

Sexual Issues:

Men, Women and Couple Sexual Health

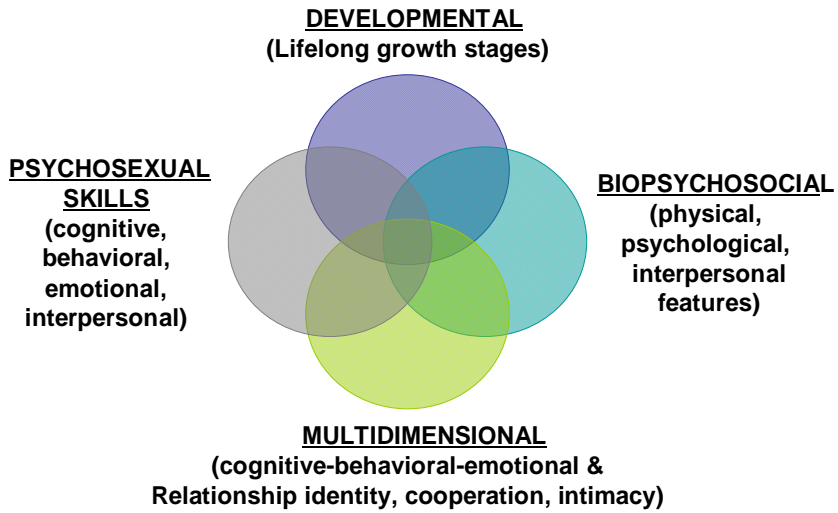
January 20, 2009 Rochester, MN

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Learning Objectives: Participants will...

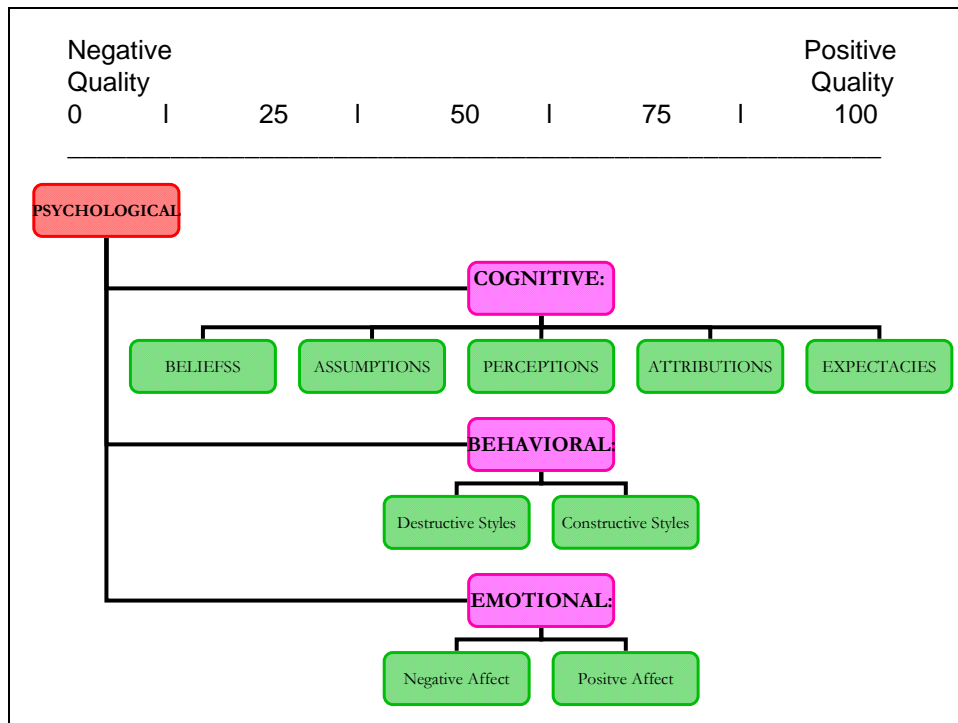
- 1) explain the integrative, multi-dimensional model of healthy sexuality;**
- 2) discuss sexuality across the life span and common sexual concerns for individuals and couples;**
- 3) describe a comprehensive biopsychosocial approach to clinical assessment (10 SD “types”);**
- 4) identify goals and interventions to treat individual and couple sexual problems (e.g., features of “Good Enough Sex”);**
- 5) list several basic, cognitive-behavioral clinical tools to promote sexual growth and health for individuals and couples.**

