together, a couple can develop an intimate, interactive sexual style that promotes desire, arousal, orgasm, and satisfaction for both partners.</td>
</tr>
<tr>
<td>3. Receptivity and responsivity to giving and receiving pleasurable and erotic touch is core to arousal and orgasm.</td>
</tr>
<tr>
<td>4. Arousal involves both subjective components (feeling responsive and turned on) and objective components (vaginal lubrication and physical receptivity to intercourse).</td>
</tr>
<tr>
<td>5. &quot;Foreplay&quot;—which in the man stimulates the woman to get her ready for intercourse—increases self-consciousness and performance anxiety. The experience of &quot;pleasuring&quot;—which emphasizes mutuality and sharing—facilitates arousal.</td>
</tr>
<tr>
<td>6. Erotic and arousal can lead to intercourse, but intercourse is not necessary for a satisfying sexual experience.</td>
</tr>
<tr>
<td>7. The prescription for satisfying sexuality is to integrate intimacy, pleasuring, and eroticism. Traditionally, female sexual socialization underplayed eroticism. Erotic scenarios and techniques are integral to female sexuality.</td>
</tr>
<tr>
<td>8. As you develop your &quot;sexual voice,&quot; you increase awareness of the scenarios and techniques that enhance arousal. Use that awareness to make requests and guide your partner, verbally and nonverbally.</td>
</tr>
<tr>
<td>9. State your preferences—single versus multiple stimulation, taking turns versus mutual stimulation, when and how to transition from sensual to erotic stimulation; your emotional and practical conditions for a vital sexual relationship. Feel free to request erotic techniques (vibrator stimulation, your fingers or his for clitoral stimulation during intercourse, cummings to orgasm).</td>
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<tr>
<td>10. You can initiate the transition from pleasuring to intercourse and guide intromission.</td>
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<tr>
<td>11. Women who prefer multiple stimulation during pleasuring/eroticism usually prefer multiple stimulation during intercourse. You can utilize additional clitoral stimulation with your hand or his, request breast or anal stimulation, fantasize, kiss, and/or switch intercourse positions.</td>
</tr>
<tr>
<td>12. Many women are interested in using medications, such as Viagra or testosterone, to enhance sexual response. Medication can be a valuable additional resource, but it is not a &quot;magic pill.&quot; The sexual enhancement medication needs to be integrated into your couple's sexual style of intimacy, pleasure, and eroticism.</td>
</tr>
<tr>
<td>13. Many women, especially after 40, use some form of estrogen and/or water-based lubricant to enhance lubrication and facilitate intercourse.</td>
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<tr>
<td>14. Only one in four women follow the traditional male pattern of one orgasm during intercourse without needing additional stimulation. Female sexual response is flexible and variable. A woman may be nonorgasmic, single orgasmic, or multiorgasmic, and orgasm might occur during pleasuring, intercourse, or afterplay.</td>
</tr>
<tr>
<td>15. Sex is not a performance in order to have a G-spot orgasm, multiple orgasms, &quot;vaginal&quot; orgasm, extended orgasm, or whatever is the new fad. Each woman develops her own pattern of desire, arousal, and orgasm.</td>
</tr>
<tr>
<td>16. Orgasm is a 3- to 10-second experience. Orgasm is a natural result of giving yourself permission to enjoy arousal, eroticism, and letting go, so that arousal flows to orgasm.</td>
</tr>
<tr>
<td>17. The distinction between &quot;clitoral&quot; and &quot;vaginal&quot; orgasm is not scientifically valid. Whether orgasm occurs with manual, oral, rubbing, intercourse, or vibrator stimulation, the physiological response is the same. Subjective feelings of satisfaction vary depending upon preferences, experiences, and values.</td>
</tr>
<tr>
<td>18. Desire and emotional satisfaction are more important than orgasm.</td>
</tr>
<tr>
<td>19. It is unrealistic to expect arousal and orgasm during each sexual experience. You are not a sexual machine. Female sexuality is more variable and complex than male sexuality.</td>
</tr>
<tr>
<td>20. Remember, sexuality is not about proving anything to the partner, yourself, or anyone else. It is about experiencing and sharing intimacy, pleasure, and eroticism.</td>
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</table>
Painful Intercourse

The problem of painful intercourse is paradoxical. Whereas some cases are quite easy to resolve, others require the coordinated efforts of a gynecologist, sex therapist, and the most important member of the treatment team, a female physical therapist (because the intervention involves direct teaching and practice of control over pelvic floor musculature) with a subspecialty in female sexual health. The woman increases awareness and comfort with her genitalia, uses general relaxation and specific pelvic relaxation techniques, controls the type and pacing of genital stimulation, is comfortable using lubricants, initiates and guides introversion, and finds intercourse positions and types of thrusting that are comfortable. Involvement and arousal are the antidotes to passivity, hypervigilance about pain, and viewing intercourse as the man’s domain.

Clinicians and researchers who deal with sexual pain recognize it as a complex psychosocial phenomenon that needs to be addressed in a multicausal, multidimensional manner (Bunik, Bergeron, & Khalife, 2007). The new emphasis is on approaching sexual pain as a pain disorder rather than as a sexual dysfunction. Assessment often requires the participation of a gynecologist with a subspecialty in pain to assess syndromes such as vulvodynia, vaginal tears, vulvar vestibulitis syndrome, infections, sexually transmitted infections, poor vaginal tone, and medication side effects. Medical interventions include surgery, oral medications, and vaginal creams. A common therapeutic technique is exercising the pubococcygeal (PC) muscle, which increases awareness and strengthens the vaginal wall. Clinicians emphasize the efficacy of the PC muscle exercise, although empirical support is weak.

Couple sex therapy focuses on psychological and relational factors that facilitate comfort, pleasure, eroticism, and intercourse. This requires major attitudinal, behavioral, and emotional changes for both partners. It requires that she be assertive, and that he be open to her requests, guidance, and especially her rhythm for the sexual scenario. Comfort is the underpinning of desire and arousal. Pain, or fear of pain, sabotages sexual pleasure.

Vaginismus, spasming of the vaginal introitus that makes intercourse painful or impossible, is no longer considered a separate dysfunction but a variant of painful intercourse. As Donahue (1998) observed, many women who experience vaginismus have high anticipatory anxiety, are unaccepting of their bodies, and are intimidated by their partners’ sexual desire and erection. The change process for painful intercourse may be slow, with a need for carefully crafted individual and couple interventions, especially comfort with vaginal insertion. Use of fingers (hers, and then his), graduated sizes of dilators, and insertion of the lubricated penis are stepwise interventions. Insertion is more comfortable when the woman is both subjectively and objectively aroused.

In summary, assessment and treatment of female sexual dysfunction require a broad-based approach to psychological, physical, relational, cultural, and psychosexual skills factors. The organizing concept is the woman as an aware, comfortable, and responsible sexual person—speaking with her clear “sexual voice.” Couple interventions center around partners feeling and functioning as an intimate team in which the woman is an equal partner. Her anticipation and the feeling that she is deserving, and both partners’ respect for her conditions for healthy sexuality are crucial in facilitating desire. Integrating intimacy and eroticism, and openness to requests and guidance, and focusing on erotic techniques (especially multiple stimulation and the woman guiding intercourse) are important for arousal. Awareness of her arousal—orgasm pattern, use of self- or partner stimulation during intercourse, multiple stimulation and orgasm triggers, and giving herself permission to be erotic and let go are important for orgasm. Developing afterplay scenarios, sharing intimacy, acknowledging emotional and sexual connection, and feeling bonded are important for satisfaction.

