Sexual desire and satisfaction: The balance between individual and couple factors

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The new mantra for couple sexuality is desire, pleasure, eroticism, and satisfaction. This clinical/conceptual commentary examines individual and couple factors that can facilitate or subvert desire and satisfaction. Eight challenging clinical situations are described, some of which can be successfully resolved, whereas others can indicate a fatally flawed relationship. Conceptually, clinically, and empirically, sexual desire and satisfaction requires careful examination, assessment, and interventions with special attention to cultural and value issues.

Keywords: sexual desire; sexual satisfaction; sex therapy

The classic book, Human Sexual Inadequacy (Masters & Johnson, 1970), introduced a paradigm shift in understanding sexual function and treating sex dysfunction by providing groundbreaking work focused on arousal and orgasm. Although these authors followed the medical model of individual sex dysfunction, they argued that the treatment of choice was a couple approach to enhancing sexual comfort and pleasure, emphasizing sensate focus exercises to enable a natural sexual response (Masters & Johnson, 1970). However, a major flaw of this model was that it ignored the vital role of sexual desire.

In recent years, models aimed at helping to understand and treat sexual function and dysfunction provide a more comprehensive approach. The new mantra of healthy couple sexuality incorporates desire, pleasure, eroticism, and satisfaction (Foley, Kope, & Sugrue, 2012). The psychobiosocial model of sexual function and treatment places prime emphasis on the crucial role of sexual desire and satisfaction (McCarthy & McDonald, 2009b). The critical challenge for serious couples, whether married or unmarried, straight or gay, is to develop a couple sexual style that integrates each person’s “sexual voice” (i.e., autonomy) with being an intimate sexual team (McCarthy & McCarthy, 2009).

A core issue remains whether sexual desire and satisfaction is best understood, assessed, and treated as an individual or couple issue. Currently, the DSM-IV-TR (APA, 2000) is organized around individual sex dysfunction. However, Aubin and Heiman (2004) cogently argue for assessing sexual problems as a couple issue, and the predominant approach in sex therapy is to emphasize sexual desire and function as a couple concern (Metz & Epstein, in press). As one of the most influential theoreticians/clinicians in the field, Schnarch (1997) emphasizes the critical role of individuation in sexual desire. Perel (2006) provides a different perspective by...
highlighting each person’s sexual autonomy as integral to maintaining erotic vitality. Finally, Johnson and Zuccarini (2010) provide the major voice for the attachment approach to intimate relationships by emphasizing intimate connection as the basis of sexual desire.

Metz and McCarthy (2010) focus on the couple maintaining sexual desire and satisfaction in a long-term relationship. Additionally, McCarthy and McCarthy (2009) describe the core couple sexual styles as involving two dimensions: (1) the balance of one’s sexual voice with being an intimate sexual team and (2) how to integrate intimacy and eroticism into a serious ongoing relationship. The challenge of sexual desire and satisfaction involves both individual and couple dimensions. An important conceptual and clinical issue is how to understand and intervene when individual and couple dimensions are not mutual or even congruent.

This conceptual/clinical commentary will examine a range of clinical situations where incongruence occurs between partners in sexual desire, preferences, feelings, and/or goals. We present a clinical model regarding how to understand, assess, and treat differences to promote sexual desire and satisfaction. It is important to emphasize that much of this work is based on middle-class heterosexual couples. In addition to the need for empirical validation of this therapeutic approach is the importance of studying couples from different socio-economic classes, cultural backgrounds, and sexual orientations.

Healthy couple sexuality
Before exploring differences and coping strategies, let us examine couples who present the optimal situation, one in which there is no need for clinical intervention (McCarthy, 2003).

When a couple finds a mutually comfortable level of emotional intimacy that provides a solid attachment, as well as the freedom to initiate sexual encounters, this represents one such optimal situation. Each person exhibits comfort regarding affectionate, sensual, and playful touch, and the couple values non-demand pleasuring. The couple does not embody identical feelings and preferences, but shares similar, positive value about touch and pleasuring. The couple develops erotic scenarios and techniques that enhance subjective and objective arousal, including intercourse and orgasm. Few couples have the exact same erotic preferences, but each partner must remain responsive to the other’s needs. It is equally important for a couple to ensure that one partner’s desires are not left unfulfilled by attending to the other’s at the expense of the relationship. Ideally, both partners value mutual and asynchronous sexual experiences.

