CHAPTER 1

GENERAL INTRODUCTION AND OUTLINE OF STUDY

1.1 Introduction

In South Africa today, many marriages end in divorce. According to Statistics South Africa (1998:1), 66% of all first marriages end in divorce. Sexual problems or dysfunctions remain one of the prominent reasons for marital and relationship problems (Fourie, 1984:23). Research done by Mace (1958) and by Masters and Johnson (1970) confirms this statement and indicates that sexual difficulties may well be the most important single factor finally resulting in divorce. More recently, King (1999:310) refers to the fact that studies have shown that the most frequent reason given by couples for their divorce is the loss of sexual attraction, which also supports this notion. Sexual difficulties do not however occur exclusively in marital relationships. Couples in committed long-term relationships and even single people may experience sexual difficulties. Sexual dysfunctions and difficulties are also not exclusive to heterosexual couples, but may also occur in homosexual relationships.

Macklin (2000:1) states that although a contented sex life is a major key to a couple's emotional satisfaction, many therapists hesitate to address sexual issues in couple therapy. A small number of medical practitioners, social workers, psychologists and related professionals are able and/or willing to offer clients support with their sexual difficulties. An even lesser amount of professionals are able to provide professional sex therapy.

Sex therapy is multi-dimensional in nature and sex therapists originate from various professional fields such as social work, psychology and the medical fraternity. Sex therapy has been used professionally since the 1960s, but obtained mainstream recognition with the publications of Masters & Johnson (1966, 1970). These landmark publications as well as many others are viewed as classical works within the field of sex therapy. This study will therefore not be complete without referring to these classical works, although many of them may be more than ten years old.

Since the 1960s sex therapy has become a major specialty within the fields of psychology, psychiatry and medicine (Lopiccolo, 1978:ix). This view is shared by Weeks & Hof (1987:viii), who conclude that sex therapy shifted from being considered to be an individual problem, to being a couples problem and even a family problem, thereby becoming part of marital and couple therapy. When added to the fact that sex is not only important at an individual, personal level, but also socially and politically, Bancroft (1989:1) accentuates the importance of effective sex therapy in couple therapy.

Although the short-term, behaviourally oriented approach to the treatment of sexual dysfunction has proven to be an effective treatment modality, couples that experience severe marital or relationship distress demonstrate a poorer prognosis for treatment in a variety of forms of sex therapy. The research that supports this notion is listed in Berg & Snyder (1981) and confirms the belief that sexual dysfunctions do not occur in a vacuum, and that they must be viewed within the context of the total system of the client. This being the case,

it is obvious that a comprehensive and multi-dimensional approach to the treatment of sexual dysfunctions must include a thorough evaluation of the couple's relationship. Weeks & Hof (1987:xiii-xiv) confirm this view with the following statement: "The integration of sex therapy and couple therapy changes the way problems are understood from an individual to a systems perspective. This type of integration calls for a new breed of sex therapists. Therapists trained in individual-, sex-, couple-, and family therapy".

1.2 Motivation for the choice of subject

Sexuality is only one of the many components of a marriage or of a committed relationship. Relationship problems and sexual problems or dysfunctions are often interlinked. Woody (1992:5) states that people with sexual and intimacy problems seek help in various service settings. Those who know they are experiencing a sexual problem may seek help from a sex therapist. Clients with other forms of sexual distress might however see a marriage or relationship therapist. Woody (1992:6) states that: "...sadly, some clients never articulate their sexual concerns or dilemmas because of the practitioner's lack of knowledge and skills". Weeks & Hof (1987:viii) also state that many sex therapists still remain focused on treating the sexual dysfunction, even though they recognise on some level of consciousness that sex is but part of a particular couple's relationship.

It is often the case that a sexual problem is only a symptom of a relationship or marital problem, and this fact makes the social worker an ideal person to

deal with the problem, as he or she is well trained in the dynamics of marriage and relationship therapy. The problem however is that social workers are often not adequately trained in the field of human sexuality and sex therapy, and that they are therefore often unsure of their role within the multi-disciplinary team. Social workers are also often unaware that they have existing knowledge and skills to deal effectively with sexual problems and dysfunctions within the relationship context. "Some marital therapists may not be aware that after months of treatment, or even after termination, the couple had a sexual dysfunction. Often clients and therapists seem to have a collusive taboo against dealing with sexual problems" (Weeks & Hof, 1987:ix). Clients with sexual problems or dysfunctions are often sent from therapist to therapist without being treated effectively. This is very disturbing for clients and has an important influence on client motivation and prognosis.

This emphasises the importance of education and training of social workers in the field of human sexuality and sex therapy to develop a more positive attitude towards sexuality. It is also important to raise the comfort level of the social worker regarding sexual issues. The social worker should also be able to identify sexual problems and dysfunctions by asking the appropriate questions and then to be able to refer clients where necessary to the appropriate specialists in the field.

The World Health Organisation, Technical Report (Author unknown, 1975:50) stresses as far back as 1975, the need for education and training in human sexuality of sexual health care workers as well as of auxiliary workers such as

social workers. The report goes further in stating that in order to develop a better understanding of problems of human sexuality, it is necessary for health care workers to develop healthy attitudes toward sexuality, marriage and contraception. An understanding by the worker of his or her own sexuality and rational approach to his or her own sexual problems will help him or her to be able to deal better with the problems of others. More recently, the Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:31) states that basic sexual health education for all health professionals should be included in their basic training as well as in continued educational programmes. Health professionals include the medical fraternity, nurses, clinical psychologists, social workers and general health practitioners in their opinion. According to Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:43) this basic training should include the following:

- Basic knowledge of human sexuality.
- Awareness of personal attitudes toward one's own and other's sexuality, which should include a respectful attitude toward persons with different sexual orientations and sexual practises.
- Basic skills in identifying clients with sexual difficulties, and if necessary, referring these clients to the appropriate specialised professional.

A search done by the National Research Foundation in 1999 proved that very little research had been done in the combined field of sex therapy, marriage-

or couple therapy and social work in South Africa. Only seven related studies could be identified of which only three dealt with sexuality in the field of social work specifically. Hurwitz (1979) stressed in his study the need for the training of social workers in the field of sex therapy. Woods (1995) concluded that social workers in many countries have a history of dealing with sexuality-related issues, and that society plays an important role in determining which sexuality issue they deal with, and in what way they are dealt with. He incorporated the sexuality-related issues that occurred most consistently into a framework of social work and human sexuality. Fourie (1984) confirmed the findings of previous studies, and states that sexual dissatisfactions are one of the main reasons of marital breakdown, in his D.Ed study, entitled: "The training of sex therapists in South Africa – a multi-disciplinary approach".

1.3 Problem formulation

The nature of the research problem evolves around the proposed lack of knowledge of social workers regarding human sexuality and sex therapy. Social workers come into close contact with individuals in different communities and environments and might often be required to assist individuals with sexual problems, as relationship difficulties and sexual problems often co-exist. Sexuality and intimacy needs are connected, and therapists ought to be able to treat them holistically.

It is proposed that social workers often do not identify sexual problems because they avoid the subject of sexuality and are afraid to "open a can of

worms" which they may not be able to deal with effectively. In South Africa especially, many people and therapists are still uncomfortable with the subject of sexuality because of their conservative Victorian heritage.

Lister & Shore (1983:15) are of the opinion that it is the role of the social worker to understand the complex interplay of sexual problems and relationship difficulties and to intervene with social work skills to change or enhance both individual and social patterns that bring about sexual dysfunction. Lister & Shore (1983:16) are further of the opinion that the practice of social work has great potential for impacting the increased responsiveness of a health care system to the sexual needs of clients. In order to approach the topic of sexuality with confidence, the social worker should have accurate scientific knowledge regarding the facts of human reproduction and human sexuality. Social workers should know what are the common sexual problems experienced by clients, and how to deal with them effectively. The social worker should also know when the solution of a problem is beyond his or her ability and requires referral to a specialist. A social work perspective on sexual health can be described as the enhancement or restoration of optimal sexual functioning within a relationship context.

The problem that will be researched by means of this study can therefore be described as the proposed lack of knowledge of social workers specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

1.4 Goal and objectives of study

1.4.1 Goal

The aim of this study is to explore and describe the knowledge of social workers in private practice, specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

1.4.2 Objectives

To reach the above-mentioned goal, the following objectives are identified:

- To explore and describe, through a literature study, the nature, status and characteristics of human sexuality and sex therapy from a theoretical point of reference.

