Sex Therapy: Historical Evolution, Current Practice. Part 2

This is the second of a two-part series on the treatment of sexual difficulties. It presents a systemic approach to sex therapy and uses illustrative case histories to explore: the interrelationship between the presenting person or couple; the 'sexual' as part of the relationship; the symptom; the medical considerations; the cultural context; and the framework and thinking of the therapist.

People who present with sexual difficulties often believe there must be a physical cause for their problem. It feels to them as if *the mind is willing* but the body will not cooperate, causing frustration for them or their partner. Because sexual symptoms are understood as somatic markers of distress, physical, emotional and interpersonal dimensions are considered. Assessment places the symptom in context, and ensures that physical and mental illnesses are not missed. Later, I will provide an example of a first interview, and supervision related to it.

Assessment

Is it Organic?

Because sexual difficulties may be the first presentation of serious conditions such as diabetes, heart disease, kidney disease, depression or alcoholism, a medical checkup is usually a good idea. Routine tests include glucose, cholesterol and testosterone levels, with more sophisticated tests only being performed if there are specific indications (Andrology Australia, 2003). Any painful condition should be medically assessed.

Medication which can cause sexual difficulties includes antidepressants, antipsychotics and antihypertensives (among others). Alcohol, cigarettes, methadone and non-prescription drugs, including antihistamines and topical vaginal medications, can also cause problems. If symptoms start around the same time as commencement of a new medication, that medication is under suspicion of causing the symptom till proven otherwise.

Contextualise the Problem

Anything which affects the feeling that your body is your own to enjoy, and yours to share or not share, may affect feelings related to sex. These include:

- Background: culture, religion, family attitudes to sex
- Knowledge about, and response to own bodily changes; for example, menstruation, pregnancy, menopause
- Sexual beliefs: what is acceptable (e.g. the right to initiate/refuse); pleasure with self-stimulation; sexual orientation
- Traumatic experiences, including a history of sexual or physical abuse, or traumatic vaginal examinations
- Physical or emotional pain related to birth, infertility, termination or miscarriage
- Surgery, especially to 'sexual' organs (mastectomy, hysterectomy, radical prostatectomy) and its effect on self or partner
- Severe illness, including diabetes, hypertension, cancer, or any chronic illness
- Life stage: for example, anxiety at the start of a relationship (typical symptoms are premature ejaculation and vaginismus); exhaustion with young children ('lack of libido'); midlife; old age (note that these are ordinary life stages, but are profoundly important psychologically)
- Contraception
- Physical context; for example, comfort and privacy
- Emotional relationship with partner: respect for partner and self
- Medication: prescribed or recreational

Considering these factors helps us begin to understand what life and family circumstances may have contributed to the couple's or individual's presentation. Is intercourse or sexual relations not desired, physically painful, or problematic for either partner?

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Based on the Above Framework, During Initial Consultation We Ask Each Person

- To describe the problem, and their understanding of it
- What it was like growing up in their family
- Their family's attitudes and beliefs about sex: how it was talked about, or whether it was unmentionable
- How they found out about bodily changes, for example, periods
- How they found out about sex
- A brief outline of their life history, including schooling, friendships, work
- Their relationship and sexual history
- What life is like now: work, relationships, any problems they perceive
- The reason for coming now (they may have had the symptom for years).

Sometimes, people are surprised that the first interview does not focus solely on the symptom. While medical issues are dealt with and an examination may be offered, questions relate to the person or couple as a whole, not just to what is not working. Initially, many people simply want their symptom fixed, whereas this type of consultation frames treatment as being able to offer more than symptomatic relief. One way to think about psychosexual therapy is that the therapist helps translate the language of the body (expressed as symptoms) into words, so that people learn to talk about, rather than enact, their difficulties. This relocates distress from the *soma* to the *psyche* (Crowley, 2004), and provides an opportunity for individual and interpersonal growth and a deepening of the relationship.

When clients request behavioural and/or medical treatments**,** advantages and disadvantages of each are discussed. In fact, many will have already had these prescribed. As in all nonprescriptive therapy, listening to patients' concerns and desires requires a nonjudgmental approach. Referral to other professionals can be a very powerful way of helping when we feel unable to work with particular clients.

An Example of a First Interview with Tina, Using the Framework Described

Describe the problem: My doctor referred me to a gynecologist because I couldn't have sex with my husband, because it hurt too much. The gynecologist did a small operation, and told me it was successful, but I still can't have sex.

What's your understanding of that? I'm a complete failure. The operation worked, but I still can't do it. There must be something really wrong with me.

