

An Integrative Model for Treatment of Sexual Desire Disorders:

An Update of the Masters and Johnson Institute Approach

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Abstract

An integrative model for treating sexual desire disorders was developed from the original work of Masters and Johnson Institute. Sensate focus exercises and psychoeducation were combined with couple therapy for relationship conflicts and individual therapies for issues with trauma and attachment disorders. The resulting model fits trends in systemic and integrative treatment.

Keywords: sexual desire disorders, hypoactive sexual desire, Masters and Johnson Institute, integrative treatment, sensate focus, couple therapy

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Masters and Johnson (1966, 1970) wrote very little about their approach to desire phase disorders. The Institute's conceptual approach to inhibited sexual desire focused on the relationship.

As we mature, sexual response is a natural manifestation of attraction to a person perceived as appealing. This attraction evolves into a casual or committed relationship. Once a pair-bond is established, sexual desire is a natural way of expressing the sense of intimacy that develops within a committed relationship. Therefore, anything that enhances or inhibits relational intimacy may positively or negatively influence the individual's levels of sexual desire. Sex is innately pleasurable - unless something mitigates that pleasure. Couples who evidence little intimacy in the living room usually will feel distant from each other in the bedroom. Therefore, persons who are bored, pressured, fatigued, angry, guilty, fearful, anxious, or suffocated in a relationship are 'entitled' to low levels of sexual desire (Schwartz & Masters, 1988, p. 229)

Thus, the Institute's approach to treating inhibited sexual desire was similar to their treatment of sexual dysfunction. The relationship was the primary focus of treatment rather than the symptomology. An update on Masters and Johnson Institute's model for treating sexual desire disorders takes into account the primacy of the couple's relationship, since there is a connection to intimacy, as well as roadblocks or constraints that may be individual in origin. An integrative model for treating sexual desire disorders balances individual and couple issues.

Sexual Desire Disorders

Desire disorders include Female Sexual Interest/Arousal Disorder (302.72) and Male Hypoactive Sexual Desire Disorder (302.71) in the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (DSM-V; American Psychiatric Association, 2013, pp. 433-436; 440-443). There is a broader range of dysfunctions and dissatisfactions that may be considered desire disorders by experts in sexuality therapy (Kaplan, 1995; Leiblum, 2010). For the purpose of this review, desire disorders include low sexual desire or interest within an individual or between partners in a sexual relationship. There are many theories that account for lack or loss of desire including biological, developmental, intrapsychic, relational, and cultural factors. While desire discrepancy in a couple, in which one partner presents lower desire than the other, is not sufficient to diagnose a sexual problem (e.g., APA, 2013, p. 433), such differences are frequently presented in couple counseling. Discrepancies arise as the sexual relationship is affected by a myriad of nonsexual issues or intimacy dysfunction in general.

Female Sexual Interest/Arousal Disorder

Female Sexual Interest/Arousal Disorder blurs phases of interest and arousal according to the classic model of the sexual response cycle (Kaplan, 1974, 1979; Masters & Johnson, 1966, 1970). Low sexual desire in this context may be presented as lack of interest in sexual activity, absence of erotic or sexual thoughts, reluctance to initiate sex, and inability to respond to a partner's sexual invitations (APA, 2013, p. 433). Female sexual interest/arousal disorder may be lifelong or acquired; generalized or situational; and ranging from mild to moderate or severe distress. Symptoms must have persisted for at least six months duration. The symptoms cannot be better explained by a nonsexual medical or mental condition or by

severe relationship distress such as partner violence. At least three of the following characteristics are required for diagnosis of the disorder (APA, 2013, p. 433).

1. Absent/reduced interest in sexual activity.
2. Absent/reduced sexual/erotic thoughts or fantasies.
3. No/reduced initiation of sexual activity, and typically unresponsive to a partner's attempts to initiate.
4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
6. Absent/reduced genital or nongenital sensations during sexual activity in almost or all (approximately 75-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).

Female sexual interest/arousal disorder replaced “hypoactive sexual desire disorder” from the previous DSM because problems with sexual desire and arousal frequently coexist and may reflect difficulty or inability to identify cues for sexual opportunity, including physical changes in the woman's body.

While there are changes in sexual interest and arousal across the lifespan, sexual desire may decrease with aging. The lack or loss of desire is not necessarily reflected in frequency of sexual activities such as intercourse. Vaginal dryness and genito-pelvic pain constitute other sexual disorders or physical conditions. Comorbidity with other sexual dysfunctions is

common. Prevalence and incidence data were not reported in the DSM-V because of the novelty of the consensus-based diagnosis. (p. 435).

Male Hypoactive Sexual Desire Disorder

Male Hypoactive Sexual Desire Disorder (APA, 2013, pp.440-443) remains distinct from arousal/excitement and orgasm/ejaculation. The disorder shares criteria with female sexual interest/arousal disorder: at least 6 months duration; lifelong vs. acquired; generalized vs. situational; and mild-moderate-severe distress. The major diagnostic feature places hypoactive sexual desire in context.

Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life (APA, 2013, p. 440).

Prevalence of male hypoactive sexual desire disorder varies from 6% in younger men (18-24 years of age) to 41% of older men (66-74 years); however, persistent lack of interest in sex affects only 1.8% of men ages 16-44 (p. 442).

Both male hypoactive sexual desire disorder and female sexual interest/arousal disorder, were associated with five conditions in the DSM-V (APA, 2013)

1. Partner factors (e.g., partner's sexual problems, partner's health status);
2. Relationship factors (poor communication, desire discrepancies);
3. Individual vulnerability factors (poor body image, history of sexual or emotional abuse) and/or psychiatric comorbidity (depression, anxiety) or stressors (job loss, bereavement);

4. Cultural/religious factors (attitudes, inhibitions or prohibitions against sexual activity);
and
5. Medical factors (including effects of medication).

Temperament, environment, genetic predisposition, substance/medication use, and other sexual dysfunctions contribute to the emergence and maintenance of these sexual desire disorders. There are obvious gender differences in the contributing factors and presentations of the disorders.

Recent Models of Sexual Desire Disorders

Leiblum (2010) edited an authoritative text on the clinical manifestations of sexual desire disorders. In one of the last contributions to her brilliant career, she provided an overview of the field.

Sexual desire is the most elusive of passions. While easily ignited in a new relationship or a forbidden encounter, it can also be readily extinguished. Anxiety, hostility, bad memories, or frightening flashbacks can thwart it—even something simple as the sound of a door opening or a child crying. And yet, when aroused by an image or scent or fantasy or person, it can feel powerfully intense, driven, lively, and life affirming (Leiblum, 2010, p. 1).

Leiblum and colleagues traced sexual desire from libido to social construction, carefully examining cultural and gender issues involved in sustaining just the right amount of desire to facilitate bonding in an intimate relationship. She reported prevalence rates ranging from 8% to 55% in studies of women and men across the age spectrum (Leiblum, 2010, p. 9). Interestingly, while 45% of women identified low sexual desire in a survey of sexual dysfunctions, only 16% reported distress with their condition (Derogatis, Rosen, Leiblum,

Burnett, & Heiman, 2002). This finding accounts for the adaptation to sexual apathy and avoidance in many couples including “sexless” marriage.

