



Sexuality Counseling

Theory, Research, and Practice

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COUNSELING and
PROFESSIONAL IDENTITY



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Chapter 3

General Interventions and Theoretical Approaches to Sexuality Counseling

The way we commonly think about how intimacy and sex work in marriage is only part of the picture.

—Schnarch, 1997, p. 38

When considering how best to address clients' sexuality-related concerns in counseling, it is important to think more broadly about sexuality than is common in society today. As Albert Einstein is quoted saying, "Problems cannot be solved with the same mindset that created them" (Goodreads, 2015). Counselors may draw from a wide range of theory- and practice-based approaches when working with clients to address sexuality concerns. In particular, counselors may adapt sex therapy interventions, presuming they work within the bounds of their competence and training. We begin this chapter with general recommendations for competent sexuality counseling practice. Then, we review a range of intervention approaches and models, followed by treatment strategies for specific sexuality concerns. After reading this chapter, readers will be able to do the following:

- a. Understand general guidelines for conducting sexuality counseling
- b. Summarize a range of approaches to addressing sexuality-related concerns, including medical treatments and counseling interventions
- c. Describe treatment interventions that are used to address specific sexuality-related concerns
- d. Discuss research examining the effectiveness of sexuality counseling treatments

GENERAL GUIDELINES FOR SEXUALITY COUNSELING

Regardless of the treatment approach used, counselors can aim to create a supportive therapeutic environment for addressing the sensitive topics that can arise when discussing sexuality concerns. Toward that end, we offer the following eight general guidelines for sexuality counseling.

1. *Create a Safe, Private Space for Clients.* Sexuality counseling requires a supportive, cooperative context that is fostered by the counselor (Rosenbaum, 2009; Southern & Cade, 2011). It should occur in a space that is private and feels safe for the client to discuss sensitive sexuality-related topics (Juergens, Smedema, & Berven, 2009). Many clients are reluctant to seek treatment for sexual concerns, and in fact, many people with sexual problems don't seek any help at all (Stinson, 2009). Often, clients will feel too embarrassed to bring up sexual dysfunctions or may wait for a clinician to address the topic (Sadovsky et al., 2011). Because so many value-laden issues arise when addressing sexuality concerns, counselors should take steps to ensure that they establish a respectful and supportive climate for clients (van der Kwaak, Ferris, van Kats, & Dieleman, 2010). The earliest sessions of sexuality counseling should focus on building rapport, and therefore, they may not involve the client discussing their sexual concerns in great detail (Goodwach, 2005b). Because each client's perspectives and meaning systems are unique, it is important for counselors to explore and validate clients' meaning systems regarding their sexuality-related problems and experiences (Rosenbaum, 2009). One useful avenue for this exploration is to examine the social influences on those internalized meaning systems (Rosenbaum, 2009). Some other counselor practices that foster a supportive environment for sexuality counseling include demonstrating positive communication skills, conveying a professional demeanor, showing respect for the client's autonomy, providing a physically safe and private location, using active listening skills, and using culturally competent approaches (Hatzichristou et al., 2010; Southern & Cade, 2011).

2. *Incorporate Assessment Findings Into the Treatment Plan.* Sexuality counseling treatment plans should be grounded firmly in data collected through the counselor's clinical assessment of the client (Bartlik, Rosenfeld, & Beaton, 2005; Hatzichristou et al., 2010). The assessment should be comprehensive and consider the interplay between biology, psychological influences, and relational and other social factors (Basson, Wierman, van Lankveld, & Brotto, 2010). Assessment should address relationship problems, as well as other psychological symptoms that may coexist with sexual problems, such as anxiety and depression. Readers can refer to Chapter 2 for additional information about sexuality counseling assessment considerations. When establishing a treatment plan and identifying treatment

goals, it is important to ensure that those plans and goals are consistent with the clients' strengths and priorities that emerge through the clinical assessment.

3. *Consider Different Treatment Formats.* Sexuality counseling requires flexibility with regards to identifying the best treatment format. At different points in treatment, clients may benefit from individual counseling (Althof, 2010), group counseling (Althof, 2010; Basson et al., 2010), and/or conjoint couples treatment. Conjoint treatment is especially useful when sexual concerns are linked to relationship problems (Althof, Lieblum et al., 2005). Sessions may vary within the course of treatment in terms of who is included in sessions. For example, Bartlik et al. (2005) wrote that traditional sex therapy for couples typically began with a conjoint session, then moved to individual sessions for each partner, and then brought the partners back together again for subsequent sessions. Therefore, counselors should discuss treatment format options with clients and cooperatively determine the best format(s) to address the clients' presenting concerns.

4. *Refer for a Medical Evaluation as Appropriate.* Sexual problems may stem from physiological causes (e.g., anatomic or biochemical problems), psychological and relational causes, or a combination of both (Hatzichristou et al., 2010). Therefore, a physical examination should always be a precursor to clinical assessment and treatment when sexual dysfunctions are suspected (Basson et al., 2010; Goldstein, 2007; Goodwach, 2005b; Hatzichristou et al., 2010; Southern & Cade, 2011). Some physiological issues to rule out as potential causes or contributors to sexual problems include hormone levels, other physical health problems, medication side effects, drug and alcohol use, and aging (Southern & Cade, 2011).

Sexuality is an inherently interdisciplinary issue, so counselors must think beyond solely psychotherapeutic approaches to address clients' sexuality concerns (Firth & Mohamad, 2007; Hatzichristou et al., 2010; Jones, Meneses da Silva, & Soloski, 2011; Rosenbaum, 2011). Likewise, there has been a growing push for medical professionals to be more inclusive of psychotherapeutic approaches (Rosenbaum, 2011). In practice, the integration of these approaches can be difficult, so further efforts are needed to ensure that interdisciplinary models to address sexuality concerns are available to meet clients' needs (Rosenbaum, 2011). However, we urge counselors to make efforts to build collaborative relationships with medical professionals in order to provide comprehensive, coordinated treatment for their clients. Additional information about medical treatments for sexual dysfunctions is provided later in this chapter.

5. *Be Comprehensive in Your Approach.* Sexuality is a complex issue that clients experience in many areas of their lives. Clients may enter counseling with a somewhat narrow view of their sexuality concerns, such as focusing on a specific

physiological function. Counselors can help clients explore new dimensions of sexuality so that they can come to view sexuality as a more comprehensive aspect of their lives (Juergens et al., 2009). Sexuality counseling should include a consideration of multiple dimensions of functioning (e.g., medical, individual psychology, relational) (Sadovsky et al., 2011) and address a comprehensive set of topics that are relevant to clients' presenting concerns. Some of the topics that may be addressed depending on clients' unique circumstances are as follows: areas of sexual distress and sexual satisfaction, body image, cultural values, developmental history, emotional components of sexuality, family-of-origin dynamics, gender influences, intimacy issues, masturbation, mental health concerns that impact sexuality, physical health and wellness, prior abuse and other trauma, relational functioning, relationship history, sexual functioning, and spiritual beliefs (Lobitz & Lobitz, 1996; Southern & Cade, 2011; Stephenson & Meston, 2010; Tiefer, 2001; Tiefer et al., 2002). Attention also should be given to clients' readiness to make changes (Southern & Cade, 2011) and may incorporate motivational interviewing techniques. This extensive list of topics underscores the importance of counselors taking a broad view to understanding and addressing clients' sexuality-related concerns.

6. *Address Sexual Satisfaction, Not Just Problems.* Clients may present for sexuality counseling with a focus on problems. They may want those problems to be resolved, but counselors can go beyond merely aiming for problem resolution to helping clients achieve positive sexuality and greater sexual satisfaction in their lives and relationships. The Interpersonal Exchange Model of Sexual Satisfaction (Byers & Macneil, 2006) offers a useful framework for counselors to understand the dynamics of sexual satisfaction within couple relationships. This model holds that there are four main components of sexual satisfaction: (1) how balanced sexual rewards and costs are within the relationship; (2) how those *actual* rewards and costs match up with the person's *expectations* about rewards and costs; (3) how equivalent the rewards and costs are between the partners in the relationship; and (4) how satisfying other, non-sexual aspects of the couple's relationship are.

A series of research studies provides support for the validity of the Interpersonal Exchange Model in Canada and China (Byers & Macneil, 2006). Key findings from these studies have implications for counseling practice to help clients enhance their sexual satisfaction. First, when someone experiences a long-term imbalance between the sexual rewards and costs within their relationship, it's likely their sexual satisfaction will decrease. Thus, counselors can help clients examine this balance within their relationship in order to identify steps to lead to a more favorable balance of more rewards and fewer costs. Second, research suggests that sexual satisfaction is higher when both partners have higher levels of satisfaction, both sexually and within the relationship. This suggests that counselors should address

power and satisfaction imbalances to promote both partners' sexual satisfaction. In other words, if only one partner is satisfied with the couple's sexual relationship, the relationship overall may suffer. Therefore, an intentional focus on enhancing clients' sexual satisfaction—rather than just mitigating distress—can foster treatment progress and enhance clients' relationship outcomes. Additional information about positive sexuality and sexual satisfaction can be found in Chapter 10 of this book.

