Addressing Sexual Dysfunction in Therapy With Cognitive Behavioral Therapy and Sexual Script Theory

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Abstract

This capstone aimed to explore and critically analyze if cognitive behavioral therapy (CBT) and sexual script theory (SST) can be combined as a therapeutic approach to treating sexual dysfunction. An exploration of both modalities and critical analysis highlighting the strengths and weaknesses of both CBT and SST is conducted in this literature review. The literature review highlights that combining the modalities is likely to be beneficial for both the therapist and the client as the combined modalities counteract the limitations of each independent theory. Together, both CBT and SST complement each other with their strengths, which can support the therapist and client(s) to address both surface and underlying contributions to sexual dysfunction. The combined modality aligns with the College of Alberta Psychologists' (2022) *Standards of Practice* and the Canadian Psychological Association's (2017) *Code of Ethics for Psychologists*.

Keywords: cognitive behavioral therapy, sexual script theory, sensate focus, sexual dysfunction, sex therapy, treatment

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It is important for counsellors to be competent in sexual health issues and addressing sexual health concerns since sexuality is part of general mental health (Weir, 2019). In fact, within the *Diagnostic and Statistical Manual of Mental Health Disorders*, (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022) the assessment and diagnosis of mental disorders include the exploration of sexual health symptoms (Montejo, 2019). Symptom exploration may include impaired desire, arousal, or sexual satisfaction that should be addressed in counselling treatment (Montejo, 2019). While not all counsellors need specialization in sex therapy, being able to give clients some guidance is beneficial to the client (Weir, 2019). In the *DSM-5-TR* (APA, 2022) there are nine diagnostic classifications regarding clinically significant sexual dysfunctions. The following are the sexual dysfunctions that may be presented in the counselling room: delayed ejaculation (F52.32), erectile disorder (F52.21), female orgasmic disorder (F52.31), female sexual interest/arousal disorder (F52.22), genito-pelvic pain/ penetration disorder (F52.6), male hypoactive sexual desire disorder (F52.0), premature (early) ejaculation (F52.4), other specified sexual dysfunction (F52.8), and unspecified sexual dysfunction (F52.9; APA, 2022). As these sexual issues are presented in the counselling room, it is important for counsellors to understand each sexual dysfunction and address these issues in clients.

While there are multiple counselling modalities that can address sexual dysfunction, it is in the interest of this author to present cognitive behavioral therapy (CBT) with sexual script theory (SST) as a new counselling modality to consider. The research question this paper aims to address and critically assess is whether CBT and SST can be combined to provide a

comprehensive treatment for sexual dysfunction. This literature review will critically analyze CBT and SST to understand if combining these theories will give a comprehensive conceptualization of sexual dysfunction and how to treat it. See Appendix for a summary of the analyzed papers. The intersectionality of the literature review will highlight the importance to counsellors and the counselling field. Implications for counselling, next steps for research, and recommendations for practice will be reviewed.

Positionality Statement

I come into this paper as a white, heterosexual, young, attractive, higher educated, middle-class woman. As I enter this Master of Counselling Capstone Research, my research areas of interest have primarily been in child development and a newer interest in sexual development. To date, the majority of my education has been in human development, attachment theory, the psychology of learning, and cognition with the intent of working with children and families in counselling practice. I have taken two courses in human sexuality and have a particular interest in SST as it conceptualizes sexual development in the context of social learning. With my educational and research background in mind, I take a natural developmental lens to this research. While it appears unnatural for a child-focused counsellor to have an interest in sex therapy, I feel there is a natural fit with human development and the belief that a healthy home includes healthy parents in their relationship.

I come into this project with the understanding that sexuality is a personal and vulnerable experience, that naturally has some discomfort as it is deemed a private experience between partners. Thus, when clients come in to seek support for sexual health issues, the individual is vulnerable and places trust in the practitioner to support them. As part of addressing sexual dysfunction in a culturally competent manner, counsellors must respect the rights and dignity of

all persons by taking into consideration the diverse lived experiences, values, religion, language, politics, and influences among individuals (College of Alberta Psychologists [CAP], 2022). Moreover, the ethical considerations of this literature review are based on the responsibility to society to increase knowledge and promote the welfare of all human beings (Canadian Psychological Association [CPA], 2017). As psychology is a science and a profession, this research aims to contribute constructively to ongoing sex therapy development, giving a clear and appropriate interpretation of the literature to avoid misinterpretation or misuse of this research (CPA, 2017).

At this point, I have completed three academic papers on sexual script theory in relation to media's sexual scripts. However, the literature review for this capstone I find is a challenge as it goes beyond understanding how media influences sexual scripts and instead addresses the issues that prevent healthy sexual relations. I posit that CBT will be a valuable model of therapy to identify, challenge, and replace internalized sexual scripts that prevent healthy and mutually pleasurable intercourse. As SST has a cognitive component within scripts, I believe CBT will be valuable as an intervention for addressing sexual scripts correlated to sexual dysfunction. As I have more research experience in SST, I may have a bias toward this theory and I will monitor and engage in critical analysis of the literature and research in an effort to manage my bias. I will aim to include all relevant literature related to my topic and frequently reread the selected articles to continuously add any relevant information. The following section will contain my analysis of the literature.

The Literature Review

The following literature review will be organized as follows: exploration and critical analyses of CBT and SST, an evaluation of the similarities and commonalities of the theories,

and an outline of the combined modality. The purpose of this literature review is to explore the tenants of CBT and SST to critically analyze if these therapeutic modalities can be combined to form a comprehensive treatment of sexual dysfunctions. The rationale of importance for counsellors will be explored throughout the literature review.

CBT

This section will cover an overview of CBT including a discussion of CBT for sexual dysfunction and a review of evidence and gaps in research. First, the overview of CBT will be discussed from its origins as a therapy model to treat depression (Beck & Fleming, 2021). However, CBT has since been adapted to treat many psychological disorders (Beck & Fleming, 2021) including being a top choice for the treatment of sexual dysfunctions (Weir, 2019). According to an article by Weir (2019) on the American Psychological Association website, CBT, emotion-based therapy, and mindfulness are the typical choices among clinicians for treating sexual problems. When searching for a CBT treatment of sexual dysfunctions, the sole source found for guidelines of CBT treatment was founded by Metz et al. (2018). After reading the CBT treatment of sexual dysfunctions by Metz et al., it is my opinion that the treatment guidelines proposed by the authors are thorough, evidence-based, and well-adapted for the treatment of the *DSM-5-TR* sexual dysfunctions. Thus, this treatment modality is deemed a preferred modality for the treatment of sexual dysfunctions for all diverse populations.

An Overview

CBT was developed in the 1960s by Aaron T. Beck (1921–2021). Beck developed a comprehensive theory of psychopathology that can be tested for effectiveness in alleviating maladaptive thinking and behavioral patterns (Beck & Fleming, 2021). CBT is widely used

today as it is a therapy that has strong empirical support for treating psychological disorders (Beck & Fleming, 2021).