- To explore the role of sex therapy in couple therapy from a theoretical point of reference and within the social work context.

- To determine the level of knowledge of the social worker in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy.

- To make recommendations regarding the shortcomings of social workers' knowledge regarding human sexuality and sex therapy, identified by means of this study.

1.5 Theoretical assumption

A characteristic of exploratory research is that it does not have a hypothesis and the purpose is to gain insight into a situation (Bless & Higson-Smith, 1995:42). Dane (1990:5) also states that exploratory research involves an attempt to determine whether or not a phenomenon exists. De Vos & Fouché (1998:104) also state that questions are posed about the nature of real situations, while hypotheses are statements about how things can be.

The following research question is formulated:

Do social workers in private practice who specialise in couple therapy, have a lack of knowledge regarding human sexuality and sex therapy?

1.6 Research approach

It is necessary in social work research to distinguish between the qualitative and quantitative research approaches. Both approaches aim to explain the social reality. Fouché & Delport (2002:77) state that in real life, human sciences research uses both quantitative and qualitative methodology – sometimes consciously, sometimes unconsciously. Fouché & Delport (2002:85) outline a unique perspective by highlighting certain steps that are germane to both the qualitative and the quantitative perspective. According to them the steps relevant to the qualitative and quantitative research processes are the selection of a researchable topic and formal formulations. Leedy (1993:139) states that the research methodology is dictated by the nature of

the data, as well as the research problem. De Vos, Schurink & Strydom (1998:15) also quote Leedy who identifies qualitative research methodologies as dealing with data that are principally verbal, and quantitative research methodologies as dealing with data that are principally numerical. De Vos, Schurink & Strydom (1998:15) describe the qualitative approaches as more philosophical modes of operation where in contradiction the quantitative approach to research is more formalised and explicitly controlled and is close to the physical sciences. Mouton & Marais (1990:155 –156) agree that the quantitative approach is more highly formalised and explicitly controlled. It is more exactly defined than the qualitative approach and they agree with Fouché & De Vos (1998:71) that the quantitative approach is closer to the physical sciences. Reid & Smith (1981: 87-89) add with regard to the quantitative approach that the researcher's role is that of an objective observer, and that the data collection procedures and types of measurement are constructed in advance and applied in a standardised manner. The quantitative approach also uses statistical methods to determine association or differences between variables.

It was decided to utilise the quantitative research approach and not a combination of the quantitative and qualitative research approaches in this study, because very little information regarding the subject exists. This study is only an initial study. In other words, the aim is to establish whether or not a phenomenon (lack of knowledge of human sexuality and sex therapy) exists – nothing more and nothing less. This will then provide a point of reference for further, more in-depth research studies. Fouché & Delport (2002:79) state

that the quantitative research approach is defined as an inquiry into a social or a human problem, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalisations of the theory hold true. The quantitative study will be conducted by means of a self-constructed mailed questionnaire.

1.7 Type of research

According to Bless & Higson-Smith (1995: 41) the research problem guides the researcher in the selection of the type of research that will be suitable in resolving the research problem.

Applied research will be conducted as De Vos, Schumarink & Strydom (1998:8) state the goal of applied research as: "The development of solutions for problems and applications in practice". Arkava & Lane (1983:12) link applied research to immediate problems that the professional person experiences in practice. Thus applied research is implemented, as the topic is relevant and could contribute solutions to the problem of the proposed lack of knowledge of social workers about human sexuality and sex therapy.

1.8 Research design

According to Black & Champion (1983:75) most contemporary social scientific research is characterised by some type of study plan. This plan is labelled the

research design. Royce (1992:43) similarly refers to the research design as a blueprint that outlines the approach to be used to collect data. This view is supported by Grinnell & Williams (1990:140) who define exploratory research as: "The idea of an exploratory research study is to explore, nothing more – nothing less. We use exploratory designs when little is known in our research areas and all we want to do is make a beginning study".

The exploratory research design will thus be utilised, as there exist little information about the knowledge of social workers with regards to human sexuality and sex therapy in the social work context (Lister & Shore, 1983:1).

1.9 Research procedure and strategy

The research procedure chosen for this study has been selected keeping the aim of the study and research design in mind. A quantitative approach will be followed and thus a self-constructed mailed questionnaire will be used as method of collecting quantitative data.

The New Dictionary of Social Work (1995:51) defines a questionnaire as "...a set of questions on a form which is completed by the respondent in respect of a research project". Grinnell and Williams (1990: 216-217) define a mailed questionnaire as a questionnaire that is sent off by mail in the hope that the respondent will complete and return it. The advantages of a mailed questionnaire are according to Delport (2002:172) the fact that the costs are relatively low and that extension of the geographical area to be covered by the

researcher does not increase the cost level. Further advantages according to Snyman (1984:83) are that respondents enjoy a high degree of freedom in completing the questionnaire and information can be obtained from a large number of respondents within a brief period of time. Delport (2002:172-173) mentions the following limitations of the mailed questionnaire:

- The non-response rate may be very high
- Missing data may occur
- There is no control to determine that the right person in the household completes the questionnaire

The research population for this study consists of all the social workers who are registered with the South African Association of Social Workers in Private Practice (SAASWIPP) and who specialise in couple therapy. They amount to three hundred and forty four (344) in total. Three hundred and forty four questionnaires will thus be mailed, as it is the only feasible method to reach all the respondents countrywide.

De Vos, Fouché & Venter (2002:223) assert that data analysis in the quantitative paradigm entails the breakdown of the data into constituent parts to obtain answers to the research questions. Kerlinger (1992:125-126) states that the purpose of data analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied, tested and conclusions drawn. The quantitative data collected in this study via a self-constructed, mailed questionnaires will be analysed via computer, with

the assistance of the Department of Statistics of the University of Pretoria. The research results will then be interpreted and conclusions will be drawn.

1.10 Pilot study

The pilot study may be regarded as a preliminary step in preparation of more extensive and elaborate research. It can be viewed as laying the foundation for all subsequent research steps. The pilot study is defined in the New Dictionary of Social Work (1995:45) as: "...the process whereby the research design for a prospective survey is tested".

Strydom (1998:178) quotes Singleton, Straits & McAllister who define a pilot study, as: "...the pre-testing of a measuring instrument that consists of trying it out on a small number of persons having characteristics similar to those of the target group of respondents". More recently Strydom (2002:210) refers to the pilot study as an integral part of the research process. Strydom (2002:211) states that: "Its function is the exact formulation of the research problem, and a tentative planning of the modus operandi and range of the investigation".

The pilot study can therefore be seen as a preliminary study to help orientate the researcher regarding the chosen topic of research, to determine the feasibility and extent of the study and to form a cornerstone to build on. Two respondents were chosen to complete the questionnaire as part of the pilot study. Minor alterations were made with regards to spelling, wording, and the clarity of the questions.

1.10.1 Literature study

The nature of the subject being studied required a thorough study of the relevant literature. As relevant social work literature is limited, literature from the fields of medicine, human sexuality and sex therapy were also consulted. Literature on human sexuality, sexual dysfunctions, sex therapy, couple therapy as well as the integration of sex therapy and couple therapy were consulted.

Although it was attempted to utilise as many recent references as possible, the fact remains that there are many classical works regarding sex therapy without which this study will be incomplete. This is the reason why some of the references are more than ten years old.

1.10.2 Consultation with experts

People with specialised knowledge regarding the specific field of research and research in general were consulted.

- Dr. Rina Delport and Dr. Reineth Prinsloo from the University of Pretoria were consulted as experts in the field of social work research.

- Dr. Reineth Prinsloo and Dr. Madeleine Nolte were also consulted as experts in the field of couple therapy.

- Me. Joke Nicol has been consulted as a social worker in private practice specialising in couple therapy.

- Dr. Madeleine Nolte, social worker at the student support services of the University of Pretoria and Me. Joke Nicol, a social worker in private practice, participated in the testing of the pilot questionnaire.

- Dr. Elna McIntosh, a clinical sexologist in private practice, and Mr. Eugene Viljoen, a clinical psychologist with special expertise in sex therapy with couples, were also widely consulted.

- Dr. Howard Rupel, dean of The Institute for the Advanced Study of Human Sexuality, in San Francisco, USA, was visited.

- Prof. Domeena Renshaw, Department of Psychiatry and director of the Sexual Dysfunction Clinic at the Loyola University Medical Centre in Chicago, USA, was consulted.

