

Using Emotionally Focused Therapy to Treat Sexual Desire Discrepancy in Couples

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Couples in committed relationships encounter a multitude of issues. According to Metz and McCarthy (2010), when couples report high sexual satisfaction, it accounts for 15% to 20% of their overall relationship satisfaction. However, when couples report low sexual satisfaction, it contributes 50% to 70% of their overall satisfaction with their partner. Issues of sexual desire, currently referred to as sexual desire discrepancy, are among the most difficult to treat. Although there are many factors contributing to the issue of sexual desire discrepancy, current literature highlights the importance of emotional intimacy as an outcome and predictor of increased sexual desire. Given the complex nature of sexual desire, clinicians often lack the understanding and treatment options that are systemic. By viewing sexual desire discrepancy as a relational problem that can be treated using emotionally focused therapy, clinicians are better equipped to work with emotional and sexual factors that impact desire and couple distress.

INTRODUCTION

In the field of sex therapy there is a popular adage that says when a couple is happy with their sexual relationship, it contributes to positive well-being and connectedness, accounting for 15% to 20% of the couple's overall relationship satisfaction. Paradoxically, when the sex is mired in dysfunction or distress, it is responsible for 50% to 75% of the relationship satisfaction, or lack thereof. Thus, in these instances, the relationship is depleted of intimacy and vitality (McCarthy & McCarthy, 2003; McCarthy & McDonald, 2009).

Sexual dysfunction and dissatisfaction have long been frequent concerns in couple's therapy. In a survey conducted by Doss, Simpson, and Christensen (2004) that looked at why couples sought therapy, 57% of those surveyed described a lack of emotional affection, intimacy, and physical affection as their primary reason for therapy. Several recent studies have supported this association between sexual satisfaction and overall relationship quality, suggesting that sexual dysfunction is both a contributor to and a consequence of relational conflict (Byers, 2005; Davison, Bell, LaChina, Holden, & Davis, 2009; Metz & Epstein, 2002; Sprecher, 2002). Regardless of the cause of the sexual dysfunction, it can exacerbate an already conflictual relationship or provide additional distress and emotional distance (Metz & Epstein, 2002).

In a 2013 meta-analysis on sexual dysfunction, Frühauf, Gerger, Schmidt, Munder, and Barth (2013) found the overall prevalence of sexual dysfunction to be approximately 46% of the general population. According to the *Diagnostic and Statistical Manual of Mental Disorders* criterion (4th ed., text. rev.; American Psychiatric Association, 2000), hypoactive sexual desire disorder (HSDD) was found to have the highest lifetime prevalence in both men (16%) and women (26%). In addition, recent findings demonstrate the universality of low desire, stating that 27% to 40% of women and 10% to 20% of men experience distress regarding their sexual desire (Mark, 2012). This suggests that many men and women experience lowered sexual desire without meeting clinical criteria.

Though low sexual desire is the most common sexual problem, desire discrepancy is considered the more distressing due to its negative effect on the romantic relationship (Mark, 2015). Sexual desire discrepancy (SDD) is commonly defined as a mismatch between an individual and his or her partner's level of sexual desire (Mark & Murray, 2012). Several studies examined the impact of SDD, finding negative associations with sexual and relational outcomes, such as sexual and relationship satisfaction. High levels of SDD are also correlated with lower couple stability, decreased positive communication, and increased couple conflict (Bridges & Horne, 2007; Davies, Katz, & Jackson, 1999; Mark, 2012, 2014; Mark & Murray, 2012). Levine (2003) suggested that women desire intimacy and closeness as a catalyst to sex, whereas men rely on sex in order to elicit intimacy and closeness. Historically, attachment theorists have viewed the need for closeness and connection as a fundamental need that drives adult romantic relationships. This complex cycle that develops around the desire for both sexual and emotional intimacy can therefore be integrated into an attachment framework to aid in conceptualization and treatment of the SDD that negatively affects couple relationships.

Current treatment of HSDD includes medical, individual, and couple therapy interventions. Both medical and individual treatment modalities limit interventions to the symptoms of the patient without consideration for systemic factors, such as the relationship. Based on the interactive nature of sexual desire, many researchers and clinicians have sought to treat individual (usually female) HSDD as it manifests within the romantic relationship. From this viewpoint, the individual symptoms were being treated as they directly affected the dynamics of the relationship, therefore promoting relationship change as well. However, without the underlying systems perspective, sex therapists fail to address relationship dynamics that support and drive desire (Wiederman, 1998).

At this time, there is no suggested treatment for couples' SDD; however, understanding the cycle that drives SDD would be inherently beneficial in reducing the distress and conflict that this discrepancy causes for both partners. Based on the interdependent nature of intimacy and desire, the author proposes an integrative approach to treating couples' SDD utilizing emotionally focused therapy (EFT), an attachment-based, empirically supported model.

Conceptualizing Sexual Desire as an Interpersonal Process

From a systems perspective (Kaplan, 1974; Weeks & Gambescia, 2015), sexuality demands interpersonal intimacy and interaction. Thus, approaching sexual dysfunction through this lens has been thought to be useful. Nonsexual relationship conflicts, power differences, developmental experiences, and family-of-origin dynamics have all been shown to affect sexual functioning (Bagarozzi, 1987). Researchers continue to explore the connection between sexual and

relationship distress and satisfaction. Although sex therapy has historically been seen as a separate arena rooted in biological function, more and more attention is being paid to the delicate interplay between sex and overall interpersonal dynamics.

In a 2004 study, Breznsnyak and Whisman studied the link between relationship satisfaction, marital power, and sexual desire. Previous research and clinical understanding have inextricably linked sexual desire to interpersonal factors, including partner and relationship issues, sociocultural, and historical elements (Tiefer, 2001; Verhulst & Heiman, 1988). Relationship distress, dissatisfaction, and conflict were thought to impede sexual desire, wherein there is a reduction of motivation for sexual intimacy or sexual withholding. Lowered desire over time is thought to lead to dissatisfaction and disconnection within the relationship as well, promoting a reciprocal cycle of sexual difficulty and/or dysfunction (Breznsnyak & Whisman, 2004). From this study, Breznsnyak and Whisman (2004) found marital dissatisfaction to produce low sexual desire in one partner. The authors also suggest that low sexual desire could create dissatisfaction in the relationship, thus endorsing the reciprocal nature of satisfaction and desire. This conclusion supports aforementioned findings focused on the interplay between relationship and sexual satisfaction at large.