Male Sexual Dysfunction

With the exception of premature ejaculation, the great majority of male sexual problems are secondary. Males are generally eager to be in sex therapy when the problem is female dysfunction, but are reluctant and embarrassed when the problem is male dysfunction.

Male sexual socialization is antithetical to the strategies and techniques of couple sex therapy. In traditional socialization, the male is supposed to be the “sex expert,” with no anxieties or inhibitions. Sexual performance is supposed to be totally predictable and perfect; sex is competitive, and no weaknesses or questions are tolerated; and masculinity and sexuality are highly related. The
self-defeating concept is that a "real man" is willing and able to have sex with any woman at any time, in any situation (McCarth & McCarthy, 1998). Males learn that desire, arousal, and orgasm are easy, predictable, and autonomous (i.e., a man needs nothing from a woman). Traditionally, males do not value intimate, interactive sexuality. This is a prime cause of secondary sexual dysfunction as men and their relationships age.

Sex therapy can help a man resolve a dysfunction. Even more importantly, therapy can help him learn healthy attitudes and skills, especially the value of intimate, interactive sex, setting the stage for relapse prevention and inoculation against sexual problems with aging.

Sex therapy concepts and techniques are more acceptable to women, but they are just as beneficial for men. When partners stop having sex, whether at 40 or 70, it is typically the man's decision (McCarthy, 1999). A major cause is feeling embarrassed and stigmatized because he has failed at the male sexual performance model. In therapy, he learns to view sexuality as pleasure, not as a performance; to value the woman as his sexual friend, not as someone for whom he performs or must prove something; to enjoy a variable, flexible couple sexual style rather than a rigid intercourse pass-fail test; and to regard sexuality as intimate and interactive, not as autonomous. The core concept is to adopt the "good enough sex" model of male and couple sexuality (Metz & McCarthy, 2007a).

Premature Ejaculation

Although premature ejaculation is the most common male sexual dysfunction, it is not easy to measure objectively. The most clinically useful assessment/definition of premature ejaculation focuses on the couple's subjective evaluation of pleasure and satisfaction rather than a strict time criterion (Metz & McCarthy, 2003). When the man ejaculates before intromission, at the point of intromission, with fewer than 10 thrusts, or within a minute of intercourse, almost all couples identify this as premature ejaculation. Most men begin their sexual careers with rapid ejaculation, and 30% of adult males complain of chronic premature ejaculation (Metz, Pryor, Nesvold, Abuzian, & Kosasz, 1997). Strassberg, Brazao, Rowland, Tan, and Slob (1999) present evidence that for some men, a significant physiological component makes it difficult to learn ejaculatory control, and a significant number of these men relapse. A new trend, mimicking the movement to medicalize erectile dysfunction, is use of a medication that facilitates ejaculatory control (Waldinger, 2004). However, medication should be regarded as an additional resource, not as a substitute for the couple learning ejaculatory control exercises.

The essence of the assessment/intervention program is to help the man break the connection between high arousal and quick orgasm. Contrary to "do-it-yourself" techniques to reduce arousal, such as wearing two condoms, applying a desensitizing cream to the glans of the penis, or using nonerotic thoughts, the focus in learning ejaculatory control is to maintain arousal while heightening awareness, relaxation, and psychosexual skills. The strategy is counterintuitive—practicing increased stimulation and arousal, while increasing comfort and control.

For the majority of males, premature ejaculation is a powerfully overlearned habit in both masturbation and intercourse. Relearning involves two processes. The first is the ability to discern the point of ejaculatory inevitability (after which ejaculation is no longer a voluntary function), and the second is to increase erotic stimulation while lengthening the time from arousal to orgasm. The major learning technique is the "stop-start" approach, which is easier to apply and more acceptable to the partner than the traditional "squeeze" technique.

Identifying the point of ejaculatory inevitability occurs through masturbation or manual stimulation by the partner. When the man is approaching the point of inevitability, he signals (either verbally or nonverbally) for the woman to cease stimulation. The urge to ejaculate decreases after 15-60 seconds, and stimulation is resumed. At first the stop-start technique may be used three or four times, but it becomes less necessary over time as the couple makes the transition into slowing down and altering stimulation.

Men (and women) have unrealistic expectations about the time spent in intercourse. A typical sexual scenario might last 15-45 minutes, with time spent in intercourse averaging from 2 to 7 minutes. Few intercourse experiences exceed 12 minutes. Men are intimidated by the fantasy goal of hour-long intercourse. Maintaining realistic expectations is crucial. Acceptance is difficult for the man whose expectations are based on male boasting, porn videos, and a competitive, performance-based norm.

A crucial concept is for the man to view the woman as his intimate sexual friend. A man
typically emphasizes performance for the woman rather than sharing pleasure with her. The male hopes that if intercourse lasts longer, he will “give her an orgasm during intercourse.” The man acts as if ejaculatory control is for her, not for him. The purpose of learning ejaculatory control is for the man to enhance pleasure and satisfaction. The entire sexual experience becomes more intimate and erotic.

Exercises are designed in a stepwise manner; the man learns ejaculatory control first with manual and oral stimulation, then with intercourse. The “quiet vagina” exercise involves minimal movement, controlled by the woman from the female-on-top position. The most difficult position to maintain control is the man on top, using short, rapid thrusts. A man often develops better ejaculatory control with circular thrusting; with longer, slower thrusting; or with the woman controlling thrusting. The partners work collaboratively to develop sexual scenarios and techniques that enhance pleasure and satisfaction. Throughout the process, the woman’s sexual feelings and needs are important. Being intimate team members who clearly and comfortably communicate sexual feelings, techniques, and requests is integral to maintaining therapeutic gains.

A common result of unsuccessful treatment or “do-it-yourself” techniques is the development of erectile dysfunction. When the focus is on heightening awareness and pleasure, erectile functioning is not subverted. When arousal is decreased or self-consciousness raised, erectile problems or inhibited sexual desire are a likely outcome.

Erectile Dysfunction

With the introduction of Viagra in 1998, there has been a paradigm shift in the assessment and treatment of erectile dysfunction (ED) (Segreaves, 1998). The medical and lay public now view ED as a physical problem and Viagra (or the two other preerection medications: Levitra and Cialis) is considered the first-line intervention. Further assessment is typically undertaken only if Viagra is unsuccessful. Moreover, Viagra is usually prescribed by a family practitioner or internist rather than a sexual specialist.

Viagra is the first user-friendly medical intervention; it is much easier to accept taking a pill than to use an external pump, penile injection, MUSE (medicated urethral system for erections), or penile prosthesis. It has heightened public awareness of the ED frequency and ED as a side effect of surgery, illness, and medications, especially for men over 50. However, Viagra has resulted in the medicalization of male sexuality.

Althof (2003) stressed the crucial role of the sex therapist in assessing, treating, and motivating partners to integrate Viagra into their lovemaking style. McCarthy and Fucito (2005) have discussed the therapeutic and iatrogenic uses of Viagra and proposed an assessment/intervention approach that emphasizes couple sex therapy.

