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Sexual Complaints and Dysfunctions

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Sex is one of the most important spheres of human life, influencing people from their first until their last day. It can be a source of great satisfaction and pleasure, deep frustration and disappointment, or isolation and shame. Sex is the arena in which the most intimate feelings or the most severe conflicts may be expressed. It may lead to high self-esteem or to a negative self-image, to social approval and support, or to rejection and derogation.

Family therapists cannot avoid dealing with sex. They must assess sexual relationships in order to enhance relatively positive ones and to alleviate sexual complaints. Sometimes they must also treat sexual dysfunctions, sexual variations such as homosexuality and gender identity disorders, or sexual deviance.

Nearly all family therapy cases include sexual complaints. One or both spouses may complain about no sex, too little sex, or too much sex. Some partners are less interested in sex and see their spouses as oversexed and too demanding. In long-standing relationships both partners may experience a loss of mutual physical attraction. Other spouses complain about unsatisfactory sex characterized by a lack of stimulation and caressing, insensitive or inadequate techniques, or constricted and mechanical sexual expression. These partners feel frustrated, deprived, or cheated and often become depressed or hostile.

Sexual complaints can frequently be traced back to intrapsychic causes. Some spouses experience problems with their bodies; for example, they feel unattractive, are uncomfortable with nudity, or suffer from real or imagined deformations. They often have defenses against erotic pleasure—and especially men may be out of touch with tender or loving feelings—which can lead to a lack of sensitivity. Sexual problems can also be caused by shame, denial of sexual wishes, or unconscious guilt or anxiety. Individuals with little ego strength may be afraid of letting go, feel threatened by intimacy, and experience discomfort with giving or receiving.

Some sexual problems originate in early or late childhood. Many adults grew up in a constrictive environment in which physical closeness and caressing were forbidden. The parents punished pleasure-seeking or erotic behaviors like masturbation and induced guilt feelings, shame, and inhibitions by their negative attitudes toward sex. Psychoanalysts trace sexual problems to unresolved oedipal conflicts which cause castration fears and transference distortions. Traumatic sexual experiences during childhood can also have long-term negative consequences.

Sexual complaints may also result from dyadic causes. Sometimes both partners are inexperienced, uncomfortable with each other's body, or ignorant of ways to please each other. This is often aggravated by a lack of open communication and reciprocal feedback about sexual likes and dislikes, feelings, and reactions. An unsatisfactory sexual relationship is frequently caused by one or both partners' being exclusively orgasm oriented, thus neglecting erotic stimulation and caressing. Some people approach sex as work or associate it solely with reproduction and, thereby, eliminate all fun and spontaneity.

Very often sexual difficulties are caused by marital problems. They frequently reinforce each other in a circular and increasingly destructive way. The marital relationship is usually disturbed in one of the following ways: (1) Both spouses see their marriage as shaky or feel insecure in it. They are afraid of being abandoned, rejected, or hurt. (2) Both partners are disappointed with each other, become alienated, and lose (sexual) interest in each other. (3) Both spouses are excessively dependent on each other and may regress to a nongenital relationship, taking turns in parenting each other. (4) In most cases, however, the marital relationship is characterized by discord and conflict, overt or covert hostility, and ambivalence, which may lead to mutual humiliation and sexual sabotage or result in a continuous power struggle in which sex is seen as conquest and submission.

Sociocultural influences may also contribute to sexual problems. For example, each society defines norms of sexual attractiveness and thus determines feelings of personal regard and self-acceptance. Some societies constrict the expression of sexual feelings by religious or social norms. Many Christian groups, for example, equate sex and sin, thus inducing inhibitions, shame, and a fear of eternal punishment. Other societies and social groups are overpermissive and exaggerate the importance of sexuality. In addition, the media in Western societies spread destructive myths like those of macho behavior and mutual orgasm. They portray sex as something to be taken (and to be given) and as something ending with intercourse. Noncoital forms of physical closeness are rarely described in books or shown in American movies.

