

Fundamentals of Theory and Practice Revisited

Sex Therapy: Historical Evolution, Current Practice. Part I

Raie Goodwach

This is the first of a two-part series, and provides a contextual history of major trends in sex therapy, notably the psychoanalytic, behavioural and medical models, as well as detailing the family therapy contribution to the field. Part 2 will present the outline of a first interview, and use it to demonstrate a systemic model which explores the interrelationship between the symptom, the presenting person(s), the 'sexual' as part of the relationship, the biological, the broader cultural view of sexuality – and the therapist's framework and thinking. Case studies are used as illustration.

Introduction and Contextual History

Sexual health is the integration of the somatic, emotional, mental and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love (World Health Organisation).

In a pluralistic society, sex is variously thought of as an adult recreation, a saleable commodity, a set of techniques, the physical embodiment of intimacy, sacred or holy, and the usual method of reproduction.

Whereas the behavioural model of sex therapy, exemplified by Masters and Johnson, and the medical model, with drugs like Viagra, treat sexual difficulties as dysfunctions that need to be 'fixed', systemic models integrate the experiential with the functional, and address the relationship between intimacy and sexuality.

Since the dawn of civilisation, every society has attempted to control the sexual behaviour of its members. Concurrently, the search for an effective aphrodisiac — a magical potion that will heighten sexual desire, pleasure and performance — has been a continuing quest (Morgentaler, 2004). Sex and procreation have always been linked; although even in the animal world, sex appears to be regularly practised for a range of non-reproductive reasons, for example, nuzzling among zebras and kissing among bonobo apes (Kluger, 2004). Homosexuality has historically been

more tolerated in societies where marriage was delayed and female chastity was valued (Gagnon & Simon, 1973).

Ancient India, China, Greece and Rome all had sex manuals, and much sexual information was presented in Greek and Latin poetry. Ancient India had a rich tradition of eroticism, with the *Kamasutra* being a distillation of this. The Hindu *Vedas* included spells to help or hinder love-making and produce impotence. Pleasure was defined mainly from a male point of view (Bhugra & de Silva, 1995). Hindu tantric yoga saw sexual potential as natural, but believed that the fulfilment of its spiritual, emotional and physical aspects in ritual intercourse required careful preparation, prayers and meditation. In China, the emphasis was on orgasm, and the male was encouraged to bring his female partner to orgasm by delaying his own. Voluntary abstinence from sexual intercourse and celibacy of either men or women were viewed with profound suspicion (Bhugra & de Silva, 1995).

Foucault (1981) argued that while India and other non-Western nations enjoyed an erotic sensibility, the Western model was restricted to a scientific discourse. Schnarch (1991) described the sex-affirming Hebraic roots of Western civilisation as having been masked by Christian dogma. Bhugra and de Silva (1995) interpreted this as an attempt to attain perfection through subjugation of the body, with full human consciousness being achieved by suppressing the sexual energies. Foucault believed that repression of all matters sexual deepened in the West in the 18th and 19th centuries as a reflection of the burgeoning capitalist system, along with the medicalisation of sex.



Raie Goodwach, Consultant, Sexual & Relationship Counselling Clinic, Monash Medical Centre. Private Practice, 1232 Malvern Road, Malvern Victoria 3144; raie-goodwach@optusnet.com.au

Nineteenth century sexual ideology, based on monogamous marital sex for procreation (Leiblum & Pervin, 1980), saw men as having sexual appetites which women gratified out of duty. Sexual behaviours other than intercourse were seen as unnatural or wicked. Because women were not expected to enjoy sex, diagnoses like anorgasmia or premature ejaculation were irrelevant.

Radical 20th Century Approaches: Freud, Ellis and Kinsey

Sigmund Freud's discovery that sexuality began in infancy, not at puberty, and his hypothesis that sexuality was intrinsically linked to the development of personality, profoundly challenged the prevailing notion of the 'innocence' of childhood (Leiblum & Pervin, 1980).

Freud's libido theory (1905) saw sexual impulses as instinctive drives which built up and demanded expression and relief (the pleasure principle), but which were kept in check by the ego, which inhibited relief when it conflicted with the need for survival (the reality principle). Pleasure was defined as a reduction to the lowest possible level of unpleasurable excitation, or tension.

Freud named three principal erogenous zones: the mouth, the anus and the genital organs, each of which was associated with the satisfaction of a vital need: eating, elimination and reproduction. The pleasure derived from the erogenous zone could, however, be independent of the pleasure derived from the fulfillment of the vital need (e.g. thumb-sucking).

