Psychosexual and Relationship Therapy in the 21st. Century

Judi Keshet-Orr and Sarah Collings

Judi Keshet-Orr is a UKCP registered psychotherapist and psychosexual therapist (BASRT MAHPP UPCA(BASRT recognised supervisor).
She was the first person to achieve an MSc in Psychosexual Therapy in the UK
Judi was course director for eight years of the largest psychosexual and relationship approved training until it closed last year. She also held the post of Consultant Psychosexual and Relationship therapist at the Whittington Hospital, London.
She works within private practice with individuals, couples and groups. She teaches at both undergraduate and post-graduate level and supervises a wide range of therapists and educators both privately and within a variety of health authorities, universities and charitable organisations.
Contact: judiko@ulfie.demon.co.uk web site: www.partnertherapy.com

Sarah Collings MA is a UKCP registered psychotherapist and psychosexual therapist (BASRT, MAHPP, UPCA) and a BACP accredited counsellor. She works in private practice and in an NHS gynaecology clinic, and is hoping to start research for a doctorate in the autumn.
Contact: psyc1sar@aol.com

This article has been written from the position of hoping to enable the reader to understand that whilst psychosexual and relationship therapy has a great deal to contribute to the world of integrative psychotherapy it is, in and of itself, a specialism which has many strengths. Thus it can also stand alone and work comprehensively with clients in order for them to achieve enhanced sexual understanding, expand their education and to support them in making linkages to their general well being and psychological/emotional health.

Sex Therapy Today

Sex therapy has a reputation, which we believe is archaic, in that it is often seen as a simple method of 'home work tasks' and as having a largely cognitive behavioural emphasis, where events and issues from the family of origin and past, both recent and long term, do not play a significant part in the client's life. The stereotype of the 'do gooding – marriage guidance – twin set and pearls' therapist is an image which we have had recounted to us on many occasions. What is missing from this image is an understanding that many sex therapy trainings are now as, if not more, comprehensive than several of the respected psychotherapy trainings. The difference being that psychosexual therapists are required to understand and to incorporate in to the work knowledge of physiology, anatomy and the impact of prescribed and non prescribed drugs, for example the SSRI group of antidepressants such as Prozac, or the effects of cocaine or ecstasy. This in addition to working with and understanding the complexities of the couple relationship and being able to work with these complexities and puzzles.

An integrative psychosexual and relationship training should incorporate many aspects and methods within psychotherapy, however it also utilises a raft of interventions which are focussed at enabling the client to understand, make use of and integrate their unique perception of their own capacity to be both sexual and intimate. We work with a broad range of dilemmas, these might include arousal and erectile difficulties, sexual orientation issues, so called 'normal' sexual practices and their place in the clients life, communication skills difficulties and the effects of prescribed and non prescribed drugs. We work with the 'absent other' and with couples. Sexual and intimate histories are taken in depth alongside family of origin influences.

The difference therefore between sex therapists of the old Masters & Johnson ilk and modern psychosexual therapists is that the latter are more likely to have included studying various theoretical approaches in their training, such as Gestalt or other humanistic approaches and have an understanding of the analytic approaches to psychodynamics as well as CBT.

They will then hopefully have the ability to consider not only the sexual issue brought by the client from a sex therapy perspective but also the possible aetiology. By exploring the client's family of origin and how she/he negotiated the developmental stages the therapist may gain clarification of

the dynamics within these that may have resulted in deflection, patterns of confluence, family scripts and other early unconscious internalised introjects. From trying to understand how the client interprets her/his present-day world, and how she/he relates to its inhabitants, a more phenomenological picture may become illuminated. Thus the psychosexual therapist, like any other psychotherapist or counsellor, will endeavour to clarify for both client and herself/himself, how the intrapsychic and interpersonal patterns of behaviour have been developed and are presently maintained. In addition the psychosexual therapist will try to ascertain the pattern of sexual development, from first awareness of sexuality including difference of self to others, not only from gender but also looking at any sense of early difference that may emerge concerning sexual orientation or interest. Cultural factors, religious and spiritual beliefs, and ethnicity are all factors that impinge on a client's sexuality as much as any other part of their life, and need to be explored sensitively by the therapist, particularly bearing in mind factors such as the therapist's own gender, sexual orientation, ethnic background and colour may be very different to those of the client. As the majority of British therapists are still white and predominantly middle class, an understanding of racial power dynamics is especially important where sexual and relationship matters are concerned with any minority clients.

