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Sexual Health

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The Birds and Bees of Sexual Health

Sexual health is an important concept that directly and indirectly affects the lives of individuals, couples, and families. Those described as "sexually healthy" are considered to have a physically and emotionally enjoyable sexual life. The World Health Organization (2006) defined sexual health as: "the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love." Contained in this definition is the concept that sexual health affects and is affected by several aspects of a person's life, such as sexual development, sexual functioning, physiology, emotions, relationship satisfaction, intimacy, and love.

Although sexual health affects many areas of one's life, clients and marriage and family therapists (MFTs) may not make sexual health a priority. Some therapists believe they have limited knowledge to discuss concerns related to sexual health. This could be due to the fact that many MFTs do not receive specialized training in sex therapy during the course of their graduate work; likewise, sex therapy training may not include detailed education on how to provide couples therapy (Hertlein, Weeks, & Gambescia, 2008; Weeks, 2005). Further, as the treatment of sexual problems becomes more medicalized (Hertlein et al., 2008; Lieblum, 2007), MFTs may not feel that they have the adequate medical training to pursue medical options or obtain information regarding physiological etiology and treatment of a particular problem. Finally, couples may have fears that impair their ability to put sexual health at the forefront. These include fears of intimacy, anger, abandonment, and other feelings (Hertlein, Weeks, & Sendak, 2009). With a fear of intimacy, for example, the couple's overall sexual health is compromised because attempts to move toward sexual interaction would increase the likelihood of the feared object: intimacy.

MFTs and other systemically-trained therapists are capable of addressing the complex interaction of physical, emotional, intellectual, and social aspects in the promotion of sexual health. For example, MFTs can assist adolescents who have misguided notions regarding contraception, which can directly influence their decision-making regarding sexual health behaviors. MFTs can also help some couples understand the extent to which imbalances in the couple's power dynamic or fears of intimacy limit their ability to achieve overall sexual health.

There are several approaches/treatment models that are designed to help a couple achieve optimal sexual health. Treating sexual dysfunctions was originally handled from a psychoanalytic perspective, because it was believed that sexual symptomatology was derived from an underlying problem, which required long-term, intensive individual treatment (Wiederman, 1998). As the behavioral models began to take prominence in the late 1960s and early 1970s, treatment for sexual dysfunction followed suit. Kaplan's (1974) approach is primarily behavioral and in many ways was similar to that of Masters and Johnson (1966), in terms of the individually-oriented thinking that pervaded the Masters and Johnson approach. Kaplan did offer a psychodynamic overlay in her approach and was, therefore, exploring the problems from a depth perspective, similar to that of the early sex therapists. It was often difficult, however, to understand how the psychodynamic perspective added to her behavioral emphasis or created greater change (Kaplan, 1974).

Cognitive behavioral therapies (CBT) have also been utilized in the treatment of sexual problems. McCabe (2001) found that a CBT approach to treatment improves attitudes about sex, believed sex was more enjoyable than prior to treatment, and experienced improvement in the dysfunction. Some elements of the cognitive behavioral approach include communication training (including verbalization of feelings, active versus passive listening, and effectively managing conflict), reducing performance anxiety, and prescribing sensate focus activities (see, for example, McCabe, 2008).

Trepper, Treyger, Yalowitz, and Ford (2008) outlined a solution-focused sex therapy approach. In this framework, the therapist helps the client focus on small steps leading to big changes, using "solution-talk," focusing on the present and future, and the search for exceptions and emphasis on solutions. This approach can be very powerful with sex therapy clients because of the overwhelming sense of negativity and failure they experience. Many of these couples chastise themselves for not being able to do what they perceive comes naturally to others. This negative belief about themselves, paired with unsuccessful sexual interactions, creates a

heavily problem-saturated environment around the sexual problem, burdening the couple and making movement toward resolution extremely difficult.