In a study of women with HSDD, McCabe (1997) found that participants experienced lower levels of intimacy as well as decreased satisfaction with the quality of intimacy in their relationship. For many, intimacy equates to emotional closeness in the relationship. Thus, emotional intimacy has been found to have a positive association to sexual satisfaction for women (Hurlbert, Apt, & Rabehl, 1993). In addition, Pascoal, Narciso, and Pereira (2013) found emotional intimacy to be the best predictor of sexual satisfaction in both male and female samples.

It is important to note caveats regarding the relationship between sexual desire and intimacy. Therapists such as Perel (2006) and Schnarch (2009) describe intimacy as problematic due to the inherent loss of autonomy within emotionally fused couples. As Perel (2006) describes, intimacy then constricts, rather than promotes sexual desire. While Perel views intimacy as a possible hindrance to desire, Schnarch (2009) views differentiation (the balance between individuality and togetherness) as the key to both sexual desire and intimacy. According to Schnarch (2009), to keep intimacy alive, a person's level of differentiation must be equal to or greater than the growing importance of his or her partner. This is also believed to be true to keep desire alive in relationships. In both conceptualizations, intimacy and desire are only related as they apply to the individuals' ability to remain autonomous within the relationship. Without autonomy, intimacy is emotionally fused and decreases the level of sexual desire.

Recent findings support the importance of psychological factors that influence sexual desire (Breznsnyak & Whisman, 2004). According to Basson (2005), sexual arousal is moderated by perceptions and emotional experiences. When emotional experiences are not positive, the negative bio-psycho-sexual feedback loop is triggered and the sexual "center" is disengaged, regardless of the body's physiological response (Barlow, 1986; Basson, 2001a). This suggests that in female sexual response, emotional intimacy has a stronger influence than physiologic factors on a woman's sexual function.

To better understand the role of emotional intimacy on female sexual response, Basson (2003) integrated the intimacy-based sexual response cycle during an assessment of 47 couples, where the women were referred for low sexual desire. Half of the women from this sample endorsed a lack of emotional intimacy as a key factor in their low sexual desire (Basson, 2001b). Basson (2003) found multiple confirmatory feedback loops that could contribute to low desire. For

instance, the emotional response associated with physiological changes of arousal may elicit guilt, shame, or embarrassment that prohibit a positive sexual experience. Negative emotional experiences can create anxiety that further exacerbates this negative loop. In addition, the absence of a felt sense of emotional intimacy may inhibit, or “close the loop.” This would appear as decreased desire, arousal, and ultimately a lower satisfaction (Basson, 2002). This model of sexual response was developed with females; however, more recent research has postulated that Basson’s intimacy-based cycle can be applied to both male and female sexual desire (Carvalho & Nobre, 2010), further adding to the potential influence of myriad relational outcomes.

Sexual Desire Discrepancy

Despite the great deal of research on low sexual desire and HSDD, there continues to be a lack of understanding about sexual desire as it occurs relationally. Many researchers have noted that couples report the highest level of distress in their relationship when they experience a divergence in sexual desire (Ellison, 2001; Mark, 2012; McCarthy & McCarthy, 2003; Willoughby & Vitas, 2012). Shifting the perspective from one partner’s low desire to sexual desire discrepancy moves the diagnostic and therapeutic process from the individual to the dyadic level and creates a space for the individual with lower desire to be viewed within the context of the relationship, rather than pathologized or seen as dysfunctional (Davies et al., 1999). Many times, the partner with lower sexual desire, often the women, believes they are the problem. This is largely in part because the partner with lower desire uses his or her partner’s desire level as a baseline of what is normal (Hurlbert, Apt, Hurlbert, & Pierce, 2000). Therefore, therapeutically or medically treating a woman alone for low desire may be ignoring the potential root of the problem (Murray, Sutherland, & Milhausen, 2012).

Due to the complex nature of sexual desire and desire discrepancy, many studies have focused on exploring the link between SDD and dimensions of sexual desire, as well as relationship and sexual satisfaction. Much of the research identified differences in perceived satisfaction based on gender (Bridges & Horne, 2007; Ellison, 2001; Willoughby & Vitas, 2012). In a 2001 study, Ellison found that lack of desire or conflicting desire to their partner was the most common sexual complaint among women.

When looking at the role that sexual desire and sexual frequency had on overall relationship satisfaction, Willoughby and Vitas (2012) found that for females, high sexual desire was associated with high relationship satisfaction, even when sexual frequency was low. Furthermore, Bridges and Horne (2007) found that female participants’ SDD was significantly associated with lower sexual satisfaction, not relationship satisfaction. Confirming this finding, Mark (2012) looked at the impact of individual sexual desire and couple SDD on satisfaction with 133 couples and found that for both men and women, higher individual sexual desire predicted higher sexual satisfaction.

For men in the study, desire discrepancy was a significant predictor of sexual and relationship satisfaction (Mark, 2012). Willoughby and Vitas (2012) also found that when male partners experienced high sexual desire discrepancy, there were markedly lower scores in relationship satisfaction. In addition, Mark and Murray (2012) found a significant correlation between high SDD for male partners and decreased relationship satisfaction, but found no significant interaction between SDD and sexual satisfaction. This suggests that for men, discrepant desire may impact

overall relationship distress more (Mark & Murray, 2012). This variability between SDD and male and female satisfaction points to the interpretive and contextual factors that play an integral role in sexual and relationship expectations.

Whether decreased sexual desire is viewed in the context of the individual symptoms or the influence it has within an existing relationship, diminished sexual desire has been shown to be the most common, and most damaging, sexual problem that a couples face. Over the years, researchers and clinicians alike have focused on understanding and identifying causes and underlying contributors to the development and persistence of low sexual desire. Although effective treatments continue to be limited, there are many options to consider.