An overview of Psychosexual Relationship Psychotherapy

- Heal or cure – Looking at the psychological aspects of psychosexual therapy increasing sexual knowledge, awareness and capacity to be intimate

- Holding the tension between medical & psychotherapeutic - Good psychosexual therapy should be able to work with both ends of the spectrum

- Understanding the unconscious processes of family of origin, developmental stages, family scripts/ introjects, attachment issues

- Working knowledge of the physiological aspects of human sexuality, including top down- bottom up, sexual arousal circuit, addressing organic problems for which there may be no medical 'cure' or the opposite where a medical cure may be found and unmasks a psychological problem

- Interest in organic issues and awareness of how the physical and psychological aspects of sexuality are profoundly interwoven – accepting at times the unsolvable chicken and egg issues of aetiology

- Making the work 'human' through the therapeutic relationship, thus integrating the more mechanistic aspects of traditional sex therapy and

also honouring the client who comes and wants a purely 'instructive' or behavioural programme. Thus being able to offer a wide range of interventions.

- Being open to learning about pharmacological innovations while not losing sight of being a therapist
- Liaison with medical practitioners creating cooperative and respectful working alliances

The most commonly presented problems and issues are as follows, this list is by no means exhaustive but gives the reader an indication of the day to day work undertaken by psychosexual and relationship therapists:

ISD (Inhibited sexual desire) in both men and women. The absence of desire which can be long standing or a relatively new phenomena

Dyspareunia – pain upon penetration making intercourse difficult; it can be either superficial i.e. pain in the vulval area or deep i.e. pain in the pelvic area

Vaginismus – spasm of the vaginal muscles preventing penetration, these women are unable to have intercourse, undergo vaginal examination or use tampons

Anorgasmia – the inability to achieve orgasm, this may be with partner sex or alone

Rapid Ejaculation (formally called premature ejaculation) Ejaculation usually within 0-15 seconds and at times without an erection

Retrograde ejaculation – the man experiences orgasm but the seminal fluid pumps backwards rather than out through the penis

Retarded or delayed ejaculation – often these men can achieve ejaculation with masturbation but have difficulties with penetrative/partner sex

Erectile dysfunction – formally known as impotence, men who are unable to achieve an erection hard enough for penetration, this may be primary or situational

The causes of the above may be either psychological/emotional or physical or both.

Physical causes may include:

Men:
Blocked arteries
Spinal cord injury
MS
Chronic illness
Diabetes
Postoperative difficulties
Side effects of prescribed medication
Drug/alcohol abuse
Penile abnormalities
Cancer treatments
Priapism

Women:
Much of the above and
Endometriosis
Vaginal abnormalities
Painful scar tissue
Menopause

Emotional/psychological causes may include:
Depression
Stress & anxiety which is either work related or home related
Discordant relationships
Survivors of abuse and neglect
Sexual orientation confusion
Inappropriate or absent sex education
Performance anxiety
Low self esteem
Sexual phobia
Trauma

Heal or Cure – Holding the tension

Within sex therapy it may be possible to offer a 'cure' for a presenting problem. For example the diabetic who presents with erectile difficulties or failure, the war victim who has had his penis destroyed by a bomb, or the woman who is suffering with extreme effects of the menopause, birth trauma or an imperforate hymen. All of these and more can be 'cured'. Medical or pharmacological interventions can be recommended. Whilst the organic healing is attended to, the emotional healing which may also be required can also be addressed. Thus sex therapy often works from a two-pronged approach looking at both healing and curing. It is of little value to offer the client with a physical difficulty no medical intervention if there is one, which will, with some immediacy, address the 'presenting problem'.

