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The Social Determinants of Sexual and Reproductive Health in Integrative Sex and Couples Counseling: A Structural Competence Perspective

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The Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2015) call for counselors to address equity issues via social justice and advocacy. One equity issue relevant to counseling sexology is sexual and reproductive health inequities. This article applies the social determinants of sexual and reproductive health (SDSRH) to counseling sexology, specifically integrative sex and couples counseling, to address health inequities. A fictional case study incorporates the SDSRH from a cross-theoretical structural competence perspective. Future research should further elaborate SDSRH frameworks and evaluate the efficacy of their clinical applications.

Keywords: Sexual and reproductive health equity; social determinants; structural competence; couples counseling; sex counseling

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Introduction

Practitioners in counseling and related mental health fields are increasingly recognizing the value of integrative sex and couples counseling (McCarthy, 2001; Nelson, 2020a; Weeks, 2005). This approach applies the couples and family counseling concept of the system to sex counseling, which had previously emphasized the individual (Weeks, 2005). A more recent development in integrative sex and couples counseling is the use of broader systems concepts such as biopsychosocial theory (Rosen & Kranz, 2020) and Bronfenbrenner's bioecological systems theory (Jones et al., 2011), which acknowledge the impact of social identities (e.g., gender, race, social class) and sociocultural context (e.g., gender role socialization, racism, health care accessibility) on couples' sexual and overall health. This perspective aligns with Ratts et al.'s (2015) Multicultural and Social Justice Counseling Competencies (MSJCC), which call for counseling and advocacy interventions, imploring that "privileged and marginalized counselors intervene with, and on behalf, of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels" (p. 11). To more fully apply the MSJCC, the social determinants of sexual and reproductive health (SDSRH) framework (Stumbar et al., 2018) can guide sex and couples counselors' understanding of and response to sexual and reproductive health inequities related to clients' social identities and experiences of oppressive structures. This article will discuss sexual and reproductive health equity in relation to the SDSRH in integrative sex and couples counseling. Additionally, a fictional case study will apply the SDSRH to integrative sex and couples counseling via a cross-theoretical structural competence perspective (Ali & Sichel, 2014; Wilcox et al., 2024). The article will conclude with broader implications for practice to address equity and social justice in integrative sex and couples counseling.

Integrative Sex and Couples Counseling

Systems theory has been dominant in couples and marriage counseling in that elements interact via circular, not linear, causality (Weeks, 2005). By contrast, sex counseling has historically focused on the individual, such as by emphasizing individual etiological factors of sexual dysfunction even when a couple was in treatment (Weeks, 2005; Wiederman, 1998). More recently, however, the perspective that sexual dysfunction in a couple's relationship is influenced by the interaction between partners, not just by factors within the identified patient, has led to recommendations for couples and marriage counselors to consider the systemic and developmental dimensions of sexual dysfunction and sexual wellness (Nelson, 2023; Nelson, 2020a; Weeks, 2005). Even in the absence of a sexual problem, integrative sex and couple's counselors recognize that for many people, their sexual health and wellness influence the health of their primary romantic relationship and vice versa (Nelson, 2020a).

One limitation is the lack of research on the efficacy of integrative sex and couples counseling, both for the general population and specific cultural groups. However, scholars continue to push the field forward with conceptual articles and case studies, including cultural and contextual influences on clients' well-being and sexual health, often guided by multicultural competence or sociocultural systems theories (Jones et al., 2011; Rosen & Kranz, 2020). Some argue that this practice, while necessary, is insufficient given social justice, equity, and advocacy goals in professional standards such as the MSJCC (Smith, 2015; Wilcox, 2023). One option for

moving beyond multicultural competence is structural competence (Ali & Sichel, 2014; Wilcox, 2023; Wilcox et al., 2024). Structural competence does not conflate culture or identity (e.g., race, gender) with structurally perpetuated oppression, inequity, and injustice (e.g., racism, sexism, government policies based on -isms, health inequities; Wilcox, 2023). While many inequity areas exist, sexual and reproductive health inequities are especially relevant to integrative sex and couples counseling from a sex-positive focus and represent a growth area for the field of counseling (Murray et al., 2017; Southern & Cade, 2011).