Helen Singer Kaplan (1974), who advanced the New Sex Therapy as an expansion of the original work of Masters and Johnson (1966, 1970), added the desire phase to arousal and orgasm in her triphasic model of sexuality. She described increases in sexual desire disorders over a 20 year period with corresponding growth in the acceptance of desire phase diagnoses by sexuality therapists (Kaplan, 1995, pp. 7-11). Kaplan and her colleagues found deeper causes for hypoactive sexual desire and treatment failures in other sexual dysfunctions. In examining the underlying factors in deficient sexual desire, Kaplan (1995, pp. 3-4) concluded

...the pathological decrease of these patients' libido is essentially an expression of the normal regulation of sexual motivation gone awry (her emphasis).

Desire disorders arise in the course of development as responses to situations that inhibit erotic exploration or opportunity for intimacy. The inhibition of sexual desire has an extensive history in the literature.

All of the following factors may contribute to problems with sexual desire (Leiblum, 2010, p. 13)

- Biological factors: hormonal or neurotransmitter imbalances; medications and their side effects; and illnesses or accidents
- Developmental factors: lack of adequate sex information; sex negative messages; neglect or deprivation; emotional, physical, or sexual abuse
- Psychological factors: fear/anxiety; depression; attachment disorders; personality disorders or other clinical syndromes

- Interpersonal/relational factors: conflicts and discord with a partner; withdrawal or avoidance; partner sexual dysfunction
- Cultural factors: religious beliefs and cultural norms; beliefs regarding sexuality and marriage
- Contextual factors: comfort and safety in surroundings; relaxing or stressful environments; topics or situations that trigger thoughts, feelings, and behaviors

Individual and couples depend upon internal peace and relational harmony to find pleasure and meaning through initiating or responding to sexual overtures.

Perel (2010) described the paradox in which partners strive for the comfort and consistency of intimacy while craving the heightened passion associated with the unfamiliar and unpredictable. Eroticism is a type of longing based on the human need to explore and experience mystery and novelty. Organizing intimacy around the norms and expectations delineated from the family of origin can lead to numbness and blocks to sexual desire. Perel (2010) challenged couples to sustain intimacy while using fantasy, imagination, and experimentation to breathe life back into sexual desire.

Tiefer and Hall (2010) expressed a skeptical view of socially constructed norms that defined sexual desire complaints. The New View of Women's Sexual Problems work group (cf. Tiefer, 2008) rejected biological and cultural mandates in defining problems and prescribing solutions for sexual desire problems. Traditional sexual relationships built on gender stereotypes, heterosexist/heteronormative biases, and oppressive patriarchy extinguish opportunities for matching sexual interests and preferences in unique, evolving sexual relationships. The New View facilitates exploration of gender and cultural influences. The

therapist becomes a coach for discussing and exploring options without preconceived notions of what is “normal” and what is disorder (Tiefer & Hall, 2010).

Kleinplatz (2010) described sexual desire disorders as opportunities to pursue optimal erotic intimacy. She noted that desire problems and discrepancies were the most common presenting problems in her practice. Sexuality therapy as experiential therapy enables the therapist to act as guide through the landscape of sexual options and choices. Partners are encouraged to share their fears and concerns, preferences and wishes, fantasies and dreams to determine what is possible. Complaints frequently come from the higher-desire partner; however, the lower desire of the other is not a pathology. Rather, the desire discrepancy heralds the opportunity for optimal sexuality characterized by each being present, authentic, vulnerable, emotionally accessible, and connected. The bond of the partner is the platform for exploring and achieving optimal sexual desire (Kleinplatz, 2010). The symptom of hypoactive sexual desire is a record of the past, an alarm of present difficulties, and a beacon for a satisfying future.

Dynamics of Hypoactive Sexual Desire

Hypoactive sexual desire in couples is frequently presented in marital and couple therapy (Leiblum, 2010). While the construct of low sexual interest or drive is as old as psychotherapy, recent developments in diagnosis and treatment invite attention (e.g., Leiblum, 2010). Freud’s original positions on sexuality accounted for the contributions of neurosis to problems with desire. His original views on the etiology of hysteria anticipated models of childhood traumatization and intimacy dysfunction in adulthood.

Freud described the “sexual scenes” enacted between adults and children in his 1896 lecture on the *Aetiology of Hysteria* (Freud, 1896/1962). He related the powerlessness of the

child victim to his own fears of failure in relationships, even the “impotence of the therapist” (Marcel, 2005, p. 15). The following quote (a single sentence) highlights the combination of premature or overexcitation of a child’s vulnerable nervous system and betrayal by an adult caregiver in the development of trauma.

All the singular conditions under which the ill-matched pair conduct their love-relations-on the one hand the adult, who cannot escape his share of the mutual dependence necessarily implied by a sexual relationship, and who is yet armed with complete authority and the right to punish, and can exchange the one role for the other to the uninhibited satisfaction of his moods, and on the other hand the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility and exposed to every sort of disappointment, and whose performance of the sexual activities assigned to him is often interrupted by his imperfect control of his natural needs-all these grotesque and yet tragic incongruities reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail (Freud, 1896/1962, pp. 214-215).

Freud’s original model was remarkably consistent with contemporary views articulated by such contributors as Bessel van der Kolk (1989, 2014).

In Freud’s emerging psychoanalysis, the repetition compulsion motivated the re-enactment of the abuse experience, literally or symbolically, with the aim of gaining a sense of resolution or mastery (1914, 1920). Later, Freud renounced the seduction theory in favor of the Oedipus complex, stages of psychosexual development, and focus on fantasy. Marcel (2005) described the evolution of Freudian psychoanalysis in terms of Freud’s own history of

sexual abuse and struggles with his sexual theory in the medical and scientific communities of the time.

Others interpreted Freud's contributions to understanding sexual dysfunction, particularly disorders of desire. Kaplan (1979, 1995) emphasized underlying psychodynamics in understanding and treating disorders of sexual desire. She observed that early childhood erotic experiences were highly influential in shaping adult sexual desire (Kaplan, 1995, pp. 39-49). The ontogeny of sexual desire included mother/child eroticism, conditioning of fantasies, integration of sensory lovemaps (Money, 1986, 1988), negative early sexual programming, erotization of childhood trauma, and emergence of perversions or paraphilias (Stoller, 1975). Erotic fantasies turn childhood trauma into triumph (Money, 1986, p. 36; Stoller, 1975, p. 30), similar in construct to the repetition compulsion in which a person is driven to recreate painful and shameful experiences to attain mastery. Erotic fantasies preserve sexual desire that may otherwise be coded in the developing psyche as a turnoff, aversion or repulsion (Kaplan, 1995, pp. 47-49).

Kaplan (1979) applied psychoanalytic theory to explain the complexity of cases involving low sexual desire. Based on complications in the Oedipal situation, some individuals and couples fear sexual and relational success or fulfillment. They cannot enjoy sexual sensations and may lack pleasure in many areas of life having attained success that is increasingly burdensome. "Winning" elicits fears of retaliation or rejection immobilizing some and contributing to avoidance of intimacy in others. Freud (1915) described two persons who were "wrecked by success." Kaplan (1979, pp. 176-182) reported cases of inhibited sexual desire and romantic avoidance associated with sexual success, anxiety and anger over intimacy. Fear of intimacy (Kaplan, 1979, pp. 183-192) was the most common cause of low

sexual desire and avoidance of sexuality. Over time, cumulative consequences for the aforementioned psychodynamics contribute to sexless marriages and relationships.

Intimacy and Intimacy Disorder

A couple often establishes reactive distance related to dependence-independence, closeness-distance, freedom versus control, privacy versus self-disclosure. Once established, though both adapt to low sexual desire, it is often a sign that this distance is too little or too much and needs realignment. Though the attachment styles of each individual complement each other, an individual can feel engulfed. As the partner experiences a move toward greater autonomy, the result may be a reactive response toward greater control to maintain a bracketing in mutuality and connectedness.