Embodying both an emotional and physical experience that involves orgasm, sexual satisfaction is not defined by orgasm as the pass/fail performance test. Ideally, the couple would adopt the variable and flexible Good Enough Sex (GES) model (Metz & McCarthy, 2012). This model embraces individual, gender, and couple differences for the roles and meanings of sexual desire, function, and satisfaction, and can empower individuals and couples at any stage of life.

Clinical sexual issues
Myriad and complex clinical issues involving sexual desire and satisfaction are present in sex therapy. We will examine eight common issues with a range of
therapeutic interventions and outcomes. The clinician utilizes comprehensive sex therapy strategies and techniques throughout the first five examples and thus provides instances that likely result in positive therapeutic outcomes for the couple. The final three sexual issues might result in the sexual conflict causing a fatally flawed marriage.

First challenging sexual situation: Sexual power struggles

The couple power struggle represents the traditional and most common pattern in challenging sexual situations. This conflict typically occurs when the man has high sexual desire, seeks more frequent intercourse, and pressures his partner to be desirous and orgasmic. The partner protests that he ignores her needs for intimacy and affection and that any touch results in a demand for intercourse. Power struggles, whether emotional or sexual, very seldom lead to sexual satisfaction. A partnership based on a positive influence process that emphasizes pleasure sharing, with sexual desire and satisfaction facilitated by anticipation, choice, freedom, and unpredictability regarding sexual scenarios and techniques, represents a healthy relationship. Conversely, sexual power struggles involving pressure, demands, secrets, and blame subvert desire and satisfaction.

The four-session assessment model, beginning with an initial couple session, is a key strategy to helping the clinician understand the couple’s sexual problem(s). Acquiring the individual’s psychological/relational/sexual histories through an individual session, followed by a couple feedback session, begins the process of creating a new narrative and a therapeutic plan (McCarthy & Thestrup, 2008). Utilized to broaden each partner’s perspective, this strategy reduces the polarizing power struggle, and introduces the concept of a one-two combination of honoring each person’s sexual voice while working together as an intimate sexual team.

Additionally, Basson’s (2007) concept of “responsive female sexual desire” is of great value in validating the woman’s sexual voice as different, yet equal, to that of the man’s voice. From this perspective, the challenge for the woman is to identify facilitating factors toward her receptivity and responsiveness to pleasuring and eroticism. She also seeks to engage her partner as her intimate sexual friend rather than the demanding man whom she has to catch up with in terms of sexual response. Sexual desire and pleasure acts not as a competition between partners, but as a cooperative effort, representing an interactive team sport. For the man, placing value on pleasuring as an interactive give-and-take process rather than traditional “foreplay” acts as his challenge. Expanding on the traditional notion that sex remains limited to intercourse to incorporating and accepting sensual, playful, and erotic touch is also important, and thus provides a multi-faceted approach to couple sexual desire and satisfaction.

Additional aspects must be met in order for a positive, healthy relationship to ensue. For example, the notions of desire and sexual connection must also be addressed. Desire is broadly redefined as an intimate connection that includes sensual, playful, erotic, and intercourse experiences rather than intercourse as the pass/fail test. Positive sexual connection is redefined as sharing pleasure and embracing a variable, flexible approach to sexuality. Specifically, this means the couple can feel connected and satisfied with a sensual, cuddly scenario; a playful scenario; an erotic, non-intercourse scenario that is mutual or asynchronous; as well
as an intercourse scenario that is positive even if not highly arousing or orgasmic for
the woman. The mutual, synchronous intercourse and orgasm scenario is most
highly valued, but must not be a demand or pressure.

Second challenging sexual situation: Male sexual avoidance
Another common sexual situation is one where the man, due to his lost confidence
with erections, intercourse, and orgasm, avoids a sexual encounter (McCarthy &
Metz, 2008). This represents a particularly common pattern for men over the age of
50. Regarding sexual socialization, the man learns to associate sexual desire with
spontaneous erections and to proceed to intercourse and orgasm during his first
erection. In other words, his sexual functioning is very predictable, under his control,
and autonomous. Anything less than predictable erections, intercourse, and orgasm
becomes unacceptable to him.