Social change, especially if it involves the sex roles, may lead to confusion and disturbed sexual relationships. For example, many spouses misunderstood the goals of feminism and ended up with a never-ending struggle between the sexes, thus wreaking havoc on their marital relationship. For women, especially those with children, the stress caused by strenuous or full-time work often results in physical exhaustion and loss of sexual interest. Problems can also be caused by an antierotic environment like that found in small, overcrowded, or unpleasant dwellings.

Family therapists must deal not only with sexual complaints but also with sexual dysfunctions such as impotence, premature ejaculation, and retarded ejaculation in the male and frigidity, orgasmic dysfunction,

and vaginismus in the female. These problems are caused by factors similar to those described above and are usually aggravated by fear of failure, performance anxiety (need to excel or compete), spectating, early conditioning (early sexual failures), fear of the partner's sexuality, or the spouse's demand for performance. In some cases sexual dysfunctions are also caused by physical factors (pathology of the genitals), illness, drugs, and medication. For further information, see Masters and Johnson (1970), Hartman and Fithian (1972), or Kaplan (1974, 1979).

Sex therapists usually use individual diagnostic categories and distinguish between symptomatic and asymptomatic partners. They thus sometimes neglect the total relationship, which allows the asymptomatic partner to assign blame and to limit his or her participation in therapy (e.g., by striving to become a "cotherapist"), causing the symptomatic spouse to feel like a victim or culprit and to become defensive. Family therapists usually avoid these pitfalls by focusing on the total (marital, sexual, parental) relationship and by making both partners responsible for change. Their approach is supported by an empirical research project carried out by Cole and associates (1979). They divided 130 individuals taking part in sex therapy into symptomatic and asymptomatic partners and compared them with respect to parental attitudes toward sex, the age at which heterosexual dating began, early sexual experiences, sexual knowledge, current sexual practices and attitudes, sexual communication, wishes, and the like. They found nearly no significant differences and concluded, "One could argue, therefore, that classifying individuals into symptomatic and asymptomatic categories did not serve as a useful analytic dichotomy for comparing predisposing factors leading to sexual dysfunction or predicting outcomes for treatment" (p. 85). Thus, family therapists should always consider intrapsychic, interpersonal, and socio-cultural causes of sexual complaints and dysfunctions—and couples usually state their sexual problems in terms of dissatisfaction with their total relationship.

Another difficulty should be mentioned in this context. Some couples try to keep the treatment focus on the sexual complaint or dysfunction in order to prevent an overall assessment and treatment of their total relationship. They resist talking about more fundamental

problems and do not want to change their marital relationship. Using the sexual complaint as a myth they try to sabotage the treatment and tend to attack and humiliate each other. Family therapists have to consider this possibility and deal with it in the same way as they do other resistances.

TREATMENT OF SEXUAL COMPLAINTS

Family therapists should be able to treat sexual complaints effectively. They need to be acquainted with the physiology and psychology of the sexual response, common sexual problems, and specific treatment techniques. They should also be comfortable with talking about sex, provide a permissive atmosphere, facilitate discussion, and model sexual communication by maintaining an information-seeking, non-judgmental stance.

Inquiries about the spouses' sexual adjustment are nearly always necessary. In the presence of all family members, family therapists may discuss intimacy, affection, body contact, sex-role behavior, or attitudes related to sex. Children can often contribute much to the assessment of the nongenital aspects of their parents' (sexual) relationship, and the discussion may give them valuable learning experiences, lead to more open and honest communication, and increase the closeness among family members. If the therapist deems it necessary to explore the physical aspects of the spouses' sexual relationship or if the partners want to talk about unsatisfactory sex (techniques) or dysfunctions, the children should be excluded from the sessions.

Family therapists can approach sexual issues by mentioning that sexual behavior is important to the spouses' relationship and that it, therefore, has to be evaluated in the context of the total relationship. If the partners do not accept the definition of their sexual complaint as a relationship problem, the therapist should help them explore the interactional components of their complaint and recognize the impact of (and its impact on) marital problems. But if the definition is accepted, the family therapist can proceed to inquire about the onset of the sexual problem (takes a history), problems occurring at the same time (developmental crises), and the sexual problem's causes. The therapist

should also assess relationship needs, modes of communication and problem solving, role flexibility, affectional responses, attitudes, values, and so on before deciding whether the sexual problem must be treated separately (either by the therapist or a specialist) or together with other problems, or whether it will disappear by itself after more fundamental conflicts have been resolved.

