Chapter 1

Sex and Couples Therapy: Biopsychosocial and Relationship Therapy

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Traditionally, there has been a disconnect between the fields of couples therapy and sex therapy in that therapists trained in one field are generally not trained in the other. This division may be due to the fact that couples therapy and sex therapy are not easy to integrate. Most couples therapy is focused on *process*—that is, helping couples look at their patterns of relating to each other and guiding them to change their interactions. The process of a couple's conflict is the focus of the session, instead of the content, as the process is the root of the problem. Sex therapy, however, is primarily focused on *content*. The content of sex therapy consists of the physiology of sexual functioning, psychoeducation about healthy sexuality, and tools to change sexual performance and interaction. Sex therapists need to have this body of knowledge at their fingertips at all times.

However, knowing content alone will not help clients if there are underlying intrapsychic difficulties or issues in the relationship. Sex and couples therapists must be attuned to each partner in the relationship, as well as to the quality of the relationship, to effectively move from focusing on sexual dysfunction to helping the couple develop a positive, healthy sexual relationship. Another essential factor in providing integrative sex and couples therapy is the ability to help individuals in a relationship understand the various influences that have contributed to their sexual self-esteem and their beliefs about sexuality. Often, an individual's sexual self-esteem needs healing in the context of the relationship and within themselves. It takes skill on the therapist's part to distinguish when to focus on the process of a session versus the content.

This chapter explores the theory and practice of the integration of sex and couples therapy through these three lenses: (1) basic knowledge of sexuality, (2) relationship systems, and (3) intrapsychic factors affecting sexual self-esteem, identity, and connection. It also provides methods to intervene in these three important areas.

Sex Therapy as Cognitive Behavioral Therapy

There is a body of basic knowledge about sexual functioning that is essential in helping couples address sexuality problems. Much of this original knowledge and practice was developed through the research and work of Alfred Kinsey, William H. Masters, Virginia E. Johnson, and Helen Singer Kaplan from the late 1940s until the 1960s (Kaplan, 1974; Kinsey, 1948, 1953; Masters & Johnson, 1966, 1970). From this work, we have come to understand that sexuality is a natural physiological process in the body, as is eating, sleeping, and drinking. When people try to control their sexuality by attempting to change it, direct it, or make it happen in a certain way, they interfere with this natural body function and can experience physiological anxiety. In fact, underlying almost every sexual dysfunction, such as anorgasmia, erectile dysfunction, premature ejaculation, and hypoactive sexual desire, is anxiety. *For the most part, anxiety is a physiological response that is incompatible with sexual responsivity*.

When people are anxious, their blood vessels contract and thus constrict the flow of blood throughout the body. In sexuality, genital and pelvic floor responsivity, such as lubrication in the female and erection in the male, occurs when blood flows into these regions in the body. When a person is anxious about sexuality or their performance and tries to control their response, the blood flow does not occur or stops; this can happen in the beginning, middle, or later stages of the sexual encounter.

Using this body of knowledge regarding the human sexual response, one of the earliest interventions for sexual dysfunction—the PLISSIT model (Annon, 1976)— was operationalized through the practice of cognitive behavioral therapy (CBT). Given that CBT is considered the gold standard of treatment for anxiety disorders, it makes sense that the original treatment of sexual dysfunctions was based on this modality. Broadly speaking, the PLISSIT model provides an approach to addressing sexual dysfunction that is based on the following acronyms: P for Permission Giving, LI for Limited Information, SS for Specific Suggestions, and IT for Intensive Therapy. Understanding each of these components provides a framework to practice sex therapy in a way that addresses anxiety and can improve sexual functioning.

Permission Giving

Permission Giving is the process of creating safety and acceptance in order for clients to discuss the most vulnerable parts of themselves: their sexuality, sexual beliefs, and sexual self-esteem. Although maintaining a nonjudgmental attitude often comes easily to therapists, helping clients be open about sexuality requires that therapists be comfortable discussing sexuality as well. For therapists who are not comfortable, it is helpful for them to receive supervision or attend a Sexual Attitude Restructuring (SAR) workshop. These workshops can easily be found at the website for the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). The ability to discuss sex in a natural, open way is the most essential skill in giving clients permission to share their sexual concerns.

From my experience, about 50 percent of couples have seen other therapists prior to coming to me for sex and couples therapy. These couples have sometimes experienced previous therapists who have allowed arguing, put-downs, and other forms of blaming in their past sessions. It is my job to be the authority in the room—the person who will contain the process. Therapists need to set boundaries around reactive behavior in order for both individuals in the couple to feel safe. There is security in knowing that the therapist can manage

the energy in the office, which then creates permission to discuss the sensitive topics around sexuality.