I'm going to ask you some questions now that may not seem connected, but may help us understand what's been happening …

What was it like growing up in your family? I grew up in a big and loving family, but sometimes it would get a bit frightening when Dad had been drinking, and then he might get violent. The only thing to do was get out of the way.

How did you find out about periods, about sex? Mum didn't talk about those things, but my older sister explained about using pads. I never used tampons because I thought I'd hurt myself. The girls at school talked about sex, and it seemed exciting, but scary. I always expected that sex would hurt, because that's what everyone said, but I thought I'd be able to put up with it, because I'd had a lot of pain as a teenager and managed it.

What happened? I was running away from my dad one night when he was drunk and chasing me because I said something a bit rude — disrespectful — to him. He hit me and I tripped and fell down the stairs. I was unconscious for a few days, broken bones, etc. He felt really terrible about it.

What was school like? I wasn't such a good student, but I had lots of friends, so I enjoyed it mostly. I missed quite a bit of school because of all the treatment I needed. Some of it was quite painful. Lots of injections.

Did you have boyfriends? Not till after I finished school. I never went much past kissing till I met John, because I was brought up to believe you should wait till you're married.

Life till now: work, interests? I did a secretarial course, and got a job in the city straight after. I've worked my way up, and now I'm the boss's personal assistant. I'm thinking of changing jobs because the boss is unpredictable, so work's sometimes tense. I played netball till we got married, but haven't gone back to it since.

Tell me about your relationship with John: We love each other very much, so it's very disappointing that we haven't been able to have proper sex. I really thought it'd be okay once we got married. Beside that, we'd like to start a family.

You said 'proper sex'. Did you mean with penetration? Yes. I get scared even at the thought of that, and John doesn't want to hurt me, so he's stopped trying. I feel bad for him.

What's John's view of the problem? He says he loves me, and that he can wait. He knows I want it too, so I suppose it might be different if he thought I didn't care.

Could you imagine putting your finger in your vagina? I couldn't — I'd be scared it would hurt — it's too small — and I wouldn't want to touch down there. I'd rather John do it, if we really have to.

Are you able to reach orgasm? Oh yes. We have fun in bed, and we both orgasm, but that's not the same — besides, you can't get pregnant like that.

Formulation

Tina needed to learn to feel more comfortable and in control of her body. She needed to separate the memory of her painful rehabilitation as a teenager from the idea of physical intercourse with her husband. Because her expectation of sex was that it would hurt, she may have equated penetrative sex with the pain of repeated injections and other invasive procedures she suffered as a teenager.

Course of Therapy

Tina came for six sessions, during which she discussed her painful past experiences in detail. She was also taught to insert her own finger into her vagina, in a way that she could be comfortable and in control, and was encouraged to talk about how she felt in doing that. As she gained confidence, the initial reluctance turned to a sense of mastery and pride in achieving what she wanted. Therapy ended when she was able to have intercourse with her husband.

Some people only need their physiological functioning explained, or simple reassurance, for symptoms to disappear.

> Chris, a 17-year-old apprentice carpenter, was concerned that he could not satisfy his girlfriend, Melissa, because he had premature ejaculation. He had always ejaculated quickly by himself, but that never mattered. He attended only one appointment, in which there was a detailed discussion of male physiology. This clearer understanding increased his confidence. He phoned two weeks later to say he no longer had a problem.

Others become interested in understanding their sexual difficulty in the context of their relationship. Success is then measured in terms of mutual pleasure and increased intimacy (Ellison, 2001). Whatever has prevented them from being able to connect sexually is addressed. While this might include learning to live with medical problems, it would also include acknowledging buried feelings, developing new solutions to interpersonal problems, recognising differences and developing more realistic expectations, sexual and otherwise.