Intrapsychic causes of sexual complaints can be treated by using cognitive insight methods such as interpretation and confrontation, experientially oriented (Gestalt) methods, and/or behavioral techniques. Family therapists can assist individuals to work through negative thoughts and feelings concerning their bodies and genital organs, help them overcome shame and embarrassment, and encourage them to explore their own bodies (some women know very little about their genitals). They can also relieve guilt feelings, work on inhibitions and childhood strictures against erotic pleasure, and give permission to enjoy sex, have fun, and indulge in sexual play and fantasy.

Treating interpersonal causes of sexual complaints usually involves teaching the spouses to communicate openly about sexual likes and dislikes and reactions and preferences. Family therapists alleviate the anxiety about talking about sex, clarify the sexual interaction, and help the partners share their feelings and verbalize appropriate expectations. They have the couple discuss how to please each other and encourage them to explore each other's body. They also help the spouses confront avoided problems, teach conflict-resolution, deal with power struggles, and alleviate fears of being rejected or hurt. It is often necessary to remove rewards from sexual symptoms or to rekindle sexual interest in the partner.

Another important function of family therapists is to educate and inform about the physiology and psychology of sexual behavior. They eliminate misconceptions and clear up confusions, talk about alternative ways of giving erotic pleasure, teach more sensitive or adequate techniques, and encourage the partners to experiment. Quite often the therapists have to change negative attitudes or destructive myths (e.g., of mutual orgasms). Meisel (1977) wrote, "Men often need help in allowing themselves to be given to sexually, to take a more passive role and enjoy being receptive. Women often operate with the myth that sex is something a man does to a woman, and need help in feeling comfortable being more assertive about giving and getting" (p. 206).

Sex Therapy

Family therapists are usually not trained to treat sexual dysfunctions and, therefore, sometimes need the help of sex therapists. The latter see their primary goal as relieving sexual dysfunctions and improving the overall sexual functioning. Accordingly, they use a symptom-focused form of therapy which is usually rapid and task oriented. Because of this limited focus, family therapists should refer clients for sex therapy only if the marital relationship is relatively healthy and if the partners are motivated and do not suffer from any severe psychopathology. Otherwise, the family and marital conflicts or the disturbed partner(s) should be treated first before referring them for sex therapy. If the sexual dysfunction, however, is central and impedes any progress in family therapy, concurrent sex therapy is indicated, or the spouses are referred to sex therapists and later returned by the latter. Less severe cases of sexual dysfunction (e.g., secondary impotence) can be treated by family therapists if they incorporate techniques from sex therapy (thereby recognizing the limitations of their experience and knowledge) or use sex therapists as consultants. It is important to maintain good professional relationships with sex therapists and to confer with them as often as necessary.

A sex therapist usually works with a heterosexual cotherapist. Together they sort out the physical causes of the sexual dysfunction by means of a (joint) medical exam. Then they assess intrapsychic and interpersonal causes and treat them in a way similar to those described earlier. In addition, they usually start the treatment by prescribing the "sensate focus" exercise (see Kaplan 1974, Masters and Johnson 1970). They help the partners relax by removing the pressure for intercourse (forbidding it) and encouraging physical closeness and caressing instead. Thereby, the couple experiences new erotic pleasures and develops trust. The demand for performance is replaced, and the therapists receive new information about the sexual behavior and the causes of the dysfunction by exploring the partners' reaction to these exercises.

Later, the sex therapists use various systematically structured erotic tasks and prescriptions in order to treat the specific dysfunction or cause. They may use systematic desensitization or flooding to alleviate fears, teach techniques to stop distracting thoughts or spectating (like concentrating on sexual fantasies), prescribe muscular exercises to

make the partners relax, and undo early conditioning with the help of reinforcement techniques. They describe nondemand coitus, give responsibility to each spouse for his or her own erotic fulfillment, and teach the principle of taking turns in order to dispel the fear of failure or performance anxiety. Women suffering from sexual dysfunctions are encouraged to experiment with masturbation and vibrators or are taught how to heighten vaginal and clitoral arousal, while at the same time their partners learn better ways of genital stimulation. These tasks are usually performed at home and are of great effectiveness in relieving sexual symptoms. They are described in detail by Masters and Johnson (1970), Hartman and Fithian (1972), Kaplan (1974, 1979), Meyer (1976), and Lo Piccolo and Lo Piccolo (1978).