Finally, there are approaches that integrate cognitive, behavioral, psychodynamic, and couple components. The Intersystems Approach is one such approach and incorporates the variety of contexts in which the individual and couple are embedded. Conceptualized as a vulnerability model (i.e., assessing several areas of vulnerability to sexual problems) (see, for example, Trepper & Barrett, 1989) and grounded in the Intersystems approach developed by Weeks (1994) and outlined in detail by Hertlein et al. (2008), helping couples attain optimal sexual health includes assessment and treatment across five dimensions: individual-psychological, individual-biological, dyadic, family-of-origin, and sociocultural. In this approach, these domains help clients develop and maintain a positive, respectful approach to sex and sexuality. The Intersystems Approach grew out of the early theoretical thinking of Weeks (1977) and was refined over many years. The approach was first applied to sex therapy by Weeks and Hof and later in books by Weeks and Gambescia (2000; 2002). The Intersystems Approach moves beyond technical eclecticism to a comprehensive theory, which can embrace multiple theoretical perspectives. While the approach itself has not been empirically validated, the factors contributing to each component of the theory (i.e., individual biology, individual psychology, etc.) has at least one supporting piece of research (see Hertlein et al., 2008, for specific references). Thus, if you examine the individual, interactional, and intergenerational aspects of each system, you will find there is research that supports each component. Logically, it would follow that if a problem is maintained by several factors that are determined during assessment, then the treatment of each of those factors would be essential to recovery or improvement.

Though there are many clinical models, there are few empirically validated approaches to treatment (Heiman & Meston, 1997a). Of the studies reviewed by Heiman and Meston, some approached validation, but none had any long-term data and the short-term data showed a high relapse rate. This is likely due to several reasons:

- The youth of the field of sex therapy (Wiederman, 1998)
- Few certified sex therapists (approximately 444 certified sex therapists in the U.S., per www.aasect.com), most of which are in practice
- Treatment manuals are uncommon (Heiman & Meston, 1997a)
- Lack of control groups (Heiman & Meston, 1997a)
- Limited research funding (Heiman & Meston, 1997a)

These factors make it virtually impossible to research the effectiveness of sex therapy. As usual, clinical practice runs ahead of the science or empirical validation.

Diagnosis and Assessment

Because sexual health encompasses both physical and emotional well being, MFTs have a distinct advantage in forming a diagnostic impression from a systemic perspective, including how individual, interpersonal, and contextual dimensions contribute to sexual health concerns. The traditional view of treating sexual problems is individualistic and behavioral, whereas our perspective is clearly systemic, resulting in a comprehensive assessment and treatment experience. The *DSM-IV-TR* (APA, 2000) based its definition of problematic sexual behavior on the Masters and Johnson (1966) human sexual response cycle. The sexual dysfunctions listed in the *DSM-IV-TR* are "characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" (APA, 2000, p. 535). Sexual dysfunctions are classified as being in one of four categories (see Table 1).

One way to identify the extent to which the sexual health problem stems from organic or psychological factors is through using the specifiers as outlined in the *DSM-IV-TR* (APA, 2000). Sexual dysfunctions identified as "lifelong" are those that the client describes as being present since her earliest sexual activity. For example, some clients may report they have never experienced an orgasm in any context or with any partner. Such a case might suggest that the sexual dysfunction may be associated with a longer-term health issue or physiological characteristic. Similarly, cases where the sexual dysfunction seems to occur in every situation (generalized) may point to a different etiology than a situational specifier. For example, one of our clients found himself to be unable to obtain an erection with his wife, but could with his affair partner. This suggests that the erectile problem was situational and that treatment could focus more heavily on issues pertaining to his relationship with his wife.

Other Diagnostic Considerations. One of the challenges about sexual dysfunction and diagnosis of sexual health problems is the extent to which the symptomatology meets the *DSM-IV-TR* (APA, 2000) diagnostic criteria. One diagnostic item is that the condition results in "marked distress" (APA, 2000, p. 541). This is an important consideration for those cases where the symptomatology does not meet the criteria for a diagnosis with the existing *DSM-IV-TR* (APA, 2000) categories, but still produces distress for the client (Nathan, 2003). Specifically, the *DSM-IV-TR* focuses on the more traditional sexual dysfunctions rather than problems such as too little foreplay, little affection, afterplay, variety, etc. One early research team showed that minor problems produced more marital distress than some of the major problems (Frank, Anderson, & Rubenstein, 1978). Our theory about why this might be true is that the major problems are perceived as out of the person's control. For example, a couple might believe one partner strongly desires to have an erection, but is unable to because of health reasons or medication. The "minor problems" such as choosing an inconvenient time or too little foreplay are usually perceived as being under voluntary control. In one case, a wife told her husband many times she was not a "morning person" and did not want to have sex in the morning. He only approached her in the mornings for sex and never at night. This type of problem does not require a sex therapist but is an ideal problem for an MFT to treat. MFTs should review the presenting sexual problems that may not qualify as an Axis I dysfunction, but do produce similar levels of distress (i.e., varying levels of sexual desire or different ideas about turn-ons). Some options for diagnosis in this factor are discussed later.