Features of the Integrative Approach

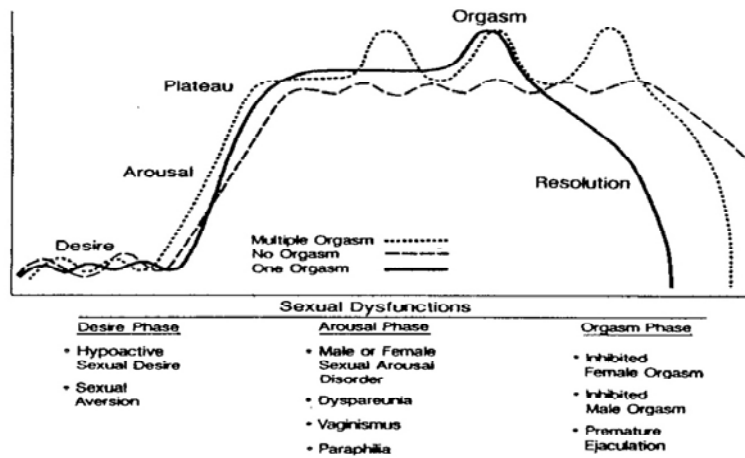


(From: Metz, M. E. (submitted). Healing Sexually Fractured Couples from Problems with Men's Sexual Health)

The Integrative Approach: Psychological Dimensions



Classic Human Sexual Response Cycle (Masters & Johnson, 1970)



Basson, R. 2001. Using a different model for female sexual response to address women's problematic low sexual desire. *Journal of Sex and Marital Therapy* 27:395-403.

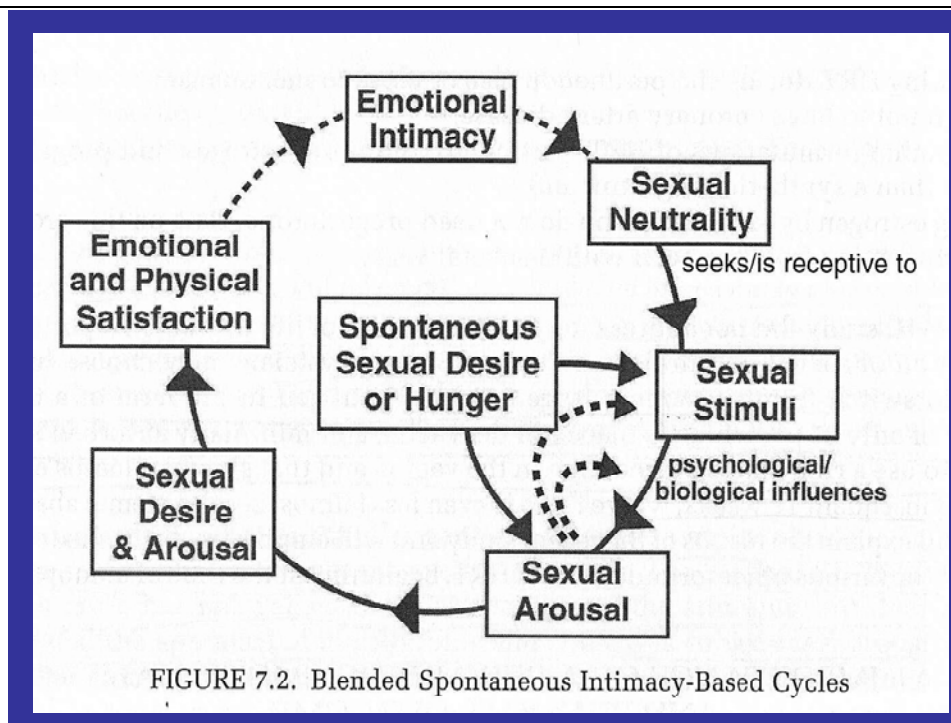


FIGURE 7.2. Blended Spontaneous Intimacy-Based Cycles

ASSESSING THE 10 TYPES OF SEXUAL DYSFUNCTION (SD)

Michael E. Metz, Ph.D.

The 5 Physiological Types of SD

Consider possible medical and physical causes of and effects from your difficulty. Talk to your physician if you have concerns or want to rule out a medical factor.

1. Bio-Neuro-Hormonal System → Do you have congenital problems in your genetic, circulatory, neurologic, hormonal, or urologic system? These sources are very rare.