The erogenous zones were important in the progressive development of personality because they provided the first important 'irritating excitations' with which the baby had to contend, and they yielded the first experiences of pleasure when manipulation of them afforded relief. Actions involving the erogenous zones would also bring the child into conflict with his parents (external reality), and the resulting frustrations and anxieties led to adaptations, compromises and defenses on which personality was based.

In Freud's initial theory, man, driven by impulses to survive and to have pleasure, was primarily isolated, but entered into relations with members of the opposite sex in a bid to satisfy his own needs. In *Beyond the Pleasure Principle* (1920), Freud replaced the original dichotomy between the reality principle and the pleasure principle with a dichotomy between life and death instincts. He relinquished the old physiological concept of drives in favour of a more profound biological orientation in which each living cell was seen as simultaneously endowed with the strivings for life and death as the basic conflict of human existence.

Both theories had a common premise that the governing law of the psychic apparatus was the tendency to reduce tension (or excitation) to a constant low level (the constancy principle on which the pleasure principle rests) or the zero level (the nirvana principle, on which the death instinct is based).

In the revised formulation, the life instinct was called eros — as was the love instinct. Freud no longer conceived of human beings as primarily egocentric, but as being primarily

related to others, impelled by the life instincts which make them need union with others. Life, love and growth became one and the same, more deeply rooted and fundamental than the relief of tension known as 'pleasure'.

Freud viewed sexual symptoms as simply manifestations of deeper conflict in the individual. Long-term treatment targeted the underlying neurotic and characterological difficulties. Transference and countertransference and the development of insight were the catalysts for change. Symptoms were not addressed directly, and most often remained unchanged.

Early 20th century English sexologist Henry Havelock Ellis (1859–1939) and American Alfred Kinsey (1894–1956) questioned the traditional institutional contexts of human sexuality (marriage and family), legitimised the existence of female sexuality and broadened the range of socially acceptable sexual behaviour.

Ellis, a physician, wrote a highly controversial six volume series, *Studies in the Psychology of Sex* (1897–1928), which was initially banned on charges of obscenity, and was only legally available to the medical profession until 1935. He saw sex as a natural human instinct. He challenged the notion that masturbation caused illness, insanity and depravity, and argued that homosexuality was inborn and therefore could not be considered a vice. Ellis categorised female sexuality as more passive, elusive and complex than male sexuality, and emphasised the need for extensive foreplay, including cunnilingus.

Kinsey conducted the first large-scale surveys of sexual behaviour in the United States. In *Sexual Behaviour in the Human Male* (Kinsey et al., 1948), he drew a distinction between what society deemed to be normal and what people actually did. In a society in which sexual behaviour was rigidly policed by moralists, the church and the law, and in which oral sex was an imprisonable offence, Kinsey's observations that premarital sex, homosexuality and even bestiality were all part — albeit a hidden part — of the fabric of American life (Brown, 2004) was shocking. He reported a significant incidence of sexual dysfunction in men, and that half of all normal males had had at least one homosexual experience to orgasm. There is now widespread recognition of a significant incidence of both male and female sexual difficulties, especially lack of interest in sex for both males and females (Richters et al., 2003). In *Sexual Behaviour in the Human Female* (Kinsey et al., 1953), he presented data that more than 60% of women had masturbated, over 50% had premarital sex, and 25% had engaged in extramarital sex. He concluded that variations in sexual behaviour were so great as to make any definition of normality meaningless.

Behaviourism to Psychotherapy in the Age of Aquarius

In the 1950s, behaviour therapists began using aversion therapy to treat deviant sexual behaviour. Sex therapy centred on controlling sexual expressiveness, from suppressing masturbation in children and imprisoning 'sexual perverts',

including homosexuals, to finding ways to discourage too frequent intercourse (Leiblum & Pervin, 1980). By the late 1950s, behaviour therapy, which assumed that a sexual difficulty was a learned (conditioned) anxiety response, aimed to extinguish the anxiety or performance demands (LoPiccolo & LoPiccolo, 1978) using techniques such as systematic desensitisation (Lazarus, 1963).

Masters and Johnson are credited with having revolutionised the treatment of sexual problems with their brief, intensive, behaviourally-oriented interventions to treat specific symptoms, outlined in their book *Human Sexual Inadequacy* (1970). While most of their interventions had already been described by Wolpe (1958), their names became synonymous with sex therapy. They pioneered the idea of couple therapy for sexual difficulties, and popularised 'sensate focus' exercises to alleviate performance anxiety. The idea was to become absorbed in the pleasures of the moment and avoid 'working' at sex. When premature ejaculation was a problem, they prescribed the 'stop-start' and 'squeeze' techniques to build confidence in self-control. They recognised women as equal to men in their ability to enjoy sexual experience.