For example, when John and Julie came to couples therapy, it became clear by the second session that they were there to address their conflict around desire discrepancy. Julie expressed a litany of provoking and blaming comments in a raised voice, "You only think about yourself. This is all your fault. You don't initiate sex ever. It is never the right time for you. You are a narcissist." Upon hearing this, John stood up, kicked the trash can, and left the room. He came back about 10 minutes later. At that time, I made the boundaries clear to both of them: "It is important to slow down and speak for yourself. It is my job to keep the space in the therapy room safe by helping you both to slow yourselves down and begin to listen to each other. When you speak everything that comes to your mind, instead of monitoring your own thoughts, your partner is not able to stay present to you. Additionally, physical reactions, such as kicking the trash can, will frighten your partner and are not okay in the session."

I inform couples that this type of contract is essential to keep the therapy room as a safe container where they can explore the more vulnerable feelings around their sexual relationship. I ask each of them to verbally agree to this contract. In later sessions, if it is needed, I remind them that they have made a contract with me to this effect.

In addition to setting boundaries, the following are some other ways therapists can help clients feel safe discussing sexuality:

- Educate clients about sexuality as it relates to their problem. This gives them confidence and hope that the therapist can help them. For example, when working with a female with hypoactive sexual desire, I inform the client about the difference between spontaneous versus responsive desire. In other words, desire often comes after arousal. Women are relieved and validated by this knowledge. Whether they have a male or female partner, this information is a relief to the partner, as they have often taken their partner's lack of desire to mean that there is something wrong with them.

- Use correct sexuality terms. For example, speak openly and plainly, using the correct words for body parts: penis, vagina, oral sex, and sexual intercourse.

- Normalize clients' anxiety about discussing sex with a therapist who was until now, a stranger, by saying things like, "This must be uncomfortable, talking about the most intimate details of your life. I want you to know there is little I haven't heard in this office."

- Use good listening skills and validate their experiences.

Limited Information

Limited Information is the process of providing basic education regarding the topic at hand. It is synonymous with the process of helping clients change their cognitions in CBT. Cultural, familial, religious, and societal norms usually do not provide clients with education about healthy sexual attitudes and beliefs. It is this history that therapists need to access to make attuned interventions.

Consider the case of Lauren and Ron, who came in for therapy to discuss their sexual issues and who were both quite emotional. Lauren had grown distant from Ron. As a coping mechanism, Ron was viewing pornography more frequently than he was comfortable with. His wife interpreted this behavior to mean that Ron was not attracted to her and wanted women who looked similar to the pornographic actors. She often became angry in this discussion, both at home and in the sessions, and eventually became quite tearful.

An important intervention for the therapist to make in this situation is to teach the couple about the use of pornography by giving limited information on the topic. Some examples of giving important limited information might be:

- Pornography and fantasy can sometimes be a way to create more arousal.
- Pornography can help bring the brain into the sexual experience.
- Most people are not interested in doing what they see in a video.
- Viewing more pornography than a person is comfortable with is often a coping mechanism.

However, some new therapists, in their excitement to help clients achieve results, can give too much information in a way that is not attuned to the couple. It is important to use limited information in session only when the therapist clearly understands the problem and has made space for clients to explore the necessary emotions underlying their beliefs. If a therapist were to offer this information too soon in the course of treatment, the opportunity could be missed to go deeper and explore the client's underlying emotions. For example, Lauren thought she was not enough for her husband both in terms of her body image and as a partner. These were important places to explore in order to help both Lauren and Ron as a couple.

Therefore, therapists should ask themselves a number of questions before offering important limited information, beginning with, "Why am I giving this information, and this amount of information, at this time?" Some other questions for the therapist to ask themselves when considering when to give attuned limited information include:

- Am I anxious about the amount of emotion shown and thus interrupting the flow?
- Have I fully understood the client(s) before I offer information?
- Am I uncomfortable with the subject they are discussing?

There are many examples of how limited information might be helpful in an integrative sex and couples therapy session and facilitate cognitive restructuring. Some examples that are helpful include:

- Most of the time, anxiety and sexuality are incompatible physiological responses. Blood vessels close when people are anxious and open when they are relaxed. Blood flowing into the genitals is the primary mechanism for physiological arousal in the pelvic and genital areas.
- Sexuality is about options. When something is not working, do something else rather than continuing to do the same thing over and over or withdrawing from one's partner. Remember the quote by Albert Einstein, "Insanity is doing the same thing over and over again and expecting different results."
- Sex is a journey. Pay attention to the journey instead of worrying about or focusing on arriving at the destination (the orgasm or intercourse).