> Alan, an overworked doctor, and Jenny, a part-time family lawyer, presented 12 months after Alan's radical prostatectomy for cancer, because Alan had been unable to have an erection since the operation. Alan's urologist had suggested he try a vacuum device or have a penile implant as Viagra hadn't worked, but he was as put off by these suggestions as by the idea of penile injections. Jenny said she was prepared to support whatever Alan decided to do. They both said they missed the closeness of penetrative sex. Since the operation there had been little physical closeness. Jenny told me they had three children and four grandchildren. Their disabled son still lived at home. She quietly asked if perhaps they should just accept that they were getting older – maybe they needed to accept their days of sex were over. An initial suggestion to give each other a back massage did not eventuate because, while Jenny was willing, Alan said he couldn't. They had never done that sort of thing before, and he wasn't about to start now.
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> This innocent prescription unleashed Alan's festering anger, which he turned on himself, for having 'rushed' into the operation (on the advice of the surgeon), on Jenny, for everything wrong in their marriage, and on me, for making such a facile suggestion. There was no room to think about the overwhelming loss that the operation entailed, especially for Alan, for whom the only real sex was penetrative sex.
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> While he had recovered well physically, and was out of danger medically, their longstanding marriage was now at risk. For Alan and Jenny, sex had been a balm in a sometimes difficult relationship. Necessary surgery had destroyed this soothing connection. While Jenny wanted to work through their difficulties, they were struggling to maintain any good feelings.
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> Therapy was very painful for both, as longstanding grievances and then feelings of loss were aired. Each needed some individual sessions to talk about their personal pain, but most sessions were held together. After many difficult months of therapy, mutual respect, appreciation of each other, and eventually physical affection began to emerge. They held hands when walking down the street for the first time. As their relationship started to come alive, and humour appeared, they began to discuss what they wanted to do about sex; whether they would want to use medical devices; and whether they were brave enough to experiment with change to a sexual relationship which had been satisfying in the past for both, when both enjoyed penetrative sex. Therapy ended when they were ready to explore the possibilities the urologist had originally suggested, because they could now think of them as tools they could decide to use or not.

The decision to see only one of a couple when both have presented remains contentious. Some therapists believe that couples, once seen together, should only be seen together, both to stop the possibility of the therapist being told a secret, and to underline to the couple that while the symptom is expressed in one person, the problem is there for both. While I generally agree, I believe that at times, it is in the interest of both partners for a private space to be available to address individual concerns.

Supervision

Supervision is an important safeguard for both clients and therapists, particularly as challenges inevitably arise when therapists are not doing 'recipe book' therapy. Less experienced therapists can use it to further their clinical acumen, and learn the value of listening and not feeling obliged to solve problems (Crowley, 2004). Whereas therapy focuses on

the relationship between the clients and their problems, supervision extends this to include a focus on the relationship between the therapist and clients, with questions such as 'What was it like for you in the session?'. This parallels therapy in which clients are asked 'What happens?' and 'What is it like for you?' and provides an experiential context for learning about the client, as well as our own biases and vulnerabilities, especially when therapy has stalled. Presenting what you feel worried or embarrassed about — for example, feeling angry/bored/stupid with particular clients — not only mirrors how clients may feel when they present to you, but also gives you the opportunity to understand these feelings in relation to a particular client.

> I could still feel my moral indignation as I described to my supervision group how angry I had felt in the first consultation with Tina, the 26-year-old personal assistant who presented with vaginismus. I wasn't angry with her, but with her treatment. I could not believe that she didn't feel the same way.
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> *Describe the client:* Dark-haired, bubbly, attractive, sweet, full of life.
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> *What about her history?* She presented because she still couldn't have sex with her husband after a 'technically successful' operation for vaginismus. Her doctor had originally given her a choice – therapy or a gynecological referral – and she had chosen the gynie because she wanted as quick a solution as possible.
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> *Her past history?* She described being from a large and loving family, but that her father would get drunk at times and go on a rampage. She was a bit rude to him one night; he hit her, she fell down the stairs, and was unconscious for a few days. She stressed how bad her father felt about it, and how remorseful he was. She had needed lots of physical therapy, some of which was very painful, and she became terrified of injections.
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> *Her relationship with her husband?* Good. They enjoy each other's company. He sounds caring and isn't pressuring her.
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> *You're angry about her treatment. What was her view of it?* That's what I couldn't get over: she praised the gynecologist, and believed that he'd done a very good job, because he told her after the operation that it had been a complete success. Of course, that meant to her that she was a terrible failure, because she couldn't translate that positive outcome into being able to have sex.
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> *[Feedback from the group]: It sounds like you experienced the anger we might also have expected Tina to feel: she's had this operation, is told it is all fixed, but she still can't have sex. But if we listen to Tina's story, she never gets angry, no matter what happens; and, if anything, she usually blames herself. Her father knocked her down the stairs in a drunken rage; she implied she provoked him and, since he was remorseful, she really couldn't blame him. She had several painful medical procedures as a teenager, and learnt that a good patient puts up with it and doesn't complain. She wants to have sex with her husband, but till now her body hasn't felt like her own – it has been a painful body.*
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> *That's about her. About you – it sounds like it was hard for you to listen to her gratitude to the gynecologist when you believe he was doing the wrong thing. For you, it was as if he was assaulting her by performing the operation. It seems it was hard for you to accept that different frameworks provide different solutions – but this was the initial solution of choice for this patient; her first choice was to go to a gynecologist, not a therapist, because she wanted the problem fixed as quickly as possible – she wasn't really interested in therapy. Her view matched the gynie's view; his solution was the one she wanted.*
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> *Outcome:* The feedback helped me listen to her story in a less reactive way. When my moral indignation subsided, it opened a space for her to explore her feelings about what had happened, and how her body felt to her. She then became ready to be examined under her direction, and then to put her own finger into her vagina; she was ready to 'own' her own body. This gave her the 'know-how' and confidence to teach her husband the approach that, through experience, she had learnt could make penetrative sex a comfortable and welcome experience for her.

