

Addressing Issues of Sexuality in Couples Therapy: Emotionally Focused Therapy Meets Sex Therapy

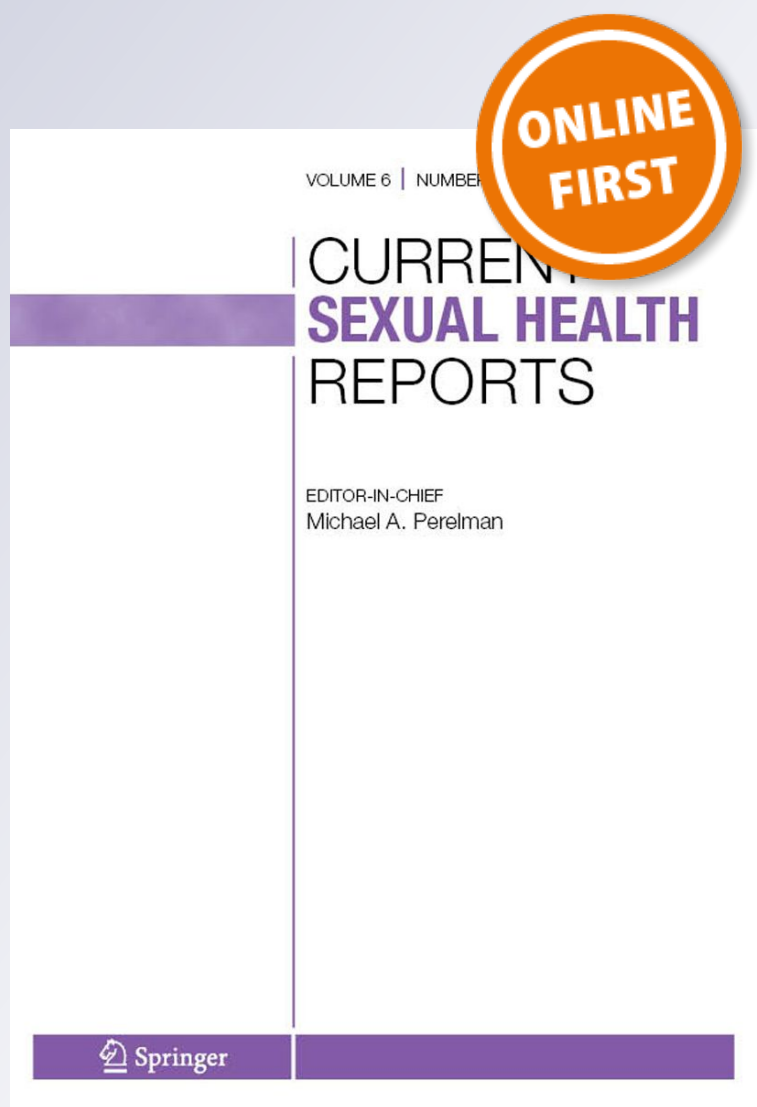
**Susan M. Johnson, Zoya Simakhodskaya
& Michael Moran**

Current Sexual Health Reports

ISSN 1548-3584

Curr Sex Health Rep

DOI 10.1007/s11930-018-0146-5



Your article is protected by copyright and all rights are held exclusively by Springer Science+Business Media, LLC, part of Springer Nature. This e-offprint is for personal use only and shall not be self-archived in electronic repositories. If you wish to self-archive your article, please use the accepted manuscript version for posting on your own website. You may further deposit the accepted manuscript version in any repository, provided it is only made publicly available 12 months after official publication or later and provided acknowledgement is given to the original source of publication and a link is inserted to the published article on Springer's website. The link must be accompanied by the following text: "The final publication is available at link.springer.com".



Addressing Issues of Sexuality in Couples Therapy: Emotionally Focused Therapy Meets Sex Therapy

Susan M. Johnson¹ · Zoya Simakhodskaya² · Michael Moran³

© Springer Science+Business Media, LLC, part of Springer Nature 2018

Abstract

Purpose of Review The purpose of this article is to describe the use of Emotionally Focused Therapy (EFT) with couples presenting with sexual concerns and how to integrate sex therapy interventions with EFT.