The chances are great that the spouses will return for family therapy with their sexual dysfunctions having disappeared. This usually has a beneficial effect on their overall marital and family functioning. The partners have more positive and warm feelings for each other and are more optimistic and confident. They have found that they can cooperate effectively and solve problems—now they might even tackle other conflicts on their own. Besides, their attitudes toward therapy are more positive, and they are more willing to change.

Sometimes, however, sex therapists are not successful, as the main problems lie in the marital or family relationships. In some cases, improvement in the sexual sphere leads to the exacerbation of other family problems as the family tries to maintain its homeostasis (e.g., by developing new symptoms or by the children's acting out). Sex therapists then can provide new data on the relationship and the problem that will help the family therapist be more successful.

PSYCHOSEXUAL IDENTITY DISORDERS AND SEXUAL VARIATIONS

Sex-role and sexual behaviors are not inborn but are learned during childhood and adolescence. Children experiment with different ways of expressing their own gender, thereby growing into their sex roles and developing a sexual identity. But it is also common for them to imitate the opposite sex in play and fantasy or participate in activities that society reserves for the other gender. This is normal as long as it

does not occur too often or in combination with adjustment problems. If parents are upset by these behaviors, they need only some reassurance. The same is true if they worry about their child being a homosexual if he or she plays only with peers of the same sex: This is normal for children during the latency period. The awakening of the heterosexual drive in puberty may lead to confusion, as the adolescents have not yet learned how to express it appropriately. Accordingly, they may experiment with heterosexual, homosexual, or masturbatory behaviors. Parents should be reassured that this is common and that no therapy is indicated as long as the children do not show symptoms of any psychopathology.

But there are also cases in which children indulge in the activities, habits, and behaviors of the other sex. For example, boys might wear dresses, jewelry, or makeup (openly or in secret), consistently move and talk with feminine mannerisms, prefer girls' games and toys, avoid the company of males, and converse only about topics that women are interested in. They frequently pretend to be girls in play and fantasy or even express the desire to be a woman or to change their sex organs. These behaviors are often very distressing to their parents and usually lead to rejection by relatives, teachers, and peers, often causing these boys to feel isolated, lonely, and unhappy. If girls behave like boys, it is usually accepted by their environment, as a greater variety of sex-role behaviors is permitted for girls.

Parents of children with psychosexual identity disorders usually have unhappy marriages without affection and real communication and with much conflict and frustration in the marital and sexual relationship. Higham (1976) noticed that "gender transposition in the child paralleled the direction of parental dissatisfaction: When the father disparaged his wife, the daughter rejected femininity; when the mother disparaged her husband, the son rejected masculinity" (p. 55). This is often aggravated by disturbed sex roles and negative or confusing gender attitudes which prevent these children from accepting their sex and developing a secure sexual identity.

The relationship between the parents and their child is often disturbed. For example, fathers of feminine boys are often absent from their families, tend to be cold and distant, or are only a little emotionally involved with their children. They thus are not available as models for masculine behaviors. Moreover, they may be indifferent and uncon-

cerned or avoid, reject, and punish their sons instead of helping them alter their feminine behaviors. The mothers of these boys often feel incomplete, depressed, and empty, use their children to find sense in their lives, and cling to them in a symbiotic way. They try to make them into "female" companions by encouraging every feminine trait, regarding their effeminate behavior as graceful and sensible, and shielding them from a critical environment. In this family situation the boys do not pass through the oedipal phase, as they cannot develop incestuous feelings and do not experience their fathers as rivals inducing castration anxiety.