- Hundred and thirty-five hours of supervised clinical training in sex therapy were completed in 1997, at the Loyola University, Sexual Dysfunction Clinic, in Chicago, USA.

1.10.3 Feasibility of the study

Monette, Sullivan & De Jong (1989:92) state that the feasibility of a research study is the practical consideration of what can be accomplished within a specific time, and with limited resources.

Sufficient funds were available to carry out the research project as a bursary from the National Research Foundation, as well as a merit-bursary from the University of Pretoria, were awarded to the researcher.

Very little research has been done regarding this topic and the only current registered research project that could be found in this field relating to social work, is the study described in this dissertation.

The South African Association of Social workers in Private Practice (SAASWIPP) offered a suitable resource (database) for the execution of the research. All social workers in private practice, with their specific area of speciality, are registered with SAASWIPP. SAASWIPP published a resource book in 2000 where all the social workers in private practice, with their specific speciality are listed. This resource book offers a set sampling frame, which improves the practical feasibility of the study. Mailed questionnaires will be utilised to collect the data. It is therefore not necessary to make use of another sampling method such as cluster sampling to narrow respondents down to a certain geographical area. Six hundred and seventeen social

workers are registered as private practitioners in South Africa. Three hundred and forty four of these specialise in couple therapy.

1.10.4 Pilot test of questionnaire

A preliminary questionnaire was drawn up for completion by selected social workers and academic personnel. The results of the pilot questionnaire gave an indication of the usability and validity of the self-constructed questionnaire and whether it still needed to be refined.

Me. Joke Nicol and Dr. Madeleine Nolte completed the preliminary questionnaire. They are specialists in the field of couple therapy and are social workers with many years of experience. They were also consulted regarding the content validity of the questionnaire. The preliminary questionnaire was also handed to Dr. Ezio Baraldi, Mr. Eugene Viljoen and Me. Christa Coetzee for comments regarding content validity. They are members of the executive board of the Southern African Sexual Health Association (SASHA), and are specialists in the field of sex therapy. Minor changes were made with regards to typing errors and the clarity of questions.

Dr. Borain and Me. Rina Owen from the University of Pretoria's Statistical Department also evaluated the questionnaire.

1.11 Description of the research population, boundary of sample and sampling method

The research population is described as the total group of individuals involved in the study (Bailey, 1994:109). The research population for this study consists of all social workers who are registered with SAASWIPP and who specialise in couple therapy. A total of six hundred and seventeen social workers are registered countrywide as private practitioners. Three hundred and forty four of the registered social workers specialise in couple therapy. The study is conducted country wide to ensure validity. The population is relatively small (344) and a mailed questionnaire will be utilised. The response rate of a mailed questionnaire is between 20% and 40% (Bless & Higson-Smith, 1995:112). The whole population will therefore be used to conduct a thorough study and a sample will not be selected.

1.12 Ethical aspects

Dane (1990:58) describes the conducting of ethical research as a balancing act. Researchers must balance their general obligation to promote knowledge with the general obligation to treat others fairly. Strydom (1998:24) defines ethics as: "...a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students".

Dane (1990:39) defines the term voluntary participation as: "...the participants' rights to freely choose to subject themselves to the scrutiny inherent in research". This research project was done with the willing co-operation and informed consent of the participants without any coercion involved. The participants were also aware of the nature of the research project and of its ultimate aim and objectives. The participation of the respondents was obtained via a cover letter accompanying the questionnaire. The anonymity of participants and the confidentiality of information gathered were guaranteed. Strydom (1998:28) states in this regard that privacy implies the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner. The respondents were not exposed to physical or emotional harm in any way.

1.13 Definition of key concepts

As stated previously there are some historical textbooks and resources that have to be included to make this study complete. This is especially true when key concepts are defined. The following key concepts can be defined:

1.13.1 Sex therapy

Many authors and researchers do not give a specific definition or description of sex therapy. Masters and Johnson (1970) for example do not give a definition of sex therapy. They however give a detailed outline of their therapy

strategy and the steps in their therapeutic model. Kaplan (1974:217) also spends little time on a definition of sex therapy. She does however mention: "... the primary objective of all sex therapy is to relieve the patient's sexual dysfunction. All therapeutic interventions, tasks, psychotherapy and couples therapy, are ultimately at the service of this goal".

Lopiccolo (1978:534) defines sex therapy as: "...brief (often ten to fifteen sessions) therapy, with the emphasis on directly changing the client's sexual attitudes and sexual behaviours". Ducharme (1997:20) states that sex therapists are counsellors who specialise in working with people who have sexual difficulties. The kinds of problems they deal with include a difficulty in achieving erections, premature or retarded ejaculation, and lack of sexual desire. For women, sex therapists address problems of reaching orgasm, painful intercourse, or lack of interest in sexual activity. A group of researchers who can be described as traditional sex therapists emphasises sexual functioning per se. (Compare Cole, 1985:337; Rosen & Weinstein, 1988:2 and Weeks & Hof, 1987:xii.) Cole (1985:337) describes sex therapy as: "...those therapeutic processes which are used to attempt to initiate or restore sexual function in an individual or between a couple, where it had been previously absent". Rosen & Weinstein (1988:2) state that the basic goal of sex therapy is the relief of sexual dysfunctions, resulting in the improvement of sexual functioning. These authors support the more narrow view of sex therapy that emphasises the sexual dysfunction as such without taking the relationship into account. Weeks and Hof (1987:xii) define sex therapy as an approach to therapy which is brief, problem-focused, has an

educational component, involves seeing a couple together, consists of specific treatment formats and techniques, and often involves giving clients specific homework assignments.

There is however today a shift in focus from the more narrow minded approach of sex therapy with the emphasis on sexuality as such, to a more broader perspective of which the sexual aspects are viewed from a broader conceptual framework. This statement can be confirmed by the following view held by Weeks & Hof (1987:xiv): "The traditional individual behavioural perspective of sex therapy is broadened to include the contextual and interactional dimensions of relationships". Barker (1991:213) defines sex therapy as: "Professional, clinical treatment of the psychological and physiological dysfunctions of human sexuality".

Sex therapy today is a field that includes practitioners of many different backgrounds – psychology, medicine, social work, nursing, counselling, and theology to name but a few. There are many approaches to sex therapy and therefore many definitions and perspectives. For the purpose of this study there will be focussed on sex therapy from a social work perspective, utilising the framework of sex therapy as part of marriage and relationship counselling. The relationship between the couple is taken into account. The sexual dysfunction will be viewed from the systems perspective, as the sexual dysfunction usually has a profound effect on the couple's relationship in general.

1.13.2 Human sexuality and sexual health

In the SIECUS publication, Common Ground Sexuality (Author unknown, 2001:4), it is stated that sexuality encompasses personal and social meanings as well as sexual behaviour and biology. A comprehensive view of sexuality includes social roles, personality, gender and sexual identity, biology, sexual behaviour, relationships, thoughts and feelings. This publication (Author unknown, 2001:5) states further that sexuality and sexual health are concepts that are often used interchangeably. Sexual health is however a component of sexuality.

Masters, Johnson & Kolodny (1995:21) define human sexuality as a multidimensional phenomenon having biological, psychological, behavioural, clinical, moral, and cultural aspects. They conclude further that no single dimension of sexuality is universally dominant.

Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:6) agrees with the previous statement and adds that sexuality refers to a core dimension of being human, which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment, love and reproduction.

Sexual health is defined by the World Health Organisation (Author unknown, 1975:41) as: "The integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that

enhance personality, communication and love". King, Cameron & Downey (1991:268) define a sexually healthy person as someone who feels comfortable with his/her sexuality and who feels free to choose whether or not he/she wishes to try a variety of sexual behaviours.

In the SIECUS publication, Sexual Health: An Introduction (Author unknown, 1997:5) sexuality is defined as:

- **self-esteem**: the way people feel about themselves as men or women;
- **body image**: the way they feel about their bodies and the way they use them;
- **social roles**: the roles they take on and the expectations other people have of them;
- **relationships**: the way in which they relate to others.

Common Ground Sexuality (Author unknown, 2001:5) defines sexual health as: "...women's and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is positively enriching, includes pleasure, and enhances self-determination, communication and relationships". In The Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:6) sexual health

is defined as: "...the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality".