Treatment of Sexual Desire Discrepancy

Shifting the focus of decreased desire as an individual disorder to a relational dynamic creates space to view desire as it functions to pull couples closer or to push couples apart. Conceptualization of sexual desire through an interactional framework brought attention to the nature of desire, as it serves multiple functions within the relationship. Zilbergeld and Ellison (1980) suggested that desire is reliant on sexual cues that each partner has developed over time. Desire-discrepant couples often view the function of sex differently, ultimately contributing to conflict and the labeling of one partner as “inhibited” in his or her sexual desire (Fish, Busby, & Killian, 1994).

Although there is currently no literature on treatment of SDD, couples with discrepant desire are advised to seek treatment as a couple to approach the issue systemically. Some research suggests that SDD may be multifaceted (Mark, 2015). Mark, Herbenick, Fortenberry, Sanders, & Reece (2014) looked at how desire is viewed based on gender. In this sample, women described it as a desire for intimacy and to feel sexually desirable. Women scored highest on their desire for intimacy and emotional closeness through sex, while men placed emphasis on their desire to please their partner, as well as sexual desires of orgasm (Mark et al., 2014). However, in a study of 400 men and women, Heiman and colleagues (2011) found that physical intimacy such as cuddling, caressing, and partner’s touch predicted relationship happiness in men only. However, for both men and women, sexual frequency was related to sexual satisfaction, but not relationship happiness, suggesting that the role of intimacy is important across gender. This inclusion of intimacy and emotional closeness provides additional support of the intimacy-based sexual response model proposed by Basson (2003). From this perspective, the fundamental need for closeness and connection in romantic relationships provides a foundation for the conceptualization and treatment of SDD in couples.

Attachment and Satisfaction in Couples

Researchers have found a positive relationship between the level of emotional intimacy and marital satisfaction, where emotional intimacy fosters greater satisfaction, which subsequently increases both physical and emotional intimacy (Greeff & Malherbe, 2001). This finding is consistent in literature exploring the similar role of physical intimacy as well, highlighting the multifaceted nature of intimacy. Additional evidence has been found highlighting the link between insecure attachment, intimacy, and couple satisfaction (Dandurand & Lafontaine, 2013; Mikulincer & Shaver, 2007; Pielage, Luteijn, & Arrindell, 2005).

Drawing from literature on adult romantic attachment, secure attachment to a partner facilitates physical and emotional closeness. Previous research has described insecure attachment to be associated with lower sexual satisfaction, negative feelings during sex, lower arousal and intimacy and pleasure (Birnbaum & Reis, 2006). Therefore, it could be posited that couples who experience increased levels of attachment security would inherently feel more connected, and foster a greater desire for physical and emotional intimacy. In 2003, Gehring integrated the Basson model into the treatment of low sexual desire, suggesting that females experience intimacy-based sexual motivation. Female sexual desire, seen from this perspective, is a reaction to a felt sense of emotional intimacy with her partner. Keeping this notion in mind, EFT was conceptualized as a treatment for low sexual desire; however, no study was conducted (Gehring, 2003).

Emotionally Focused Therapy

Emotionally focused couple therapy (EFT) was created by Sue Johnson and Les Greenberg in the early 1980s as a response to a lack of clear and empirically sound couple-therapy interventions (Greenberg & Johnson, 1988; Johnson & Greenberg, 1985). Drawing from systemic, humanistic, and experiential roots, EFT highlights the inherent need for emotional closeness and connection while promoting change by creating new, positive emotional experiences and interactions (Johnson, 2004). EFT views relationship distress as the cycle of negative interactional patterns that are driven by underlying emotional processes linked to attachment needs. In EFT, emotions are understood as a set of responses that help predict, interpret, and respond to individual experiences (Johnson, 2004). Underlying emotional experiences are filtered through each partner's fundamental attachment need and thereby drive reactions and behaviors within situations of perceived threat. Change in EFT is seen through the ability to access and organize key emotional experience underlying each partner's stance in the relationship. By reprocessing emotional responses and shifting interactional patterns, the therapist is able to assist the couple in building a secure attachment to adapt and change (Johnson, 2004). Born out of an intrapsychic and interpersonal assimilation, EFT provides a framework to look at how individuals process experiences and how they organize interactions. The focus of EFT is to look at both systemic patterns of interaction, and the inner experiences and perceptions of self for each partner (Johnson, 2004).

EFT has been shown to be effective in reducing relationship distress in a variety of studies, including a number of randomized clinical outcome trials (Ahmadi, Zarei, Fallahchai, & Abbas, 2014; Dalton, Greeman, Classen, & Johnson, 2013; Dessaulles, Johnson, & Denton, 2003; Honarparvaran, Tabrizy & Navabinejad, 2010; MacPhee, Johnson, & van der Veer, 1995; Soltani, Shairi, Roshan, & Rahimi, 2014; Walker, Johnson, Manion, & Cloutier, 1996). It is important to note that only two of these studies focused on sexual issues within the couple (Honarparvaran et al., 2010; MacPhee et al., 1995). In 1999, Johnson, Hunsley, Greenberg, and Schindler conducted a meta-analysis of the current outcome and process research on EFT. Overall, outcomes suggested EFT was effective in significantly reducing couple distress in 90% of couples. Studies have also shown that the effects of EFT continue after termination in approximately 70% of the couples (Johnson & Greenberg, 1985; Johnson & Talitman, 1997; Walker et al., 1996). EFT has been shown to be effective in working with several different populations around the world, including LGBTQ couples. EFT is contraindicated when there is active partner violence, substance

abuse, or an ongoing infidelity in the relationship. Though many therapists train and work within the model explicitly, others receive basic training and integrate key interventions into their current repertoire.

Integrating EFT and Sexual Issues

In many relationships, partners are stuck in negative cycles of pursue-withdraw. This dynamic shows up in both general and sexual interactions. Often, the pursuing/demanding partner holds more of an anxious attachment position and is ultimately seeking affection and reassurance. This can be the stance he/she holds in all interactions, although a common complaint from the pursuer is “I don’t feel like having sex when I don’t feel emotionally connected.” The partner who withdraws during conflict is more avoidant, generally, and may seek connection primarily through sexual contact while avoiding emotional closeness (Johnson & Zuccarini, 2010). In essence, the negative sexual cycle is stuck in a holding pattern, where one partner desires emotional intimacy as a precursor for sex, and the other partner uses sexual intimacy to feel emotionally close. As either partner feels a disconnection or threat to his or her sexual behavior system, that partner’s working model is cued, shifting that individual into hyperactivation or deactivation of the sexual system (Shaver & Mikulincer, 2006). These hyperactivating and deactivating strategies are seen in the context of the cycle and deconstructed in the same manner.

