Developing a Humanistic Model of Psychosexual Therapy

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Humanistic views on sexuality

Human sexuality is a 'bio-psychosocial phenomenon' including creativity, self-esteem, self-expression and playfulness. It is not just about physiological functioning, but includes sexual identity, which informs sexual desire and sexual behaviour and spirituality, including religious and philosophical beliefs. A humanistic practitioner would also acknowledge the social and political construction of sexuality and the constraints this places on people. Sexuality can be seen as a metaphor for life - how do we get excited by something, build a charge and allow the giving and receiving of pleasure? How easy do we find it to surrender and let go, to experience satiation and bask in the afterglow, in all areas of our life?

Psychosexual Therapy

Psychosexual therapy offers valuable insight into the role of both body and mind in sexual functioning, showing how external environmental factors and inner fears and beliefs can effect our physical functioning. Humans are seen to have a 'brain' sex centre and a 'body' sex centre, with an understanding that the mind can interrupt the body's sexual functioning. This idea, of *psycho-soma*, is central to the philosophy of many complementary therapies.

Psychosexual therapy provides education about sexual functioning by explaining sexual physiology and the process of sexual arousal. We learn that sexual arousal is a reflex, that is, a stimulus creates an automatic reflex reaction through the autonomic nervous system. A physical or external stimulus triggers the release of hormones through the body leading to physiological arousal. The five senses (sight, sound, touch, taste and

smell) are the gateway between the environment, the 'outer zone' and sensations within the body, the 'inner zone'. An interplay between the two is needed to build a charge of sexual energy through the stages of arousal. The 'middle zone', the mind - memory, thoughts and beliefs - interprets and chooses. Either the natural reflex, leading to orgasm, can be satiated or it can be blocked.

Traditional sex therapy is fundamentally a medical model acknowledging sexual functioning as a body-mind experience. It offers an educational, behavioural and therapeutic model. Sexual dysfunctions are defined around the inability to have intercourse and treatments to cure that. One aim is to separate 'organic' dysfunctions (side effects of medication, illnesses etc.) from 'psycho-somatic' issues such as stress, anxiety, relationship issues. The former are treated with physical treatments, drugs like Viagra or vacuum pumps, and the latter with, mainly, behavioural couple focused therapy.

Although sex therapy currently offers help to many people, some issues within a wider context of sexuality are excluded. Sex therapy provides its behavioral and psychotherapeutic approach within a 'sexual and relationship' framework. 'Childhood issues' are deemed the field of 'psychotherapy', and referred outside the therapy; the impact of sexual violence on sexual functioning gets ignored. As more psychotherapists are training in psychosexual therapy such ideas are being questioned and the remit of this therapy is expanding.

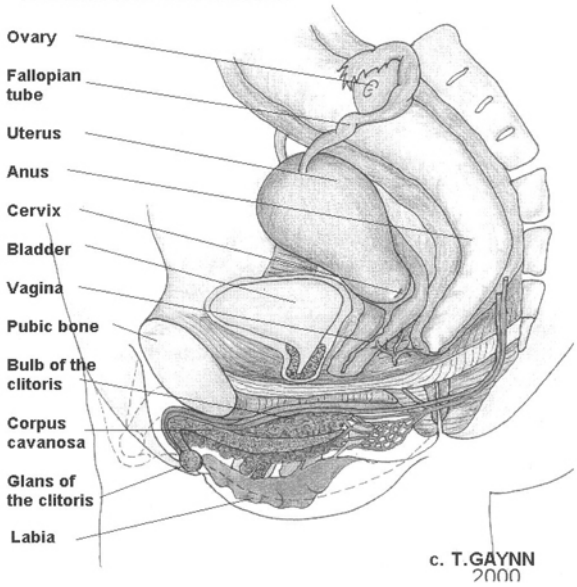
I have worked with many survivors of sexual violence and have learnt to integrate my trainings. My practice is to hold a psychotherapeutic approach more 'foreground' bringing in educational and experiential aspects of my psychosexual training, as and when appropriate. My work in the field of fertility and sexuality has led me to question the reproductive model of sex, which minimises women's sexual capacity and lesbian and gay experience. The education I provide includes information about women, left out of most biology and sex therapy books.

The sex education lesson you didn't get at school

A humanistic model of sex education would challenge the current reproductive model of sex. Sex and reproduction are linked for men in a way they are not for women. Physiologically, the male sexual organs are also their reproductive organs - the penis, testicles, prostate and cowpers gland. For men to reproduce, biologically they need to get an erection and ejaculate, for this to be delivered into the vagina of a fertile woman. The male process of sexual arousal is seen as erection and orgasm with ejaculation. In a heterosexual model, every time men have sex, they could be reproducing.

For women however, the biological processes are distinct from each other, although obviously linked. Female reproductive organs and sexual organs are different and each process works independently of the other. Women's reproductive organs are the uterus, fallopian tubes, ovaries and the vaginal canal. The menstrual/ ovulatory cycle happens regardless of whether the woman is sexually active or not.

