Couples Therapy and Counseling

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33.1 Introduction

Traditionally, physicians in sexual medicine (e.g., urologists, gynecologists, sexual medicine specialists, and psychiatrists) focused on biomedical factors that caused sexual dysfunction. The first-line intervention was medication (pro-erection medications or hormonal enhancement); the second-line intervention included injections, external pumps, or the MUSE® system; and the third-line intervention was surgical (penile prosthesis). Although there is literature on female dysfunction, especially the newly named diagnosis of sexual interest arousal disorder (SIAD), the great majority of the work in sexual medicine focused on male dysfunction. Since the introduction of sildenafil [1], the biomedical model has been the predominant approach to the study and treatment of sexual function and dysfunction. Rowland [2] raised concerns that psychological and relational assessments and interventions were being ignored both in clinical practice and research. Although the dramatic increase in understanding of vascular, neurological, and hormonal components of sexual function and dysfunction was extremely welcomed, in reality, the biomedical model as a stand-alone intervention has not delivered the promised results. The best example is the treatment of erectile dysfunction (ED). Contrary to advertisements and media hype, the man taking a pro-erection medication rarely returns to having easy, predictable erections and intercourse 100 % reliably. The most important understanding is that the woman's role is much more than encouraging the man to ask his physician for medication [3]. In the Good-Enough Sex (GES) approach to male and couple sexuality, the best predictor of maintaining satisfying couple sexuality is the woman's active role in treatment and her investment in their sexual relationship [4]. Although the standard biopsychosocial model gives "lip service" to psychological and social/relational factors, these are usually not addressed unless the medical intervention has been unsuccessful [5].

The new mantra in couple sexuality is desire, pleasure, eroticism, and satisfaction [6]. From this perspective, the most important factor is desire. The couple approach is not an optional resource, but is the optimal intervention.

Traditionally, in assessment and treatment of male sexual dysfunction, the woman usually had no therapeutic role. The biomedical model for premature ejaculation (PE) emphasizes PE as a bio-physiological dysfunction involving treating solely the man using a stand-alone medication intervention [7]. This approach is also true for ED, whether

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treated by a primary care physician or urologist. The man is seen alone, assessed for any comorbid illness, and prescribed a PDE5 inhibitor with little or no counseling about psychosexual factors to optimize results. This is a major factor leading to disappointing outcomes and a high treatment dropout rate [8]. When he stops medication, the man reverts to a pattern of anticipatory anxiety, performance anxiety about erection and intercourse as a pass-fail sex test, frustration, embarrassment, and eventually sexual avoidance. The decision to stop trying to be sexual and to avoid any sexual touch is often made unilaterally and conveyed nonverbally. The woman is usually confused and distressed, unsure whether to blame herself, the medication, or her partner [9].

McCarthy and Fucito [10] suggest a couple approach to the assessment, treatment, and relapse prevention of ED. This is also relevant to PE, ejaculatory inhibition (delayed ejaculation), and male hypoactive sexual desire disorder (HSDD). In the comprehensive, integrative biopsychosocial approach, the couple is the prime patient. The urologist or primary care physician sees the man for assessment and gives a prescription for a PDE5 inhibitor or other medical intervention. Ideally, the couple therapist and physician work together in a synergistic manner, which is in the best interest of the man and couple. This is the special challenge of a mental health-medical team approach. Rather than the physician being the team leader, the physician and therapist cooperate as trusting colleagues working in a coordinated manner for the man, woman, and couple.

The couple therapist is working in the context of the biopsychosocial model and educates the partners to take personal responsibility for sexuality while recognizing that, in essence, sexuality is a "team sport." This combination of personal responsibility/intimate sexual team is at the core of this approach to sexual function and dysfunction [11]. In the four-session assessment model, the clinician seeks to identify the biological, psychological, and socio-relational factors which subvert healthy sexuality, especially sexual desire [12].