Structural Understanding of Sexual and Reproductive Inequality

Just as health is a human right, so is sexual and reproductive health (World Association for Sexual Health, 2021). Sexual health is defined as "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (World Health Organization, 2006, p. 5). Relatedly, reproductive health means that "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (World Health Organization, 2006, p. 4). Finally, some researchers advocate for definitions of sexual health to explicitly include asexuality, wherein people are as free not to have sexual desires or experiences as they are to have them (Conley-Fonda & Leisher, 2018). Although all people should have an equal chance to live their intended sexual and reproductive lives, we still see many sexual and reproductive health inequities—that is, unfair and avoidable differences in sexual and reproductive health among social groups—in the U.S. (Sutton et al., 2021) and globally (Macklin, 2006). Examples include relatively high rates of HIV among gay men and other men who have sex with men (Stahlman et al., 2016), poor maternal health outcomes among Black women (Davis, 2020), sexual dysfunction among women of low socioeconomic status or SES (Kim et al., 2022)—and relatively low rates of "thick desire" among young women (Fine & McClelland, 2006).

Social scientists from public health and other disciplines have generally dominated the dialogue around health inequities. At the same time, counseling, psychology, and other related helping fields trail behind in research and practice (Thurston et al., 2023). For example, in integrative sex and couples counseling, applications of biopsychosocial theory (Rosen & Kranz, 2020) and Bronfenbrenner's bioecological systems theory (Jones et al., 2011) address sociocultural factors impacting the sexual health of couples (e.g., financial stress, gender role socialization, contraception access) but not underlying structures that perpetuate oppression and inequity (e.g., the interplay of healthcare policies, sexism, and income inequality), nor comprehensive steps for social justice advocacy. According to the MSJCC and structural competency, best practice in counseling is to include conceptualizations of structural inequity and intervene accordingly, including with advocacy and systems navigation (e.g., connecting clients to social services and community resources, such as Planned Parenthood or a women's well-being group). While systems navigation has often been reserved for social workers, other mental health practitioners increasingly engage in this work to address systemic inequities (Juntunen et al., 2022). For example, in their application of social determinants of mental health to counseling, Lenz and Litam (2023) wrote that one treatment plan objective is to "…increase awareness, knowledge, and use of available community resources that support development and well-being" (p. 10). Overall, while integrative sex and couples counseling has made some strides toward considering sociocultural influences on sexuality and well-being, the profession's value of social justice advocacy warrants a more significant commitment to a sexual and reproductive health equity lens.

Social Determinants of Sexual and Reproductive Health (SDSRH)

As social determinants of health (SDOH) are used to understand health inequities more broadly (Solar & Irwin, 2010; U.S. Department of Health and Human Services, 2020), SDSRH are used to understand sexual and reproductive health inequities. One definition of SDOH is "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health and Human Services, 2020, para. 1). According to the World Health Organization in a publication by Solar and Irwin (2010), SDOH encompass both the social causes of health (e.g., material circumstances such as housing quality and consumption potential) and the social factors determining the distribution of these causes (e.g., structural forces such as racism, government policies affecting labor markets, housing, education, and more). Relatedly, SDSRH can be defined as the social and structural influences on sexual health and well-being, factors including but not limited to "health care access, social and cultural norms, insurance status, educational level and health literacy, economic status, gender identity and bias, and sexual orientation" (Stumbar et al., 2018, p. 2). While health equity and SDOH originated in public health, mental health fields are beginning to recognize their importance, especially as they relate to broader calls for culturally responsive and social justice-focused practice. For instance, Thurston et al. (2023) advocated for clinicians to increase their focus on health equity by using SDOH frameworks in research, education, and practice.

It is imperative that counselors providing integrative sex and couples counseling address the profession's goals of social justice, equity, and advocacy by considering more than sociocultural factors and embracing structural competence. Lenz and Litam (2023) proposed that counselors integrate an SDOH-related concept—social determinants of mental health (SDMH)—into case conceptualization and treatment planning to enhance existing applications of biopsychosocial theory and culturally informed care. Thus, applying the SDSRH to counseling, specifically integrative sex and couples

counseling, is a natural extension of recent applications of SDOH and SDMH to mental health fields.