It is therefore evident that human sexuality and the term sexual health are multidimensional and interchangeable. The notion of sexual health however implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems. Sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values. In sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

1.13.3 Sexual dysfunction

As in the case of the term sex therapy, Masters, Johnson & Kolodny (1995:462) only refer briefly to the term sexual dysfunction by stating that it is: "...a condition in which the ordinary physical responses of sexual function is impaired". Grazioli (1998:31) states that a sexual dysfunction is characterised by psychological and/or physiological disturbance in the four processes that characterise the sexual response cycle: desire, excitement, orgasm and resolution. Clinical judgement about the presence of a sexual dysfunction should take into account the individual's ethnic, cultural, religious and social background, which may influence sexual desire, expectations and attitude about performance.

Kaplan (1974:281) emphasises individual and physiological factors. She defines sexual dysfunction as: "...psychosomatic disorders which make it impossible for the individual to have and/or enjoy coitus". Five years later Kaplan (1979:21) goes further and describes sexual dysfunction as: "...disturbances of the desire, excitement, or orgasm phases of the sexual response cycle. All of these are psycho-physiologic disorders caused by sexually related anxiety and all are, to some degree at least, amenable to sexual therapy". Barker (1991:213) defines sexual dysfunction as: "The inability of an individual or couple to experience sexual intercourse in a satisfactory way".

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (1994:164) groups sexual and gender identity disorders under four headings: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified. Sexual dysfunctions are further grouped under sexual desire disorders, sexual arousal disorders and sexual orgasmic disorders.

It is evident that sexual dysfunction is an embracing term. The disturbance causes marked distress or interpersonal difficulty and the main complication is usually a problematic marriage and a disturbed sexual relationship.

1.13.4 Couple

The Macmillan English Dictionary (2002:318) defines a couple as two people who are married or involved in a romantic relationship with each other. For the purpose of this study a couple is defined as two people within a committed relationship. A couple may consist of a male and a female (heterosexual) or of a male and a male, or of a female and a female (homosexual). In order to simplify matters the term "couple" will be viewed from here onwards as consisting of a male and a female, but it should be noted that homosexual couples are also implied.

1.13.5 Couple therapy

Russell & Russell (1992:80) define couple therapy as a strategy of treatment that intervenes in a committed relationship. Couple therapy is an appropriate therapeutic context through which sexual dysfunction can be treated. The New Dictionary of Social Work (1995:65) describes therapy as social work assistance, which focus on the emotional and psychological needs of the client. Barker (1991:139) describes marital therapy as an intervention procedure used by social workers and other professionals to help couples resolve their relationship, communication, sexual, economical, and other family problems.

Barker (1991:139) distinguishes counselling from therapy and states that counselling is a form of therapy, which is less intense and more directive.

For the purpose of this study the terms marital therapy, relationship therapy and couples therapy will be viewed as interchangeable. The preferred term is however couple therapy as sexual dysfunctions and sexual difficulties do not occur exclusively within marital relationships. Sexual dysfunctions may also occur within committed relationships and single men or women may also experience sexual difficulties. Sexual difficulties should however be seen as a relationship problem and not as an individual problem.

Kaplan (1974:196) compares marital and relationship therapy to sex therapy. She asserts that the goal of sex therapy is to cure sexual difficulties, while the goal of marital and relationship therapy (couples therapy) is broader and includes a more extensive modification of the transactional dynamics, which lie at the root of the couple's difficulties. Kaplan (1974:217) states further that: "...the main aim of marital therapy extends beyond relief of the clients' sexual problems and includes the resolution of broader intra-psychic and interpersonal difficulties". Thus couple therapists do not treat the sexual symptoms in isolation from other problems. Sexual problems are usually the result of some or other dysfunction in the relationship and must therefore be treated by a holistic, eclectic approach, utilising basic social work marriage- and couples therapy skills as well as utilising specialised sex therapy skills.

Sex therapy has also evolved toward the integration of both couples therapy and sex therapy approaches. Through the integration of both couple and sex

therapy approaches, there is a unique opportunity for the social worker to act in a dual role with the clients.

1.13.6 Social Work

Compton & Galaway (1989:5) define social work as a profession, involving knowledge, values and skills developed by social sciences for furthering the goals of social welfare. They quote Boehm's definition (1989:6) of social work as: "Social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused upon their social relationships which constitute interaction between individuals and environments". Hepworth & Larson (1986:12) site a similar definition of social work. They define social work as: "The professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favourable to their goals". Morales & Sheafor (1989:7) agree that social workers help people to improve their interaction with various aspects of their world. "Social work is a profession committed to improving the quality of life for people through various activities directed toward social change" (Morales & Sheafor, 1989:8). Barker (1991:221) defines social work as the applied science of helping people achieve an effective level of psychosocial functioning. The New Dictionary of Social Work (1995:60) describes social work as a professional service aimed at the promotion of the social functioning of people.

Social work can thus be defined as a scientifically based profession, aimed at providing a service to clients (individual, group or community based) to improve their social functioning.

1.13.7 Social Worker

Barker (1991:222) refers to a social worker as someone who graduated from a school of social work, and who uses his or her knowledge and skills to provide social services to clients. The New Dictionary of Social Work (1995:60) refers to a social worker as a person who is registered and authorised in accordance with the Social Work Act, 1978 (Act 110 of 1978), to practice social work. The Macmillan English Dictionary (2002:1358) describes a social worker as someone who is trained to give help and advice to people who have severe social problems.

With regards to this study a social worker is defined as a person who is registered as a social worker with the South African Council for Social Service Professions (SACSSP), and who is operating through a private practice. They are therefore also registered with the South African Association of Social Workers in Private Practice (SAASWIPP).

1.13.8 Knowledge

Knowledge is defined by the Oxford Dictionary (1989:517) as a person's range of information, familiarity gained by experience and practical or

theoretical understanding of a subject. The Macmillan English Dictionary (2002:791) describes knowledge as that which someone knows about a particular subject. Morales & Sheafor (1989:181) define knowledge as the acquaintance with theoretical and practical understanding of some branch of science, art, learning or other area involving study, research, or practice, and the acquisition of skills. Barker (1991:128) refers to the social work knowledge base as: "The aggregate of accumulated information, scientific findings, values, skills and the methodology for acquiring, using, and evaluating what is known".

This study aims to assert the level of knowledge of social workers in private practice regarding human sexuality and sex therapy.

1.13.9 Comfort

The Oxford Dictionary (1989:273) describes comfort as being at ease with a subject or liking or accepting it. This study aims to assert the comfort level of social workers in private practice, specialising in couples therapy, with regards to the subject of human sexuality.

1.14 Problems encountered with this research

No major problems were encountered with this study. The only problems encountered were:

- The high non-response rate. Only 23% of respondents completed the questionnaire. This could mean that many respondents may view the topic of sexuality as threatening. According to Bless & Higson-Smith (1995:112) the response rate of a mailed questionnaire however is between 20% and 40%.

- Forty-three of the 344 questionnaires were returned undelivered because the SAASWIPP database was not up to date.

- A lot of missing data occurred, which may confirm the statement that there is a basic lack of knowledge regarding human sexuality and sex therapy among many of the respondents. Some questions may also have remained unanswered because the respondents viewed them as threatening or too personal.

- The fact that only the quantitative research approach was used, led to the fact that little data regarding respondents' perspectives and feelings, regarding human sexuality and sex therapy were obtained.

1.15 Outline of this research study

This research study consists of a number of chapters:

Chapter 1: General introduction

This chapter consists of the motivation for the choice of the study, the problem formulation and the aim and assumptions of the study. The research methodology, ethical issues and the definitions of the main concepts are also provided.

Chapter 2: Literature Overview: Part 1 – Human sexuality and sex therapy: An overview

Literature regarding human sexuality and sex therapy are explored and described. An historical overview of sex therapy as a science is provided. Key concepts are defined, and the different perspectives in human sexuality are discussed.

Chapter 3: Literature overview: Part 2 – Clinical sex therapy

Literature regarding clinical sex therapy are explored and described. The state of theory in sex therapy is discussed. The classification of sexual disorders is discussed, as well as different treatment modalities for sexual dysfunctions.

Chapter 4: Literature overview: Part 3 – The integration of couple therapy and sex therapy

The integration of couple therapy and sex therapy is discussed. The role of the social worker in sex therapy is described from a theoretical perspective and sex therapy within couple therapy is discussed from a social work perspective.

Chapter 5: Empirical results

A description of the data collected and the interpretation of the empirical research findings are given and illustrated by various tables and figures.

Chapter 6: General summary, conclusions and recommendations

This chapter ends the dissertation and includes a general summary, conclusions reached and recommendations made as a result of this study.