Erection is not solely a male concern, separate from the couple’s experience. Viagra promises a return to the autonomous male model with predictable sex, while downplaying the woman’s sexual feelings and role. Metz and McCarthy (2004) have presented a couple psychosocial model that emphasizes intimate, interactive sexuality, with a focus on pleasure and satisfaction. Marital sex may not be as frequent or intense as premarital sex, but quality, pleasure, and satisfaction can increase with time and age. A major transition for middle-aged and older males is being open to partner involvement and penile stimulation to enhance arousal and erection.

The frequency of at least mild ED for males over 50 is estimated to be more than 50%. ED is a multicausal, multidimensional phenomenon, with wide individual and couple differences. The simplistic “organic versus psychological” dichotomy of causation is recognized as scientifically invalid and therapeutically unproductive. The present folklore suggests that 95% of erection problems are caused by physical factors, is no more valid than the past folk wisdom that 90% of erection problems were caused by psychological or relational factors. Prostate surgery, poorly controlled diabetes, and spinal cord injury usually cause organic deficits. But even in a couple affected by such a disorder, an examination of psychological, relational, motivational, and psychosexual skills/factors is important to integrate Viagra or other medical interventions successfully into the couple’s lovemaking style. When the man gets firm erections during masturbation, oral sex, sex with a partner other than his spouse, or a fetish arousal pattern, use of Viagra is unlikely to be successful and may be iatrogenic, because the core psychological and relationship problems are ignored.

The recommended assessment/intervention strategy is couple sex therapy, with a medical assessment of vascular, neurological, and hormonal functioning. Common health factors that interfere with erections are drinking, smoking, and drug abuse. In the individual sexual history, it is cru-
cial to obtain an honest assessment of situations in which the man is functional. Being able to flag sensitive or secret material encourages honest reporting. A common pattern is that the man attains erections while masturbating, viewing pornography, or engaging in cybersex; in an affair (whether with a man or a woman); or in a variant erotic scenario with a prostitute. This information is vital in constructing an intervention strategy. The man who does not obtain an erection by any means requires a thorough medical assessment. The clinician assesses whether a desire problem preceded or followed the erection problem. A sexual secret—whether an affair, variant arousal, compulsive masturbation, or a sexual orientation issue—needs to be carefully explored for both function and meaning.

A question to explore during the woman’s history taking is how she felt about sexuality before the ED began. How has the problem affected her sexual desire and arousal? In many cases, she blames herself for the erection problem (attributing it to her weight gain, lack of erotic skills, or his boredom with the relationship) and/or sees it as a symbol of loss of love. In other cases, the woman has resented the man’s sexual attitudes and behavior for years and is secretly glad he is not able to have erections and intercourse. In still other cases, the woman is hostile or verbally abusive about the ED. In contrast, a woman may be pleased, because the partner now devotes time and energy to pleasing her. The woman’s attitudes and feelings both before and since the ED are carefully assessed. ED makes some men more open to receiving and giving sensual and erotic stimulation. Unfortunately, most males with ED avoid any affectionate or sexual contact, so that they do not have to face “the embarrassment of erectile failure.” The arousal–erection guidelines in Table 21.3 are given to the couple as a handout.

The paradigm shift in the conceptualization of ED is more than the medicalization of the penis. It views erections as primarily, if not solely, the male’s domain. In contrast, sex therapy emphasizes the one–two combination of personal responsibility and the couple functioning as an intimate team. In selected couples, Viagra is used during genital pleasuring exercises. A healthy cognition is that Viagra is an additional resource to facilitate maintaining an erection. With genital pleasuring exercises, it is important to reinforce the necessity of erotic stimulation to facilitate erection (it does not automatically occur because of Viagra) and the wax-and-wane exercise (when erotic flow is interrupted, the erection decreases, and it recurs with relaxation and stimulation). This reinforces for both partners that it is not just the pill that works magically; intimacy, pleasuring, and eroticism matter. This experience facilitates the integration of Viagra into the couple’s lovemaking style.

Therapeutic gains made with Viagra must be generalized and maintained. The partners can use Viagra as a backup resource should they have a series of unsuccessful intercourse attempts. As in the treatment of female sexual dysfunction, we encourage the male to use self-stimulation in conjunction with partner stimulation. Many males are embarrassed to touch themselves when a partner is present—an inhibition that can be successfully confronted.

Exercises (Metz & McCarthy, 2004) are designed to rebuild comfort and confidence with arousal and erection. The cognition of “intercourse as a special pleasuring technique” is a significant change. This flexible, variable conceptualization of the “good enough sex” model is more easily accepted by the woman than by the man. Traditional male sexual socialization, cultural norms, urologists, and the media emphasize that “real sex is intercourse” and “intercourse is the only measure of treatment success.” However, intercourse as the rigid 100% performance criterion is self-defeating.

A positive, realistic conceptualization is that intimacy, pleasure, and eroticism flow to erection and intercourse in about 85% of experiences. When intercourse does not occur, the couple can comfortably make a transition to one of two alternative scenarios—a sensual, cuddly scenario or an erotic, nonintercourse scenario resulting in orgasm for one or both partners. Whether erectile problems occur once a year or once a month, it is normal to have occasional dissatisfying or dysfunctional sexual experiences. If this fact is not accepted, a man is “one failure away from square one.” Clinging to the adolescent expectation of easy, automatic, 100% predictable erections is self-defeating. Even when using Viagra each time, men cannot live up to such perfectionistic criteria (McCarthy & Metz, 2007).

Hypoactive Sexual Desire Disorder

For the great majority of males, HSDD is a secondary dysfunction. HSDD affects approximately 15% of men and increases with age. The most common cause is another sexual dysfunction (ED or ejaculatory inhibition) that becomes chronic and severe over time. The man becomes stuck in the
TABLE 21.3. Arousal and Erection Guidelines

1. By age 40, 90% of adult men experience at least one erectile failure. This is a normal occurrence, not a sign of ED.

2. ED can be caused by a wide variety of factors, including alcohol, anxiety, depression, vascular or neurological deficits, distraction, anger, side effects of medication, frustration, hormonal deficiency, fatigue, or not feeling sexual at that time or with that partner. As men age, the hormonal, vascular, and neurological systems become less efficient, so psychological, relational, and psychosexual skills factors become more important.

3. ED is a psychosocial problem with multiple causes, dimensions, and effects. To evaluate medical factors comprehensively, including side effects of medication, consult a urologist with training in erectile function and dysfunction.

4. Medical interventions, especially the oral medications—Viagra, Cialis, Levitra—can be a valuable resource to facilitate erection function, but they are not magic pills. The partners need to integrate the medical intervention into their lovemaking style of intimacy, pleasing, and eroticism.

5. Do not believe the myth of the male machine, ready to have intercourse at any time, with any woman, in any situation. You and your penis are human. You are not a performance machine.

6. View the erectile difficulty as a situational problem. Do not overreact and label yourself as impotent or put yourself down as a failure.

7. A pervasive myth is that if a man loses his initial erection, then it means he is sexually turned off. It is a natural physiological process for erections to wax and wane during prolonged pleasing.

8. In a 45-minute pleasuring session, erections will wax and wane two or more times. Subsequent erections, intercourse, and orgasm can be quite satisfying.

9. You do not need an erect penis to satisfy a woman. Orgasm can be achieved through manual, oral, or rubbing stimulation. If you have difficulty getting or maintaining an erection, do not stop the sexual encounter. Women find it arousing when the fingers, tongue, or penis (erect or flaccid) are used for stimulation.