Yes _____ No _____
(What problem: _____)

2. Physical Disease / Illness → A number of illnesses can cause SD. If you have, or suspect you have, one of the illnesses below, it is important to talk with your doctor about the possibility. Some illnesses that can sometimes cause SD:

Diabetes mellitus	Cardiac disease	Vascular disease
Multiple sclerosis	Sleep apnea	Peyronies Disease
Hypothyroidism	Hypopituitarism	Hypogonadism
Polyneuropathy	Systemic lupus	Prostatitis
Lipid abnormalities	Chronic renal failure	Epilepsy
Hypertension	Cancer/chemotherapy	STD

Yes _____ No _____
(What Illness: _____)

3. Physical Injury → Injuries such as pelvic surgery, prostate surgery, or neurologic trauma can cause SD. This cause is infrequent.

Yes _____ No _____
(What Injury: _____)

4. Pharmacological side-effect → A number of medications, over-the-counter drugs, and illicit drugs commonly cause SD such as an antihypertensive, mental health medications, chemo-therapy. Agents include:

- (1) Cardiovascular drugs -- antihypertensives; diuretics; Antiarrhythmics.
- (2) Antidepressants medications (e.g., SSRI (e.g., Fluoxetine/Prozac); MAOIs, (e.g., phenelzine); heterocyclics (e.g., Amitriptyline/Elavil; clomipramine/Anafranil).
- (3) Antipsychotics: (e.g., thioridazine/Mellaril, trifluoperazine/Stelazine).
- (4) Antianxiety (e.g., alprazolam/Xanax; clonazepam/Klonopin)
- (5) Illicit drugs: marijuana (decreased desire); MDMA (ED, orgasmic delay)

Yes _____ No _____
(What agent: _____)

5. Health Habits → Do you have problematic health patterns such as smoking, poor cardio-vascular conditioning, over-training (e.g., marathon), sleep deprivation, drinking, overweight, drug abuse? These are common causes with aging.

Yes _____ No _____
(What Issue: _____)

(over)

ASSESSING THE 10 TYPES OF SEXUAL DYSFUNCTION (SD) -- 2

The 5 Psychological-Relationship Types of SD

Consider potential psychological and relationship causes and effects of SD:

6. Psychological System → Do you have a chronic, psychological character pattern or significant mental health problem such as bipolar mood disorder, obsessive/compulsive, dysthymia, or generalized anxiety disorders? These causes of SD are infrequent.

YES _____ NO _____
(What problem: _____)

7. Individual Psychological Issues → Individual psychological issues, current psychological stresses such as depression, anxiety due to work stresses, parenting, loses, are common causes and effects of SD.

YES _____ NO _____
(What issues: _____)

8. Relationship Issues → Are you and your partner experiencing relationship distresses such as unresolved emotional conflicts, alienation, loneliness. Such issues are common causes and effects of SD.

YES _____ NO _____
(What issues: _____)

9. Psychosexual Skills Deficit → Do you doubt your lovemaking skills? Do you lack knowledge about your body, your partner's body, hold unreasonable expectations about sexual performance; lack essential sensual skills for arousal, interpersonal skills such as warmly talking of sex, cooperating to make sex comfortable and to achieve sexual satisfaction. Skills-deficits are very common causes and effects of SD.

YES _____ NO _____
(What skills deficit: _____)

10. Multiple or "Mixed" Sexual Dysfunction → It is common (1/3rd of SD?) for individuals and couples to experience multiple SDs, often interacting with multiple causes and effects. For example, a woman's dyspareunia may interact with the man's erectile dysfunction; or the man's premature ejaculation interact with the woman's orgasmic difficulties.

YES _____ NO _____
(What issues: _____)

Clinical Worksheet: Evaluating the Possible Causes/Effects of a Sexual Dysfunction

Michael E. Metz, Ph.D. & Barry W. McCarthy

TYPE of SD	√ if this is a feature	If a feature, % of total
A. <u>PHYSIOLOGICAL SD</u> (Biogenic):		
1. <i>Bio-Neuro-Hormonal System</i>	_____	_____
2. <i>Physical Disease / Illness</i> (Illness: _____)	_____	_____
3. <i>Physical Injury</i> (Injury: _____)	_____	_____
4. <i>Pharmacological side-effect</i> (Agent: _____)	_____	_____
5. <i>Lifestyle Issues</i> (Issue: _____)	_____	_____
B. <u>PSYCHOLOGICAL SD</u> (Psychogenic):		
1. <i>Psychological System</i>	_____	_____
2. <i>Individual Psychological Issues</i> (Issues: _____)	_____	_____
3. <i>Relationship Issues</i> (Issues: _____)	_____	_____
4. <i>Psychosexual Skills Deficit</i> (Issues: _____)	_____	_____
B. <u>"MIXED" Sex Dysfunctions</u>		
5. (Other dysfunction: _____)	_____	_____

Number of causes / effects: _____

100%

Appreciation of Biopsychosocial Human Sexual Drives

Michael E. Metz, Ph.D.