Recent Findings Sexual issues always present in the relational context and typically have a significant impact on intimate relationships. Literature on attachment theory and sexuality indicates that in long-term committed relationships, attachment and sexual behavioral motivational systems overlap with attachment systems playing a significant role in creating security and safety for optimal sexuality. Research on effectiveness of medical sex interventions reflects the importance of integrating psychological approaches, as well as working systemically with clients and their intimate partners. EFT can be used successfully to improve sexual satisfaction of distressed couples, as well as to improve effectiveness of sex therapy interventions.

Summary EFT with its emphasis on distilling emotional experience and guiding couples to create a more secure bond offers a model for addressing many sexual concerns and a more successful implementation of sex therapy interventions. This article explores the Emotionally Focused approach to dealing with sexual problems and the implications of this attachment-oriented perspective for our understanding of sexuality and the treatment of sexual issues. Recent research on psychological interventions for sexual dysfunctions is reviewed. Principles of addressing sexual concerns in EFT, as well as ways to integrate behavioral sex therapy interventions, are described and examples given.

Keywords Emotionally focused therapy · Sexuality · Couples therapy · Sex therapy · Attachment theory

Introduction

Sexuality in the medical and therapeutic field is often described as a purely physical process and with diagnoses and interventions focusing on different physiological aspects of the problem [1]. Clinicians who see partners together, however, approach sexuality as a reciprocal dance that occurs in a specific interactional context. Indeed, Dr.

Sue Carter, Director of the Kinsey Institute, has recently stated that the time has come for us to move away from exploring mechanical sex to understanding human sexuality in the context of relationships. Sex is a dance and how partners respond to each other in the sexual context determines the quality of their sex lives. Most modern sex therapists acknowledge that “sex therapy is ... inextricably tied to relationship issues and psychological functioning” [1]. The attachment perspective offered in this article implies that the relational issues are the defining context for sexual functioning and are primary.

This article will explore the Emotionally Focused approach to dealing with sexual problems and the implications of this attachment-focused perspective for our understanding of sexuality and the treatment of sexual issues. It will present a brief description of Emotionally Focused Couple Therapy (EFT), a well-validated approach to relationship distress [2–4]. Ten principles of addressing sexual concerns in EFT, as well as ways to integrate behavioral sex therapy interventions, will be described and examples given [5••].

This article is part of the Topical Collection on *Clinical Therapeutics*

✉ Zoya Simakhodskaya
drzoyasim@gmail.com

¹ International Centre for Excellence in Emotionally Focused Therapy, University of Ottawa, Ottawa, Canada

² New York University School of Medicine, New York Center for Emotionally Focused Therapy, 352 7th Avenue, Suite 1005, New York, NY 10001, USA

³ New York Center for Emotionally Focused Therapy, New York, USA

The Attachment Perspective on Adult Love and Sexuality

John Bowlby, the father of attachment theory, wrote about three main motivational behavioral systems: attachment, sexual, and caregiving [6]. In the beginning stages of relationship, attraction and sex serve to promote attachment bonds [7•]. For example, research shows that being sexual leads to increased intimate self-disclosure [8]. In long-term intimate relationships, the three behavioral systems overlap with secure attachment serving as a foundation. At times of uncertainty or stress, we seek physical and emotional proximity to our attachment figure, a “safe haven.” An attachment bond also becomes a secure base that supports exploration and autonomy. Universally, separation distress from attachment figure creates distress responses such as protest, clinging, emotional desperation, and despair that can eventually lead to numbing and detachment. For adults, such bonds are reciprocal as they involve mental representations, rather than simply physical proximity. And, physical proximity and comfort can be achieved through sexual interaction.

When we have a secure emotional bond in a long-term relationship, we can put aside defenses, be playful, and trust our bodies; we can tune into ourselves and another person, express our sexual wishes and needs, and resolve any sexual differences and problems. At the same time, being sexual in a long-term relationship can help resolve conflicts constructively, decrease a sense of insecurity, and increase relationship satisfaction [7•]. It can become a positive reciprocal loop: a more secure attachment with its accessibility and responsiveness can lead to optimal sexual experience and a secure sexuality can grow emotional connection and bonding. In addition, securely attached partners can deal with shifts in sexual focus or variations in their partner's needs, without increased sense of rejection or fears of abandonment.

