Chapter 11

Treatment of Sexual Problems

Not many aspects of life differ as much from fantasy or ideals as do matters of sex and love. Fairy tales, novels, and films commonly end with two people falling in love and leading a happy romantic life. The reality of love and intimacy is not quite as sanguine. It overlies both the ideals and conflicts that arise from many complex and often hidden worlds. Increasingly, as diverse populations become more connected through the Internet and social media, activities, sexual and otherwise, that were once clandestine are becoming more visible. As a result, sexual behaviors that were considered aberrant or pathological are increasingly perceived as legitimate and normal. As information about sexuality and its broad manifestations becomes more and more available, professionals are forced to assess, diagnose, and treat problems that in the past were rarely if ever encountered. In short, the complexity of assisting people with sexual problems has become far more demanding than in the past.

An additional complication beyond these social changes is the subjective issue of defining sexual pathology. People seeking help do not do so because they have discovered their symptoms in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (DSM-5), or the *International Classification of Diseases* (ICD). In fact, it is likely that the problems that people experience do not neatly correspond to the diagnoses in these professional manuals. And when the symptoms do correspond with those in the diagnostic manual, they tend to only do so partially. A man seeking treatment for a penis that markedly contracts when he is not aroused does not meet any diagnosis per se, having only a weak link to the ICD diagnosis

of koro.[1] When does this man's concern become pathological? If his penis does contract, resulting in objective negative assessments of his attractiveness, is the man mentally dysfunctional for being concerned?

In treating clients with sexual problems, therapists must first be aware that each person's experience is complex. In evaluating people with sexual problems, it is therefore important to assess whether their distress is indicative of deeper and more complex issues than the sexual problem being presented. If not, the therapist is likely to spend a great deal of time treating only an expression of a set of far more intricate problems. This is especially true if the problem seems formulaic and straightforward. The therapist often forgets that the therapeutic process is his or her job. To the person seeking sexual help, it typically represents an embarrassing and desperate effort to deal with an intractable problem. The therapist must remember that all conditions or relationships that are troubling to individuals should be given careful and thorough attention. Therapists are challenged to identify which problems warrant treatment, which can be a complicated task. This difficulty can be seen in the following case study.

The Case of Sharon

Sharon sought therapy for her anxiety and depression, problems that were the focus of the first two months of treatment. As Sharon became confident that she need not fear judgments within the therapeutic relationship, she disclosed that she was raped in her mid-teens. Her father was a cruel alcoholic and would assault her when intoxicated. Her mother and siblings actively ignored the nightly horrors that Sharon experienced. The sexual assaults stopped when Sharon began to threaten to report her father or to tell members of her extended family.

However, Sharon's father continued verbally abusing her and beating her when she disobeyed him. Living in a continual state of emotional agitation, Sharon was an extremely poor student, and her continual anxiety led her to be socially awkward. These shortcomings were exacerbated by impairments in both her ability to speak clearly and to comprehend what others said. These deficits were socially isolating and led Sharon to use sex to create a social life. She would have sex with virtually any young man who treated her kindly, even if the man showed no interest in any ongoing relationship. Sharon reported that she would always have fantasies of physically hurting men or sexually humiliating them. Rather than acting on this fantasy, Sharon would submit to, and be particularly aroused by, sex acts that most would consider to be degrading.

[1] Koro is an ICD and DSM culture-bound condition occurring most often in Southeast Asia. The afflicted suffers an increasing panic centered upon the fear that his penis is contracting into his body and that this condition will lead to death. Penile contraction is a trait that occurs in some men and is exacerbated by fear or panic. This raises the question of whether or not the penile fears in koro are secondary to a less specific panic that leads to penile contraction.

This lifestyle came to an end when Sharon turned 20, when Guy, a recent college graduate working in a secure state job, began to date her. Sharon's working-class family, of whom no members had ever attended college, was impressed with her suitor. However, her father would repeatedly tell Sharon that she was too ugly to be wanted for anything other than sex. Even her younger sister, with whom she was very close, was surprised by how attractive Sharon's boyfriend was. To the astonishment of her family, Sharon and Guy were married within a year. By the time Sharon sought professional help, Guy had become the director of a state agency and had earned a great deal of social prominence. Sharon and Guy were also raising an adolescent son and an early teenaged daughter. Given Sharon's origins and the stable and apparently ideal lifestyle she was living, it was surprising that Sharon would continually express dissatisfaction with her life and with her husband Guy.

The most critical problem with Guy and Sharon's relationship began to arise shortly into their marriage. Sharon discovered that Guy was bisexual and he expected Sharon to participate in his bisexual encounters. Frequently, this involved driving to a squalid section of a nearby town, where Guy would have Sharon solicit a man for a three-way sexual encounter. Men that Guy would select for Sharon's solicitations were invariably impoverished and unattractive. The three would then proceed to a motel where Guy would masturbate while watching the recruited man have sex with Sharon under Guy's direction.

Sharon hated these three-way sexual encounters, but she was fearful of explicitly expressing her feelings. Sharon believed that Guy had saved her from her abusive home, and despite her loathing of his sexual predilections, she deeply admired Guy. It took two years of working with Sharon before she could be encouraged to tell Guy that she would not participate in his fetish any longer. She had suffered repeated bouts of major depression during this period. It was her deteriorating emotional state that eventually led Guy to attend a couples therapy session.

At the joint session, Guy entered confidently and sat next to Sharon on a small sofa. He put his arm around her as if to make clear that he was in charge. Despite his evident effort to challenge the psychologist, he was articulate, charming, and gregarious. When the psychologist began setting ground rules for the discussion that included equal time and silence when each partner was making a point, Guy interrupted as if hearing none of these parameters, and thanked the psychologist for helping Sharon, as she was a "very sick woman." Guy further warned the psychologist that not everything Sharon said should be taken seriously. He said, "It is important that you not believe everything you hear." A caution that was stated with a bit of an ominous tone.

In short, Guy refused to discuss the problem at hand and continued parrying every effort to discuss any of the issues that Sharon wanted to address. Sharon made a couple of meek efforts at sharing her thoughts, but they were totally unheeded by Guy. The session ended when Guy stated that he believed the time was up, took Sharon by the hand, and condescendingly thanked the psychologist for his good work, and left with his wife.

Sharon informed the psychologist that Guy had harshly rebuked her for discussing family business with a psychologist. Nonetheless, the sex outings began to wane as a result of the meetings. It was not the clinical intervention that stopped the paraphilic exploitation of Sharon, but Guy's awareness that someone else knew about it, and Guy apparently would not risk his status in what could be an embarrassing disclosure. Guy knew that his session was confidential, but as he seemed not to take rules seriously, he would likely fear that others would not either. The outings were replaced, however, by Guy's total loss of interest in and neglect of Sharon. Sharon still had a home and children to raise, but Guy saw to it that she had little else of worth in her life. She did not have a car, her spending money was reduced to subsistence level, and she was shut out from Guy's active social life. Sharon

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died of disorders that are considered to be stress-related two years after the meeting. Her situation is emblematic of many of those faced by therapists helping people with sexual problems. Complexities include illnesses that are both related to or exacerbated by the sexual problem. They can include lifestyle circumstances that are often out of the reach of the therapist and that interact with the client's problems in complex ways. Or they can include family, friends, or lovers who are playing a major role in the client's life, but have no intention of supporting the client's therapeutic change.

THE NUANCES OF SEXUAL ASSESSMENT

Of particular significance in the previous case study is that it sets forth some of the many complex and interacting issues that are often faced by therapists treating clients' sexual problems. Who was the patient in this case? Was it Sharon, who was struggling to survive a lifetime of sexual abuse and degradation? Was it Guy, whose paraphilia had created a marriage of resentment and sexual alienation? Or was it the couple as a unit, as it would be in a family systems approach? In treating people whose quest for psychological help includes a problem predicated on or including a sexual issue, it is uncommon that such an issue is clearly acknowledged at the outset of therapy. Oftentimes the sexual problem will be disclosed long after a number of life problems have been presented. Sexual problems typically are laden with shame, and their disclosure is made with caution. One of the most effective ways to accelerate a thorough understanding of the client is objective testing. Such tests are important, as many sex therapists work without supervision, review, or evaluation. They are largely evaluated solely by themselves. Consequently, confirmation bias is a major risk to appropriate treatment. Confirmation bias occurs when a therapist diagnoses a client and subsequently attends primarily to those statements or actions of the client that confirm his or her initial diagnosis. Therapists don't like to be wrong, and without external measures of performance, they never learn that their diagnoses may be inadequate or completely wrong. Instead, the therapists can go on treating people for a problem they determine to be critical without ever discerning that at no point was it the primary problem of the client. Lilienfeld and his coworkers point out that without objective feedback, therapists with 2 years of experience fare just as well as those with decades of practice (Lilienfeld, Lynn, & Lohr, 2003). In fact, at times a therapist's experience is inversely related to efficacy. This points to the importance of objective measures in assessing people with sexual or other psychological problems.