- A sexual experience is similar to meditation. When someone gets distracted by their thoughts, they can notice them, let them go, and return to focusing on the sensations in the moment.
- Other than medical problems, the brain is the primary organ in the body that interferes with sexual functioning.
- Different and multiple types of stimulation help enhance arousal.
- The use of fantasy is another form of stimulation that can help a person focus more on sensations, rather than observing or worrying about their own or their partner's arousal. Using fantasy is not necessarily a sign that a person is not attracted to their partner or wants a different partner. Fantasy is a thought, not (necessarily) a desired action.
- The goal of sexual encounters is not performance; rather, it is about pleasure, connection, fun, and stress relief. Focus on the many positive aspects of sex instead of how each person is performing.
- Touch has two points of contact. When a person is touched, their focus is on the specific body part being touched. The other person's focus is on touching and noticing what they experience in touching. Pleasure can be experienced in both ways.
- Accepting differentiation in sexual relationships helps deepen sexual intimacy and connection. Examples of this are:
    - Couples are not always aroused by the same type of sexual activities. This is not a sign of incompatibility. For example, individuals can address different arousal triggers by taking turns.
    - Welcome one's own sexuality, as well as that of one's partner. Shaming a partner for their desires is often based in one's own fear and can be damaging to the relationship.
    - Many people have different doors into their sexuality. Despite the differences, pay attention to what stimulates sexual interest in the partner.

Specific Suggestions

Specific Suggestions involves giving clients specific suggestions for behavior changes that can help improve sexual satisfaction or functioning. It is similar to treating anxiety within a CBT framework, in which clients work their way up a hierarchy of anxietyprovoking situations. For example, clients with a fear of flying may first begin treatment by looking at pictures of airplanes until they habituate to the anxiety that this stimulus causes. The next step in the hierarchy might be going to the airport, followed by walking into the airport, going to the gate, getting on the plane, and eventually flying. This method of systematic desensitization helps clients gradually overcome their anxiety to become comfortable with flying.

Helping clients change in integrative sex and couples therapy is based on the same principles. Sex therapists offer couples a ladder of activities to help them work through their sexual anxiety to become more comfortable and present in their sexual interactions. Sensate

focus, which is an intervention developed by Masters and Johnson, is a prime example of using an anxiety hierarchy. The purpose of sensate focus, which is a form of mindfulness, is to help people create an experience in the present moment wherein they concentrate on the sensations in their body instead of focusing on their thoughts. In doing so, it releases people from the anxiety of performance and pleasing their partner. In the long run, this creates a more satisfying, pleasurable, and sensual experience. The hierarchy of exercises involved in this process could be as follows:

1. The couple is first given directions to explore their partner's body through touch, while not touching the breasts or genitals.
2. After a comfort level has been achieved by both partners with the nonsexual touch, exercises include incorporating gentle touch that adds the breasts and genitals.
3. Positive verbal and nonverbal communication are added in order for individuals to guide their partner's touch.
4. Eventually intercourse is experienced, focusing on mindfulness.

However, the anxiety hierarchy may not always work as planned. Sometimes, difficulties with compliance occur when therapists do not have the client's "buy-in" when it comes to the exercises. Other times, clients may simply be asked to start with activities that are too far up the ladder for them. For example, a couple may not be ready to start with a naked-body touching exercise. To avoid these challenges, it is more useful for the therapist to first define the overall concept of sensate focus, educating the couple on the purposes of sensate focus and then asking them what touching exercise might work for them. In other words, cocreating the exercise together makes it more likely that there will be buy-in from the couple, and it ensures the therapist does not inadvertently assign the couple a starting exercise that elicits too much sexual anxiety.

There are other reasons couples have difficulty with compliance in "doing the exercises" between sessions. The explanation for this noncompliance can be found in the complexities of sex and couples therapy. If CBT is not working, therapists need to turn to other factors affecting sexuality: the relationship and intrapsychic beliefs about one's sexuality. This is when the therapist turns to the final step of the PLISSIT model: intensive therapy.

INTENSIVE THERAPY

The final level of the PLISSIT model is *Intensive Therapy*, in which the therapist works to uncover the underlying issues contributing to the sexual difficulty at hand. To address these issues, the sex therapist needs to explore two important factors: (1) the dynamics of the couple's relationship and (2) the formation of each partner's sexual self-esteem.

Exploring the Relationship Dynamic

Becoming a skilled relationship therapist is an essential component in sex therapy. Addressing a sexual problem, dysfunction, or issue cannot be easily accomplished through individual therapy alone, especially if the client is in a relationship. Often, a partner unknowingly

contributes to the sexual difficulty in unconscious, unaware ways. Generally, the sooner the therapist can work with the couple, the more effective the therapy.

In couples therapy, therapists work with the relationship. In fact, the relationship *is* the client rather than the individual. Indeed, there are three entities in every dyadic couple's relationship: Partner A, Partner B, and the relationship itself. It is the therapist's job to help clients see the relationship as an entity unto itself. The relationship is the energy that a therapist observes between the couple. The easiest way to initially understand this concept is to ask a couple what the energy between them feels like when they are in an argument. If partners have an argument and retreat from each other, they will describe a negative, tense energy between them. Partner A could be on the second floor of a house and Partner B in the basement. They will feel tension all the way from the basement to the second floor. Most couples identify with this example.