Unlike SDOH and SDMH, a stand-alone framework has not yet been developed for SDSRH, which should be an area of future research. While rare, existing mentions of SDSRH in any field generally fall into one of two SDOH frameworks. The first is the U.S. Department of Health and Human Services (2020) initiative Healthy People 2030. In one application, the sexual health curriculum for medical students at Florida International University borrowed from an earlier version, Healthy People 2020, to discuss SDSRH (Stumbar et al., 2018). The second framework is the World Health Organization's Commission on Social Determinants of Health (WHO CSDH; Solar & Irwin, 2010), in which SDSRH were highlighted by the WHO Department of Reproductive Health and Research (Malarcher, 2010). Less rare in mental health fields are fragmented discussions of individual SDSRH areas—own and/or partner's income, employment, education level, race, gender, sexual orientation, incarceration experiences, immigration status, ability level, etc.—in texts that may not even reference the SDSRH. For example, Higgins et al. (2022) do not mention the SDSRH but do outline three pathways linking poverty and sexual well-being: (a) housing and sexual spaces, (b) financial-associated stress and sexuality, and (c) poverty-fueled expectations for enjoyable sexual experiences. As another example, das Nair and Butler (2012) edited a book on issues of intersectionality and sexuality in counseling, addressing sexual health factors such as aging, refugee status, (dis)ability, and social class in the context of LBGTQ+ identities. However, they did not discuss the SDSRH (das Nair & Butler, 2012). There is a demonstrated need for a stand-alone SDSRH framework to address equity and advocacy in integrative sex and couples counseling.

Applying the SDSRH to Integrative Sex and Couples Counseling

As stated above, integrative sex and couples counseling has been used with a variety of couples counseling theories and modalities (Jones et al., 2011; Nelson, 2020b). No matter the clinical perspective, the SDSRH can be applied to treatment. This way, the approach is modeled on the cross-theoretical multicultural orientation framework (MCO; Davis et al., 2018). The MCO derives from multicultural competence frameworks (Davis et al., 2018), whereas this application of the SDSRH is more aligned with structural competence (Ali & Sichel, 2014; Wilcox et al., 2024). In the MCO, cultural opportunities are ways counselors can recognize and respond to markers of culture and social identity in sessions (Davis et al., 2018). The SDSRH includes culture and social identity but also goes beyond the MCO to place a greater focus on oppression and privilege, as well as health factors such as material circumstances (e.g., housing and sexual spaces; Higgins et al., 2022) and access (to healthcare, childcare, transportation, etc.). Thus, this application of the SDSRH will discuss structural opportunities: how counselors can recognize and respond to the SDSRH in and out of sessions. Of note, while structural opportunities can be extended beyond the SDSRH (e.g., to SDOH and SDMH) and beyond integrative sex and couples counseling (e.g., to individual counseling), that is not the current focus. Finally, although the term structural opportunities has not been used before and is based on the term cultural opportunities from the MCO (Davis et al., 2018), ideas of attending to structural forces in counseling are not new (Ali & Sichel, 2014; Wilcox et al., 2024).

The two components of structural opportunities in integrative sex and couples counseling are (a) recognizing and (b) responding to the ways that the SDSRH manifests in clients' lives. With both components, counselors face a variety of options. For instance, when recognizing the SDSRH, a counselor can make a mental note of clients' spontaneous references to the SDSRH. When a client says, "My parents could never afford to keep me in sports when I was younger, and I think that affects my body image and the way I feel having sex with my partner even now," a counselor may make a mental note of the multiple determinants being referenced, including childhood SES, health behaviors, social identities (perhaps this speaker is a woman of larger body size), cultural values (women should be thin), and psychosocial factors (body image). Another way to recognize the SDSRH is to ask couples about SDSRH areas like housing and sexual spaces (e.g., "How do you feel about the spaces where you two normally have sex? Is there privacy, comfort, and pleasure in these spaces?"). When a counselor responds to the SDSRH, they may ask more about a determinant (e.g., "You mentioned trouble accessing birth control when you were younger. What specifically got in the way, and how did that affect your sexual wellness?"). Counselors can also respond by reducing self-blame and addressing issues of equity and justice, even if they do not use those terms (e.g., "Everybody deserves enjoyable sex, and it's unfair that you don't have more privacy for that" or "The quality and quantity of housing is just stacked against people these days, and it's not your fault that your living space isn't ideal for sex"). This type of response trends toward raising critical consciousness and building strength and resistance, concepts discussed in liberation psychology and radical healing frameworks, often by Black scholars (Adames et al., 2023; French et al., 2020).