Psychological tests can be invasive or threatening, but without them, a therapist assumes that his or her clinical judgment is supreme. To use them effectively, a clinician must first establish rapport with the client, such that there is both trust and a clear understanding of what the therapist is working on, and how he or she intends to address it. To do so, the therapist must rapidly convey that he or she is not judgmental and accepts all sexual expressions as equally legitimate. The client must be confident that even if the therapist believes some sexual behaviors are self-defeating, none will be deemed shameful. This trust is especially important as there is no discourse in psychotherapy that is potentially as sensitive as matters of sex. In fact, it is rare that someone presents with a sexual problem—even in a case in which the client is a victim of abuse—in which there is no shame or anxiety in disclosure. In fact, in the vast preponderance of sexually abused people treated by the present author, the afflicted seem to feel and act as if they were the perpetrators. After the client is clear in her or his comfort with the therapist, the process of performing a clinical evaluation can begin.

The therapist can begin by eliciting the client's beliefs about him- or herself, his or her attitudes about other people, his or her recent history, and details of the problems that brought the client to therapy. Very often a client will have been acculturated to believe that therapy requires a complete recapitulation of his or her life story. Should the client begin a historical narrative, it should not be cut off but gently guided to current issues, conflicts, and life performance. Indeed, the past is important, but it is useful in therapy only by exploring its role in the client's current construction of the world and his or her perceived role in it. If the client feels himself or herself to be a sexual victim, one need not find the source of the belief, because, as Loftus (see interview in this book) has compellingly argued, memory is highly malleable. Thus it is far more meaningful to look at the impact this belief has on the client's current social or sexual functioning. Each client has a unique construction of the world, a personal philosophy. An effective therapist needs to thoroughly understand the components of the client's worldview. The therapist must also focus on those life events that the client states have led to the current distress. After this stage, the therapist must translate the client's expressions into a model of the underlying beliefs or schemas that the client maintains about his or her life and love. Beliefs like "I must always be receiving love if I give love to someone"; "it is horrendous if a significant other rejects me"; "I am never good enough"; or "because I was sexually accosted as a youth, I am a defective broken adult" can be inferred through the client's discussion of his or her life and of the significant others in it.

After a fundamental understanding of the client is achieved and the therapist is confident that a therapeutic rapport is established, the therapist can administer a validated objective test like the *Minnesota Multiphasic Personality Inventory-RF* (*MMPI-RF*). Objective instruments like the *MMPI-RF* that can best be employed after a strong therapeutic relationship is developed are supposed to test the

therapist's hypotheses about the client. The client came to therapy to disclose his or her troubles, and the objective test frequently offers a safe conduit in which to convey them. The therapist can then use the discussion of the results of the test to elicit further discussion about issues which may have been withheld. With a sensitive review of the sources of distress and vulnerability revealed on the instrument, the client can be made to feel validated. That is, the client can come to feel that his or her suffering is legitimate and objectively measurable. Armed with the information obtained from the psychological testing, the therapist can be reasonably assured of being on the right path with their client.

There are numerous instruments that measure gender, sexual interest, and sexual behavior. However, these are not significantly better than the client's own depiction of his or her sexual history. The generic objective test, combined with the therapist's own assessment, provides the personality and vulnerability profile that can reveal the client's susceptibility to sexual problems. Indeed, there are few problems in sexuality that are not exacerbated or attenuated by the client's personality and temperament. In essence, sexual problems are a function of the unique attributes of the individual, his or her physical functioning, and the social milieu in which the client is situated.

The case study below raises some of the aforementioned complex and problematic issues found in treating sexual problems. As detailed, the therapist must determine if the presenting problem is the complete or even the actual problem. Importantly, the therapist must pinpoint whether there are psychological, emotional, or physiological culprits behind the issue at hand—or maybe all of these. In recent decades, there have been a number of advances in treating physiological sexual problems like erectile dysfunction, dyspareunia (vaginal pain during intercourse), and related disorders like vaginismus, a type of dyspareunia, in which the woman suffers painful muscular contractions of the vagina during or in anticipation of coitus. However, issues of sexual dysfunction frequently extend beyond physiological impediments that can be treated by medical interventions. More often than not, sexual dysfunction is a symptom of multiple factors, as the case of Fabrice illustrates.

The potential contradictions between a person's private sexual life and his or her public life can be associated with an outward appearance that is inconsistent with the issues that brought the person to therapy. For example, the male fetishistic crossdresser who needs to appear feminine to be sexually aroused, strongly eschews female affectations in his nonsexual life. Similarly, a person who is passive in sex is generally not submissive in other aspects of life.

In many Western cultures, sexual desires and activities are typically hidden from the public eye. Thus when a person seeks therapy, particularly for a sexual problem, he or she will typically be anxious or fearful of judgments made by the therapist.

The Case of Fabrice

When Fabrice began therapy, he was in his mid-40s and indicated that he needed help with depression during the winter months. He was assessed over several sessions and took the *MMPI-2* (*Minnesota Multiphasic Personality Inventory-2*, a test of adult personality and psychopathology that is an older and somewhat longer version of the *MMPI-RF*) with great interest. The test corroborated the clinician's impression that he was a man with a poor self-image, high levels of anxiety, and low levels of self-worth. His gender scores on the exam revealed weak identification with the traditional male role. It was not until his second month into therapy that Fabrice began to mention his frustration with his sexual functioning. It was with this disclosure that it became apparent that his problem was more complex than depression. Fabrice needed to feel extraordinarily trusting of the therapist before he would disclose what was his greatest shame—his perennial inability to maintain an erection. The therapist carefully elicited the extent of this sexual problem. Fabrice was encouraged to discuss the problem at his own pace, while continually being reassured that one's sexual performance does not define one's worth as a man. He revealed that he was burdened by this problem almost every day and that he felt worthless because of his sexual dysfunction. In fact, Fabrice revealed, over several sessions, that at the age of 41, he had yet to be able to penetrate a woman. He showed great pain and frustration that although women aroused him, he was largely unable to act on that arousal. He reported that he would usually get an erection during foreplay, but he would invariably lose it upon attempting penetration. This problem had been consistent through several relationships and two marriages.

He was persuaded to see a urologist to determine if he suffered from any medical conditions that might underlie the erectile dysfunctions. No medical issues were found, and Fabrice was prescribed a series of medications and mechanical aids, including the medications Viagra and Cialis, a medical erection pump with an elastic band to maintain the erection, and intraurethrally injected prostaglandin-based medications. While Fabrice obtained harder and more frequent erections, they would collapse when proximate to the vagina. After more than a year of efforts with these urological interventions, the final medical suggestion was a penile implant that would mechanically or hydraulically sustain an erection. Fabrice drew the line at this suggestion, deciding against further medical treatment.

Fabrice continued therapy but insisted that he wanted to focus on his depression and confidence building. He said he had come to terms with never having intercourse. After another year, the therapist very gradually introduced the possibility that he did not actually find women attractive. Surprisingly, Fabrice did not strongly dispute this suggestion, and over the next few weeks, he confessed that he never really was particularly aroused by women and even found the vagina unaesthetic. However, Fabrice made it clear that the possibility that he might be gay would not be discussed. He would only concede that he was a straight man who did not get aroused by women. Today, Fabrice accepts himself this way and is better able to view himself as a complete man who happens to be unable to penetrate women. His feelings of deficiency continue, but in a much attenuated form.

The significance of this case is that Fabrice, similar to a number of people seeking help for sexual problems, framed his problem in a way that was ego-sparing and socially acceptable. Fabrice entered therapy stressing that he was experiencing depression during the winter months (Seasonal Affective Disorder). However, it was a more socially sensitive issue, related to sexuality, that was the primary cause of his emotional distress—an issue that was not articulated until some time in therapy. Furthermore, the possibility of Fabrice being a homosexual was not broached until nearly a year after that, although it was quickly established that this was a condition that he would not consider.

To avoid contributing to any sense of judgment, the therapist must attempt to avoid even subtle biases. This can be facilitated by an objective assessment. As Lilienfeld et al. (2003) and his colleagues have found, therapists often fall prey to numerous pitfalls like confirmation bias (attending only to those pieces of information that support the therapists' previously formulated hypothesis), social bias (prejudice against social groups), and diagnostic errors that can result from these biases.

One modality of sex therapy recommends having the client complete a brief survey at every session (Miller & Donahey, 2012). Perhaps more incisive than having the therapist diagnose, treat, and assess outcomes based solely on subjective observations and communications with the client, this method has setbacks. Quite often, an effective therapist can develop an alliance with the client, leading to the client's willingness to conform to the therapist's beliefs and the treatment being offered, even if he or she is not truly satisfied that his or her problems are being adequately addressed. While the usefulness of regular surveys is questionable, it is advisable to implement some type of objective testing early in treatment.