A deeper appreciation of the primordial human sex drives, and appreciating there are gender differences, can be powerful invitation to understand one's feelings as well as to reach out to better understand the other. Such appreciation serves as the foundation for couple's relationship and sexual cooperation and inoculates against sexual conflict and dysfunction as a couple. Helen Fisher, in *Why We Love* (2004) describes the three kinds of love.

LUST is sex drive, passion, "biological imperative", "urge to merge" or craving for sexual gratification to motivate individuals to seek sex. Its function: reproduction, procreation. Physiologically, lust is associated primarily with androgens (testosterone) and estrogens and related brain pathways in both sexes.

ROMANTIC LOVE is characterized by ecstasy, heightened energy, focused attention on a preferred mating partner, attraction, "limerence," infatuation, exhilaration, obsessive thinking and emotional craving for him or her. Its function: to motivate or enable individuals to select among potential partners, prefer specific features, and focus their courtship attention on genetically appropriate individuals. Physiologically, romance is associated with elevated levels of central dopamine (DA) and norepinephrine (NE) and decreased levels of central serotonin (5-HT).

ATTACHMENT involves feelings of calm and emotional union with a long-term, committed partner, yielding or surrender, security, and social comfort. Its function: to motivate individuals to sustain affiliative connections to fulfill parental duties; care-giving, and emotional bonding for infant survival. Physiologically it is associated with the neuropeptides oxytocin and vasopressin and their neural circuits. Oxytocin, produced in the pituitary and hypothalamus, is associated with stress reduction, calming and soothing (e.g., orgasm), memory, learning.

Such basic biopsychosocial sex information can help couples appreciate differences and promote working as an "intimate team." For example, research suggests that male sex drive is stimulated to a greater degree by visual stimuli (which drive up dopamine for men) and are more aroused by novel things (e.g., a smile) than the female sex drive (Ellis & Symons, 1990) (Hamann, Herman, Nolan, & Wallen (2004), while women are more sexually aroused by romantic words, images, and themes in stories and films (Ellis & Symons, 1990).

Male sex drive is more constant while the female sex drive is more periodic but more intense (Basson, 2002), and male sex drive is focused more directly on copulation while the female sex drive is embedded in a wider range of stimuli (Fisher, 1999). Both sexes express romantic love with approximately the same intensity. Both men and women are attracted to partners who are dependable, mature, kind, healthy, smart, educated, sociable, and interested in home and family (Buss, 1994). There are differences in what men and women find attractive in a mate. In the most basic dimensions, men tend to be more attracted to a partner's physical appearance – particularly signs of beauty and health. Women are more inclined to be attracted to men with success, education, and/or position (Buss, 1994)

Dimensions of the “Good-Enough Sex” Model For Couple Satisfaction

Michael E. Metz, Ph.D. & Barry W. McCarthy (2003, 2004, 2007, 2008)