As sex therapists we often hold the tension between the psychological and medical models. We need to be as fully conversant as possible with current medical or surgical interventions as well as offering a psychological support to the client. We will also work with the client where no medical intervention or cure can be offered thus working with the emotional aspects of sexual disappointment.

Sex therapy is a constantly changing world, new medication and interventions are produced regularly in addition to a redefining of sexual problems that move away from the largely heterosexual, white definitions which were common throughout the 1960's and 1970's.

For example the previously known 'frigidity' became 'inhibited sexual desire' and more recently has been classified as 'sexual interest disorder'

Rosemary Basson M.D from the University of British Columbia suggests when working with women and in order to limit pathologising we should look at the following:

' 1. Factors to do with the woman herself from her past, which may be associated with psychosexual mal-development.

2. Current contextual factors that appear to provide logic for her dysfunction

3. Medical factors.'

By using this rubric sex therapists are able to address all facets of the woman's presenting problem or difficulty.

We fully acknowledge the current danger of allowing the medical model or discourse to permeate women's presenting problems, which has arisen from the pharmacological success of sidenafil/Viagra and its successors during the past few years. Women who experience their sexual problems as being lack of desire have been the main targets of an increasingly medicalised and pharmacological approach This has led Leonore Tiefer, an American

psychosexual therapist, to initiate a campaign to counteract this, and her website – www.fsd-alert.org - is dedicated to refuting the 'medicalization of women's sexuality' (Tiefer, 2003:129). Equally we are open to a two-pronged way of working with women who experience sexual problems arising from organic conditions such as incontinence or genital pain from vulval problems, when both a medical as well as a therapeutic approach may be found more useful. A precedent for this can be found in Bergeron (2003) where she has described a recent study in Montreal in which an integrated treatment approach of physical and psychological therapy was adopted for women with genital pain associated with sexual activity.

To extend this concept Heiman (2002) puts forward the idea that

'Many successful treatments for sexual dysfunction are psychophysiological, in that physiological change circularly interacts with psychological change'

and adds

'the prescription of a physiologic treatment which ignores the fact that human sexuality is infused with individual meaning may invite further interference with sexual functioning'.

Top down – Bottom up

Bowlby's attachment theory has been receiving a lot of attention in the last decade, and since attachment patterns created in childhood are often played out in adult relationships, particularly when one or both of the partners are experiencing trauma such as loss or fear, being cognizant with the developments in Bowlby's theoretical approach may facilitate working with relationship distress. The developments in neurobiology are also important for any psychotherapist, but for the psychosexual therapist essential, in that the brain may be considered as integral a part of the human sexual arousal circuit as the genitals, reproductive organs and central nervous system. Researchers such as Schore, and van der Kolk have interesting hypotheses regarding how the autonomic nervous system regulates homeostasis regarding affective states. In particular the amygdala, the cingulate and the orbito- frontal cortex are, as Carroll (2003) puts it 'a convergence zone for information related to learning by experience and each acts as a representational system'. The amygdala in particular may be of importance in psychosexual work since this is the area in the brain that 'triggers reflex actions such as the startle response' and often becomes over-activated in traumatised individuals (Carroll, 2003:3). Therefore when working with survivors of incest and other sexual abuse, an understanding of developments in hypotheses

regarding cerebral process may lead to a greater understanding of why a woman has vaginismus, or why a man is unable to sustain an erection. An interest in these developments may help a therapist more fully comprehend why it has been said that the brain is the largest sexual organ.