Finally, advocacy is another response to structural opportunities. On an interpersonal level, counselors can navigate systems with clients. On a macrosystem level, they can contact government representatives to voice support for specific proposed sexual and reproductive health bills. One resource for counselors engaging in systems navigation with clients is an article by Lenz and Litam (2023), which provided a table (p. 3) with SDMH domains and related interventions and resources (e.g., Supplemental Nutrition Assistance Program for food access) and a sample treatment plan (p. 10) with additional community resources (e.g., RxResource medication assistance program for healthcare access). Many of these general health resources are relevant to the SDSRH. Counselors can also keep in mind resources specific to sexual and reproductive health (e.g., local public health clinics for STIs/HIV) and social identities (e.g., LGBTQ+ community

groups), and they can utilize existing social support navigation assistance (e.g., calling 211). Finally, one resource for political advocacy is online lists of reproductive health legislation, which often include links for contacting representatives. These are just some examples for counselors to recognize and respond to the SDSRH in integrative sex and couples counseling.

To guide the process of structural opportunities related to the SDSRH, Table 1 provides some SDSRH domains, examples, and relevant questions for counselors to ask. Since no stand-alone SDSRH framework exists, the domains and sub-domains were chosen based on prior SDOH and SDMH literature (Lenz & Litam, 2023; Solar & Irwin, 2010; U.S. Department of Health and Human Services, 2020). The questions in Table 1 are not novel to integrative sex and couples counseling or any type of sex counseling but rather use the SDSRH framework to organize sexual health factors and offer lenses of health equity and structural competence. Of note, areas of health (mental, physical, sexual, and more) interact in complex ways, as do the social determinants themselves, patterns that cannot be fully captured in Table 1. For example, good perceived general health has been associated with sexual satisfaction (Castellanos-Torres et al., 2013), and two common risk factors for sexual dysfunction are poor mental and physical health (McCool-Myers et al., 2018). Thus, specific social determinants (e.g., loneliness outside one's primary romantic relationship) may impact sexual health and satisfaction by first impacting mental and physical health (e.g., heart disease and depression, which are linked to loneliness; Hegeman et al., 2018). Additionally, the lines between SDSRH categories are not solid; for instance, discrimination can fall under cultural and societal values, social identities, social and community contexts, and more. Due to these complex pathways, some clients' limited insight, and other factors, specific clients may not be able to directly answer Table 1 questions such as "How does your involvement with the immigration system affect your sexual well-being?" However, counselors should still ask themselves these questions about their clients' lives, aligning with structural competence. We now turn to a fictional case study to examine some of these complexities in greater detail.

Table 1

Some questions for recognizing and responding to the social determinants of sexual and reproductive health (SDSRH) in counseling.

SDSRH domains	Examples	Relevant Questions
Cultural and societal values	Cultural beliefs and practices may influence attitudes toward contraception, family planning, and sexual health. Religious beliefs and doctrines may impact individuals' choices regarding contraception, family planning, and abortion.	• What were your parents' / caregivers' attitudes toward sex? Names for genitals? • Growing up, how did you and your friends/peers discuss sex? • How were your sexual questions answered? • What did you learn about sex from television, movies, music, social media, pornography, advertising, and other media? • What was your first experience witnessing an explicit sexual scene in media? • How do certain cultural values (heteronormativity, mono-normativity, White supremacy, patriarchal values, etc.) affect your sexual well-being?
Social identities	Gender, race, sexual orientation (including asexuality), age, religion/spirituality, social class, nationality, ability level, size/appearance, immigration status, and resulting oppression and privilege. These factors impact beliefs about sex, beliefs about the self, relationship preference (monogamy, consensual nonmonogamy, etc.),	• What does your identity as a [insert social identity] mean for your attitudes toward and experiences of sex, now and past? - *Some attitudes to probe*: who should initiate sex, expected level of desire, appropriate contexts for sex (casual, in a committed relationship, only in marriage, etc.), appropriate goals of sex (pleasure, emotional intimacy, procreation, etc.) • How does discrimination based on [insert social identity] affect your general and/or sexual well-being? - *Note:* Counselors should also consider internalized oppression (e.g., internalized racism), intersectionality, and identity development models
Social and community context	Loneliness, community and civic participation (clubs, voting), etc. Exposure to trauma, abuse, neglect, or violence, including intimate partner violence (IPV) and community violence; adverse childhood experiences (ACEs) Involvement with the justice system, incarceration, foster care, etc.	• How, if at all, do your social groups support your sexuality? Can you discuss sex with friends if you want to? • *Probe exposure to trauma, abuse, neglect, and violence, for example:* Have you ever been abused? What type of abuse (physical, emotional, sexual)? How does that affect your general and/or sexual well-being? • *Probe involvement of self or close others with systems such as incarceration, foster care, etc.* How does this involvement affect your general and/or sexual well-being?
Socioeconomic status (SES)	Income, education, occupation, financial stress, work satisfaction, and more affect	• What types of partners and sexual experiences have been linked to the educational or workspaces you have been in?