The **bibliography** for the study is arranged alphabetically.

1.16 Summary

This chapter consists of a general introduction to the research study. The research approach, methodology and methods of data-collection were described as well as problems encountered with the conducting of the research. Various key concepts and ethical considerations were identified and discussed.

- Sexual difficulties may well be the most important single factor resulting in marriage or relationship break-ups. There exist an interaction between sexual difficulties and relationship problems.

- Sexual dysfunctions and difficulties are not exclusive to heterosexual couples but may also occur in homosexual relationships.

- Sexual dysfunctions do not occur in a vacuum, and must be viewed within the context of the total system of the client.

- Relationship problems and sexual problems or dysfunctions are often interlinked.

- Because of this interaction between sexual difficulties and relationship problems, the social worker is the ideal person to deal effectively with these kinds of problems, as he or she is well trained in the dynamics of marriage and relationship therapy.

- There is a need for specialised education and training in human sexuality and sex therapy, of social workers.

- The problem that will be researched by means of this study can be described as the proposed lack of knowledge of social workers specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

In chapter 2, literature regarding sex therapy and human sexuality will be reviewed.

CHAPTER 2

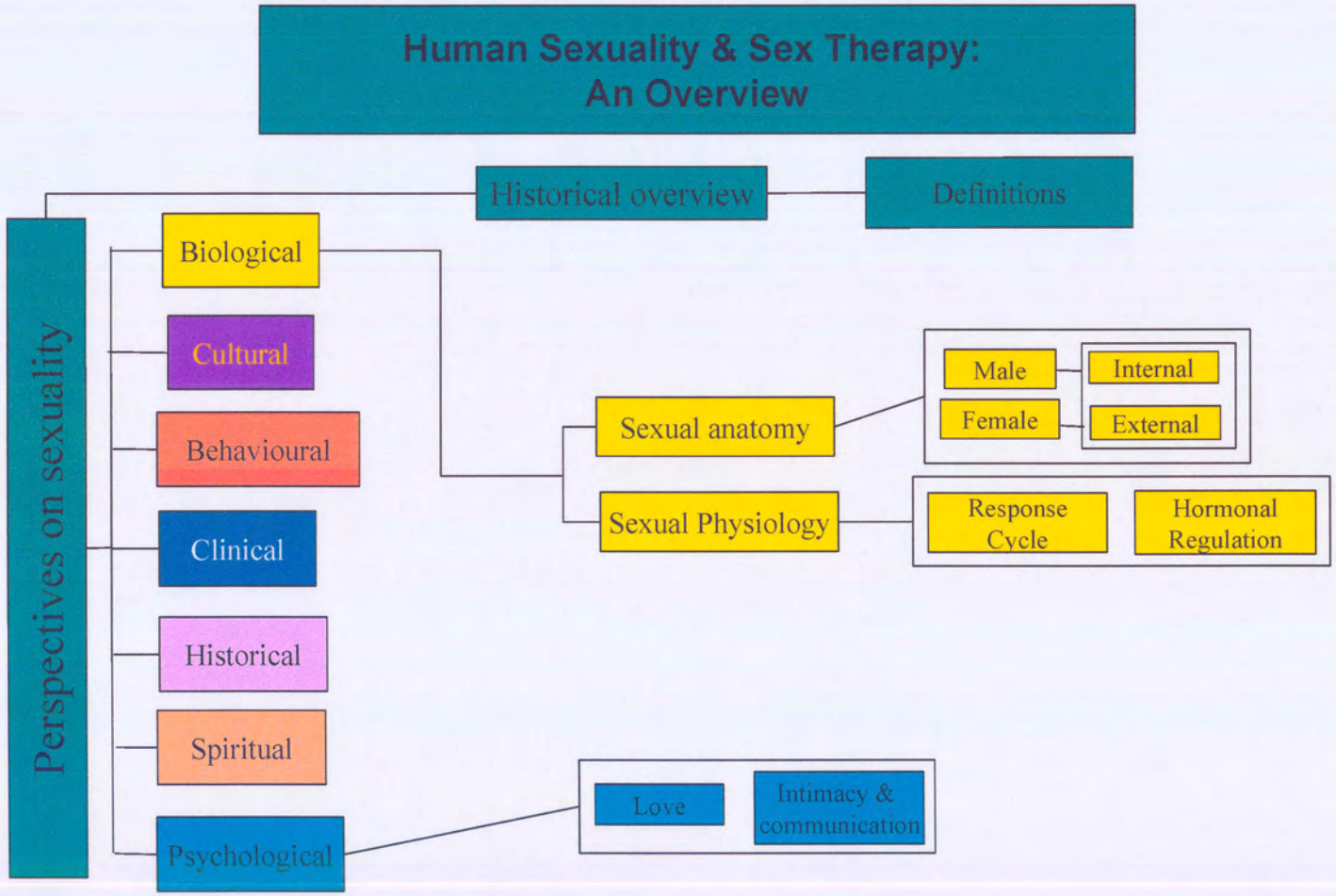
HUMAN SEXUALITY AND SEX THERAPY: AN OVERVIEW

2.1 Introduction

It is appropriate to start the theoretical overview of human sexuality and sex therapy by discussing the history and the origins of sex therapy. A short historical overview of the origins and background of sex therapy will therefore be discussed. A discussion of various definitions of human sexuality, sexual health and sex therapy follows. Various perspectives on human sexuality, namely, the biological dimension, the physiological dimension, the psychosocial dimension, the behavioural dimension, the clinical dimension, the cultural dimension and the spiritual dimension will then be discussed. The chapter concludes with a summary.

Figure 1 shows a schematic representation of the outline of this chapter.

Figure 1: Schematic representation of layout of chapter 2



2.2 Historical overview of sex therapy

Sexuality has fascinated people in all walks of life from the ancient times until the present. Masters, Johnson and Kolodny (1995:2) state that sexual themes have been common in art and literature. Religions, philosophies and legal systems, who are all concerned with shaping human behaviour, have typically tried to establish sexual values and taboos. Fourie (1984:12) states that Magnus Hirschfeld founded the first Institute of Sexual Science in Berlin, in 1919. This was followed by the establishment of a number of "Leagues of Sexual Hygiene" in Germany, Austria, Denmark and Sweden. The main emphasis of these consultation services was on sexual education and counselling. The leading figures in the field of sexology during this time were Hirshfeld, Block, Moll and Max Marcuse. Marcuse is often described as the father of sexology. Fourie (1984:13) quotes Block who defines sexology as: "... the study of the phenomena and effects of sexuality, in the relation to the physical and psychological, on the individual and emotional level".

The history of sex therapy as a discipline however, is relatively brief. Wiederman (1998:88) states that from the start of the twentieth century until the late 1960's, sexual dysfunction was typically treated within a psychoanalytic framework. From such a psychoanalytic perspective, psychological and sexual problems were viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one's

parents. Sexual problems were seen as symptoms of greater psychopathology. As such, treatment consisted mostly of long-term, individual psychotherapy. In contrast to this, a few clinicians like Lazarus, Obler and Wolpe also applied behavioural principles in the treatment of sexual dysfunction, but such approaches were not the norm prior to the 1970's. Barnes (1995: 351) asserts that society experienced a sexual revolution throughout the 1960s and 1970s, which allowed for increased openness toward sexual issues and a greater awareness of the importance of sexual fulfilment within intimate and significant relationships. While this increased openness about sexual issues provided the impetus for the evolution and growth of sex therapy, its practitioners focused primarily on the individual experiencing a sexual dysfunction.

King, Cameron & Downey (1991:15) and Wiederman (1998:88) agree that sex therapy as it is known today, was essentially founded by Masters and Johnson, whose report on a "new" therapeutic approach to sexual problems which was published in 1970, revolutionised what health professionals saw as the appropriate treatment for sexual difficulties. Weeks and Hof (1987:viii) quote Sager who states that: " With the publication of Masters and Johnson's research on the anatomy and physiology of sex and on the definition of sexual dysfunctions, in the late 1960's and early 1970's, an explosion took place in psychiatry, psychology and many other fields which is still reverberating...". In contrast to psychoanalytic approaches, the "new" sex therapy was relatively brief, problem focused, directive, and behavioural with regard to technique. Masters

and Johnson emphasised social and cognitive causes of sexual dysfunction. Ultimately the large majority of sexual difficulties were seen as arising from a sexually restrictive or religiously conservative background. Such a personal history appeared to result in decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequently anxiety and preoccupation over performance during sexual interactions. Masters and Johnson therefore used a learning model with the objectives of treatment consisting of effectively achieving alleviation of performance anxiety and re-educating clients regarding human sexuality.