In many cases, the distress is not individual or intrapsychic, but interpersonal. In fact, in our experience, many couples present with sexual problems because it is the partner without the "problem" who is upset. This can occur when there are different expectations of the sexual relationship or sexual behavior, different learning histories, role changes, or others. It is incumbent upon the therapist to identify to what extent, if any, there is a discrepancy in the couple's report regarding the problem and identify whether the distress is experienced by the individual or couple.

Comorbidity. Frequently, sexual health concerns also co-occur with chronic illness, physical conditions, mental health problems, mood/anxiety disorders, and/or substance abuse problems. Depression can contribute to a variety of sexual problems, including hypoactive sexual desire disorder (HSD), dyspareunia, and erectile dysfunction, to name a few. Other sexual problems such as painful intercourse and erectile dysfunction may increase the likelihood of the development of HSD (Weeks, Hertlein, & Gambescia, 2008). A classic example involves a couple experiencing an erectile problem. A husband, significantly older than his wife, was taking multiple heart medications. He found that when he tried to have intercourse, he failed to obtain an erection and consequently began to avoid sexual interactions in order to avoid the feeling of failure and of disappointing his partner. His wife's interpretation of his hesitation to engage in sexual activity, however, was that he simply lacked desire for her (not an uncommon interpretation in couples). A single therapy session cleared up this misinterpretation and initiated the process of how to have sex more effectively. In this case, the wife was convinced that his erection problem demonstrated he was losing sexual interest in her. It was critical that she be educated on the following: (1) erections and desire are not necessarily the same; (2) given her partner's age, medical problems, medications, and rapidly increasing performance anxiety to please her, it was very likely he would demonstrate some erectile problem. The therapist worked with the man to help him understand that it was essential that he verbalize his desire for her and to take enough Viagra to overcome his medical condition. The most important element of this session, however, was that they both knew the other still felt strong

Table 1

Disorder	DSM Code	Diagnosis (from DSM-IV-TR) "Persistent or recurrent..."
Sexual Aversion Disorder	302.79	Extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner
Hypoactive Sexual Desire Disorder	302.71	Deficient (or absent) sexual fantasies and desire for sexual activity.
Female Sexual Arousal Disorder	302.72	Inability to attain, or to maintain until completion of sexual activity, an adequate lubrication-swelling response of sexual excitement
Male Erectile Disorder	302.72	Inability to attain, or maintain until completion of sexual activity, an adequate erection.
Female Orgasmic Disorder	302.73	Delay in, or absence of, orgasm following a normal sexual excitement phase.
Male Orgasmic Disorder	302.74	Delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity and duration
Premature Ejaculation	302.75	Ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.
Dyspareunia	302.76	Genital pain associated with sexual intercourse in either a male or a female.
Vaginismus	306.51	Involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

desire, which for them was equated with love and commitment.

Men with a unique physiological composition or illnesses such as diabetes, epilepsy, and multiple sclerosis may be more vulnerable to erectile dysfunction, but negative cognitions and performance anxiety also contribute (Betchen, 2008). Patients with certain types of cancer may be more prone to arousal and desire problems for both physical reasons (e.g., damage to sexual organs) (Seagraves & Balon, 2003) or psychological reasons (e.g., body image concerns) (Waldman & Eliasof, 1997). Therefore, MFTs need to conceptualize and treat the problem within the entire client context and research how sexual problems stem from or contribute to other issues. There may be a reciprocal relationship between the level of relationship satisfaction and sexual problems. For an overview of the individual biological and psychological factors related to each sexual dysfunction, see Hertlein et al. (2008).