The therapist confronts the man and provides him with the choice to either be a
“traditional” man, where he will likely stop being sexual in his 50s or 60s, or a
“wise” man who adopts the GES model and can be sexual in his 60s, 70s, and 80s.
Initially, however, the man tends to view GES as a “second class” or “settling”
option. Through therapy, he learns to value GES as the optimal male and couple
sexuality scenario.

GES embodies a model congruent with female sexual socialization (i.e., an
intimate and interactive sexual response rather than one that is autonomous) and
experience (i.e., a variable, flexible sexual response rather than entirely predictable).
Regarding sexual desire and satisfaction, the man turns to his partner not as
someone whom he needs to perform for, but as his intimate sexual friend. A
powerful advantage of sex and aging becomes the partners’ need for one another and
sexuality as more genuine and human (Foley, 2005). After 50, sexuality becomes
more of a team sport.

Additionally, an important factor of sex after 50 is the concept of “responsive
male sexual desire.” Men who accept, or ideally embrace, the strategy of being open
to affectionate, sensual, playful, and erotic touching as a bridge to sexual desire have
a positive approach to male and couple sexual desire.

Embracing a less than 100% expectation of sexuality flowing to intercourse
rather than clinging to intercourse performance as the pass/fail sex test exhibits yet
another empowering strategy. If the man enters the situation with the mindset,
“intercourse or nothing,” nothing will win. Additionally, a healthy strategy is to
approach a sexual encounter with the notion of engaging in “sexual play” as a
pleasurable activity that will energize the relationship. A mutual, synchronous
intercourse and orgasm experience is optimal. There are, however, ranges of both
synchronous and asynchronous experiences that can evoke sexual connection and
satisfaction.

Third challenging sexual situation: Sexual trauma
The effect of childhood or adolescent sexual trauma on adult sexual function
represents one of the most contentious topics in mental health. McCarthy and Breetz
(2010) reviewed the empirical and clinical literature and argue that the in vivo
trauma management and whether the person sees herself as a proud survivor or a
shameful, anxious, or angry victim is a core issue in adult sexuality. Maltz (2012)
argues that the optimal intervention for those with a history of trauma is couple sex therapy with the spouse acting as a “partner in healing.”

Often, the clinician is faced with a couple whose sexual relationship is controlled by one (or both) of the client’s sexual trauma history. Their sexual relationship is inhibited and low in frequency. The partner does not want to retraumatize the affected individual, so they collude in de-eroticizing their intimate relationship. A variant of this pattern occurs when the partner with trauma history engages in an affair and she (or he) experiences desire and eroticism. This results in the confusion and destabilization of both spouses and their relationship. In this situation, the history of trauma has been poorly processed and given too much power in controlling the person and the sexual relationship. As a result, safety is overemphasized at the expense of playful and erotic sexuality. The person who discovers desire, pleasure, eroticism, and satisfaction in an affair is responding to a new sexual experience, one not weighed down by the trauma history. This allows the person to develop an adult “sexual voice.”

The couple who survive the affair, and in turn create a genuine meaning of the lessons learned, have taken a major step. The challenge to the couple remains the ability to create a new sexual style that is neither controlled by a trauma history nor the affair history (McCarthy & Wald, in press). However, it should be noted that breaking the power of sexual trauma and inhibition would ideally occur without the drama of an affair.

The essence of sexual trauma (i.e., whether a child experiences sexual abuse, rape, incest, or other negative sexual experiences such as being exhibited to, sexual humiliation, or sexual harassment) is that the adult’s sexual needs are met at the expense of the child or adolescent’s emotional needs. The essence of healthy adult sexuality is that the sexual experience is intimate, voluntary, pleasure-oriented, mutual, and feelings and preferences are open to being processed. In the adult sexual relationship, when the person with the trauma history is able to experience desire, pleasure, eroticism, and satisfaction, she (or he) is a proud survivor for whom sexuality plays a positive 15–20% role in their intimate relationship. The person embraces the understanding that “living well is the best revenge.” As a result, sexuality energizes the relationship and promotes feelings of desire and desirability.