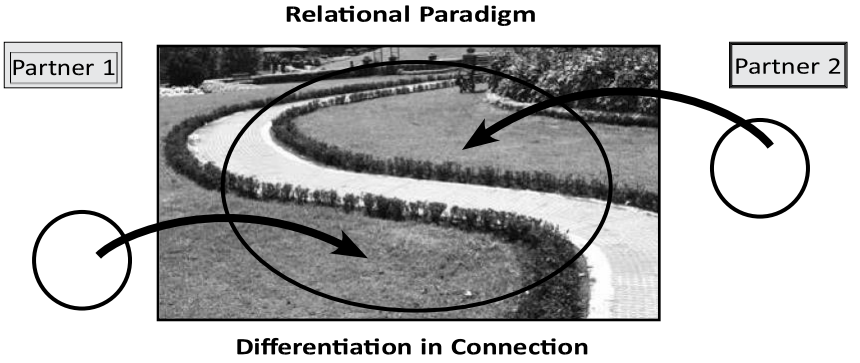
It is the therapist's job to help the clients understand they are responsible for the energy between them. This energy between couples is described as the "relational space" or "the space in between," both in Imago Relationship Therapy (IRT) and Emotionally Focused Therapy (EFT). Philosophers, such as Martin Buber and Jalāl ad-Din Muhammad Rumi (most often known as Rumi), have described this space as well. Martin Buber says, "When two people relate to each other authentically and humanly, God is the electricity that surges between them." Similarly, Rumi notes, "Beyond our ideas of right-doing and wrong-doing, there is a field. I'll meet you there. When the soul lies down in that grass, the world is too full to talk about. Ideas, language, even the phrase 'each other' doesn't make sense anymore." It is the therapist's job to teach couples about this space and how to take care of it.

In order to take care of this relational space, each partner needs to understand they contribute to creating ruptures within it. When a person feels unsafe in the relationship, they instinctually respond in ways to protect themselves and make themselves feel safe, even though that behavior often causes ruptures in the relational space. For example, they may withdraw, lash out, or leave their partner alone following a conflict. These adaptive coping mechanisms reflect the body's instinctual fight, flight, or freeze response. They mobilize the body for action in response to a threatening situation, regardless of whether the threat is real or imagined.

What shows up in the therapist's office is an interaction between couples—a dance of sorts—that reflects the disconnection between them. The relational conflict observed in the therapist's office is a microcosm of the interaction occurring between them at home. It reflects the couple's pattern of relating that is driven by their adaptive coping mechanisms, which, in turn, creates the disconnection. It is the job of the couples therapist to help couples change this pattern of relating so each partner can relax their protective behaviors and share their underlying feelings, beliefs, fears, and values. This type of sharing reflects an expression of what is often called the individual's "essence," "Self," "true identity," or "centered self."

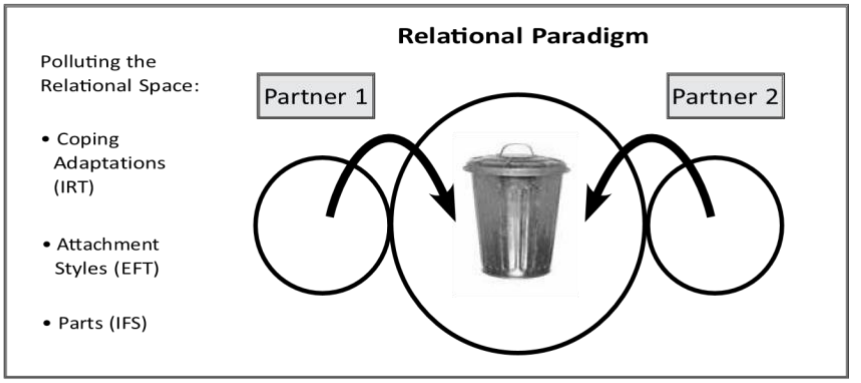
As individuals express their essence, the relational space becomes more connected, safe, and intimate, and each partner begins to feel calmer and more fully alive. Differentiation in connection, which is the ability for each partner to express their individuality and remain connected, is achieved as well. There is then room for each partner to fully express themselves,

no matter their differences, and still feel connected in the relational space.[1] The following diagram reflects the creation of differentiation in connection in the relational space.



The goal of couples therapy is to change the process between the partners in the relationship instead of focusing on the details of the conflict (i.e., the content). It is the therapist's job to help the couple see their sexuality dance *and* speak about what is underneath the dance. However, in integrative sex and couples therapy, therapists also offer feedback about the content of the problem (i.e., the sexual issues) to help the couple change their emotional and sexual interaction. As they change their dance and take care of the relational space, differences in sexuality can then be welcomed, and these differences can enhance their sexual connection.

Ultimately, it is possible to help couples relax their coping mechanisms and share their underlying feelings, beliefs, fears, and needs to restore connection, safety, and aliveness, both emotionally and sexually. In the following section, a discussion of these coping mechanisms and interventions to address them will be explored through the lens of IRT, EFT, and Internal Family Systems (IFS). At the heart of each of these theories is the notion that these coping mechanisms create disconnection in the relational space by "polluting it with trash."



Imago Relationship Therapy

[1] The same types of interactions are seen in dyadic partnerships or polyamorous relationships. At times, in polyamorous relationships, the dance may be more complex, as more people are involved, but the dynamics are similar. Therefore, any of the information presented in this chapter can be applicable to polyamorous relationships.