1. **Sex is valued as intrinsically good**, an invaluable part of an individual’s and couple’s self-esteem, pleasure, intimacy, comfort, and confidence.
2. **Sexuality is inherently relational**. Relationship and sexual satisfaction are the ultimate developmental focus and are essentially intertwined. The couple blends the 12 facets of intimacy; views the partner as “Sexual Friend”; their relationship as “Intimate Team.”
3. The partners ground their **sexual expectations** on realistic, age-appropriate expectations. Accurate and reasonable knowledge about sexual physiology, psychology, and relationship health are crucial for sexual satisfaction
4. **Good physical and psychological health**, ensured with healthy behavioral habits, are vital for sexual health. Individuals value their and their partner’s sexual body.
5. **Relaxation** is the foundation for sexual pleasure and physiological sex function.
6. **Sensual touch & emotional pleasure** are valued as well as sexual performance.
7. Valuing **variable, flexible** sexual experiences and abandoning the “need” for perfect performance inoculates the couple against sexual dysfunction by overcoming performance pressure, anxiety, and fears of failure and rejection.
8. The five **purposes for sex** are integrated into the couple’s sexual relationship -- blending pleasure, tension release, self-esteem, intimacy, and/or procreation.
9. Partners integrate and flexibly use the three basic **sexual arousal styles** to cope with “sexual over-familiarity” by balancing and blending multiple styles of sexual arousal --> sensual “self-entrancement”, “partner interaction”, and “role enactment”.
10. **Gender differences** are respectfully valued and similarities mutually accepted. Each is attentive to integrating their psychological and physical sexual feelings. The man learns to self-regulate his sexual drive and arousal while the woman self-regulates her emotional drive and sexual arousal. They consciously accept and respect the body’s “biological sexual nature,” he learns to personalize his biologically natural tendency toward “sexual objectification,” and each differentiates and integrates emotional and sexual feelings (issues of “emotional sexualization” and “sexual emotionalization”) to enhance relationship intimacy.
11. Sex is integrated into **real life** and real life is integrated into sex. Sexuality is developing, growing and evolving throughout life. The healthy couple integrates the events of daily life to create their realistic, distinctively personalized, and enriched sexual style. Sexual health and satisfaction are directly influenced by the quality of relationship conflict resolution. Conflict presents the ordinary, day-to-day opportunity to cooperatively address it and thereby deepen emotional and sexual intimacy. They each become leaders in cooperation for intimacy – in and out of the bedroom.
12. Sexuality is **personalized** --> **occasionally playful, special, spiritual**. Mature playfulness is characterized by acceptance, emotional trust, and pleasure.

Improving the Quality of Sex

The Purposes of Sex and The Styles of Arousal

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While prevalence studies consistently report frequent sex dysfunction among U.S. couples (40-50% of couples at any given time), an even greater percent (78%-95%) complain of common sexual difficulties (Frank, Anderson, & Kupfer, 1976; Laumann et al., 1994; Metz & Seifert, 1991). For example, sex partners sometimes complain of disagreements over sexual frequency, styles, and preferred behaviors (self pleasuring, oral sex, etc.), amount or quality of partner interaction, experiences of sexual boredom, hypersensitivity to the sexual partner, anxiety about intermittent sex performance problems, interpersonal conflicts over fertility prescriptions, whether or not to share fantasies, watch erotic videos together, or discomfort with sex.

Clinical experience has taught us that some of these sexual difficulties can arise from (A) differing goals or purposes for being sexual together; and (B) misunderstandings about the different styles of sexual arousal and the behavioral patterns that are typical for each.

(A) There are FIVE GENERAL FUNCTIONS OR PURPOSES FOR SEX:

- (1) Reproduction or procreation
- (2) Tension release or anxiety reduction
- (3) Sensual enjoyment or physical pleasure
- (4) Individual Self-Esteem and confidence
- (5) Relationship closeness or satisfaction

Reproduction or procreation is the "natural" or biological function of sex. *Tension release* or reduction of stress and anxiety is a common psychophysiological purpose of sex. Physical *pleasure* is thought to be the basic function of sex in long term, satisfying sexual relationships -- what keeps partners interactive. Individuals may also seek enhancement of their *self-esteem* through sex, and pursue feelings of self-worth, confidence, or pride in being and functioning as a sexual person. A fifth function is the use of sex for a variety of *relationship qualities*, such as love, affection, healing and joy. In healthy relationships, these are positive purposes. In dysfunctional relationships, the purposes are more negative, such as manipulation, destructive control, or hurt.

It appears that individuals typically pursue each of these five purposes for sex at one time or another in their lives. Often multiple purposes are pursued simultaneously. In fact, when the focus becomes too singular -- for example to reproduce or conceive at all cost as sometimes happens for infertile couples -- sex can become distressing, and even dysfunctional.

It also appears that the priority or ratio of one purpose to another can fluctuate significantly from time to time -- even day to day. For example, one partner may engage in sex with 40% of the purpose to feel the physical pleasure, 40% for relationship "love", 10% for self-esteem, and 10 % for procreation. The other partner may seek sex for 50% procreation, 20% self-esteem, 10% love, 10% tension release, and 10% for pleasure. The potential for conflicted sexual interaction then exists as the partners may feel this difference in "agenda". Realizing and accepting that we have sex for multiple and fluctuating purposes, clarifying the sexual agenda, and developing more partner congruence is helpful.