A side view of women's reproductive and sexual organs, showing the internal structure of the clitoris



the vulva. The erectile tissue within the penis in men - the corpos cavenosa and the corpus spongiosum - is mainly internal in women. The clitoris is much larger than the very tip, the externally visible 'glans'. When erect the clitoris is actually 30 times larger than the glans. It spreads the length of the labia and surrounds the vaginal canal to a depth of one third. The perineal sponge, between the vaginal entrance and the anus, is also sexually sensitive. The clitoris also surrounds the urethra, creating the 'urethral sponge' or G-spot as it is more commonly called. Stimulation of this area can lead to female ejaculation, being released from the paraurethral gland. The pelvic floor muscles play a crucial role in the sexual arousal process, in both men and women, particularly at orgasm.

See diagram 1

Women's sexual organ is the clitoris and the sexual arousal process of clitoral erection, vaginal lubrication and orgasm can happen when the women is in a fertile phase of her cycle, and when she is infertile, which is most of the time. On average women are fertile for one week out of every four-week cycle, during their fertile years. Their post menopause years can be as many as their fertile years. The point is, that when women are having sex, they are more likely NOT to be capable of conceiving.

The reproductive model of sex is also a culture bound model. It focuses on the vagina as women's sexual organ. Women's external sexual anatomy is Culturally, the size and capacity of women's sexual organs, whose sole purpose is for sexual pleasure, is sidelined. In some cultures the clitoris is cut out literally, in ours it is excluded symbolically. Penetration provides good genital stimulation for male sexual needs. However many orgasmic women do not orgasm during intercourse. Women need to know about the clitoris, the G zone and see the whole vulva as a highly erogenous area to be able to fulfil their sexual potential. When I trained as a psychosexual therapist in 1994 detailed diagrams of the clitoris were not provided. There were none in Masters, Johnson and Kolodny's *updated* 'Heterosexuality' (1995) yet

I managed to find women's health books showing such diagrams 25 years ago (Sherfey 1973, Hite 1976).

The educational aspect of a humanistic model would teach men and women about their sexual potential, as opposed to focusing on reproductive abilities. When clients are aware of the possibilities they can then choose how they wish to utilise this potential depending on their own sexual values, their spiritual and cultural beliefs, their sexual identities and their desired sexual practices. Many men feel pressurised to 'perform' sexually. Beginning to see intercourse as one of many options of ways to express sexual love seems to liberate both men and women. It widens the context of sex, encouraging clients to explore their sensuality, sexual responses and sexual desires.

Working experientially – therapeutic interventions

Intercourse is the central focus of current sex therapy. The notion that 'real sex' is ejaculation during vaginal penetration excludes many sexual practices. The focus for men, becomes an erection good enough for penetration and ejaculation after penetration, and for women, lubrication of the vagina. Successful vaginal penetration is seen as the goal. Sexual dysfunctions are defined by an inability to have intercourse and treatments aimed at curing that. Discussing the sexual dysfunction 'vaginismus' (involuntary contraction of vaginal muscles), Ng (1999) says, current definitions emphasise whether penetration is possible, rather than the woman's experience of pain or her fear of pain. Sexologists at Amsterdam University see vaginismus as 'a defence against sexual violation' and do not use the vaginal trainers commonly used in Britain, in their clinics.

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A humanistic model would move away from 'couple focused therapy' and start with a journey of self -discovery. This would include body awareness and self- image, sensualising exercises and sexual fantasy. We work with experiential exercises to help clients identify their beliefs, sexual values and desired goals. The sexual arousal cycle is used to explore sensuality and the process of sexual arousal. Clients can discover what, via each of the five senses - sight, sound, touch, taste and smell, turns them on and what turns them off. Having learnt about 'sensation'- physiological changes in the body, like heartbeat, breath, muscle relaxation and tension, clients can identify how they may block the reflex of sexual arousal, where blocks occur and how they could overcome them. Having learnt more about their desires, their hopes and fears, client's can begin to manifest their own sexual identity and sexual expression. People do often have a desire to share sexual

behaviour. This not only requires a good sense of sexual self- esteem, but sometimes a need to develop communication and relationship skills.

Healing after sexual trauma

Many of the clients who come to me are survivors of sexual violence, which is central to their sexual problems. Little attention is given to the impact of sexual violation on sexual functioning in main sex therapy texts. Bancroft (1989), for example, allocates 5 out of 725 pages to the subject. Smith (1995) discusses some research on the effects of sexual abuse on sexual functioning. Jehu's 1988 study found a prevalence of some sexual dysfunction in 94% of women sexually abused as children. Common dysfunctions included sexual phobia/ aversion, impaired sexual motivation, arousal and orgasm, post traumatic stress reactions to flashbacks, memories.