Through the lens of IRT, the protective mechanisms that individuals engage in when they feel unsafe in the relationship are referred to as coping adaptations. These coping adaptations are expressed through behaviors that reflect energy-out adaptations (e.g., fighting, overtalking, verbal shaming) or energy-in adaptations (e.g., withdrawing, stonewalling, fleeing, freezing). Individuals with energy-out coping mechanisms are called maximizers, "tigers," or "hailstorms," and those with energy-in styles are called minimizers or "turtles."

The following example illustrates how the coping adaptations that individuals engage in can create ruptures in the relational space. Mary and Joe were referred to me for help with their sexual dysfunction. Joe was diagnosed with premature ejaculation, as he ejaculated shortly after intercourse began. As a result, he developed secondary erectile dysfunction. In other words, he became anxious about his ability to maintain an erection because of his anxiety about having an orgasm prematurely. He also had low testosterone, which resulted in lower sexual desire, and he was taking testosterone prescribed by his urologist to address this concern. Mary had no functional sexual problems, but she was avoiding sexual encounters with Joe because of his frustration about his own lack of sexual response.

In their fourth therapy session, we explored their sexual interaction in detail, which revealed their sexual pattern (or "dance"). At some point in the beginning of each sexual interaction, Joe would have difficulty with his erection or ejaculate within minutes of insertion into Mary's vagina. Joe would grow frustrated and leave the

bedroom in a fit of anger. Mary would be upset but unable to express her feelings. Instead, she would withdraw and begin to avoid sex as often as possible.

The ways Mary and Joe protected themselves and created a rupture in their relationship are clear. Joe protected himself by getting angry. As long as he felt angry, he was unaware of his underlying feelings about his lack of sexual responsivity and functioning. Mary responded by withdrawing and did not express her feelings. Joe was a "maximizer," coping by "blowing up" and leaving the room. Mary was a "minimizer," withdrawing from Joe and withholding sex.

Using the steps involved in the "Imago Dialogue"—which include mirroring, validation, and empathy—Mary and Joe were able to actively listen to each other with understanding and without reactivity. In listening intently and without reactivity, both partners were able to express the deeper roots of their internal struggle, which originated from injuries they experienced in childhood. Joe was not angry with Mary, but it looked and felt that way to her. Joe was, in fact, angry at himself. Joe grew up in a family where he was shamed for his "failures." Joe felt shame and inadequacy when he was not able to respond sexually. In therapy, he was able to share this with Mary because she was truly listening and present to him. I helped Mary set aside her defenses so she could be present to Joe, which allowed her to feel empathy toward him.

With the safety of the Imago Dialogue, Mary shared the root of her coping strategies that were triggered by Joe's anger. In her childhood, Mary's mother would often "blow up" at her in a way that made Mary feel she was responsible for her mother's anger. Mary was angry at her mother for blaming her for things that were not her responsibility. Mary was quite tearful in telling her story, and underneath she also felt responsible and shamed, like Joe. Similarly, she felt blamed in the relationship. She thought Joe was blaming her for his sexual difficulties. She felt she did not deserve his anger and blame, and thus withheld sex from him to punish him. Withholding gave her a sense of control and power, something she did not have as a child.

As Joe listened in the session, he heard the origins of Mary's pain and anger. He was empathetic and moved by her feelings and story, actually leaning toward her and listening deeply. He reached for her physically and hugged her. This loving response healed old wounds inside of Mary, as her mother had never responded to her in an empathic way. This session created a change in their relationship in which the relational space, emotionally and sexually, felt warmer to both of them. They described the energy between them as more loving and said they felt more connected.

Emotionally Focused Therapy

Emotionally Focused Therapy (EFT) is another type of therapy from which the relationship paradigm can be understood. EFT is a form of couples therapy developed by Susan Johnson and her peers based on attachment theory, which helps couples create a secure, safe attachment with one another. It helps couples stop their negative cycle of interacting by teaching them to speak up and express their underlying vulnerabilities, feelings, and needs (Johnson, 2004, 2008). In EFT, coping adaptations are reflected in people's attachment styles.

When a person experiences inconsistent availability and abandonment by a parent or primary caregiver in their early years, they often develop an "anxious preoccupied" attachment

style that persists into adulthood. In relationships, they may pursue their partner and perpetually seek attention as a way to get their emotional needs met. In contrast, individuals who grow up with a parent who is detached, unavailable, and cold will often develop a "dismissive avoidant" attachment style, in which they keep an emotional distance between themselves and their partner. Finally, individuals who grew up in an erratic household characterized by oscillating patterns of abuse/distance and warmth may develop a "disorganized" attachment style. They often are in inconsistent connections in adulthood and exhibit the same "come hither, go away" dynamic. All of these attachment styles reflect ways individuals cope with pain and anxiety in an effort to get their needs met. These attachment styles create a dance, which creates ruptures in the adult relationship.