Research demonstrates that the sexual relationship is often affected by insecure attachment strategies used to cope with distress, such as anxious pursuit or reactive numbing [7•, 9–11]. In any long-term relationship one has to face the inevitable changes in desire, arousal, and orgasm experiences and insecure partners struggle to deal with such failures, frustrations, and changes in levels of desire or arousal. Those with avoidant strategies are more likely to question the relationship, to have sex for self enhancement, to impress peers, or to relieve stress; they might engage less in foreplay or affectionate holding after sex; they might masturbate more and have less sex with their partner; they are also more likely to cheat on their partners which might be explained by their low commitment and their attempt to back away from their partner's desire for closeness. Those with an anxious attachment style tend to channel their attachment needs into the sexual realm. They

tend to have sex to avoid abandonment and gain approval or reassurance. For that reason, they also can downplay and inhibit their own sexual needs, which can lead to unwanted sexual behavior. During sex, they might have aversive feelings and thoughts, such as anger at their partner or doubts about being loved, which can lead to problems with arousal or orgasm.

Heiman suggested that sexuality is an affect-oriented interaction [12]. How we regulate and express emotions affects ways we engage with others. In a recent comprehensive review of studies on emotion regulation and attachment strategies, Mikulincer and Shaver provide research support for our clinical experience of working with clients who either tend to suppress their emotions or are overwhelmed by them [13]. People with both more avoidant and anxious attachment styles tend to have problems accurately identifying and describing emotions. Those with avoidant orientation tend to have poorer memories for emotional experiences and an easier time suppressing and compartmentalizing negative emotions. Interestingly, if an additional cognitive load was added, avoidant individuals had more trouble suppressing, indicating fragility of avoidant defenses. In contrast, people with anxious attachment orientation tend to perseverate on negative experiences. Studies using brain imaging supported these findings and demonstrated changes in the brain supporting the model of how stressful attachment experiences in childhood impair both attachment security and emotion regulation. Any intervention addressing sexual concerns must involve focus on triggers of negative emotions and each person's coping strategies.

Sex Therapy and Psychological Interventions

While the practice of sex therapy has grown enormously in the last 50+ years, the field has essentially always operated within the bio-psycho-social paradigm, exploring how sexual challenges arise within biological, psychological, and social areas. The PLISSIT model of sex therapy (giving permission, providing limited information, specific suggestions, and intensive therapy if need be) guides the clinician with respect to structuring the intervention given the presenting problem, and taking a thorough sexual history is always emphasized to understand the etiology of the issue.

The literature consistently indicates that addressing relational concerns when dealing with sexual problems is essential. The success of more traditional graduated sexual stimulation techniques (e.g., sensate focus exercises) seems to be largely determined by a couple's ratings of communication prior to treatment [14]. McCabe recently reviewed literature on how erectile dysfunction (ED) is developed and maintained [15]. While medical treatments can help with regaining an

erection, they do not address relational issues these men struggle with. Adding psychological or educational components frequently increased effectiveness of medical intervention. When one partner has ED, couples are often affected by longstanding and complex psychological and relationship problems. She concludes that including the patient's partner in the treatment process can help understand how the couple relational interactions affect ED symptoms.

A review article of empirical research of psychological treatments for premature ejaculation (PE) indicated that there are only a few studies available and those have significant methodological limitations [16]. However, there is some evidence that, similar to the ED research above, combining medical interventions with psychological or psychosexual treatments might be more effective. One of the future research recommendations included identifying the most effective psychological techniques for both addressing specific sexual complaints and for improving general satisfaction with a marital relationship.

An interesting study was conducted by Conaglen et al. to explore sexual dysfunction in female partners of men with erectile dysfunction [17]. While using quantitative methods to assess impact of medical intervention for ED on female partners' sexual satisfaction and dysfunction, authors followed up with qualitative interviews. Five common themes emerged as reasons for women's experience of each type of sexual dysfunction: physical reasons (including medical problems), menstruation and/or menopause issues, and psychological reasons including stress and fatigue, relationship issues, and issues related to the partner's ED. Those few women who failed to improve related their continued desire problems to relationship difficulties.