10. Actively involve yourself in giving and receiving pleasurable and erotic touching. Erection is a natural result of pleasure, feeling turned on, and getting into an erotic flow.

11. You cannot will or force an erection. Do not be a "passive spectator" who is distracted by the state of his penis. Sex is not a spectator sport. It requires active involvement by both you and your partner.

12. Allow the woman to initiate intercourse and guide your penis into her vagina. This reduces the performance pressure, and because she is the expert on her vagina, is the most practical procedure.

13. Feel comfortable saying, "I want sex to be pleasurable and playful. When I feel pressure to perform, I get uptight and sex is not good. We can make sexuality enjoyable by taking it at a comfortable pace, enjoying playing and pleasure, and being an intimate team."

14. Erectile problems do not affect your ability to ejaculate (men can ejaculate with a flaccid penis). You can relam ejacula-
tion to the cue of an erect penis.

15. One way to regain confidence is through masturbation. During masturbation, you can practice gaining and losing erections, relam ejacula-
tion with an erection, and focus on fantasies and stimulation that transfer to partner sex.

16. Do not try to use a waking erection for quick intercourse. This erection is associated with REM (rapid eye movements) sleep and results from dreaming and being close to the partner. Men try tu vain to have intercourse with the morning erection before losing it. Remember: Arousal and erection are regenerative. Morning is a good time to be sexual.

17. When sleeping, you have an erection every 90 minutes—three to five erections a night. Sex is a natural physiological function. Do not block it with anticipatory anxiety, performance anxiety, distraction, or by putting yourself down. Give yourself (and your partner) permission to enjoy the pleasure of sexuality.

18. Make clear, direct, assertive requests (not demands) for stimulation that you find erotic. Verbally and nonverbally guide your partner in how to pleasure and arouse you.

19. Trying to stimulate your penis when it is flaccid is counterproductive. A man becomes distracted and obsessed with the state of his penis. Engage in sensual, playful, non-demand touching. The basis of sexual response is relaxation and sensuality. Enjoy giving and receiving stimulation rather than trying to will yourself to have an erection.

20. Attitudes and self-thoughts affect arousal. The key is sex and pleasure, not sex and performance.

21. A sexual experience is best measured by pleasure and satisfaction, not whether you had an erection, how hard it was, or whether she was orgasmic. Some sexual experiences are great for both partners, some are better for one than for the other, some are mediocre, and others are unsuccessful. Do not put your sexual self-esteem on the line at each experience. The "good enough sex" model of sexual pleasure is much healthier than the perfect intercourse performance criterion.
cycle of anticipatory anxiety, tense and failed intercourse experiences, and sexual avoidance. Sex becomes an embarrassment rather than a pleasure. Although some men stop being sexual, the majority continue to masturbate, and some develop a secret life of pornography, cybersex, or prostitutes.

Primary HSDD is rare (less than 10% of men) because of the cultural link between masculinity and sexuality, as well as adolescent experiences with masturbation. Sex is viewed as a positive, integral part of being a male. Causes of primary HSDD can range from testosterone deficiency to rigid family or religious antisexual messages. The most common cause is a sexual secret, such as variant arousal pattern (paraphilia), greater confidence with masturbatory sex than with couple sex, not dealing with past sexual trauma, or conflict about sexual orientation. Approximately 2–5% of males have a paraphilia (Abele, Weigel, & Osborne, 2007). Most are benign, involving fetishes, cross-dressing, or cybersex. Noxious (deviant) paraphilias—exhibitionism, voyeurism, pedophilia, obscene phone calls—are illegal, cause trauma to others, and must be vigorously treated.

Conflicts regarding sexual orientation are in a different category. The emotional and sexual commitment to men is an acceptable sexual variation, and is in fact optimal for gay men. The scientific and clinical data strongly support the acceptance of homosexuality as a normal sexual variation, although this remains controversial (especially among conservative political and religious organizations). There is also major disagreement regarding the prevalence of homosexuality. The best estimate is that 25% of males have been orgasmic with a man in adolescence or young adulthood, and 10% have had major sexual involvement with men. Perhaps 4–6% of males have a "homosexual orientation," defined as an emotional and erotic commitment to sexuality with men.

Another subgroup of men with primary HSDD are afraid of sexual failure, have a history of sexual trauma, or are guilty or shameful about sexuality. The majority of primary HSDD involves a substitute sexual outlet rather than an absence of desire. A man with HSDD who attends couple therapy is usually coerced by his partner. His goal is to avoid self-disclosure and therapy. He wants to keep his sexual life secret from his partner, as well as the therapist. Partner sex usually results in dysfunction, leaving him feeling embarrassed and defeated. It is crucial that the therapist be empathic, nonjudgmental, and not coerce the man to be sexual. The man feels alone and deficient; sexuality is his "shameful secret." The therapist’s empathy and understanding of how the problem has developed and is maintained constitute a valuable intervention.

The man usually feels that his partner is his worst critic rather than an intimate sexual friend. The woman’s role in assessment and treatment is crucial. She feels bewildered and rejected as a result of his HSDD and avoidance. Underneath the anger, she feels hurt, as well as abandoned. It is important to explore whether the woman has a sexual outlet—this could include either masturbation or an affair. Does she experience HSDD herself? If so, did her problem precede or follow the man’s? Is the woman motivated to be an active, involved partner? Her sexual desire and arousal can facilitate the man’s desire and arousal.

Male HSDD, whether secondary (usually linked to a dysfunction) or primary (usually caused by a sexual secret), is one of the most difficult problems to treat. A common sexual secret is that the man is engaged in an affair he is unwilling to give up. An active affair is a contraindication for couple sex therapy. Affairs require time and energy. Couple therapy typically fails when there is an active affair, primarily because the man lacks the motivation and focus to confront his HSDD in the marriage.

The presence of a sexual dysfunction does not necessarily make couple sex therapy the treatment of choice. Severe individual problems, such as untreated alcoholism, bipolar disorder, or panic disorder, can subvert sex therapy. Severe relationship distress (including partner abuse, lack of respect or trust, or conflict over money or children) can sabotage couple sex therapy. Traditionally, individual and/or couple therapy for such problems was recommended before proceeding with sex therapy. This decision requires high levels of clinical judgment, because the danger, especially with male HSDD, is that sexual avoidance becomes more severe and chronic. Rather than the traditional hierarchical model (treat alcoholism or depression first, relationship or communication problems second, and only then, sexual problems), we advocate a "both-and" therapy approach of addressing alcoholism and sexual issues in an integrated couple approach.

In successful treatment, each person develops bridges to sexual desire. The woman’s responsiveness serves to reignite the man’s sexuality (Mc-
Carty, 1995). The man usually has an unspoken wish to return to the "good old days" when he was the sexual initiator and expert. However, this is self-defeating. Strategies and techniques for treating male HSDD are similar to those for treating female desire problems, but with a somewhat different focus. The permission-giving element is for the man to find a new "sexual voice" that emphasizes intimate, pleasure-oriented sexuality. Males are encouraged to use both internal and external cues to enhance sexuality, including fantasies; erotic stimuli, such as X-rated videos; elaborate and intricate pleasuring scenarios; multiple forms of stimulation during intercourse, and erotic non-intercourse scenarios. The man is encouraged to be aware of the multiple positive functions of sexuality for himself and the relationship.

