



10181

Working Group on Concepts of Sexual Health

EURO, 5-7 May 1987

ICP/MCH 521/20
9614F
10 March 1987
ENGLISH ONLY

KNOWLEDGE GAINED FROM SEX THERAPY AND COUNSELLING OF COUPLES
AS REGARD TO SEXUAL HEALTH

by
J. Bancroft

MRC Reproductive Biology Unit,
Centre for Reproductive Biology, Edinburgh, United Kingdom

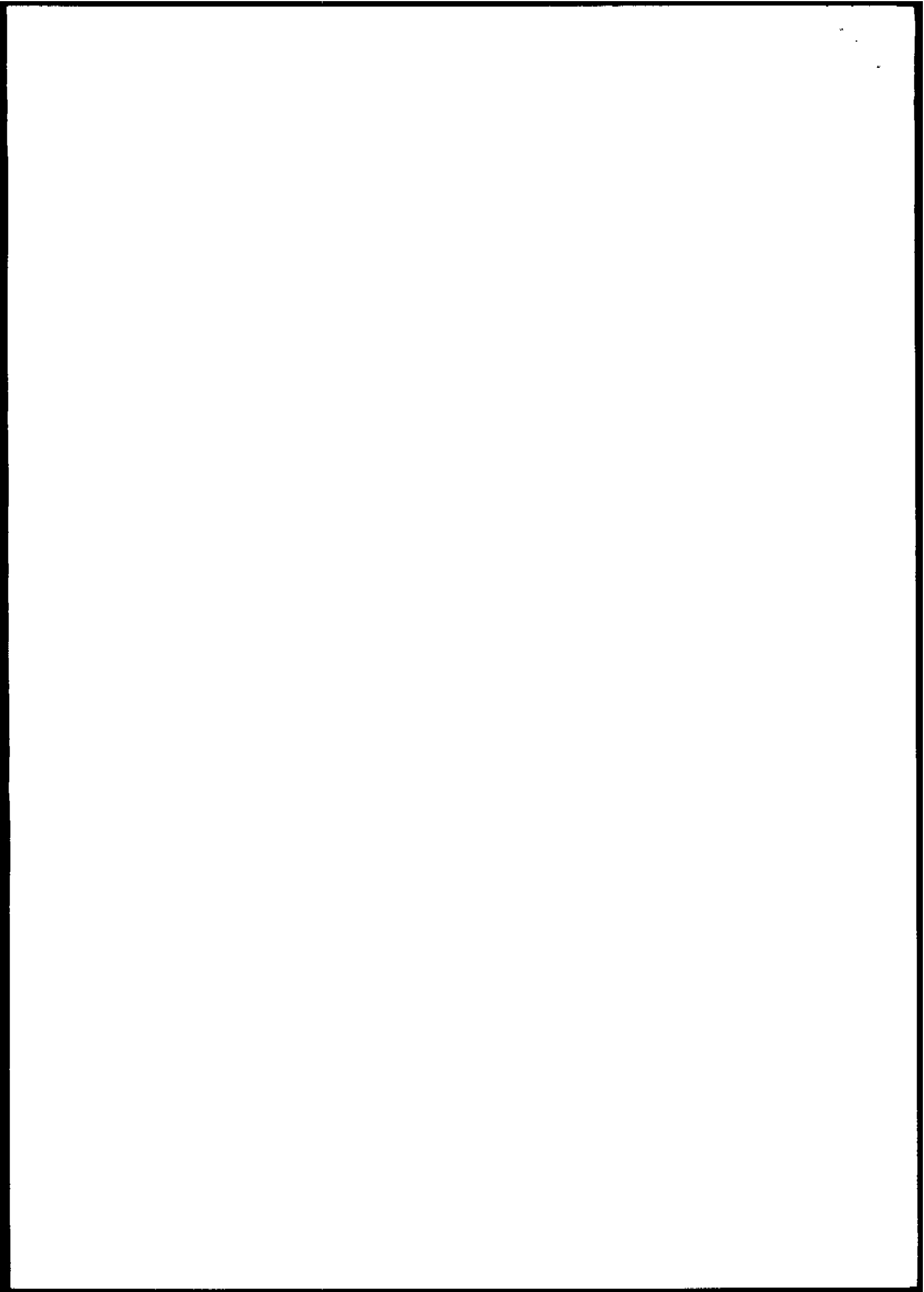


The issue of this document does not constitute formal publication. It should not be reviewed, abstracted or quoted without the agreement of the World Health Organization Regional Office for Europe. Authors alone are responsible for views expressed in signed articles.