Objective testing is even more important when considering the comorbidity of sexual disorders with many other mental health problems (Nobre, Pinto-Gouveia, & Gomes, 2006; Raymond, Coleman, & Miner, 2003; van Lankveld & Grotjohann, 2000). Thus a therapist must be able to rule out the possibility that a sexual problem is secondary to another psychological problem. Virtually any mental health problem can result in sexual difficulties. Anxiety and depression can inhibit sexual response. Personality disorders can lead to a range of such dysfunctional sexual behaviors as aggressive sexual acts in the case of antisocial personality disorder or impulsive sexual behavior in the case of borderline personality disorder. Schizophrenia is linked to increased rates of paraphilic sexuality (Yang & Liang, 2010).

Because of the complex interaction of human sexuality with most facets of the mind and body, a differential assessment using some objective measures is necessary. These assessments help to rule out even the most remote possibility that the presenting problem has a purely medical cause. One need only be reminded of the intensive psychoanalysis that the composer George Gershwin underwent when he complained of memory lapses, mood swings, strange sensations, and disturbing orders. He was given various psychoanalytic diagnoses, including "hysteric with conversion disorders" (Pollack, 2007). It was likely his previously undiagnosed glioblastoma was triggering symptoms typical of these disorders. This example highlights a tendency among some professionals to psychologize physical disorders (Ballweg, 1997; Frances, 2012; Jorgensen, 2008), though such dramatic misdiagnoses are rare. However, it is not unusual for therapists to commence treatment for sexual problems without exhaustively ruling out a strictly physiological cause.

Following a medical evaluation that eliminates the possibility of an underlying physiological issue, the next step for the therapist is to evaluate the client's

functional status. This includes a brief history that assesses for trauma, prior sexual functioning, and the client's self-assessment of the nature and origin of his or her problem. Detailed histories, family relationships and accompanying medical histories or developmental histories are not useful. The work of people like Elizabeth Loftus (1975, 1976) (see her interview in this text) and Daniel Schacter (1996) compellingly demonstrates that memory is constructed and malleable. Our memory captures the essence of events, not eidetic images. Even more problematic for therapists, memory tends to be altered upon recall and changed repeatedly when discussed (Loftus, Donders, Hoffman, & Schooler, 1989). It can be manipulated simply by changing the way a question is phrased (Schacter, 1996), and false memories can be readily implanted by asking loaded or repeated questions (Brainerd & Reyna, 2005; Loftus, 1997; Schacter, 1996). In brief, a client in distress or with emotional problems is an unreliable source for his or her own biography.

There are various tools that can help objectively evaluate a client's condition. These can include instruments like the *MMPI-2* discussed earlier and the *Millon Clinical Multiaxial Inventory-IV* (*MCMI-IV*), which is a relatively brief instrument developed to assess people in therapy. In addition to assessing most psychological pathologies and personality disorders, the *MMPI-2* has scales measuring gender identification. If depression or other pathologies are suspected, these tests can be combined with more specific instruments like the *Hamilton Depression Inventory* or the *Brief Symptom Inventory.* However, the combination of *MMPI-2* and *MCMI-IV*—especially with their validity scales to detect defensiveness, exaggeration, or malingering—allows for a comprehensive evaluation of the client's mental state.

As previously discussed before administering psychological tests, the client needs to be fully informed about the nature of the test, and preferably be offered the opportunity to have the results of the tests explained. This has two benefits: It engages the client in the assessment process, and it also helps the client obtain a better understanding of how his or her psyche works. A client who is interested and fully committed to taking a psychological test will tend to be more open and will not perceive it as an intrusion or a barrier to a continued therapeutic alliance. Most importantly, such highly validated objective tests serve as a second opinion for the therapist's assessment and diagnosis.

Along with the objective tests, the therapist needs to appraise the client's cognitive style in terms of his or her tendency to endorse beliefs that lead to emotional dysfunction. Albert Ellis (Ellis, Abrams, & Abrams, 2008) and Aaron Beck (1989), the founders of therapies that would be synthesized into what is now called cognitive behavioral therapy, both argued that irrespective of the presenting problem, it is a client's tendency to rigidly and consistently think in a self-defeating fashion that needs to be addressed in psychotherapy. This is as true in treating sexual problems as it is in treating phobias, social anxiety, and other commonly presenting problems.

What is uniquely critical to treatment of problems related to sexual functioning is the absence of judgment, moralizing, or condescension. There is no therapeutic encounter in which it is more important that any judgments of the therapist are kept in check, and the client is made to feel that his or her troubles are not abnormal or shameful. This absence of judgment does not preclude attempts to change or alter the problematic behaviors or deficiencies. It merely conveys to the client that there is no absolute good or bad in sexual behavior, save for behaviors that involuntarily harm others. This is of particular importance, as few presenting problems in psychology are as dramatically associated with shame and guilt as those related to sexual performance or behavior.

COMMON FACTORS IN SEXUAL TREATMENTS

After the intake and evaluation and the development of a therapeutic alliance, the work on alleviating the issues that led a client to seek treatment can be more directly dealt with. Oftentimes the client will make allusions to a sexual problem and yet be quite evasive about specifying the unique details of his or her problem. As the therapist guides the client to discussing his or her issue, the therapist must continually convey a sympathetic stance to the client's conflicts, but must remain composed when discussing the particulars of the problem.

As Beck (1989) and Ellis (1971b, 1975, 1985) made abundantly clear, all psychological problems are associated with irrational or distorted beliefs. The following are some common irrational beliefs regarding sexual performance:

- It would be absolutely humiliating if a partner were unfaithful to me.
- It would be unbearably shameful if I made overtures to a person that I have known for a while and was rejected.
- My lover must be attracted to me to the same degree as I am to him or her.
- If I believed someone was attracted to me, and I found out that I was wrong, I would be a complete fool.
- If I failed to perform sexually even a few times, I would feel like a complete failure as a man or a woman.
- If I were closely involved with a sexual partner and discovered that people in my life found him or her unattractive, I would be deeply upset or embarrassed.
- If someone with whom I am romantically involved hurts or rejects me, I must hurt him or her back.
- If a lover cheats on me, I feel that he or she is (or I am) a completely worthless person.
- If someone criticizes or ridicules my body or any of its parts, I am completely degraded or valueless as a person.

- If I have sexual desires not consistent with my role as a man or woman, I am completely defective or shameful.
- I must understand the cause of my sexual problems in order to resolve them.
- My worth as a person is completely based on my sexual role or performance.
- It would be catastrophic if others found out that I have unusual sexual desires/practices.
- I must be completely normal in order to be loved or desired.
- I am completely sexually inadequate if I cannot have coitus or traditional sex.
- If I heard that a former lover was disparaging my sexual performance to others, I would be unbearably shamed.
- My partner must be completely open to me about his or her past behaviors.
- If my lover were unfaithful, it would be absolutely terrible and unbearable.
- If someone loves me (or I love someone), he or she must be sexually compatible with me.
- If I have sex with someone, he or she must love me or have romantic feelings for me.

These are prime examples of the typical distorted or irrational cognitions expressed by people seeking help with sexual problems. Despite the high frequency of people troubled by sexual dysfunctions, paraphilias, and gender and orientation, the client commonly believes that he or she has a uniquely dark secret. Based on the prevalence of paraphilias presented in this book and other studies of sexual disorders (e.g., Heiman, 2002), it is ironic that people are often ashamed of having a characteristic that may be shared in some form with as much as 80% of all other people. Consequently, the early goal in sex therapy is to help the client see that his or her problem carries with it no unique burden of abnormality or shame.

COGNITIVE APPROACH

The cognitive behavioral approach to sex therapy has two essential components as implied by its name: cognition and behavior. The cognitive component requires that the therapist listens carefully to the client's description of his or her problems. During this process, the therapist must pay close attention to the stated or implied cognitive distortions, defective schemas, or irrational beliefs that the client has about himself or herself or others. Upon determining that an irrational cognition is a basis of a sexual or related problem, the therapist must strongly challenge the client's distorted cognitions or beliefs. This can only be achieved when the client is confident that the therapist is not attacking him or her as a person. In

addition, the therapist must establish a relationship in which the client feels the therapist is unequivocally on his or her side, but does not necessarily support his or her ideas.

When such a therapeutic partnership is achieved, the therapist can dispute a client's dysfunctional beliefs in several ways: Socratically, empirically, didactically, philosophically, or metaphorically. A Socratic dispute involves the therapist systematically questioning the client's belief until he or she reaches a point at which the belief cannot be supported. This is a favored approach among clinicians who apply any of the treatments that fall under the cognitive behavioral rubric. The empirical dispute requires the therapist to show the client that the essential facts that underlie his or her belief are untrue. A didactic dispute essentially teaches the client through examples, research evidence, and other instructional means, including the therapist's claims to the client, that the client's belief cannot be rationally maintained. The philosophical dispute engages the client to examine the aspects of his or her worldview that support the belief in question. It can involve the use of implied syllogisms inherent in the client's beliefs, the exploration of the conditional statements implied by the client's philosophy, and exploring other implicit and self-defeating life judgments directly or implicitly expressed by the client. Metaphorical disputing requires the therapist to restate the client's dysfunctional belief in the form of a metaphor that dramatically illustrates the flaws in his or her reasoning.