Helen Kaplan followed Masters and Johnson in 1974 and introduced her version of the "new" sex therapy. Kaplan's model included an initial emphasis on immediate symptoms. If the direct approach to symptom treatment worked, the case was closed. If, however, the "new" behavioural techniques met with resistance, the therapist relied on psychodynamic theory, or consideration of "deeper" issues, to understand the possible intra-psychic and interpersonal roles the sexual dysfunction might be serving (Kaplan, 1974:264).

In the years subsequent to Masters and Johnson several changes have taken place in sex therapy. Wiederman (1998:89) states that sex therapy in the 1970's was an outgrowth of an earlier cultural shift toward greater focus on increased gratification and discussion of sexual issues. Wiederman (1989:89) concludes further that because of this focus on gratification, anorgasmia in women, and

premature ejaculation in men, were the prominent sexual dysfunctions presented to therapists in the early days of contemporary sex therapy. At the same time as the birth of contemporary sex therapy, there was a noticeable increase in mass media attention to issues of sexual enhancement. Barnes (1995: 351) agrees that society experienced a sexual revolution, which allowed for increased openness toward sexual issues and a greater awareness of the importance of sexual fulfilment within intimate and significant relationships. Renshaw (1983:33) agrees that the positive aspect of sex therapy is that much can be done with brief behavioural intervention. According to her the goal of sex therapy is symptom reversal – a direct approach.

Terapists therefore agree that the types of cases commonly seen in sex therapy clinics today have changed dramatically from the earliest days of sex therapy. Wiederman (1989:90) asserts that as the proportion of the clients who simply needed education and direction dwindled, the proportion of clients with more pervasive and chronic sexual problems increased. Accordingly, instances of erectile failure, low sexual desire and compulsive sexual behaviour have become an increasing part of sex therapists' caseloads.

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. With increasing frequency, systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists. Also, greater

attention has been paid to the role of early sexual trauma in subsequent sexual dysfunction. In general, a more complex, integrative, or post-modern approach to the conceptualisation and treatment of sexual dysfunction has emerged. With the continuing development in the field of sexual medicine as well as continuing research into human sexuality and relationships, new models and techniques for sex and marital therapy are constantly being developed. There is a movement today towards combining sex therapy and marital therapy, and also to use a more holistic approach by which the medical practitioner is more actively involved in the therapeutic process.

2.3 Definitions of human sexuality, sexual health and sex therapy

Although these definitions were already discussed in chapter 1, the importance of defining these concepts is stressed by the more detailed discussion that follows.

2.3.1 Human sexuality

Lister and Shore (1983:3) identify four spheres of human sexuality: biological and reproductive, gender identity and sex role behaviour, sex activity, as expressed privately or in interaction with other and the influence of erotic and sensual stimuli, as expressed internally by each individual. Masters, Johnson and Kolodny (1995:5) define sexuality as a broadly encompassing term that is used to refer to all aspects of being and feeling sexual. They assert further that every

person has sexual feelings, attitudes, and beliefs but everyone's experience of sexuality is unique because it is processed through an intensely personal perspective.

Masters, *et al.* (1995:21) are further of the opinion that it is impossible to understand human sexuality without recognising its multidimensional nature. Weeks and Hof (1987:24) define sexuality as a primary force in the life of every individual. It is a pervasive and integral force, involving physiological and psychological processes. Weeks and Hof (1987:25) state further that: "Sexuality is the process of being male or female, a man or a woman, masculine or feminine; it is how we think and feel about and express our gender, our sex organs, our body, our self-images, and our choices and preferences". Petitgirard (1992:5) defines sexuality as: "...self-esteem: the way people feel about themselves as men or women; body image: the way people feel about their bodies and the way they use them; social roles: the roles they take on and the expectations other people have of them; and relationships: the way in which people relate to others". Sexual Health: An Introduction (Author unknown, 1997:5) also makes use of Petitgirard's definition. Masters, *et al.* (1995:6) define human sexuality as a multidimensional phenomenon having biological, psychological, behavioural, clinical, moral and cultural aspects. They conclude further that no single dimension of sexuality is universally dominant.

In Common Ground Sexuality (Author unknown, 2001:4), it is stated that sexuality encompasses personal and social meanings as well as sexual behaviour and biology. A comprehensive view of sexuality includes social roles, personality, gender and sexual identity, biology, sexual behaviour, relationships, thoughts and feelings. The authors of this publication (2001:5) state further that sexuality and sexual health are concepts that are often used interchangeably. Sexual health is however a component of sexuality.

Promotion of Sexual Health: Recommendations for Action (Authors unknown, 2000:6), agree with the previous statement and add that sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction.

It can thus be concluded that human sexuality is multi-dimensional in nature, and no single dimension of sexuality is universally dominant. This stresses the importance of a holistic approach to therapy. Human sexuality includes biological, psychological, behavioural, clinical, moral and cultural aspects. Sexuality plays an integral part of human functioning from birth until death.

2.3.2 Sexual health

According to Wiederman (1988:90) all sex therapy approaches appear to share the underlining assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client. Petitgirard (1992:5) describes sexual health as the positive expression of a person's sexuality: "... sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values". King, Cameron & Downey (1991: 268) define a sexually healthy person as someone who feels comfortable with his/her sexuality and who feels free to choose whether or not he/she wishes to try a variety of sexual behaviours. Sexual health is defined by the World Health Organisation (1975:41) as: "The integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love".

Common Ground Sexuality (Author unknown, 2001:5) defines sexual health as: "... women's and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is

positively enriching, includes pleasure, and enhances self-determination, communication and relationships". In The Promotion of Sexual Health: Recommendations for Action (Author Unknown, 2000:6), sexual health is defined as: "...the experience of the ongoing process of physical, psychological, and socio-cultural well-being related to sexuality".

It is therefore evident that human sexuality and the term sexual health are multidimensional. The notion of sexual health however implies a positive approach to human sexuality, and the purpose of sexual healthcare should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems.

Sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values. In sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

2.3.3 Sex Therapy

Many authors and researchers do not give a specific definition or description of sex therapy. Masters and Johnson (1970) for example do not give a definition of sex therapy. They however give a detailed outline of their therapy strategy and the steps in their therapeutic model. Kaplan (1974:217) also spends little time on

a definition of sex therapy. She does however mention: "... the primary objective of all sex therapy is to relieve the patient's sexual dysfunction. All therapeutic interventions, tasks, psychotherapy, couples therapy, etc., are ultimately at the service of this goal". Kaplan (1974:217) states further that sex therapy parts from traditional therapeutic techniques by employing a combination of prescribed sexual experiences and psychotherapy.

LoPiccolo (1978:534) defines sex therapy as: "...a brief (often ten to fifteen sessions) therapy, with the emphasis on directly changing the client's sexual attitudes and sexual behaviours". Ducharme (1997:20) states that sex therapists are counsellors who specialise in working with people who have sexual difficulties. The kinds of problems they deal with include a difficulty in achieving erections, premature or retarded ejaculation, and lack of sexual desire. For women, sex therapists address problems of reaching orgasm, painful intercourse, or lack of interest in sexual activity. Some researchers who can be described as traditional sex therapists emphasises sexual functioning per se. (Compare Cole, 1985:337; Rosen & Weinstein, 1988:2 and Wiederman, 1988:88.) Cole (1985:337) describes sex therapy as: "...those therapeutic processes which are used to attempt to initiate or restore sexual function in an individual or between a couple, where it had been previously absent". Rosen & Weinstein (1988:2) state that the basic goal of sex therapy is the relief of sexual dysfunctions, resulting in the improvement of sexual functioning. Wiederman (1988:88) defines sex therapy as any systematic attempt by a health professional

to alleviate sexual dysfunction or difficulties experienced by a specified client. These authors support the more narrow view of sex therapy that emphasises the sexual dysfunction as such without taking the relationship context into account.

Weeks and Hof (1987:xii) define sex therapy as an approach to therapy that is brief, problem-focused, has an educational component, involves seeing a couple together, consists of specific treatment formats and techniques, and often involves giving clients specific homework assignments. Renshaw (1995:120) states that sex therapy works holistically on the whole person – body, mind and feelings. She states further that sex therapy combines sex education and relationship counselling with sexual activity at home.