Dieses Dokument erscheint nicht als formelle Veröffentlichung. Es darf nur mit Genehmigung des Regionalbüros für Europa der Weltgesundheitsorganisation besprochen, in Kurzfassung gebracht oder zitiert werden. Beiträge, die mit Namensunterschrift erscheinen, geben ausschließlich die Meinung des Autors wieder.

Ce document ne constitue pas une publication. Il ne doit faire l'objet d'aucun compte rendu ou résumé ni d'aucune citation sans l'autorisation du Bureau régional de l'Europe de l'Organisation Mondiale de la Santé. Les opinions exprimées dans les articles signés n'engagent que leurs auteurs.

Настоящий документ не является официальной публикацией. Не разрешается рецензировать, аннотировать или цитировать этот документ без согласия Европейского регионального бюро Всемирной организации здравоохранения. Всю ответственность за взгляды, выраженные в подписанных авторами статьях, несут сами авторы.



For the past 20 years I have treated couples using an approach derived largely from that of Masters & Johnson. What we learn about 'sexual health' from sex therapy does depend on the type of therapy we use, so I will briefly summarise the main features of my approach.

Its primary objective is the establishment of an emotionally secure relationship that allows normal sexual responses to occur and be enjoyed. A basic assumption is that, with many sexual problems, by concentrating on the relationship and resolving interpersonal difficulties sexual function will improve. In some instances however, specific techniques are used in addition, to deal with particular problems such as premature ejaculation or vaginismus.

This treatment method is an example of behavioural psychotherapy in which the couple are given clearly defined behavioural tasks to carry out in the privacy of their home. The therapist then examines closely their ability to carry out those tasks and identifies and seeks understanding of the difficulties that are encountered, and explores ways of overcoming those difficulties. The behavioural tasks therefore serve two functions. They represent small graduated steps in rebuilding a satisfactory sexual relationship and secondly, by simplifying the sexual interaction, help to uncover the key problems underlying the sexual difficulty. In general the early stages of the behavioural programme bring to the surface interpersonal problems of unresolved resentment, insecurity or lack of trust. The later stages, when genital stimulation is involved, highlight the intrapersonal problems of sexual anxiety, fear of loss of control etc. This form of treatment is therefore a parallel process of behavioural change and discovery and combines three crucial components: the behavioural, educational and psychotherapeutic.

As an approach this assumes certain fundamental qualities of a 'good' sexual relationship; in particular it is reciprocal with both partners having equal entitlement to sexual pleasure and to asserting and protecting themselves. It highlights the vulnerability that is inherent in sexual interaction. For an individual to 'let go' sexually is to be vulnerable and at risk of rejection or humiliation. If such negative consequences do not occur then the sexual experience is likely to have a bonding effect on the relationship. Good communication in the sexual relationship enhances the special intimacy that sexuality allows.

I shall consider the lessons for our understanding of sexual health under the following headings.

1. The goals of therapy - discrepancies between those of therapist and patient.
2. Reactions to specific behavioural tasks and the problems that are commonly found to be relevant.
3. Sex differences in responding to treatment.
4. Difficulties in evaluating outcome.
5. Socio-cultural implications.

The goals of therapy. Couples often present with specific goals e.g. to increase the frequency or intensity of orgasm, or to improve erectile function. This reflects the extent to which 'goal orientation' and specific expectation of what should happen are associated with problems and dissatisfaction. The therapist therefore encourages much less behaviourally specific goals and focusses on 'enjoyment', 'security' and 'satisfaction'.

Reactions to behavioural tasks. In the early stages of the behavioural programme couples are asked to keep within limits and not attempt sexual intercourse or even genital contact, but to focus on receiving and giving pleasure. Reactions to these stages demonstrate very clearly the importance of communication - the need to let each other know what they enjoy and what they find unpleasant or threatening. The powerful effects of 'performance anxiety' and goal orientation are revealed when, by setting limits and hence making such goals irrelevant, responses and enjoyment improve, sometimes dramatically. The setting of limits frequently reveals problems of trust and emphasises the importance of feeling emotionally secure before one can properly enjoy sex.

The later, 'genital' stages, by revealing more the intrapersonal problems, bring to light issues of early sexual experiences and upbringing in childhood. One should be cautious in attributing current problems too readily to experiences during childhood. But in recent years there has been a dramatic increase in the reporting of childhood sexual abuse by patients undergoing sex therapy. Whilst in some cases these early experiences may be used to deflect attention away from more immediate problems, it is difficult to avoid the conclusion that these early experiences of betrayal of trust have adverse consequences on later sexual development.