Sexual Abuse and Sex Therapy

While many people with sexual difficulties have a past history of sexual abuse, not all those who were sexually abused have sexual difficulties. Many survivors present for counselling because of a partner's frustration, and some are more worried by the consequences of sexual problems than by their existence (Maltz, 2001). Some feel intense fear, guilt, disgust or nausea when touched; others have difficulty becoming aroused or feeling sensation; and some feel emotionally distant during sex, or have disturbing and intrusive sexual thoughts and fantasies.

In tandem with performance-based models, sex therapy for victims of sexual abuse often aimed to make sex safe and tolerable, and therefore possible. Therapy often focused on issues common to incest survivors; for example, shame, anxiety, control and low self-esteem. The guiding premise was that the abuse had left the person afraid, especially when confronted with intimacy. Finding ways to make sexual relations increasingly safe, however, were often stultifying rather than liberating.

Newer concepts aim to develop enjoyable sexual relationships, rather than tolerable ones. To begin, for clients, just being able to sit, breathe, feel relaxed and stay present

when touching their own body can be a challenge. Comfortably touching a partner or feeling pleasure from a partner's touch can be even more difficult. For therapy not to feel abusive, it needs to encourage client choice, empower the client and respect his or her reactions (Maltz, 2001). Fears need to be confronted rather than avoided (Mahrer, 1996), and confusing feelings, including pleasurable ones associated with the abuse, acknowledged. Talking about sex can stir up sexual feelings, so that helping a person get in touch with their physicality needs great care for therapy to be physically and psychologically safe.

The challenge is to help people learn to feel good about their sexual energies, body parts, passions and expressions, in spite of the abuse. It is helpful to involve both partners to some level, because otherwise couples can get trapped in a cycle of anger and emotional distancing. Survivors need to stop engaging in sexual behaviours which undermine the healing process, including obligatory sex, which by definition mimics abuse dynamics. It is helpful to identify triggers and be alert to personal reactions. If a reaction occurs, survivors are encouraged to stop, use breathing techniques to calm down, affirm reality by reminding themselves that they are older and have choices, and decide if they want to continue — but in a way which feels good in the present moment.

> Jane, an athletic 29-year-old sport physiotherapist, made an appointment because she could not understand why she was feeling increasingly alienated from Derek, her husband of 18 months. She loved him and they had sex twice a week, mainly because she wanted to please him. History taking revealed that she had been abused by her uncle as a young teenager for about two years, but she had put the abuse out of her mind and got on with her life: 'You can't do anything about it … No-one wanted to know about it anyway'. We spent some time discussing what had happened, and then her current fears about her marriage. Eventually she felt brave enough to invite Derek into the session, and tell him about the abuse. He was horrified and concerned about her. She told him that she often had sex when she didn't really want to, because she felt bad saying 'no' to him — he was entitled to have sex with his wife. While she realised it wasn't his intention, she felt pressured. He responded that it was true that he could enjoy sex at any time, but he only really wanted to have sex if it was a good experience for both of them. He reminded her that at times he had asked if she was okay, because he sensed her discomfort, but she had always told him to continue. Jane, with Derek's support, began to experiment with keeping her own comfort and pleasure in mind, and stopped her old pattern of pretending things were all right when they weren't. Derek reported being happier with intimacy, even though penetrative sex stopped for a while because, he said, 'When I know she's saying "no" to whatever she's not comfortable with and she trusts that, I respect what she says; it means she is more willing to explore things. It's been good for our relationship more generally too, because, for the first time, I really feel her opening up and trusting me.'

Ethics, Values and Meaning

Sex therapy often involves specific recommendations to patients and direct responses to patient's questions, so there is a significant potential for the values of the therapist to influence the patient. In the past, moral judgements about sexuality were most often negative (premarital sex, extramarital sex, homosexuality and masturbation), and earlier treatments (e.g. aversive therapy) were often punitive.