**Fourth challenging sexual situation: Inhibited sexual voice**

A less dramatic, but common, pattern is evident by the couple that comes to therapy saying, “we love each other, but we are no longer in love.” Often, they began as a romantic love/passionate sex/idealized couple, but after six months, or when they began living together or planning their wedding, sexual desire significantly decreased or completely disappeared. Although some of these couples remain sexually functional, their desire and satisfaction are low.

In essence, the couple does not make the transition from the romantic love/passionate sex phase to discovering a couple sexual style that balanced each person’s sexual voice with being a sexual team who find their unique way of integrating intimacy and eroticism. Whether this problem has existed for eight months or 20 years, the challenge for the clinician is to help the couple develop a sexual style that promotes desire and satisfaction. The great majority of couples in therapy choose the complementary couple sexual style. Clinical experience indicates the popularity of this sexual style follows the therapeutic model of personal responsibility and being a
sexual team, while facilitating passion by creating “his,” “hers,” and “our” bridges to sexual desire. Motivating the demoralized and blaming couple to work as a team represents a major clinical challenge. The couple develops a level of intimacy that invites sexual connection, reengages sensual and playful touch, discovers erotic scenarios and techniques, and establishes positive, realistic sexual expectations. In turn, the couple does not compare their sexual relationship with the drama of the romantic love/passionate sex phase where sex flowed naturally and easily.

Lisa and Keith

To illustrate the therapeutic process of rekindling desire and rebuilding sexual satisfaction, let us examine the case of Linda and Keith (names and details changed to protect anonymity) who came to sex therapy as a very demoralized couple. They viewed therapy as a last resort before moving to divorce.

Keith (38) and Lisa (32), had been married six years, and had a three-year-old daughter. Early in their courtship Keith and Lisa were very satisfied with their sexual relationship, which was frequent and exciting, although Lisa was seldom orgasmic. Keith felt high desire and was pleased that Lisa enjoyed sex, especially giving and receiving oral sex before they transitioned to intercourse. Lisa felt they were a “hot” couple and was very enthusiastic about sharing her life with Keith. During the first two years of marriage, sexual frequency remained high (3–4 times per week), but sexual quality dramatically decreased, particularly for Lisa. Their sexual scenario settled into a 10-minute routine with a quick transition to intercourse and perfunctory afterplay. Lisa was disappointed in both her sexual response and Keith as a lover, but said nothing. There was an increase in sexual desire and frequency when they were trying to conceive (which occurred after three months). The pregnancy, unfortunately, was the quietus for Lisa’s sexual desire. During the pregnancy, intercourse was infrequent and grudging. Lisa was aware Keith was using Internet porn with masturbation, and accused him of “beating off to disgusting images.”

Over the past two years, intercourse occurred less than once a month. Keith continued to be sexually functional but found couple sex less erotic than masturbation with porn. Lisa felt no desire or satisfaction in their sex and blamed Keith for being a selfish, sexually compulsive man. Rather than sexuality playing a positive 15–20% role in their marriage, it occupied a 50–75% negative role, draining the relationship of intimacy and threatening marital viability. The major area of common enjoyment for Keith and Lisa was parenting their daughter.

The four-session assessment process was valuable for both the clinician and couple. Keith became aware of how his “blaming” Lisa was alienating and that his masturbation to porn sites had become compulsive. For Keith, masturbation was more about expressing negative emotions than genuine sexual desire. The therapist asked Keith to monitor his thoughts and emotions before and after masturbation. Keith decided to masturbate only to cues of sexual desire, and temporarily not to use porn sites. Eventually, his masturbation frequency settled into a 3–4 times per week occurrence rather than his previous 12–15 times a week compulsive masturbation.

Lisa realized she had been demonizing Keith and his sexuality. She had come to view sex as bad and feared sexual demands and pressures. Lisa had completely lost her sexual voice, something she did not want for herself, her marriage, or as a role model for her daughter.
The couple feedback session is the core intervention in this sex therapy model. In an empathic, respectful manner the clinician helps create a new, genuine narrative that encourages both Keith and Lisa to see their individual strengths and vulnerabilities. In a non-blaming manner they became aware of how their individual and couple sexuality had fallen into self-defeating traps. Each person needed to regain a pro-sexual approach and confront “sexual poisons.” It is a couple challenge to build a new couple sexual style in which they develop a mutually comfortable level of intimacy, re-introduce non-demand pleasuring, and create new erotic scenarios and techniques. The couple challenge is to develop a sexuality that reenergizes their bond.