If at all possible, the initial session is conducted with the couple. This emphasizes the powerful therapeutic message that, at its core, intimacy and sexuality are a couple issue. In the initial session, we seek to identify when sexuality was most positive and what they valued about each other and as a couple. It is important to assess the sexual problems the couple has tried to address on their own so that mistakes are not repeated. The clinician does not overpromise or set unrealistic expectations, but it is therapeutic to be positive and realistic about changing intimacy and sexuality.

If the psychological/relational/sexual history is done with the partner present, it is likely the clinician will receive a "sanitized" version rather than a genuine narrative, which includes a careful exploration of emotional and sexual vulnerabilities. Appropriate therapeutic intervention (medically, psychologically, and relationally) requires a genuine understanding of personal strengths and vulnerabilities, especially motivational factors. Ideally, the couple would share the value of a satisfying, secure, and sexual relationship. However, the clinician should not assume this, but recognize the need to assess motivational factors. Common causes for failure of medical interventions include lack of motivation on the part of one or both partners, negative emotions such as resentment or shame, sex as a manipulation rather than a sharing of pleasure, a secret sexual life of variant arousal or greater confidence with masturbation than couple sex, a question of sexual orientation, an extramarital affair, a focus on fertility but not value of sexuality, a history of sexual trauma which is a shameful secret, or a hidden health issue such as an eating disorder or bipolar disorder. Understanding each partner's psychological, relational, and sexual strengths and vulnerabilities is crucial for treatment planning and a successful outcome.

The fourth session in the assessment model is a 90-minute couple feedback session where the clinician has three areas of focus:

1. Sharing a genuine individual narrative with each partner, with the other present, involving processing past and present psychological, relational, and sexual issues.
2. Discussing couple sexual strengths and vulnerabilities. Establishing a therapeutic plan with mutually acceptable goals.

3. Assigning the first psychosexual skill exercise to be completed in the privacy of the couple's home. The message is that half of the therapy occurs in the therapist's office (including when to implement the medical intervention), and the other half of the change process occurs in the reality of the couple's home [13]. There is neither nudity nor touching in the clinician's office, but it is crucial to implement a new couple sexual style in the couple's home.

The issue of integrating medical interventions into the couple's sexual style of intimacy, pleasuring, and eroticism is discussed in the couple feedback session and is a focus for discussion and implementation in therapy. The danger of the biomedical model, where the physician sees the patient alone and asks the yes-no question "Is sex ok?" or "Are there any problems?" is that the patient, especially the man, will give the easy, socially desirable response that everything is ok. However, if the therapist or physician has both partners in the office and asks an open-ended question such as "At this time, how are desire, pleasure, eroticism, and satisfaction progressing? What is going best and what is most problematic?" This encourages the couple to be forthcoming and specific about individual and couple sexuality so that the intervention can be modified and tailored for the couple's needs.

Sex therapy is more focused, time-limited, and change-oriented than most couple therapy. Although there is a range of interventions from a single couple consultation to therapy lasting years, the most typical format is therapy involving 6–25 sessions over a 3-month to 1-year period. Typically, couple therapy begins on a weekly basis, but sessions usually transition to biweekly within 4–6 weeks.

A special feature is an individualized relapse prevention program to ensure gains are maintained and couple sexuality continues to have a 15–20 % role in relationship vitality and satisfaction. Ideally, the couple can call for a booster session to ensure a lapse does not turn into a relapse. Hopefully, the couple would schedule follow-up sessions every 6 months over a 2-year period. The follow-up sessions involve discussing the couple's sexual style to reinforce the desire, pleasure, eroticism, and satisfaction mantra as well as establish a new goal for the next 6 months to facilitate continued sexual growth. The core focus is on strong, resilient sexual desire.

33.2 Case Study: Alexis and Alexander

Forty-four year-old Alexis and 52-year-old Alexander were an alienated, demoralized couple when they appeared for sex therapy. This was a second marriage for both. They married 4 years ago, but the marriage was clearly headed toward divorce due to being nonsexual as a result of Alexander's struggles with ED. The referral for therapy came from the third urologist Alexander had consulted. He was afraid that Alexander's tearfulness in the individual consultation could indicate a suicide risk. This urologist had recommended a third-level intervention—a penile prosthesis. Over the past 3 years, Alexander had tried Viagra, Cialis, MUSE, and penile injections, but found only fleeting improvement and then a regression. Over the 3 years, Alexander had consulted three urologists, an internist, an endocrinologist, a cardiologist, and a psychiatrist. Only the psychiatrist had asked to see Alexis for one individual consultation.