7. Address Sexuality Concerns Within a Developmental Context. Sexuality is not static over time, and individual and relational development impacts how people experience sexuality and intimacy. In particular, significant developmental transitions can affect individuals' and couples' sexuality. For example, the transition to having children often signals a shift in the role of sexuality in couples' relationships (Trice-Black & Foster, 2011). Even later life brings new developmental challenges related to sexuality, such as relationships following the passing of one's spouse and accepting one's body as it ages (Seeber, 2001). At these transitional points, counselors can help clients re-evaluate and re-establish their sexual identity in relation to the context of their new phase of life (Trice-Black & Foster, 2011).

Changes in sexuality and sexual satisfaction naturally fluctuate over time. For example, up to half of all women may experience low sexual desire during their lifetimes at some time (Mintz, Balzer, Zhao, & Bush, 2012). In addition, Lobitz and Lobitz (1996) suggested that relational intimacy waxes and wanes throughout couples' relationships. Like Schnarch (1997), they suggest that greater emotional intimacy often leads people to feel less safe to take sexual risks, which ultimately may decrease sexual excitement and satisfaction. Lobitz and Lobitz also suggest that couples may go through periods of increased risk-taking, as well as periods of more safe encounters through the process of developing sexually. Sexual problems present opportunities for personal and relational growth (Kleinplatz, 2003). Counselors can help clients take advantage of these opportunities, rather than become discouraged by them. It is useful to maintain a focus on strengths at any developmental phase, so counselors also should address positive emotions and affection between partners, such as love and care (Althof et al., 2005).

8. Apply the Common Factors Framework. In the next section, we discuss a variety of specific sexuality-counseling treatment approaches. Although specific treatment approaches are useful for providing a framework to conceptualize and treat clients, a growing body of research suggests that specific approaches are less influential on treatment outcomes than other common factors that underlie all psychotherapy. Donahey and Miller (2000) applied the common factors approach to sex therapy, arguing that enhancing these factors is more beneficial to treatment than is developing new techniques and theoretical approaches. Donahey and Miller

apply the four common factors contributing to success in general psychotherapy, which involve extra-therapeutic factors, the therapeutic relationship, expectancy effects, and models and/or techniques. In previous research, the specific therapy models and techniques used accounted for only about 15% of the effectiveness of therapy. More influential were the extra-therapeutic factors (which accounted for 40% of change) and the therapeutic relationship (which accounted for 30%). The final 15% is accounted for by expectancy effects (i.e., a placebo).

The sizeable contribution of extra-therapeutic factors provides a reminder to counselors that much of clients' progress toward their treatment goals stems from clients' actions and experiences that occur outside of counseling sessions (Donahy & Miller, 2000). As such, counselors can support their clients in seeking out useful resources and support systems to promote progress between sessions, as well as remind clients that the changes they experience come mostly from their efforts outside of counseling. Likewise, the therapeutic relationship is an important consideration for sexuality counselors. Especially given the sensitive nature of the issues discussed, counselors must be especially mindful of building a strong alliance with their clients to address their clients' sexuality-related concerns. Regarding expectancy effects, counselors should seek to understand their clients' beliefs about what they hope and expect to receive through the sexuality counseling experience. Clients who begin counseling with negative expectations or limited hope that they will change may benefit from motivational interventions, as well as a more intentional focus on positive changes that they experience.

Further highlighting the impact of expectancy effects, Bradford and Meston (2011) studied the effect of a placebo intervention for women experiencing sexual dysfunctions. They defined a placebo as "the outcome of a richly contextualized clinical encounter in which elements other than the presumed active treatment are beneficial" (p. 191). They cited previous research that showed that placebo effects contributed to reduced sexual dysfunctions among women. One possible explanation for the benefit of placebos is that they prompt women to make behavioral changes that are consistent with the changes they desire from the placebo intervention. For example, a woman who expects to see an improvement in her sex life may set aside a greater amount of time for sexual encounters with her partner. Bradford and Meston's study included 50 women diagnosed with female sexual arousal disorder, based on DSM-IV criteria. The women were asked to take the placebo tablet before engaging in any sexual activity during a 12-week treatment time frame. A majority of the participants experienced statistically significant positive changes, and about one-third demonstrated clinically significant positive changes in sexual satisfaction as a result of experiencing the placebo. Although the researchers noted the range of individual variation in responses to the placebo, this study provides a powerful example of the impact of expectancy effects on sexuality-related interventions.

Although specific therapeutic modalities contribute a relatively small percentage to the change that clients experience through counseling, Donahey and Miller (2000) suggest that approaches remain valuable by providing a specific structure and lens for conceptualizing clients' cases and guiding interventions. Therefore, although Donahey and Miller suggest that sexuality counseling is enhanced to the greatest extent by focusing on helping clients change outside of sessions and strengthening the client-counselor relationship, specific treatment modalities are important to understand and utilize in connection with clients' treatment goals. Given the broad range of approaches to sexuality counseling, counselors have a variety of resources at their disposal to be able to incorporate different theoretical approaches and techniques to meet each client's unique needs.

The common factors framework is not a call to abandon theory altogether. Rather, it underscores the importance of delivering theory-based interventions within a context that fosters positive growth by mobilizing the power of the other powerful influences on client change. In particular, counselors can help clients create a supportive environment for change (e.g., by connecting to other resources in the community and fostering additional social support), develop positive expectations about their ability to change, and feel valued and supported within a strong relationship with the counselor. It is in that spirit that we move to the next section, which reviews a range of treatment approaches for addressing sexuality concerns. Before proceeding to that section, however, please read through Case Illustration 3.1, and consider the Reflection Questions to apply the general guidelines presented in this section to a client case.

CASE ILLUSTRATION 3.1

CASE STUDY: APPLICATION OF GENERAL GUIDELINES FOR SEXUALITY COUNSELING

James (age 54) and Sheila (age 53) have been married for 25 years and recently had the last of their three children move out of the home to go to college. The partners report that they are enjoying the extra time they have now that they are "empty nesters," and they've been focusing on reconnecting and re-establishing their relationship with each other. They've been in couples counseling for four months to address relationship concerns that came up during the transition to living on their own again, and they reported to their counselor that they are happy with their progress and feel closer to one another than they did when they first started counseling.

When their counselor suggested that the couple may be getting close to the point of terminating counseling, James became quiet and then said quietly, “There is one other issue that we haven’t talked about yet that I want to address before we stop coming in.” He went on to explain that the couple has not had vaginal intercourse for about 3 years. Sheila shared that they’d attempted intercourse a few times during that period but that James was unable to sustain an erection. Not wanting to create conflict in their relationship, both partners seemingly accepted the lack of intercourse, although James admitted in the session that he would like to be able to regain a sexual relationship with his wife. Sheila admitted that she doesn’t view this as a major concern, but she’s willing to talk about it if James wants to.

Reflection Questions:

1. What steps might the counselor take to maintain a supportive relationship with both clients as they move to addressing sexuality concerns?
2. How do you think the counselor can meet each client’s unique needs and expectations for counseling at this point?
3. In addition to a referral for a medical evaluation, are there other community resources that you would recommend for this couple? If so, what are they?
4. How might developmental transitions be impacting the couple’s sexuality concerns?
5. How do you think you would begin to address this couple’s sexuality concerns? What issues might you focus on first?
6. What other concerns might arise as treatment progresses? How would you address these?
7. What do you think this couple’s prognosis for sexuality counseling is, and why?

REVIEW OF APPROACHES TO SEXUALITY COUNSELING

Historically, there have been three main approaches to sex therapy (Goodwach, 2005a). First, medical approaches, such as Viagra, are used to produce physiological changes to clients’ sexual functioning. Second, cognitive-behavioral therapy focuses on helping clients change their sexual behaviors and beliefs to produce the positive changes they seek. Third, a more systemic and comprehensive approach looks at clients’ sexuality within a broader context of their psychological and relational

functioning. In this last category, scholars have applied a number of theoretical frameworks to addressing sexuality in counseling.

In this section, we aim to familiarize readers with the range of sexuality counseling approaches and interventions that are available. First, we discuss medical treatment approaches, which may be used in conjunction with or instead of counseling. Second, we review cognitive-behavior therapy interventions, including sensate focus exercises, masturbation training, and mindfulness-based counseling. Third, we discuss integrative and other theory-based approaches to sexuality counseling. Then, we provide information about treating specific sexuality concerns and the applicability of unique treatment modalities (e.g., Internet-based treatment). The chapter concludes with a discussion of treatment outcomes in sexuality counseling.

Medical Treatment for Sexuality Concerns

The value of medications to address clients' sexual problems has been hotly debated (Althof, Rosen et al., 2005; Binik & Meana, 2009; Graham, 2007; Kleinplatz, 2003; Pacey, 2008; Rowland, 2007; Winton, 2000). The medicalization of sex therapy has been criticized by some professionals, who argue that the emphasis on medical interventions and understandings overlooks many other important influences on sexuality (Tiefer, 2012). In particular, some scholars believe that women's sexual problems are complex and contextual and therefore are more suitable for psychosocial interventions (Graham, 2007; Pacey, 2008). Overemphasizing the medical aspects of sexuality also runs the risk of devaluing diversity of sexual experiences and expressions (Tiefer, 2012). However, clients often seek, and even may prefer, medical interventions to counseling and therapy, and medical interventions can be used as an adjunct to counseling. Therefore, counselors should be familiar with basic information about medical interventions for sexual problems so that they can assist their clients in understanding all of their available treatment options, as well as be equipped to engage in interdisciplinary collaborations with medical professionals.