The first psychosexual skill exercise Lisa and Keith attempted at home was the “comfort” exercise. Used to re-establish a touch connection both in and outside the bedroom, this exercise involves instances where the couple experiment with being clothed and nude, with and without talking, and with mutual touching (i.e., partner interaction arousal) or taking turns (i.e., self-entrancement arousal) (McCarthy & McCarthy, 2012). The strategy to rekindle desire is an anti-avoidance approach with the focus on touch as a prime bridge to build sexual desire.

Prior to therapy, Keith and Lisa had fallen into the traditional gender power struggle where Keith emphasized eroticism and intercourse frequency, whereas Lisa felt her needs for intimacy and affection were negated. Thus, the therapeutic strategy is for both people to value intimacy, pleasuring, and eroticism. In essence, couple sexuality becomes a team effort based on a positive influence process allowing Lisa and Keith to become intimate and erotic friends.

Therapy sessions begin on a weekly basis. Between sessions the couple is urged to engage in two to three psychosexual skill exercises at home during the week. Exercises are described during the session, the couple is encouraged to read about the exercise, and then discuss their preferences and feelings. The most important component is to engage in the psychosexual skill exercises to build comfort and confidence. In the therapy session, positive learnings (e.g., cognitively, behaviorally, and emotionally) are processed first and anxieties, inhibitions, or disappointments are then addressed. Similar to the majority of therapy couples, Keith and Lisa made the emotional commitment to adopt the complementary couple sexual style. In subsequent sessions, they individualized their sexual style to enhance desire and satisfaction. In addition to psychosexual skill exercises to build attraction, trust, and creating their preferred sexual scenarios, they created “his,” “hers,” and “our” bridges to sexual desire.

Like most couples, Lisa and Keith’s pleasuring and erotic preferences do not mirror one another. They developed sexual scenarios and techniques that built positive anticipation, pleasure, and sexual response. The most important learning for Lisa was valuing her sexual voice. When she felt receptive and responsive to pleasure-oriented touch she requested and guided multiple erotic stimulation. Lisa learned to be orgasmic with manual and oral stimulation before and during intercourse, and utilized multiple stimulation (e.g., simultaneous clitoral stimulation with Keith’s fingers while she used erotic fantasies). Placing value on pleasuring and erotic, non-intercourse sexuality represented the most important lesson Keith learned. Rather than rushing to intercourse, Keith became aware of the positive feelings generated by giving and receiving pleasure. Similarly, Keith became aware of the value of erotic creativity and unpredictability for himself and for them as a couple. Perhaps the most important technique for Keith was that he
enjoyed pleasuring Lisa after he achieved orgasm, rather than sex ending at his ejaculation.

The six-month follow-up sessions after termination of regular therapy were very important in maintaining sexual desire and satisfaction. Lisa wanted to ensure Keith did not regress to destructive sexual attitudes and habits. Positively, Lisa wanted Keith to embrace her responsive sexual desire, as well as the value of variable, flexible sexual expression. Lisa needed to feel like a first class sexual partner rather than Keith comparing her sexual response with his. Keith acknowledged Lisa’s desires and concerns. He found them easier to implement when there were specific psychosexual skill exercises and goals. Keith especially enjoyed sexual dates every three months when there was a prohibition on intercourse. The most valuable relapse prevention exercise involved creating “his,” “hers,” and “our” afterplay scenarios, which enhanced couple sexual satisfaction.

Fifth challenging sexual situation: Variant sexual arousal

Approximately 4% of males experience a variant arousal pattern that can subvert couple sexuality (McCarthy & McDonald, 2009a). The woman is aware something is missing, but remains unaware of the man’s secret sexual life. The combination of high secrecy, high eroticism, and high shame controls the variant arousal pattern and becomes poisonous for the man and destructive for the couple’s sexual relationship. Examples of variant arousal include fetishes, dominance–submission scenarios, and cross-dressing.