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Working with survivors of sexual abuse requires a gentleness, a slowness and sense of timing. Also, a rigorous approach, holding strong boundaries and a proactive approach to transference and countertransference issues. Both Alice Miller (1985) and Judith Herman (1997) have been most influential in deepening my understanding of working with recovery from sexual violation and developing a humanistic approach to the theory and practice of psychosexual therapy.

Herman describes a 5-step process for recovery and empowerment. The first step is to create a healing relationship, where empowerment can be experienced while in relationship with another. This includes establishing a good working alliance, a contract, strong boundaries and fostering trust. Choices are of vital importance for those recovering from sexual violence. Herman identifies 'traumatic transference' and the importance of the therapist's support system, which is crucial to understand and address when working with sexual trauma.

Secondly she recommends establishing safety - naming the problem, restoring control of the body and the environment, issues of self-care. She reminds us to complete this stage thoroughly and slowly. Experiential work may trigger issues requiring psychotherapeutic sensitivity. The psychological and physiological responses to sexual violation are complex and overlapping. A common issue clients bring is sado-masochism. If first experiences of sexual arousal were associated with humiliation or pain, brain to body pathways can be set so clients find an automatic association with pain and sexual pleasure. Clients may also experience images or memories of sexual violence as both arousing and repulsive. This requires a sensitive exploration to discover whether this indicates a shame-bound repulsion or a desire to change by the client.

The next stage is remembrance and mourning - reconstructing the story, a testimonial - moral solidarity,

transforming the traumatic memory, the grief, the anger, coming to terms with the impossibility of getting even. In my experience there is a clear correlation between clients' demeaning sexual behaviours and an acting out of abusive sexual histories. Alternately, many survivors block their arousal cycle very early in the process - lack of desire, before any arousal begins, no sexual motivation, fear of sexual feelings. There is often a sense of mistrust of the body and feelings of shame about body responses during sexual violation. Many clients counter their beliefs that their sexuality somehow attracted the violence, by blocking any further arousal, playing down their sexuality. Challenging ideas of self -blame are crucial.

The final stages are reconnection and commonality - the new self, who can look after their wounded part, can reconnect with and learn to trust again, not only the self, but others. Addressing the psychotherapeutic issues behind sexual functioning is crucial to clients. We can then, if appropriate, move back to behavioral tasks to 're-educate' the body, to re-set the neurological pathways away from early experiences. Exercises such as 'healing the yoni' (Anand 1990) help women to reconnect with their genitals and reclaim experiences of sexual pleasure. Developing self-awareness and a sense of boundaries allows clients to being to trust their bodies, themselves and others again.

Towards a Humanistic Model of Psychosexual Therapy

I aim to practice humanistic psychosexual therapy by working from a client centre, to re-empower through a healing relationship. I like to work experientially and creatively from an eclectic view, to hold theory as 'background' and keep the therapeutic relationship more 'foreground'.

Through regular supervision I can reflect on and monitor my work, and fine-tune my practice to each individual client. I hope to help clients harness their 'adult' to care for their 'wounded child' and be more proactive in their lives.

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My psychosexual training came after ten years working with sexual and reproductive issues. I was disappointed with the reproductive and culture bound model of sex, which minimises women's sexual capacity and excludes other sexual practices. Many of my clients are women, not heterosexual, and the majority have experienced sexual violation. In my experience sexual violence and sexual shaming is at the root of most female 'dysfunction'. To pathologise the individual is to ignore the wider social and political issues. The knowledge of psychosexual therapy actually has a lot to offer to aid in the recovery process. Herman (1997) says:

> '.. creating a protected space where survivors can speak their truth is an act of liberation...

> bearing witness, even in the confines of that sanctuary, is an act of solidarity... moral neutrality in the conflict between victim and perpetrator is not an option.'

Not addressing sexual violence within our profession acts to further silence survivors and to minimise the impact on sexual functioning.

Sex is still a taboo subject especially in British culture. Sex is also everywhere in our society presenting many contradictory messages. The topic often generates strong or mixed feelings, including shame, in many people. Sexuality is also sacred, a precious gift that can bring great pleasure in an often stressful modern life. I feel passionately about the importance of sexual healing work, it is inspiring to see people reclaim their sexual and creative potential. I challenge the idea that sexual 'liberation' means being willing to do anything, with anyone, anywhere, any time. We are being sexually assertive, not frigid, when we put boundaries or limits on our sexual preferences. Knowledge allows people to make informed choices. Educational material is crucial to provide the information about human sexual functioning and the process of sexual arousal that many people lack.

Through experiential exercises clients can develop sensual and sexual awareness and clarify their views, beliefs and sexual values. They can begin to listen to the messages from their bodies. They can choose how they want to be sexually. By providing an educational and behavioural approach within a psychotherapeutic framework, we can facilitate the grieving process about sexual violation and encourage clients to develop sexual self-care and sexual self-esteem. They can reclaim an understanding and trust of their body and their sexual functioning and begin to fulfill their sexual potential as they wish.

Further reading

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