	the time and energy people have for sex, family planning decisions they make, sexual partners to which they are exposed, reasons for staying in sexual and/or romantic relationships, and more.	• Have you ever stayed in a sexual and/or romantic relationship that you didn't want to be in anymore because of financial reasons? For any other reasons? • How has your SES changed over time? How does this relate to your general and/or sexual well-being?
Material circumstances	Housing and sexual spaces, working conditions, food availability and quality, neighborhood and built environment, access issues (to transportation, childcare, technology, internet, etc. These circumstances affect some prerequisites for good sexual health (e.g., time, energy, space).	• How do you feel about the spaces where you usually have sex? Is there privacy, comfort, and pleasure in these spaces? • What barriers do you face to having the sex you want? - *Barriers to probe*: Lack of time/energy because of work, inadequate nutrition, long commute on public transport, taking care of children with limited support, etc.
Healthcare access and quality	Testing for sexually transmitted infections (STIs), access to needed medication (e.g., HIV medications), access to contraception and abortion, discrimination in healthcare settings, healthcare literacy (e.g., knowing what sexual and reproductive health services to ask for), etc.	• Are you confused by any sexual health topics that have come up for you over the years, such as how specific STIs spread or are treated? • Was there ever a time when you would have gotten better medical care if you had had a different identity (different race, ethnicity, gender, body size, etc.)? • Do you have health insurance? Are you satisfied with it? • Is there ever a time when you needed medical care [can probe sexual health care], but you put it off or did not get it because of financial reasons, transportation, or other barriers?
Government policies	Government policies affecting healthcare issues (e.g., insurance coverage, gender-affirming care for transgender individuals, contraception, and abortion access), paid maternal/paternal/parental leave from work, labor and housing markets, etc. Policies affect the other determinants and can directly affect family planning, sexual health, etc.	*Note: Some clients may want to discuss government policies (e.g., the Supreme Court's Dobbs v. Jackson abortion decision in 2022), and some may not. Follow their lead.* • It sounds like you're aware of insufficient maternal leave at your workplace [insert other policy here]. How does this affect you in general? How does it affect your sexual well-being?
Downstream psychosocial and behavioral factors	Stress levels, motivation, self-efficacy, coping, interpersonal experiences, health behaviors (e.g., diet, exercise, contraception use), and more. These factors affect people's ability to engage in mutually fulfilling sexual and/or romantic relationships, make informed family planning decisions, and more.	• What are your levels of stress with finances [or any SDSRH]? How does this affect your well-being, sexual and other? • What is the quality of your sex life [and overall relationship] with your partner, in your view and your partner's? Why? • How often do you and your partner get tested for STIs? • How do you and your partner use contraception, if at all? • How much do you feel that your sexual health [can also probe satisfaction and pleasure] is in your own hands? • In terms of sexual health [can also probe sexual satisfaction and pleasure], what do you think you deserve? What do you realistically expect? How did you come to these ideas?