In order to address this very difficult dilemma, the man’s secret sexual life needs to be disclosed and processed in a non-shaming manner. The man and couple need to decide between three strategies: acceptance, compartmentalization, or giving up the variant arousal. This process provides another example of “sexually one size never fits all.”

“Kink-friendly” therapy advocates such as sex columnist, Dan Savage, urge acceptance of variant arousal by both the man and his partner (Savage, 2006). The man’s erotic preferences are allowed free rein, with the woman accepting her partner’s asynchronous erotic scenario. Although this approach allows for other scenarios that meet the partner and couple’s needs for intimate connection, the highest level of eroticism is met playing out the “kink” scenario.

The second strategy is compartmentalization. In this approach, the man is not shamed by the variant arousal, but accepts that it does not meet the couple’s need for sexual satisfaction. He is open to experimenting with sexual scenarios and erotic techniques that allow functional sex for both partners. Once a month or once a quarter the couple plays out the variant arousal (a form of role enactment arousal). Most of their sexual scenarios are mainstream and the man employs erotic fantasies of the variant arousal as a bridge for his desire and orgasm.

Although most challenging, the third strategy is often the best for the couple’s intimate relationship. This approach involves giving up the variant arousal as a “necessary loss” (McCarthy & Cintron, 2005). Many men and couples find that the acceptance and compartmentalization strategies simply do not work. The erotic charge of variant arousal is narrow and compulsive, which cannot be replicated in couple sex. In other words, the variant arousal cannot be integrated into the couple’s sexual style. In this case, he decides to give up the variant arousal as a necessary loss with the ultimate goal of building a new couple sexual style that integrates intimacy,
pleasuring, and eroticism. Although less intensely erotically driven, the new couple sexual style can energize their relationship. Giving up the variant arousal is the man’s responsibility. Creating a strong, resilient sexual desire, genuine and satisfying for both partners, is a joint challenge. The man cannot compare the erotic intensity of the variant arousal with this new couple sexuality; it is an “apples to oranges” comparison.

The emotional commitment to adopt the acceptance, compartmentalization, or necessary loss strategy requires the input of the partner since ultimately, in a serious/marital relationship, sexuality is an interpersonal process. The fourth option, however, is that the sexual conflict can result in a fatally flawed marriage.

Sexual situations that could indicate a fatally flawed marriage

Not all marriages can or should continue. Some marriages, for sexual and non-sexual reasons, are fatally flawed (McCarthy, Ginsberg, & Cintron, 2006). In an attempt to examine causes of fatally flawed marriages, Gottman (1995), unfortunately, found no clear empirical data regarding sexual factors. Although, it appears that issues relating to desire have the greatest negative impact (Heiman et al., 2011). Sexual factors that can result in fatally flawed marriages include: (1) not valuing couple sex, (2) the homosexual orientation of one spouse, and (3) when one spouse continues a secret sexual life. Although these represent problems that some people can resolve or accept, most decide the marriage is not viable.

Sixth challenging sexual situation: Marital sex is not valued

Alan and Judy had a celebratory wedding two years ago. Family and friends viewed them as a special couple: in love, attractive, sexual, and sharing religious and life values. The sexual challenge for a couple like Alan and Judy is to develop and integrate a couple sexual style into their marriage. Sadly, the opposite occurred. Neither Judy, family, nor friends were aware that Alan did not value intimate marital sex. For Alan, his sexual desire centered on novelty, illicitness, and conquest. Subsequent to the couple’s separation, a friend informed Judy that Alan carried out sexual liaisons throughout their courtship and engagement and invited two of these sexual partners to the wedding.

Marriage theorists and clinicians assume that both spouses value marital satisfaction and stability and that sex is a natural outcome of an intimate relationship; this, in turn, provides a solid base for healthy marital sexuality (Metz & McCarthy, 2010). However, for some couples this is not the reality. For example, marital satisfaction and marital stability constitute two very different dimensions. Neither intimacy nor marital satisfaction guarantees sexual desire or sexual satisfaction.