A recent clinical article by McCarthy and Wald addresses strategies to improve sexual desire in couples [18]. In implementing sex therapy exercises and other strategies, authors encourage the couple to become a team and see exercises as an opportunity to experiment with what generates pleasure and what factors inhibit sexual feelings. They also promote the view that couples should try to consider each other as both intimate and erotic friends, that "sexuality is a team sport" where they can turn to each other to share pleasure and eroticism.

While the recent outcome research for EFT with couples presenting with relationship distress demonstrates increased sexual satisfaction at the end of treatment and at follow-up, the empirical research on the integration of sex therapy and EFT is still lacking. However, case studies and clinical observations support its potential effectiveness in this area. Grayer presents a compelling case of using EFT with cancer survivors and their partners [19]. Cancer diagnosis can have significant impact on patient's sexual functioning and their relationship. Helping couples re-establish a sense of safety from which to explore, and reconnect

with, their sexual relationship is essential in the healing process. EFT provides a venue to share their deepest fears, pain, and longing with each other. "For those couples where the sexual consequences of cancer continue to challenge them, knowing that they can turn to each other will help them to regulate their distress and as such to cope better and to be more likely to reach their sexual potential." Another example of applying EFT is with couples dealing with infertility issues who often present with significant relational distress and sexual dissatisfaction. Study conducted with 30 infertile couples in Iran showed that even after 10 sessions of EFT, couples showed improved marital adjustment and sexual satisfaction [20].

The EFT Model of Couples Therapy

Emotionally Focused Couple Therapy (EFT) sees relationship distress as resulting from partners' rigid engagement in negative interaction cycles [2]. These interaction cycles are driven by partners' unacknowledged and unmet attachment needs [21]. The process of change in EFT helps couples develop new positive interaction cycles, which includes vulnerable sharing of attachment needs and an improved ability to respond to one another with attuned support.

Theoretically, EFT is an integration of humanistic/experiential and systemic assumptions [22, 23]. EFT combines a shared focus on interpersonal interaction patterns and intrapsychic processes, which are understood in terms of adult attachment theory [24]. The therapist serves as a process consultant focused on facilitating in-session experiences of interactive and inner experiential emotional cycles. The approach assumes that couples have mutual goals and a workable commitment to changing their relationship.

EFT has been extensively empirically validated. The most rigorous older studies find that 70 to 73% of couples move out of distress by the end of therapy, and 86–90% report significant improvement [4, 25]. EFT has been used with depressed and traumatized couples with good success and has been found to lead to improvement in both depression and trauma symptoms (both of which affect sexuality) among individuals within the couple [26, 27]. A more recent study, in which 20 sessions by more experienced therapists were offered to couples facing relationship distress and insecurity, found that improved outcome was also associated with an increase in sexual satisfaction [28].

For many couples, sexual problems begin as a result of relationship breakdown and wane when the relationship is restored. For some partners, however, sexuality and sexual issues are front and center and have to be addressed in a relationship therapy in a more systematic and focused manner [5•, 29].

The ten principles for addressing sexual problems from an EFT attachment perspective [5 © 2017 John Wiley & Sons Ltd]:

1. *Assessment of patterns of emotional disengagement.* Sexual disconnection is placed in the context of a couple's negative cycles of interaction that undermine safety and intimacy. Therapy always begins with an assessment of a couple's patterns of emotional engagement and disengagement and the patterns of sexual interaction are viewed in this context. For example, while a depressed, emotionally withdrawn male partner might occasionally seek sex, his already disconnected partner cannot respond to him. Even if a partner has a history of sexual trauma and now struggles with lack of desire and numbing, her interactions with the partner will either improve or block healing [30].
2. *Assessment of sexual functioning.* When couples present with specific sexual complaints that are central to relationship distress, the therapist will conduct a sexual functioning assessment (in the individual sessions that are part of the assessment process in EFT) to explore physiological functioning, childhood trauma, cultural and family scripts about sexuality, coming out process, current medical treatments, and mental health issues such as anxiety and depression. If needed, the therapist consults an expert professional specializing in sexual dysfunction. When focusing on the details of current sexual interactions, a relational perspective is still maintained. For example, couples' problems can be mutually sustaining: a woman's arousal difficulties can make her husband's premature ejaculation worse and vice versa. Steve struggled with premature ejaculation for most of his life and had much anxiety about being sexual. His partner, Stacy, had learned that she would need to become aroused before she had the desire to have sex with him. While Steve understood this and they had developed strategies to accommodate this, it was still difficult for him because of his anxiety. They eventually learned to come together and work on this as a team. As Steve learned how to arouse Stacy and slowly build her desire, she learned to take the pressure off Jack to "perform" and instead focus on pleasure that was generated beyond the act of intercourse.
3. *Stage 1: De-escalation.* The focus of Stage 1 of EFT is on de-escalating conflict and distancing strategies and slowly create safe touch and emotional connection before addressing sexual issues. If sexual interactions create a negative cycle, the couple is encouraged to put aside attempts at intercourse for a period of time until they can create a secure base to explore the blocks to positive sexuality and until they are capable of supporting each other. The therapist tracks the