In working with Mary and Joe around their sexual relationship, it became clear that Joe was the pursuer ("anxious preoccupied") and Mary was the distancer ("dismissive avoidant"). These attachment styles created a dance in the relational space because each partner was unable to speak about their needs or their true feelings. The goal of EFT would be to help them recognize this dance and join together to fight it. Through EFT, Mary and Joe would express their underlying feelings—including their fears of being shamed or abandoned—and their needs to be valued and connected. Sex therapy techniques could then be used to help them express their needs sexually, as well as address their specific sexual dysfunctions.

Internal Family Systems Therapy

Internal Family Systems (IFS) theory maintains that everyone has a system of parts inside themselves that relate to each other, similar to those in a family (Schwartz, 2001). Some of these parts are protective, which explains why in IFS therapy, the coping adaptations are described as "protective parts." These protective parts often come into being because they are taking care of younger parts that were hurt as a child. These younger parts are termed "exiles." People have to protect and hide their exiles in order to survive. For instance, Mary's exiled part was her shame for being blamed unjustly for others' problems. Joe's protective part was created as a result of his underlying feelings of inadequacy.

All protective parts serve a purpose, as they help people to function and protect themselves. Sometimes, though, the protective part takes over, causing it to be the only part that others see. In IFS therapy, the goal is for the "Adult Self" (or Self- Energy) to be in charge so it can recognize the protective parts, heal the exiled parts, and speak for these parts as well. In the context of couples therapy, this process occurs through a method of IFS therapy known as Intimacy From the Inside Out (IFIO; Herbine-Blank, 2015). In IFIO, the therapist works to dissect the sequence (or dance) occurring between partners, as this sequence reflects an interaction between the protective parts. When the sequence becomes unraveled, each partner can begin to speak "for" their protective and exiled parts, rather than "from" their parts. As the Adult Self begins to speak for the parts, communication between partners becomes more authentic, open, and vulnerable. It is through this "courageous communication" that the relational space becomes more intimate, safe, and alive.

Though the IFS lens, the dance between Mary and Joe can be seen. Joe had a protective part that was reactive and responded with anger. In IFS, this protective part is called a "firefighter," a part that thinks there is an emergency and needs to react immediately to avoid

danger. This protective part existed to protect Joe's exiled part from feeling shame related to his perceived sexual inadequacy.

In the dance, Mary responded by withdrawing and shutting down her unexpressed anger. This protective part is called a "manager," and it tried to prevent Mary from feeling blamed and responsible for another's feelings. She too was protecting a younger part, an exile, that was hurt and shamed unjustly. By unraveling the sequence between them, Mary and Joe could have a courageous conversation, in which they would speak for their protective parts, as well as the younger parts they were protecting. Communication between Mary and Joe might look as follows:

Mary: "I have a part of me that is female, called my 'righteous indignation' part. The righteous indignation part withdraws from you. She feels mad because she believes you blame her for your sexual difficulties when you storm out of the room in anger. She wants you to suffer for hurting me. The righteous indignation part protects me from hurt and shame."

Joe: "Wow! I was not aware that you were experiencing this. I feel so sorry for hurting you. I have a part that feels angry and takes over. When that angry part shows up, I have another part that comes in—the 'runaway' part—that tells me to leave the room. The 'runaway part' of me is protecting my 'inadequacy' part, which feels so much shame about my sexual performance. It is much easier for my anger and 'runaway part' to take over so I don't feel the pain and shame carried by the 'inadequacy' part."

Mary: "I had no idea that was what your anger meant. It sounds so painful. Now that I understand it, let's see if we can work together to help each other feel more relaxed as we try to figure out our sexual relationship."

This conversation helps them take care of the relational space and create connection, warmth, intimacy, and aliveness. Subsequently, sex therapy techniques could be incorporated to help Mary and Joe express their sexual needs, as well as CBT techniques to address any specific sexual dysfunctions.

No matter what type of couples therapy a therapist uses, they are employing methods to help couples change their dance and express what is underneath in terms of beliefs, fears, needs, and emotions. Such communication helps couples find connection and takes care of the relational space. When sex therapists help couples unravel the dance, they are then able to teach them more positive cognitions about sex and help them make the necessary behavioral changes to improve sexual functioning. However, the intrapsychic beliefs people have about themselves regarding their sexuality may still interfere with couples' ability to create a thriving sexual connection, which is when exploration of each partner's sexual self-esteem becomes necessary.

Exploring the Formation of Sexual Self-Esteem

Sexual self-esteem is created by a multitude of factors. Culture, religious upbringing, ethnicity, gender roles, and family influences contribute in intricate ways to the beliefs, feelings, and selfesteem people have related to sexuality. When CBT or relational therapy techniques are not enough, it is time to explore the internal beliefs clients have about themselves as sexual

beings and in sexual relationships. Therapists need to delve into historical issues that influence the relationship and sexual dynamics. Through my experience, certain themes consistently show up in the context of this deeper exploration: (1) the three P's (performance, pleasing, and play) and (2) shame, guilt, and trauma.