Master's and Johnson's work took place in a milieu of freedom and permissiveness, a result of the sexual liberation of the late sixties, with its emphasis on spontaneity, sensuality and rejection of restrictive inhibitions (Ayto, 1999). Bernard (1976) described it as a time of liberation of the body, in which the 'diabolical' body became a 'glorious' body — a tabernacle of all positive sensations and energies.

The movements of women and homosexuals for equality, the increasing proportion of women in the workforce, and the increasing commercialisation of sex all fostered a substantial revision in sexual attitudes and behaviour, and women considered liberating their sexuality along with the rest of their lives. Sex acts once considered deviant became widely incorporated into heterosexual relations and, from the mid-1960s on, the disparity in premarital sexual experience for men and women started to decline.

The availability of reliable contraception and legal abortions, and the instability of the traditional nuclear family encouraged the reorganisation of sexual standards. Aided by the values of a consumer culture and encouraged by the growing visibility of sex in the public realm, many now regarded sexual pleasure as a legitimate component of their lives, unbound by older ideals of marital fidelity and permanence (D'Emilio & Freedman, 1988). Sexual behaviour as a 'moral category' weakened significantly as the Judeo-Christian emphasis on the moral value of restraint (virginity) and the moral failure of excess (the orgy) lost their hold (Gagnon & Simon, 1973).

Masters and Johnson based their clinical work on reports of the human body's physiological responses to erotic stimulation (*Human Sexual Response*, 1966), and described a pattern of four phases: excitement, plateau, orgasm and resolution, drawing a parallel between male and female sexual responses by describing analogous changes in males and females throughout each phase of

the cycle. They saw sexual arousal as a linear progression toward orgasm. The fact that therapy was constructed around measurable, physiological responses helped to establish the legitimacy of the field (Kleinplatz, 2001). Feminists enthusiastically adopted Masters and Johnson's physiological sex research to support their political agenda. In Masters and Johnson's initial formulation, sexual desire was not considered (Kaplan, 1979).

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Sexual dysfunction was defined in terms of frequency and adequacy of sexual performance. The focus was on achieving penetration and ejaculatory control; the goal was sexual intercourse and orgasm. Sexual surrogacy as a method of treatment fitted this pragmatic model, with its idea that achieving penetrative intercourse with a surrogate partner would teach isolated men to form their own relationships, and that supervision of surrogates made it different from prostitution.

While Masters and Johnson reported high success rates with their treatment regime in an intensive residential program with highly-motivated couples, their program was not as successful for Dr Helen Singer Kaplan when delivered in a hospital outpatient setting. She therefore used their behavioural exercises to stimulate therapeutic dialogue when the exercises were not curative in themselves. She found that symptomatic relief could be obtained by adding brief psychodynamic therapy to deal with current conflicts. Kaplan further recommended that those with sexual dysfunctions learn to bypass their thoughts and feelings in order to allow their bodies to respond 'freely' (Kleinplatz, 2001).

Her techniques included an eclectic blend of sensate focus exercises, marital therapy, dynamic counselling, behavioural exercises and masturbation. Kaplan (1974) experimented with various treatment formats, including conjoint couple therapy and same-gender group therapy. She introduced the notion of desire as part of a triphasic model (desire, excitement, orgasm), placing desire before physiological response. She also introduced medication, especially SSRI antidepressants, as an aid to overcoming sexual phobias. Kaplan's prolific writing did not include outcome statistics. Ideas from Masters and Johnson and Kaplan continue to inform current practice.

The Institute of Psychosexual Medicine (IPM) developed in the United Kingdom when a group of Family Planning Clinic doctors, with no prior training in psychological matters, requested supervision from the psychoanalyst Dr Tom Main, because of their difficulty in treating patients who presented to the family planning clinics with sexual symptoms. The term 'psychosexual medicine' recognised the link between mind and body, and that emotions could be expressed in the form of bodily symptoms. The focus in training and supervision for these doctors was the description of the patient's behaviour at the vulnerable time of the genital examination, and the doctor's feelings in response to this. The examination of the doctor-patient relationship (transference-countertransference phenomena) *at the time of the genital examination* became the sine qua non of the British Institute's definition of psychosexual medicine.

Medicalisation of Sex

The mid-1980s ushered in a psychobiological era, distinguished by the medicalisation of treatment approaches, especially for male sexual dysfunction (Tiefer, 1987). Erectile difficulties, previously treated with behavioural exercises or external vacuum pumps, were treated by increasingly sophisticated penile implants, then in the 90s, penile injections, intraurethral inserts and drugs like Viagra. Low-dose antidepressants prescribed for treatment of premature ejaculation capitalised on the delayed ejaculation which is a side-effect of antidepressant medication (Sussman, 1999), and testosterone and other hormone therapies were introduced to treat both men and women who presented with sexual aversion or lack of desire. Most doctors today suggest starting treatment for erectile difficulties with tablets such as Viagra (Andrology Australia, 2003).