Alan provides an example of an individual who places value on marital stability and family, evident in his desire to immediately have children, but does not value marital sexuality. Prior to the marriage, he had de-eroticized Judy. Alan had no desire for a sexually satisfying marriage. For Alan, marriage was about family, religion, and community acceptance, not about intimacy, eroticism, or sexual satisfaction. Sadly, he had not shared his values with Judy, who in turn became confused and demoralized. She did not know whether to blame Alan, herself, sex, or their relationship.
The advice from friends, family, and religion was that with time and children the marriage would be fine. However, from the perspective of sexual desire and satisfaction, this was a fatally flawed marriage unless either Alan or Judy was able to redefine the role and meaning of their marriage and couple sexuality.

**Seventh challenging sexual situation: Sexual orientation incongruence**

Couples who have different sexual orientations, commonly a gay man and straight woman, raise very difficult, and often impossible, issues for the marriage and marital sexuality. These issues are also present for lesbian women and for bi-sexual men and women (Kort, 2008). A great deal of fluidity in female sexual orientation can exist, but male sexual orientation is usually “hard-wired” (Diamond, 2003).

Any number of facilitating factors may lead to the existence of this particular challenging sexual situation. For example, a man might marry with the hope that marriage will “cure” his sexual orientation conflict, and his spouse is typically unaware of her partner’s sexual orientation issue. For the majority of couples, this particular sexual orientation difference signifies a fatally flawed marriage. Occasionally, the gay spouse is blamed and shamed, but often the couple experiences an amicable divorce and successfully co-parent. In terms of sexual desire and satisfaction, it is very difficult to maintain a marriage devoid of genuine erotic interest.

In addition to individual therapy aimed at addressing this particular challenging situation, group therapy is also an option. One of the largest self-help groups (not adhering to the 12-step principles) focuses on gay married men. Additionally, “The Straight Spouse Network” exists as a self-help group for wives.

**Eighth challenging sexual situation: Secret sexual life**

Although the majority of people who engage in a secret sexual life are male (McCarthy & McDonald, 2009a), let us use a female secret sex life as an example.

Rebecca married Lane four years ago because she viewed him as a “mench” who would be a good spouse and a father for the child she desperately wanted. Ever since adolescence, Rebecca viewed herself as pro-sexual and prided herself in not adhering to traditional female stereotypes of valuing intimacy rather than eroticism. Rebecca joked she would rather have sex first and talk later.

At age 38 Rebecca’s biological clock drove her to marry Lane, a solid person but anxious sexual performer. Initially, Rebecca’s pro-sex approach and free use of manual and oral stimulation acted as a positive sexual impetus for Lane. However, scheduled sex for fertility was a disaster for him and couple sexuality. Lane’s anticipatory and performance anxiety combined with Rebecca’s frustration about not getting pregnant presented a “perfect storm.” Lane dealt with this through emotional avoidance and apologizing, which further alienated Rebecca. She reacted by engaging in sexual liaisons with younger men (whom she told she was on the birth control pill) in a desperate attempt to become pregnant.

This pattern continued for almost a year until an emotionally catastrophic fight ensued where Rebecca blamed Lane for the fertility problem, sex dysfunction, and finally for her extra-marital affairs. Lane was devastated, and within two weeks was psychiatrically hospitalized for depression. Lane’s family and friends demonized Rebecca, and any hope of a marital resolution was eliminated.
Summary

Sexuality, especially sexual desire and satisfaction, is multi-causal and multi-dimensional with large individual, couple, cultural, and value differences. This conceptual/clinical commentary explored this complexity by illustrating the importance of individual and couple factors in promoting or subverting couple sexuality. Healthy sexuality requires both partners to value being an intimate sexual team. The challenge is to develop a couple sexual style that balances each person’s sexual voice with being a sexual couple who integrates intimacy and eroticism.

Conceptually, clinically, and empirically, sexual desire and satisfaction deserve careful study regarding the effects on individual psychological well-being, relational satisfaction, and relational stability.

Notes on contributors

Barry McCarthy, Ph.D. is a professor of psychology at American University. He has authored over 95 professional articles, 24 book chapters, and co-authored 14 books for the lay public. In addition, he has made over 350 presentations to professional audiences both nationally and internationally. His areas of special interest are establishing and maintaining sexual desire, the psychobiosocial model of assessing and treating sexual difficulties, and relapse prevention programs.

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References