The first P is related to **performance**. When men are focused on their erection, they might ask themselves: "Am I hard?" or "Can I stay hard?" or "Can I stay hard long enough for my partner to have an orgasm?" As discussed, this focus creates performance anxiety, which interferes with sexual responsivity. When a client finds it difficult to move out of this anxiety, it is helpful to explore how that person experienced performance pressure growing up.

For example, a married couple, Jack and Amy, came to see me because Jack was experiencing difficulty keeping his erection. He was not progressing with the CBT protocols for erectile dysfunction. When asked about his experiences with performance pressure growing up, he told a number of stories about being chastised whenever he didn't make all A's in school. He also experienced shaming when he made mistakes in sports. As his wife, Amy, heard these stories, she felt compassion for his pain and expressed this to him. Amy reached for Jack. Her voice softened and her eyes filled with tears. She said, "I had no idea you experienced so much pressure to perform when you were younger. I feel sad seeing your pain." She also saw that, at times, she triggered this reaction in him when she felt disappointed in his waning erection. Amy apologized and also comforted Jack about his childhood experiences.

She said, "You never deserved to have so much pressure as a child. I would never want you to feel that way with me." In sharing his story and through the healing and owning of his past, Jack received empathy from Amy and accepted the natural waxing and waning of his erections. He was able to try different options when his erection waned, which helped them to reconnect sexually in a more loving, positive way.

The second P is **pleasing**. In sexual encounters, people are often focused more on their partner's pleasure than their own, which represents another form of performance pressure. Sometimes, pleasing the partner is the only way an individual can relax enough to enjoy their own sensations. However, this focus creates pressure for both partners. The person who needs to please the other feels badly about themselves when that does not happen, which can result in low sexual self-esteem. Similarly, the partner being pleased feels pressure to respond in a certain way, which creates anxiety and lack of responsivity, or results in their faking a response to please the other person. In order to address issues related to sexual self-esteem, it is important to discuss the root of this need to please others as well.

I once worked with a lesbian couple, Sue and Betsy, in which I clearly saw this dynamic. Sue had a mother who was volatile on a whim. She learned to watch her mother's moods and tried to please her to protect herself from her mother's explosiveness. Sue did the same with her wife, Betsy. This pressure to please interfered with both Sue and Betsy's ability to enjoy their sexual encounters. Sue was focused on Betsy's pleasure, not on herself or her own experience. Betsy felt anxious to feel pleasure because it was so important for Sue to please her. Betsy would often shut down in response to Sue's desire to please her. This resulted in anxiety for both of them, with little pleasure for either.

When Sue saw she was creating so much pressure for Betsy, she wanted to learn how to let go of this need to please. I asked Sue if that part of her would be willing to stay in a different room of the house when they engaged sexually. She agreed, and she started making that mental

separation prior to sex. She also worked on her own self-soothing. She had the adult within her be present and compassionate to this younger part of her that wanted to please when she became fearful of Betsy's lack of arousal. She reminded herself that while Betsy could "blow up" about other things, she did not blow up in the sexual encounter. This helped Sue's younger part to relax a little. Betsy began to understand Sue's fears and was able to become more reassuring and loving, which helped Sue relax during sex. Betsy wanted to provide some healing for Sue around her childhood experiences by staying present in a loving way no matter what happened sexually.

The third P is **play.** Sensuality and sexuality reflect the ways adults engage in play. At its best, sexuality is a fun endeavor that brings pleasure to those involved. Unfortunately, many individuals are taught that play happens only after work is done. For example, children who come home after school are often told by their parents or caregivers that they must complete their homework before they can play. This message is often carried into adulthood, often making sex the last thing on anyone's list.

A couple with whom I worked illustrates the importance of discussing play in treatment. At the time of our discussion, I had been working with George and Lisa for about one year. They had addressed a number of issues that had little to do with sex. However, George was still upset by the infrequency of their sexual interactions. Lisa enjoyed sex when they had sex, but it was the last thing on her list. Lisa had a highpowered job and two children at home. Her tasks felt never-ending. At one session, I asked Lisa about her childhood as it related to her need to work so hard at home and work. She told a powerful story.

From the time Lisa was five years old, her mother woke her up at 5:00 a.m. on Saturdays to clean the house. Cleaning the house was often a process that continued until noon. By noon, the Saturday morning cartoons on television were over. The message Lisa took from this childhood experience into her adulthood was: "There is no play until the work is done." Her demanding job and desire to be a good mother resulted in the experience that her work was never done. Therefore, play was never a possibility. After Lisa understood this and saw the origin of this story, she decided she was no longer willing to put play last on their list. She and George began to find ways to connect sexually *before* all of the work was done.