Goldstein (2007) proposed a five-step process for addressing sexual health problems in medical practice. First, the nature of the sexual health problem is identified and diagnosed. The second step involves educating the client (with the partner, if applicable) about the diagnosis. Third, any easily reversible causes are addressed (e.g., time-management strategies, stress reduction). Fourth, basic medical solutions, such as medication and devices, may be used. Finally, surgery is considered as a last step if other solutions have not corrected the initial concerns. Counselors can help their clients understand this process and process the possible ramifications of various treatment options.

Medical treatments for sexual dysfunctions may include medication (e.g., Sildenafil citrate or Viagra), herbal remedies (e.g., ginkgo biloba), and surgery (e.g., to repair drainage failures) (Winton, 2000). The dosage of prescribed medications may

need to be adjusted to find the best dose (Sadovsky et al., 2011). One advantage of the medicalization of sexual dysfunctions is that it may reduce the stigma that people feel in seeking treatment (Rowland, 2007). However, medications may have undesirable side effects, such as diarrhea and nausea, and their benefits typically wear off once the medication is no longer taken (de Carufel & Trudel, 2006). Furthermore, medications do not offer guaranteed positive outcomes. For example, Pallas, Levine, Althof, and Risen (2000) defined four categories of “success” that men may experience from using Viagra. First, they may be *cured*, meaning that they use the drug for a limited time, and after that time, they no longer need to use it to maintain an erection for satisfying intercourse. Second, they may demonstrate *drug-dependent success*, which means that they are able to have satisfying sex while using it but not when they haven’t used it. Third, they may experience *drug-dependent erections with new sexual symptoms developing*, such as pain or a desire disorder. And fourth, they may show *improvement with no intercourse*, meaning that the man has more satisfying erections but is not able to have intercourse (e.g., due to one partner’s psychological blocks). In contrast, failure for Viagra to produce positive change may result from an inability to sustain improvement over time, resistance to using the drug, or failure of the medication to produce any meaningful physiological improvements.

The use of medical interventions should not preclude psychological or relational interventions, and medical interventions alone often fail to address mental or relational health concerns (Althof, Leiblum et al., 2005). Medications alone are limited in their effectiveness to treat sexual problems because sex is such an inherently relational and emotional issue (Perelman, 2002). Clients using medical interventions for sexual dysfunction should learn about realistic expectations for those treatments (Sadovsky et al., 2011). In part due to the influence of advertisements touting the seemingly quick and easy medical solution to sexual dysfunctions, clients may need information to understand the psychological and relational context for sexual concerns when they first present for treatment (Rowland, 2007).

Medication and psychotherapy can be used to complement one another in the treatment of sexual problems (Perelman, 2002). Perelman noted that although Sildenafil (i.e., Viagra) has grown increasingly common in the treatment of female sexual dysfunction, its effectiveness can be impaired by lifestyle and environmental factors, such as fatigue and relational problems. Pharmaceutical-only treatments can breed additional problems once the initial problems are resolved, including the following: adjusting to resuming sexual activity after lengthy periods of limited to no activity; the partner may resist the client’s changes, such as through their behaviors and sexual desires; the partner may have sexual problems that were masked by the client’s problems; a lack of self-confidence and self-esteem resulting from the sexual problems; anxiety about one’s sexual performance; and the emergence of underlying relationship problems (Althof, 2010). Counseling can be useful for

addressing these concerns, and it can enhance the effectiveness of medical treatment alone and play a critical role in ensuring the success in pharmaceutical interventions for sexual dysfunction (Althof, 2010; Perelman, 2002). Overall, despite the growing use of medications to treat sexual dysfunctions, professionals generally accept that the complexity of sexuality-related concerns warrants complex, multifaceted treatments (McCarthy, 2004).

Cognitive-Behavioral Therapy Interventions

Cognitive-behavioral therapy interventions are used widely in sexuality counseling and sex therapy (Althof, 2010). The main elements of this approach include providing educational information to clients, cognitive restructuring, skills training, and the use of homework between sessions, especially sensate focus exercises. In addition, recent advances have integrated mindfulness training with cognitive-behavioral approaches. In this section, we discuss each of these elements of cognitive-behavioral sexuality counseling, followed by examples of research evidence that supports the effectiveness of this approach.

Client Education

Education is a critical component of treatment for sexuality-related issues (Althof, 2010; Guldner, 1995; Hatzichristou et al., 2010; Sarwer & Durlak, 1997; Tiefer, 2001). Educational information can benefit clients and their partners (Hatzichristou et al., 2010), especially in the early treatment phases (Basson et al., 2010). Many clients enter counseling possessing limited information and/or misinformation regarding sexual functioning, often as a result of minimal sex education at home or school (Guldner, 1995). As such, many clients benefit from learning accurate information and developing new skills to enhance their sexual functioning (Guldner, 1995). As Hatzichristou et al. (2010) said,

Each patient has the right to be fully informed concerning his or her sexual health status, as well as the evidence-based treatment options that are available, in order to participate actively in the decision-making process. (p. 344)

Topics that clients may seek information about include “What is normal when it comes to sexuality?” and “How do disabilities, health conditions, or medications impact my sexual functioning?” (Juergens et al., 2009). Counselors should be prepared to provide basic educational information to clients about these and other topics, including the following: sexual anatomy and physiology, sexual stimulation and response, sexual health skills, and suggested sexual activities (Basson et al., 2010; Guldner, 1995; Juergens et al., 2009; Public Health Agency of Canada, 2003).

Counselors can deliver educational information through verbal instruction, assigned readings, videotapes, illustrations, and anatomical models (Althof, 2010). When counselors reach the limits of their own knowledge, they should direct clients to other resources for more information (Juergens et al., 2009).

Cognitive Restructuring

Cognitive restructuring may be used to help clients create new cognitive schemas that allow for more positive sexual functioning (Althof, 2010; Basson et al., 2010; Binik & Meana, 2009). Clients may hold unrealistic expectations about sexuality and sexual functioning, so one goal of cognitive restructuring may be to help the client develop new expectations that are more realistic (Juergens et al., 2009). A more general goal of cognitive restructuring is anxiety reduction (Althof, 2010), which may be achieved by identifying cognitions that contribute to clients' sexuality-related anxieties (e.g., "I am an inadequate lover," "There is something wrong with my body that makes me unattractive," or "Everyone else is having better sex than me"). Likewise, clients may benefit from exploring thoughts about certain aspects of their sexuality that have led to feelings of guilt or shame. For example, some people have come to feel guilty or ashamed about masturbation (Coleman, 2002). A cognitive focus in sexuality counseling can help the client identify these beliefs, evaluate whether they are helping or hurting their overall functioning, and reframe or recreate new belief systems that are more conducive to positive sexual functioning.

Skills Training

An assumption of behavioral sex therapy approaches is that non-biological sexual dysfunctions stem from modifiable behavior problems that have become problematic over time (Sarwer & Durlak, 1997). Through counseling, clients can learn and implement new skills to help enhance their sexual functioning. This includes skills that are related directly to sexuality (e.g., masturbation), as well as skills that enhance their resources in other areas of their lives that reap benefits in their sexual functioning. For example, clients may benefit from learning stress reduction techniques, relaxation strategies, coping skills, and relationship-strengthening techniques. In particular, clients can learn how to communicate their sexual needs more effectively and assertively (Sarwer & Durlak, 1997; Tiefer, 2001).

Masturbation training has been used to address a range of sexual health concerns, including sexual-desire disorders and orgasm disorders, to help clients learn more about their sexual functioning and anatomy (Althof, 2010; Binik & Meana, 2009). Some of the benefits of masturbation may include improved capacity for orgasms, greater overall sexual satisfaction, and becoming more comfortable with

one's body (Coleman, 2002). Clients' masturbation patterns and history are worth considering in treatment for sexual dysfunctions (Lipsith, McCann, & Goldmeier, 2003). Clients who consistently have masturbated in a certain way may grow to be able to only experience orgasm in that context, inhibiting the orgasm response with a partner (Lipsith et al., 2003). In particular, orgasms through masturbation may occur more quickly and readily than those with a partner, so people who grow accustomed to this form of stimulation may not reach climax through the less-consistent stimulation that occurs during intercourse (Lipsith et al., 2003). Therefore, an exploration of clients' masturbation patterns may help to identify a need to alter or expand upon masturbation behaviors in order to help clients make progress toward their treatment goals.

Homework Assignments

Cognitive-behavioral sexuality counseling often incorporates homework assignments that clients complete outside of the session (Althof, 2010). Homework assignments are designed to help clients change non-productive behaviors or to practice new skills and techniques learned in session. For example, clients may be assigned to abstain from having intercourse at the outset of treatment (Binik & Meana, 2009). This assignment can be beneficial if clients' intercourse is adding to pressure or anxiety about performance during sexual activity. Homework assignments also may come in the form of suggested readings or keeping a log of sexual activities, along with corresponding emotions or relationship patterns.