In his journey of theory development, Beck began working at the Philadelphia Psychoanalytic Institute researching evidence and support for psychoanalysis (Beck, 2019). When the research for psychoanalysis revealed alternative directions in understanding the mechanisms that support depression, Beck began to focus on automatic thoughts, schemas, and belief systems (Beck, 2019). *Automatic thoughts* are sudden thoughts that emerge in response to stimuli (Beck, 2019). *Schemas* are a structure or theme of information that when triggered, produces an automatic thought (Beck, 2019). And belief systems are sets of beliefs or principles used to interpret experiences; later called *core beliefs* (Beck, 2019). In CBT, the interpretation of an event influences an individual's emotional, behavioral, and psychological reactions more than the event itself (Beck, 2019; Beck & Fleming, 2021). Moreover, a stressful event that matches an individual's vulnerabilities or negative core beliefs and schemas explains why some are more vulnerable to experiencing distress to the same stimuli than others (Dozois & Hayden, 2022). *Cognitive distortions* then became the understanding of misinterpreting events that lead to distress (Beck, 2019). When patients correct these cognitive distortions, patients begin to feel better and engage in healthier processing and behaviors (Beck, 2019; Beck & Fleming, 2021). Thus, CBT aims to target dysfunctional beliefs and behaviors contributing to the problem (Beck & Fleming, 2021). CBT has been important to the counselling profession as it has empirical support and effectiveness for alleviating human suffering (Beck, 2019; Beck & Fleming, 2021). In the realm of addressing sexual issues, CBT feels like a natural fit to address the thoughts, emotions, and behaviors that are preventing healthy sexual functioning.

CBT for Sexual Dysfunction

Metz et al. (2018) published *Cognitive-Behavioral Therapy for Sexual Dysfunction,* giving comprehensive treatment guidelines for the use of CBT in treating sexual dysfunction. CBT treatment for sexual dysfunction focuses on addressing cognitions, emotional states that interfere with sexual functioning, and building intimacy-enhancing behaviors (Metz et al., 2018). The overall goal of treatment is to enhance sexual satisfaction, which requires partner cooperation and intimacy in the relationship (Metz et al., 2018). Healthy sexuality for individuals regardless of sexual orientation requires the following: having positive value for the body and sex; the realistic expectation for oneself and partner; responsibility for one's desire, arousal, and orgasm; and flexible attitudes and openness to sexual experience (Metz et al., 2018). The authors understanding holds that clients commonly have unrealistic beliefs and assumptions about sex, themselves, and their partner that contribute to sexual dysfunction and/or poor sexual satisfaction (Metz et al., 2018). It also recognizes the multiple factors of both individual and interpersonal factors to sexual functioning (Metz et al., 2018). Early life experiences and cognitive schemas act as a template in which an individual interprets sexual experiences (Metz et al., 2018). Negative schemas may be directed toward the self, one's partner, or the relationship (Metz et al., 2018).

CBT's focus on relieving distress targets the cognitive, emotional, and behavioral components of dysfunction (Metz et al., 2018). The following paragraphs will explore the cognitive, emotional, and behavioral interventions that counsellors may use in addressing sexual dysfunction. Cognitive interventions used by counsellors are normalizing or reframing interpretations of sexual experiences, validating sexual self-interest and self-concept, taking responsibility for one's pleasure, thought-stopping techniques, challenging unrealistic sexual standards, and psychoeducation (Metz et al., 2018). Cognitive restructuring is used to identify

negative cognitions and validate their role in sexual distress, evaluate evidence for and against the thoughts, test thoughts by inviting partner feedback, replace negative thoughts with more empowering thoughts, and offer psychoeducation (Metz et al., 2018).

Emotional interventions used by counsellors are relaxation training, mindfulness, and distress tolerance (Metz et al., 2018). The CBT therapist helps individuals build comfortability in talking about sex and sexual feelings and introduces relaxation tools like deep breathing exercises, pelvic muscle management, and progressive muscle relaxation to promote comfortability and relaxation as it is viewed as foundational for pleasure and arousal (Metz et al., 2018). Deep breathing exercises promote relaxation and can be done during couple spooning, and breath matching to additionally promote comfort and cooperation within the relationship (Metz et al., 2018). Pelvic muscle management is used to identify and learn control of the pelvic muscle to raise awareness of the sensations of the pelvic muscle (Metz et al., 2018). This can best be done in men by cutting off urination and in women by squeezing the legs together (Metz et al., 2018). Progressive muscle relaxation involves tightening body muscles, holding and feeling the tension, releasing the tension, and enjoying the sensation of relaxation (Metz et al., 2018).

Behavioral interventions used by the CBT counsellor include relationship-enhancing communication training, intimacy skills training, and sensate focus to enhance intimacy and sexual functioning (Metz et al., 2018). *Sensate focusing* is a psychosexual skill exercise (Metz et al., 2018). The technique begins with a focus on non-genital touching and the client(s) is to focus on the sensation of touch and relaxation rather than cognitive distractions (Metz et al., 2018). The client(s) is to take turns in giving and receiving touch, where the giver focuses on touching in ways they find enjoyable rather than what they think the partner likes, and the receiver focuses

on the sensation (Metz et al., 2018). The therapist's role is to highlight the sexual exchange, with a focus on pleasure rather than on intercourse performance (Metz et al., 2018). Subsequent sessions can increase the touch privilege (Metz et al., 2018). The CBT therapist can utilize the sensate focusing exercise as a format for intervening in cognitive, emotional, behavioral, and relationship contributions to sexual dysfunction (Metz et al., 2018).

A final aspect for consideration in Metz et al.'s (2018) CBT treatment for sexual dysfunction is the distinction between dimensions of touch that can be part of the behavioral activation for the CBT therapist. The authors discuss the differences between affectionate, sensual, playful, and erotic touch that enhance pleasure and sexual functioning (Metz et al., 2018). Affectionate touch is a nonsexual touch that indicates closeness, comfort, and warmth through embraces, holding hands, kissing, and hugging (Metz et al., 2018). Sensual touch is non-genital holding, stroking, cuddling, and massage that involves responsiveness to pleasure (Metz et al., 2018). Playful touch includes both non-genital and genital touch in body massage, dancing, showering or bathing, and sexual playfulness (Metz et al., 2018). Erotic touching then involves manual or oral stimulation of the genitals that may proceed to orgasm and/or sexual intercourse (Metz et al., 2018).

To summarize, this CBT modality presented by Metz et al. (2018) includes evidence-based practices like sensate focus, CBT interventions, emotional interventions, and mindfulness that Weir (2019) discusses are at the front of modalities for addressing sexual problems in counselling practice. The CBT treatment stays true to CBT interventions by addressing cognitive, emotional, and behavioral factors contributing to the distress, while also pulling in interventions to complement and enhance client functioning. The versatility and adaptability of

this modality give the CBT therapist flexibility in addressing client issues that put client-centered care at the forefront.

Critical Analysis

There is limited empirical data to support the effectiveness of CBT for treating sexual dysfunction primarily due to the expense and challenge of conducting controlled clinical trials (Metz et al., 2018). Early sex therapy publications with high success rates may have led practitioners to use treatments without empirical validation (Metz et al., 2018).