Multiaxial Diagnosis from the Intersystems Perspective. In many cases, problems with one's sexual health are exacerbated by relationship difficulties, such as power imbalances, resentments, or communication concerns. With this etiology, traditional behavioral non-systemic prescriptions will not change the sexual problem. Our preference is to treat the couple problems first and then move on, or begin to phase in, the treatment of sexual problems (Guay et al., 2003). A couple locked in conflict, or one that has intimacy problems, which are expressed via sex, will fail to respond to the traditional approach of giving sensual/sexual prescriptions. Once again, the systemically-oriented therapist has the advantage over the behaviorally/individually-oriented therapist due to the more comprehensive perspective.

In same-sex relationships, there are other considerations. In addition to the assessment of how individual, interactional, and intergenerational factors play a part in the development and maintenance of a sexual problem, MFTs should attend to the problems of heteronormativity and internalized oppression (Hertlein et al., 2009) and recognize that heteronormativity underlies the diagnostic categories in the DSM. For example, the sexual pain disorders refer to pain during intercourse, which eliminates lesbian women who experience pain under other circumstances (Hertlein et al., 2009). Other factors specific to same-sex relationships that need to be considered are lack of education, HIV status discrepancies, and therapists should also be aware that their knowledge and any countertransference issues about same-sex relationships can affect the treatment process (Bettinger, 2004; Nichols, 1989).

There are several authors who outline how to conduct sex therapy for same-sex couples. Reece (1988), George and Behrendt (1987), and Carballo-Diéguez and Reimen (2001) identified specific interventions for working with same-sex couples, such as therapist education and awareness of own values, addressing internalized homophobia, and specific sexual strategies. Further, Reece (1987), Hall (1987), and Bettinger (2004) each developed frameworks for treating same-sex couples with sexual problems. Bettinger's approach is systemic and was developed for gay male couples; Hall's approach is for lesbian couples and includes looking at the larger contexts in which the couple is embedded; Reece's (1987) framework is directed toward gay couples experiencing discrepancies in sexual desire.

The Intersystems approach provides a framework for therapists to consider both the physical as well as dyadic concerns, which are impairing a couple's sexual health. The severity of the relationship problem and the extent to which it impacts sexual health will be a critical component to the course of treatment (Hertlein et al., 2009) and therefore should be reflected in the multiaxial diagnosis. Relational diagnostic codes most frequently used by sex therapists include Partner Relational Problem or Physical/Sexual Abuse of an Adult (V61.1), Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9), or Relational Problem (V62.89).

Because "sexual health" is an all-encompassing term relating to one's physical, social, and emotional well being, MFTs should account for each axis in their diagnosis. In order to promote sexual health, therapists should attend to all aspects which might be

Figure 1

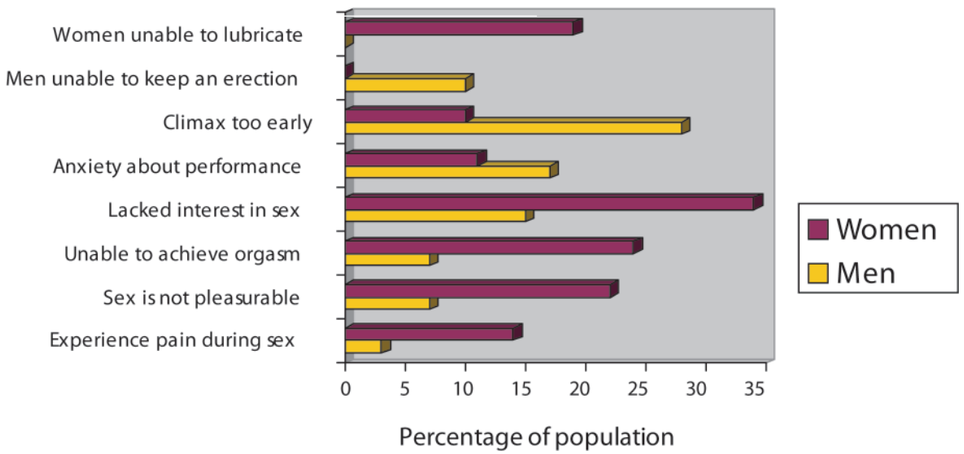

Figure 1 shows the frequency of sexual dysfunction in the general population in the U.S. This study is fairly consistent with other studies that have been conducted. This research team and others have demonstrated that almost every couple coming to therapy has a high probability of having a major sexual problem. Percentages are taken from individuals completing the survey in regard to their own behavior.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press. (p. 369)