Understanding the sexual arousal circuit is part of understanding the physiology of human sexuality. In the most simplistic terms the 'top down' brain 'sends messages' via the central nervous system to the sexual organs, which can be interrupted by such emotional states as fear, stress, depression, while the 'bottom up' messages from the sexual organs may equally fail to deliver the go-ahead should there be pain or lack of physical arousal, such as may be experienced by women undergoing vaginal dryness from the menopause. Women suffering from incontinence may suffer both lack of desire and arousal from fear of leakage, while women who may have had episiotomy scarring may experience inhibited desire due to physical pain. Men who have had a heart attack may experience erectile failure from fear of incurring another fatal attack. These organic causes of sexual fear and possibly aversion may only be able to be addressed from a psychological and emotional base. There may be no 'cure' except exploring therapeutically what this means for each client and how they may learn to live with and transcend such issues. At times the aetiology can become blurred, and we have to remember that though we may co-investigate such issues with our clients, we are not psychic detectives with a crime to solve which will put everything right in our client's life, any more than we would hope to do with a client who presented with bereavement issues. We cannot make the dead alive, or restore scarred tissue and repair nerve endings.

Making the work 'human' for all types of clients

Much psychosexual work is performed with couples, this brings with it additional aspects and puzzles. Holding the joint anxiety and desire of two people within the therapeutic arena is often challenging. As sex therapists we again hold the tension, however in these occasions it is with the needs and wishes of two people, who often have a long history, and we are working with the variants in their needs. While in individual psychotherapy we are used

to clients coming to us with the wish to change patterns of behaviour, in couple work, whether with heterosexual or same sex clients, a psychosexual therapist may need to be aware that he/she is working with a family system rather than with two individuals. Therefore when a couple presents with an issue such as a male partner's lack of ability to sustain an erection or a female partner's lack of interest in having sex, it is important for the therapist not to be drawn into this dynamic that may involve shaming and blaming but to continue to see them as a unit. Behaviour may have a meaning within the unit that is not immediately apparent but has been created as a way of avoiding some other difficulty. For example a client's reluctance to have sex with their partner may have resulted from their own difficulty in being tender or refusal to really commit to their due to lack of affection from their own mother in childhood. A man's inability to sustain an erection may be from fear of impregnating his partner and losing her attention to a baby, or from reluctance of recreating his/her traumatic experience of sexual abuse as a child. Again this is where we believe in the importance of taking a full sexual and relationship history from both members of the couple, but also this is where the therapeutic working alliance needs to have been firmly developed as much and as early as possible in the work. Same sex couples will present with some similar difficulties as heterosexual ones, but in addition they have some that are specific to living a homosexual lifestyle – arousal/erectile difficulties are as prevalent within same sex relationships as they are in heterosexual and bi-sexual ones. Communication skills,verbal, emotional and physical, or their lack, are present irrespective of partner gender choice.

Therefore the importance of the therapeutic alliance is an integral part of psychosexual work, and may be deemed as important as it is in more general work, since most people are as unaccustomed to discussing their sexual issues with someone new as they are to disclosing their bowel habits. While trust is an essential part of any therapeutic relationship, within psychosexual work it is paramount, since discussing such intimate details may be very upsetting, even shaming to many clients. We often encourage clients to have a reality check here as few of us were encouraged to talk about our genitals as children. While adults may have expressed delight that we could name body parts such as 'arm, leg, nose', most were not so comfortable when we said 'this is my front bottom', or 'look at my wee-wee'. Equally we try to dispel the many myths about sex: it has to be penetrative, a woman has to have an orgasm, a man must always have a twelve inch rock hard penis, real men can make love all night, real women enjoy that, gay men are never faithful, lesbians don't like sex and so on. Among the functions of sexual therapy may be educating and normalising, permission giving, and reassuring.

Pharmacology and doctors

Some clients will prefer a more cognitive-behavioural programme to a more integrative psychosexual psychotherapeutic approach. Honouring a client's preference is important as some clients would not seek more general psychotherapy or counselling and may only be concerned about overcoming their perceived sexual problem. This may particularly apply to clients from cultural backgrounds that are unfamiliar with the eurocentric concept of seeking psychological help, to the extent that it may seem a betrayal of the family or even the community. Psychosexual therapy may however appear as an adjunct of medical intervention, and therapists need to be respectful of this, and try to adapt to work with the client in a more phenomenological way, setting homework exercises and possibly considering referring for pharmacology where and when it is appropriate.