Married men who have a secret life with prostitutes, compartmentalized affairs, cybersex, or compulsive masturbation are asked to assess carefully whether any elements of those experiences can be generalized to marital sexuality. Traditionally, the man's wife is kept in a circumscribed role. As one male said, "Since I pay the prostitute, it's her role to turn me on." His wife said, "I don't need your money, but I do need you to be there, open to my touch, and willing to share intimacy." The major aphrodisiac is an involved, aroused partner.

**Ejaculatory Inhibition**

Ejaculatory inhibition (EI) is the least common and most misunderstood male dysfunction. Usually the man can ejaculate with masturbation, and some man can ejaculate with manual or oral stimulation, but not during intercourse (or only rarely). Among young males, EI is mistakenly envied because the man is thought to be a "stud" whose lasting power ensures that the woman has an orgasm during intercourse. EI is frustrating for both the man and woman. The typical pattern is that he gets an erection and quickly proceeds to intercourse, but his level of subjective arousal is low and intercourse is not erotic. By thrusting mechanically, he hopes finally to "come." Most women find that after 15 minutes of thrusting, arousal and lubrication wane. Intercourse becomes emotionally frustrating and physically irritating. Nonerotic intercourse is not pleasurable for either partner.

The most common pattern is that men over 50 develop intermittent EI that is the result of reduced eroticism during intercourse. For males in their 20s, it is easy (often too easy) to reach orgasm; this is not true for males in their 50s. Thrusting alone is not enough. The man is stuck in the performance myth that a real man does not need additional erotic stimulation to reach orgasm. Once again, the key to successful treatment is for both partners to value intimacy, interactive sexuality. More specifically, the man requests multiple forms of stimulation before and during intercourse and utilizes "orgasm triggers" (Men & McCarthy, 2007b). Ejaculation is a natural result of high arousal, so the couple collaborates to increase subjective arousal. The woman's responsiveness and arousal reinforce the man's arousal. An important technique is delaying the onset of intercourse until the man is highly aroused. Traditionally, a man begins intercourse as soon as he achieves an erection, even if his subjective arousal level is 2. He is advised not to make the transition into intercourse until his subjective arousal level is a 7 or 8. Intercourse requires verbal and nonverbal communication, as well as an emphasis on the reciprocal effect of partner arousal and multiple forms of stimulation throughout the sexual experience. The technique suggestion is to utilize multiple forms of stimulation during intercourse and orgasm triggers (learned from masturbation) at high levels of arousal.

**CASE ILLUSTRATION**

This was the first marriage for 32-year-old Jeb and the second marriage for 31-year-old Maria. She was the custodial parent of her 8-year-old son from her previous marriage. Jeb had established a very good stepparent relationship with the boy, and both Jeb and Maria wanted another child.

It was Maria who called for the initial appointment. She and Jeb had been a couple for almost 4 years, lived together for over 3 years, and had been married for 15 months. Maria was considering leaving the marriage due to disappointment and frustration over their sexual relationship. Her dilemma was whether to become pregnant and then leave or to tell Jeb about her intense unhappiness and attempt to save the marriage. In the initial telephone consultation, the therapist urged Maria to set up the first appointment as a couple and engage in a four-session assessment process. Maria had four previous experiences with counseling therapy, none of which she had found personally helpful. However, five couple counseling sessions, 1 year earlier, had helped Jeb accept that he would
not be able to adopt Maria's son, because the biological father wanted to maintain parental rights. Maria's first therapy experience had been six sessions at a college counseling center. Her second experience had been a structured group program to fulfill requirements for a DUI (driving under the influence) program when she was 22. The third was a weekend retreat, followed by three couple sessions with the minister who had married Maria and Jeb.

At the first couple session, Maria and Jeb presented as a demoralized, alienated couple. It was clear that Jeb blamed himself for all the marital and sexual problems. However, Jeb very much wanted the marriage to work, and he also wanted a successful four-person family. He was aware of Maria's dissatisfaction and feared that she would leave him. Maria said she recognized that Jeb was a good person who had a successful career and was a wonderful stepfather. However, she was bitterly disappointed with their failed sexual relationship and felt that she could not accept this for the next 50 years. Maria had said to Jeb, "You're a good guy and good husband, but a sexual loser." Jeb accepted all the blame and said he would do anything to change, despite the fact that he was clueless regarding ways to improve their sex life. The last time they had tried to have sex, on their anniversary, 7 months earlier, Maria had had no desire and was very upset by Jeb's premature ejaculation.

The advantage of conducting the first session with both partners is that it sends a powerful and positive message about addressing marriage and sexual problems as a couple. It gives the clinician an opportunity to see how the partners interact, how they have previously attempted to address the problem, so that they do not repeat the same mistakes, as well as how motivated they are to address problems as an intimate team. At this session, the partners are asked to fill out a release of information form(s) to send to past and present individual therapists, psychiatrists, couple therapists, and ministers. The release of information form should mention that these individuals will be contacted within the next week. Waiting for a written report is like "waiting for Godot." Professionals will respond by phone, not in writing. It is important to hear other professionals' assessments of the individual and couple, their evaluation of the intervention, and suggestions about how to deal with the couple. It is fascinating to compare the couple's evaluation of the intervention with that of the professional.

The therapist usually ends the initial session by assigning the couple a short reading (no more than 20 pages, preferably 10) to reinforce the concept of each person taking responsibility for his or her sexual behavior and working as an intimate team member to resolve the problem. The reading does not cure problems, though it can help to reduce stigma and set reasonable expectations regarding the process of change.

The next step in the four-session assessment model is to interview each spouse separately regarding psychological, relational, and sexual history. The history begins with the following statement:

"I want to understand your strengths and vulnerabilities both before this marriage and within the marriage. I want you to be as blunt and forthcoming as possible. At the end, you can 'red flag' any sensitive or secret material, and I will not share it without your permission. However, I need to know this information in order to be as helpful as possible in resolving these problems."

Jeb had the first appointment and was extremely anxious and apologetic about himself, particularly regarding sexuality. Jeb had a lifelong problem of premature ejaculation, as well as a fetish arousing pattern to women's boots. Almost all of his sexual encounters had occurred when he was drinking heavily (Jeb needed "liquid courage" to be sexual). At the age of 23, Jeb had a particularly humiliating experience with a woman who said that he was "a pathetic excuse for a lover." Until he met Maria at 28, Jeb had avoided relational sex, engaging only with women he met at a bar. Jeb had wanted to get married and have children, and he felt that Maria was exactly what he needed. She was bright, attractive, prosexual, an excellent single parent, and interested in marriage and having another child. Her promiscuity, prosexual attitude quickly won Jeb over. They began living together 6 months after they met, and everything seemed on track except the issue of premature ejaculation. Although it was a celebratory wedding with much support from family and friends, Jeb was aware of Maria's sexual disappointment and greatly reduced sexual desire. He felt worried and embarrassed, and retreated into Internet sex sites focused on the boot fetish. At the time of the interview, he was spending about $1,000 a month on cybersex. Jeb felt shameful and desperate, and was overwhelmed
with the fear that Maria would leave him. Jeb originally wanted to “red-flag” his past and present sexual issues, especially the alcohol use and boot fetish. However, with some gentle prodding, he was willing to share this material during the couple feedback session. Jeb idealized Maria, put her on a pedestal, and was convinced that she had no psychological, relational, or sexual vulnerabilities.