Working with the Chronically Ill

Therapists should be vigilant for clients who have been diagnosed with chronic illness and are experiencing sexual problems. There are several illnesses that affect sexual functioning, including (but not limited to): Parkinson's disease (Yu, Roane, Miner, Fleming, & Rogers, 2004), Multiple Sclerosis (Smeltzer & Kelley, 1997), stroke (Monga & Kerrigan, 1997), cancer (Waldman & Eliasof, 1997), diabetes (Schover & Jensen, 1988), and cardiac concerns (Schover & Jensen, 1988).

Physical consequences of illness. Physical consequences of experiencing chronic illness can include a range of sexual issues, including loss of desire, arousal problems, orgasm problems, erectile dysfunction in men (Schover & Jensen, 1988; Tilton, 1997), and dyspareunia in women. For some illnesses such as cancer, women may experience lubrication difficulties (Schover & Jensen, 1988) and changes in genital sensation. There may be changes in the motor system that can make sexual acts more difficult (rigidity, tremors, etc). Another issue may be the greater occurrence of genitourinary infections.

Physical consequences of pharmacotherapy treatments. While pharmocological treatments for physical and mental illnesses frequently address the disorder and reduce symptomatology, these medications may have unintended sexual side effects. Seagraves and Balon (2003) reviewed the side effects of medications, and therapists should have this book on hand as a reference guide in order to understand how medications are impacting the sexual clinical picture. Heiman and Meston (1997b) noted that there are three principal ways medications affect sexual functioning: peripherally, centrally, and hormonally. Common consequences appear to be delayed/inhibited orgasm, impaired sexual desire (more common with SSRIs as opposed to MAOIs) (Heiman & Meston, 1997b). Further, some of the sexual side effects of antipsychotic medications include reduced desire and orgasm problems, though such effects could be related to the extrapyramidal side effects of antipsychotics and the likely lowered sexual functioning prior to the illness (Heiman & Meston, 1997b). Hormone therapy may also result in diminished desire and arousal for both men and women. For men, treatments for prostate cancer that involve reducing the testosterone level as low as possible frequently reduce desire and arousal. Retrograde ejaculation can be a side effect of some treatments. In cases where there is surgery because of damage to important nerves, there may be reduced sensation as well as impaired erectile ability for men and lubricating capacity for women. For women, healing from pelvic or genital surgery can cause scar tissue, reducing the size and shape of the vagina, and result in dyspareunia.

Psychological consequences. Psychosocial factors have been identified as contributing to sexual dysfunctions in populations discussed above with chronic illness, including relationship dissatisfaction, depression, and body image concerns (Waldman & Eliasof, 1997). After a period of suspended sexual activity, anticipatory anxiety can fuel the loss of desire, creating a self-fulfilling belief that spirals into further sexual difficulty. Pelvic or genital surgery can also have a psychological impact, in that patients may question their gender and sexual identities.

Treatment considerations. MFTs need to be vigilant about the presence of illness as a contributing factor of sexual problems for a couple by conducting a thorough history. For many clients, they need to be reassured that normal or near normal functioning will return, but they need to be patient and find other means of sexual expression until that time. For other clients who will not have the opportunity to return to normal functioning, the therapist and couple can develop alternate ways to demonstrate sexuality. This involves being creative about sexual behavior and their definition of intimacy. Further, MFTs need to be aware of the importance of collaboration between therapists and the primary care or specialist treating the patient for this concern. Many of our clients do not report their sexual health concerns to their physicians because of embarrassment and shame. Collaboration allows the most effective course of treatment to be implemented.

affecting one's sexual life. Assessment via the Intersystems Approach as described by Hertlein et al. (2008) and Hertlein et al. (2009) highlighted the manner in which relationship dynamics, emotional contracts, communication patterns, messages from family-of-origin, and sociocultural pressures all precipitate, contribute to, or exacerbate the sexual problem.