(B) There are THREE GENERAL STYLES OF SEXUAL AROUSAL -- that is, individuals get "turned on" in a combination of different ways or patterns (source: see Mosher, 1980).

(1) Sensual Self-Enhancement Arousal:

- becoming aroused by focusing upon one's own body, the wonderful physical sensations, the sensual pleasure;

(2) Partner Interaction Arousal:

- becoming aroused by focusing upon the partner, his/her body, his/her responses, and the "romantic" interaction with the partner;

(3) Role Enactment Arousal:

- becoming aroused by role playing with one's sexual partner, one's private imagination or fantasy, or acting out one's feelings or fantasies.

These styles behaviorally look different. The individual pursuing arousal primarily by "*self-entrancement*," for example, typically closes one's eyes, goes within, becomes quiet, and looks detached and passive. Routine, sameness, and stylized touch help this person to become aroused. On the other hand, the person who pursues arousal by "*Partner Interaction*" is very active, eyes open, looking at the partner, talkative (sex-talk or romantic, "sweet" talk), and energetic. This is the sexual style portrayed on television and in movies -- passionate and impulsive sex. The partner interaction person gets pleasure and excited by focusing attention outside one's body -- such as seeing the partner respond -- and getting carried away in sexual tension. The person aroused by "*Role Enactment*" finds fantasy, variety, and experimentation arousing, such as dressing in sexy lingerie, role playing being "tough" or "hard to get", acting out a scene from a movie or fantasy, having sex in new places (e.g., vacation), using "toys" such as massage oil, vibrator, dildo, etc. By imagination and trying new things, this person finds excitement and arousal through sexual playfulness, feeling a trust, freedom, and uniqueness with the lover.

Each style is common and one is not better than another. It is thought that men regularly employ "partner interaction" and women often use sensual "self-entrancement." While individuals appear to have a preference for one style, every person has the capacity for arousal by each style and may use them interchangeably. For example, an individual may begin love-making with role enactment, change to partner interaction, and then switch to entrancement. An individual's use of the three styles seems to vary over time. It is likely that there are developmental stages which individuals and couples go through. For example, early in a couple's sexual life, partner interaction seems common, giving way to individual entrancement and a more "sedate" sexuality for a while, then enlivened with role enactment, or a resurgence of partner interaction. Many individuals report that the fluctuations are probably not so stable, however, and that they may pursue a different type of arousal even from one sexual meeting to the next -- Tuesday, entrancement, "because I was very tired"; and Saturday, partner interaction because I was really appreciating my partner."

Sexual partners who may not realize that there are different kinds of arousal may misinterpret their partner's behavior in a hurtful, personalized way. For example, the primarily entrancement focused individual having sex with a partner interaction person would likely find the partner interaction individual's love-making efforts distracting (the looking, talking, heavy breathing, interacting, being expressive and passionate), and wonder why the lover is "interrupting" or seeming to work against their arousal. The partner interaction person, on the other hand, might interpret the entrancement partner as "disinterested", "rejecting", or bored. The potential for misunderstanding and hurt is evident.

Learning that people have different purposes and ways of getting aroused helps couples appreciate their differences and accept them. It also helps couples to cooperate so that both partners may feel respect and caring from the other as they mutually pursue satisfying sex for each other, and the preferred ways of getting aroused. Sharing and discussing one's sexual feelings, cooperating, and collaborating in pleasure, are perhaps the most crucial sexual skills.

Variable Sexual Experience Distinguishes Satisfied Couples in “Good-Enough Sex.”

(From: McCarthy, B.W. & Metz, M.E., (2007). *Men’s Sexual Health*. NY: Routledge.)

Valuing variable flexible sexual experiences (the 85% approach) and abandoning the need for perfect performance inoculates the man and couple against sexual dysfunction by overcoming performance pressure, fears of failure, and rejection.

The reality for emotionally and sexually healthy couples is that the quality of sex varies. The male myth portrayed in the romantic love/passionate sex media (including R and X-rated videos) is that each sexual experience involves perfect performance. What nonsense. In truth, both scientific findings and clinical experience show that emotionally satisfied, sexually functional couples have a variable, flexible sexual response (Table 6.2). This means that about 35–45% of encounters are very satisfying for both partners, another 20–25% are better for one (usually the man) than the other, and 15–20% are okay but not remarkable. The most important information is that 5–15% of sexual encounters are unsatisfying or dysfunctional.