Case Study

Camila (age 20) and Mateo (age 23) are a monogamous heterosexual couple who have been married for ten months after dating for one year and being friends for many years. They present to counseling with concerns related to sexual intimacy. Additionally, Camila reports harboring jealousy related to Mateo's relationships with other women. Camila identifies as a cisgender, heterosexual, Catholic, Mexican American woman with an associate degree who works as a receptionist at a veterinary clinic. Mateo identifies as a cisgender, heterosexual, Catholic, Mexican American man who went to a trade school and works as an electrician. They were both born in the U.S. to parents who immigrated from Mexico, and they live in a two-bedroom apartment in the town where they grew up. Camila and Mateo describe themselves as "kind, quiet" people with shared interests, including watching scary movies, having two dogs, and spending time outside. Their counselor, Shauna, is a White, bisexual, cisgender woman who practices integrative sex and couples counseling with evidence based Emotionally Focused Couple Therapy (EFT; Johnson, 2004; Wiebe & Johnson, 2016) and a structural competence perspective (Ali & Sichel, 2014; Wilcox et al., 2024).

The first part of treatment involves establishing a working alliance and beginning an assessment. Per EFT, Shauna assesses Camila and Mateo's personal histories and relationship interaction cycles from an attachment perspective (Johnson, 2004; Welch et al., 2019). Per best practices in sex counseling, Shauna also takes an in-depth sexual history (Miller, 2020). Finally, Shauna integrates some SDSRH questions into the sexual history assessment while remembering that structural opportunities to recognize and respond to the impacts of

SDSRH will occur throughout treatment. Camila and Mateo report attending the same Catholic church throughout childhood, which preached abstinence until marriage. Camila reported no sexual activity or contact, including kissing, before Mateo, but Mateo disclosed one previous sexual partner in counseling and had shared that with Camila near the beginning of their relationship. Mateo and Camila were friends for many years until Mateo suggested that they date. They currently report a committed relationship with emotional and spiritual intimacy despite recent troubles. Since marrying, Camila and Mateo have not been able to have penetrative sex, although they have wanted to and tried to many times. Camila is embarrassed to share that every time Mateo attempts penetration, she feels pain "down there," and they stop. This pattern began on their wedding night and continued through the next two months when Camila and Mateo lived with her parents to save money; they had their own room but were still self-conscious about being heard during physical intimacy. Despite their hopes, this pattern did not improve when they moved into their apartment eight months ago. As a result, Mateo stopped trying to initiate sex, which led to a decrease in other kinds of physical intimacy and words of affirmation. Camila has expressed concerns about Mateo seeking fulfillment outside their marriage despite Mateo's assurances of loyalty. It is noteworthy that there is currently no concrete evidence supporting the suspicion of infidelity. Camila said, "Part of me believes Mateo would never cheat on me, but the other part of me is afraid I'm not enough for him." She conveyed efforts to internalize her feelings of jealousy and acknowledged occasional challenges in containing them, resulting in expressing criticism of Mateo during moments of emotional intensity. Mateo said he tries to reassure Camila, but when it does not work, he shuts down; "I just can't get through to her." Both individuals engage in individualized patterns of shame, hindering their ability to engage in constructive discussion about matters such as sex, jealousy, and more.

In line with the first stage of EFT, cycle de-escalation (Johnson, 2004), Shauna continues to identify negative interactional cycles that contribute to the couple's distress and work to interrupt and de-escalate them. Shauna diagnoses Camila with Genito-Pelvic Pain/Penetration Disorder (F52.6) after Camila's healthcare provider rules out medical causes (American Psychiatric Association, 2022). Additionally, from an EFT perspective, Shauna sees Camila as a pursuer (she cannot pursue Mateo sexually, so she pursues his attention with jealousy) and Mateo as a withdrawer (he is cautious and does not want to hurt Camila by initiating sex or by sharing some emotionally complex feelings), ultimately continuing a negative cycle and insecure emotional connection in their relationship. Shauna notes that Camila experiences a deep-seated fear of abandonment influenced by her early childhood circumstances. Specifically, Camila was separated from her father, who faced deportation to Mexico when she was five years old. He later legally re-entered the U.S. when Camila was 11. Camila's history highlights the impact of systemic issues surrounding immigration policies and the importance of recognizing the legal complexities within the context of Camila's familial experiences. Additionally, Shauna approaches the structural perspective of shame tied to scripts about how a "good" Catholic wife should fulfill all her husband's desires in a heterosexual, monogamous marriage. As for Mateo, Shauna recognizes his fear of being overwhelmed, both by the intensity of his emotions and by Camila's feelings, such as jealousy and suspicions of infidelity. This fear is rooted, in part, in Mateo's past experiences with his family. His father, who struggled with anger issues, frequently directed his frustration through yelling at Mateo, his mother, and his two younger sisters. For Mateo, this history underscores the impact of familial dynamics and the importance of acknowledging potential intergenerational influences on one's emotional well-being. Shauna assists Mateo in exploring latent feelings of anger triggered by Camila's accusations. This process includes examining the structural factors that contribute to his resistance to expressing healthy anger. These factors include dynamics in Mateo's relationship with his father and societal stereotypes, as he seeks to avoid conforming to the stereotype of being a macho, angry, and unempathetic Mexican husband.