Treatment/Biomedical Interventions

There are a wide variety of specific interventions, techniques, and resources that are used in sex therapy. Seasoned MFTs may be familiar with the more commonly utilized techniques, such as sensate focus (Lazarus, 1965), implementing relaxation strategies, using medications, teaching sexual skills, and others. The breadth of interventions can be classified into three categories: behavioral, biomedical, and systemic, and are outlined as follows.

Behavioral Treatments. Sex therapy has its roots in behavioral interventions. The names associated with the origin of sex therapy include Masters and Johnson (1970), Heiman and LoPiccolo (1988), Kaplan (1974), and Rimm and Masters (1974), who based their treatment approach on the assumption that sexual problems are the result of several faulty conditionings, including: faulty learning, misinformation, lack of education, negative attitudes about sex, and limited sexual experience. Behavioral interventions include such activities as homework assignments (Leiblum & Rosen, 2000; Wincze & Carey, 1991), communication training, and education. In general, there was little appreciation of the numerous systemic factors that could precipitate and maintain sexual problems (Weeks, 2005). Frequently, the use of relational or psychodynamic techniques occurred when the behavioral interventions were not effective (Kaplan, 1974). As aforementioned, however, the paucity of research and empirical-based sex therapy treatment warrants further investigation to determine if relational treatment for sexual health concerns is still secondary to individually based care today.

Sensate focus is a behavioral intervention where a couple systematically becomes desensitized to sexual stimuli as a way to reduce anxiety surrounding intercourse (Lazarus, 1965). It was introduced by Masters and Johnson (1970) and refined by Kaplan (1974). In general, the therapist begins by working with the couple to identify any barriers toward engaging in sensate focus activities. Once any barriers have been removed, treatment focuses on moving the couple forward incrementally toward experiencing varying degrees of sexual pleasuring through non-anxious situations. Typically, couples are asked to participate in sensate focus-related homework activities three times per week, with a processing period after each activity to detail what was pleasurable and focus on how each partner communicated to the other. Eventually, the couple gradually moves from positive, non-genital touching experiences to intercourse. See Weeks and Gambescia (2008) for a further discussion of how to conduct systemic sensate focus work.

Biomedical Treatments. Recently, many pharmaceutical companies have worked to address the problem of sexual dysfunction through pharmacological treatments. The development of Viagra® (sildenafil) in 1998 dramatically shifted the sex therapy field toward a medical intervention orientation. Since its development, other companies began to develop comparable medications to stake their claim on this issue, such as Levitra® (vardenafil) and Cialis® (tadalafil) (Verhulst & Reynolds, 2008). In short, there are many pharmaceutical options to assist men with their erectile problems, and these problems are seen as strictly medical problems that can be corrected via pharmaceuticals rather than marriage and family therapy or systemic sex therapy (Ridley, 2008; Verhulst & Reynolds, 2008). Another treatment approach for men is testosterone replacement therapy, particularly if they suffer from a low level of the hormone. As a result of continued medical developments, individuals experiencing these sexual problems may pursue medical solutions rather than therapeutic approaches (Ridley, 2008; Weeks & Gambescia, 2000). However, this does not allow for an understanding of the sexual problem as something that may be caused by other problems.

Drug companies have been working to develop solutions to address the other factors in sexual health, including medications that are designed to treat low desire. For women, such medications tend to focus on adjusting hormone levels. Estrogen therapy helps women by improving vaginal tone and elasticity, and increasing vaginal blood flow and lubrication. Progestin therapy can increase desire and arousal when paired with estrogen therapy. Androgen therapy provides male hormones to women, though the treatment can be controversial since long-term effects are unknown. Other physiological treatments for women include strengthening pelvic muscles through Kegel exercises (Hertlein et al., 2008; VandeCreek, Peterson, & Bley, 2007), consultation with a physical therapist (Meana, 2008) and herbal supplements, such as Ginkgo biloba, which can improve circulation throughout the body. However, therapists should advise clients that there can be severe risks to any supplements taken (FDA, 2006) and that many of these supplements are not approved by the FDA. Further, while there are some studies that suggest Viagra® can be effective for women, most of the research fluctuates between being inconclusive or demonstrating it is not effective. Bancroft (2002) advised that therapists exercise caution when considering the use of Viagra® for women, particularly because of the differences in sexuality between men and women and the recognition that sexuality is a complex interplay of emotions, cognitions, and other factors.