The Good-Enough Sex model accepts that among satisfied couples, up to 15% of the time their sexual encounters will not flow to intercourse. Rather than thinking of these as failures, accept them as part of normal variability. Instead of apologizing, you can transition to a backup scenario—either a warm, sensual scenario or an erotic, non-intercourse scenario leading to orgasm for you, her, or both. The Good-Enough Sex approach encourages relationship satisfaction with an acceptance of variability in the quality of sex grounded on positive, realistic expectations. This serves the man and couple well and inoculates them against sexual problems with aging. Accepting Good-Enough Sex is often easier for the woman than for the man, but it promotes sexual satisfaction for both.

Table 6.2

The Quality of Good-Enough Sex in Well-Functioning, Satisfied Married Couples

35–45%	Very Satisfying
20–25%	Good (at least 1 partner)
15–20%	Okay (not remarkable)
5–15%	Unsatisfying (dysfunctional)

Note. Adapted from “Frequency of Sexual Dysfunction in Normal Couples,” by E. Frank, C. Anderson, and D. N. Rubinstein, 1978, *New England Journal of Medicine*, 299; and *The Social Organization of Sexuality: Sexual Practices in the United States*, by E. O. Laumann et al., 1994, Chicago: The University of Chicago Press.; Table 10.10, p. 374

Three Essential Sexual Health Learnings for Men

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Throughout life with its various “stages” (e.g., childhood, adolescence, young adult, middle age, older age), men developmentally learn three important psychosexual skills for sexual health. Men develop and adapt a maturing awareness of thoughts, feelings, and motivations for behaviors, as well as the ability to balance and “regulate” the physiological, psychological, and interpersonal dimensions of sexuality.

Learning Task #1 → You value and embrace your male sexuality as good. You accept the male “BIOLOGICAL SEXUAL NATURE”, “biological imperative,” “lust” or “urge to merge” without shame. You respect this fundamental power of sex and accept the need to self-regulate. You learn to regulate this drive with healthy sexual knowledge and attitudes, and with physically healthy habits, exercise, and self-discipline. When this regulation is in balance, your lust does not create problems for you and you can freely enjoy sex with your appropriate partner. When under-regulated, sex drive can cause a variety of personal, sexual, and relationship problems by mechanically acting out; or conversely, when over-regulated deprive you of healthy lust and passionate pleasure.

Learning Task #2 → You accept as normal and healthy your male biological tendency to be VISUALLY ATTRACTED BY EXTERNAL SEXUAL STIMULI. Accepting this requires you to regulate this tendency toward sexual “objectification” by disciplining your thoughts, and placing conscious priority to “personalize” your sexual interests and relationship.

Learning Task #3 → You come to appreciate and handle the male tendency to “SEXUALIZE EMOTIONS”. To ignore or be unaware of emotions such as loneliness, frustration, sadness, resentment, anxiety, irritability or fear of inadequacy, and to misinterpret and transform these to sexual feelings, fuels problematic sexual behaviors (e.g., compulsive use of pornography; affairs; excessive sexual demands on your partner).

Sexual health involves developing an emotional sophistication about your feelings, using direct, healthy ways for emotional management, and balancing emotional and sexual feelings in one’s intimate relationship.

COUPLE C-B-E INTERACTIONAL ANALYSIS WORKSHEET

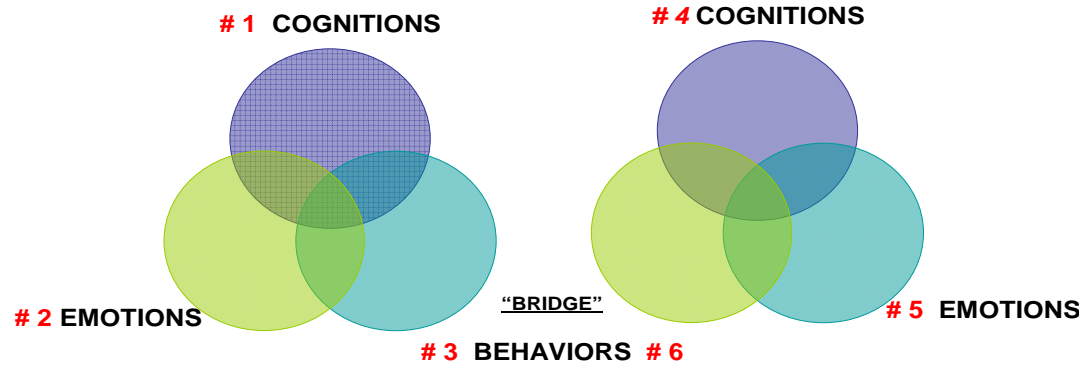
Michael E. Metz, Ph.D.