When shifting the focus to the sexual cycle, the EFT therapist continues to view the perceptions, behaviors, and emotional experiences within the context of the attachment relationship. In Stage 1, the therapist would delineate the sexual responses and tie them to an underlying need for safety and connection. As the negative sexual cycle becomes explicit and understood, deeper primary emotions that are linked to the sexual responses and internal (sexual) working models are accessed and filtered through the lens of the unmet attachment needs and fears (Johnson & Zuccarini, 2010). Applying EFT to couples with SDD directly addresses the disconnection and distress caused in the relationship by the perceived desire of each partner. By viewing sexual desire through the intimacy-based response cycle, there is an essential need for emotional intimacy to provide the scaffolding for positive sexual experiences. While there may be a discrepancy in levels of desire, regardless of perceived emotional connection, addressing the distress that the couple experiences remains the objective of the therapist. EFT bridges the gap between current treatments that address relational dynamics that influence desire and the research that points to the intrinsic need for emotional intimacy as a catalyst to sexual desire and satisfaction in relationships.

Using EFT to Treat SDD

Emotionally focused therapy is organized around nine steps, which are broken down into three primary stages. Stage I involves deescalating the couple’s negative interaction cycle and consists of Steps 1 through 4. Stage II involves helping the couple learn to connect through creating emotional bonding experiences and consists of Steps 5 through 7, and stage III involves consolidating changes and consists of Steps 8 and 9. The application of EFT to SDD will be laid out based on the three stages and nine steps of EFT.

Stage I: Cycle Deescalation

The key tasks in Stage I of EFT are to develop a strong alliance with both members of the couple, assess and map out their interaction cycle, access attachment-related primary emotions, and reframe the problem in the context of the negative cycle and underlying attachment-related emotions. As applied specifically to SDD, Stage I consists of the following:

Step 1. Develop a therapeutic relationship with both partners and assess for general relationship distress. Complete a thorough assessment including the degree of SDD, the history of SDD, when the SDD is most and least likely to happen, and the level of distress—both individually and within the relationship—due to the SDD. The assessment involves both a relationship history, especially as it relates to their sexual interaction, and an assessment of each partner’s experiences around touch and sex generally as well as their mental and physical health. It is important for all assessment to be from a systemic viewpoint rather than one person being “too sexual” or being “sexually deficient.” Although distressing, the difference in sexual desire is normalized as being common and is framed as something that can change.

Step 2. Identify the general negative cycle the couple is caught in and the specific cycle around SDD. For example, one partner may anxiously pursue for connection in general and withdraw around sexual intimacy, and the other partner may withdraw generally while anxiously pursuing sexual intimacy. Partners may get caught up in blaming or pushing as well as shutting down and withdrawing. There is typically a layer of reactive emotions such as frustration, anger, and resentment, as well as a layer of more vulnerable emotions such as feeling deeply hurt and rejected, and being afraid of being abandoned and unloved. People are seen as inherently having deep needs for loving, safe connection.

Step 3. Access unacknowledged emotions and attachment needs around their experiences of the negative cycle in general and around SDD specifically. Partners often feel deeply rejected abandoned, defective, or broken. They may have profound fears that unless they can eliminate the SDD, they will lose their partner. The fears of losing the other person and the security of the relationship can be a powerful emotional driver and tends to exacerbate the discrepancy. This worsening fear makes it more difficult to cue into and accurately read partner signals and tune into one’s own bodily experience. The goal in Step 3 is to access the underlying fears.

Step 4. Reframe the problem as being about the cycle, and the underlying attachment-related emotions and longings. SDD is typically framed as being both a result of and a contributor to the negative cycle. The more disconnected and reactive partners become, the greater the discrepancy in sexual desire can become. As the partner with lower desire feels less connected and interested, the higher desire partner focuses on sex as a means for connection more and more, attributing additional fear to the meaning of his or her partner’s low desire. With greater disconnection, both partners begin to miss each other’s cues for sexual connection, continuing the negative cycle.

In the context of the negative cycle, SDD is also framed as being both the source and the product of profound fears of losing the other and deep pain from feeling unloved and rejected. For example, partners who have lower sexual desire may fear they are defective, may fear that no matter how much they try it will not be enough, may fear the other “just wants sex,” or may fear they will lose their partner. Higher desire partners may fear they are doing something wrong, that they are unloved or unwanted, or that they are defective. For both partners, these fears are

typically associated with intense pain, sadness, and loneliness as well as more reactive emotions such as anger and resentment.

Stage II: Changing Interactional Positions

Steps 5 and 6. In Step 5, the therapist works to help members of the couple own and share their deeper attachment needs and aspects of self. In Step 6, the therapist works to help each member of the couple see and accept the deeper needs and longings that have been owned and shared in Step 5. As couples share their individual and different attachment needs to feel safe, loved, valued, and accepted directly with each other, and they are seen and accepted by the other person, these needs become a central defining aspect of both the self and the relationship. So rather than the self and the relationship being defined through the lenses of sexual deficiency or sexual disconnection or rejection, they are defined by the attachment longings each partner has in relationship to the other.

The process of tuning into one's own needs and desires creates greater self-awareness, which can help partners with lower desire be aware of sexual desires and the circumstances that help enhance sexual desire. This process can help partners with higher sexual desire tune into attachment-related longings and needs that can drive sexual desire.

Steps 7. In this step, the therapist facilitates the direct expression of needs and wants and works to create emotional bonding. This can only be done effectively when each member has been able to own his or her attachment-related longings and is able to see and accept the longings of the partner. When couples are able to directly ask for comfort, connection, and safety in the relationship from a position of vulnerability to a partner who is tuned in, it creates powerful, emotionally intimate bonding events. The emotional intimacy typically increases sexual desire in the partner with lower sexual desire. It can also help the higher sexual desire partner feel accepted and loved, regardless of the other partner's sexual desire. It also allows couples to more accurately express and read each other's sexual cues, thus better enabling sexual engagement to become a safe and exciting adventure of connection (Johnson, 2013).