The ethics of prescribing medication or performing surgery which has potential side-effects on people whose problems are not organically-based has not received much attention. This is because of the value placed on 'normality' which translates to performance, the high value placed on the quantifiable ('evidence-based'), and the persuasive marketing of a pharmaceutical industry which promotes a view of sexuality as a medical condition needing treatment (Moynihan & Cassels, 2005).

Future Directions

The public discourse around sexual difficulties is largely stuck in the medical and the behavioural. We need to venture beyond the therapy room to challenge both the discourse and social context in which sexual problems exist. Many children still do not feel good about their bodies, or learn about sex in a positive way. Many girls expect sex to hurt, and many boys think about sex in terms of conquest or performance. A lot of sex education in the classroom is little more than basic biology, and a lot of what teenagers learn outside the classroom is not based in fact. We should aim to address the potent feelings: the mixture of excitement, curiosity, bewilderment and shame that is part and parcel of growing up. Notions of pleasure, passion, self-respect and diversity, and the difference between performance and connection in sex need to be addressed, because sexuality is an important and fundamental aspect of life.

The media runs articles on g-spots, dream creams, nasal sprays and pills (Lemonick, 2004) as 'treatment'. We do not see articles looking at the reasons for people's vulnerabilities concerning sex, or exploring the broader options for treatment. We need to think about the effect of pornography in shaping ideas about sex and body image, especially on young people, because pornography is now available in the privacy of the home, courtesy of the Internet. As a community, we do not challenge these denigrating and damaging images. The fact that women, who increasingly want sexual fulfilment for themselves, are more attracted by men's behaviour toward them than by their physical attributes, needs a more prominent and positive profile in the public domain.

Conclusion

While treatment of sexual difficulties is predominantly with medication, and the popular understanding of sex therapy is that it is largely behavioural (Masters & Johnson, 1966; 1970), therapy is now available that has moved beyond the concept of alleviation of symptoms to the idea of sexual difficulties as the physical expression of problems with intimacy. This framework recognises that medical and behavioural treatments alleviate symptoms, and can be useful for simpler problems, or when people are unable to think about symptoms in the context of their lives. The person of the therapist is crucially important in this formulation, with his or her capacity to listen to and facilitate clients' understanding of their difficulties and implementation of their preferred solutions.

The framework based on a psychosexual understanding of symptoms offers an enlivening therapy for clients as they are invited to consider what would have to change for sex to give both partners pleasure beyond function. The relevance of what happens outside the bedroom becomes more vital as sexuality moves beyond the physical act to become a metaphor for the way people treat themselves and each other. Therapy is also more alive for therapists as their capacity to help their clients is enriched by supervision in which transference/counter-transference phenomena — how they feel in relationship to their more challenging clients — are examined in a supportive context.

References

Andrology Australia, 2003. Men's Health Matters. Erectile Dysfunction. Impotence and Related Health Issues, Melbourne, Andrology Australia.

Crowley, T., 2004. Balint: The Basic Fault and Psychosomatic Illness, *Institute of Psychosexual Medicine Journal*, 36: 10–13.

Ellison, C., 2001. Intimacy-based Sex Therapy. In P. Kleinplatz (Ed.), *New Directions in Sex Therapy: Innovations and Alternatives*, Philadelphia, Brunner-Routledge.

Lemonick, M., 2004. The Chemistry of Desire, *Time Magazine,* 51–55.

Mahrer, A., 1996. *The Complete Guide to Experiential Psychotherapy*, NY, Wiley.

Maltz, W., 2001. Sex Therapy With Survivors of Sexual Abuse. In P. Kleinplatz (Ed.), *New Directions in Sex Therapy: Innovations and Alternatives*, Philadelphia, Brunner-Routledge.

Masters, W. & Johnson, V., 1966. *Human Sexual Response,* Boston, Little, Brown.

Masters, W. & Johnson, V., 1970. *Human Sexual Inadequacy,* Boston, Little, Brown.

Moynihan, R. & Cassels, A., 2005. *How Drug Companies Are Turning Us All Into Patients,* Sydney, Allan & Unwin.

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ANZJFT Research Issue 2007

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Paul Rhodes will be the guest editor for an edition of the ANZJFT in 2007 with this edition being dedicated exclusively to research in family therapy. Paul is seeking papers that report on completed studies or studies in progress and is hoping for a rich variety of topics and methodologies. Papers can range from traditional empirical efficacy studies, to studies of family therapy process, grounded theory, single case designs, discourse analysis, and so on.

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