Fundamental to each of these therapeutic techniques is that the therapist conveys a sense of loyalty and alliance that can ultimately lead to a willingness on the part of the client to accept that his or her belief is flawed. Again, it is essential that questions posed by the therapist are not overly leading or biased. Otherwise, a therapist may inadvertently support a client's beliefs. The following is an example of Socratic disputing with a client who will not consummate a relationship for fear of disappointing his or her partner:

Therapist: I see what you are seeing, that if you don't look great and perform like an adult film star, your relationship would definitely be over.

Client: I didn't say it would definitely be over, but it could be disappointing or embarrassing.

Therapist: I understand that if you disappoint your lover, you will have done something shameful.

Client: Well, I want to please my lover.

Therapist: But didn't you say that you are avoiding intimacy for fear of not doing well?

Client: Something like that, yes.

Therapist: Doesn't that mean you feel you either do perfectly in sex or you shouldn't even try?

Client: I didn't say that exactly . . .

Therapist: Don't you do a lot of important things without having a guarantee that you will do them well?

Client: Of course, life has no guarantees.

Therapist: But in this case you are avoiding sex unless you have a guarantee, aren't you?

Client: I wasn't asking for any kind of guarantee, exactly.

Therapist: Maybe not exactly, but if you feel calm only if you are sure of doing well, it is pretty close to that.

Client: Maybe.

Therapist: Imagine you were going to have sex with a completely indifferent prostitute whom you had very little regard for . . .

Client: I would never have sex with someone like that.

Therapist: Probably not, but just imagine that some life situation invariably led you to do it.

Client: Okay. . . .

Therapist: In this highly fictional encounter, do you think you would be the least bit apprehensive or concerned?

Client: No, probably not, why would I care what he [or she] thinks?

Therapist: So doesn't it follow that you are worried that your lover will think badly of you?

Client: Well, of course I care what he [or she] thinks!

Therapist: Isn't it more than caring if it leads to worry or avoidance?

One can see the trajectory of this session. The goal is to lead the client to strongly disavow the premise behind the belief and to subsequently take a middle ground.

BEHAVIORAL APPROACH

The behavioral component of therapy can include exposure or visualization, especially for those whose sexual problems include social fears, avoidance, or

nonspecific anxiety. Visualization exercises may be of the type employed by exposure therapies. Behavioral exercises can include confronting shame or self-esteem by having the client intentionally perform acts (safely and legally) that exceed his or her greatest fears. For example, Ellis (Personal observation, 1991) instructed men whose shame about their penis size was an impediment to attempting sex to enter a crowded pharmacy and negotiate a price for a gross of condoms. When that step was completed, the client would then ask for the condoms in the smallest size available. The clients who carried this out uniformly said they felt empowered. One reported that the pharmacy staff seemed to feel more embarrassed by the transaction than he did.

The alleviation of damaging and painful emotions is an essential starting point of sex-related psychotherapy. Most rational-emotive/cognitive behavioral therapy (RE/CBT) clinicians encourage psychoeducational interventions. This approach requires the sex therapist to be well informed on current research, evidence-based sexual norms, cultural mores, current sexual practices, and evidence-based treatments. By being familiar with these factors, the therapist can demonstrate to clients (and even have clients read data for themselves) that their darkest secrets are common and their shame and anxiety is for naught.

Although a CBT approach to treating sexual problems is discussed here, therapists must also have a working knowledge of behaviorism, medical treatments, interpersonal therapy, psychodynamic approaches, action and commitment therapy (ACT), dialectical behavior therapy (DBT), exposure therapy, solution-focused therapy, and emotionally focused therapy. If therapists use a certain modality because that is the only one they know, one must question their commitment to the profession. While it is not required to have a mastery of the many hundreds of psychotherapeutic approaches, it is important to be conversant in all the therapies found to have proven efficacy by the American Psychological Association when treating the complex problems found in people with sexual conflicts or dysfunctions. This knowledge assures the client that the therapist has the ability to take an integrative approach[2] when necessary. Specifically, when there is a more appropriate approach that can augment CBT, the therapist first needs to know that alternative approaches exist and can be integrated into the treatment plan.

[2] Integrative therapy denotes the informed application of different therapeutic techniques when clinical evidence supports that each treatment is best for a specific presenting problem. Additionally, an integrative therapist may apply several methods for individuals suffering from multiple problems. Integrative therapy differs from the eclectic approach in which a therapist will apply multiple techniques based primarily on his or her personal judgment.

The Case of Vincent

For example, Vincent came in for therapy with a cluster of life adversities. He was struggling to enter a new career, one in which he feared he was incompetent. His girlfriend was sexually demanding and often critical of his performance. Vincent's father had abandoned his mother and college-aged brother. And the most troubling of all was Vincent's premature ejaculation. A half session into his recent history and life complexities, he and the therapist began to address this issue. It seemed that Vincent would usually ejaculate in approximately 3 minutes. He found this to be humiliating and a potential barrier to a long-term relationship. Vincent was asked whether he knew of the treatments for early ejaculation, and he responded at length. He knew of the squeeze technique, counter-arousing mental imagery, topical penile anesthetics, preintercourse masturbation, and low-dose serotonin selective reuptake inhibitors (SSRIs, such as paroxetine). Vincent had used these methods on occasion with varying degrees of success.

The nature of his problem became clearer when he was asked whether his girlfriend had ever complained about his condition. He reported on a couple of occasions that when he ejaculated particularly quickly, she would ask him to help her "finish" by providing oral sex. When questioned whether he felt that taking longer to orgasm would allow him to enjoy sex more, Vincent indicated that he enjoyed it so long as he reached orgasm—irrespective of the time it took. In fact, he stated that efforts to prolong sex impeded his pleasure. From these questions it became increasingly apparent that Vincent's problem was the belief that he had a problem. He had a distorted schema based on the model of an ideal lover who was always capable of passionate and prolonged love sessions. In his model of the ideal male lover, the woman would be transported with passion and marvel at his mastery of lovemaking. He also subscribed to the irrational belief that he was inadequate if he came before the woman did. Within a few sessions of RE/CBT, Vincent saw that although it was preferable to make prolonged passionate love, it was not a requirement and he was not subhuman for failing to provide it. Within these sessions, Vincent became aware that he had burdened himself with demands for excellence in all areas of his life, including sex. He was challenged to examine which of these values actually motivated him to excellence and which served only to burden him. He was informed that his assessed time to orgasm was within a minute or so of the average man of his age and that the time of orgasm usually increases with age. With these psychoeducational techniques, empirical and didactic disputes, Vincent rapidly concluded that if no woman had ever complained of his performance or ended a relationship based on it, the preponderance of the problem was essentially within him. It was agreed in therapy that it might be beneficial for future relationships for Vincent to learn how to delay orgasm. However, Vincent was mostly disturbed that superior sexual performance didn't come to him naturally, as did most of his other talents. Vincent came back intermittently over a two-year period, almost always with problems related to failing to meet his standards in life. During this time, he had risen in his career and had a very satisfying sex life. But he would periodically have to challenge his personal philosophical demand that everything should come easily to him and that failing at anything was a disaster.

TREATMENT OF TROUBLED RELATIONSHIPS

In the first part of the chapter, the fundamentals of treating sexual problems were presented. As indicated, the RE/CBT approach is effective for almost every sexual problem if properly applied. Still, there is a range of couples treatments extant,

including psychodynamic, rational-emotive behavior therapy, and emotionally focused therapy. All approaches must include an accurate assessment of the problem, a confidential and mutually trusting therapeutic relationship, a conveyance of hope and optimism, and the client's assurance that the therapist is skilled in a specific and readily communicable methodology. The second half of the chapter will focus on these treatments used to ameliorate the sexual problems that occur in relationships.

In most relationships, the early part of the romance is fairly easy, with the greatest adversities coming later as goals, sexual desires and expectations, and life circumstances change. For a couple to have a successful relationship, both people need to stay focused on mutual goals and work toward maintaining some level of mutual infatuation and desire. This proposition, of course, is easier said than done. Although love and sex play an essential part in our lives, we can be remarkably unsuccessful with them.

Why are our romantic and sexual lives so complicated, even between people who are in long-term committed relationships? The answer is that sexuality is dynamic; rarely does one pattern leading to sexual satisfaction work across the duration of a relationship. Rather, partners must adapt to changes and continue to cultivate passion and romance. The works of Albert Ellis and Aaron Beck shed great light on this issue. Beck (1989) observed that strong, infatuating romantic feelings and passion are ubiquitous in the beginning of relationships but tend to diminish throughout the months and years. This trend does not mean that the relationship is weak or flawed, but it appears to be the natural course of a romantic relationship. In the beginning, infatuation helps to create a bond that forms the basis of the romantic relationship. However, the level of infatuation, and the expenditure of energy and emotion that result from it, cannot last forever, as individuals must eventually invest their time and energy in other areas of life. This reality leaves many feeling sad and disappointed.