As feminine boys (masculine girls less so) usually suffer from rejection and ridicule, feel isolated and unhappy, and nearly always want to become like their same-sex peers, family therapy is indicated. The probability of treatment success is very high, as reported by Bates and colleagues (1975), Newman (1976), and Metcalf and Williams (1977), as long as the children are between 5 and 12 years old. Treatment programs usually consist of play therapy with the child conducted by a same-sex therapist. He or she acts as a role model, encourages identification, reinforces activities typical for the respective gender, teaches lacking sex-role behaviors, and tells stories to develop normal interests. Bates and colleagues (1975) also use group therapy to encourage peer interaction and social skills. They use a behavior modification (token) program which is also taught to the parents in order to increase masculine behaviors. Metcalf and Williams (1977) train parents and teachers to use an operant conditioning program.

But family therapists also have to treat the relationship between parents and child. They should explore the parents' feelings about the child's behavior; make the distant parent give up shaming, rejecting, and punishing the child; increase his or her involvement with the child (e.g., by motivating joint activities typical for the respective gender); and help the symbiotic parent give the child some autonomy. Both parents need to be educated about masculinity and femininity and should define their gender roles sharply for a while so that the child can more easily develop a sexual identity. Metcalf and Williams (1977) recommend that the child should take part only in those activities and domestic duties that are typical of members of his or her gender and that are also performed by the same-sex parent. Family therapists also

should improve the marital relationship so that the spouses no longer need to derogate the opposite sex.

If psychosexual-identity disorders, cross-dressing, or experimentation with homosexual relationships are maintained through adolescence, they usually become irreversible, as these young adults usually have accepted that they are homosexuals or lesbians, transsexuals, or transvestites. They want to be accepted as such and rarely are motivated to change their sexual orientation. Therefore, if family therapists are contacted by the parents, they should aim at rehabilitation and not at therapy—especially as there is no legal (and little social) pressure to treat these young adults against their will (which, anyway, is not possible). They can help them sort out their feelings, become more knowledgeable (e.g., about the homosexual life-style or sex changes), and enhance the quality of their sex life. These young adults often need help in accepting themselves, handling social disapproval, and achieving independence. Family therapists also should show the parents that rejecting their child will only add one more burden to his or her difficulties. Then they can encourage them to accept their child's sexual identity and his or her right to make decisions about his or her sexual behavior. The parents should support their child, keep the channels open for meaningful communication, and show empathy and understanding.

Family therapists rarely have to treat families in which both partners are homosexuals or in which one spouse is a transvestite. They should treat them in the same way as other clients and promote their growth and happiness, whether or not they come with problems related to their sexual behavior. Most family therapists have to make a special effort to understand a different life-style and to work through prejudices and negative countertransferences (DiBella 1979). There is the danger of their focusing too much on sexuality and, thereby, losing sight of the total person and other interpersonal aspects.

Sexual Variations and the Law

The sex drive is very malleable and diffuse and can be aroused and satisfied in many different ways. Anthropologists describe a great variety of allowed or forbidden sexual behaviors in primitive and

developed societies, and historians note that the range of permitted sexual behaviors changes in the course of time within one society. For example, homosexuality was considered to be a disease and legal offense in the United States some 20 years ago. But today it is better tolerated. Society determines which are the best and right ways of sexual expression, which ways are criticized but permitted, and which are forbidden and punished. The family and the peer group are the most prominent social institutions which transmit the society's norms, values, and attitudes regarding sex to its younger members, whereas other institutions (churches, courts, councils, and so on) control the adults' sexual behavior.

Western societies permit a wide range of sexual behaviors. In many countries even sexual variations such as homosexuality, transsexualism, transvestism, and fetishism are tolerated officially. Individuals expressing their sexual feelings in these ways may still be criticized or stigmatized by some social groups, but they can find subcultures of people who desire similar sexual experiences. They are permitted to gather in bars, form clubs, publish journals, and voice their interests in national organizations. Other forms of sexual behavior, however, are considered to be deviant. All Western societies prosecute and punish pedophilia, incest, childhood prostitution, rape, and exhibitionism.

Sex offenders are usually incarcerated, though the treatment facilities in the prison system are usually inadequate, and few therapists are interested in working with these individuals. Family therapists are generally not trained to deal with sex offenders and rarely see them as patients. As well, few families will travel to the prison in order to take part in weekly family therapy sessions, though in at least some cases the wife can be involved in the treatment.

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