attachment narrative around disappointments in sex as they are often experienced as shaming and trigger catastrophic expectations of rejection and abandonment. At the end of Stage 1 of EFT, both relational cycles that affect sexuality and specific cycles of sexual disconnection are clear. Partners also begin to see how they can work together to name these cycles as they occur, understand how they trigger each other's pain, and help each other stop the pattern. James and Martin were feeling hopeless when they arrived at the therapist's office. Martin, an ambitious gay man who had always prided himself on his sexual prowess, had been having problems keeping his erection during sex for the last few years, while James mostly dealt with it by withdrawing and minimizing the impact it had on their relationship; it was difficult for them to talk about. They both felt that their sexual connection was a crucial component of their life together and were highly distressed about the situation. After any physiological issues for erectile dysfunction were ruled out by a urologist who specializes in sexual health, the therapist began tracking the negative sexual interactional cycle between them. As James started to feel more comfortable in therapy, he shared "I'm scared that the bottom line with this is that you're just no longer attracted to me," and Martin was able to come forward and to say "It's not about attraction. But I can always feel your worry and I get freaked out I'm just going to disappoint you more." They learned together that Martin's ability to stay engaged and present while being sexual was a large component of his erection problems; he was so preoccupied with staying erect, it was difficult to relax into his body and allow his sexual response to build and sustain organically. As the couple de-escalated and became more comfortable talking about the vulnerable feelings that were occurring beneath this pursue-withdraw dance, they were able to create a more positive sexual cycle where Martin was more apt to maintain his erection...and even when he did not, "it wasn't the end of the world."

4. *Attachment frame.* The EFT therapist places sexual responses in an attachment frame. When Tom is struggling to keep an erection since his wedding, it is understood in the context of him suddenly feeling the risk and vulnerability because Alice now has power to hurt him because he "depends" on her as his life partner. Vivian's rage at her husband's lack of desire is connected to her fear that he finds her to be "ugly and deformed" since her mastectomy.
5. *Stage 2: Restructuring the bond.* Once a couple has de-escalated and each partner has felt a sense of how they impact each other emotionally, the EFT therapist actively guides towards deeper emotional accessibility

and responsiveness. Each partner undergoes a process exploring their attachment needs and fears and expressing them in re-engagement and softening dialogue. These dialogue, where vulnerable emotions such as sadness, shame, and fear are owned and expressed, are also called “Hold Me Tight” conversations [31]. These conversations could focus on the sexual presenting issue and if not, are repeated with the sexual issue as the focus. For example, Helene and Jerry begin their Stage 2 conversations with Jerry re-engaging from his withdrawn position by sharing how small and inadequate he feels facing Helene’s assertive presence and how this impacts his ability to relax into his body and share what he would like when they are sexual together. In another example exploring the intersection of gender identity/expression and sexuality, cisgender female Violet and her transmale partner Andre began their Stage 2 dialogue with Andre coming forward with his deeper yearnings to pleasure Violet in ways where he had previously felt inadequate. They had been together for many years, the majority of which Andre had identified as a “butch” lesbian and now, post transition and fully embracing his masculine gender, Andre longed to be viewed as male and to own his sexual power in his true gender. “I need to know you can love me as Andre now.” As he stepped forward, first tentatively and then more assertively, Violet opened to Andre’s needs for validation and was able to share her own vulnerable feelings regarding his transition. Violet developed her own clarity to say, “Yes this has been difficult for me in many ways, but I’ve always known this is your deepest truth and we’ll get through this together.”