From an SDSRH perspective, Shauna sees multiple factors at play for Camila and Mateo. These include but are not limited to (a) social identities: given their various identities and associated scripts, Camila experiences extra pressure to be a "good" wife and meet Mateo's needs, leading to feelings of inadequacy and jealousy, and Mateo is averse to confirming to the stereotype of a hypersexualized Latinx man, leading him to stop initiating sex; (b) social and community context: Mateo endured psychological mistreatment as a result of his father's struggles with regulating his anger, and Camila's father's involvement with the immigration system led to attachment trauma; and (c) socioeconomic status and material circumstances: for a period of time, Camila and Mateo faced limitations in their housing choices and intimate spaces due to their working-class status. A detailed but not comprehensive accounting is in Table 2.

Shauna then begins the next stage of treatment, employing the four levels of the PLISSIT model of sex counseling (Annon, 1976). Camila and Mateo benefit from receiving permission to discuss non-penetrative sexual activities, which are culturally taboo in their Catholic church. To address limited information, Shauna shares specific information related to Genito-Pelvic Pain/Penetration Disorder (GPPPD). She also offers specific suggestions to treat GPPPD, such as how to implement exposure and response prevention instead of avoiding sex (Dias-Amaral & Marques-Pinto, 2018) and how to use sensate focus to increase sexual pleasure and de-emphasize penetrative sex (Weiner, 2022). Finally, Shauna provides intensive therapy via EFT to address attachment and relationship issues. Through this process, Shauna takes structural opportunities to reduce Camila and Mateo's self-blame, such as by highlighting inadequate sexual education in the U.S. and the Catholic Church, which did not equip them to prioritize pleasure, navigate contraception options, address sexual dysfunction like GPPPD, and more. Shauna also

engages in advocacy to connect Camila and Mateo to supportive resources. For example, they both want to learn more about contraception options other than condoms, so Shauna directs them to Planned Parenthood. Additionally, Camila wants to process her father's deportation experience further, so she and Shauna devise a plan for her to be a volunteer facilitator for a Rainbows for All Children group, helping children cope with parental deportation. Finally, Shauna uses an online action center outside the counseling room to support proposed legislation to improve U.S. sex education (Real Education and Access for Healthy Youth Act, 2023).

Table 2

Some social determinants of sexual and reproductive health (SDSRH) for Camila and Mateo.