Specially trained physiotherapists, as well as sex therapists, began to treat women with vaginismus (pain on penetration) with dilators as a form of systematic desensitisation to introducing objects into the vagina. Surgical procedures to increase the size of the vaginal opening and treat vulval pain were also devised.

There are well-recognised medical causes of sexual difficulties, and sexual problems can be the first sign of serious illness. But if surgical procedures and medication are the only treatments offered regardless of cause, medicine ironically falls into step with pornography, treating sex and sexual difficulties as if they were independent of the relationship between the partners.

Pornography

Pornography, long confined to a shadowy underground, became more widespread with the introduction of videocassette recorders in the late 1970s, making it readily available for home consumption. At the same time, best-selling sex manuals such as *Everything You Always Wanted to Know about Sex* endorsed sexual experimentation in language that

20 years earlier had been the province of pornography (D'Emilio & Freedman, 1988). By the 1980s, economic analysts were referring to the 'growth potential of the sex industry', with advertising projecting the message that consumption promised the fulfillment of erotic fantasies and appetites. The glorified body of the 1960s became a fetish object in the 1980s, and usage of pornography underwent exponential growth in the late 1990s with the increased affordability, accessibility and anonymity of the Internet.

The coincidental increasing incidence of sexual violence to, and sexual harassment of women, however, mocked the rhetoric that sexual freedom applied to women as well as to men, in a culture in which men's needs for intimacy and nurturing have been denigrated and their sexual needs overemphasised.

Critique of the Various Models

Freud's emphasis on biological and intrapsychic explanations ignored the effects of social learning and expectations. His focus on individual difficulties ignored the dynamics of relationships. Freud's masculine bias reflected the influence of a patriarchal Western society, with notions of penis envy and female masochism constructed on the basis of male understanding and experience (Fromm, 1980; Olivier, 1989). The idea that the vaginal orgasm was the marker of sexual maturity limited female sexuality for generations until refuted by Masters & Johnson's physiological studies.

Because the British Institute of Psychosexual Medicine considered the genital examination to be essential to psychosexual counselling, doctors were the *only* professional group able to examine sexual problems in this way. Goodwach (2001) suggested that while the genital examination provided unique information, it was the framework of learning by examination of the therapist-patient relationship which separated this mode of treatment from behavioural and medical models. Hence it could be applied to the treatment of couples, as well as of individual patients, by a broader group of non-medical therapists who understood sexual difficulties as psychosomatic symptoms, and who were interested in the process of learning through ongoing supervision. This is the basis of a model used by a number of therapists in Australia.

Both the behavioural and biomedical models are primarily genital and goal oriented, and rely on sexist research, language and theory (Tiefer, 1987). They promote function without any serious attempt to integrate emotional and relational needs with sexual desire, in a framework in which sex is understood as an entitlement within a relationship: something that a partner is duty-bound to provide (a bit like the Victorian notion that it was a wife's 'duty' to provide sex).

The fundamental flaw in these models is the notion that life experience is reducible to objective physiology (Gagnon & Simon, 1973). The underlying assumption is that sex can be separated from the rest of life, and that what is needed for sexual pleasure in an ongoing relationship is the same as what is needed for casual sex: functioning body parts, a

variety of positions and physical sensation: parameters which match those of the sexual behaviour described in hard-core pornography (Gagnon & Simon, 1973). For Masters & Johnson, sexual arousal was a linear progression to orgasm. More recent discussions have questioned whether women, especially in long-term monogamous relationships, have a more circular pattern, with satisfaction possible at any stage, and orgasm not necessarily the goal (Basson, in Leiblum & Rosen, 2000).

The medicalisation of sexual difficulties has come to be seen as exacerbating the problematic way that sexuality has been constructed, with its emphasis on performance (Kleinplatz, 2001). As penile injections were replaced in the late 1990s with oral medications such as Viagra, the pharmaceutical industry's advertising implied that etiology did not matter, because this simple medication could not only deliver firm erections for men with either organic or psychologically-based problems (Rosen, 2000), but that improved function would improve their relationship. Men were often perplexed when this didn't happen.