There is however today a shift in focus from the more narrow-minded approach of sex therapy with the emphasis on sexuality as such, to a more broader perspective of which the sexual aspects are viewed from a broader conceptual framework. This statement can be confirmed by the following view held by Weeks & Hof (1987:xiv): "The traditional individual behavioural perspective of sex therapy is broadened to include the contextual and interactional dimensions of relationships".

Woody (1992:45) refers to traditional sex therapy as the approach that evolved from Masters and Johnson's seminal work along with elaborations and refinements of the basic method. The elements of Masters and Johnson's

approach that have remained integral to sex therapy are according to Woody (1992:47):

- treatment of the dyad;
- viewing the sexual dysfunction as the problem to treat and remedy;
- assessing sexual attitudes and specific behaviours;
- providing accurate information about sexuality and eliminating myths and sex-negative attitudes;
- assigning clients behavioural/experiential tasks to be done at home.

LoPiccolo (1978) named seven basic principles of sex therapy that can be summarised as follows:

- **Mutual responsibility** emphasises the view of sexual dysfunction as a shared disorder in which both partners must participate in the solution.
- **Information and education** are provided by the therapists through discussion and recommended reading material and educational films. This education is provided to overcome client's ignorance of sexual response and function.
- **Attitude change** is indicated when clients hold negative attitudes toward sex or sexual pleasure.
- **Eliminating performance anxiety** is essential, because many clients endorse socio-cultural myths and stereotypes that emphasise the end goal

of erection, orgasm, and ejaculation as opposed to mutual sensual and sexual enjoyment.

- **Increased communication** about, and effectiveness of sexual technique, is encouraged through home assignments, as well as through therapy, discussions and advice about communication skills.
- **Changing destructive life styles and sex roles** is actively encouraged by the therapist to enable clients to reserve quality time for their sexual relationship.
- Prescribing changes in behaviour involves the therapist's assigning a **planned series of at-home experiences**, with the exact prescription depending on the specific sexual dysfunction.

It is therefore evident from these seven basic principles of LoPiccolo (1978) that the sexual dysfunction is not merely viewed as a dysfunction of one individual, but is seen in the context of the relationship between the couple.

Renshaw (1983: 32) states that sex therapy includes:

- An explicit sexual history of each partner, plus a complete medical and family history;
- Exploration of the overall and sexual relationship: tasks, roles, nurturance, interdependence, trust, problem-solving, acceptance, caring, commitment and love;

- Consideration of the context of the sexual problems;
- Excluding physical causes by a thorough physical examination;
- Suggestions for step-by-step home practise of sensual pleasuring;
- Intensive-therapy for specific problems or symptoms.

The primary goal of sex therapy is to relieve the couple's sexual dysfunction or sexual problem. Successful sex therapy however employs both acknowledged sex therapy techniques, as well as psychotherapy and couples therapy, in order to enhance the couple's physical and emotional intimacy. The sexual dysfunction is thus again viewed from the context of the relationship between the couple.

2.4 Perspectives on human sexuality

Sexuality has fascinated people since the beginning of time. Masters, Johnson & Kolodny (1995:2) state that every person has sexual feelings, attitudes, and beliefs but everyone's experience of sexuality is unique because it is processed through an intensely personal perspective. This perspective comes from both private, personal experience and public, social sources. It is impossible to understand human sexuality without recognising its multidimensional nature. Learning about sexuality, in all forms, is really learning about people and the complexities of human nature.

Masters, *et al.* (1995:3) state that Freud was of the opinion that sex is a powerful psychological and biological force, while Malinowski emphasised the sociological and cultural dimensions of sexuality. Masters, *et al.* (1995:3) state further that: "The word sexuality generally has a broader meaning than the word sex, as it refers to all aspects of being sexual. Sexuality means a dimension of personality instead of referring to a person's capacity for erotic response alone".

There are various dimensions of sexuality, namely, biological, physiological, psychological, behavioural, clinical, cultural, historical and spiritual, which will be discussed in further detail:

2.4.1 The biological dimension

According to Masters, Johnson & Kolodny (1995:6), biological factors largely control sexual development from conception until birth and our ability to reproduce after puberty. The biological side of sexuality also affects our sexual desire, our sexual functioning, and (indirectly) our sexual satisfaction. The biological dimension of sexuality encompasses both sexual anatomy and sexual physiology of the male and the female.

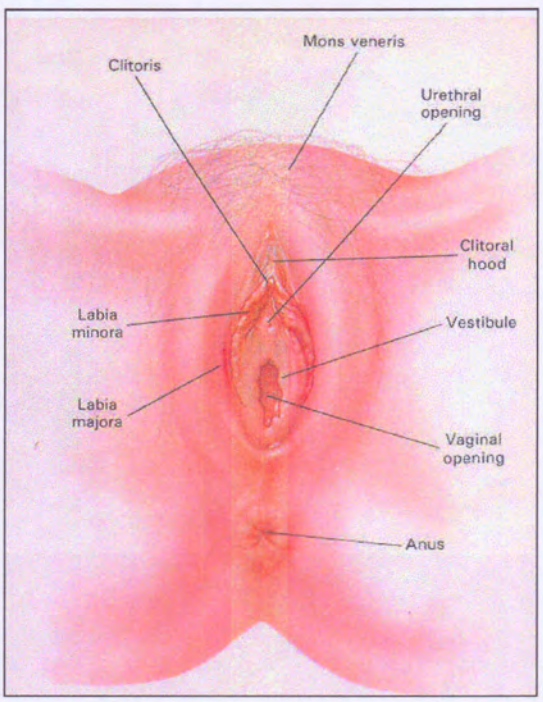
Many authors agree on the basic female and male anatomy. (Compare Masters, Johnson & Kolodny, 1995:47-69 and King, 1999:27-48.)

2.4.1.1 Female sexual anatomy

2.4.1.1.1 External female sexual anatomy

The external female anatomy (Figure 2) is collectively referred to as the vulva. It includes the mons veneris, labia majora and labia minora, clitoris, vaginal opening, and urethral opening. (Compare King, Cameron and Downey, 1991:27; King, 1999:27; Masters, Johnson & Kolodny, 1995:45 and Berman & Berman, 2001:42.)

Figure 2: External female genital anatomy in King, *et al.* (1991:23).



The vulva:

The external sex organs of the female, called the vulva (meaning "covering"), consist of the mons veneris, the labia, the clitoris, and the perineum. Although the vagina has an external opening (the introitus, or entrance), it is principally an internal organ.

The mons veneris:

The mons veneris is the area over the pubic bone that consists of a cushion of fatty tissue covered by skin and pubic hair. Since this region has numerous nerve endings, touch and or pressure here may lead to sexual arousal. Many women find that stimulation of the mons area can be as pleasurable as direct clitoral touch.

The labia:

The outer lips (labia majora) are folds of skin covering a large amount of fat tissue and a thin layer of smooth muscle. Pubic hair grows on the sides of the outer lips, and sweat glands, oil glands, and nerve endings are liberally distributed in them. The inner lips (labia minora) are like curving petals. They have a core of spongy tissue rich in small blood vessels and without fat cells. The inner lips meet just above the clitoris, forming a fold of skin, called the clitoral hood.

Bartholin's glands

These glands lie within the labia minora and are connected to small ducts that open on the inner surface of the labia next to the virginal opening. Although they produce minimal amounts of lubrication, there function is unknown.

The clitoris:

One of the most sensitive areas of a female's genitals is located just beneath the point where the top of the inner lips meet. The only directly visible part of the clitoris is the head or clitoral glans. The clitoral hood hides the clitoral shaft, the spongy tissue that branches internally like an inverted V into two longer parts or crura. The clitoris is richly endowed with nerve endings that make it highly sensitive to touch, pressure and temperature. It is unique because it is the only organ in either sex whose only known function is to focus and accumulate sexual sensations and erotic pleasure. The clitoris has no known reproductive function except to focus on sexual sensations, and many cultures around the world practice clitoral circumcision in order to minimise female sexual desires.

The perineum:

The perineum is the hairless area of skin between the bottom of the labia and the anus in women and between the scrotum and anus in the male.

The hymen:

Many sexually inexperienced females have a thin membrane called the hymen that partially covers the vaginal opening. The hymen, which has no known function, typically has perforations in it that allow menstrual flow to pass from the body. The hymen may vary in shape, size and thickness.