When Alexander called the sex therapist, he was seeking an individual appointment, but the therapist suggested the four-session assessment approach, with the first session being with the couple.

In the first couple session, the therapist asked whether desire, pleasure, eroticism, and satisfaction had ever been a part of Alexander and Alexis's relationship. Sexuality had been a major strength and a factor in taking the risk to commit to a second marriage. Alexis felt left out of the medical consultations and interventions, and it was she who was threatening to leave the marriage. Her feeling was that no matter what Alexander said, he no longer found her attractive nor did he love her. She did not think surgery was a good idea nor would it resolve the core issue of lack of love and desire. Alexander felt blamed

and shamed. He did not want to be divorced a second time, but felt besieged by Alexis's negativity. She had become his worst critic and blamed him for anything that was wrong. The destructive sexual power struggle dominated their relationship.

In the first session, each person is asked to sign release of information form(s) so the therapist can contact past or present, individual or couple, and medical or mental health providers. The perspective of other clinicians and their treatment suggestions can be of value. Rather than wait for a written report, the clinician calls the medical and/or mental health professionals.

A second suggestion for the initial session is to provide the couple with reading not to exceed 20 pages. Reading does not cure a dysfunction, but it serves to destigmatize the problem. For example, it was helpful for Alexis to learn that one in five married couples have a nonsexual marriage (i.e., sex less than ten times a year), most commonly occurring within the first 2 years of the marriage. In addition, learning that few men experience the dramatic turnaround with Viagra illustrated in the television advertisements served to reassure the couple that they were not alone.

The individual psychological/relational/sexual history (sessions two and three) begins with the therapist saying, "I appreciate you being as honest and forthcoming as possible about your life both before this marriage and since you became a couple. At the end, you can red flag anything you do not want shared with your spouse. I will not share this without your permission. I do need to know as much as possible to help you understand and change this difficult sexual situation." Like 85 % of couples, both Alexis and Alexander had sensitive/secret material.

In conducting the history, it is crucial to ask open-ended questions and to elicit the genuine stories, including confusing, sad, or traumatic experiences. For example, rather than asking, "Have you ever had an affair?" the question is, "The majority of people have thoughts, feelings, fantasies, or experiences of being sexual outside their marriage. Tell me about your experiences." Another example is, "Before leaving home, what was the most confusing, negative, guilt-inducing, or traumatic experience that happened to you sexually or emotionally?"

A core issue in Alexander's history was the humiliation he endured during his first intercourse attempt (ejaculation prior to intromission). His first marriage ended because his ex-wife found marital sex dull and routine and had an affair. Alexander now frequented massage parlors twice a month and paid extra for manual stimulation to orgasm (he had an erection). He loved her, but resented her criticalness, especially sexually.

Alexis had a very different set of vulnerabilities. As an adolescent, she had two abortions, which she had never discussed with her first husband or Alexander. She had used an affair (in her first marriage) as a reason to leave a fatally flawed marriage. Alexander's sexual enthusiasm and desire were a major motivator for Alexis to take the risk of a second marriage. Although she loved Alexander, she felt the ED was a sign the marriage was doomed. She was confused that Alexander could become erect but quickly lost his erection when she touched him. She was very hurt that he was unwilling to pleasure her to orgasm, although she had never asked.

The clinician lobbied each partner to share sensitive and vulnerable issues to help motivate them to work together in changing the nonsexual state of their marriage. Both Alexander and Alexis agreed to share sensitive/secret material at the couple feedback session.