Stage III: Consolidation/Integration

Steps 8 and 9. In these steps the therapist supports couples in finding new solutions to old relationship problems (Step 8) and consolidating the gains they have made in therapy (Step 9). Although many sexual desire discrepancy issues are resolved in Stage II work, sometimes more difficult sexual issues need the safety of Stage III work to be resolved. If sexual desire discrepancy is still an issue, more traditional sex therapy techniques such as sensate focus (Weiner & Avery-Clark, 2014) can be used. However, the safety and security of the couple's attachment relationship must be the foundational context for all additional sex therapy techniques. The focus is on assisting the couple to view sex from a wider lens, to encompass sexual intimacy from a broadened perspective, wherein sexual engagement serves as a loving, safe, adventurous bonding experience.

The following is a case example intended to provide a snapshot of how a therapist might use EFT to work with a couple with sexual desire discrepancy. It is not intended to illustrate a

comprehensive overview of EFT. The couple presented in this example is fictitious, with details and dynamics informed from multiple couples seen in therapy.

Case Example: Adam and Jen

Adam and Jen, a Caucasian couple in their mid-thirties, presented for treatment to work on their desire discrepancy and overall concerns with intimacy. Adam and Jen had been together for five years and had been engaged for the past year. The couple had been living together for the past three years. Approximately 14 months into their relationship, Adam and Jen separated due to issues with a lack of intimacy and sexual frequency. The couple reconciled after one month of being apart and shortly thereafter began living together. The couple sought out sex therapy to work on their desire discrepancy and overall concerns with intimacy.

In an individual session at the beginning of therapy, Jen shared that she enjoyed sex with Adam in the beginning of the relationship. She reported that back then she rarely initiated, but would enjoy sex when it happened. Jen stated that she began being sexual in college, and that she had a few short-term relationships, but nothing serious. Jen reported intercourse being pleasurable most of the time, with intermittent pain during penetration. Adam reported having two sexual partners before Jen, one being his previous girlfriend of two years, and a fling. Adam reported high levels of performance anxiety and problems maintaining his erections. This was a source of distress in the couple's relationship.

Jen reported that she was very stressed with her job and often felt too tired to be sexual with Adam. While she assured the therapist that she was still extremely attracted to her partner, she did not desire him sexually. Adam expressed that he was extremely stressed because of his partner's disinterest and stated on multiple occasions that he felt like she did not desire him at all. Often, the couple would go without sexual contact for three to four weeks at a time. Adam shared that he was the only partner who would initiate sex, and when it happened, Jen did not seem to enjoy intercourse. Jen stated that she was uncomfortable physically and emotionally. Both partners were noticeably upset about their lack of sex; however, Jen reported that she felt pressured to have sex and would otherwise not think about it at all. During arguments, Adam got angry and threatened to leave Jen if she did not fix this part of their relationship.

In the first few sessions, the therapist worked to assess for the couple's interactional cycle and understand the function of their behavioral patterns. Both Adam and Jen reported their sexual issues to be the primary stressor in the relationship; however, they also experienced conflict around marriage and family as well. Through this process, the couple's cycle was outlined: Adam primarily pursued connection—both physical and emotional—while Jen became easily overwhelmed and withdrew from the situation, often feeling pressured, blamed, or attacked.

In Steps 2 and 3 with Adam and Jen, the therapist began to focus on the dynamics of their SDD and how this was experienced for both partners. Adam would begin by initiating physical intimacy, with the desire to feel close and connected to Jen. Jen experienced his bid for sex as uncomfortable, and would feel anxious. Jen reported racing thoughts, heightened anxiety, and an inability to stay present. Often she felt tense and worried that if she didn't agree to Adam's attempt, he would become angry, as he had done in the past. In return, Adam could sense Jen's uncertainty and was conflicted. He began to fear that he was not attractive to his partner, that she did not desire him, and that he could not please her. This increased his anxiety and fear, and was

experienced by Jen as desperation. At this point in their sexual cycle, Jen would often attempt to have sex with Adam, with moderate success. She explained that she had a difficult time feeling connected to him and felt an immense pressure to please him. As the treatment progressed, Jen was able to identify a deeper emotional experience of feeling flawed and not good enough. Deep down, Jen felt that no matter how hard she tried, she could not please Adam.

In Step 4, the therapist helped Adam and Jen view this pattern in the larger context of their relationship as well as within their sex life. By tracking their emotional experience during these times of disconnection, the therapist worked to externalize the blame and pressure felt by both partners. The process of reframing the negative sexual cycle allowed the couple to come together to break the cycle, rather than the cycle slowly leading to greater disconnection.

As the couple moved into Stage 2 of EFT, the focus was on owning and sharing their deeper fears that came up through the activation of their negative cycle. For Adam, these fears were focused on his view of himself as being unwanted and rejected. Jen's underlying fears surrounded her feeling not good enough and defective. As they were able to access and own their fear and the primary emotions attached, they were able to turn toward one another to ask for these attachment longings to feel safely connected and loved. For Adam and Jen, this process of accessing their fears, vulnerabilities, and needs was slow and gradual. Each partner took small risks to share openly about their experience in the cycle at large, and their sexual cycle specifically. By turning toward one another to ask for closeness and comfort, they were drawn closer, both physically and emotionally.

The following example dialogue could occur as part of a session, in any of Steps 3 through 6, where the therapist is helping the couple identify their attachment needs and longings that drive their sexual cycle. The dialogue in the transcript was modified, based on an integration of various couples. This dialogue is intended to illustrate elements of EFT applied to a specific context. In this dialogue, Jen shares her underlying fears and is able to identify the pain of feeling not good enough. As Adam hears her, he anxiously tries to soothe Jen by minimizing her hurt, and the therapist works to access and heighten his pain to make him more available to her.