The importance of self esteem to the sexual relationship is readily revealed, most often in relation to poor body-image. Also the 'bartering' aspect of sex is frequently evident, in which one partner, most often the wife, sees sex as something that is provided in return for other benefits from the spouse. Progress in therapy may be sabotaged if these other benefits are not forthcoming or problems related to them are not being dealt with.

Sex differences in response to treatment. Different attitudes to male and female sexual behaviour quickly become apparent. One is the assumption that a man cannot be expected to be responsible for his behaviour (as when keeping within agreed limits) once he is sexually aroused; it is the woman who is assumed to be the carrier of responsibility for what happens in the sexual relationship. Women are often reluctant to initiate lovemaking, seeing it as the male prerogative and unacceptable in a 'good' woman. The reciprocal nature of the behavioural programme often reveals how difficult it is for men to be 'passive' in love making, sensing it as a threat to their masculinity and comparable to the difficulty many women have in being 'active'.

One interesting and recurring finding from controlled outcome studies of sex therapy has been a tendency for the female partner to feel more comfortable with the general style of the treatment. This particularly relates to the emphasis on two way communication and the expression of feelings. It is not unusual for the woman to say, in response to the therapists suggestions, "this is what I have been saying we should have been doing all these years". There is a remarkably widespread tendency for women to be more prepared to express feelings, and for men to be more inclined to 'bottle them up'. The process of sex therapy may therefore be more confronting and less comfortable for the male partner.

Difficulties in evaluating outcome of sex therapy.

Although a number of studies have reported either short-term or long-term outcome of sex therapy, such reporting has been plagued with difficulties. Of most relevance to this paper has been the uncertainty how to measure success. Masters & Johnson, in defending their much criticised policy of reporting outcome in terms of failure rather than success, said the following - "...when symptoms were not reversed it was quite obvious; whereas when symptoms were reversed little was known about whether that actually constituted sexual health". A couple may present with a specific complaint, such as erectile failure. This dysfunction may have been caused by organic impairment, but became associated with serious disruption of their sexual relationship. Sex therapy may produce very little change in erectile function in such a case yet produce substantial improvements in the quality of the relationship and the ability to enjoy lovemaking which does not depend on penile erection. Does this constitute a successful outcome? The problem stems from the fact that sex therapy is dealing with something much more complex than basic sexual response and its evaluation needs to deal with more than this one aspect. This also applies to sexual health.

Socio-cultural factors. The model of a sexual relationship advocated in the Masters & Johnson approach has often been described as middle-class, white Anglo-Saxon and Protestant! Certainly it is laden with values about relationships which are more compatible with some socio-cultural backgrounds than others. It is not unusual to find working class men somewhat threatened by the apparent challenge to their masculinity. Different religions also have different implications. For example Catholic women may find it more difficult to strive for their own sexual pleasure rather than that of their partner, seeing their own as a secondary issue. In Moslem marriages, there are deeply held beliefs that the woman should be sexually available to the husband, making the reciprocal limit setting of our approach difficult. Most therapists in Britain have found considerable difficulty in applying this approach to Asian couples, whether Moslem, Hindu or Sikh. It is certainly possible that

the same basic principles of behavioural therapy could be used, but the more specific objectives would need to be modified if conflict with powerful cultural influences are to be avoided. In many cultures the type of male-female relationships we are promulgating would be regarded as revolutionary. This poses one of the main ethical issues in sex therapy. It is perfectly possible to make couples problems worse by provoking conflict between the aims of treatment and the cultural and religious principles that normally guide their lives. Our position therefore has some similarities with that of the Christian missionary.

Conclusions. Whilst sex therapy can give us many clues about the nature of sexual health, we must be cautious in generalising across cultures and religions. It is arguable that many of the world's problems would be lessened if more equitable and less exploitative relationships, of the kind that we seek in sex therapy, prevailed between men and women. I find it difficult to question whether good communication and an expectation that both partners will assert and protect themselves, is of benefit to any human relationship, sexual or otherwise. The special fostering of intimacy and the bonding effect that an emotionally secure sexual relationship produces would seem to be of universal relevance. Yet we must be careful that they are promoted in ways that do not conflict with the powerful social and religious influences of the couples normal environment, if we are to avoid adding to personal problems. It is an age-old dilemma which has confronted the helping professions; the conflict between the needs of the individual in distress and the need of a society for change in its values and mores. Professionals can play a part in both respects, but it is important not to confuse them or combine them in ways which are counterproductive.