Over time, as the infatuation diminishes and partners relate to each other in a more mundane manner, cognitive distortions that lead to conflict may occur. One example of a cognitive distortion that Beck addressed is mind reading. Mind reading refers to a situation in which one of the partners believes that he or she knows what the other partner thinks or expects, which can lead to great misunderstanding over the short and long term. Thus, this presumed awareness of the other's desires, motivations, and intentions must be avoided or at least checked and reconsidered. Beck (1989) offered alternative solutions to the cognitive problem of mind reading. Such solutions included having the client develop alternative hypotheses for why the significant other behaved in a specific way. Or, the client is requested to think back about the occasions in which the client acted similarly to their partner. Often one will discover that he or she subjects the partner to double standards, in which it is acceptable for the client to behave in a particular manner

but unacceptable for his or her partner to do so. Cognitive exercises that minimize automatic negative responses are often helpful. While cognitive and cognitive behavioral therapies help partners address and improve relationships, many theorists often fail to explain why specific problems in relationships commonly occur. This is true of cognitive couples therapy, emotionally focused couples therapy (Johnson, 2004), and acceptance and commitment therapy (Jacobson & Christensen, 1996), among others. The solutions to these problems are becoming increasingly clear, however, with the growth of evolutionary psychology. As set forth throughout this book, cognitive styles, social biases, and what appears to be irrational behaviors in love will often make sense in the light of evolution. In short, many of these inclinations to think and act in self-defeating ways are often inclinations that were adaptive in the early eras of human evolution.

As early as the 1940s, Albert Ellis (1957) addressed the issue of waning sexuality. In doing so, Ellis recognized the importance of the evolutionary and biological bases of sexuality, but he did not ignore the ever-changing nature of sexuality, in particular the influence that culture can have on sexuality at any given time. He recognized that sexual desire is easily influenced and changed and, therefore, can be sporadic and unpredictable. If a couple is committed to the longevity of a relationship, they may need additional sources of stimulation as well as therapy (Ellis, 1972). Ellis believed that professionals dealing with couples therapy should have a solid understanding of psychology, sexology, and anthropology (Ellis, 1954). Only by understanding the attributes of human behavior that all of these fields explore would the complexity of human relationships and sexuality be better understood.

In general, sexual and relationship problems are perceived through a sociocultural lens. That being said, therapists should always be aware of underlying biological/evolutionary influences. Therapists armed with a scientifically based model of social and sexual behavior will be more effective in treating problems in love and sex, as it will provide a better understanding of underlying rationales for a client's behavior, which can lead to more efficient communication with and deeper understanding of the client. In contrast, if a therapist bases treatment on the poorly evidenced notion of psychodynamics, repression, and mental objects, then he or she will naturally use interventions that have little to do with the underlying problem. For example, most studies suggest that the experience of love is a biological phenomenon. Accordingly, the evolutionary adaptiveness of love is in keeping two people together only for as long as it is necessary to wean a child (Fisher, 2004). This is not a modern hypothesis. Schopenhauer, and even Darwin, had a similar idea. Darwin observed that men who are better able to take care of their "families," even in the short term, would have access to more attractive females in the future, as these males, in effect, "advertise their wares" by showcasing the health of their existing mates and offspring.

It is wrong to say that there is only one predetermined pathway and length for all romantic and sexual relationships. People engage in relationships of different lengths and different qualities ranging from one-night stands to decades-long passionate love. Individuals in the latter type of relationship tend to experience happier, more satisfying lives in general (Sternberg, 2013). These relationships, however, require hard work to maintain, and ultimately, many people are unable or unwilling to put in the effort regardless of the potential long-term benefits.

In addition, the wide range of what can be considered "normal" in love necessitates that the therapist needs to be aware of the many social variables that impact the satisfaction of partners in a relationship. For example, time spent together is proportionate to the longevity of a relationship. This is also true with the level of commitment that partners perceive themselves as having. Partners who recognize and accept that it is natural for romance and sex to change over the course of the relationship will have more stable relationships. By accepting change, relationship pressure or stress will be less likely to arise because one partner judges another to intentionally withhold romantic gestures, emotions, or sex. Lastly, social support (approval) of the relationship is also critical, as is the need for an optimistic outlook on the future of the relationship. Many sexual problems can be assuaged as the therapist educates the couple on the natural evolution of committed romantic relationships.

Couples seek help from therapists for reasons other than changes in sexual desire, frequency, or satisfaction. Some couples experience problems associated with sexual orientation or paraphilias, both of which can greatly inhibit emotional and sexual intimacy and are much more difficult to treat. Problems with sexual arousal and infidelity may also be a cause for a couple to seek treatment. Some of these issues and potential treatments for them are addressed in the following section.

PARAPHILIAS

To review the material in Chapter 10, paraphilias move the focus of sexuality away from the sexual partner and toward peripheral conditions, such as settings, objects, and specific behaviors. They typically involve perceived risks on the part of the paraphile. Paraphilias can present themselves in moderate forms that do not endanger the primary orientation toward another person. However, in severe cases, paraphiles can completely degrade intimacy and alienate (potential) lovers. From a clinical perspective, paraphiles need to experience distress caused by their condition in order for their paraphilia to be categorized as a disorder (American Psychiatric Association, 2013). If the paraphilia is not causing shame, distress, or social impairment to the paraphile, it is highly unlikely that it is a disorder.

Paraphilias are challenging for therapists because they are particularly resistant to change. According to Moser (2009), paraphilic sexuality is as much a part of the paraphile's sexuality as heterosexuality is to a straight person. However, a paraphile's sexuality is similar to individuals who suffer from various addictions, as paraphiles tend to become resistant to their initial arousal cues and require greater stimulation over time. Thus more intense sexual relations are sought. Like an addict, a paraphile has a brief refractory period and needs to repeat the act as soon as possible and with greater intensity to feel satisfied. A paraphilia often becomes an unsustainable and frustrating condition. In contrast to most sexual proclivities, those of the paraphile appear to be less biologically based and more learned. The sexual scenarios of domination, submission, or humiliation require a greater social complexity than ordinary sex.

As discussed previously, paraphilias as dominant sexuality are an almost exclusively male condition. They become problematic when they are either dangerous (or illegal), or more commonly, when they prevent or impede the intimacy and bonding that is desired between partners. A partner's paraphilia can be alienating and hurtful to the lover, who can essentially become a "prop" that is necessary for sexual arousal.

Because most paraphiles have learned to keep their propensities hidden, they will typically be exposed in a relationship when they let their guard down. For example, a man will be caught masturbating to fetishistic pornography; his wife may discover sexual implements; or a partner may discover a membership to a fetish site. Common reactions among women who discover their mates are paraphiles are, "He is a pervert and a terrible person for having these desires"; "He completely deceived me about his love, and our relationship is a total lie"; "He should be able to be turned on by me without his fetishes"; or "If he really loved me, he would be attracted to me without needing his sex games." When exposed, men frequently deny or dismiss the behavior, or vow to change the behavior (e.g., O'Donohue, 2014). Nonetheless, the "outed" men tend to feel great shame and have negative self-talk that is reflective of the women's reactions. These include "I am a pervert and a terrible person for having these desires"; "I am not a real man if I need to be aroused in such a sick way"; or "I can never be happy as long as I have these desires."

Depending on their intensity, paraphilias may make long-term relationships nearly impossible for many paraphiles and their partners. Therapists counseling a couple with this problem must include an assessment of the severity of the paraphilia. In more severe forms, a paraphilia tends to exclude all traditional sexual intimacy and be obsessively consuming. In such cases, the relationship is in great peril unless the nonparaphilic partner is extraordinarily accommodating. In milder forms, if both members are willing, the couple can be encouraged to build a sex life

that includes the fetish. The therapist also needs to address the feelings that both partners feel regarding shame, rebuke, or betrayal.

Importantly, the woman needs to be helped to assuage her belief that the paraphilia is an act of volitional betrayal, or that her lover's sexual desires indicate a lack of love and commitment. If this reassurance can be successfully conveyed, then the next phase of counseling can begin. This involves strategies to help the couple develop a sexual compromise that permits some degree of expression (albeit limited) of the paraphilia. For example, if the man has a lingerie fetish, and he is aroused by wearing women's undergarments, then his spouse must find her comfort level with his dressing this way prior to or during sex. If the woman finds it offensive or distracting, then a compromise can be reached. For example, a woman may allow the wearing or use of lingerie for arousal, but not during coitus. In short, the therapist can help the woman find her comfort zone within a paraphilic relationship, and potentially expand her comfort level so that sex is not as restricted by a narrow set of criteria.

As stated earlier, women tend to experience paraphilias at a much lower rate than men. In addition, it is the experience of the present author that when they do, the paraphilias tend to be less severe than those observed in men. The most salient exception is the sexual masochism observed in women who were severely sexually abused in childhood (Abrams & Stefan, 2012) For these individuals, treatment must follow the kind described in the case of Sharon above.