One of the most widely used interventions in sexuality counseling and sex therapy is sensate focus exercises (Althof, 2010; Binik & Meana, 2009; Sarwer & Durlak, 1997; Stinson, 2009). Sensate focus exercises are a form of systematic desensitization, and they are designed to provide clients with gradual exposure to increasingly intense emotional and physical sensations and intimacy (Stinson, 2009). Sensate focus exercises involve nonsexual and non-demanding but intimate contact between partners (Southern & Cade, 2011). These exercises occur within a positive relational context, and they begin by creating a solid foundation of good communication, intimacy, love, support, and understanding (Southern & Cade, 2011). Clients also learn strategies for addressing their discomfort that may arise with the increasingly intense exercises (Southern & Cade, 2011). Then, partners begin by exploring their partner for their own benefit, not desiring to pleasure the partner (Southern & Cade, 2011). The exercises move through different levels of touching, starting with breasts but no genitals, then adding genitals, then full body but with self-directed stimulation (Southern & Cade, 2011; Winton, 2000). Throughout the process, the focus is on pleasure and enjoying the experience, rather than on the outcome of orgasm (Southern & Cade, 2011; Stinson, 2009). Clients aim to develop increasing awareness of the physical sensations in their

bodies, a broader range of sexual behaviors, and a greater focus on foreplay (Southern & Cade, 2011; Stinson, 2009). An important assumption underlying sensate focus exercises is that every person is the expert in his or her own sexual functioning (Southern & Cade, 2011). Therefore, each person is guided to learn about their own and their partners' sexuality through the exercises with an emphasis on greater attention to the process and pleasure of the experience, rather than just focusing on the outcome of orgasm.

Mindfulness Training

Similar to sensate focus, mindfulness training focuses on helping clients be more mindful and aware of the current moment and their enjoyment of sexual experiences (Althof, 2010; Brotto, Basson, & Luria, 2008; Stinson, 2009). Clients are taught to focus on their physical and emotional sensations in the moment without judging themselves (Althof, 2010). Mindfulness-based approaches have been used with clients experiencing depression, sexual arousal and desire problems, and survivors of child sexual assault (Althof, 2010). As one example, Brotto et al. (2008) applied mindfulness training in their psycho-educational approach to address sexual desire and arousal disorders that affect women with gynecological cancer. They described mindfulness as having the client take a stance of being aware of the present moment in a nonjudgmental way. The group-based approach incorporated homework assignments, including cognitive restructuring, communication-skills practice, and reading assignments, in addition to activities to promote mindfulness. In an evaluation of the approach with a sample of 35 women between the ages of 26 and 37, participants showed positive treatment outcomes, including increased sexual desire. The researchers suggested that mindfulness is a valuable focus in sexuality counseling because it encourages clients to become more aware of their physical and emotional responses without judging them.

Evaluation of Sample Cognitive-Behavioral Sexuality Counseling Interventions

In this section, we review two examples of cognitive-behavioral interventions that have been evaluated in order to illustrate the potential effectiveness of cognitive-behavioral therapy for addressing sexual health concerns. First, Sarwer and Durlak (1997) conducted a field trial of a behavior therapy intervention for patients at a university-based sexual dysfunction clinic in the Midwestern United States. The sample included 365 patients between the ages of 20 and 65. The seven-week intervention included weekly group sessions for couples, with sessions lasting about four hours each. Participating couples were instructed to complete daily

30-minute sensate-focus homework exercises between sessions. The participants demonstrated a variety of diagnosed sexual dysfunctions at the outset of treatment. Of the 182 women with diagnosed conditions, 124 demonstrated hypoactive sexual desire disorder, 34 had inhibited female orgasm, and 24 were diagnosed with vaginismus or dyspareunia (based on DSM-III-R criteria). Among the 257 men who had been diagnosed, 100 had erectile disorder, 90 had hypoactive sexual desire disorder, and 55 were diagnosed with premature ejaculation. In only about one-fifth of the sample were both partners diagnosed with a sexual dysfunction. Sarwer and Durlak defined successful treatment outcomes to be indicated by the elimination of the original symptoms, the lack of new symptoms emerging, and the couple engaging in intercourse on at least a weekly basis during the final phase of treatment. The factors that this research demonstrated that had the greatest impact on clients' ability to achieve successful outcomes were how often participants completed the sensate-focus homework assignments and the wives' motivation for treatment. Overall, Sarwer and Durlak suggested that short-term behavioral therapy interventions for sexuality dysfunctions hold promise for promoting positive client outcomes.

Research also suggests that cognitive-behavioral therapy interventions can be integrated with other approaches to promote positive client outcomes. McCarthy (2004) outlined an integrative cognitive-behavioral therapy approach to sexuality counseling for women experiencing sexual dysfunction. In addition to the influences of cognitive-behavioral therapy, McCarthy integrates systems theory, the medical model, and known information about sexual functioning. There are four main strategies used in McCarthy's treatment approach. First, the woman develops a "sexual voice" (p. 22) and sense of responsibility for her own sexuality. This often involves addressing gender socialization issues, as female sexuality is often viewed as secondary to males' desires and control within sexual encounters. Second, the female client develops awareness of her personal preferences and desires for the types of sexual activities that she enjoys. Women may find this challenging if they have given limited previous attention to understanding their sexual desires. The third strategy focuses on increasing the woman's positive attitudes and skills to increase her ability to experience orgasms. The final strategy is relational, in that it focuses on increasing the positive relational bond with her sexual partner, especially related to her ability to communicate her sexual needs and experience emotional connection with her partner through sexual activities. When working with a couple, McCarthy encourages partners to focus less on how they are performing sexually and more on the enjoyment and satisfaction they experience within their relationship. Ultimately, a goal of McCarthy's approach is to empower women to feel that they deserve sexual pleasure and can integrate their sexuality with other areas of their lives.

Integrative and Other Theoretical Approaches

Modern sexuality counseling approaches tend to be highly integrative (Southern & Cade, 2011). In today's postmodern world, sexuality counseling and sex therapy have adopted interventions from a variety of other approaches to psychotherapy (Binik & Meana, 2009). Rather than adhering rigidly to one specific treatment approach, many sexuality counselors prefer to draw upon numerous theory-based intervention strategies. This is good news for clients, who benefit when they are able to choose from a range of potential treatment options (Pukall & Reissing, 2007). Therefore, in this section, we briefly discuss a number of different approaches that scholars and practitioners have proposed to address clients' sexuality concerns.

Psychodynamic Therapy

Sexuality was a major consideration in the early development of psychodynamic and object relations therapy (Althof, 2010; Binik & Meana, 2009), such as Freud's explanation of the Oedipus complex and penis envy. Although used less widely today, the influence of psychodynamic therapy on psychological understandings of sexuality remains significant. In particular, hypnosis may be integrated into sexuality counseling and sex therapy (Binik & Meana, 2009).

Social Constructivist and Postmodern Approaches

These approaches focus on the meaning that clients make of their sexuality (Southern & Cade, 2011). For example, Zumaya, Bridges, and Rubio (1999) outlined a systemic-constructivist approach to sexuality counseling with couples. Drawing on systems theory, Zumaya et al. suggest that sexuality issues need to be considered within the context of multiple subsystems, especially focusing on gender, eroticism, the interpersonal bond, and reproduction. At each level, counselors can explore the meanings that clients ascribe to their experiences and perceptions, especially as those meanings are influenced by the social context. Through counseling, clients aim to integrate their various meaning systems, and when necessary, they may reconstruct their meaning systems in order to promote progress toward their treatment goals. Understanding and exploring clients' perspectives toward key experiences in their sexual development and history are also central to this approach. However, the ultimate focus remains on understanding and exploring how clients make meaning of their sexuality and sexual experiences, as well as how those meaning systems have been influenced by the broader social context.

Experiential Therapy

Experiential therapy holds promise for helping clients address sexuality concerns, which often are hidden and wrapped up in an intense emotional context (Kleinplatz, 2007). Through an experiential therapy framework, an initial focus in sexuality counseling is identifying clients' strong emotional responses and then to examine those responses as a window into the client's inner world. As experiential treatment progresses, the client comes to experience a new approach to living that is more in line with their inner experiences with the world. With couple therapy, the presence of one's partner provides opportunities to identify emotional responses that arise through dialogue and experiences within the relationship. Other points of focus in experiential sexuality counseling include clients' fantasies, feelings of sexual deviance, sexuality-related memories, and sexual preferences and desires. Each of these can provide a powerful view into clients' inner experiences and meaning systems surrounding sexuality. Kleinplatz (2007) suggests that the experiential therapy approach is especially well-suited to address sexuality concerns because of the intense feelings (e.g., shame) that are attached to sexuality-related issues, especially when clients believe that sexuality problems within their relationships (e.g., sexual dysfunctions) are their fault. Experiential therapy is client-driven, and clients' unique needs drive the pace and focus of treatment.

Systemic Therapies

Systems theory allows sexuality counselors to consider multiple systemic levels that impact clients' sexuality beliefs, behaviors, and experiences (Binik & Meana, 2009; Jones et al., 2011). These systems extend from the person's biological systems to relational and broader social systems (Jones et al., 2011). The relational systems that impact clients' sexuality may include their family system, peer systems, and the intimate relationship system (Jones et al., 2011). Systemic influences can impact virtually every aspect of clients' sexuality, from their beliefs and values to their expectations within sexual encounters to their comfort with talking about sexuality in different contexts (Jones et al., 2011). Jones et al. suggested that systems theory provides a foundation for both assessment and interventions in sexuality counseling. In particular, counselors can educate clients about resources and information available about sexuality at various systemic levels. This information can facilitate discussion of the various systemic influences on each client's sexual development, which may offer insights into creating positive change.