- Therapist: So Jen, what I'm hearing you say is that when you perceive Adam as being unhappy with your sex life, you feel a great deal of pressure ... to perform, to make him happy, to show him that he matters to you.
- Jen: Well, yes. I can tell when Adam is frustrated and upset with me that we aren't having sex, I feel like it's all my fault. And if I can't fix this and make it better, I will lose him.
- Therapist: Right, you feel like it's all your fault. You feel like it is all on you to fix this problem, like you are the problem?
- Jen: I am. If I wanted to have sex more, maybe he would be happy.
- Therapist: So you feel like somehow there is something wrong with you ... that you aren't making him happy.
- Jen: I feel like I can never make him happy. No matter what I try to do, it doesn't seem to really matter. He still gets frustrated and angry, even when I do try.
- Therapist: I see. Even when you try to make him happy, try to satisfy him, he is still upset. Somehow, no matter what you do, you don't feel like it is good enough?
- Jen: (crying) I just don't know what else to do anymore. Every time he gets frustrated, I know it's because of me. I can see the disappointment on his face when I'm not in the mood and I feel terrible, like there is something wrong with me.

- Therapist: You feel terrible. You see his disappointment and immediately you believe that there is something wrong with you, you blame yourself for what is happening. And you begin to feel like, *if I can't fix this, if I can't make him happy, I might lose him—he will leave me*. Is that it Jen? Did I get that right?
- Jen: (muffles under her breath) Yes.
- Therapist: Jen, what would it be like for you to reach for him now, to take a risk and let him know that you fear losing him?
- Jen: (to Adam) I feel like no matter what I do, I'm letting you down. I feel like I can't make you happy, and that eventually you are going to leave me. I'm terrified of losing you.
- Adam: You aren't going to lose me; I don't ever want to leave you.
- Therapist: What's happening for you right now, Adam? What are the tears about, this sadness that's coming up? Tell her about it.
- Adam: My frustration is never about the sex itself. Sure, I would love to have sex more ... but it's not that. It's that when you wouldn't be interested, or you seemed so anxious, I felt totally unwanted. I felt rejected and alone. So to hear you say that you're scared to lose me—well, I had no idea. Hearing that makes me feel like you care, like you want to be with me.
- Therapist: So as you hear Jen express her fears of losing you, and of not being good enough, what you hear is that she isn't rejecting you, but that she cares for you *so* much that her deepest fear is of losing you, of losing this relationship.

In this short segment, the therapist works to help Jen express her underlying fear of losing Adam, and the longing of feeling good enough, both sexually and in the context of the relationship at large. The therapist helps Jen turn to Adam to share her fear, and guides Adam as he reacts to Jen's fear, by responding to Jen from a place of understanding and vulnerability. The therapist then validates Adam's understanding of Jen's fear and ties it into their negative cycle to externalize both partners' fears and promote closeness.

Throughout this process, both partners took great risks to be expressive and open during the session. As they worked to share and accept one another in their moments of vulnerability, their interactional cycle began to change. The therapist included exercises to integrate sensual touch and bonding outside of therapy to help them gradually reconnect. In session, challenges and continued anxieties about performance were addressed to help both partners feel comfortable opening a dialogue around sexual desires. As the couple began to speak openly about their sexual interests and focus less on the functional aspects of intercourse, both Adam and Jen were able to enjoy sexual activities. Although Jen continued to report lower spontaneous desire than Adam in session, she was more open to being sexually intimate. The therapist also provided psychoeducation about the differences between spontaneous and responsive desire to expand the couples' understanding.

This couple, like many couples, experienced both physical and emotional barriers to pleasurable, connected sex. Through this therapeutic process, a couple is able to increase their ability to connect emotionally, thereby increasing the desire for physical connection. From this lens, desire is both a catalyst and an outcome. While some couples may experience a difference in their individual levels of desire, they may feel less distressed about the discrepancy and overall more satisfied (Mark & Murray, 2012). On the other hand, couples also experience a decrease in discrepancy as well.

In a couple like Jen and Adam, treatment length is dependent on concomitant issues that the couple is struggling with. For some, 12 to 18 sessions is adequate, while others may be in therapy

for several months or more. Therapist training and experience may also inform treatment duration. For many therapists, regardless of their experience level, EFT is learned in stages, first with a broad overview during a class or four-day externship, followed by a more intensive set of trainings. Therapists can often operate along this continuum and provide effective treatment. In some cases, the mere understanding of the steps, stages, and key interventions can provide a useful framework in working with couples. In addition, there are several books, educational training videos, and supervisory resources to assist therapists as they become proficient.

As previously stated, the most recent meta-analysis (Johnson et al., 1999) found 70% to 73% of couples were no longer distressed at the end of therapy, with 70% remaining nondistressed at a three-month follow-up (Johnson & Talitman, 1997). Although these studies focused on relational distress in general, one may posit that sexual concerns are seen as a component of such relational distress. As with most therapeutic models, EFT does not fit for all couples. During the assessment phase of therapy, the clinician should be mindful of contraindications for couple's therapy, such as an ongoing affair, substance abuse, or intimate partner violence. Referring partners to individual therapy may also be warranted and based on the primary therapist's discretion.

CONCLUSION

Low sexual desire and the discrepancy in desire between partners have been shown to be the most distressing sexual concerns that couples face. Both sexual and relationship satisfaction are impacted by the degree of SDD in couple relationships. By viewing SDD as a relational issue consisting of multiple levels of interaction, clinicians are able to conceptualize and treat problematic desire discrepancy as an interpersonal process rather than an individual's problem.

In recent years, researchers have focused on understanding the role that emotional intimacy plays in sexual desire and responsiveness (Basson, 2001a, 2001b, 2005; Carvahlo & Nobre, 2010; Levine, 2003). With a greater understanding of the intricate relationship of physical and emotional needs, treatment is best viewed systemically. In treating couples with problematic SDD, this complex cycle that develops around the desire for both sexual and emotional intimacy can be conceptualized and treated with EFT to promote closeness, connection, and satisfaction.