The challenge for Alexis and Alexander was to rebuild sexual desire and address ED as an intimate sexual team. In the couple feedback session (session four), we processed each partner's sexual narrative in order to understand and change the pattern of sexual avoidance. This involved Alexis understanding that Alexander's ED was caused by a combination of physiological vulnerability, anticipatory anxiety, and approaching intercourse as a pass-fail performance test. Alexis had a vital role in helping them develop a new couple sexual style focused on sharing pleasure and adopting the GES approach in order to confront performance anxiety.

For Alexander, the challenge was to turn toward Alexis as his intimate and erotic ally and accept the GES approach that 85 % of sexual

encounters will flow to intercourse and orgasm. When sexuality does not flow to intercourse, he is open to sensual or erotic alternative scenarios, rather than panicking or apologizing. A core challenge for Alexander was to rebuild sexual desire based on being present and sharing pleasure-oriented touching.

In the ongoing therapy sessions, mostly conducted with the couple (although the therapist recommended that Alexander and Alexis ask for an individual session as needed), the focus was on revitalizing sexual desire, developing the complementary couple sexual style which balanced each partner's sexual autonomy with being an intimate sexual team, and learning to value both synchronous sexual encounters (both Alexander and Alexis experience desire, pleasure, eroticism, and satisfaction) with asynchronous scenarios (the experience was better for one partner than the other). A major breakthrough for Alexander was experiencing that Alexis could enjoy an erotic scenario to orgasm with manual and/or oral stimulation. He learned to "piggyback" his arousal on her arousal.

The change process was neither easy nor straightforward. There were emotional and sexual successes intermixed with frustration and disappointment. At the therapist's urging, Alexander, accompanied by Alexis, was referred to a new urologist who recommended they utilize a daily low dose of Cialis for a 3-month trial period. This urologist reinforced positive, realistic GES expectations rather than overpromising a return to 100 % predictable erections and intercourse. Alexis made the point to Alexander that even when couple sex was at its best early in their relationship, she was not orgasmic 100 % of the time. In addition, Alexis was similar to a great many women, although she valued orgasm during intercourse, her orgasmic response was easier, both in frequency and intensity, through erotic stimulation.

In the 3-month follow-up session with the urologist, Alexis and Alexander queried about the option of using regular dose Cialis on an as-needed basis. The urologist was willing to try that regimen, but since the present regimen was working so well, he recommended maintaining the daily dose.

A particularly valuable component of the couple integrative biopsychosocial model is the individualized relapse prevention plan. In most health and mental health treatment programs, relapse prevention is ignored or the problem is dealt with by focusing on medications and dosage. Developing an individualized relapse prevention program is an integral component of the couple biopsychosocial model. Sexuality, especially ED and desire problems, cannot be treated with benign neglect. Healthy couple sexuality requires thought, energy, and communication. Alexis and Alexander agreed to three dimensions in their relapse prevention plan: (1) quarterly, they would have a sensual date with a prohibition on intercourse and orgasm to reinforce sensuality as a shared pleasure; (2) if they went 3 weeks without a positive sexual experience, they would schedule a "booster" session to ensure a lapse did not become a relapse; and (3) they would schedule a follow-up session every 6 months for 2 years in order to ensure they maintain gains and set new sexual goals aimed at reinforcing their commitment to a vital, resilient, sexual desire.

33.3 Summary

The comprehensive integrated couple biopsychosocial model for sexual dysfunction includes couple sex therapy as the core dimension. The physician, couple therapist, and other professionals work as a respectful, collaborative team as they engage in a comprehensive assessment, treatment, and relapse prevention program for sexual problems. The prime client is the couple rather than the individual. The focus is not on individual sex dysfunction, but building desire, pleasure, eroticism, and satisfaction. In assessment and treatment, the biological, psychological, and relational factors that subvert sexuality are confronted, and the biological, psychological, and relational factors that promote healthy couple sexuality are reinforced. Rather than hoping for a "cure" and a return to "normal" sexual performance with totally predictable erections and intercourse for the man and totally predictable orgasms, ideally during intercourse,

for the woman, there is an acceptance of the inherent variability and flexibility of couple sexuality. The GES approach and expectations are a key to maintaining sexual desire and satisfaction while accepting the complexity of roles and meanings for couple sexuality.

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