6. *Focus on positive moments.* The therapist focuses on positive interactions between relationship safety and sexuality to ensure that partners understand them. As Susan has come out from behind her wall and is now initiating sex more often with Alex, the therapist helps Alex express how good that feels to be desired which leads him to be more affectionate and attentive to Susan at other times.
7. *Sharing erotic cues and sexual desires.* As the couple feels closer and more comfortable letting each other into their sexual worlds, the sexual dance is tracked and explicitly illuminated. As emotional vulnerability deepens, they are encouraged to risk sharing sexual longings and desires. For example, Sally and Patricia sought therapy due to a sense of increasing distance relationally and sexually. Once longstanding resentments and fears had been processed and the couple was feeling closer again, they wanted to work on their sexual connection. Patricia shared, “What happened to all those toys we used to have, I always loved it when you’d dip into our ‘pleasure chest’...that was my cue that you were wanting me.”

The therapist used this as an opportunity to help the couple discover together an updated version of their “pleasure chest” where they could slowly “simmer” and cultivate sexually gratifying time together. In addition, partners may now be encouraged to share their sexual fantasies, especially if such fantasy has significant erotic charge, that perhaps they kept private in the past because of a lack of emotional safety. That said, when fantasies are the result of sexual abuse or other trauma, the EFT therapist will take great care to ensure the traumatized partner is not retraumatizing themselves or ritualizing the abuse when playing out such fantasies.

8. *Processing sexual trauma.* If trauma is present in either partner’s history, one’s sexual response can become hijacked by negative emotions (fear, shame, rage) which in turn impedes the capacity for sexual energy to increase and flow between partners. In such cases, the work in therapy becomes a safe haven in which to unpack the trauma and process emotionally all that is occurring. Andrea and John had been together for almost 10 years when Andrea began processing traumatic memories (flashbacks, intrusive thoughts, hypervigilance when triggered) of a rape that occurred during her freshmen year in college that she had largely repressed and minimized. The couple came to therapy highly distressed as Andrea had completely shut down sexually to her partner and wondered “if she’ll ever want to be sexual again.” After the initial sessions of validating, normalizing, providing psycho-education and tracking how the trauma was impacting their relationship, and consulting with Andrea’s individual therapist, the EFT therapist utilized the sex therapy behavioral intervention of Sensate Focus to slow things down, take the pressure off of being sexual, and help the couple begin to tune into their bodies and what occurs with touch. The therapist worked very hard to “slice it thinner,” helping Andrea to track the moment when her body would begin to feel unsafe and shut down. As Andrea and John became more engaged in the exercise and John became more attuned and responsive to Andrea’s experience, she was slowly able to allow her body to feel sensual/sexual feelings without the trauma of the rape hijacking her sexual response. When using sex therapy behavioral interventions and homework assignments, the EFT therapist always processes the experience through the attachment lens and targets emotional handles.
9. *Stage 3 of Consolidation and Sexual Intimacy.* During the third and final stage of EFT, the restructuring of emotional, physical, and sexual connection that has occurred in the therapy is fully integrated and celebrated. Therapist and couple reflect on this new dance of

emotional engagement, how they achieved it, and way to repair in the future. In this way, each partner is requested to see their part in this pattern of emotional and sexual connection, misattunement, disconnection, and reattunement to then fulfilling connection again. As such, they are united in their capacity to create and recreate their emotional and sexual bond. As McCarthy and Wald reflect, “Eroticism invites taking emotional and sexual risks...and asks each partner to be open to creativity, mystery, and unpredictability” [18].

10. *Psychoeducation*. Last but not least, throughout treatment, the EFT therapist offers education concerning sex and normalizes each partner’s response. For example, Jim and Robert had been married 5 years when they began therapy due to both partners feeling that the spark in their sex life had died. They both reported that they still very much loved each other but that sex had become routine, predictable. The therapist validated their feelings and normalized their concerns and introduced several concepts to give them an understanding of sex in a long-term committed relationship. For example, they discussed the difference between spontaneous and responsive desire [32], and how after a certain amount of time, couples must learn to navigate the cross-currents from a spontaneous model of desire to a more responsive model, where they learn to build desire and arousal by responding to each other’s sexual cues rather than simply relying on the anticipation of pleasure. The therapist then introduced the dual-control model and helped them both examine their turn ons and turn offs [33]. As reflected earlier, the utility of EFT in discussing sex therapy psychoeducation and behavioral interventions can be quite powerful when helping couples restructure how they respond to each other sexually.