Damien, a 48-year-old electrician, presented because he 'couldn't hold his erections'. His wife of 23 years, Tracey, wouldn't let him use Viagra a second time after he'd used it once, because she said he was only in it for himself: only interested in sex – not in her, which he said wasn't true. With Viagra, the erection definitely lasted longer. He was pleased, but she wasn't – she said lasting longer wasn't all that needed to happen to make it better for her. He knew he didn't really need Viagra, because he could hold an erection when masturbating, but he thought if he didn't have to worry about the erection lasting, he'd be able to satisfy her more. She often pushed him away, saying she wasn't interested, and then his erection would go. That happened more when they weren't getting on – and that was quite a bit these days. At times when she seemed to enjoy sex, it was better. I suggested he invite her to come in to talk about their problems together.

A positive outcome of Viagra has been that its advertising has normalised older people's interest in sex. However, it has done little to boost men's confidence in themselves or their bodies, the result being that many men now feel a need to be pharmacologically enhanced to feel adequate (Morgentaler, 2004). It makes sense to use Viagra for occasional difficulties, like using simple analgesia for occasional headaches. It also makes sense to men with erectile difficulties who 'mate then meet' in the gay and disco scenes, when they don't want to question the personal implications of this aspect of the subculture.

Peter, a busy 27-year-old real estate agent, presented to his doctor with a 2-year history of erectile difficulties. His social life was the disco scene, where (he believed) you had to have sex if you wanted to get to know a girl better. His doctor tried to suggest that that might be the wrong way around: that it was a help to feel comfortable with someone before you had sex with them. Peter wasn't interested; he knew about Viagra, and only wanted to check with the doctor that it was all right medically for him. His doctor prescribed the medication, and told him

that Viagra might kick-start his confidence, but that if it didn't, he'd like to see him again to discuss things further.

The search is now on to find a drug to cure low libido, a common problem in both men and women (Richters et al., 2003). Biologically-oriented doctors, funded by the pharmaceutical industry, have turned to testosterone. While concern has been raised that lack of interest in sex has become a new disease market (Tiefer, 1997), some doctors believe that men and women with sexual difficulties are helped by having their problems labeled and treated medically. That patients benefit from both placebo and test drugs underlines the value of hope, and the complexity of sexuality in which mind, body and experience are inextricably linked (Lemonick, 2004), and in which sexual satisfaction, love and orgasm are not synonymous.

Surgical procedures used to treat vaginismus (when penetration is either painful or impossible) are based on an idea that the vaginal muscles need to be cut or stretched to allow penetrative intercourse. This is markedly different from an idea that for a woman to be an equal partner who is able to enjoy accepting physical love, she needs to be able to set her own limits and boundaries, to consciously make her own decisions (Shaw, 1994), and to feel emotionally ready. In contrast, dilators are usually used as an adjunct to therapy, rather than as a treatment in themselves.

The Politics of Nomenclature

The diagnostic system for coding sexual disorders in DSM IV is based on the triphasic model of sexual responsivity proposed by Masters and Johnson (1966), modified to include Kaplan's work on lack of desire (1974). This nomenclature has become a key contributor to reductionist thinking in the area of sexual difficulties, because it does not reflect the complexity of sexuality and sexual desire. Ironically, it was introduced in part to facilitate payment by the American insurance industry to psychologists and social workers for treating 'disorders of sexual dysfunction' (Kleinplatz, 2001).

The nosology involves arbitrary separation of interrelated aspects of sexual function (Foreman & Doherty, 1993), and relies on defining problems as deviations from 'the human sexual response cycle' (Masters & Johnson, 1966). Original categories were erectile difficulties, premature ejaculation, vaginismus, dyspareunia (pain with intercourse) and anorgasmia (Segraves & Althof, 1998) — all showing heterosexual bias (Tiefer, 1997).

Newer disorders include four subtypes of hypoactive sexual desire disorder, sexual aversion disorder, vaginal engorgement insufficiency and clitoral erectile insufficiency (Goldstein & Berman, 1998). DSM categories assume that sex is synonymous with penetrative intercourse. The sexual complaints that often bring lesbians and gay men to sex therapy, including oral sex aversions and anal sexual difficulties, are not included (Rosser et al., 1998). DSM IV locates problems in the individual, implying that the partner has no reciprocal involvement.

Classification in DSM provides the framework for hospital ethics committees to approve funding for new product trials, with the problematic assumption that these descriptions denote underlying 'disease'. The current nomenclature fails to differentiate medical causation from psychosexual difficulties, and so contributes to the prescription of medication (e.g. testosterone or Viagra) when the problem may be relational. Treatment based on DSM categories is problematic because symptom removal in one partner doesn't necessarily translate into sexual pleasure and satisfaction for both.

The declassification of homosexuality as a sexual disorder illustrates that diagnoses are not simply medically based, but are influenced by prevailing social mores.