Because sexuality is largely expressed within the context of intimate relationships, couple therapy is often used in sexuality counseling (Althof, 2010). When addressing sexuality concerns in a relationship context (i.e., couple therapy), counselors must

help couples navigate the balance between respecting each partner's needs and boundaries, in that one partner's preferences may conflict with the other partner's range of perceived acceptable behaviors (Wylie, Crowe, & Boddington, 1995). Increasingly, efforts have been made to integrate sex therapy with couple therapy (Schnarch, 1997; Zumaya et al., 1999). Historically, however, these two areas have not been well connected to one another (Zumaya et al., 1999).

One conjoint treatment approach that has been applied to sexuality counseling is emotionally focused couple therapy (EFT; Johnson & Zuccarini, 2010). EFT applies attachment theory to understanding the role of sexuality within intimate relationships. Johnson and Zuccarini emphasized the influence of attachment style on clients' experiences of sexuality, in that secure attachments offer support for taking risks and fostering positive growth. In contrast, insecure attachment styles can lead to greater negative emotionality, distress, and detachment. Within EFT, the lens of attachment theory offers therapists a lens into how and why clients experience sexuality concerns the way they do. Sexuality, therefore, becomes an entree into clients' inner working models that impact how they relate to others. Clients' attachment styles can impact their sexual functioning through such factors as anxiety about body image, their emotional engagement during sexual activity, preferences for physical affection, and how partners make sexual requests of one another.

A therapist using an EFT approach in sexuality counseling would likely focus on helping clients become more aware of their emotional responses to sex- and relationship-related events, create a more supportive and responsive context between the partners, and help the clients more readily support and care for one another (Johnson & Zuccarini, 2010). Treatment begins with an assessment, which focuses on understanding the negative relationship patterns and emotional responses associated with them. Next, the clients begin to respond more calmly and thoughtfully to their emotional responses, and then partners make efforts to increase their positive relational bond. Some EFT techniques that can be applied within sexuality counseling include showing empathy, validating clients' emotional responses, tracking interactional patterns, discussing attachment theory with clients, and promoting positive communication exchanges between the partners. Although Johnson and Zuccarini (2010) did not present empirical outcomes for this specific approach, there is evidence for the effectiveness of EFT as a treatment modality for relationship concerns in general.

TREATMENT FOR SPECIFIC SEXUALITY CONCERNS AND USING UNIQUE TREATMENT MODALITIES

Moving beyond theory-based approaches, intervention strategies have been suggested for a range of specific sexuality concerns. In this section, we address some of

the existing treatment guidelines for specific client populations and other specific treatment modalities.

Dysfunction-Specific Treatments

Treatments for specific sexual dysfunctions have been proposed throughout the sexuality counseling and sex therapy literature. As a context for reviewing these treatment strategies, it is important to note that most have been developed and evaluated within the context of heterosexual relationships. Therefore, there is limited information about their applicability to same-gender relationships and other relationship forms. Counselors should therefore use caution in applying this information beyond heterosexual client populations. In addition, dysfunction-specific treatments have been criticized for inadequately addressing the psychosocial context surrounding the dysfunctions. As Kleinplatz (2003) said

We treat soft penises rather than the man or couple concerned about the erection problem. We treat the apparent vaginal spasm in “vaginismus”. . . rather than the woman who has difficulty with sexual intercourse. (p. 96)

Nonetheless, it remains valuable to understand dysfunction-specific intervention strategies, as these may provide valuable treatment guidelines that may be applied to meet clients’ unique needs and circumstances in counseling. Therefore, the following sexual dysfunctions are addressed in this section: male erectile dysfunction, male orgasmic disorder, premature ejaculation, female pelvic pain, hypoactive sexual desire disorder in females, hypersexual behaviors and sexual compulsions, and dysfunctions that result from medication side effects.

Male Erectile Dysfunction

The greatest amount of attention to the treatment of sexual dysfunction has been on male erectile dysfunction (Althof, 2010). Of course, much of this attention stems from medications such as Viagra, Cialis, and Levitra, which have been heavily advertised in mainstream media for many years now. Despite the focus on medication, research suggests that counseling combined with medication may produce better outcomes than medication alone. For example, Banner and Anderson (2007) pilot tested an integrative approach to treating erectile dysfunction that combined sildenafil and cognitive-behavior sex therapy. This brief (i.e., 4- to 8-week time frame) approach incorporates psychoeducation, homework assignments, and interdisciplinary treatment providers (i.e., medical and psychological), with a goal of helping men improve their erectile functioning and sexual satisfaction. Some specific homework assignments included asking clients to list positive traits about themselves and their partners, developing new ways to show their partners affection,

and having partners take turns creating romantic experiences for each other. Banner and Anderson's pilot test compared the integrated treatment with treatment just using sildenafil. Both groups of men demonstrated improved erectile functioning following treatment. However, the men who received the integrative treatment, as well as their partners, had higher levels of sexual satisfaction following treatment as compared to the medication-only group. These results suggest that an integrative approach is more effective than medication alone for addressing the relational and intimacy context of erectile functioning.

Male Orgasmic Disorder

Ribner (2010) provided specific guidelines for the treatment of male orgasmic disorder (i.e., those men who do not regularly orgasm during intercourse). Ribner's approach is based on two assumptions: (a) that men who experience male orgasmic disorder face feelings that they do not meet expectations about masculinity within the larger culture and (b) that male orgasmic disorder is impacted by conflicting messages that men receive from society about the importance of self-control, yet also about the need to let go and release control during sexual activity. Therefore, an important goal of treatment is to help men become more comfortable with letting go of an intense need to be in control of oneself. The steps in Ribner's approach are as follows. First, the couple ceases from engaging in sexual intercourse for the first part of treatment. Second, when using the bathroom, the man practices starting and stopping the process of urination by contracting and releasing his PC muscle. Third, the man begins practicing using those same muscles for increasing periods of muscle tension and release, gradually increasing to tension for 10 seconds, and release for 3 seconds. Fourth, once the client has practiced these exercises for at least a week, he and his partner may resume intercourse. Fifth, during thrusting in the missionary position, the man contracts and releases the PC muscles when he feels excitement during intercourse. Ribner suggests that the release of the PC muscles during intercourse leads to orgasm. Ribner presented only anecdotal evidence for the use of this intervention. Of the four men in treatment that Ribner described, two ended treatment (one because he thought that the exercises were "annoying"; p. 10), and the other two experienced regular orgasms during intercourse. However, one of the latter two men contacted Ribner within a year after treatment to report that symptoms had come back. Therefore, there is very limited research to support the effectiveness of this approach. However, because it offers tangible steps for men experiencing male orgasmic disorder, it warrants further examination.

Premature Ejaculation

Perelman (2006) suggested that premature ejaculation occurs within a relational and psychological context. Perelman described the "Sexual Tipping Point" as "the

characteristic threshold for an expression of sexual response for any individual, which may vary dynamically within and between individuals and any given sexual experience” (p. 1007). Both the male with premature ejaculation and his partner may experience distress related to the condition. Perelman suggests that treatment for premature ejaculation is most effective when it integrates pharmaceutical and sex therapy interventions. Treatment aims to help men better regulate arousal to gain control over ejaculation. It begins with a comprehensive assessment of the client’s sexual history, psychological health, and sexual functioning.

Because premature ejaculation may result from physiological sources, a medical evaluation should be a precursor to therapy (Betchen, 2009; Perelman, 2006). Counseling can address intra-psychoic and interpersonal contributors to premature ejaculation, such as anxiety, body image issues, poor relational skills, and fears about intimacy and sexual performance. Issues that counselors can address with clients experiencing premature ejaculation include family-of-origin dynamics, religious values, and internalized definitions of masculinity. Betchen (2009) described a systemic approach to treating premature ejaculation within couple therapy that integrates psychodynamic systems therapy with sex therapy. The first session is conjoint, followed by two individual sessions with each partner. Additional individual sessions may be added if the clinician deems necessary. The assessment process incorporates constructing a genogram to examine sexual patterns and the client’s sexual history. Treatment may include sex therapy exercises (e.g., sensate focus).

The counselor may suggest that the clients use the stop-start method as they move in and out of sexual activity while the male focuses on his emotional and physical sensations (Betchen, 2009). Clients may do stop-start exercises multiple times each week to provide the opportunity for the man to increase his ejaculatory control. Through the stop-start exercises, a male client begins to notice the point at which he is aroused but still has control over his ejaculation, allowing him to choose how to respond at that point (i.e., whether to continue to orgasm or to back off to sustain the erection longer; Perelman, 2006). Male clients may view the stop-start technique as overly technical and mechanical and as an interruption to sexual activity (de Carufel & Trudel, 2006). In addition, it can detract from the intimacy and eroticism involved in sexual activity (de Carufel & Trudel, 2006).