The Development of the Affectional Systems

It is valuable to view sexual desire through the lens of attachment theory because desire is often an aspect of pair bonding, courtship, attraction, love, affection, and intimacy. Sexual desire and arousal are the endpoints of a series of developmental events that begin with genetics and temperament, move through the child's early attachment environment with caretakers, and can be disrupted by subsequent experiences that are so overwhelming the child is unable to assimilate them. This disruption can result in affect dysregulation and impaired socialization and self-development, all activated by pubertal hormones.

A person's attachment style is established in the first two years of life and remains stable from 18 months to 20 years with about 72% consistency (Main & Solomon, 1995). The mother's attunement to her child facilitates the experience-dependent maturation of the child's neurological structure, which directly influences the child's biochemical growth process, as well as dendritic and axonal development in the first two years of life. When feedback from caretakers is absent, punishing, frustrating, invalidating or rejecting, the consequences can be

written into the structure of the developing personality. Children may be emotionally constricted, turn into themselves and disconnect from others (avoidant), or become emotionally dysregulated (Main and Soloman, 1995). An emotionally dysregulated child will either fail to use others for comfort or become anxious, fearful and so dependent on others for comfort, so preoccupied that he or she refuses to separate and explore the environment and interrupting individuation.

As children age, they seek familiar, consistent environmental interaction, even if it may be damaging to the self. So, they will recreate and reenact familiar early rejection and frustrations (Stroufe, 1988). Children dismissive of attachment are picked on more by bullies, disliked by their teachers, viewed as less popular and do less well in school by age 10. Injured early attachment bonds, like those described, are highly predictive of later relational distress and create the framework for how an adult couple will interact sexually. Individuals rated anxious/ambivalent are both starving for affection and fearful of close relationships; avoidant individuals report never having been in love nor having had strong experiences of love.

Individual differences on the anxiety and avoidance dimensions accurately predict differences in the way people experience romantic and sexual relationships. People who rank low on anxiety and avoidance (i.e., securely attached) tend to have long, stable, and satisfying relationships characterized by high investment, trust, and friendship (Collins & Read, 1990; Simpson, 1990). In the sexual realm, they are open to sexual exploration and enjoy a variety of sexual activities, including mutual initiation of sexual activity and enjoyment of physical contact, usually in the context of a long-term relationship (Hazan, Zeifman, & Middleton, 1994). Secure adolescents engage in regular dating and establish romantic relationships. They are more likely than insecure adolescents to be involved in long-term relationships, and they report having more frequent sexual intercourse than avoidant adolescents (Tracy, Shaver, Albino, & Cooper, 2003).

Avoidant adolescents, as one might predict, tend to avoid sexual relationships altogether. Tracy et al. (2003) found that avoidant adolescents were less likely than their anxious or secure peers to have had a date, sexual intercourse, or any sort of sexual experience. Avoidant virgins scored high on measures of erotophobia. Avoidant people are less likely than their counterparts to fall

in love (Hatfield, Brinton, & Cornelius, 1989), and their love style is characterized by game playing (Shaver, Hazan, & Bradshaw, 1988). Tracy and colleagues (2003) observed "attachment avoidance interferes with intimate, relaxed sexuality because sex inherently calls for physical closeness and psychological intimacy, a major source of discomfort for avoidant individuals" (p.141). Avoidant females distrust their bodies and are numb during adolescent experimentation.

The cost of living with an avoidant style of attachment is numbing: the absence of emotions, including compassion, plus an inability to experience the full breadth of love, and the sheer beauty of the world. Avoidant persons feel a spiritual disconnection with the planet and its people. To avoid the pain of loss and grief, they must limit the capacity for pleasure and play - both essential for satisfying sex.

The type of insecure attachment style also helps to determine a person's behavior in romantic and sexual relationships. Persons who rate high on the anxiety dimension and low on the avoidance dimension tend to become obsessed with their romantic partners (Hazan & Shaver, 1987) and experience low relationship satisfaction and a high breakup rate (Carnelley, Pietromonaco, & Jaffe, 1996; Collins, 1996, Collins & Read, 1990). They are more likely than secure or avoidant people to experience passionate love (Hatfield, Brinton & Cornelius, 1989) and exhibit an obsessive, dependent style of love (Collins & Read, 1990; Feeney & Noller, 1990; Shaver, Hazan, Bradshaw, 1988). On average, they display a stronger preference for the affectionate and intimate aspects of sexuality (hugging and cuddling) than for the genital aspects (vaginal, anal or oral intercourse; Hazan et al., 1994). Attachment anxiety is also associated with concern about one's own sexual attractiveness and acceptability, an extension of anxious individual's general concern with rejection and abandonment (Hazan et al., 1994; Tracy et al., 2003).

Development of Self

One of the remarkable findings of Sroufe and his colleagues (2005) is that children who developed a pattern of disorganized attachment, with co-existing avoidant and preoccupied strategies at 18 months, were dissociative in long-term follow-up, suggesting segregated internal

models of self and the attachment figure. The individual clinically presents with a statement such as, "I don't know who I am," "I feel like an imposter," or "I feel like I'm bad and pretend to be good." Individuals who feel unloved and lack a developmental history of caretaking often fail to present structural capacities to connect with self and others because of an inner emptiness.

At the core of one's capacity to bond are self-empathy and the capacity for self-care. In the absence of validating caretakers, the individual does not internalize a caring relationship with self. A rejected or abandoned child tends to develop negative core schemas or beliefs about self, and in some cases about their gender or body. Selective modes of processing and organizing information unfold such that these beliefs become self-perpetuating. These modes ultimately organize an individual's range or type of interactions, which constrain possibilities of new learning with respect to intimacy.

The self comes to exist primarily in the context of others, within an aggregate of experiences of "self-in-relationships." Invariant aspects of self and others are abstracted into what Bowlby (1969, 1973) called "internal working models." New experiences are then absorbed into earlier representations, creating, maintaining and repeating core schemas. The internal working models of individuals with disorders of intimacy may be filled with self-hatred, so the person compensates by being powerful, controlling, dominating or alternatively, feeling inadequate and weak. The result can become a self-fulfilling prophesy as the individual creates the abandonment and rejection they fear is inevitable.

Perfectionism and self-hatred manifested in the bedroom can result in obsessive pleasing or depersonalization. The effect on sexual desire is that sex is used as a performance to feel adequate, desirable, and attractive and to "keep the partner satisfied" rather than for mutual satisfaction. The experience is one of "otherization," being overly focused on others at the expense of self. Sex as a performance creates enormous pressure to perform well, which can eventually degrade performance and desire. The result is the same type of numbing noted in the earlier descriptions of avoidant adolescents.

During the second or third year of life, tolerance for separation and the capacity for self soothing is organized. Having a "secure base," allows for exploration and the capacity to master and solve problems, thereby feeling effective, competent and powerful. The secure child begins to internalize the belief of "being valued and loved," and does not need constant reassurance.

Individuals with attachment injury do not form this secure base, and require the constant mirroring of others to maintain their sense of self. They can become suggestible and susceptible to influence. They become human "doings," perfectionists always trying not to disappoint others, feeling only as good as their last accomplishment. They tend to have difficulty with creative problem-solving, constant worry and feeling powerless. Often, they suppress affect, becoming mechanical and instrumental.

In their attempt to gain affection, they need to conquer the partner who is rejecting them. Once they conquer, their sexual arousal diminishes, and their sexual goal is for physical release rather than true affection. Intimacy terrifies them due to fears that the closeness makes them vulnerable to abandonment. To protect themselves, they create distance by losing interest in the partner, and using pornography, affairs, or other distractions to stay busy and tired.