Gender and Same Sex Issues

Behavioural and biomedical models are both heteronormative models, with the resumption of penetrative sex the main goal (Ritter & Terndup, 2002). Newer models are more sensitive to gender issues, and the reality that women by and large do not say that penetrative sex is their goal: they have a broader definition of intimacy. Modern therapies recognise that for substantial, meaningful change, *both* male and female perspectives must have equal weight. Specific questions for same sex couples reflect the influence of context on the couple relationship, for example, the degree of self-acceptance for each regarding sexual orientation; the coming-out history, including any negative messages; medical concerns, including HIV status; and the amount of family and community support (Peterson & Stewart, 1985).

Family Therapy and Sex Therapy

Family therapists have used family of origin, structural, cybernetic and systemic/relational interventions in treating sexual difficulties. Mackinnon and Miller (1984) reviewed the literature on sexuality and sexual difficulties, focusing on relationships, dysfunction and abuse in heterosexual and gay relationships. They found the family therapy literature frequently less sexist than other paradigms. Atwood and Weinstein (1989) identified organic causes, as well as psychological, interpersonal and systemic issues, as important factors to assess. Hof and Berman (1989) discussed family structure and three-generation transmission of loyalties and myths, as well as power, intimacy and sex-role learning. Roughan and Jenkins (1990) considered the developmental and interactional context of the relationship, and used White's (1984) strategies for interventions in marital therapy to disrupt unhelpful patterns of interaction, particularly around the attribution of blame regarding ownership of the symptoms. Sanders and Tamm (1989) used cybernetic and systemic thinking to orient therapy toward a future-oriented self-healing process, and brief therapists today use these principles to address sexual issues specifically (Green & Flemons, 2004).

Guldner (1987) incorporated family-of-origin therapy within sex therapy where individuals within a couple had not achieved sufficient self-differentiation from their family-of-origin. LoPiccolo (1992) described the postmodern approach as emphasising a detailed look at the couple's overall relationship in a systemic way, with scrutiny of such areas as power, intimacy and closeness. Fraser and Solovey (2004), in their social constructionist approach (based on Watzlawick, 1976), described co-creation of reality in the construction of meaning as honouring clients' contexts and traditions, while also acknowledging the influence of the therapist's background. Iasenza (2004) used an expanded sexual history, based on Carter and McGoldrick's (1999) multicontextual perspective to explore the unique experience of lesbian women, including how their sexual interactions may differ from those of gay male or heterosexual couples, and how familial, political and social forces affect their sexual behaviour.

Shaw (1994) described differentiation as a major gateway to sexual actualisation, as did Schnarch (1991), citing the maturing process of differentiation as essential for erotic sex between life partners. In *Constructing the Sexual Crucible*, Schnarch employs the metaphor of the crucible both as a nonreactive (metallurgical) container in which a transfiguring reaction takes place, and as a severe (spiritual) test, like Christ's crucifixion. Schnarch defines differentiation as the ability to tolerate pain for growth even when feeling 'crucified by' a partner, when the decisions to be faced seem untenable and overwhelmingly anxiety producing.

Schnarch's major difference from other systemic approaches has been his insistence on the sexual relationship as the focus of treatment. Because couples play out their individual, dyadic and family dynamics within their sexual relationship, issues that patients are unable/unwilling to articulate are also displayed in their sexual styles. This permits the use of sexuality as an elicitation window. He sees eroticism and intimacy in marriage as developing in the 'crucible of seeing eye to eye' (having sex with prolonged eye contact). This, however, is not enough. For Schnarch, the important step involves having sex 'I' to 'I': letting oneself see and be seen 'behind the eyeballs'. He adds that 'folks' spontaneously avoid 'I' contact ('their eyelids are up, but their emotional shades are drawn'), because the implications may be overwhelming.

He allies himself with tantric yoga, seeing 'eyes open' sex as demonstrating a deep and open connection, with a merging of the physical and spiritual dimensions. He describes the sexual crucible as the embodiment of the hero's quest: 'the dauntless struggle to be fully human with one's partner'. His mission is to introduce 'I to I' sex to a world which he describes as 'unwilling to recognise the mediocrity of normal sexual relationships'.

While focusing on the sexual relationship can be very useful and is most direct, it is neither the only, nor necessarily the most universally appropriate approach. People who are more reticent about sexuality for personal, cultural or religious reasons might find it intrusive and prescriptive.

Schnarch sees therapists as potentially the 'crack in the crucible' unless they have personal therapy, because 'therapists don't necessarily know any more about intimacy or have better sex or marriages than the general public'. While this may be true, there is a strong history of young therapists being mentored as they work at their current level of competence, and developing their expertise through good supervision.