Another technique that Betchen (2009) recommends is slow-fast penile stimulation, which involves the man’s partner helping him achieve sexual arousal by stroking him, then slowing down the stroking. The other exercises that Betchen outlines gradually increase in intensity until they use varying speeds and stop-start processes during vaginal intercourse. As counseling progresses, the counselor can help the clients identify and address any interpersonal or internal challenges that arise, such as new conflicts or anxiety. Betchen suggests that counselors need to support clients in avoiding the propensity to blame one another for their problems throughout the course of treatment. The length of treatment varies, and follow-up

sessions can be used to ensure gains are maintained over time. Evidence for this approach is not provided, and its applicability to same-sex couples is unclear. However, it provides an example of an integrative approach that addresses the relational context of premature ejaculation.

De Carufel and Trudel (2006) proposed a functional-sexological treatment for premature ejaculation, and they compared it to a behavioral intervention that incorporated the stop-and-start technique and the squeeze technique. The aim of the functional-sexological treatment was to help partners notice the physical states that indicate the man's level of sexual excitement, especially to notice points at which ejaculation is imminent and is still able to be controlled. During intercourse, the couple may modify their behaviors to allow the man to develop greater control over his level of sexual excitement. This may involve slowing the pace of the activity or even taking a break. The man may also use deep abdominal breathing and muscular tension control to regulate his excitement level. One important distinction that this approach makes is that while it is possible for a man to control his level of excitement, it is not possible for him to control ejaculation once a certain physical point has been reached. This approach also emphasizes the importance of enjoying the process of sexual activity, not just focusing on the orgasm. The study included 36 couples, of whom half received the functional-sexological intervention, and half received the behavioral intervention. Within each condition, half of the couples were assigned to a wait list control group. The results showed that participants in the functional-sexological intervention demonstrated longer intercourse duration, increased sexual pleasure, and greater sexual satisfaction following treatment. Participants' partners also demonstrated improvements as a result of the treatment. It's important to note that the behavioral treatment also produced treatment gains, and the researchers noted that clients may prefer the more traditional behavioral approach because the behavioral techniques are less complex to master.

Although the approaches described above have demonstrated some treatment effectiveness in research, many clients find them to be time- and energy-intensive (Perelman, 2006). Therefore, counselors should discuss the requirements of various premature ejaculation treatment options with clients so that they can understand the advantages and drawbacks of each and make an informed decision.

Female Pelvic Pain

Sexuality counseling can benefit female clients who experience chronic pelvic pain (Howard, 2012). Some conditions that can contribute to chronic pelvic pain in women include dysmenorrhea, dyspareunia, and vulvar pain, and this pain is often associated with sexual problems (Howard, 2012). Pain may be heightened during intercourse and other sexual activity. Some ways that counselors can help women facing chronic pelvic pain include validating their experiences and perceptions,

educating clients about treatment options and sexual health, suggesting resources (e.g., useful books and websites), and providing options for creating change (e.g., therapy, new positions for intercourse, and medications). In some cases, intensive sex therapy may be warranted.

Vaginismus (i.e., “the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, particularly the perineal muscles and the levator ani muscles”; Jeng, Wang, Chou, Shen, & Tzeng, 2006, p. 380) can make vaginal penetration painful and/or impossible (Jeng et al., 2006). Treatment may include the use of dilators, especially combined with relaxation training (Althof, 2010). Jeng et al. described a team approach to treating vaginismus, with professionals that included gynecologists, psychologists, sexuality counselors, and psychiatrists. Treatment consisted of weekly sessions over a three-month time frame, and it included vaginal dilation exercises with one’s and one’s partner’s fingers that progressed through systematic desensitization, Kegel exercises, the topical application of Xylocaine jelly, and the use of muscle relaxants. The client also receives educational information about female genital anatomy. Among 120 female clients seeking treatment for vaginismus at the authors’ sexual health clinic, over 90% had experienced sexual intercourse 3 months following treatment. By the one-year follow-up, over 80% of the clients reported that they had regular intercourse and orgasms. Any treatments used for female vaginal pain must consider the cultural context (Kabakci & Batur, 2003), as different cultural understandings of female sexuality can impact the acceptability of treatment approaches to clients.

Hypoactive Sexual Desire Disorder

Sexual desire disorder can be complicated to treat, in that the low sexual desire may result from a host of reasons, including relationship problems, stress, physical health issues, and adjustment to major life transitions. Trudel et al. (2001) suggested that cognitive-behavior therapy is effective for women with hypoactive sexual desire disorder. They tested the efficacy of a couples’ group therapy intervention for female hypoactive sexual desire disorder that was based on cognitive-behavioral therapy. A sample of 74 couples was randomly assigned to either the intervention or a wait list control group. The treatment lasted for 12 weeks, with weekly two-hour sessions with groups of four to six couples each. The groups were facilitated by two teams of mixed-gender therapists. The manualized treatment incorporated the following interventions: homework assignments, psychoeducation, sensate focus and communication skills exercises, and cognitive restructuring. These researchers found that nearly three-fourths of all of the female participants had improved or were “cured” of hypoactive sexual desire disorder at the end of the treatment, and this rate remained high (64%) at 3- and 12-month follow-up assessments. Some personal characteristics that influenced the acceptability of treatment for participants

included busy schedules due to work demands, relationship problems, and a history of trauma. Therefore, the researchers suggested that the effectiveness of this treatment approach could be enhanced by adding personalized interventions (e.g., individual counseling) to the standard group format.

Bibliotherapy interventions also hold promise for addressing hypoactive sexual desire disorder. Mintz, Balzer, Zhao, and Bush (2012) tested a bibliotherapy intervention for women who experienced low sexual desire. They used Mintz's book, "A tired woman's guide to passionate sex," which is a self-help book for women in heterosexual relationships who have low levels of sexual desire. Topics covered in the book include causes of low desire, benefits people experience from sex, the impact of stress on low sexual desire, cognitive strategies for helping people have more positive thoughts about sex, sexual communication strategies, time management, adding novelty to sexual experiences, and the value of scheduling sex rather than expecting it to be consistently spontaneous. Half of the study's participants were asked to read the book in a 6-week time frame, while the other half was in a wait list control group. Pretest posttest measures showed that the participants who read the book demonstrated more positive outcomes than the control group in the following areas: increased sexual desire, arousal, and satisfaction, as well as improved overall sexual functioning. At a 7-week follow-up assessment, only the participants' gains in desire and overall sexual functioning were maintained. The authors suggested that a bibliotherapy approach to addressing low sexual desire can be effective on its own, although it may even be further enhanced by adding sessions with a therapist.

Low sexual desire disorder must always be considered in the relational context (Schnarch, 1997). Furthermore, it is important to understand the perceptions of the level of sexual desire, especially in relation to the client's partner's level of desire. Counselors can normalize the fluctuations in sexual desire that may occur over time, as well as help clients explore and address other issues that are impacting sexual desire. It is important to avoid judging or blaming clients for low sexual desire. As Schnarch (1997) said, "Low sexual desire is almost always considered a problem. I've found it often reflects good judgment: healthy people don't want sex when it's not worth wanting" (p. 127). Therefore, counselors should focus on understanding the meaning behind the low sexual desire and help the client determine how best to address it, which may go beyond the individual client to addressing patterns in their relationship and/or other areas of their lives.

Hypersexual Behaviors and Sexual Compulsions

Sexual compulsions may stem from obsessive thoughts about their preferred sexual experiences, which often are based in early negative experiences involving degradation, such as abuse (Bergner, 2002). Bergner suggests that counselors should

begin by examining these clients' idealized sexual preferences (i.e., lovemaps), as well as the early experiences from which they stemmed in order to understand the meanings that the client ascribes to these. Therapy may focus on altering the client's problematic cognitions, such as this example Bergner provided: "I am a sexually abnormal, tainted, inadequate, and undesirable person" (p. 379). In addition, because clients may be especially vulnerable to engage in sexual compulsions after experiences that threaten their self-esteem, counselors can assist clients to build up coping skills and a positive sense of self-worth. Ultimately, counseling can provide these clients with corrective experiences to address their early experiences of degradation.

Hypersexual behaviors also may serve an emotional regulation function by providing a release to feelings of stress and anxiety (Reid, Carpenter, Spackman, & Willes, 2008). As such, treatment for hypersexual behaviors may focus on stress management and emotional regulation, such as by helping clients become better equipped to identify and modulate their distressing emotions. In addition, clients may benefit from learning how to better communicate their needs for comfort and support with their partners and others in their support system. Finally, counselors can help clients monitor their emotions to identify times when they may feel impulses to engage in undesirable hypersexual behaviors (Reid et al., 2008).

Dysfunctions Resulting From Medication Side Effects

Medications, such as some antidepressants, for example, selective serotonin reuptake inhibitors (SSRIs), can have sexual side effects that contribute to sexual dysfunctions (Balon & Segraves, 2008). Some medical approaches to addressing these include adding other medications (e.g., dopaminergic agents), changing the antidepressant used, and altering the dose (Balon & Segraves, 2008). Clients may be embarrassed to admit sexual side effects to their doctors, so counselors can support their clients in communicating these concerns to health care providers. Clients who experience sexual side effects to medications can benefit from learning that there are options to address these concerns, including changes to medication regimens and psychological and relational strategies. However, it is important that clients receive proper medical guidance from a physician or other qualified health care provider when addressing these changes and certainly before making any changes to their medication routines.