A lot has been written about the breakthroughs in drug therapy – both good and bad – in journals and in the popular press and media in general. Too often sexual drug therapy seems to provoke the divisions and outrage sparked by the Botox adherents. Most psychotherapists and counsellors will however be used to working with clients who are taking prescription medication ranging from the SSRI antidepressants to psychotropic medication for more severe conditions such as bi-polar disorder. As psychosexual therapists it is important to be aware of developments without becoming overly seduced by the medical allopathic approach. In the same way that schizophrenia has become more easily treatable and has freed people suffering from the mild to middle range of the spectrum to be able to live a more normal life, so people with diabetes mellitus and other illnesses that affect erectile function, have been greatly helped by the advent of viagra and its successors. Hormone replacement therapy is another addition to aid a woman through the menopause, but must remain an individual choice. Some women may prefer the alternative route using herbal remedies, others seize gleefully on HRT. Whichever the choice, including doing nothing, a menopausal woman now has some say in how she intends to deal with the effects of the menopause, which as well as causing mood swings, hot flushes, and night sweats for many may also herald the beginning of vaginal atrophy, dryness and possible dyspareunia or pain on intercourse. Some women who have experienced or are fearful of experiencing any of the latter, and are happy to go the medical route, may therefore enjoy a sex life without any pre-menopausal pregnancy fears, while others preferring the alternative route, may back up their choice by using such vaginal products as Replens to continue enjoying pain free sex. Holding the tension between the medical model and the therapeutic requires us to be open-minded, flexible, and respect the client's autonomy of thought and action where his or her sexual desires, choices and decisions are concerned, unless they would involve harm to the client or their partner.

Conclusion

As sex therapy has this medical component it behoves us as psychosexual practitioners to create a link with the gynaecologists, obstetricians, urologists, physicians and psychiatrists who may refer to us, or work alongside us as part of a co-operative enquiry. Often it can be an enjoyable process of mutual learning, requiring only that both parties have respect, tolerance and open-mindedness, all qualities that any good therapist should hold.

Sex therapists may be called upon to address issues of gender dysphoria, orientation confusion, sexual habits and practices which are commonly regarded as being outside of the 'norm', penis and vagina size issues, anorgasmia, absent womb, retrograde ejaculation, fertility issues, non-consummation, sex during and after cancer. The list may seem endless, however sexuality with all its vagaries and puzzles is commonly brought into the consulting room of the sexual and relationship therapist and not necessarily, in our experience, into the consulting room of the more generalist practitioner.

Thus we endorse the role and the specialism of the psychosexual and relationship therapist as having expertise, which is distinct, and outside the usual remit of the general psychotherapist, not better, simply different.

'To know the way
We go the way
We do the way
The way we do
The things we do.

I am me
And you are you
As you can see;
But when you do
The things that you can do
You will find the Way
And the Way will follow
you'. (Hoff 1982)

Further Reading

Rosemary Basson M.D Clinical Professor in Department of Psychiatry, Obstetrics & Gynaecology, UBC, Vancouver, Canada. *'Woman's response cycle.'* Paper given at The first European Symposium on Female Sexual Dysfunction, London 2003

Bergeron S. & Lord M.J (2003) The integration of pelvi-perineal re-education Sexual & Relationship Therapy Vol:18, No:2, pp.135-141

Carroll R. (2003) Love in a scientific climate The Psychotherapist Issue 20, pp.11-12 *& also in https:www.thinkbody.co.uk*

Heiman J. R. (2002) Psychologic Treatments for Female Sexual Dysfunction: Are They Effective and Do We Need Them? Archives of Sexual Behaviour Vol:31, No.5, pp.445-450

Hoff B. (1982) *The Tao of Pooh*. Mandarin, UK

Tiefer L. (2002) Beyond the medical model of women's sexual problems Sexual & Relationship Therapy Vol:17 No: 2, pp.127-135