In contrast to Schnarch's paternalistic approach, Penny Roughan (1997) is concerned with fostering equality in relationship between female therapist and clients, in order to model the value of equality in the couple relationship. In 'Stages in Therapy For Men Whose Partners Do Not Enjoy Sex' (1997), she suggests that women therapists neither behave submissively to, nor enter into confrontation with dominant men, especially those who have grown up in traditions of patriarchy. She emphasises that anxiety, excitement and escalation of conflict may all occur along the road to each partner learning to appreciate the different contribution that each makes to the relationship, with the development of a new balance of respect and concern. These principles continue to inform our work today.

Differentiation/Individuation

The family therapy concept of differentiation, defining yourself with respect to your family of origin, mirrors psychoanalytic writing in emphasising the importance of individuation for there to be the possibility of sex as erotic union. As most of us take until midlife and beyond to develop such levels of differentiation (Schnarch, 1991; Shaw, 1994), this is the foundation for sexual development beyond the honeymoon discovery stage in an ongoing relationship.

The concept of 'individuation' has its origins in the mother-child relationship, with its inevitable tension between the bliss of fusion and the push toward independence. The associated archaic fears reflected in the adult sexual relationship are those of being swallowed up and losing your identity in intimacy (engulfment), and abandonment (McDougall, 1989). These feelings form the basis of the deepest anxieties associated with sexual and relationship difficulties. Sexual symptoms can alleviate these (unconscious) fears by stopping the physical connection. At the same time, it is not uncommon for a partner to feel rejected when erectile difficulties or vaginismus powerfully prevent penetration, or when premature ejaculation makes contact brief and unsatisfying. When partners can't tolerate difference, or fear rejection, if a professional inadvertently colludes by treating a resulting lack of interest in sex as the medicalised 'lack of libido' and prescribes medication, the dissatisfaction behind the lack of interest remains hidden. Failure to address underlying issues may result in further breakdown of the relationship, or allow it to continue in a functional, but disconnected way.

Metaphor and Story in Addressing Sexual Problems

Milton Erickson (1901–1980), master storyteller, believed the therapist's responsibility was to create a climate for

change by creating an atmosphere of expectancy for success and by incorporating the patient's style and 'resistance' into treatment (O'Hanlon, 1987).

He believed that patients sought therapy 'not primarily for enlightenment about the unchangeable past but because of dissatisfaction with the present and a desire to better the future' (Erickson in Watzlawick, Weakland & Fisch, 1974). At the time, this was a radical departure from Freud's promotion of insight to precipitate change. Erickson was solution-oriented and based his therapy on the assumption that people were capable of changing their behaviour.

His therapy, carried out in the form of a conversation, often included anecdotes and assignments not easily recognised as therapeutic interventions. He saw these as providing just enough loosening of rigidities for the person to discover other ways of thinking and behaving that could eliminate the symptom. His interventions were specific to particular patients, and not intended as a template for treatment of particular conditions.

Erickson used these same general principles in treating patients with sexual symptoms. For example, he talked to a woman with vaginismus about inserting a finger into her mouth when he felt that talking directly might have been too confronting. 'Why shouldn't I talk in a completely safe way and fixate attention?' (Erickson, 1960).

Sex Education

Biologically and metaphorically, sex is a core experience, and is part of the total person, not just the genitals. Later sexual pleasure is related to positive experiences from an early age, and acceptance and comfort with one's sexual responses and with one's own body beginning in infancy (De Lora, 1981). While we continue to debate the right balance for sex education in schools, informal sex education at home — starting with helping children feel good about themselves and their bodies — has received scant attention. Many people who present with sexual difficulties appreciate having their physiology explained, because when they were children clear, accurate information was not available or allowed.

What is learnt about sex is important: the context in which it is learnt is more important. Sexual behaviours are often described in moral terms ('dirty', 'bad', 'good girls don't'). Girls receive little training in sexual activity that is not prohibitory (Gagnon & Simon, 1973). The guilt engendered may not change behaviour, but can interfere with enjoyment. Boys, on the other hand, don't learn to enjoy more general touch for comfort and connection.

Teenagers systematically misinform each other about sex, passing on the distorted information they pick up from each other and the media. Adolescent males' predatory and aggressive styles of sexual behaviour, increasingly shaped by exposure to pornography on the Internet, coupled with adolescent girls' participation in sex when they really want affection, is the beginning of the 'sex for love' equation which needs to be challenged.

For a long time, as part of sex education in Sweden, volunteers with disabilities have helped teach adolescents, both with and without disabilities, a broader and more thoughtful view of sexuality. Through role-play and fantasy, teenagers are taught, for example, to imagine what it would be like for people with disabilities to undress and engage in a sexual relationship, including those circumstances where movement is extremely limited (Bullard & Knight, 1981). Sexuality is thus understood as part of all human experience.