From the limited literature available, CBT in combination with medical intervention has been found to be more effective in treating sexual dysfunction than medication alone (Khan et al., 2019; Weinberger et al., 2019 in males for erectile dysfunction (Khan et al., 2019) and in an overall finding in a meta-analysis for all female sexual dysfunction disorders (Weinberger et al., 2019. Mestre-Bach and colleagues (2022), in their research literature review, found suitable support for CBT in treating female sexual dysfunction in all *DSM-5* categories of female sexual dysfunction. Unfortunately, the study from Kane and colleagues (2019) did not test the effectiveness of CBT alone to understand if CBT alone improves sexual dysfunction compared to in combination with medication. Future studies should test CBT effectiveness both compared to medication and with medication to determine and understand if and how the combination is more supportive in treatment.

In terms of alternative therapy compared to CBT, Brotto and colleagues (2020) looked at reducing female genital pain with mindfulness therapy or CBT and found that both treatments reduce self-reported pain, sexual dysfunction, and pain catastrophizing. However, those with lifelong symptoms and longer relationships independently improved more with CBT treatments, but those with more recent pain and newer relationships independently responded better to

mindfulness (Brotto et al., 2020). This is important for counsellors to know in deciding on treatment considerations to support the clients with their sexual dysfunctions.

A main drawback of CBT is its limitation in not being adaptable to diverse cultures (Beck & Fleming, 2021). While Metz et al.'s (2018) CBT treatment mentions the role of early life experiences, there is little information or conceptualization about how to address this influence or how it presents in current functioning. In my opinion, the CBT treatment lacks a conceptualization of how language, culture, values, religion, and lived experiences play into the presenting issues of sexual dysfunction. As CAP (2022) and CPA (2017) recognize the importance of culture and lived experience in counselling, this gap in CBT's conceptualization of sexual issues is an important consideration for counsellors.

Despite the limitations of CBT not having sufficient empirical support for treating sexual dysfunction, CBT remains a frontline treatment to support sexual dysfunction in counselling (Weir, 2019). The modality presented by Metz et al. (2018) has a strong foundation and can be adapted and used in combination with medication (Khan et al., 2019; Weinberger et al., 2019, mindfulness (Brotto et al., 2020; Metz et al., 2018), and emotion-focused techniques (Weir, 2019) to adapt to the client.

SST

This section will cover an overview of SST and a critical analysis of the modality. While the CBT modality by Metz et al. (2018) acknowledges the role that early life experiences contribute to sexuality, it lacks a strong conceptualization of these factors. In contrast, SST provides a strong conceptualization of sexuality development in the context of one's lived experiences within their culture and social locations (Wiederman, 2015). Furthermore, SST takes into account how intersectionality of religion, socioeconomic status, ethnicity, social position,

culture, education, social groups, government, laws, and family influences sexuality and sexual dysfunction (Gagnon & Simon, 1987; Simon & Gagnon, 1973). For the culturally competent and ethical therapist, this theoretical understanding provides a template for the therapist to explore the role of culture and experience of the client that respects their rights and dignity (CPA, 2017). It is the responsibility of the ethical therapist to consider the intersectionality of the client that gives meaning to their life (CPA, 2017). SST gives the CBT therapist a foundation for exploring the intersectionality that contributes to sexual dysfunction.

An Overview

SST was developed by William Simon (1930–2000) and John H. Gagnon (1931–2016) in 1973 and fully explained in their book entitled *Sexual Conduct. Sexual Conduct* has since had a second edition published by both authors in 2005, and a second edition reprint in 2017. SST is still used in research today to explore why unwanted intercourse happens (Benoit & Ronis, 2022; Ford, 2021; Quinn-Nilas & Kennett, 2018; Schuster et al., 2020), to understand sexual consent practices (Newstrom et al., 2021; Williamson et al., 2023), and to understand sexual scripts presented in media (Aubrey et al., 2020; Dajches & Aubrey, 2020; Gamble, 2019; Jozkowski et al., 2019; Maes & Vandenbosch, 2022; Masterson & Messina, 2023; Willis et al., 2020). Since the first publication of *Sexual Conduct*, Simon and Gagnon have continued to publish interpretations and continuation of SST both jointly (Gagnon & Simon, 1973, 1987, 2005; Simon & Gagnon, 2002, 2003) and separately (Gagnon, 1973; Gagnon et al., 1982; Simon, 1973).

Simon and Gagnon worked together at the Kinsey Institute for Sex Research. The Kinsey Institute provides scientific research and knowledge on issues of sexuality (accessible at https://kinseyinstitute.org/). Both researchers rejected the idea that sexuality is reduced to simple biology or natural drive (Simon, 2017). Rather, Simon and Gagnon position that sexuality is

learned (Frith & Kitzinger, 2001; Gagnon & Simon 1973, 2002; Simon, 2017). Sexual acts of kissing, manual and oral stimulation of the body, followed by intercourse appear as normalized fantasies and experiences in Western culture (Simon & Gagnon, 1987). However, while this sequence of events appears normal for those well-versed in sexual encounters, for those less knowledgeable, acquiring information on navigating the experience is more complex than biological drive or instinct (Simon & Gagnon, 1973). An instruction manual is not given to provide information like who these activities can be done with, under what circumstances, how to begin, in what order, and how one should feel during or about the activity (Simon & Gagnon, 1987). From the conceptualization of the authors, information about sexual conduct is learned through one's experiences in their culture (Simon & Gagnon, 1973).

Within the social learning context, an individual receives messaging, or scripts, on behavior that is appropriate or not and desirable or not (Simon, 2017). According to SST, the blueprint or instructional messaging, called *cultural scripts,* is received from one's experiences in their culture (Simon & Gagnon, 2002). While CBT describes these clusters of information as schemas, SST dives deeper and is more specific in its identification of scripts. In SST, the cultural scripts are influenced by several layers including government, laws defining legal and illegal sexual behaviors, education systems, media consumption, religious affiliations, family, and peers (Wiederman, 2015). Cultural scripts are the messages that inform individuals about sexual behaviors that are antisocial (illegal, harmful, stigmatized, cautioned) or prosocial (instructed, encouraged, and sought after; Wiederman, 2015). Children in typical Western societies learn attitudes and competencies like gender role conduct, body anatomy, morals, values, and lifestyle commitments (like finding a partner, getting married, and having children), which contribute to sexual development and sexual scripts (Gagnon et al., 1982). Already from

these attitudes and competencies, a variety of scripts are present that explain what sex is, who is appropriate to have sex with, when and where sexual activity occurs, and why sexual activity happens (Gagnon et al., 1982). While cultural scripts account for the social learning component of sexual motivation and behavior, these scripts are "too abstract to be applied in all circumstances" (Simon & Gagnon, 2002, p. 8).