The individual history conducted with Maria presented a very complex and ambivalent picture regarding sex and the marriage. Maria revealed several substantial strengths. She was smart, extroverted, prosexual, resilient, and an excellent single parent, with a strong desire for another child and a genuine respect and fondness for Jeb. However, she also revealed some notable vulnerabilities, including poor marital and sexual models; high sexual desire early in a relationship, giving way to disappointment in the man, resulting in HSDD; disappointment in Jeb and seeing him as a “sexual loser”; and the belief that their marriage was not viable. In addition, shortly after she became pregnant, Maria’s first husband had revealed that he was gay, which reinforced her sensitivity about hidden agendas and disappointments. Maria had had three affairs since her marriage to Jeb, including “hookups” with two old boyfriends and an ongoing compartmentalized affair with a coworker. With a great deal of trepidation, Maria agreed that these sensitive/secret issues needed to be shared and processed if there was any chance of revitalizing trust and sex in the marriage.

The 90-minute couple feedback session began with a description of Maria’s strengths and vulnerabilities. This was purposeful, to challenge Jeb’s perception that he was the entire problem. They needed a new “her–his–out” narrative that was not only genuine but also motivating and hopeful. Maria felt relieved to have this information “on the table.” She committed to using birth control to prevent pregnancy as they tried to rebuild their marriage and marital sexuality. She also committed to ending the work affair and to being transparent with Jeb. Most of the material that Maria shared was new to Jeb, and had the beneficial effect of taking Maria off the pedestal and presenting the sex problems as a couple issue. This information, including disclosure of extramarital involvement, was now open for processing as the couple therapy progressed. It was neither denied nor made the most important factor in the couple’s relationship.

Jeb was very concerned about Maria’s reaction to his history of performance anxiety, dependence on alcohol for sexual confidence, and misuse of funds for the Internet fetish site. In fact, Maria increased her understanding and empathy for Jeb’s sexual struggles and was touched to hear how motivated he was to turn around the marital and sexual pattern. Jeb agreed to move the computer to the family room and to install an “Internet nanny” to block the fetish site. In addition, Jeb agreed to have no more than one drink before sex and to focus on learning psychosexual skills, especially for ejaculatory control.

Maria and Jeb were relieved that all of the issues were now clear. They would need to continue to process this material, because these were difficult issues. However, they were no longer afraid that “another shoe would drop.” They were motivated and made a 6-month “good faith” commitment to revitalize their marriage and build a new couple sexual style.

The first homework “exercise” was to find at least one (preferably two) “trust position” to which they felt physically connected and safe. In subsequent psychosexual skills exercises, if either person became anxious or had a negative experience, he or she could use the “trust position” as a method to regroup. This exercise also served to begin rebuilding their couple trust bond.

In ongoing couple sessions, the first focus was to do a fine-grained analysis of the positive and negative attitudes, behaviors, and feelings the partners experienced during the exercises (ideally two or three) over the past week; the second focus was on their developing couple sexual style, and the role of intimacy and sexuality in their relationship, then discussing exercises and areas of focus for the coming week. Initial exercises focused on rebuilding sexual desire (comfort, attraction, trust, and each person’s sexual scenario). For Jeb, the key was to stop apologizing for himself sexually and to stop avoiding touching and sexuality. Subsequently, they focused on Jeb learning ejaculatory control. For Maria, the focus was on rebuilding positive anticipation and a sense of deserving, so that sex might play a positive 15–20% role in the marriage. It was crucial that they value an integrated intimacy and eroticism, and confront disappointments and turn-offs.

Couple sex therapy involves four clients: each individual, the relationship, and the sexual relationship. It is an individualized, complex endeavor, and Maria and Jeb required the therapist to be actively involved to keep them motivated and focused. The trap for Maria was to become frustrated, disappointed, and critical. For Jeb, it
was to become anxious, apologetic, and to focus on performing for Maria rather than sharing pleasure with her. Therapy sessions began on a weekly basis and after six sessions switched to biweekly sessions, for a total of 18 couple therapy sessions.

The most important couple exercises involved developing "his," "hers," and "our" bridges for sexual desire. For Jeb, the key for ejaculatory control was learning self-entrapment arousal, slowing down the sexual process, and doing circular thrusting from the woman-on-top intercourse position. For Maria, the issue was less about exercises and psychosexual skills, and more about trusting and valuing intimate, interactive couple sex.

Developing a relapse prevention program was a crucial therapy component for the couple. Jeb had to learn to make sure that a "lapse" did not turn into a "relapse." He had to accept that whether it occurred once a month or once a year, it was all right if he ejaculated rapidly. He did not need to apologize or worry.

Maria was now 4 months pregnant and needed Jeb's encouragement to "beat the odds" and maintain a healthy sexual relationship throughout the pregnancy. They learned to utilize the sitting/kneeling intercourse position for the third trimester and liked the position so much that it became a regular part of their sexual repertoire.

Maria and Jeb made an up-front agreement to prevent future extramarital affairs (McCarthy & McCarthy, 2003). Maria shared her personal vulnerabilities with Jeb, including how powerfully validating it was when a man came on to her. She shared how erotic she felt in a new relationship, particularly if life was boring or depressing. Maria agreed to talk to Jeb if there was a high-risk person or situation, rather than acting out the sexual impulse. Maria and Jeb had worked hard to build a functional, satisfying couple sexual style. They wanted to enjoy it, not to risk destabilizing the marriage or marital sex.

Jeb particularly valued the 6-month "check-in" sessions, which extended over a 4-year period (which is unusual; the norm is 2 years). At each follow-up session, they would set a new sexual goal for the next 6 months. Maria emphasized getting away as a couple, without the children, whether overnight or for a week, to revitalize their couple and sexual bond. Jeb emphasized adding something to their sexual repertoire, such as trying a new intercourse position; a new, sensual lotion; or being sexual in the shower. Jeb reveled in the role of confident, sexual husband.

**OTHER CLINICAL ISSUES**

**Relapse Prevention Strategies and Techniques**

Relapse prevention is often ignored in psychotherapy, including sex therapy. Metz and McCarthy (2004) have argued that relapse prevention strategies and techniques should be an integral component of sex therapy. The best prevention strategy is comprehensive, high-quality therapy that helps a couple develop a comfortable, functional sexual style and motivates the partners to maintain and generalize therapeutic gains. A relapse prevention program, like a sex therapy program, must be individualized. Common relapse prevention techniques are to keep the time allotted to a therapy session open, but, rather than attend therapy, have an intimacy date at home; schedule a pleasuring session every 4–8 weeks with a ban on intercourse; design a new sexual scenario every 6 months; and when there is a negative experience, to initiate a sensual or erotic date within 1–4 days. If the couple has not been sexual for 2 weeks, the partner with higher desire initiates a sensual or sexual experience; if that does not occur, the other partner initiates one the next week; if the partners have gone a month without a significant sexual experience, they schedule a "booster" session.