Name: _____

Name: _____

1 cognitions

4 cognitions



2 emotions

3 ← behaviors → # 6

5 emotions

APPENDIX:

ASSESSING THE FIVE FEATURES OF RELATIONSHIP CONFLICT

In evaluating relationship conflict, several qualities may characterize the disagreement and offer unique information about a particular couple's conflict. The following areas of assessment summarize the basic areas to probe during a clinical interview. The interview material can be supplemented by self-report questionnaires.

1. **Conflict ENVIRONMENT**

This feature considers the “**Who**,” “**Where**,” and “**When**” of the couple's conflict. What are the descriptive patterns of conflict?

Probes of remote features:

- What individual personality traits, mental health difficulties (e.g., depression, anxiety), or unresolved issues in your personal history may play a role in the conflicts that occur between the two of you?
- When you and your partner have gotten into conflict or disagreement in the past, what positive ways have you dealt with it? What negative ways?
- What unsettling events in the past have influenced the way(s) you and your partner approach conflict resolution now?

Probes of immediate features:

- Do you currently have any medical problems that seem to have an effect on your relationship? If so, please describe.
- Where do you usually have conflict?
- Describe any patterns in the times when you typically disagree/argue/fight? Any particular days? Any particular time(s) of the day?
- What happens before the conflict—what circumstances seem to “set the stage”?
- Who else is present or nearby when you have conflict?
- How long does the disagreement typically last?
- What happens after the disagreement?

2. **Conflict SUBJECT or AREA**

This feature considers “**What**” the couple is fighting about? What subject or topic becomes the focus of the fighting?

Probes:

- How much do you disagree about each of the following topics?

__religious practices	__parenting	__making decisions
__politics/ideas	__lifestyle/recreation	__household chores
__sex	__sense of humor	__career/work
__finances	__past histories	__alcohol/drugs

__friends __how to act or behave
 __in-laws/relatives __goals in life/philosophy/ideas
 __time together __other:

3. **Conflict SEVERITY**

Severity combines the **frequency** and **intensity** of the couple's conflict.

Probes:

- How frequently do you have disagreements or conflicts in your relationship?
- How emotionally intense are your relationship disagreements?
- How long do they last?
- How upset are you/your partner about the relationship conflict or disagreement?

4. **The STYLES of Interaction**

This feature considers "**How**" the partners respond to each other when disagreement occurs? What are the behavioral patterns, such as assertion, aggression, playfulness, withdrawal, submission, and denial?

Probes:

- How do you deal with your partner when you have a disagreement? If I were watching, what would I see you doing?
- How do you engage your partner during conflict: cooperate, confront, act playfully?
- How do you avoid your partner during conflict: yield, evade, withdraw?
- How do you perceive that your partner typically behaves toward you when you disagree? If I were watching, what would I see your partner doing?

5. **The MEANING of Relationship Conflict**

This feature considers "**Why**" this couple is fighting. The meaning of conflict involves the goals that each member of the couple has, which appear to be blocked, or potentially blocked, by the intentions or behaviors of the other person. What does the disagreement mean to each member of the couple, in terms of his or her goals and the attributions that the person makes about the partner?

Probes:

- What thoughts typically go through your mind about your partner and the conflict when the two of you are having a disagreement?
- What is it that you focus on that is upsetting to you when you have a conflict?
- When you and your partner get into conflict or disagreement, what do you think causes the conflict?

- What is upsetting to you about the fact that you and your partner have a conflict or disagreement in this particular area? Describe any ways in which the conflicts between the two of you are based on having different beliefs about how your relationship should be.
- What do you expect will result when the two of you discuss important topics in your relationship?
- Ideally, what would you like to see happen when you and your partner disagree about an area of your relationship?
- What would ultimately calm you or make you feel satisfied when a conflict occurs between the two of you?