Interpersonal scripts generally adhere to the template that cultural scripts present for engaging in sexual behavior (Gagnon & Simon, 1973, 1987, 2005). However, each individual creates interpersonal scripts based on their engagement and exposure to cultural scripts and also adapts to the situational factors at play in the experience (Wiederman, 2015). Even for those with experience, the appropriateness of behaviors and expectations change between partners (Simon & Gagnon, 1987). Interpersonal scripts are essentially the plan for directing sexual behavior and anticipating the response of the other to facilitate sexual exchange (Gagnon et al., 1982; Simon & Gagnon, 2002). Similar to CBT, Beck (1979) described this type of planning as rules that individuals follow that can potentially lead to distress. As sexual relations occur between two or more persons, having similar interpersonal sexual scripts allows for relative ease and comfort in the experience (Simon, 2017; Wiederman, 2015). Having differing interpersonal sexual scripts leads to awkward or potentially dangerous results (Wiederman, 2015). When looking at human sexual motivation and behavior, it is challenging as there appear to be common sexual behaviors, yet there are variable differences in sexuality and desires (Simon & Gagnon, 1973). Further exploration of how the counsellor may assess these scripts will come in later sections of this capstone.

Intrapsychic scripts utilize the messaging and memory of cultural scripts to fantasize about sexual encounters (Wiederman, 2015). The meaning attributed to the act and the sexual

object, or other person, becomes a critical component of eliciting and sustaining sexual arousal and performance (Simon, 1973; Simon & Gagnon, 2002). Derived from the experiences within the culture, symbolic social meanings give the context of the sexual experience, including what acts are performed, with whom the encounter occurs (stranger, lover, prostitute, etc.), where the encounter takes place (public space, at home, at a hotel, etc.), how sexual acts are done (slow, gentle, rough, forceful, etc.), and why the sexual act was done (for fun, love, joy, to gain power, to manipulate, etc.; Gagnon & Simon, 1973). Cues for sexual initiation and sexual arousal, or the recognition of sexual possibility come from the social and cultural environment (Simon, 1973; Simon & Gagnon, 2002). If a sexual experience occurs, the perception of the experience also comes from the cultural symbolic meanings where there is an emotional response and attributed meaning tied to the sexual experience (Gagnon et al., 1982; Simon, 1973). Consider the language and labels attributed to the sexual act and the associations made from the labels: making love, screwing, or other connotations or slang terminology both positive and negative for the act of sexual intercourse (Simon, 1973). Depending on the cultural script messaging and exposure to multiple sources of cultural scripts, these messages influence intrapsychic fantasies and internal rehearsals that contribute to desire and the sustainability of arousal (Gagnon & Simon, 1973).

Essentially, intrapsychic scripts are the internal planning, desire-generating, and skill development component of sexual motivation and behavior (Simon, 2017; Wiederman, 2015). For a mutually pleasurable sexual encounter to occur, a transformation of viewing the sexual object as a participating other requires the recognition of the other as a reflection of oneself (Simon & Gagnon, 2002). Meaning, the individual recognizes the behavior and feelings communicated by the behavior (e.g., pain, pleasure, discomfort, enjoyment) to understand not only one's own intrapsychic experience but also the intrapsychic experience of another (Simon,

1973; Simon & Gagnon, 2002). In other words, there is a conflicting concern for one's own orgasm and the orgasm of the other (Simon, 1973). Understanding the factors that contribute to maintaining desire and arousal is an important component for the therapist in addressing sexual problems.

In my opinion, understanding the client's cultural, historical, and potential religious influences on their perception of sexual relations and sexual being is essential to consider in overall sexual functioning. For instance, consider the diversity in sexual perceptions for those whose religious affiliations require no premarital intercourse compared to those with early sexual experiences. Another example may be those raised as nonbinary compared to those socialized as their assigned sex at birth. Utilizing SST as a theoretical understanding of how these influences shape the way the individual perceives sexual experiences will give the CBT therapist direction in exploring the influence of these factors on the thoughts, emotions, and behaviors that play out in sexual experiences in the opinion of this author. Thus, the CBT therapist can support the client in identifying, challenging, and replacing or modifying the thoughts, emotions, and behaviors that contribute to their sexual dysfunction (Metz et al., 2018).

In my opinion, SST is a conceptualization of the whole individual that is present in the therapy room. Regardless of sexual orientation, culture, ethnicity, gender role, socioeconomic status, religion, or other intersectionality, SST addresses sexual dysfunction at the individual level by rescripting the cognitions, emotions, and behaviors that interfere with healthy sexuality (Gagnon et al., 1982). In therapy, the therapist supports the client by exploring the concepts of rescripting initiation, foreplay, genital stimulation, and after-play, while also addressing the cognitions and performance scripts that lead to incongruence, performance anxiety, and

ineptitude (Gagnon et al., 1982). These interventions can be adapted to an individual's diverse historical and present functioning that contribute to sexual dysfunction.

Simon and Gagnon do comment on sexuality that differs from the heteronormative scripts in terms of the consequences that labels have (Gagnon et al., 1982; Simon & Gagnon, 2002). While Simon and Gagnon view sexual identity as separate from an individual's everyday identity, labels we apply to individuals consequently lead to judgements whereby we then consider the individual as anything but a sexual being (Gagnon et al., 1982; Simon, 1973). For example, consider the labels homosexual, prostitute, stripper, and virgin that can conjure up an erotic judgement (Gagnon et al., 1982; Simon, 1973). The labels we apply lead to judgements of behaviors or individuals that make it difficult for the individual with the label to separate their everyday self from their sexual self (Gagnon et al., 1982; Simon & Gagnon, 2002). Labels can often also reveal the changing morals and values of society as we see how the connotation of the labels has changed over time (Gagnon et al., 1982). For example, the once cherished virgin may now be viewed as sexually incompetent in Western society (Gagnon et al., 1982; Simon, 1973). Counsellors and therapists should be aware of the labels attributed to their client(s) and the meaning society and the client attributes to them as these may contribute to the sexual dysfunction.

In summary, both CBT and SST recognize the cognitive clusters of information that relate to the self, one's partner, and the experience of sexual relations that contribute to sexual dysfunction. SST dives deeper and is more specific in its conceptualization of sexual scripts that form the cognitive structuring around the sexual experience. Thus, the inclusion of SST allows the CBT therapist to further explore the lived experiences, thoughts, feelings, and beliefs of the client(s) that contribute to the sexual dysfunction. For the CBT therapist, the inclusion of SST

would primarily be in the assessment period where the therapist is exploring historical and current sexual functioning, thoughts, feelings, and behaviors that contribute to the sexual dysfunction.

Critical Analysis

The main strength of SST is the metaphoric ability to conceptualize and deepen the cognitive sexual schemas and scripts individuals hold and the cultural components that influence them (Wiederman, 2015). However, SST is criticized due to its lack of being a conventional theory that provides an explanatory relationship between variables and a testable hypothesis (Wiederman, 2015). This is problematic to the couselling field as the mechanisms that promote change are undetermined, there is not a comprehensive counselling format for counsellors to follow, and the effectiveness is not easily testable. Thus, there is a lack of empirical support for the existence of sexual scripts or the interplay of the script levels to influence behavior (Wiederman, 2015). Moreover, most research using sexual scripts has occurred in Western societies, so it is unclear if there would be support for sexual scripts in non-Western cultures (Wiederman, 2015). This review and critique of SST by Wiederman (2015) is now roughly 8 years old, and there has been further research that may give more empirical support to SST. For instance, a more recent publication by Sartin-Tarm et al. (2021) found support for cultural and social influence on sexual development. The study looked at sources of cultural information and their influence on sexual self-schema, or the cognitive representation of oneself as a sexual person (Sartin-Tarm et al., 2021). The study suggested that varied sources of sexual information produce diverse sexual self-schemas which supports Simon and Gagnon's conceptualization that sexuality and sexual identity are learned (Sartin-Tarm et al., 2021; Simon & Gagnon, 1973).