PDE-5 inhibitors (like Viagra®) should not be viewed as the solution for returning to a satisfying sex life. When the sexual problem has some of its roots in communication problems, conflict, and other relationship issues, medications will not achieve the desired end. Additionally, medical intervention focuses on an individual rather than a couple, and treatment decisions are made by the symptomatic individual. Once erection can be achieved, it may be difficult for the couple to resume the same rhythm in the sexual relationship that they had previously, particularly if there was a significant amount of time where the couple was abstinent. MFTs are trained to consider how each system is working to contribute to the problem, and there is a demonstrated need to shift to a paradigm that encompasses the systemic case conceptualization of an MFT. The Intersystems approach fills this niche. The end result is that the couple realizes that sexual problems cannot be "cured" with a pill, etc. The therapist facilitates work that resolves the complex myriad of issues that may have produced the problem as well as the distress that the problem has created for the relationship. The key for MFTs is to understand that medical alternatives are available, but to encourage the couple to conceptualize the case from an Intersystems perspective in order to pursue a wide range of treatments (behavioral, relational, etc.) for the greatest chance of success. MFTs should bear in mind that, while the medical solution may be a tempting one, physicians often do not have the time or training to discuss potential relationship factors that are complicating the sexual problem for partners, and this information is typically not included in the medical evaluation (Leiblum, 2007).

Systemic Treatments: The Intersystems Approach. Because the field of sex therapy was based on behavioral and psychodynamic interventions, there are few truly systemic treatments. Wincze and Carey (2001) outlined a model that integrates biological and psychological factors in sexual dysfunction; Borrelli-Kerner and Bernell (1997) emphasized the importance of couples' treatment in sexual cases. Yet each of these approaches falls short in consistently and completely attending to the individual, interactional, and sociocultural factors in sexual functioning, as the Intersystems Approach does. Developed by Weeks (1977) and described in detail by Weeks and Cross (2004) and Hertlein et al. (2008), its roots are in systemic theories and represents a framework that incorporates the behavioral constructs, biomedical advances, and relational components impairing one's sexual health. This framework relies on conducting assessment and treatment across five dimensions: individual-biological, individual-psychological, dyadic, family-of-origin, and sociocultural factors. Our approach guides the therapist in addressing not only the individual biological issues, which may be contributing to the problem, but also systemically attends to the psychological, emotional, and cultural factors that surround the problem. Treatment is organized around individual, interactional, and intergenerational components of a client system. See Hertlein et al. (2008) for a detailed description of how to apply the model to the sexual dysfunctions.

Improving Sexual Health

Considering sexual health from a systemic perspective, there are several specific ways we have developed to improve sexual health for clients. The first step is to conduct an assessment addressing each of the dimensions outlined in the Intersystems approach. This includes a comprehensive sexual history attending to individual dynamics, relationship satisfaction, family-of-origin factors, and socialization factors. In conducting your assessment, attend to the physical, social, emotional, sociocultural, and intellectual factors that are contributing to the vulnerabilities in sexual health. The second step is to provide education to the clients. This can involve correcting the misinformation that the couple may have, as well as providing more alternatives to sexual interaction, as a way to redefine sexual health and intimacy. Bibliotherapy and education can be very powerful adjuncts to treatment in such cases where the problem is compounded by a lack of education. Couples may hold many myths about sexuality and sexual behavior, and bibliotherapy can be one manner of helping clients separate myth from reality. Effective bibliotherapy in sex cases can include videos, books, and use of the Internet. Specific suggestions are outlined in the Resources section of this Update as well as in Hertlein et al. (2009).