Additional response prevention strategies include the couple agreeing to take a weekend away, without the children, at least once a year. On occasion, the partners are sexual outside the bedroom. Sexuality cannot rest on its laurels; it needs time, attention, and energy. Perhaps the most important relapse prevention technique is establishing positive, realistic expectations. People wish that all sex would flow smoothly, yet the reality is that sexuality has natural variability. Among well-functioning, satisfied married couples, fewer than 50% of sexual encounters involve equal desire, arousal, orgasm, and satisfaction. Even more important is the fact that it is normal for 5–15% of sexual experiences to be dissatisfying or dysfunctional (Frank et al., 1978). Rather than seeing this as a source of panic or embarrassment, the couple can accept normal sexual variability. The best way to react to a negative, dysfunctional, or disappointing experience is to view it as a "lapse" and actively prevent it from turning into a "relapse." The strategy is to return to being sexual in 1–4 days, when both partners feel open, awake, and aware, anticipating a pleasure-oriented experience. There are specific "traps" to be aware of for each sexual dysfunction, so a relapse prevention program for ED (McCar-
thy, 2001) will have different components than a relapse prevention program for HSDD (McCarthy, Ginsberg, & Fucito, 2006).

**Sex Therapy with Gay and Lesbian Couples**

There are more data and clinical discussions of gay male sexual dysfunction than of lesbian sexuality. Rosser, Metz, Bockting, and Buroker (1997) suggest that more than 50% of gay men experience a sexual dysfunction or dissatisfaction. Rates of ED and EI appear to be the same or higher for gay versus straight men, with lower rates of premature ejaculation and HSDD. In Chapter 24, this volume, Green discusses couple therapy with gay and lesbian clients. A particular issue for same-sex couples is the relational context of sex. Is there a committed, monogamous relationship, or a loosely bonded, open relationship? Sexually open relationships were formerly widely accepted as healthy for gay couples (McWhirter & Mattison, 1984), but this concept has become questionable because of STD/HIV risks, as well as relationship instability.

Clinical guidelines require a commitment to monogamy during the course of sex therapy, although there is no empirical evidence to support it. The agreement to be monogamous during therapy is not because of moral issues; rather, couple sex therapy requires a time commitment and focus that would be subverted by extrarelationship involvement. An advantage gay men have is freedom to utilize a variety of erotic techniques—self-stimulation, erotic videos, one-way sexual scenarios, use of prorection medications, use of anal stimulation, and a proerotic value system (Nichols & Shennoff, 2007). Issues that interfere with treatment are comparisons with other partners; comparison with the stereotype of hot, problem-free sex; lack of commitment to work through difficult relationship and intimacy issues; pressure to perform for the partner; the assumption that if chemistry is present, than sex should be easy; and intimacy or erotic inhibitions.

A common issue for gay male couples involves high desire for recreational sex, but inhibited desire for intimate, interactive sexuality. In the therapy session, it is important to explore initiation patterns, erotic scenarios, affection outside the bedroom, and the meaning of couple sexuality. A particularly difficult issue is that of HIV/AIDS and safer sex. Will the partners jointly do an STD screen and HIV test? Will they commit to monogamy? If there is an incident of extrarelationship sex, will the man tell the partner and use condoms for 6 months until retesting?

Sexual exercises need to be modified and individualized for gay couples, but the basic format is transferable. However, pleasuring concepts might not be easily accepted. The combination of traditional male and traditional gay focus on goal-oriented sex (i.e., orgasm) has resulted in deemphasizing the importance of intimacy and pleasuring, though these can be of great value in a gay relationship. Of particular importance are comfort with and responsiveness to manual, oral, anal, and rubbing stimulation. In being specific about behavior and feelings, a common inhibition is challenged—"Gay men do it, they don't talk about it."

Awareness of the frequency of sexual dysfunction and dissatisfaction allows the partners to "normalize" their experience. The concept that being gay is optimal, and that each partner deserves to feel desire, arousal, orgasm, and satisfaction is a powerful antidote to internalized heterosexism and the sense of gay sex as "bad but exciting." There are few outcome data on the effectiveness of sex therapy with gay male couples (MacDonald, 1998).

There is even less scientific and clinical information on sex therapy with lesbian couples. Typically, lesbian couples seek out a female therapist. The most common complaint is HSDD. More lesbian women than straight women have a multiorgasmic response pattern. This is hypothesized to be the result of greater awareness of female sexual response and use of cunnilingus.

With lesbian couples, there is less fear of STD/HIV, as well as freedom from fear of pregnancy. Some clinicians hypothesize that an over-emphasis on cohesiveness at the expense of autonomy and initiation is a core factor in HSDD. Others hypothesize that traditional female socialization dampens sexual initiation and eroticism. Being overly solicitous of the partner's feelings and caretaking can inhibit desire, initiation, and eroticism. Sexual exercises encourage partners to take responsibility for their own sexuality and work as an intimate team to develop a comfortable, functional couple sexual style. Lesbian sexuality is facilitated by the cognition that each partner has a right to her "sexual voice." Issues of initiation and "bridges to desire" are particularly important. Each partner is encouraged to develop her bridges, and to realize that these do not need to be shared bridges.
A special emphasis is placed on exploring a level of intimacy that promotes sexual desire and initiation, taking turns initiating, exercises that emphasize pleasuring and eroticism, and promoting an erotic flow in which each person's arousal plays off that of the partner. The couple can experiment with focused versus multiple stimulation; pleaser-recipient format versus mutual stimulation; one-way sex versus interactive sex; and manual, oral, rubbing, and vibrator stimulation. Traps of self-consciousness, not wanting to outperform the partner, tentativeness, and spectatoring are confronted.

**Therapy with Unmarried Couples**

Perhaps the best way to break up nonviable, unmarried partners is to put them in sex therapy; that is, the focus on intimacy and sexuality will destroy a fragile relationship. Rates of sexual dysfunction are higher in unmarried couples (in which the partners have been together more than 2 years) than in married couples.

Unmarried couples have a right to have their problems addressed. A therapeutic contract that focuses on mutually agreed-upon goals is crucial. For some, the assumption is that resolving the sex problem will result in marriage. For others, the sexual dysfunction is primary or chronic, and the man wants the partner to be a sexual friend, with the expectation that the relationship will last at least until the sexual dysfunction is resolved. The meaning of intimacy and commitment needs to be carefully explored, as well as the motivation for addressing the problem. For example, a divorced couple came to therapy to address the man's ED. The woman's motivation for therapy was guilt, because she had left him for another man. His motivation was to perform so well that she would return to the marriage. In that case (and others like it), couple sex therapy can be an iatrogenic intervention.

Couple sex therapy is an appropriate intervention when an unmarried couple experiences a sexual dysfunction that subverts satisfaction, and the partners are motivated to address the problem jointly. Rates of dysfunction, especially HSDD and nonsexual relationships, are higher. There has been little empirical support for the "commonsense" hypothesis that suggests the sex problem is caused by ambivalence and lack of commitment. Common causes are anticipatory anxiety, performance anxiety, lack of sexual awareness, poor psychosexual skills, unrealistic performance expectations, and low-quality sexual communication. The couple and therapist need to decide whether to focus on sexual dysfunction or to look broadly at attitudes, values, and emotional intimacy.

The couple is cautioned not to treat sex therapy as a test for a marriage. In other words, successful resolution of the sexual dysfunction does not mean that persons are viable marital partners. The person with the dysfunction does not owe the partner for his or her sexual help, nor is the opposite true. Moreover, an unresolved sexual problem does not mean that a couple cannot marry; sexuality is but one area of the relationship. There are no empirical data on therapy outcome and the decision to marry. Our clinical experience is that the majority of unmarried couples who attend sex therapy do not marry.