Moreover, there is a need to review current research to determine if there is more empirical support for SST (Wiederman, 2015).

Despite these limitations, SST complements the limitation of CBT to include the intersectionality of culture and its influence on sexual issues. Moreover, being based on CBT complements SST as CBT is empirically supported which is the main limitation of SST. The two modalities complement each other and allow the counsellor to engage with the client fully to explore further contributions to their presenting sexual issues. More directions on conducting treatment will be presented in the following sections.

Commonalities in the Theories

Both SST and CBT have some notable similarities. The first commonality is that both CBT and SST recognize the importance of early life experiences in how one interprets sexual experiences (Gagnon et al., 1982; Metz et al., 2018). While CBT describes this idea as cognitive schemas that act as a cluster of information to interpret present scenarios (Metz et al., 2018), SST views the way that early experience influences present interpretation as scripts or the blueprint of present experience (Simon & Gagnon, 1987). The second commonality is that both CBT and SST recognize the template that individuals follow in social contexts (Beck, 1979; Simon & Gagnon, 1987). Beck (1979) described this idea of the template as strict rules that individuals follow that lead to distress and unsuccessful experiences, and Simon and Gagnon (1987) refer to this idea as interpersonal scripts or the blueprint one uses to make sense of the experience. While there are many differences between these theories, these commonalities can serve to connect the theories and give a comprehensive understanding of an individual's sexual dysfunction to create a thorough treatment plan that addresses surface and underlying issues. Humans are not consciously aware of the layered scripted components of sexual behavior, thus when it comes to

sexual dysfunction, attention is paid to the dysfunction itself, failing to consider the influence of larger scripts (Gagnon et al., 1982). Thus, a comprehensive personal history and identifying lived experiences associated with the presenting concerns are important aspects of treatment that a counsellor can gather during intake, assessment, and continued counselling sessions (Metz et al., 2018).

Putting Them Together

This section will provide an overview of how SST and CBT can be combined to have a comprehensive conceptualization of sexual dysfunction and treatment direction. Building rapport, assessing sexual dysfunction, and treatment considerations will be covered.

Building Rapport

As there is a threat to self-esteem when it comes to discussing sexual functioning, it is important to establish rapport with both partners, building comfortability by exploring the couple's history and strengths (Metz et al., 2018). Discussing sexual identities and experiences is a vulnerable experience as sexual competence is also a demonstration of social, gender, and moral competence, placing high pressure and demands on the sexual actor (Simon & Gagnon, 2002). The therapist builds rapport through their own comfortability in addressing and discussing sexual feelings and behaviors (Metz et al., 2018). Clients will follow the clinician's emotional lead as the clinician models comfort in addressing sexual concerns while respecting the values and comfortability of the clients (Metz et al., 2018). The clinician is to provide leadership and collaboration to enhance client "buy-in" by emphasizing that the key goal of therapy is making the sexual relationship more enjoyable for both partners (Metz et al., 2018).

It is important for the therapist to obtain thorough informed consent that includes what aspects of the client's sexuality will be inquired about, the nature and purpose of sex therapy,

confidentiality and the limits of confidentiality, and the risks and benefits of treatment (CPA, 2017). When discussing the nature and purpose of sex therapy, it is important to inform the client and gain consent to inquire about past and present sexual functioning, historical sexual identity development, social learnings, patterns of masturbation, and current relationship patterns if applicable (Mets et al., 2018). The following sections will give a brief overview of how treatment may be conducted based on Metz et al.'s (2018) modality and SST. Clinicians may wish to seek further information and training such as training through the American Association of Sexuality Educators, Counsellors, and Therapists (AASECT; accessible at https://www.aasect.org/).

Assessment

A comprehensive assessment of historical and current sexual functioning is important for conceptualizing sexual dysfunction (Metz et al., 2018). As part of the assessment of sexual functioning, both SST and CBT emphasize cognitive, interpersonal, and arousal factors that contribute to sexual functioning that should be assessed (Gagnon et al., 1982; Metz et al., 2018). This section will highlight the cognitive, interpersonal, and arousal factors in terms of assessment of historical and present sexual functioning.

As part of historical functioning, it is important to assess the history of sexual development that has been influenced by each individual's experiences within their culture (Gagnon et al., 1982), any history of sexual abuse or infidelity (Metz et al., 2018), and any adverse childhood experiences or psychopathology that may influence sexual functioning (Metz et al., 2018). A thorough history taking will give the clinician more information regarding the multifactorial contributions to sexual dysfunction, as sexual dysfunction is a complex and multidimensional issue, likely to have multiple causes (Metz et al., 2018). When assessing sexual

scripts, the counsellor seeks the client's perception about the learning of sexual conduct and gender role, and initiation of sexual conduct/masturbation practices, current satisfaction, and ideal sexual experience (see more at https://www.thecenterforgrowth.com/tips/how-to-assess-your-sexual-scripts). Additionally, the meaning each of these components has for the individual can be assessed to identify their perception and level of importance for pleasure (Center for Growth, 2017). The counsellor can assess and identify the thoughts, emotions, and behavior through interviewing and inquiring both the couple and each individual if applicable.

As part of assessing current sexual functioning within couples counselling, it is important to obtain a detailed analysis of a couple's sexual interaction (Gagnon et al., 1982; Metz et al., 2018). This analysis includes the cognitive, emotional, and behavioral components of each partner's interpretation of events that lead to the understanding of the scripts present (Gagnon et al., 1982; Metz et al., 2018). When desires turn into cognitive interpersonal scripts, there can be confrontations and discrepancies between partners (Gagnon et al., 1982; Simon & Gagnon, 2002). In assessing the desired outcome of sexual experiences versus what actually occurs, it is important to assess the complexity, rigidity, conventionality, and satisfaction of experience and desire (Gagnon et al., 1982). Complexity refers to the 5W's (who, what, when, where, and why) of sexual encounters and the ideas that each individual has about sexual encounters (Gagnon et al., 1982). It is important to understand the meaning each individual attributes to the 5W's to elicit if there are distressing scripts or schemas that are contributing to the presenting issues (Gagnon et al., 1982; Metz et al., 2018). Rigidity refers to the routine versus flexibility of the sexual encounters, where having more flexibility and openness to sexual encounters will enhance intimacy compared to a rigid experience (Gagnon et al., 1982; Metz et al., 2018). And finally, conventionality refers to if the sexual encounters are socially acceptable, socially disapproved, or

criminal, and if there is satisfaction in sexual encounters for both partners (Gagnon et al., 1982). Assessing conventionality is where the counsellor may encounter ethical dilemmas and will need to engage in ethical decision-making while abiding by laws within their geographic region (CPA, 2017).