Treatment for Post-Menopausal Women With Sexual Problems

Treatment is complicated for post-menopausal women with sexual problems, especially when their partners also have sexual dysfunction (Goldstein, 2007). Goldstein (2007) suggested that these clients should be able to choose from a wide

range of treatment options, and this often includes an educational component to teach women about physiological functioning. Counseling can be especially useful for addressing mental health and relationship concerns that are related to the sexual problems. Post-menopausal women also may benefit from medical interventions, including hormone therapy or a vacuum clitoris therapy device. In general, treatment should progress from least to most invasive options, with a high level of collaboration between the client and counselor throughout the entire process (Goldstein, 2007).

Treatment for Infidelity

Counseling to address infidelity is inherently complex, whether it involves the person who had an affair, their partner, or both. Each person may have a different goal for counseling, and clients may be unsure as to whether they wish to continue the relationship or end it. There are no simple guidelines here, and counselors can inform clients that the process of rebuilding a relationship after an affair can take a long time, especially in order to re-establish trust (Cano & O'Leary, 1997). Therapy should include early individual sessions with each client to determine if conjoint treatment is appropriate (Cano & O'Leary, 1997). In addition, through individual sessions, the therapist can discuss each partner's goals for the future of their relationship (Cano & O'Leary, 1997). Conjoint treatment may be counterproductive if partners have vastly different goals for their relationship, such as one partner wanting to continue the relationship and the other wanting to end it. Conjoint treatment, unless it is for the purpose of constructively and smoothly ending the relationship, is unlikely to be successful if either client continues to maintain a relationship with a third party. Thus, to begin conjoint treatment, the affair should be terminated.

For couples who hope to rebuild their relationship and remain together, topics to address include the emotional impacts of the affair on the partners and their relationship, what function the affair may have served in the relationship, the development of coping skills, and the role of jealousy in their interactional processes (Cano & O'Leary, 1997). Counselors can help partners develop a contract for the behaviors that they will agree are and are not acceptable (Cano & O'Leary, 1997). These behaviors may include contact with the affair partner, acceptable uses of technology, and whether any secrets may be kept between partners. The partner(s) who engaged in the affair are typically expected to engage in extra-positive behaviors that promote trust within the relationship (Cano & O'Leary, 1997). For example, this partner may seek out individual therapy, allow the partner full access to their cell phone or other electronic accounts, and agree to other situation-specific conditions (e.g., not traveling alone if the affair occurred while traveling for business).

Individual counseling may be warranted for partners who had an affair, as well as those whose partners engaged in infidelity. For clients who have had an affair or

otherwise been unfaithful to a partner in a committed relationship, counselors can help these clients explore their beliefs and attitudes toward commitment in relationships. In addition, they can examine their goals for relationships and their lives in general to understand whether and how a committed relationship may or may not fit within that vision for their lives. These clients may carry a significant amount of guilt and shame that counselors can help them process. In addition, counselors can help these clients develop strategies to promote positive relationship behaviors for their current or future relationships. Clients whose partners have had affairs may have a high level of emotion attached to this experience that can be discussed in counseling. Clients may need to discuss various aspects of the affair in counseling, including when and how they learned about the affair, additional consequences of the affair on their relationship (e.g., financial and physical health concerns), and what type of relationship they would like to continue with their partner. Overall, individual counseling can be beneficial to address each partner's unique concerns and needs in the aftermath of infidelity.

Treatment for Sexual Abuse Survivors

Clients with a history of sexual abuse may seek counseling for many reasons, which may or may not be related directly to their experiences of abuse. Therefore, it is important for counselors to understand clients' goals for counseling and develop treatment plans accordingly (Wise, Florio, Benz, & Geier, 2007). When clients present for counseling with concerns related to past sexual abuse, treatment should generally progress slowly, as it may take time for clients to process the full range of their thoughts and experiences related to the abuse (Wise et al., 2007). Counselors should be careful to manage transference and countertransference, as well as to maintain clear boundaries in the relationship, including the timing of sessions, how the counseling room is arranged, and how close the counselor sits to the client (Wise et al., 2007). Some treatment approaches that may prove useful include art therapy, Rogerian therapy with a focus on validating the clients' experiences, family systems theory to address family patterns that may have contributed to the abuse (Wise et al., 2007), and mindfulness training (Brotto, Seal, & Rellini, 2012). Depending on the nature and timing of the abuse, counselors must be careful to follow any relevant legal guidelines for reporting the abuse, if applicable (Wise et al., 2007).

When clients have a history of sexual trauma, counselors should use an empowerment approach and allow the client to guide the pace of treatment (Goodwach, 2005b). Some common issues to address in treatment with survivors of sexual abuse include the following: feelings of being invalidated by others following disclosure of the abuse, shame, intimacy issues, trust, other relationship concerns, anger, a lack of trust in one's own judgment, and trauma symptoms (e.g., flashbacks or dissociation during sexual activity; Brotto et al., 2012; Rosenbaum, 2009;

Wise et al., 2007). Overall, treatment should be delivered in a way that is sensitive to the client's history of trauma in order to help the client examine how that past trauma history may be linked to current concerns.

Treatment for Sex Offenders

Many counselors are uncomfortable and lack training to be able to work competently with clients who have perpetrated sexual abuse and other sex-related crimes. Treatment for sex offenders aims to reduce the harm caused by the offense and prevent reoffending (Ho & Ross, 2012). Reoffending rates alone offer an incomplete view of the outcomes of sex offender treatment, in that sex offenses are often significantly underreported. Typically, treatment combines cognitive-behavioral therapy and medications to reduce the offender's libido. The existing research provides minimal and mixed support for whether treatment for sex offenders produces actual reductions in recidivism (Ho & Ross, 2012). Counselors should seek additional specialized training before beginning to work with members of this client population.

Treatment for Former Prostitutes

Clients who have previously engaged in prostitution may have unique needs in counseling. One reason for this is the high rates of other difficult complicating factors, such as sexual assault and rape, as well as drug and alcohol use (Stebbins, 2010). Clients who have a history of prostitution should be referred for testing for STIs (Stebbins, 2010). A history of prostitution may contribute to sexual dysfunction within intimate relationships, particularly as a result of dissociating during sexual activities (Stebbins, 2010). Treatment approaches for clients with a history of prostitution may address past trauma histories, how to create a positive sense of sexuality, fostering healthy relationship intimacy, and changing problematic patterns of sexual behaviors (Stebbins, 2010). Interventions may include psychoeducation, relaxation training, building a social support network, coping skills training, and sexuality counseling to address sexual communication and behaviors (Stebbins, 2010). Although most counselors likely will not work extensively with this client population, it is useful to understand some unique concerns they may bring to sexuality counseling, especially given the sexual nature of prostitution work.

Treatment via the Internet

In recent years, there has been growing interest in delivering sex therapy and sexuality counseling interventions via the Internet (Althof, 2010; Jones & McCabe, 2011; Tiefer, 2012; van Lankveld, Leusink, van Diest, Gijs, & Slob, 2009). An advantage of these approaches is that clients can seek help anonymously and in a setting that is comfortable to them (Althof, 2010; Jones & McCabe, 2011). Internet approaches are

also useful for clients who are geographically isolated, and they also can be made to be more affordable than face-to-face interventions (Jones & McCabe, 2011). However, Internet-based approaches are likely not suitable as stand-alone treatments for clients with severe sexual problems or other major problems related to the sexuality concerns (e.g., relationship or mental health problems; Jones & McCabe, 2011). Furthermore, guidelines for ethical and legal practice of Internet-based sexuality counseling are just beginning to emerge, so for now, counselors have minimal guidance as to how to do this appropriately and competently (Althof, 2010). In addition, deciphering whether Internet-based information is credible presents a challenge for counselors and clients alike, as the Internet allows virtually anyone with ideas about sexuality to share their views with the general population (Tiefer, 2012).

Two research studies by van Lankveld et al. (2009) and Jones and McCabe (2011) provide examples of Internet-based sexuality interventions. Van Lankveld et al. (2009) pilot tested an Internet-based sex therapy intervention for men in heterosexual relationships who were experiencing sexual problems. The evaluation consisted of a pretest posttest follow-up, wait list control group design. The 89 male participants who reported either erectile dysfunction or premature ejaculation were randomly assigned to either the treatment group or the wait list. The 3-month long treatment incorporated sensate focus exercises and cognitive restructuring techniques, and the therapists were eight licensed sex therapists, of whom half were male and half were female. Almost one-fourth of the participants were recommended by their therapists to seek medication in conjunction with the therapy. Among the participants who received the Internet-based intervention, 48% reported that their sexual functioning improved, 43% reported that their sexual functioning neither improved nor deteriorated, and 8% reported that their sexual functioning was worse at the end of treatment. Participants in the treatment group showed better improvement compared to those in the wait list group. Although these findings show some support for Internet-based sex therapy interventions, more research is needed to compare the effectiveness of Internet-based interventions as compared to face-to-face interventions.