PROBLEMS WITH AROUSAL

The most common problem in sexual arousal is the fundamental gender difference in arousal cues. Men are visually aroused and tend to be less discriminating. Women are more aroused by men who display emotional commitment, affection, and stability. One arousal problem that is particularly dreaded yet easy to treat is erectile dysfunction. Erectile dysfunction can be particularly humiliating to the men experiencing it, in large part because most men are not aware of how common it is. This is a critical piece of information to convey in a counseling session. One study that surveyed the top sexual problems among men listed them as follows: problem getting an erection, problem maintaining an erection, premature ejaculation, and inhibited enjoyment (Dunn, Croft, & Hackett, 1999). The same study found that the most common female sexual problems were arousal problems, orgasmic dysfunction, inhibited enjoyment, vaginal dryness, and dyspareunia.

Prior to the advent of phosphodiesterase inhibitor (PDE5) medications (e.g., Viagra, Levitra, and Cialis), the most frequent problem addressed in sex therapy for men was erectile dysfunction. The high prevalence of erectile dysfunction,

especially among older men, was measured in a study examining men over 40 years old (Laumann et al., 2007). The study found that frequency of moderate to severe erectile dysfunction was 8.8% for men 40 to 49, 15.2% for men 50 to 59, and 29.2% for men 60 to 69. Another study showed a similar prevalence of erectile dysfunction among younger men, in which 19% of men who were 25 to 28 years old reported mild erectile dysfunction, and 5% reported a moderate to severe condition (Heruti, Shochat, Tekes-Manova, Ashkenazi, & Justo, 2004).

While PDE5 inhibitors are frequently able to treat the symptoms of erectile dysfunction, medications will not treat the multivariate causes of the problem if it is psychological in nature. As noted earlier, the waning of romantic love is usually linked to a decline in sexual arousal over time. However, sometimes the lack of arousal is due to more specific circumstances that have led to anger, resentment, or other negative emotions. Or it can be that one or both partners have emotional barriers to intimacy that initially did not affect sexual relations, but have ultimately damaged the ability of one or more partners to become aroused. Prior to treating a couple using psychotherapeutic interventions, it is important to rule out organic causes of the symptoms. For example, reduced free testosterone levels can contribute to loss of arousal and erectile dysfunction in men, and reduced estradiol and testosterone levels can have the same effect in women.

Once the presence of undiagnosed organic problems is ruled out, therapy can commence. It is important that the therapist is aware that the loss of sexual arousal may result from the natural tendency of a person to habituate to one's lover over time; that is, the excitement and romance that partners experience at the onset of their relationship will inevitably decrease. As previously discussed, men tend to habituate to their partners earlier than women do. This happens because men are generally aroused visually, while women are more socially sexually aroused, and it is far easier to habituate to a person's looks than to a person as a social being. Whatever the cause, when sexual attraction attenuates, so too will romantic love. This is commonly associated with increased arguments, the idiosyncrasies of one's lover become harder to overlook, and a partner may begin to consider possibilities of sex outside the relationship.

If attraction has indeed diminished, the counselor then needs to determine if both members of the couple are committed to the relationship through private interviews with each partner. In many cases, if the partners have matured into a union based on conjugal love and friendship, then the loss of passion does not invariably lead to the end of a relationship. One of the therapist's most important tasks is to address the irrational beliefs and related emotions that develop when one or both partners experience a loss of arousal. These include beliefs like: "I won't be able to get over the fact that my lover does not get excited by me!"; "I can't stand that she doesn't excite me anymore!"; "I am a terrible person for fantasizing about

The Case of Lorraine and Mark

Lorraine was a senior administrator for a pharmaceutical company and Mark was a structural engineer with a full-time job and a part-time consulting practice. According to Lorraine, sex in the first two years of marriage was frequent and highly satisfying. During this time, they had a child, Sara. Until their fourth year of marriage, Lorraine, Mark, and Sara were a tight-knit family of three. However, shortly after Sara's third birthday, Lorraine began to express criticism about Mark's manhood. Lorraine made it clear that she was disappointed by Mark's lack of assertiveness and masculinity, as well as the way in which he related to and disciplined their daughter Sara.

Around that same time period, Lorraine withdrew sexually from Mark, asserting that having intercourse with Mark once per month should not be considered a problem. When pressed further on her attitudes about her emotional and sexual relationship with her husband, Lorraine expressed that Mark's inconsistent parenting of their daughter made her lose respect for him, and subsequently led her to lose sexual interest in him as well. Lorraine was quite vocal and adamant about her feelings and accusations related to Mark's manhood and parenting skills. In contrast, Mark was quite shy and taciturn. He was not entirely unresponsive, seeming to react in a passive-aggressive manner by acting deliberately obviously sullen.

Discussions during counseling revealed that although their personalities had not noticeably changed since the beginning of their relationship, Lorraine's attitudes toward Mark had become increasingly negative as Sara had grown. In a one-on-one session, Lorraine acknowledged that Mark did not arouse her any longer and insisted his behavior was the reason for this problem. While Mark asserted his expected sexual relations with Lorraine, he nonetheless exhibited some childlike behavior (frequently complaining about life stresses and asking her to console him) that seemed to exacerbate Lorraine's loss of sexual attraction to Mark. In his one-on-one session, Mark shared that he did not believe that his actions had dramatically changed since he had married Lorraine, and felt Lorraine's rebuke of him was unfair. Furthermore, he deeply believed that his wife should be attracted to him simply because they were married, regardless of any intervening circumstances (such as pregnancy, giving birth, and raising a child).

In response to this, the counselor suggested that Mark accept that Lorraine's feelings had changed and that Mark should consequently change his behavior if he wanted Lorraine to be sexually interested in him. Lorraine acknowledged that in the past Mark's need for emotional support and reassurance evoked maternal feelings, but now it was sexually alienating. Lorraine's belief was that Mark was supposed to know that her attitudes toward him had changed and should change his behavior without her having to ask. Once this belief was revealed to the couple, and they realized that they both had to change if they wanted to maintain sexual intimacy, then the couple saw improvement. Mark was still not happy that he had to maintain a façade of machismo to keep Lorraine sexually attracted. And Lorraine continued to feel that she was compromising by staying with Mark. Nevertheless, the relationship continued and their sex life improved. From an evolutionary point of view, Mark initially offered Lorraine satisfactory qualities as a mate and father. However, having had a child, the weaknesses that she had initially overlooked became less acceptable—especially if she were to have more children. On a deeper level, her sexual interests began to focus on men who offered a more suitable set of genes. Her conscious apprehension of this change was an increasing dissatisfaction with Mark's negative qualities, despite the fact that they have never changed.

other men"; or "This relationship is a complete failure because he [or she] doesn't want sex." As a couple is counseled that sexual arousal and interest do ebb and flow for a variety of reasons and that the loss of desire over time is completely normal, then the couple can be talked through their irrational thoughts and beliefs. Ideally, each partner will be able to recognize the fallacy of these ideas and ultimately disavow them in front of his or her partner. The couple can then begin to talk honestly and engage in a sexuality that is compatible with each partner's expectations.

INFIDELITY OR "CHEATING"

In 1895 Breuer and Freud, leaders in the field of psychoanalysis, published a book titled *Studies in Hysteria*. Its basic premise was that all human behavior is influenced if not determined by expressed or repressed sexuality. While nearly all of the tenets of Freudian-inspired psychoanalysis were ultimately rejected by empirically based research (Ellis, Abrams, & Abrams, 2008), it appears that, by happenstance, they shared one element in common with current evolutionary psychology. In short, individuals' behaviors are consciously or unconsciously aimed at gaining better access to the best possible mate.

Even behavior that is socially disruptive and violent may be derived from this sexual motivation (Buss 2005; Potts & Hayden, 2008). This evolutionary perspective of violence is based on both direct and indirect sexual jealousy. Direct jealousy relates to a male guarding the physical body of his mate, who he feels is in physical danger. Indirect sexual jealousy involves anxiety about tangential elements that are viewed as potentially detrimental to the sexual exclusivity of the female. This type of jealousy may include circumstances that lead to the loss of a male's prestige or social standing. Many evolutionary psychologists argue that homicidal jealousy is an evolutionary adaptation since killing a direct or indirect sexual competitor was an efficient solution during human evolution, as it smoothed the path toward passing one's genes to future generations.

Psychologists who treat couples in distress must understand human social behavior in terms of our evolutionary past. The sexual relations of our distant ancestors would have looked very different from those of modern individuals in Western long-term, monogamous relationships. One aspect of ancient and modern sexuality that is similar, however, is the feeling of jealousy. The fear of losing one's mate to another partner was and still remains very real. This fear is well founded; indeed, cheating occurs across many species. Across nonhuman species, extrapair copulation is aimed at facilitating a mate switch, allowing an individual to assess whether he

or she has chosen the best mate available. There is little doubt among evolutionary psychologists that this mechanism is also the cause for cheating among humans. And even among psychologists who do not work with an evolutionary perspective, there are few that deny that jealousy plays a powerful role in relationships. The only difference between the evolutionary and traditional perspective is the former sees jealousy as originating out of a once-adaptive emotion, and the latter tends to see it as pathological.