In part of assessing arousal, the clinician assesses what actually occurs versus what is desired or ideal in terms of the above-mentioned four factors (Gagnon et al., 1982). In this assessment, the clinician can elicit the cognitive, emotional, and behavioral experience each partner has in response to the other (Metz et al., 2018). From here, the therapist and client(s) identify the thoughts, emotions, and behaviors that contribute to the sexual dysfunction, and goals for treatment can emerge (Gagnon et al., 1982; Metz et al., 2018). Assessment tools may be used in part of the assessment, though discussion and critical analysis of such tools are not within the scope of this paper. However, Metz et al. (2018) recommend the interview process with both the couple and each individual if applicable.

Treatment

While treatment is tailored to the individuals, there are generalized treatment goals and interventions in SST and CBT in the treatment of sexual dysfunctions. In both CBT and SST, treatment is directed toward addressing the cognitive, emotional, and behavioral change goals that are identified in the assessment process by the client(s) and clinician (Gagnon et al., 1982; Metz et al., 2018). Treatment focuses on modifying cognitions, reducing discrepancies and emotional states, and rescripting behaviors to enhance intimacy and compatibility (Gagnon et al., 1982; Metz et al., 2018). For example, the therapist may use sensate focusing to rebuild the foundation for sexual intimacy by requiring the couple to begin with nonsexual touching and communicating their likes and dislikes during the act. This intervention will enhance the sense of

safety and trust through physical relaxation and sensory awareness, manage performance anxiety, reduce negative expectations and distractions, and build communication skills, to be built on in further sessions (Metz et al., 2018).

Based in Metz et al.'s (2018) therapy approach, treatment is done in five phases: developing comfortability and cooperation, promoting desire and arousal, enhancing desire and eroticism, enjoying eroticism and flexible sexual behavior, and couple satisfaction and relapse prevention. In phase one, developing comfortability and cooperation, the therapist and couple identify and restructure sexual cognitions, work on relaxation training, and work on positive value for body image and intercourse (Metz et al., 2018). In phase 2, promoting desire and arousal, the focus is on promoting relaxed pleasuring, valuing pleasure and touch, and partner genital exploration (Metz et al., 2018). In phase 3, enhancing arousal and eroticism, the focus is on confident arousal and erotic pleasuring (Metz et al., 2018). In phase 4, enjoying eroticism and flexible sexual behavior, the focus is on initiating intercourse and sexual arousal, enjoying flexible intercourse, sexual playfulness, and developing flexible sexual encounters (Metz et al., 2018). And finally, in phase 5, couple satisfaction and relapse prevention, the focus is on reviewing the features of satisfying sexual experiences and maintaining satisfaction (Metz et al., 2018). In my opinion, throughout all of these phases, the integration of SST with rescripting overt behaviors of sexual initiation, foreplay, stimulation, and after-play to reduce couple ineptitude and incompatibility is not out of scope in CBT treatment. Rather, there would be mindful inclusion of referring to the roles that each actor plays in sexual behavior, the cues for initiation, and their preferred methods (Gagnon et al., 1982).

Summary of Findings

To summarize, CBT remains a frontline treatment to address sexual dysfunctions. CBT treatment addresses the thoughts, emotions, and behaviors that contribute to sexual dysfunction through various techniques described in the literature review. While CBT treatment for sexual dysfunction recognizes the role that early life experiences and sexuality development have in sexual dysfunction, it lacks the conceptualization of these factors. SST has the potential to be a strong contributor to CBT's treatment of sexual dysfunctions as it has a strong conceptualization of an individual's intersectionality contributing to sexual dysfunctions. Therefore, I recommend the inclusion of SST as part of the assessment component of sex therapy to assist the clinician in the conceptualization of the influence of early life experiences, culture, and sexuality development on sexual dysfunction.

Implications for Counselling

From my analysis and understanding of the research, combining CBT and SST is a novel idea. When searching for previous work on CBT and SST, my search revealed no previous work combining the two modalities. While there may be potential work that I have not come across, it appears that this capstone initiates the exploration of how CBT and SST can fit together. This capstone is important to the counselling field as it suggests the combination of two treatment interventions, expanding the repertoire of counselling interventions available to counsellors. It is important to support counsellors and therapists with thorough treatment guidelines that support client issues and client intersectionality with regard to sexual dysfunction. Addressing and giving support to sexual dysfunction is an important aspect of a client's mental health and well-being (Weir, 2019). This literature review is supportive of the idea to combine CBT and SST to give a thorough conceptualization and treatment of sexual dysfunction. This section will review the findings of this research and its importance to counsellors and its relevance to the counselling

field. This section will first review CBT and SST independently, then review the combined approach of CBT and SST together.

CBT alone as a modality is a topline choice for treating sexual dysfunction among therapists (Weir, 2019). Research has shown CBT to be effective in supporting all female *DSM-5-TR* categories for sexual dysfunction (Weinberger et al., 2019), erectile dysfunction (Bilal & Abbasi, 2020), and premature/early ejaculation (Mohammadi et al., 2013). While there is some supportive evidence, more research and controlled clinical trials may be needed to have empirical support for CBT as a modality of treating sexual dysfunction (Metz et al., 2018). Controlled clinical trials should aim to isolate the effects of CBT treatment alone, compared to other treatment interventions like mindfulness-based therapies, emotion-based therapies, and medical interventions as its isolated effects were not assessed in each of the trials reviewed in this literature review. While CBT with medication was shown to be more effective than medication alone, the effectiveness of CBT alone was not assessed in some of the studies (Khan et al., 2019; Weinberger et al., 2019). In my opinion, the consideration of the efficacy of CBT alone is important for counsellors as a sole intervention for sexual dysfunction and for the field of counselling to push for further research and clinical trials to provide empirical support for CBT in the treatment of sexual dysfunction. Despite this limitation, CBT treatment has some efficacy for treating sexual dysfunction, and its limitations may be counteracted by the theory's flexibility and adaptability to include other evidence-based interventions.

CBT's main goal in treatment is to enhance sexual satisfaction by addressing the cognitions and emotional states that interfere with sexual functioning and build intimacy-enhancing behaviors (Metz et al., 2018). The goal is important for clients and therapists to understand as it gives direction for therapy and a focus on the outcome. The modality by Metz et

al. (2018) uses CBT interventions and pulls in other evidence-based interventions like sensate focus, mindfulness, and progressive muscle relaxation. The CBT interventions and these additional interventions support the client in identifying, challenging, and replacing cognitions, emotional states, and behaviors that interfere with sexual functioning with healthier, intimacy-enhancing alternatives. This is important for counsellors as the counsellor can adapt to client issues and bring in interventions with further training and learning as the field of counselling continues to grow.

The field of counselling acknowledges the diversity and intersectionality of clients and how intersectionality contributes to presenting issues (CAP, 2022). Client's rights and dignity are to be respected, inclusive of language, values, culture, religion, and lived experiences (CPA, 2017; CAP, 2022). It is important for counsellors to recognize and understand the role of culture and the role of culture in the expression of presenting issues. Thus, the inclusion of SST in CBT treatment of sexual dysfunction provides conceptualization and a framework for addressing the contribution of intersectionality to sexual dysfunction.