Jones and McCabe (2011) evaluated an Internet-based cognitive-behavior therapy intervention for treating female sexual dysfunction. They compared a no-treatment control group with a group of women who completed a 10-week intervention. All participants had one of the following forms of female sexual dysfunction: hypoactive sexual desire disorder, sexual arousal disorder, anorgasmia, or genital pain. The intervention, called *Revive*, involved the participants and their partners engaging in communication skills and sensate focus training, along with e-mailed communications with the therapist. A unique feature of this treatment was that it involved couples engaging in guided discussions before they began their sensate focus sessions. Technological features were incorporated into the program,

such that participants had to indicate that they'd met their treatment goals at each stage before they were able to access the next treatment module. The evaluation findings showed that participants who completed the treatment had better outcomes than those who didn't have treatment in the following areas: communication, emotional intimacy, sexual desire, arousal, lubrication, orgasm, satisfaction, and pain. However, about one-third of the women who completed the program reported that they still had sexual problems at the end of the treatment.

Treatment With Sex Surrogates

The use of sex surrogates has been debated (Binik & Meana, 2009; Tiefer, 2012). Today, the International Professional Surrogates Association (<http://www.surrogatetherapy.org/>) exists to support "a worldwide community of professionals in the field of surrogate partner therapy, which includes surrogate partners, therapists, and individuals of surrogate partner therapy" (IPSA, 2013a, para. 1). The IPSA (2013b) describes Surrogate Partner Therapy as follows:

In this therapy, a client, a therapist and a surrogate partner form a three-person therapeutic team. The surrogate participates with the client in structured and unstructured experiences that are designed to build client self-awareness and skills in the areas of physical and emotional intimacy. These therapeutic experiences include partner work in relaxation, effective communication, sensual and sexual touching, and social skills training. (para. 1)

However, the use of surrogates is "no longer sanctioned" (Binik & Meana, 2009, p. 1021) by most sex therapy professional groups. Beyond the lack of professional support for the use of surrogates, this approach may be considered illegal prostitution in many jurisdictions (Tiefer, 2012). Therefore, we recommend that counselors not consider the use of sex surrogates as part of sexuality counseling, and counselors may need to discuss the reasons for this recommendation with clients who have heard about this treatment approach.

TREATMENT OUTCOMES IN SEXUALITY COUNSELING

Due in part to the influence of managed care, there has been an increasing emphasis on the need to demonstrate effective treatment outcomes related to sexuality counseling (Branney & Barkham, 2006). Research suggests that clients can reap benefits from counseling that addresses sexual problems. For example, Firth and Mohamad (2007) examined treatment outcomes for men at a sexual health clinic in the United Kingdom. Typically, treatment at the clinic lasts for up to 12 sessions, and it is coordinated with medical treatment when appropriate. The treatment

outcomes for 70 male clients at the clinic were studied. Some of the disorders for which men were seeking treatment included erectile dysfunction, premature ejaculation, and low sexual desire. About half of the clients who participated in individual counseling demonstrated positive treatment outcomes. Other treatment approaches that the researchers identified as having good outcomes included masturbation training and sensate focus. However, clients who attended only an assessment and no subsequent treatment demonstrated poor outcomes. Interestingly, clients who had experienced some sort of significant early loss were more likely to experience negative medication side effects, although the researchers did not identify any other background characteristics that impacted treatment outcomes. This research demonstrated methodological limitations (e.g., non-random sampling and unclear measures of treatment outcomes), so its results must be considered preliminary. However, it does suggest that clients may experience positive changes through sexuality-focused interventions to address sexual dysfunctions. Future research should consider more fully the impact of client background characteristics on clients' unique needs in treatment and how these affect outcomes.

More broadly, the existing evidence base supporting the effectiveness of sex therapy interventions is limited and mixed (Binik & Meana, 2009; Guldner, 1995). There is more concrete evidence for the treatment of sexual dysfunctions through medication than there is for treatment through therapy (Rowland, 2007). A need remains for more research on the effectiveness of various treatment strategies, especially to support the ongoing need for psychological and relational interventions in combination with medical ones (Rowland, 2007). Although earlier studies, such as those by Masters and Johnson (1966; 1970), showed extremely positive results, modern critiques of these studies suggest that they were highly biased by methodological limitations, such as a lack of controls and unrepresentative samples (Binik & Meana, 2009). However, whenever possible, empirically supported treatments should be incorporated into sexuality counseling (Hatzichristou et al., 2010).

Counselors also should put in place strategies to track the effectiveness of their use of interventions in sexuality counseling (Althof, Rosen et al., 2005; Corty, Althof, & Wieder, 2011). A variety of outcome measures may be tracked to determine the effectiveness of sexuality counseling interventions, including diaries, questionnaires, physiological tests, and open-ended interviews (Rellini & Meston, 2006). As one example, Corty et al. (2011) developed an instrument to assess women's treatment satisfaction for female sexual dysfunction, called the Women's Inventory of Treatment Satisfaction-9 (WITS-9). Items were developed through focus groups with women and men. Once the final item pool was created, the researchers assessed its content validity through feedback from a panel of researchers and clinicians whose work addresses female sexual dysfunction. The final scale had three factors: (a) satisfaction with sexual activity and interest; (b) treatment satisfaction; and (c) perceived partner satisfaction. The total scale and subscales of the

final nine-item scale demonstrated good internal consistency. An instrument such as the WITS-9 is useful for sexuality counseling because treatment satisfaction may impact how likely a client is to continue in treatment over time (Corty et al., 2011).

In sum, the research base supporting the effectiveness of sex therapy and sexuality counseling remains limited, especially in comparison with evidence for the effectiveness of medical treatments. However, there is a growing body of research that supports the value of sexuality counseling, especially to address the social and emotional context of sexual problems. To address a growing demand for evidence that the interventions they use work, sexuality counselors should use evidence-supported interventions when available and track treatment outcomes with the clients they serve. Before leaving this chapter, readers are encouraged to complete Exercise 3.1 to reflect upon their current level of comfort and competence to provide sexuality counseling interventions.

Exercise 3.1

GUIDED REFLECTION ACTIVITY: CURRENT COMFORT AND COMPETENCE TO PROVIDE SEXUALITY COUNSELING INTERVENTIONS

Now that you've reviewed information about several different approaches to sexuality counseling, take some time to reflect upon the following questions:

- Which treatment approaches seem to you to be most useful for working with clients to address sexuality concerns? Why do you prefer these approaches?
- How competent do you feel to conceptualize clients' sexuality concerns from a theoretical framework, as well as to use theory-based intervention strategies?
- What treatment issues (e.g., infidelity, specific dysfunctions) would you be most and least comfortable addressing in sexuality counseling, and why?
- How competent do you feel currently to create a safe, supportive, professional context for clients to discuss their sexuality-related concerns in counseling? What might you do in order to increase your level of competence?
- What are your reactions to the idea of delivering sexuality counseling over the Internet?
- How might you respond if a client sought counseling from you and asked about using a sex surrogate as part of counseling?
- What do you envision the future will hold for the treatment of sexual concerns, especially with regard to medical versus counseling approaches?

SUMMARY

In many ways, sexuality counseling is similar to counseling in general and other specialization areas. Counselors must work to establish a strong therapeutic relationship with their clients, base counseling interventions on solid, clinical-assessment data, use theoretically sound intervention strategies, and track client progress over time. However, the sensitive nature of sexuality concerns provides a unique context for sexuality counseling, as clients (and counselors!) may demonstrate a high level of discomfort throughout treatment, especially early in the process and when new challenges and issues emerge. Therefore, counselors should build a solid foundation of knowledge about sexuality, as well as a broad repertoire of skills and intervention strategies, in order to best serve clients seeking counseling to address sexuality-related concerns.

KEYSTONES

- Regardless of the treatment approach used, counselors can aim to create a supportive therapeutic environment for addressing the sensitive topics that can arise when discussing sexuality concerns.
- The earliest sessions of sexuality counseling should focus on building rapport, and therefore, they may not involve the client discussing their sexual concerns in great detail.
- Some counselor practices that foster a supportive environment for sexuality counseling include demonstrating positive communication skills, conveying a professional demeanor, showing respect for the client's autonomy, providing a physically safe and private location, using active listening skills, and using culturally competent approaches.
- Sexuality counseling treatment plans should be grounded firmly in data collected through the counselor's clinical assessment of the client.
- A physical examination should always be a precursor to clinical assessment and treatment when sexual dysfunctions are suspected.
- Given the broad range of approaches to sexuality counseling, counselors have a variety of resources at their disposal to be able to incorporate different theoretical approaches and techniques to meet each client's unique needs.
- Medication and psychotherapy can be used to complement one another in the treatment of sexual problems.
- Moving beyond theory-based approaches, intervention strategies have been suggested for a range of specific sexuality concerns.

- Due in part to the influence of managed care, there has been an increasing emphasis on the need to demonstrate effective treatment outcomes related to sexuality counseling. Research suggests that clients can reap benefits from counseling that addresses sexual problems.

ADDITIONAL RESOURCES

- American Association of Sexuality Educators, Counselors, and Therapists (AASECT): <http://www.aasect.org/>
- American Sexual Health Association: <http://www.ashasexualhealth.org/>
- U.S. Centers for Disease Control and Prevention (CDC) Sexual Health Resource: <http://www.cdc.gov/sexualhealth/>
- WebMD's Sexual Health Center: <http://www.webmd.com/sex/>

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