When one is emotionally and sexually committed to another person, there are few life events that are as traumatic as discovering that the loved one has been intimate with another person. The infidelity can be purely romantic and emotional, without any sexual relations. Or sex can be a part of it. While husbands and wives both find the former hurtful, it does not approach the escalation of emotions that ensue when the infidelity is sexual. The emotional suffering that almost universally ensues from the discovery of sexual infidelity belies the argument that men (and women to a lesser extent) are evolutionarily predisposed to cheat. Those who argue that cheating is somehow acceptable because it is an evolutionarily natural behavior need to be reminded of the naturalistic fallacy. This cognitive distortion holds that things that occur naturally are consequently better, more moral, or right. However, a simple examination of the many thoroughly natural things that can be lethally bad demonstrates how invalid this premise is. Disease, predatory violence, aging, and cancer are all natural parts of life, but they certainly are not inherently good. In fact, Darwin himself argued against natural selection and its endowment of evolutionary traits as representing something intrinsically good. In *The Origin of Species,* Darwin wrote of the relentless cruelty in nature,

> For instance, we can understand on the principle of inheritance, how it is that the thrush of South America lines its nest with mud, in the same peculiar manner as does our British thrush: how it is that the male wrens (Troglodytes) of North America, build 'cocknests,' to roost in, like the males of our distinct Kitty-wrens, a habit wholly unlike that of any other known bird. Finally, it may not be a logical deduction, but to my imagination it is far more satisfactory to look at such instincts as the young cuckoo ejecting its foster-brothers, ants making slaves, the larva of ichneumonidæ feeding within the live bodies of caterpillars, not as specially endowed or created instincts, but as small consequences of one general law, leading to the advancement of all organic beings, namely, multiply, vary, let the strongest live and the weakest die. (Darwin, 1996)

For the therapist, the evolutionary imperative that drives socially unacceptable behaviors serves as an explanation of the behavior. In addition, it helps clarify why

some people feel so compelled to act against their immediate interest and those that they may love. Understanding infidelity as a natural behavior that is also a social and interpersonal wrong allows for a clearer perspective in addressing it. In addition, many evolutionarily based behaviors will seem or feel right to the offender, even in the face of social rebuke or his or her own logic.

Evolutionary theory helps explain why men sometimes react in a much more explosive manner when discovering their mate has cheated. Evolutionary psychologists (e.g., Buss, Larsen, Westen, & Semmelroth, 1992) assert that violent jealousy in the face of sexual infidelity is a male adaptation. This explanation is supported by the correlation between the physical aspects of the body of males who have exhibited aggressive behavior or anger resulting from sexual jealousy. A negative relationship exists between the length of the second finger to the fourth finger and increased anger at sexual jealousy (Fussell, Rowe, & Park, 2011). The second digit to fourth digit ratio is a correlate of prenatal testosterone levels such that men or women with ring fingers longer than their index fingers were usually exposed to higher levels of testosterone. Thus a masculinized brain experiences greater distress at sexual infidelity. As was stated earlier, biological and evolution-based causes of infidelity should be taken into an account when considering any particular case of infidelity and the reaction to the infidelity. The therapist must also evaluate other variables that commonly contribute to infidelity. These can include psychological, sociological, and economic factors (Tsapelas, Fisher, & Aron, 2011).

It is important to note that a significant percentage of people whose partner cheated will never forgive that partner (Cann & Baucom, 2004; Shackelford, Buss, & Bennett, 2002). Thus this possibility needs to be explored early in treatment. If it seems that infidelity represents an unforgivable offense, then the couple needs to be counseled in a way that prepares them for the type of relationship they may have in the future, whether as a couple or not. Specifically, the unfaithful partner needs to be advised that if he or she stays in the relationship, then he or she may always be treated with hostility and resentment.

As with all couples therapy, treatment for a couple with an unfaithful partner should begin with an individual session with each partner, in part to determine whether each partner really wants to stay in the marriage. This is important, as one or both partners may argue that if they attend couples therapy, then they can say they have done everything to make the relationship work. Therapy can then allow for what they may feel is a less emotionally demanding and guilt-ridden departure from the relationship. If a counselor judges that therapy is being used as an exit strategy for one or both of the partners, or if one or both of the partners expressly disclose that they do not want to continue the relationship, the counselor should caution both partners that therapy is not likely to be productive. If, however, it is

evident that both people want to stay in the relationship and repair the damage caused by the infidelity, then the counselor can begin therapy.

As Beck (1989) emphasized, couples radically change their judgments when romantic passion diminishes. The role of the couples counselor is to assess the factors that led one of the partners to seek sexual satisfaction outside the relationship. These may include diminished attraction on the part of one or both partners, pairing for reasons other than sexual attraction such that one or both were never compellingly sexually attracted to each other, succumbing to a brief intense temptation, anger at the lover or spouse leading to retribution through infidelity, undisclosed sexual performance issues, and undisclosed sexual pathology.

There are changes in a relationship that can be as damaging as infidelity. In these situations, if such changes fundamentally undermine the marital bond (such as deep changes in spousal expectations, loss of sexual attraction, disavowal of commitment to the relationship, etc.) the counselor must assist each partner to understand and accept the new nature of their relationship. Briefly, this is achieved by helping each partner accept that the other partner has a right to change his or her mind or feelings at any time. Each partner can be Socratically guided to the conclusion that the other is not bound by the partner's own needs, demands, or values (Abrams, 2012). The ultimate goal is that the partner becomes aware that he or she is irrationally arguing that the lover should feel the way he or she wants the lover to feel. Indeed, even if a partner's falling out of love is painful, he or she cannot be forced to feel another way.

When treating a couple whose relationship has become tenuous, the therapist can be faced with issues relating to the couple's loss of sexual passion, the development of anger or resentment, or infidelity. When dealing with a partner who is aggrieved by some type of betrayal, the counselor must encourage the offended partner to understand his or her hurt, anger, and vengefulness in terms of personal demands or other irrational beliefs. The offended partner must be helped to see that retribution and rage are not compatible with restoring the relationship. To accomplish this, irrational beliefs must be elicited and collaboratively challenged. Similarly, the irrational beliefs that led the unfaithful partner to stray must be identified. If the unfaithful partner hopes to remain in the relationship, the irrationality of his or her actions needs to be explored and challenged. Both partners must be helped to see that creating a new relationship without the ruminations about the past is the best path to resolution. If both can come to view a betrayal such as infidelity as unacceptable, but not terrible or irredeemable, the infidelity can eventually become no more relevant than the sexual encounters that took place prior to the relationship.

The Case of Marisol and Vlad

Vlad was of Eastern European heritage and took great pride in his physical prowess and his ability to manage rugged construction workers as a part of his job. His hobby was martial arts, and he was quick to share that he was quite proficient in self-defense and fighting when necessary. At the time of treatment, Vlad was cohabiting with Marisol, an administrative secretary in the main office of a national corporation. Her job required her to work late on many nights and to attend corporate functions. Marisol and Vlad had three young children who were cared for by Marisol's mother when both parents were at work.

Notably, in the early years of the relationship, Marisol regularly lobbied for marriage and Vlad would evade the issue. Within the past two years, Marisol had stopped pushing Vlad to marry her and seemed satisfied with cohabitation. The couple came to treatment to address the increasing number of arguments about Marisol's late hours at work and Vlad's growing discomfort with her socializing with men at corporate functions. When asked if he was jealous of any specific man, he said no, but he was not comfortable with her being away from home for several hours during the evenings. Marisol insisted that attending these functions was essential for her career, but Vlad angrily argued that her job was secretarial, not social. She responded that he couldn't possibly understand the corporate world. This was a particularly hurtful response, as Vlad was insecure about the social and economic echelons of corporate men, which differed dramatically from his professional life in construction.

To treat the tension and hostility that was evident in the relationship, the counselor employed RE/CBT. In doing so, the therapist helped each partner understand the irrational and inflexible nature of his or her demands. For example, Marisol would insist that late work was necessary and would make no offers of compromise to set some limits. Examples of her tacit irrational beliefs were: "He has absolutely no right to restrict my behaviors," and "He doesn't work in a corporate setting and is making completely unfair demands based on ignorance." Marisol was encouraged to see that her rigid stance only provoked Vlad to become more demanding and hostile. Vlad operated under a different set of beliefs, such as, "She is the mother of my children and her presence at home should be her absolute priority," and "Her failure to compromise is completely demeaning of my masculinity and leadership role in the family."

Vlad was helped to see that although he had a strong desire to be in control of the relationship, Marisol did not have to completely accept his patriarchal standards. In addition, Vlad was encouraged to change his negative attitude when addressing the problem, as anger and aggressiveness did not set a positive tone for a potential compromise with Marisol. There appeared to be moderate success with this approach. Treatment ended after five sessions, and both Vlad and Marisol agreed to work on homework assignments that would help to reinforce what was revealed to them in therapy.