SST acknowledges that sexual experience in humans is more than biological drive or instinct (Simon & Gagnon, 1973). SST conceptualizes how messaging or scripts that an individual receives within their culture contribute to their sexual thoughts, emotions, and behaviors (Simon & Gagnon, 1973). SST views sexuality development within a social learning context where government, laws, education, media, religious affiliations, family, and peers all contribute to an individual's perception of sexual conduct (Weiderman, 2015). The varied messaging from multiple sources of information is integrated into the individual's sexual identity (Simon & Gagnon, 2002). The information informs what sex is, who is appropriate to have sex with, when and where sexual activity occurs, and why it happens (Gagnon et al., 1982). This

conceptualization is important for counsellors to understand so counsellors can intervene and support their clients in potential underlying issues contributing to sexual dysfunction. The sexual scripts can assist the therapist to identify sources of sexual information and challenge and replace the cognitions, emotional states, and behaviors that contribute to the dysfunction with healthier and appropriate alternatives.

This literature review highlights how CBT and SST thoroughly conceptualize an individual's sexual dysfunction by addressing surface and underlying contributing factors. Both SST and CBT emphasize cognitive, interpersonal, and arousal factors of sexual functioning by interviewing the client about historical and present sexual functioning (Gagnon et al., 1982; Metz et al., 2018). During a session, the counsellor or therapist assesses what actually occurs within the perception of the client(s) and what is desired or ideal (Gagnon et al., 1982). Within the assessment, the counsellor or therapist also elicits the cognitive, emotional, and behavioral experiences of the partner(s) in response to the other and modifies or reduces discrepancies and emotional states (Gagnon et al., 1982; Metz et al., 2018). The strengths and adaptability of the two combined modalities are an asset to counsellors and therapists to provide client-centered care to their clients in treating their sexual dysfunction.

CBT and SST can be used complementarily with other therapy interventions or treatment options. For instance, the inclusion of mindfulness interventions can be of benefit to the CBT therapist (Brotto et al., 2020). CBT and SST could additionally be used in combination with medication (Khan et al., 2019; Weinberger et al., 2019). The therapist may indicate the need for medical intervention to help support the therapeutic goals and ask the client to seek consultation from a medical professional (Metz et al., 2018). Although an Alberta psychologist or counsellor is unable to prescribe medication, this is an opportunity to collaborate with other professionals to

support the client. The combined CBT and SST as an intervention have the adaptability and flexibility to work in collaboration with other professionals or with other evidence-based interventions in my opinion.

The limitations of both theoretical modalities must be considered. While CBT is limited by its lack of consideration for culture and intersectionality (Beck & Fleming, 2019), adding SST gives CBT the conceptualization of culture that it needs to include. Additionally, SST has its limitations as it is not a formal testable theory, however, using SST in combination with CBT to address the sexual scripts strengthens the rationale for this theoretical collaboration. Together, the modalities provide support to counteract the other's weakness, creating a strong and effective new option for treating sexual dysfunction in clients.

In order to continue to grow in the field of counselling, counsellors and researchers must consider their contributions to the field of psychological counselling and therapy. There is a need and growing demand to consider the culture and intersectionality of client diversity when treating individuals to respect the dignity and rights of each client (CPA, 2017). Individuals present in the counselling room with diverse experiences in language, culture, history, values, politics, and lived experiences that shape their perception of their presenting issues (CAP, 2022). Adding SST to CBT's conceptualization of sexual issues and dysfunction may support the CBT therapist to conceptualize and address client intersectionality. For therapists wanting to apply the combination of CBT and SST, therapists should engage in further learning by reading Metz et al.'s (2018) *Cognitive-Behavioral Therapy for Sexual Dysfunction* and Simon and Gagnon's (1973) *Sexual Conduct.* Counsellors and therapists may also wish to seek further education, training, supervision, and certification in both CBT and SST.

Future Direction for Research

Additional research is needed in exploring SST and the theory's basic principles. SST appears to not have a current review of the literature to support or refute the theoretical basis for SST. A current literature review on the theoretical basis for SST would help establish the theory's efficacy and validity, as the most recent review is from Wiederman (2015). For example, SST does not explain why some scripts hold in cultures while others do not, cultural shifts over time, or why individuals integrate some scripts over others (Wiederman, 2015). Although I do not believe it is necessary to have all of these questions answered prior to offering CBT and SST together in individual and couples counselling, I can acknowledge the benefit of future research, and addressing these questions can address how society can influence sexual conduct. Understanding of why some scripting messages are integrated by the individual over other scripts is another research question that may be warranted to explore. Engaging in future research considering the integration of particular scripts could advance research regarding deviant sexual behavior.

Further research and investigation are needed to provide empirical support and a scientific foundation for SST. Though Simon and Gagnon state never intending for their scripting perspective to be a scientific theory (Simon & Gagnon, 2003; Wiederman, 2015), there is a benefit and need for empirical support. It is essential for counsellors and the field of counselling to maintain a standard of evidence-based treatment that benefits and supports client dysfunction. Further research will support the efficacy of the combined CBT and SST treatment approach for treating sexual dysfunction and further the field in providing evidence-based treatment. Other areas to be explored could be whether CBT and SST can be utilized in working with vulnerable populations such as youth, the elderly, and 2SLGBTQI+ identifying individuals.

Most research on sexual health issues is primarily done with heterosexual couples (Metz et al., 2018). It is important to note that there are mentions of adaptability for working with those from the 2SLGBTQI+ community from Metz et al. (2018). Metz et al. stated that characteristics of individuals like performance anxiety, sexual trauma, and depression that contribute to sexual dysfunction are similar regardless of sexual orientation. Some other considerations for same-sex couples and 2SLGBTQI+ identifying individuals may be discrimination, family and community support, and gaps in the "coming out" process in couples (Metz et al., 2018). These considerations of future research are essential to counsellors because research findings can enhance counselling interventions and may encourage collaboration in a client-centered manner.

Recommendations for Practice

Counsellors and researchers should strive to improve the counselling field by producing credible, valid, reliable research and scholarly work in sexual dysfunction treatment. Counsellors and therapists should strive to maintain professional and effective treatment approaches while considering intersectionality and the role that culture and lived experiences contribute to dysfunction. As the field of counselling and psychology is both a profession and a science, it is important for the continued development of evidence-based and empirically supported treatment approaches (CPA, 2017).

Counsellors should seek education, training, supervision, and certification for treating sexual issues, though certification is not necessary for treating sexual issues in counselling. AASECT is currently the only governing body to grant credentials for the practice of sex therapy in North America (see https://www.aasect.org/aasect-certification). While this certification is not necessary for counsellors to provide support for sexual issues in counselling practice, having foundational knowledge, training, and supervision is beneficial both for the counsellor and the

client (Weir, 2019). Education and training to support sexual health issues should be provided in master's level education in counselling and psychology programs. This will give future counsellors and therapists foundational knowledge that can be used to provide some support and guidance to clients, even if the counsellor or therapist chooses not to specialize in sex therapy (Weir, 2019). Foundational knowledge will be an asset to counsellors and therapists for potential interventions (Weir, 2019).