The attachment system evolved as a biological alarm. It ensures the survival of the species by detecting potential harm and signaling terror to stimulate action. If the caretaker moves away, disrupting the secure base, and the individual has an internalized working model to create a secure base, the attachment system will be activated, and the natural result will be terror. The child will seek the caretaker or cry for attention.

For the preoccupied individual who lacks a secure base, people wanting to have sex with him or her is reassurance of desirability and reduces fears of abandonment. In avoidant attachment, getting close activates fears of danger or annihilation, since the people a child once depended on were demanding, controlling, dangerous or neglectful. In disorganized attachment, both systems alternate, thus needing sex and needing distance simultaneously. Many symptoms of relational distress as well as psychiatric symptoms can be better understood when seen through the lens of

attachment activation. Helping the individual form internal and external safety zones can neutralize fears related to closeness and distance and reverse sexual desire issues.

Most critical for developing a secure base are self-core schemas of safety, trust, esteem, power, control, and intimacy. The development of these core schemas is altered when early events engrave negative beliefs into the developing brain (e.g., I am fat. I am stupid. I am bad) although the thoughts are irrational and without evidence. Such self-hatred requires the person to perceive others consistent with these beliefs, thereby setting up biased filters. If the partner is perceived as smart, beautiful and thin, the signal of fear is activated, increasing a preoccupied person's desire for reassurance, or an avoidant person's loss of interest. Fear and avoidance are involved in the construction of love maps or templates for organizing incoming information and making intimate choices.

Love Maps

Another critical component of the developing affectional systems is what John Money (1981) defines as a love map: a personalized developmental representation or template in the mind that depicts the idealized lover and the idealized program of sexual erotic activity with the lover as projected in imagery and idealization or actually engaged in with the lover (Money, 1986; Money & Russo, 1981). Money believed that actual biographical events related to attachment and trauma influence the development of love maps, and that they can be "vandalized" (Money & Lamacz, 1989). Too much punishment associated with the unfolding of genital sexuality or premature sexualization in the family can interfere with sexual arousal development.

The developing love map includes partner characteristics that sexually arouse the body to respond to touch, and the sense of self as attractive, which indirectly influences the perception of another as desirable. The love map is hard-wired to respond to a variety of emotions such as illicitness, conquest, fear, intimacy, romantic love, and challenge. Early themes such as taking care of others or caretakers being out of control, hostile or abusive become templates for "falling in love." The way one is loved as an infant can become a "blueprint" for adult affectional style.

Puberty then activates the love map that was established throughout childhood.

Hendrix and Hunt (2013) used the word imago to describe the sexual arousal love map formed by attachment figures in infancy even before the cerebral cortex is fully differentiated. The imago is at the core of repetition compulsions which Freud (1901, 1914, 1920) described, in which an individual repeatedly is attracted to destructive, self-injurious partnership, such as alcoholics and rejecting, injured partners. Hendrix offered a formula that actually predicts the image based on positive and negative early childhood experiences and identifies the neural substrates for such repetitions.

The fantasy or imagery a person uses to arouse oneself in masturbation can then organize the choice of partner, affectional interchange, and sexual desire and arousal. If the adolescent uses pornography, these images then serve to over-learn certain arousal patterns. Some avoidant individuals use it as a form of disengagement. For these individuals, more stimulation seems to become necessary to reach orgasm. Tolerance or habituation to frequent stimuli increases through the biobehavioral reward system. Sexual arousal becomes channeled toward the visual computer screen rather than through the natural channels of touch, closeness, and affection.

If a man develops avoidant attachment, for example, he might become fixated on the woman's breasts and become aroused by the image of the breasts rather than the woman, a strategy that allows him to maintain a distance from the person. Another man might require the image of his "secretary" or a scene from pornography to maintain distance and not become too intimate. Eventually, the imagery alone satiates, undermining any sexual interaction with the partner. For preoccupied individuals, sexual activity can become a means of reassurance that their partner desires them, and sex then becomes obsessive, mechanical, and often reversing the partner's desire for sex. One's sexual arousal is affected by the partner, so one partner's lack of passion often results in the other's lack of arousal. As approach and avoidance conflicts increase in relationships affected by vandalized love maps and damaged affectional systems, genuine intimacy cannot be sustained. Relationship issues and conflicts contribute to sexual desire problems.

Relationship Issues and Sexual Satisfaction

Relationship conflict and couple distress have been considered major contributors to sexual problems in the absence of direct physical cause. Unresolved conflicts affect both relationship satisfaction and sexual satisfaction. Dysfunctional conflict resolution styles contribute to sexual dysfunction and dissatisfaction while constructive communication and interaction deepen emotional and sexual intimacy (Metz & Epstein, 2002).

While relationship satisfaction and couple satisfaction typically change concurrently in long term relationships (Byers, 2005), sexual satisfaction can enhance relationship satisfaction in some couples presenting difficulty in communicating (Litzinger & Gordon, 2005). Adult attachment style had a direct effect on marital satisfaction, while sexual communication, as a mediating variable, was positively related to sexual satisfaction and marital satisfaction (Timm & Keiley, 2011). Differentiation of self may contribute to sexual desire, intimacy and couple satisfaction in heterosexual couples (Ferreira, Narciso, Novo, & Pereira, 2014). Levels of sexual and nonsexual communication contributed to relationship and sexual satisfaction in college-age heterosexual couples (Mark & Jozkowski, 2013). It is essential to respond to relationship issues, maintain communication, and sustain sexual intimacy whenever possible.

Emotional and sexual aspects of intimacy are important correlates of relationship satisfaction in romantic couples (Yoo, Bartle-Haring, Day, & Gangamma, 2014). The results of a path analysis in this subset of the Flourishing Families Project indicated that sexual satisfaction predicted emotional intimacy in husbands and wives. Emotional intimacy and sexual satisfaction mediated appraisal of partner communication and their own relationship satisfaction. Gender differences revealed that relationship satisfaction of wives was not associated with sexual satisfaction reported by their husbands. However, husbands reported higher levels of relationship satisfaction when their wives endorsed greater sexual satisfaction.

Emotional and sexual intimacy interact to contribute to relationship and sexual satisfaction in heterosexual couples (You et al, 2014).

Achieving and maintaining intimacy through good communication and making meaning in the relationship can contribute to sexual satisfaction, without regard to illness or sexual problems, through stress relief, pleasure, playfulness, and spirituality (Metz & McCarthy, 2007). The New View of Women's Sexuality (Tiefer, 2008) rejected an exclusively biological and illness model of sexuality emphasizing instead political, cultural, and especially relationship factors in sexual dysfunction and dissatisfaction. Southern and Cade (2011) presented an intimacy-oriented, relational model for sexual health to counteract the over-medicalization of sexuality counseling and therapy. A model for integrating marital and sexuality therapy across various contexts in life has been advanced (Hertlein, Weeks, & Gambescia, 2015).

Relationship distress and couple conflict interfere with communication, intimacy, and satisfaction in the relationship and sexuality. Sexual satisfaction is important in relationship satisfaction even when there are problems with communication, attachment, or intimacy. Concurrent treatment of emotional and sexual intimacy is indicated in couples attempting to overcome relational distress and establish a secure and meaningful bond. Relationship-oriented therapy remains an essential component of treatment of sexual issues and counteracts the contemporary overmedicalization of sexual problems.