The successful resolution of the sexual dysfunction improves the relationship, but the partners' decision to commit to sharing their lives involves a very different dimension. In other cases, a breakdown in the sex therapy is often attributable to a relationship that is not viable. An example of the first type of outcome was a woman with primary nonorgasmic response, who learned to engage in self-stimulation to orgasm, then be orgasmic with partner sex. Although they had an intimate friendship and both partners enjoyed the relationship, religious, political, and life organization factors made it clear that this was a better dating relationship than a marriage. An example of the latter situation was a man with premature ejaculation, who was contemptuous of his depressed, professionally underfunctioning girlfriend, although she was a prossexual, responsive partner. Engaging in couple therapy and processing exercises was enough to highlight their incompatibilities and resulted in the termination of their cohabitating relationship. He continued individual sex therapy with a focus on masturbation training, guided imagery, and discussion about choosing a woman he trusted and found attractive, and with whom he was comfortable.

Women without partners can benefit from female sexuality groups. Sexuality groups for men without partners have been difficult to organize. Individuals with sexual dysfunction benefit from interventions that include exploring sexual history; masturbatory training; relaxation and guided imagery; establishing conditions for good sex; dealing with sexual health and contraception; setting positive, realistic sexual expectations; and choosing an appropriate partner.
Couple Sex Therapy When There Is a History of Sexual Trauma

The conceptualization, assessment, and intervention with persons who have undergone sexual trauma involve some of the most complex and controversial issues in mental health. The major types of sexual trauma are childhood sexual abuse, incest, and rape. Negative sexual experiences can be broadly defined to include dealing with an unwanted pregnancy, having an STD, experiencing a sexual dysfunction; being sexually humiliated or rejected; guilt about masturbation; shame or confusion about sexual fantasies; being exhibited to or peeped on; receiving obscene phone calls; or being sexually harassed. Negative, confusing, guilt-inducing, or traumatic sexual experiences are almost universal phenomena for both women and men, whether they occur in childhood, adolescence, adulthood, or old age. The model espoused by trauma theorists and therapists has emphasized dealing with the trauma and its aftereffects first, then, once these are resolved, focusing on couple sexual issues. The problem with this "benign neglect" strategy is that the longer the sexual hiatus, the stronger the cycle of anticipatory anxiety, tension-filled sex, and avoidance. Sexual avoidance reinforces anxiety and self-consciousness.

An alternative strategy proposed by Maltz (2001), and supported by McCarthy and Sypeck (2004), is to challenge the couple to be "partners in healing." A traumatized individual who is able to experience desire, arousal, and orgasm, and to feel intimately bonded, has taken back control of his or her life and sexuality. The person is a proud survivor, not a passive or angry victim. He or she accepts the adage "Living well is the best revenge." The partner plays an active role in the healing process; sexuality is voluntary, mutual, and pleasure-oriented. If the traumatized person vetoes something, the veto is respected and honored (i.e., the opposite of sexual abuse). A crucial concept is that one cannot say "yes" to sex until one is able to say "no."

The PLISSIT Model and Prevention

Azrin (1974) has suggested an intervention model with four levels of clinician involvement. PLISSIT stands for "permission-giving, limited information, specific suggestions, and intensive sex therapy." Ideally, all couple therapists are aware of and comfortable with being permission givers, and provide accurate prosexuality information to individuals and couples.

Permission giving entails an accepting attitude toward sexuality as a positive component in the individual's and couple's life. Affectionate, sensual, and erotic expression is valued as a shared pleasure, a means to develop and reinforce intimacy, and a tension reducer to deal with the stresses of marriage and life. The clinician is comfortable and encouraging, so that the couple can explore erotic scenarios and techniques, as well as the meaning of intimacy and sexuality. The permission-giving therapist does not approach sexuality with benign neglect; sexuality is treated as a positive, integral component of the person's and couple's life. The clinician takes a prosexuality stance, not a neutral, value-free stance. The therapist is aware of and respects individual and cultural differences, while working within the couple's values system. The therapist acknowledges the integral role of sexuality in a relationship. A powerful permission-giving intervention is a consultation with a minister of the couple's faith, because almost all religions are prosexuality in terms of marriage.

In the limited information component, the therapist provides accurate, scientifically valid information about biological, psychological, and relational aspects of sexual function and dysfunction. He or she helps the couple to establish positive, realistic sexual expectations. Limited information includes referral to an appropriate subspecialist in dealing with issues such as infertility, diagnosis and treatment of an STD, hormone replacement therapy, or side effects of antidepressant or blood pressure medications. Limited information involves confronting sexual myths, including new myths of sexual performance and pressure to prove that a couple is "liberated." It also emphasizes the importance of developing a couple sexual style that is comfortable and functional for both people. This style includes acceptance that occasional dissatisfaction or dysfunctional sexual experiences are part of normal sexual variability. Contraception and safe sex are other integral components of limited information. Issues of initiation, sexual frequency, erotic scenarios and techniques, and sexual variations are covered. Couple therapists are comfortable with permission giving and limited information on a wide range of sexual topics.

The third component, specific sexual suggestions, is not necessarily part of the repertoire of a couple therapist. Referrals can be made to a sex therapist, physician, or individual therapist. Specific suggestions include pleasuring exercises, with a prohibition on intercourse; experience with initiation and saying "no"; stop—start ejaculatory
control exercises; use of lubricants to facilitate female arousal; the wax-and-wane erection exercise; the use of a vibrator or self-stimulation for female orgasm during partner sex; and openness to afterplay scenarios and techniques.

Specific suggestions involve integrating sexual interventions into couple therapy. This assessment/intervention approach is diagnostic in determining whether couple sex therapy is warranted. Sometimes simply conducting a sexual history clarifies issues and helps to resolve the problem; at other times, it becomes clear that a referral for sex therapy is necessary. Some couple therapists are comfortable, skilled, and interested in integrating sex therapy into their therapeutic repertoires. The majority of couple therapists do not choose to adopt sex therapy as a subspecialty skill; they make a referral to a sex therapist, as they would to any subspecialist. Not every clinician can or should do sex therapy. The mental health clinician may choose to refer to a specialist because of a lack of interest, comfort, training, skill, or if the therapy conflicts with clinical or personal values (Levine, Risen, & Althof, 2003).

Sexual issues and problems are frequent sources of concern for both married and unmarried, straight, and gay couples. The couple therapist can promote healthy sexuality and act in a primary prevention manner by engaging in permission giving and providing personally relevant, scientifically and clinically helpful information. The clinician can engage in a secondary intervention by making specific suggestions to deal with a sexual problem in its acute stage. If a sexual dysfunction is chronic and severe, a referral for sex therapy is the appropriate choice.

**SUMMARY**

Sex therapy is a subspecialty skill. Intimacy and eroticism play a positive, integral role in sexual function and satisfaction. However, when sex is dysfunctional or absent, when there is an extramarital affair, or when fertility problems are present, sexuality can play an inordinately powerful negative role, draining the relationship of intimacy and vitality. Sexual problems are a major force in relationship disintegration and divorce. Couple sex therapy strategies and techniques enhance desire, arousal, orgasm, and satisfaction. The prescription for healthy, integrated sexuality is intimacy, pleasure, and eroticism. The model of each person being responsible for his or her own sexuality, and the couple functioning as an intimate team, is the core concept.

**SUGGESTIONS FOR FURTHER READING**


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