In summary, it is important for counsellors and the field of counselling to demonstrate competence and knowledge in the treatment of sexual dysfunction and sexual issues (CPA, 2017; Weir, 2019). Counsellors and therapists should strive to acquire and use the knowledge relevant to the well-being of clients including sexual well-being (CPA, 2017). Thus, I recommend any counsellors or therapists reading this literature review to continue to learn, train, credential, and seek supervision in supporting the sexual health and well-being of all clients in their care seeking support for sexual issues or dysfunctions.

Reflexive Self-Statement

As I researched and wrote this capstone, I went through a great deal of thinking and self-reflection. I spent time thinking about sexual health and how counsellors and therapists can be supportive of clients' sexual health. It is important that counsellors are able to give clients some direction and support for sexual health issues. However, if the therapist has limited or zero competencies in addressing sexual health issues, the therapist can make a referral, engage in ethical decision-making, and/or seek supervision (CPA, 2017).

At the beginning of the process, I did mention within the self-positioning statement that I am more familiar with SST when it comes to looking at sexual issues, so I was concerned about having a bias towards SST. I feel by executing a critically analyzed literature review on CBT and

SST, I was able to mitigate my bias. Reflecting, I was surprised by how much I enjoyed Metz et al.'s (2018) perspectives on using CBT for addressing sexual dysfunction. The authors' approach utilizes different interventions that I had learned about in courses I completed in sexuality like sensate focus. I found both modalities to be thought-provoking and sensible in their perspectives on sexual dysfunction.

Even though I came into this paper with a foundational understanding of SST, I learned more than I imagined I would about SST. I found it intriguing to learn more about patterns of masturbation, how language can reveal sexual scripting, and more about intrapsychic scripts. It was humbling to learn more about SST and learn about how CBT can be used in addressing sexual issues. I enjoyed learning further about the cognitions, emotional states, and behaviors that contribute to dysfunction and the interventions that may be used to target contributing factors.

My stance on combining CBT and SST has not changed, and in fact, is now strengthened. The two modalities fit together well and can continue to be adapted and used with other interventions to support the client. CBT and SST together counteract their limitations and together can address intersectionality with the cognitions, emotional states, and behaviors that contribute to the dysfunction. CBT and SST together are a client-centered approach that can address client presenting issues in consideration of intersectionality.

This research has impacted my counselling practice and how I view sexual issues presented in the counselling room. As a student counsellor also completing practical hours at the time of doing this research, sexual issues have presented with clients. Having participated in this research, I feel more confident in addressing sexual concerns, I feel I can better conceptualize sexual problems, and I am more confident in providing some intervention. After graduation, I

plan to take training through AASECT and certify as a sex therapist. As part of ethical practice, I aim to continue to learn, train, and seek supervision to demonstrate my competency in supporting clients with sexual issues and dysfunctions (CPA, 2017).

Conclusion

To conclude, this capstone aimed to explore and critically analyze if CBT and SST could be combined as a therapeutic approach to treating sexual dysfunction. Through the exploration of both modalities and critical analysis highlighting the strengths and weaknesses of both CBT and SST, it is deemed that combining the modalities is likely to be beneficial for both the therapist and the client. Regarding the limitations, SST is not empirically supported or a formal theory, whereas CBT is formal and has some empirical support but lacks conceptualization of the contribution of intersectionality to sexual dysfunction. With its strengths, CBT has some empirical support and is a flexible modality for therapists and SST conceptualizes intersectionality. Together, both CBT and SST complement each other with their strengths, which can support the therapist and client(s) to address both surface and underlying contributions to sexual dysfunction. Further research is needed to identify if CBT and SST independently have enough empirical support and to further understand if there is efficacy of the combined CBT and SST approach.

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Appendix

Add Title of Table (not bolded)

Authors	Year	Title	Sample Size	Selection/ Recruitment	Data Collection Process	Data Analysis Process	Qual/Quant/ Mixed/ Case	Notes on Findings
Sikandar Khan, Amira Amjad, and David Rowland	2019	Potential for Long-Term Benefit of Cognitive Behavioral Therapy as an Adjunct Treatment for Men With Erectile Dysfunction	20 men	60 men who had participated in the original study were contacted approximately 18 months following a previous study	Semi-structured clinical interview and inventories were used as data collection.	ANCOVA analysis was used to compare pre and post measures for the various treatment groups.	Mixed	CBT shows long-term benefits in men with ED treated with medication.
Lori A. Brotto, Bozena Zdaniuk, Lauren Rietchel, Rosemary Basson, and Sophie Bergeron,	2020	Moderators of Improvement From Mindfulness-Based vs Traditional Cognitive Behavioral Therapy for the Treatment of Provoked Vestibulodynia	130 women with PVD were assigned to CBT or MBCT	Participants comprised a total of 130 women who were seeking treatment for PVD at 1 of 2 tertiary care academic health centers with programs specializing in sexual medicine and vulvar pain.	Questionnaire was administered before treatment, then again at 24 weeks after the last session, and at the 6- and 12-month follow-up.	Using cross-level interactions in multilevel mixed model analysis.	Quantitative	Overall, treatment credibility, relationship length, and PVD subtype were found to moderate improvements differently in MBCT and CBT.

Authors	Year	Title	Sample Size	Selection/ Recruitment	Data Collection Process	Data Analysis Process	Qual/Quant/ Mixed/ Case	Notes on Findings
Aryn A. Benoit and Scott T. Ronis	2022	A Qualitative Examination of Withdrawing Sexual Consent, Sexual Compliance, and Young Women's Role as Sexual Gatekeepers	40 young women	Recruited from Canadian postsecondary institutions. $40 given for participation.	Semi-structured interviews with target themes and open-ended questions.	Thematic analysis was conducted. Interviews were thematically organized into broad codes (e.g., consent). Initial codes were developed by three researchers who examined the interviews independently, and then collaborated with each other.	Qualitative	(1) Women were responsible for communicating consent, (2) they were unaware it was acceptable to withdraw consent or did not know how to, (3) male partners often persisted in response to withdrawal of consent, and (4) these experiences factored into compliance.
Jessie V. Ford	2020	Unwanted Sex on Campus: The Overlooked Role of Interactional Pressures and Gendered	110 heterosexual and queer college students	Recruited from university classes and flyers on campus. $25 given for participation.	In-depth interviews.	All interviews were recorded digitally and transcribed using	Qualitative	Instances of force, threat of force, and incapacitation are present with additional pressures from

Authors	Year	Title	Sample Size	Selection/ Recruitment	Data Collection Process	Data Analysis Process	Qual/Quant/ Mixed/ Case	Notes on Findings
		Sexual Scripts				grounded theory in analysis.		gendered sexual scripts and generic interactional smoothing that emerged.
Christopher Quinn-Nilas & Deborah J. Kennett	2018	Reasons Why Undergraduate Women Comply With Unwanted, Non-coercive Sexual Advances: A Serial Indirect Effect Model Integrating Sexual Script Theory and Sexual Self-Control Perspectives	222 females	1st year university student in Ontario Canada. Course credit given for participation.	Self-report questionnaires on consenting, sexual resourcefulness, compliance with unwanted sex, and gender role measures.	Multiple regression analysis	Quantitative	Sexual resourcefulness is associated with gender role stress, which is associated with sexual compliance.