Masters and Johnson Institute Approach to Sexual Desire Disorders

Prior to 1970, treatment of sexual dysfunction and dissatisfaction involved individual psychotherapy or various models of marriage therapy. Masters and Johnson (1970) established a collaborative program for treating sexual problems based upon research initiated in 1954. The research involved observation and recording of thousands of episodes of sexual

activity, resulting in the landmark, *Human Sexual Response* (Masters & Johnson, 1966). The Masters and Johnson Institute offered therapy to couples presenting particular sexual dysfunctions using techniques innovated in the laboratory.

The basic approach involved assessment, consultation, and homework recommendations to the couple from a dual gender, co-therapy team. The team approach increased objectivity, incorporation of different viewpoints, and modeling of effective communication. Couples freed themselves from the demands of ordinary daily life, typical roles and responsibilities, and triggers for conflict or avoidance at home. They devoted themselves to recreation and intimate communication while receiving and completing daily homework exercises over a 10-14 day period. This intensive format facilitated intervention in a problem cycle of interaction and recovery of natural sexual function. Therapy sessions, while based on specific disorders, were tailored to the needs of the couple. Occasionally, individual sessions were scheduled to address roadblocks elicited by the homework exercises. Sexual therapy involved the prescription of nondemand touching exercises, sensate focus.

Sensate Focus

A cornerstone of the Institute's model for treating sexual dysfunction was the introduction of the sensate focus technique. While this intervention was criticized for being a series of straight forward touching exercises that blocked spontaneity and creativity, the Sensate Focus exercises assessed the current sexual and intimacy needs in the relationship, revealing roadblocks to natural functioning and identifying individual contributions to lack of fulfillment in sexual outlet. Apfelbaum (1995, pp. 23-24) commented on the critiques, observing that while most sex therapists use similar techniques they fail to realize the richness in the simplicity since they were not trained in the innovative climate of the Institute.

Weiner and Avery-Clark (2017), drawing on the original works of Masters and Johnson (1970) and the elaboration by Kaplan (1987), developed an illustrated manual for sensate focus in sex therapy. Weeks and Gambescia (2009) analyzed sensate focus exercises from a systemic perspective, simultaneously addressing sexual and marital/couple issues. The following functions make sensate focus a fundamental intervention in treating sexual desire disorders (Weeks & Gambescia, 2009, pp. 348–353).

1. Help each partner become more aware of his or her own sensations.
2. Focus on one's needs for pleasure and worry less about the problem or the partner.
3. Communicate sensual and sexual needs, wishes, and desires.
4. Increase awareness of the partner's sensual and sexual needs.
5. Expand the repertoire of intimate, sensual behaviors.
6. Learn to appreciate foreplay as a goal start rather than a means to an end.
7. Create positive relational experiences.
8. Build sexual desire.
9. Enhance the level of love, caring, commitment, intimacy, cooperation, and sexual interest in the relationship.

Weiner and Avery-Clark (2017) ultimately advocated sensate focus as a means by which the clinician is able to focus on a whole person in the context of a changing relationship. Sensate focus overcomes scripts for sexual behavior and expectations that contribute to anxiety, frustration, avoidance, and disinterest. In a very concrete, immediate manner, the therapist assists the partners in returning to fundamental touch and exploration of opportunities for intimacy and desire.

Sensate Focus is a series of structured touching and discovery suggestions that provides opportunities for experiencing your own and your partner's bodies in a non-demand, exploratory way without having to read each other's minds. Non-demand exploration is defined as touching for your own interest without regard for trying to make sexual response, pleasure, enjoyment, or relaxation happen for yourself or your partner, or prevent them from

happening. Touching for your own interest is further defined as focusing on the touch sensations of temperature, pressure, and texture. Temperature, pressure, and texture are even more specifically defined as cool or warm, hard or soft (firm or light), and smooth or rough (Weiner & Avery-Clark, 2017, p. 8).

Sensate focus leads each member of the couple to return to the immediate experience of one's body in the context of closeness to another person. Dr. Masters described the technique as sharing much with the child's natural tendency to explore the world through the sense of touch. He also remarked that the artist discovers and appreciates the beauty and meaning of the creative work through the experience of texture and form. Sensate focus affords a secure foundation for additional construction of an integrative treatment model.

Relational Components of the Treatment Model

The original model of Masters and Johnson Institute involved intensive treatment in an ideal situation, removed from the demands and conflicts of daily life at home. As the couple placed themselves in social isolation and followed daily suggestions to increase closeness, connection, communication and intimacy, the roadblocks that interfered with sexual desire would become obvious. Directive forms of psychotherapy were used to "neutralize" these roadblocks, and the couple's newfound levels of intimacy elevated their sexual desire. Masters and Johnson concluded that there was no such thing as an uninvolved partner and maintained their treatment focus on the relationship.

A common couple issue influencing sexual desire is explicit and implicit contracts. For example, a traditional couple might make an implicit contract that the man will be the provider, the woman the homemaker. If either fails to hold up their end of the bargain, sexual desire can be affected. Many of these contracts are doomed from the start, since such roles may contain inherent contradictions. A partner might expect the spouse to be a successful surgeon, yet also want an engaged and equal partner to assist in raising the children. When the spouse cannot do both, the partner becomes frustrated and may lose sexual desire. In other couples, when a female woman earns more money than her husband, the man may feel threatened, insecure, and lose sexual interest.

Multiple relational factors may influence attraction and desire such as the partners' responsiveness, the intimacy and closeness they created, and distractions such as work, parenting, and homemaking. Masters and Johnson insisted on the intensive treatment format to construct a "honeymoon," with time and space to be close, repair relationship issues, and enjoy intimacy. Psychoeducation and authoritative pronouncement disrupted old behavior patterns, creating opportunities for learning new skills. There was pressure to carry-out rather than avoid specific homework which could take hours each day. The demand characteristics and expectancies engendered by the intensive treatment format facilitated overcoming the roadblocks that interfered with natural functions such as sexual desire.

This focus on the relationship has limitations and shortcomings, since many roadblocks can exist for years in an individual which may predate the current relationship in which a desire disorder is manifested. Hormonal insufficiency, certain medications, and other physical conditions can cause a person to have generally low initiatory behavior and low arousal. But present this individual with a new partner, or disinhibit him or her with small amounts of alcohol, then there may be heightened interest and potential for sexual relations. Thus, dispositional and situational factors can affect desire. If an individual man has been enmeshed with mother, sexually abused, or developed body dysmorphia or any other injury to sexual unfolding, there may be emergence of hypoactive sexual desire. Therefore, treatment of inhibited sexual desire must vary relative to its contributing factors, using different interventions to achieve successful treatment.

A woman experiencing dyspareunia, vaginismus, anorgasmia or menopausal hormonal changes may find desire decreasing precipitously. Women with a history of sexual assault can discover that in certain situations such as dating, desire can increase and decrease unpredictably. In addition, since individuals often choose partners who have complementary or compounding issues, the couple together can create a more complicated problem. When one person says no to sex, the other may feel unloved or rejected. The couple then manifests marital distress and conflict in other areas of their relationship. This starts a domino effect: a series of deleterious influences on levels of

sexual desire in the relationship. Both partners may label the person most avoidant as hyposexual. The other partner feels undesirable and frequently reacts by increasing his or her demand for sexual interaction. This elevated level of sexual demand increases performance anxiety in the inhibited partner and may lead to sexual dysfunction, which further lowers desire.

More dominos fall if the individual with low desire attributes the lack of desire to "falling out of love." Feelings of low self-esteem, insecurity, guilt, and other negative emotions, such as depression, follow. Add the side effects produced by a serotonin reuptake inhibitor to treat the depression, which can function as the "icing on the cake" for serious sexual and relationship damage.