In addition to the three P's, experiences related to shame, trauma, and cultural, religious, and gender messages can interfere with sexuality. When clients have experienced sexual abuse, sexual assault, rape, or sexual harassment, they may internalize a variety of sexual messages, such as, "Men are only interested in one thing," "It is my fault that I was raped," "I will never be good enough because I am broken," "I wore something that was too provocative," or "I was special because my father/mother/clergy/ family friend chose me." These negative messages are endless. It is important to note that any time a therapist sees clients who were shamed or experienced trauma, there may be sexual dysfunction or sexual acting out as a result. One couple with whom I worked, Andy and Susan, provides a good illustration of both.

Andy had a history of paying sex workers for sex, which had begun prior to his marriage to Susan. He had secretly been engaging in this behavior once or twice a week for over 25 years. After 20 years of being with his wife, Andy finally told Susan about his compulsive behavior. In delving deeper into the root of his sexual acting out, it was revealed that there were two traumatic sexual events in Andy's childhood and adolescence. In each, he had been publicly shamed for his natural sexual impulses. At the age of five, his mother discovered him playing naked with and touching other children's genitals (who were of the same age). His

mother chastised him in front of the others, leaving him with feelings of shame and an internalized message of, "I am bad." At age 17, he engaged in heavy petting with a girl without intercourse. However, the girl subsequently told their religious community that she was pregnant. Andy was publicly shamed for a behavior of which he was innocent. He was forced to publicly apologize to the religious community and be baptized again for his sins.

In addition, Andy had received religious messages about sexuality that further affected his sexual self-esteem. In particular, he had internalized the message "No sex before marriage." Therefore, the worst thing that Andy could have experienced was being publicly shamed by his religious community for an action he did not do. This public shaming resulted in Andy feeling ashamed of his sexuality and unconsciously acting out through compulsive interactions with sex workers. Whenever his shame and inadequacy would build up inside of him, Andy would contact a sex worker, as being with them made the terrible internal feelings go away temporarily. However, after the sexual encounter was over, his feelings of shame would come back with even more force. Without understanding the experiences of shame and trauma in Andy's life, it would have been impossible to help him heal his own pain and the pain he caused in his marriage.

Another factor to explore in the development of sexual self-esteem is the messages that have been communicated through an individual's ethnicity or culture. Hannah, a client of Hispanic origin, provides a good example. Hannah was big breasted and small in her hips. She told me that wide hips were important and attractive in her culture. She believed her Caucasian husband found her unattractive because of her small hips and feared he would tire of her and leave her. Over time, we explored these messages and her fears of losing someone important to her. By looking underneath her belief, she was able to recognize her fear of abandonment. She was able to provide healing to herself around her self-worth, as well as speak openly to her husband about her fears. He was able to help her heal by proving he loved her as she was. Therapy helped her understand that her hips had little to do with his commitment to her.

In addition, gender roles can affect sexual self-esteem. While there are vast changes in the perception of gender and gender roles over the last 40 years, sexual gender roles continue to be rigid and can create performance issues. Males still have many damaging conceptions that affect sexual relationships, such as, "I should be able to be erect at any time" and "I should know what is necessary to please my partner, whether they are male or female." Females may also carry messages, such as, "I am inadequate because I don't have orgasms with my partner through intercourse" and "I will offend my partner if I ask to have my needs met." Ultimately, it is the therapist's job to uncover these internalized messages and help clients explore their underlying fears. The goal is to help clients feel safe in their present adult sexual encounters by creating new, more positive internal messages.

Conclusion

The complexities of sex and couples therapy are obvious. Integrative sex and couples therapists are required to know the mechanisms of healthy sexuality and the methods to communicate this information to clients. Any time sex therapists feel stuck in a CBT-form of sex therapy, it is necessary to unravel the dance between the couple and help them speak their truth; explore their essence, fears, longings, and desires; and take care of the relational space.

It is also imperative to take a deeper dive into clients' history, beliefs, sexual messages, and traumas. The sexual messages and beliefs people carry about themselves are created to protect themselves from underlying hurt, low self-esteem, and fear of being hurt, enmeshed, controlled, or abandoned. When sex and couples therapy stalls, therapists need to explore these protective beliefs to help clients heal some of their past hurts, both for themselves and for their relationships. This healing will help individuals achieve a better sexual self-concept and allow them to develop relationships that are more connected, alive, and differentiated. By working with the past, clients can let old beliefs go and develop a new, positive, and healthy sexual self-concept.

For professionals who are couples therapists or who are just beginning to learn about sex therapy, do not be afraid to ask clients about their sexuality. Most people feel relieved when we create a space to discuss sexuality. If a couple's dance is obvious, ask how this dance shows up in sexuality. If they talk about the influence of their family, ask how their family has influenced their sexuality. If they talk about performance anxieties, ask if this shows up in their sex lives. If they talk about their traumas, ask how these have affected their sex lives.

Most importantly, take the risk to ask this simple question at any time: "How are things going for you sexually?" If clients do not want to talk about sex, they won't. This is not a question based on the agenda of the therapist. This is a question based on the fact that sexuality is a part of living, and it needs to be welcomed into people's lives in order for them to be fully alive and connected.