Life Stages

Sexual difficulties are more likely to occur at predictable life stages, when there are major life changes. These include the start of sexual experience; with a new partner; moving in together/marrying; after the birth of a child or with small children; at midlife; and whenever there are illnesses or other stresses, because sexuality is affected by what is happening in the rest of people's lives.

Privacy and physical comfort are important because they affect the possibility of relaxing and enjoying the intimate situation. These aspects are often ignored when people expect sex to be enjoyed independently of everything else.

Andrea was referred by her doctor with the diagnosis 'lack of libido'. A trial of testosterone had made no difference. Aged 34 and the mother of two small children, she had recently gone back to part-time work as a nurse. I suggested that she come in together with her husband Brian, especially as he was the more concerned.

When they came, Brian said he thought there must be something wrong with Andrea, because before they had kids, she enjoyed sex, and initiated at least as often as he did. Andrea was angry that sex was all he seemed to think about. Where was their time together as a couple? It had been a long time since they'd had a night out by themselves. Brian countered that when he wanted to take her out, she insisted on bringing the kids.

As they started to recognise, rather than dismiss, the pressures that children and work placed on each of them, and started to think about how this made them feel, they began to acknowledge how much they had drifted apart — and that neither of them wanted this. The 'lack of libido' disappeared as they started to reconnect both through talking together about their desires and frustrations, and translating the idea of wanting to be together into action. This required some concrete moves on both of their parts, and some reconsideration of priorities, as well as practicalities like organising babysitters, and shutting their bedroom door when they wanted some intimate time together.

Sexuality as Part of Every Person

Everybody has the potential to be sexual, including old people, the disabled, those with debilitating diseases, and those who have had surgery that affects sexual functioning (e.g. radical prostatectomy, when nerve damage can destroy

the ability to have an erection). While non-disabled people often believe that a young, physically attractive body is needed to be sexual, and that age, injury or illness lead to loss of sexual relevance, the capacity to give and receive sexual pleasure (be that by ourselves or with others) is potentially available to all. Social isolation and difficulty finding a partner are the most common reasons for lack of a sexual relationship among the elderly and disabled (Bullard & Knight, 1981). Older couples with good relationships teach us about the possibility of enjoyable sex in ongoing relationships: celibacy, while a stereotype, is also a myth for older couples.

People with disabilities learn that sex does not reside only in the genitalia. Our culture's restricted discourse around lovemaking, with its focus on intercourse, is highlighted by one young man's comment eight years after a spinal cord injury in which he lost sensation and movement from the waist down, including the possibility of having an erection:

'I felt asexual for a long time because a man's sex was supposed to be in his penis, and I couldn't feel my penis. It didn't occur to me that it felt good to have my arms stroked ... I learnt ... I don't have to do anything with my genitals to have sex' (Bullard & Knight, 1981).

His experience highlights the importance of developing an internally-based sense of self beyond the physical. A very inhibitory and largely unexamined assumption in our culture is that sex *is* penetrative intercourse, and everything else is *just* foreplay. This does not, however, deny the unique connection that penetrative sex can afford (Tunnadine, 1992).

'Sex becomes more satisfying when it is not just the pursuit of orgasm; it's pleasuring, playing, laughing and sharing' (Bullard & Knight, 1981).

What's It All About?

Sexual enjoyment *for both* in a long-term relationship depends on a continuing sense of 'aliveness' in the relationship: the recognition that connection and contentment depend on dealing with difference and conflict as well as on having fun together, outside the bedroom as well as within. Sex can be exciting when it is a merging of willing bodies, so that pleasure is shared and reciprocally engaged (Merleau-Ponty 1962), in contrast to the functional sex of entitlement in a relationship with an indifferent, angry or reluctant partner.

When distress is experienced as overwhelming, it can result in a regression to infantile ways of functioning, because the ability to use language and thinking (psyche) is diminished. The body may then express the distress with a symptom (somatically — like small infants) (McDougall, 1989). While it looks as if the sexual symptom (e.g. erectile difficulties or vaginismus), has stopped the person from being able to function as an adult in the intimate situation, it is the person's difficulty in dealing with his stress by using

thought and language that results in the psychosomatic symptom: 'the body does the talking'. This differentiates clients who present with relationship difficulties, consciously aware of their interpersonal problems, from those who present as patients with sexual symptoms to be cured. Sexual symptomatology is both interesting and confusing, because a problem between two people can be expressed as a symptom in one person's body. A variety of frameworks and techniques aiming to bridge this gap have been presented in this article. Part 2 will translate theory into practice as it outlines a first interview, and discusses ways of treating different levels of difficulty.

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