Conclusions

In their newly published book on treating sexual dysfunction, Metz, Epstein, and McCarthy reflect that “sexually healthy couples cooperate as an intimate team; they ‘have each other’s back’ and provide a ‘safe harbor’ amidst the stresses of life” [34]. The Emotionally Focused Therapy approach offers an empirically validated and grounded model to not only address relational distress that contributes to the development and maintenance of sexual problems, but also an experiential way to use sex therapy behavioral interventions to continue building security in the relationship. As the world of human sexuality is complex and diverse, such focus leads to a more effective outcome both sexually and relationally for all.

Compliance with Ethical Standards

Conflict of Interest Susan M. Johnson, Zoya Simakhodskaya, and Michael Moran declare no conflicts of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:

- Of importance
 - Of major importance
1. Leiblum SR, Rosen R. Principles and practice of sex therapy. 3rd ed. New York, NY: Guilford Press; 2000.
 2. Johnson SM. The practice of emotionally focused couple therapy: creating connection. New York, NY: Routledge; 2004.
 3. Lebow JL, Chambers AL, Christensen A, Johnson SM. Research on the treatment of couple distress. *J Marital Fam Ther.* 2012;38: 145–68. <https://doi.org/10.1111/j.1752-0606.2011.00249.x>.
 4. Weibe S, Johnson SM. A review of the research in emotionally focused therapy for couples. *Fam Process.* 2016;55(3):390–407. <https://doi.org/10.1111/famp.12229>.
 5. Johnson S. An emotionally focused approach to sex therapy. In: Peterson Z, editor. *The Wiley handbook of sex therapy*. West Sussex: Wiley; 2017. **Important original chapter on using EFT with sexual issues which includes extended case study.**
 6. Bowlby J. *A secure base*. New York, NY: Basic Books; 1988.
 7. Birnbaum GE, Reis HT. Evolved to be connected: the dynamics of attachment and sex over the course of romantic relationships. *Curr Opin Psychol.* 2018;25:11–5. <https://doi.org/10.1177/0146167217695556>. **Most recent research overview of attachment and sex interplay**
 8. Birnbaum GE, Mizrahi M, Kaplan A, Kadosh D, Kariv D, Tabib D, et al. Sex unleashes your tongue: sexual priming motivates self-disclosure to a new acquaintance and interest in future interactions. *Personal Soc Psychol Bull.* 2017;43(5):706–15. <https://doi.org/10.1177/0146167217695556>.
 9. Birnbaum GE, Reis HT, Mikulincer M, Gillath O, Orpaz A. When sex is more than just sex: attachment orientation, sexual experiences and relationship quality. *J Soc Pers Relat.* 2006;24:21–35. <https://doi.org/10.1177/0265407507072576>.
 10. Stefanou C, McCabe MP. Adult attachment and sexual functioning: a review of past research. *J Sex Med.* 2012;9:2499–507. <https://doi.org/10.1111/j.1743-6109.2012.02843.x>.
 11. Birnbaum GE. Bound to interact: the divergent goals and complex interplay of attachment and sex within romantic relationships. *J Soc Pers Relat.* 2010;27(2):245–52. <https://doi.org/10.1177/0265407509360902>.
 12. Heiman J. Orgasmic disorders in women. In: Leiblum S, editor. *Principles and practice of sex therapy*. 4th ed. New York, NY: Guilford Press; 2007. p. 84–123.
 13. Mikulincer M, Shaver P. Attachment orientations and emotion regulation. *Curr Opin Psychol.* 2018;25:6–10. <https://doi.org/10.1177/2158244015604695>.
 14. Hawton K, Catalan J, Fagg I. Sex therapy for erectile dysfunction: characteristics of couples, treatment outcome, and prognostic