REFERENCES

- Ahmadi, F. S., Zarei, E., Fallahchai, S. R., & Abbas, B. (2014). The effectiveness of emotionally-focused couple therapy in resolution of marital conflicts between the couples who visited the consultation centers. *Journal of Educational and Management Studies*, 4, 118–123.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). doi:10.1176/appi.books.9780890423349
- Bagarozzi, D. A. (1987). Marital/family developmental theory as a context for understanding and treating inhibited sexual desire. *Journal of Marital and Family Therapy*, 13, 276–285. doi:10.1080/00926238708403900
- Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. *Journal of Consulting and Clinical Psychology*, 54(2), 140–148. doi:10.1037/0022-006X.54.2.140
- Basson, R. (2001a). Human sex-response cycles. *Journal of Sex & Marital Therapy*, 27(1) 33–43. doi:10.1080/00926230152035831
- Basson, R. (2001b). Using a different model for female sexual response to address women's problematic low sexual desire. *Journal of Sex & Marital Therapy*, 27(5), 395–403. doi:10.1080/713846827
- Basson, R. (2002). A model of women's sexual arousal. *Journal of Sex & Marital Therapy*, 28, 1–10.

- Basson, R. (2003). Biopsychosocial models of women's sexual response: Applications to management of 'desire disorders.' *Sexual and Relationship Therapy, 18*, 107–115. doi:10.1080/1468199031000061308
- Basson, R. (2005). Women's sexual dysfunction: Revised and expanded definitions. *Canadian Medical Association Journal, 172*(10), 1327–1333.
- Birnbaum, G. E., & Reis, H. T. (2006). Women's sexual working models: An evolutionary-attachment perspective. *Journal of Sex Research, 43*(4), 328–342. doi:10.1080/00224490609552332
- Brezsnyak, M., & Whisman, M. A. (2004). Sexual desire and relationship functioning: The effects of marital satisfaction and power. *Journal of Sex & Marital Therapy, 30*, 199–217. doi:10.1080/00926230490262393
- Bridges, S. K., & Horne, S. G. (2007). Sexual satisfaction and desire discrepancy in same sex women's relationships. *Journal of Sex & Marital Therapy, 33*, 41–53. doi:10.1080/00926230600998466
- Byers, E. (2005). Relationship satisfaction and sexual satisfaction: A longitudinal study of individuals in long-term relationships. *Journal of Sex Research, 42*, 113–118.
- Carvalho, J., & Nobre, P. (2010). Predictors of women's sexual desire: The role of psychopathology, cognitive-emotional determinants, relationship dimensions, and medical factors. *Journal of Sexual Medicine, 7*, 928–937. doi:10.1111/j.1743-6109.2009.01568.x
- Dalton, J., Greenman, P., Classen, C., & Johnson, S. M. (2013). Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy (EFT) for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice, 2*, 209–221.
- Dandurand, C., & Lafontaine, M.-F. (2013). Intimacy and couple satisfaction: The moderating role of romantic attachment. *International Journal of Psychological Studies, 5*(1), 74–91. doi:10.5539/ijps.v5n1p74
- Davies, S., Katz, J., & Jackson, J. L. (1999). Sexual desire discrepancies: Effects on sexual and relationship satisfaction in heterosexual dating couples. *Archives of Sexual Behavior, 28*(6), 553–567. doi:10.1023/A:1018721417683
- Davison, S. L., Bell, R. J., LaChina, M., Holden, S. L., & Davis, S. R. (2009). The relationship between self-reported sexual satisfaction and general well-being in women. *Journal of Sexual Medicine, 6*(10), 2690–2697. doi:10.1111/j.1743-6109.2009.01406.x
- Dessalles, A., Johnson, S. M., & Denton, W. (2003). Emotion-focused therapy for couples in the treatment of depression: A pilot study. *American Journal of Family Therapy, 31*, 345–353.
- Doss, B. D., Simpson, L. E., & Christensen, A. (2004). Why do couples seek marital therapy? *Professional Psychology: Research and Practice, 35*, 608–614.
- Ellison, C. R. (2001). A research inquiry into some American women's sexual concerns and problems. *Women and Therapy, 24*, 147–159.
- Fish, L. S., Busby, D., & Killian, K. (1994). Structural couple therapy in the treatment of inhibited sexual drive. *The American Journal of Family Therapy, 22*(2), 113–125. doi:10.1080/01926189408251305
- Frühau, S., Gerger, H., Schmidt, H. M., Munder, T., & Barth, J. (2013). Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis. *Archives of Sexual Behavior, 42*, 915–933. doi:10.1007/s10508-012-0062-0
- Gehring, D. (2003). Couple therapy for low sexual desire: A systemic approach. *Journal of Sex and Marital Therapy, 29*, 25–39. doi:10.1080/00926230390154817
- Greeff, A. P., & Malherbe, H. L. (2001). Intimacy and marital satisfaction in spouses. *Journal of Sex & Marital Therapy, 27*, 247–257. http://dx.doi.org/10.1080/009262301750257100
- Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York, NY: Guilford Press.
- Heiman, J. R., Long, J. S., Smith, S. N., Fisher, W., Sand, W., & Rosen, R. (2011). Sexual satisfaction and relationship happiness in midlife and older couples in five countries. *Archives of Sexual Behavior, 40*, 741–753. doi:10.1007/s10508-010-9703-3
- Honarparvaran, N., Tabrizy, M., & Navabinejad, Sh. (2010). The efficacy of emotionally focused couple therapy (EFT-C) training with regard to reducing sexual dissatisfaction among couples. *European Journal of Scientific Research, 43*, 538–545.
- Hurlbert, D. F., Apt, C., & Rabeahl, S. (1993). Key variables to understanding female sexual satisfaction: An examination of women in nondistressed marriages. *Journal of Sex and Marital Therapy, 19*, 154–165.
- Hurlbert, D. F., Apt, C., Hurlbert, M. K., Pierce, A. P. (2000). Sexual compatibility and the sexual desire-motivation relation in females with hypoactive sexual desire disorder. *Behavior Modification, 25*, 325–347.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection* (2nd ed.). New York, NY: Brunner/Routledge.