Insert Table 1 about here

The most frequent relational issue contributing to low sexual desire is ignorance. We consider the lack of knowledge about sex and physical intimacy, as well as communication and problem solving, a public health crisis; While there is a lot of media attention to sexuality, few persons know adequate techniques for mutually pleasurable lovemaking. This can be more difficult with repetition, boredom, lack of creativity, fatigue, and a myriad of demands of daily life. Frequently, we hear about a compulsively driven, mechanical interaction focused on orgasm, ejaculation and tension release, wherein intimacy, connection, tenderness, and affection is limited.

The widespread availability of pornography, with images of sex acts that reward size, staying power, and dehumanizing techniques, have added to the crisis, since many people "learn" about sexuality through these images. Younger generations are showing a tendency to be even more mechanical, less affectional, and unresponsive to touch. This problem is complicated when an individual is child-like and never "grows-up" to form a coherent cohesive embodied sense of self. In such instances, he or she can feel objectified, depersonalized and numbness when touched. Their personality is often focused upon anticipating others' reactions and

wishing not to displease others. Focusing excessively upon pleasing one's partner leads to "spectatoring," performance pressure, and avoidance or anxiety.

Another factor contributing to low sexual desire is the inability to express emotions to the partner, such as hurt, frustration, or anger. Sometimes the partners do not have the tools, resolution skills or training to deal with disagreements. A partner unable to feel, label, or express emotions may instead rely on sex to feel loved, placing extraordinary demands on the other partner. Passive and active expressions of anger can slowly increase or be projected onto the partner from the unfinished business of childhood.

Unexpressed or unacknowledged feelings maintain a strangle hold on intimacy, eventually choking the spontaneity and life out of even the most originally vibrant relationship. In such instances, triangulation occurs (cf. Bowen, 1978). Ongoing conflict requires the triangulation of a third object or activity to bind the troubled relationship. Preoccupation with material possessions, work or success, parenting and especially addictive substances or behaviors enable the couple to stay together: distant, detached, and resentful. One partner assumes the role of "hero" while the other suffers as the "martyr." Couples are able to grow, negotiate boundaries, resolve conflict, and create alternatives. What cannot be spoken stifles rather than seeds growth. Such difficulties steal the enthusiasm and curiosity required to maintain sexual desire. For these reasons, marital and relational therapies that include communication, problem solving, and conflict resolution are almost always integrated into the sex therapy.

Some relationship interventions focus on facilitating differentiation from the family of origin, individuation, and tolerance for the otherness of one's partner. Stuck points in development due to neglect, abuse, trauma, and adverse child events impede the capacity for genuine intimacy and pose roadblocks in the emergence of healthy sexual desire. Individual psychotherapy on "deeper" issues" is used to teach dissociative individuals to be present in their own body and accentuate the senses involved in attempting sensate focus with the partner. Often fear or anxiety triggered by closeness,

intimacy, or touch can result in a numbing response. Exposure based therapies and meditation can address emotional reactivity and afford biobehavioral healing.

A final major factor contributing to low desire is the reduction or absence of courting behavior once married. A couple fails to give a high priority to having fun, playing or being romantic once they are established in marriage. Life can become redundant and task driven. They forget, or never discover, how to be playful, spontaneous and enjoy non-goal interactions. Their sexual expression mirrors their serious hard-working lifestyles and becomes routine or orgasm-focused on tension relief. Perfectionism can also lead to the roadblock of goal orientation. Unfortunately, the harder one works at sex, the less spontaneous, playful and enjoyable it ultimately is.

Although immediate factors contribute to maintaining low desire, as Helen Kaplan (1974) noted, "deeper" issues are frequently at the core of desire and arousal problems. While Masters and Johnson focused on the relationship, each partner may bring "baggage" to the pair bond interfering with the capacity for intimacy and blocking the development of sexual satisfaction. Bonding disorders originate in the developing attachment system within the individual that is subsequently expressed in the relationship.

Individual Components of the Treatment Model

Mate selection, as driven by attachment theory, would often find the avoidant person pairing with a partner with preoccupied attachment. This coupling establishes a merger-seeker relationship in which the sex drive is high for the merger and low for the seeker. The couple presents with the seeker labeled as having low sexual desire, with subsequent damaging domino effects to the relationship, when the actual problem is their complementary attachment patterns. If either had chosen a partner with secure attachment, he or she might have avoided sexual difficulties. The focus of therapeutic intervention in these cases would be on individual issues, perhaps concurrent with couple therapy or group therapy approaches.

Our work on deeper issues has focused on shorter-term interventions to move individuals

towards what Main and Hesse (1990) defined as "Earned Secure Attachment," which refers to repairing insecure attachment. Table 2 lists the components of our work to support secure attachment and progression toward intimacy (Schwartz & Southern, 2017).

Insert Table 2 about here

The treatment consists of helping the individual revisit their memory of sequential developmental experiences.

...become more aware of his or her immediate mental state, learning to accurately mark, label, and understand affective states and cognitive status, such as maladaptive beliefs and schemas, becoming sensitized to the limitations of knowledge and beliefs, learning to identify states of mind, and becoming able to mentalize about others' state of mind and about the transference in therapy (Brown & Elliot, 2016, p. ?)

The ultimate aim is a reappraisal of their life experiences and reconsideration of their fixed beliefs and conclusions about self, others, and their capacities to master and resolve problems. Core schemas related to trust, safety, power, control, and intimacy are reconsidered and become more rationally based in their adult world, as opposed to frozen, fixed beliefs based on past traumas or adverse developmental events. At the core of one's capacity to bond are self-empathy, the capacity to be alone, and self-care.

In the absence of validating caretakers, the developmentally impaired individual does not internalize a caring relationship with self. A child who is rejected or abandoned may develop negative core schemas or beliefs about self, which organize ways of relating to others. Sroufe (2016, p. 6) reported that a history of maltreatment as a child, in a longitudinal follow-up of 170 children from birth of adulthood, "almost never has a positive outcome." The individual attempts to create safety and consistency in maladaptive ways, such as finding others who need taking care of, to create an illusion of safety and control. Sroufe also found that the long-term result of early

disorganized attachment patterns left individuals vulnerable to fragmentation or dissociation. Such fragmentation leads to the "addictive personality," or internally felt emptiness in which the individual never quite feels connected or safe.

The critical feature of recovery is learning to experience other people as a reliable source of comfort and safety. To do this, we integrate trauma-resolution therapies and grief work into the process, with a focus on challenging inappropriate family loyalties, fixed beliefs, or shame-based family rules. As the client experiences greater self-compassion and resolves past "unfinished business," they are less likely to project their internal conflicts onto their partner and use sex to feel safe and connected. Repairing vandalized love maps requires revisiting the critical experience and reactivating the affect in the safety and containment of the therapist's office, allowing for reconstruction and revision of core schemas. Our experience is that fantasy and sexual arousal patterns shift as the client establishes secure attachment, and becomes channeled toward touch, closeness, and affection.

In summary, the therapy becomes a vehicle to catalyze structural deficits from childhood as well as individual relational issues blocking intimacy, bonding, arousal, desire and passion. Being nude with a partner mindfully and "in one's body" creates anxiety and fear, which blocks desire. Masters and Johnson ingeniously used an intensive format of two weeks of daily treatment, social isolation, to foster positive expectations, learn new behaviors, and enjoy fledgling intimacy. The innovations that have unfolded over the past 30 years in trauma-resolution and grief work allow a focus on individual blocks to intimacy within the context of the couples' work. We often do one individual session, with the partner observing, and one session of couples therapy each day for the two weeks. Rapid change and increased compassion for self and others, creates even greater motivation for healing. Individual treatment components free each partner to benefit from couple's therapy and ultimately participate freely in the intimate journey to sexual fulfillment.