- indicators. *Arch Sex Behav.* 1992;21:161–76. <https://doi.org/10.1007/BF01542591>.
15. McCabe MP. Relationship factors in the development and maintenance of ED: implications for treatment effectiveness. *J Sex Med.* 2008;5:1795–804. <https://doi.org/10.1111/j.1743-6109.2008.00878.x>.
 16. Melnik TM, Glina S, Rodrigues OM Jr. Psychological intervention for premature ejaculation. *Nat Rev Urol.* 2009;6(9):501–8. <https://doi.org/10.1038/nrurol.2009.147>.
 17. Conaglen HM, O'Connor EJ, McCabe MP, Conaglen JV. An investigation of sexual dysfunction in female partners of men with erectile dysfunction: how interviews expand on questionnaire responses. *Int J Impot Res.* 2010;22:355–62. <https://doi.org/10.1080/0092623X.2013.864368>.
 18. McCarthy and Wald. Strategies and techniques to directly address sexual desire problems. *J Fam Psychother.* 2015;26:286–98. <https://doi.org/10.1080/08975353.2015.1097282>.
 19. Grayer J. Emotionally focused therapy for couples: a safe haven from which to explore sex during and after cancer. *Sex Relatsh Ther.* 2016;1(4):488–92. <https://doi.org/10.1080/14681994.2015.1126668>.
 20. Soleimani AA, Naja M, Kh A, Javidi N, Hoseini Kamkar E, Mahboubi M. The effectiveness of emotionally focused couples therapy on sexual satisfaction and marital adjustment of infertile couples with marital conflicts. *Int J Fertil Steril.* 2015;9(3):393–402. <https://doi.org/10.22074/ijfs.2015.4556>.
 21. Johnson SM, Whiffen VE, editors. Attachment processes in couple and family therapy. New York, NY: Guilford Press; 2003.
 22. Minuchin S, Fishman C. Family therapy techniques. Cambridge, MA: Harvard University Press; 1981.
 23. Rogers C. Client-centered therapy. Boston, MA: Houghton Mifflin; 1951.
 24. Mikulincer M, Shaver P. Attachment in adulthood: structure, dynamics and change. New York, NY: Guilford Press; 2007.
 25. Johnson SM, Hunsley J, Greenberg L, Schindler D. Emotionally focused couple therapy: status and challenges. *Clin Psychol Sci Pract.* 1999;6:67–79. <https://doi.org/10.1093/clipsy.6.1.67>.
 26. Dalton J, Greenman P, Classen C, Johnson S. Nurturing connections in the aftermath of childhood trauma: a randomized control trial of emotionally focused couple therapy (EFT) for female survivors of childhood abuse. *Couple Fam Psychol.* 2013;2:209–21. <https://doi.org/10.1037/a0032772>.
 27. Denton W, Burelson BR, Clark TE, Rodriguez CP, Hobbs BV. A randomized trial of emotionally focused therapy for couples in a training clinic. *J Marital Fam Ther.* 2000;26:65–78. <https://doi.org/10.1111/j.1752-0606.2000.tb00277.x>.
 28. Wiebe SA, Elliott C, Johnson SM, Burgess Moser M, Dagleish TL, Lafontaine MF, Tasca GA (2015) Attachment & sexual satisfaction in emotionally focused couple therapy. Manuscript in preparation
 29. Johnson S, Zuccarini D. Integrating sex and attachment in emotionally focused couple therapy. *J Marital Fam Ther.* 2010;36(4):431–45. <https://doi.org/10.1111/j.1752-0606.2009.00155.x>.
 30. Johnson SM. Emotionally focused couple therapy with trauma survivors: strengthening attachment bonds. New York, NY: Guilford; 2002.
 31. Johnson SM. Hold me tight: seven conversations for a lifetime of love. New York, NY: Little, Brown; 2008.
 32. Basson R. The female sexual response: a different model. *J Sex Marital Ther.* 2000;26(1):51–65. <https://doi.org/10.1080/009262300278641>.
 33. Janssen E, Bancroft J. The dual control model: the role of sexual inhibition and excitation in sexual arousal and behavior. In: Janssen E, editor. The psychophysiology of sex. Bloomington, IN: Indiana University press; 2007.
 34. Metz ME, Epstein NB, McCarthy B. Cognitive-behavioral therapy for sexual dysfunction. New York, NY: Routledge; 2018.