The proper maintenance of sexual health can be accomplished through the prevention and/or treatment of sexual issues. MFTs need to encourage their clients to talk about their sexual health, even if the therapist experiences discomfort doing so. Years of experience show that many couples are simply reluctant to bring up sexual problems until later in treatment, if at all. If the therapist asks general questions about sexual functioning, some couples will report that their sex life is satisfactory. At some point, after establishing a relationship, the therapist can suggest to the couple that little has been said about sex. The therapist can then ask specific questions such as:

- Are the two of you happy with how often sex occurs?
- Do you have any problems getting or keeping an erection? (men)
- Are you able to delay ejaculation long enough so that you are both satisfied? (both partners)

- Are you both able to have an orgasm? Would you like anything to change around your ability to have an orgasm?
- Is there any pain with intercourse?

A series of specific questions may be asked if the therapist expects to get a clear picture. The questions above are just a sample and can be worded differently to fit each couple.

In couples with no apparent sexual health concerns, create a treatment plan that will encourage them to maintain their sexual health. Include strategies such as:
- Providing education and recommend bibliotherapy
- Addressing fears
- Starting slowly
- Monitoring progress

Therapists who are best trained to attend to the sexual health of a client are knowledgeable about couple therapy, sex therapy, medical sex therapy, psychology, and larger systems. Effective treatment encompasses, at a minimum, assessment in each of these areas and hopefully intervention in whatever areas difficulties exist. Because of the perception by some clients that sexual dysfunction is easily treated with medications, it is incumbent upon the therapist to explain how each of the areas may be contributing to the sexual problem, and educate the couple on treatment options for the individual, interactional, and intergenerational components.

TERMINOLOGY

Hypoactive sexual desire disorder – hypoactive means not active or limited activity. This term in sex treatment is usually associated with desire, hence the term "hypoactive sexual desire disorder."

Dyspareunia – difficult or painful sexual intercourse. This is commonly associated with women, though men can have it as well. To be diagnosed with dyspareunia, one must have persistent and recurrent pain during and after intercourse that is not associated with a lubrication problem.

Vaginismus – painful contraction or spasm of the vagina. It is a conditioned response of the pubococcygeus muscle that prevents insertion of an object, including tampons and sexual intercourse, making penetration difficult.

Genitourinary – relating to the genital or urinary organs. The term refers to the group of organs of the urinary system and the reproductive system.

Anejaculation – failure of ejaculation of semen. This means that there is no semen from the prostate or seminal ducts into the urethra. Causes of anejaculation can include medical illnesses, injury to the spinal cord, diabetes, medication, and surgery.

Desire – the desire to engage in sexual activity, including fantasies.

Excitement – subjective sense of sexual pleasure. Physiological changes also occur during this phase, including penile tumescence and erection for men, and vaginal lubrication and swelling of the external genitalia for women.

Orgasm – defined as the peak of a sexual experience. Includes the contraction of muscles such as the anal sphincter for both men and women. In women, the vagina walls contract and in men, ejaculation of semen.

Resolution – Termination of the sexual response characterized by muscle relaxation. Men are unable to obtain a further erection or ejaculation during this time, where women can resume the cycle at any point.

Resources for Practitioners

American Association of Sexuality Educators, Counselors and Therapists (AASECT)
www.aasect.org
A resource for client referrals, ethics information, as well as job listings, and FAQ about human sexuality.

Hertlein, K. M., Weeks, G., & Sendak, S. (2008). *A clinician's guide to systemic sex therapy.* New York: Routledge. State of the art of sex therapy from a new paradigm: an integrative or systemic framework. The chapters explore the etiology, treatment, and case examples of dysfunction from the systemic perspective.

Society for Sex Therapy and Research (SSTAR)
www.starnet.org
Provides a communication forum, newsletters, sex therapist directory, and links to helpful resources.

Society for the Scientific Study of Sexuality (SSSS)
www.sexscience.org
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Weeks, G., & Gambescia, N. (2002). *Hypoactive sexual desire: Integrating couple and sex therapy.* New York: W. W. Norton. Presents a comprehensive treatment model for HSD based on the integration of medical and psychological interventions.

Weeks, G., & Gambescia, N. (2000). *Erectile dysfunction: Integrating couple therapy, sex therapy, and medical treatment.* New York: W. W. Norton. Presents a comprehensive treatment model for ED based on the integration of medical and psychological interventions.

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