SDSRH domains	Camila	Mateo
Cultural and societal values	• Camila's parents shared the Catholic Church's value of abstinence until marriage.	• Mateo's Catholic mother was relatively permissive about him having safe, consensual, premarital sex.
Social identities	• Cisgender woman in a monogamous, heterosexual, Catholic relationship - *I should fulfill all my husband's sexual desires.* - *I'm a terrible wife if I don't want to have children right away.*	• Cisgender, heterosexual, Mexican American man - *I don't want to fit into the stereotype of a hypersexualized "macho" Hispanic man cheating on his woman, prioritizing sex above everything, and getting angry quickly.*
Social and community context	• The father's involvement with the immigration system (deportation) contributed to Camila's attachment patterns (e.g., fear of abandonment).	• The father's yelling and anger issues constituted psychological abuse of Mateo and his family, contributing to Mateo's attachment patterns (e.g., withdrawing and hiding messy emotions).
Socioeconomic status (SES)	• Employment as receptionist - Some financial stress and lack of paid maternal leave contribute to a desire not to have children right away.	• Employment as electrician - Mateo meets people in their homes every day, contributing to Camila's fear he will cheat
	• For both: Working class status leads to certain material circumstances discussed below. • For both: No bachelor's degree, combined with other factors (e.g., religious community, poor U.S. sex education), leads to lower health literacy, discussed below.	
Material circumstances	- Lack of private space for sex: Lived in a room in Camila's parent's house for the first two months of their marriage	
Healthcare access and quality	• She fears getting pregnant and does not know all the different options for contraception. • She does not have the health literacy to know what is happening with her pain during penetration.	• A primary care physician once said, "If you're like those other Mexican guys I know, we should get you tested for STIs soon!" • Does not have the health literacy to know a helpful response (e.g., gentle exposure, not withdrawal) to Camila's pain during penetration.
Government policies	• Unlike many other governments, the U.S. does not require paid parental leave. • The U.S. government has not adequately addressed health education for young people. - One proposed bill in the 2023-24 Congress, H.R.3583, Real Education and Access for Healthy Youth Act of 2023, would address some of these issues.	
Downstream psychosocial and behavioral factors	• Both feel shame and low self-efficacy in talking about sexual issues, navigating appropriate contraception options together, etc.	

Shauna also integrates structural opportunities into EFT-specific processes, continuing through the roadmap of EFT stages (Johnson, 2004). After completing the first stage of EFT, she continues with the second stage, restructuring interactional positions (Johnson, 2004). Mateo transitions from withdrawal to reengagement, incorporating appropriate expressions of anger toward Camila. He concurrently communicates vulnerability by openly expressing the pain caused by Camila's suspicions. Camila in turn interprets Mateo's anger and pain as meaningful indications of love, instead of the perceived apathy of disengagement. She engages in blamer softening, becoming more honest about her feelings of shame and pain, consequently reducing her jealousy. During the therapeutic process, the couple explores additional sources of vulnerability, such as shared feelings of financial and sexual inadequacy living in Camila's parent's house, a topic previously unaddressed. Shauna validates these emotions while also broaching the structural perspective of an unjust housing market. In the third and final EFT stage, consolidation and integration of therapeutic gains (Johnson, 2004), Camila and Mateo share that they have been able to have penetrative sex without pain and have improved other areas of physical intimacy (e.g., touching, kissing) and emotional intimacy (e.g., sharing vulnerable feelings, responding empathetically, breaking the pursuer-withdrawer cycle) and have a broader understanding of social and structural factors impacting their lives (Ali & Sichel, 2014).

Conclusion

When it was first developed, integrative sex and couples counseling innovatively applied the concept of the couple system to sex counseling, which had previously focused more on the individual (Weeks, 2005). Now, counselors, sexologists, and other mental health professionals increasingly recognize the impact of broader systems factors (e.g., culture, politics, healthcare, SES) on health and health inequities, including sexual and reproductive health inequities. The social determinants of sexual and reproductive health (SDSRH) provides one framework for understanding inequities and enhancing integrative sex and couples counseling. This article argues that the SDSRH goes beyond multicultural competence, ecological systems theory, and other systems theories to better address counselor values of structural competence (Ali & Sichel, 2014; Wilcox et al., 2024), social justice, advocacy, and equity (MSJCC; Ratts et al., 2015).

Just as the multicultural orientation framework concept of cultural opportunities (Davis et al., 2018) can be applied to any counseling theory, so too can this article's proposed SDSRH concept of structural opportunities. The fictional case study illustrated how a counselor recognized and responded to structural opportunities to address the SDSRH while still following best practices in sex counseling and specific couples counseling theories. At the same time, this application is limited by the lack of a stand-alone SDSRH framework, whereas the social determinants of health (SDOH) and mental health (SDMH) have been more clearly conceptualized. Future research should formulate an SDSRH framework, explore more pathways by which these determinants affect sexual and reproductive health, and examine whether attending to structural opportunities in counseling are associated with better treatment outcomes. In the meantime, the SDSRH can help organize sexual health-related systems factors, honor counselor values of social justice and advocacy, and complement other areas of critical, anti-oppressive research and practice. This work represents another step counselors can take to support greater well-being and health equity for their clients and society.

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