- Johnson, S. M. (2013). *Love sense: The revolutionary new science of romantic relationships*. New York, NY: Little, Brown.
- Johnson, S. M., & Greenberg, L. S. (1985). Emotionally focused couples therapy: An outcome study. *Journal of Marital and Family Therapy, 11*, 313–317.
- Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice, 6*, 67–79.
- Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. *Journal of Marital & Family Therapy, 23*, 135–152.
- Johnson, S., & Zuccarini, D. (2010). Integrating sex and attachment in emotionally focused couple therapy. *Journal of Marital and Family Therapy, 36*, 431–445. doi:10.1111/j.1752-0606.2009.00155.x
- Kaplan, H. S. (1974). *The new sex therapy: Active treatment of sexual dysfunctions*. New York, NY: Brunner/Mazel.
- Levine, S. B. (2003). The nature of sexual desire: A clinician's perspective. *Archives of Sexual Behavior, 32*, 279–285.
- MacPhee, D., Johnson, S. M., & van der Veer, M. C. (1995). Low sexual desire in women: The effects of marital therapy. *Journal of Sex and Marital Therapy, 21*(3), 159–182.
- Mark, K. P. (2012). The relative impact of individual sexual desire and couple desire discrepancy on satisfaction in heterosexual couples. *Sexual and Relationship Therapy, 27*, 133–146. doi:10.1080/14681994.2012.678825
- Mark, K. P. (2014). The impact of daily sexual desire and daily sexual desire discrepancy on the quality of the sexual experience in couples. *The Canadian Journal of Human Sexuality, 23*(1), 27–33. doi:10.3138/cjhs.23.1.A2
- Mark, K. P. (2015). Sexual desire discrepancy. *Current Sexual Health Reports*. doi:10.1007/s11930-015-0057-7
- Mark, K., Herbenick, D., Fortenberry, D., Sanders, S., & Reece, M. (2014). The object of sexual desire: Examining the “what” in “what do you desire?” *The Journal of Sexual Medicine, 11*(11), 2709–2719. doi:10.1111/jsm.12683
- Mark, K., & Murray, S. (2012). Gender differences in desire discrepancy as a predictor of sexual and relationship satisfaction in a college sample of heterosexual romantic relationships. *Journal of Sex & Marital Therapy, 38*, 198–215. doi:10.1080/0092623x.2011.606877
- McCabe, M. P. (1997). Intimacy and quality of life among sexually dysfunctional men and women. *Journal of Sex & Marital Therapy, 23*, 276–290.
- McCarthy, B., & McCarthy, E. (2003). *Rekindling desire* (2nd ed.). New York, NY: Routledge.
- McCarthy, B., & McDonald, D. (2009). Assessment, treatment, and relapse prevention: Male hypoactive sexual desire disorder. *Journal of Sex & Marital Therapy, 35*(1), 58–67. doi:10.1080/00926230802525653
- Metz, M. E., & Epstein, N. (2002). Assessing the role of relationship conflict in sexual dysfunction. *Journal of Sex & Marital Therapy, 28*, 139–164.
- Milkulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics and change*. New York, NY: Guilford Press.
- Murray, S., Sutherland, O., & Milhausen, R. (2012). Young women's descriptions of sexual desire in long-term relationships. *Sexual and Relationship Therapy, 27*, 1–14. doi:10.1080/14681994.2011.649251
- Pascoal, P. M., Narciso, I., & Pereira, N. M. (2013). Emotional intimacy is the best predictor of sexual satisfaction of men and women with sexual arousal problems. *International Journal of Impotence Research, 25*, 51–55. doi:10.1038/ijir.2012.38
- Perel, E. (2006). *Mating in captivity: Unlocking erotic intelligence*. New York, NY: Harper Collins.
- Pielage, S. B., Luteijn, F., & Arrindell, W. A. (2005). Adult attachment, intimacy, and psychological distress in a clinical and community sample. *Clinical Psychology and Psychotherapy, 12*, 455–464. doi:10.1002/cpp.472
- Schnarch, D. (2009). *Passionate marriage: Keeping love and intimacy alive in committed relationships* (2nd ed.). New York, NY: Norton.
- Shaver, P. R., & Mikulincer, M. (2006). A behavioral systems approach to romantic love relationships: Attachment, caregiving, and sex. In R. J. Sternberg & K. Weis (Eds.), *The new psychology of love* (pp. 35–64). New Haven, CT: Yale University Press.
- Soltani, M., Shairi, M. R., Roshan, R., & Rahimi, C. (2014). The impact of emotionally focused therapy on emotional distress in infertile couples. *International Journal of Fertility and Sterility, 7*(4), 337–344.
- Sprecher, S. (2002). Sexual satisfaction in premarital relationships: Associations with satisfaction, love, commitment, and stability. *Journal of Sex Research, 39*(3), 190–196.
- Tiefer, L. (2001). A new view of women's sexual problems: Why new? Why now? *Journal of Sex Research, 38*, 89–96.
- Verhulst, J., & Heiman, J. R. (1988). A systems perspective on sexual desire. In S. R. Leiblum & R. C. Rosen (Eds.), *Sexual desire disorders* (pp. 243–267). New York, NY: Guilford Press.

- Walker, J. G., Johnson, S., Manion, I., & Cloutier, P. (1996). Emotionally focused marital intervention for couples with chronically ill children. *Journal of Consulting and Clinical Psychology, 64*(5), 1029–1036.
- Weeks, G. R., & Gambescia, N. (2015). A new paradigm in sex therapy. In K. M. Hertlein, G. R. Weeks, & N. Gambescia (Eds.), *Systemic sex therapy* (2nd ed., pp. 24–35). New York, NY: Routledge.
- Weiner, L., & Avery-Clark, C. (2014). Sensate focus: Clarifying the Masters and Johnson's model. *Sexual & Relationship Therapy, 29*(3), 307–319. doi:[10.1080/14681994.2014.892920](https://doi.org/10.1080/14681994.2014.892920)
- Wiederman, M. W. (1998). The state of theory in sex therapy. *Journal of Sex Research, 35*(1), 88–99.
- Willoughby, B., & Vitas, J. (2012). Sexual desire discrepancy: The effect of individual differences in desired and actual sexual frequency on dating couples. *Archives of Sexual Behavior, 41*, 477–486. doi:[10.1007/s10508-011-9766-9](https://doi.org/10.1007/s10508-011-9766-9)
- Zilbergeld, B., & Ellison, C. R. (1980). Desire discrepancies and arousal problems in sex therapy. In S. R. Leiblum & A. A. Pervin (Eds.), *Principles and practice of sex therapy* (pp. 65–101). New York, NY: Guilford Press.

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