Although there were fewer conflicts during treatment, Vlad continued to be suspicious of Marisol's behavior. Not only did she continue to spend time away from home, but she also seemed indifferent and unaffectionate, and increasingly avoided any kind of physical and sexual intimacy with Vlad. Marisol was also critical of his interests in sports and frequently pointed out his working-class status and his exaggerated machismo, attributes that had once drawn Marisol to Vlad. Eventually, Vlad was suspicious enough of Marisol's behavior that he hired a private detective. The detective presented Vlad with a series of photos that showed Marisol entering hotels, dining, and kissing an executive in her company, the very type of man he most feared and resented.

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Vlad called the counselor in a state of agitated rage. He was hurt and angry with Marisol. He was also furious with the failure of the therapeutic treatment, ranting about how all the work on communication, anger control, and irrational demands was worthless, as Marisol was cheating on him the entire time they were in therapy. Despite his rage, Vlad made an appointment for himself.

The initial sessions were dominated by Vlad venting his rage. He was particularly enraged with the man with whom Marisol was having the affair. Although he earned a respectable salary and was in a leadership position in his job managing manual laborers, Vlad was very aware of the stark difference between himself and the men that he managed and the well-educated upper-class men with whom Marisol worked. This jealousy was frequently stoked when Marisol spoke about these men with admiring adulation. Now the men he had been covertly competing with had won, and in his eyes, had humiliated him. Although Vlad had worked on one set of irrational beliefs early on in therapy, the counselor identified a new group of irrational beliefs based on Vlad's reaction to finding out about Marisol's affair:

- "I have been completely shamed and must have revenge to save my manhood."
- "I must punish Marisol."
- "Women can never be trusted."
- "I must teach Marisol a lesson by getting custody of our children."
- "I cannot stand the idea that people will know she cheated on me."
- "I absolutely must hurt the man that stole my woman."
- "I am useless sexually and cannot fulfill a woman's needs."
- "Marisol is soiled, and I can never be intimate with her."
- "The whole relationship was a disaster."
- "Marisol completely made a fool of me, so everything she ever said must be untrue."

After meeting with Vlad, the therapist requested that Marisol come in for a one-on-one session. She agreed, in large part because she saw it as a way to indirectly communicate with Vlad, who had been aggressive and explosive when confronting Marisol about the affair. At this point, Marisol had ended the affair and was agreeable to working on the relationship with Vlad, although she believed that Vlad was largely responsible for her needing to seek a liaison outside their relationship. According to Marisol, Vlad had changed over the years, becoming increasingly angry, demanding, "primitive," and suspicious.

Marisol's explanation, although defensive, might have reflected a change in perspective brought about by the type of change in romantic love that is typical in long-term relationships. As the passion for Vlad faded, Marisol began to become increasingly intolerant of Vlad's flaws, eventually leading to the loss of sexual attraction to him. Without the awareness of the normal changes that occur in romantic love, Marisol developed a set of irrational beliefs:

- "I have needs, and if Vlad can't satisfy them then I have an absolute right to pursue my sexual needs with another man."
- "Vlad is the complete cause of our failed relationship because he let himself deteriorate. He can't expect me to be with him if he has turned into this kind of man."

- "My new man is completely compatible with me and loves me more than Vlad ever has, so I can't be doing anything wrong."
- "Vlad is no longer the man I moved in with. I have an absolute right to be with that man."
- "I shouldn't have to be with a man whom I don't desire, when there are nice men who want me."
- "Vlad should accept that I had desires that he couldn't satisfy."
- "Vlad made me feel completely alone and unhappy; I have an absolute right to be happy."
- "A lot of people have affairs, so Vlad is completely wrong for condemning me."

Through a RE/CBT approach, the therapist led Marisol through a process of discovering the irrationality of the set of beliefs that supported her choice to have an affair. A part of this process was to show Marisol that one of the most significant contributing factors to the deterioration of her relationship with Vlad was a change in her perception of him. This included having Marisol identify specific characteristics of Vlad that she found repellent.

As the therapy proceeded, Marisol repeatedly said that Vlad was not the man that she had moved in with, yet she could not identify specific ways in which he had changed. The therapist helped Marisol to see that in fact, the opposite had occurred—Marisol's perceptions had changed. Marisol eventually recognized this to be the case over the course of several sessions as the therapist challenged her irrational statements. This is illustrated with a session excerpt with Marisol; her irrational statements are denoted in boldface.

Therapist: "Marisol, I guess if you weren't happy with Vlad's behavior you had no other choice but to find someone who could make you happy . . ."

Marisol: "Of course I had a choice, but . . ."

Therapist: "Oh, what were some of the choices that you had?"

Marisol: "I guess I could have told Vlad how unhappy I was."

Therapist: "But you were unable to do this?"

Marisol: "No, I could have. I could have told him that I was unhappy, but he made it **too hard.**"

Therapist: "I see. How did he make it too hard for you to talk to him?"

Marisol: "He is the type of person that is just really hard to talk to, and it always seemed like he didn't want to talk about important things."

Therapist: "So because you had the feeling he wouldn't talk to you, you felt you had to find someone else?"

Marisol: "I didn't have to . . . He just pushed me away and **I needed to.**"

Therapist: "You needed to have an affair?"

Marisol: "I guess it's something I wanted because I wasn't attracted to his, all of his macho stuff, anyway he wasn't into me either."

Therapist: "It seems that by him coming here (to counseling) he is showing you that he thinks you are important and that he is into you."

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Marisol: "He's very angry, but I guess he does care about me."

Therapist: "So maybe you could have focused on the fact that he really does care rather than seeking someone else."

Marisol: "I tried, but he makes it **so hard.**"

Therapist: "Too hard to even try?"

Marisol: "He is so hard to deal with, **I can't stand** it when he comes home and acts so macho and ignorant. He comes home and acts like he is the boss of the house. The minute he walks through the door, he starts barking orders to everyone, like he's still at work and we are his crew."

Therapist: "You were able to stand it for a lot of your relationship; did he change so much that you now cannot take it?"

Marisol: "Maybe he changed and I changed."

In this session segment, Marisol exhibited irrational demands and difficulty in tolerating frustration. She was helped to see that although she still loved Vlad, she had become less physically drawn to him. As she felt herself becoming less attracted to him, Marisol began to be bothered by behaviors and attitudes that Vlad had always possessed, and she developed a set of (irrational) beliefs that supported the idea that Vlad must have changed.

Helping Vlad was much more difficult, as he was very angry and felt mixed emotions about the value of staying in the relationship. He stated that he hated the fact that he still loved Marisol. He felt trapped by the desire to stay with her when he felt so much anger toward her. He also continued to feel rage toward Marisol's lover. Initially, the therapist approached the pragmatics of staying with Marisol and their children. Subsequently, the therapist helped Vlad challenge his irrational beliefs about Marisol, such as, "I must hurt Marisol or the man she cheated with, or I am not a real man"; "I must leave Marisol because a man who stays with an unfaithful woman is not a man at all"; and "She must be punished and contrite or she will walk all over me again." Over several individual sessions, Vlad recognized these demanding and irrational beliefs and was taught how to both identify them and challenge their validity. One method that he used to identify irrational feelings was to gauge his anger or distress signs. Vlad and Marisol stayed together, although he remained somewhat suspicious and bitter about the event. Still there was a gradual improvement in the relationship.

The most enduring sexual relationships are those in which the partners are both physically and emotionally intimate. Sexual intimacy in relationships is comprised of a complex interaction of ancient biological drives, unique personalities, and social and environmental forces. Treatment of couples with sexual problems must always begin with a working understanding of the range and complexity of the many expressions of sexuality. It is particularly important that the counselor set aside his or her own values of sexual propriety. Instead, the goal is

to perform a differential evaluation of the couple's unique approach to sexuality and the basis of its malfunction.

It is also important to be aware of the fact that a couple consists of two unique individuals, each of whom may have different values and desires from those of his or her partner. The counselor needs to explore how these differences were complementary at the beginning of the relationship and how they began to be divisive over time. This understanding is best accomplished by eliciting the beliefs each partner has about him- or herself, the partner, and relationships in general. When the demanding, rigid, inflexible, or other irrational beliefs are exposed, disputing them collaboratively offers the best hope for a satisfying and long-term relationship for the couple with sexual and intimacy problems.

This chapter presents some very specific interventions for individuals and couples with sexual problems. Although this subject is difficult to cover completely in a single text, the reader should have a general sense of some key principles in identifying the cause of sexual problems and some means to address them. The individual assisting others with sexual problems must take a historical and social perspective in doing so. Very often, what is deemed to be a problem is more a construct of social values than an objective disorder. Just a few decades ago, it was a common mental health practice to treat homosexuality as a disorder, and not treating it as such was considered unethical. The best criteria to assess if a sexual issue is a result of a diagnosable disorder is to determine whether or not it impedes the individual's ability to achieve desired intimacy, restricts his or her functioning in life, or causes distinct unhappiness. Importantly, if any of these criteria are caused by societal rebuke or social expectation then, the criteria need to be reassessed.