An Integrative Model

Recent developments in psychotherapy integration and systemic therapy afford a structure for organizing components of treatment of sexual desire disorders, based upon the original model of Masters and Johnson Institute and incorporating contemporary views on cultural, contextual and individual factors. Psychotherapy integration involves systematic or technical eclecticism, implementation of common factors for beneficial change, and assimilation of components from various theoretical models into a promising innovation. While there are common factors that account for effective therapy, there are also empirically supported treatments known to produce targeted outcomes in evidenced based practice. Systemic therapy originated in marriage and family therapy, but incorporates levels of influence from cellular biology, through individual and couple factors, to community and societal influences.

Integrative Systemic Therapy (Pinsof, Breunlin, Russell, Lebow, Rampage, & Chambers, 2018) grew out of the integrative problem-centered metaframeworks approach (Breunlin, Pinsof, Russell, & Lebow, 2011; Breunlin, Schwartz, & Kare-Karrer, 1997; Pinsof, Breunlin, Chambers, Solomon, & Russell, 2015). Integrative Systemic Therapy (IST) affords a comprehensive, integrative, multi-systemic and empirically informed process for hypothesizing, planning, and implementing solution sequences within the contexts of problem sequences of interactions and constraints that arise to restrict change.

The IST approach builds on collaboration, therapeutic alliance, strengths, and guidelines. The hypothesizing metaframeworks or domains of human functioning consist in development, organization, mind, biology, spirituality, culture, and gender (Pinsof et al., 2018, pp. 99-142). The planning metaframeworks include action, emotion/meaning, biobehavioral, family of origin, internal representation, and self (pp. 143-192). A planning matrix (p. 145) incorporates contexts of therapy and guidelines that move from direct action in family systems to increasingly complex interventions involving couple dynamics and intrapsychic mechanisms. Direct, action-oriented interventions involving at least two members of a family (e.g., the couple) are favored to replace old problem

sequences with new solution sequences. However, constraints, frequently based on family of origin issues and life trauma, may shift the focus to individual systems including biology, mind, and selfhood. Sexual desire disorders reflect culture and gender issues that require attention to release constraints and move toward direct techniques for rekindling desire.

The first of the seven metaframeworks is organization, an essential, multilevel construct in IST. Organization corresponds in many ways with Minuchin's (1974) structural, cross-generational structural family therapy model. Keynote in the organization metaframework are boundaries, which vary on a continuum from inclusive or joined to exclusive or detached. Leadership, the second of the dimensions of organization, refers to the allocation of resources, rights, and responsibilities or functions; mediation of conflicting needs, goals, and preferences; and maintenance of balance, fairness and equity. Hypotheses within the organization metaframework typically looks at relationships. However, boundaries and leadership apply to all levels of systems from cells in the human body to movements in a societal context.

Development is another central metaframework implicit in examining change over time. Macrotransitions over the family life cycle address development of the family system, but affect individuals within the group. Microtransitions, even at the biopsychosocial level of the individual, afford opportunities for growth in persons. As competencies emerge in the individual, relationships within family and social systems are affected. Similarly, the culture metaframework addresses individual, family, and societal change.

Culture applies to shared identity in groups and affords various contexts through membership. Frequently, discussing and understanding the contexts of membership (Pinsof et al., 2018, pp. 113-114) reveal conflict, distress, and constraint. The concept of intersectionality, occurring at the junction of various identities or memberships, facilitates hypothesizing related to meaning, relevance, and significance. Persons, couples, and families attempt to fashion a goodness of fit from multiple contexts or memberships. These may contribute to stuckness as they operate as constraints. Acculturation and social justice issues apply to the culture metaframework.

Mind is a metaframework central to an individual-oriented therapy in which causality is located within a person. In particular, depth approaches to psychotherapy and biological interventions frame a problem as intrapsychic or physiological to the exclusion of hypotheses framed at other levels. There are at least three subsystems or levels of mind according to ICT (Pinsof et al., 2018, pp. 117-123). The first level refers to narrative accounts of personality and life experience, as well as thoughts, emotions, and attributions associated with old problem sequences and new solution sequences. The second level of mind accounts for parts or objects experienced within a person or expressed outwardly through interactions. Second level hypotheses are especially helpful in addressing constraints in couples work. The third level involves deeper or core dynamics in personality or selfhood. Distortions related to narcissistic vulnerabilities can affect the capacity to process information, making difficulty in negotiating interventions at other system levels or through other metaframeworks (Pinsof et al., 2018, pp. 121-122).

Gender remains a key metaframework in which contemporary issues are assessed and understood. When gender roles and identities are not prescribed or declared somehow fixed, opportunities for change and adaptation arise. Today, the lesbian, gay, bisexual, transgender, and queer/questioning communities have called into question what constitutes “real” maleness and femaleness. Gender is not viewed as binary. In fact, many of the metaframeworks, including gender, do not exist as poles or only a continuum, rather one should examine the entire field or array in order to understand and respect the lived experiences of others. Feminism made the personal political and examined the gendered lens of patriarchal institutions such as psychotherapy. IST takes seriously the meaning-making function of gender exploration and recognizes externally imposed constraints that may still inhabit systems. The patriarchal and heteronormative biases of many early forms of therapy, including sexuality therapy, can be informed and revised through an integrative -systemic focus.

Biology would be the central metaframework in neuroscience and medically-informed interventions for human problems. While it is essential to examine the cycles and sequences, the problems and solutions presented by the biological factors of persons in context, the IST model places

it among the other metaframeworks in order to avoid reductionism. The biology metaframework affords assessment and intervention regarding illness and medication and in a variety of other domains: wellness, mindfulness, sleep hygiene, sexual health, and aging. Recent advances in understanding addiction, mental illness, brain functioning, hormonal influence, and genetics provide perspectives relevant to understanding and resolving problems.

Spirituality as a metaframework could seem other worldly and less scientific or empirical than biological advances. Yet, there appears to be a trend toward exploring personal meanings, emotions, and behaviors within the content of spirituality. Spirituality can be fundamental or essential in overcoming illness and responding to suffering (Pinsof et al., 2018, pp. 137-142). Mainstream psychotherapy may avoid potential strengths and resources or fail to recognize constraints associated with spirituality and religion.

Having used the metaframeworks to assess within and across systemic levels the problem and constraint sequences, the integrative systemic therapy (IST) model next posits a matrix for therapy planning, implementation, and evaluation (Pinsof, Breunlin, Russell, & Lebow, 2011; Pinsof et al., 2018, p. 145). There is an array of planning metaframeworks, incorporating common factors in psychotherapy integration, to find the best-fit for each identified constraint. Each planning metaframework contains potentially effective strategies.

The action planning metaframework is especially helpful in addressing behavioral constraints such as not knowing what to do or lacking necessary skills. Constraints based on problems with organization and development can be addressed through direct action. The next planning metaframework involves meaning/emotion. While action addresses sequences, organization, and development in hypothesizing, meaning/emotion planning addresses aspects of culture, gender, spirituality, and sequences of mind (Pinsof et al., 2018, p. 145). There are planning strategies that address thoughts, feelings, and narratives.

Some of the strategies or common factors in the meaning/emotion planning metaframework address complex meanings and emotions, some of which are related to underlying loss or trauma.

The biobehavioral planning metaframework has received a lot of attention in contemporary treatment. Some of the strategies have been viewed as primary or essential with other therapy strategies being viewed as adjunctive or devalued. “Overmedicalization” of therapy can result in ineffective or temporary outcomes with relapse or failure to maintain treatment gains. The following strategies fit the biobehavioral planning metaframework. The biobehavioral planning metaframework figures prominently in behavioral healthcare, especially the emphases on psychopharmacological intervention and addiction detoxification and treatment. In recent years, a focus on wellness and fitness balances the underlying illness or disease model with health initiatives.

The family-of-origin planning metaframework enables meaningful hypothesizing especially for adult clients. Family-of-origin problems operate as constraints in direct interventions. Family-of-origin strategies increase the range of options for solution sequences. The family-of-origin perspective interfaces with internal representation planning metaframework. After some attention to the family-of-origin issues, it is easier to address internal family systems and objects. The mind, gender, culture and development hypothesizing metaframeworks are commonly addressed through internal representation strategies. This is also the juncture in which internal systems and psychodynamics of individuals and couples inform IST practice. The planning metaframeworks conclude with the self. Self-planning addresses vulnerability and rigidity in the personality that constrains solution. The self-planning metaframework increases awareness of the demands of relationship including sustaining or repairing the therapeutic alliance.

Based upon the pervasiveness of sexual desire disorders, whether manifested in desire discrepancies in couple therapy or presented as an individual problem of hypoactive sexual desire, an integrative model based on IST can be applied to therapy and coaching modalities. The integrative model takes into account the strengths of the original Masters and Johnson Institute approach, but updates the interventions with individual and relational, contextual and cultural insights. The components of the integrative treatment of sexual desire disorders is presented in Table 3.

Insert Table 3 about here

As depicted in Table 3, integrative treatment initially focuses on direct intervention with the couple sexual system. As constraints are identified, interventions move to the couple relational system and/or individual systems including organization of mind and development of self metaframeworks. Biobehavioral interventions should be addressed either concurrently with couple sexual interventions or ruled out through a comprehensive assessment completed during the intake planning phase of treatment.

Our integrative model for treating sexual desire disorders builds upon the fundamentals of the Masters and Johnson Institute approach with initial attention to sensate focus. Psychoeducation is offered to the couple to help them understand changes in desire over time and to encourage exploration of erotic intimacy. If either member of the couple has not completed a recent history and physical with their physician, it may be warranted. Medication, especially antidepressants, may demand evaluation. Otherwise, the partners will be encouraged to exercise, practice fitness and recreation, and introduce spiritual disciplines such as mindfulness or yoga.

Should there be enmeshment or overinvolvement in the family of origin, individual, couple, and family therapies may be needed to facilitate differentiation. Couple therapy may be indicated for relationship conflicts impinging on the sexual relationship. In most cases of trauma history, some intensive individual therapy will be needed to overcome anxiety and avoidance associated with the demands of intimacy. We have found it beneficial to alternate individual sessions in which the partner is present. Several models of psychotherapy permit empathy, understanding, and insight in this matter. Bibliotherapy and homework exercises extend the value of therapy beyond the formal sessions in keeping with the intensive model advanced by Masters and Johnson (1970).

Conclusion

Repairing sexual desire is complex and requires a focus on deeper capacities for intimacy and

connection to self and others, as well as choice of partner and subsequent relational dynamics.

All of this is influenced by biochemistry, factors shaping the CNS structure during critical periods of sexual unfolding, and the mind's development of love maps. Theory, research, and practice in attachment disorders facilitate understanding of constraints on intimacy in pair bonds. Sustaining secure attachment is necessary to benefit fully from sexual therapy techniques to enrich desire.

Therapeutic intervention is now more targeted and effective, as the conceptual model has shifted from sex to loving, secure attachment. The ultimate goal of successful therapy and healthy sexual functioning is to strengthen the individual's capacity to be fully present and available in a safe and trusting relationship. Advances in evidence based and integrative approaches promise to update and expand the original model for intensive treatment innovated at Masters and Johnson Institute. Dr. Masters participated in the extension of the model to treat sexual trauma, sexual compulsivity, and other intimacy based disorders. Effective intervention in sexual desire disorders harkens back to the origins of psychotherapy and sexuality therapy. We look forward to presenting some cases in which this integrative model is applied.

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Table 1

Domino Effects in Sexual Desire Disorder

Male low desire due to hypogonadism, hormonal insufficiency

Female history of assault, trauma and low self esteem

Depression and withdrawal

Side effects of SSRI

Low frequency of initiation

Feeling undesired by partner

One partner labels the other as inhibited

Partner escalates desires

Performance pressure emerges

Sexual dysfunctions

No orgasm

Frustration and anger

Relationship conflicts

Sexual dissatisfaction, relationship dissatisfaction

Sexless relationship

Table 2

Conditions for Secure Attachment

-
1. Sense of felt safety/protection from danger and threats
 2. Sense of being seen and known (attachment)
 3. Unconditional love and support
 4. Experience of felt comfort with soothing and reassurance
 5. A sense of being valued, delight in the individual
 6. A sense of potential for new possibilities for growth and becoming oneself
 7. Self-compassion, self-soothing, and self-efficacy
 8. Venturing forth toward differentiation and individuation
 9. Increasing capacity for bonding and intimacy
-

Table 3

Integrative Model for Treatment of Sexual Desire Disorders

Hypothesizing MF	Planning MF	Context	Intervention
Organization	Action		
Equity	Teaching/coaching	Couple	Sensate Focus
	Behavioral exposure	Couple	
	Homework	Couple	
	Psychoeducation	Couple	Good Enough Sex ^a
Gender	Action		
Flexibility	Psychoeducation	Couple	New View ^b
	Teaching/coaching	Couple	Optimal Erotic Intimacy ^c
Biology	Biobehavioral		
Medication	Medication evaluation	Individual	Physician referral
Wellness	Exercise/fitness	Individual	Sport/recreation
		Couple	Outdoor sharing
Development	Family of Origin		
Transition	Differentiation	Family	Couple/family therapy
	Emotion		
	Loss/trauma	Couple	Emotion focused therapy ^d

Table 3 (Continued)

Integrative Model for Treatment of Sexual Desire Disorders

Hypothesizing MF	Planning MF	Context	Intervention
Mind	Internal Representation		
Thoughts/feelings	Inhibiting voices	Couple	Voices therapy ^e
Parts	Parts work	Individual or couple	Internal Family Systems ^f Schema Therapy ^g
	Self		
Distortions	Therapeutic alliance	Individual	Depth Oriented Therapy
	Rupture repair	Individual	Depth Oriented Therapy
	Projection	Couple	Imago Therapy ^h
		Couple or Individual	Object Relations Psychotherapy ⁱ
Spirituality	Self		
Balance	Spiritual discipline	Individual	Spiritual teacher or director
		Individual	Addiction recovery

Notes: MF: Metaframework from IST.

^aGood Enough Sex (Metz & McCarthy, 2007). Also, for bibliotherapy (McCarthy & McCarthy, 2014)

^bNew View (Tiefer, 2008).

^cOptimal Erotic Intimacy (Kleinplatz, 2010).

^dEmotionally Focused Therapy (Johnson, 2015).

^eVoices Therapy (Firestone, Firestone, & Catlett, 2006).

^fInternal Family Systems Therapy (Schwartz, 1995).

^gSchema Therapy (Young, Klosko, & Weishaar, 2006).

^hImago Therapy (Hendrix2007).

ⁱObject Relations Psychotherapy (Scharff, 1995).