The breasts:

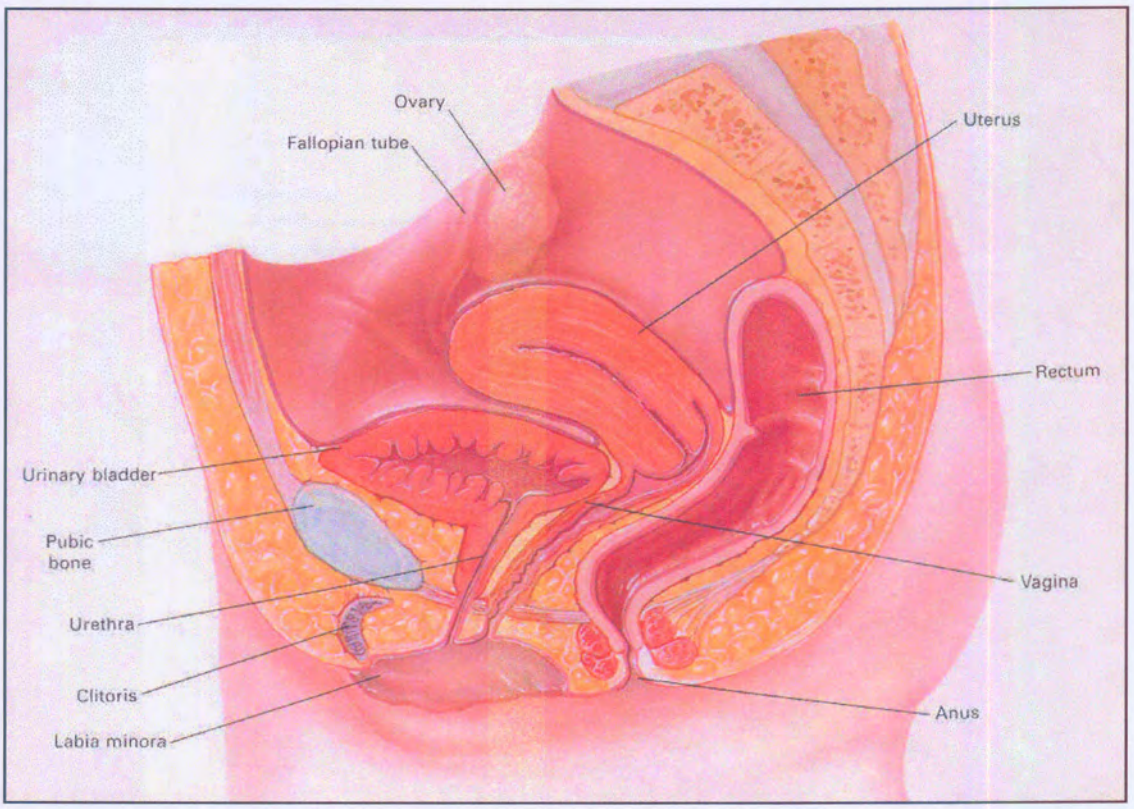
Although the breasts are not reproductive organs, they are clearly part of the sexual anatomy. There is no evidence to suggest that breast size has any relation to a woman's level of sexual interest or to her capacity for sexual response. The nipple is located at the tip of the breast and mostly consists of smooth muscle fibres and a network of nerve endings that make it highly sensitive. The dark wrinkled skin of the nipple extends onto the surface of the breast to form the areola, a circular area of dark skin with many nerve fibres and with muscle fibres that cause the nipple to stiffen and become erect. The breasts are technically not part of a woman's reproductive system, but because men in Western societies consider female breasts to be erotic, they must also be considered as part of a woman's external sexual anatomy.

2.4.1.1.2 Internal female sexual anatomy

A female's internal reproductive system includes the vagina, uterus, fallopian tubes, and ovaries (Figure 3). (Compare King, Cameron and Downey, 1991:27;

King, 1999:27; Masters, Johnson & Kolodny, 1995:45 and Berman & Berman, 2001:42.)

Figure 3: Internal female sexual anatomy in King, *et al.* (1991:24).



The vagina

The vagina is a muscular internal organ that tilts upward at a 45° angle diagonally pointed to the small of the back. The vagina functions as a potential space that, like a balloon can change shape and size. The inside of the vagina is lined with a surface similar to the lining inside the mouth. This mucosa is the source of vaginal lubrication. There are no secretory glands in the vagina but

there is a rich supply of blood vessels. The vagina has relatively few sensory nerve endings except near its opening. As a result, the inner two-thirds of the vagina are relatively insensitive to touch or pain. There have been disputed claims that a region in the front wall of the vagina midway between the pubic bone and the cervix has a special sensitivity to erotic stimulation. Called the Gräfenberg spot it has been described as a mass of tissue about the size of a small bean in the un-stimulated state.

The uterus:

The cervix is the bottom part of the uterus that protrudes into the vagina. At the mouth of the cervix, sperm cells enter the uterus and menstrual flow passes into the vagina. The cervix has no surface nerve endings, so it experiences little in the way of sexual feelings. The uterus is a hollow muscular organ. The inside lining of the uterus (the endometrium) and the muscular component of the uterus (the myometrium) have separate and distinct functions. The inner lining changes during the menstrual cycle and is where a fertilised egg implants. The muscular wall facilitates labour and delivery. Hormones regulate both aspects of uterine function. The uterus is held loosely in place in the pelvic cavity by six ligaments. The angle of the uterus in relation to the vagina varies from woman to woman.

Fallopian tubes:

The Fallopian tubes begin and extend about 10cm laterally. The far ends of the Fallopian tubes are funnel shaped and terminate in long finger-like extensions

called fimbria. The inside lining of the Fallopian tubes consists of long, thin folds of tissue covered by hair-like cilia. The Fallopian tubes pick up eggs produced and released by the nearby ovary and then serve as the meeting ground for egg and sperm.

The ovaries:

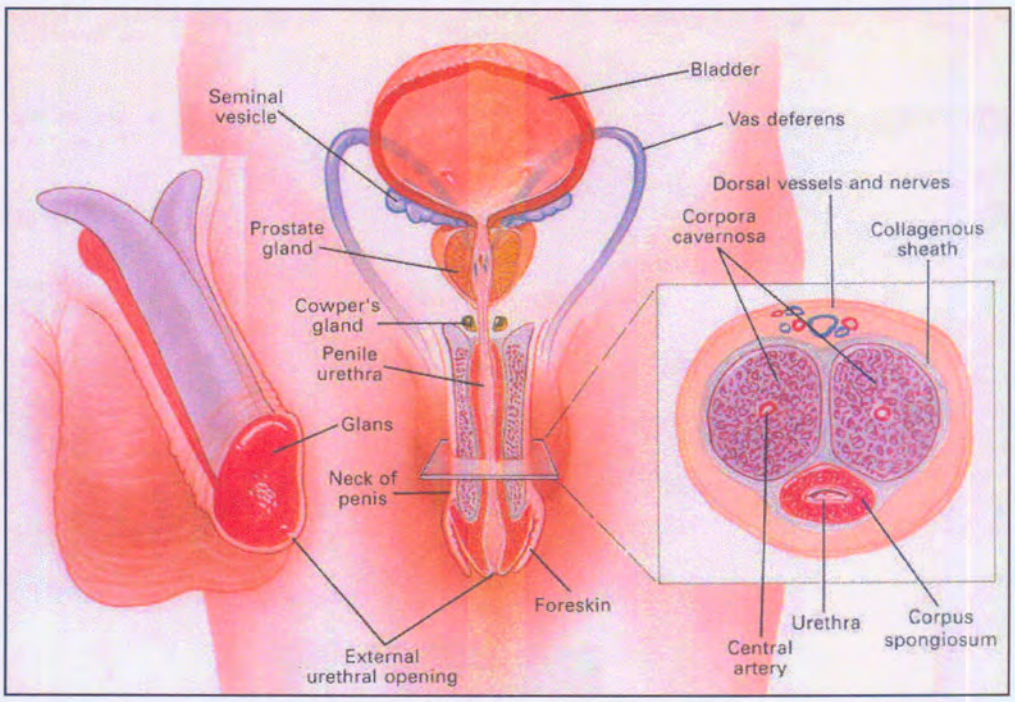
The ovaries contain the eggs (ova). When a mature egg is released from an ovary, it is picked up by a Fallopian tube and transported toward the uterus, where it normally implants if the egg is fertilised by a sperm. The vagina serves as a depository for the male's sperm. The ovaries are paired structures located on each side of the uterus. They are held in place by connective tissue that attaches to the broad ligament of the uterus. The ovaries have two separate functions: manufacturing of hormones and producing and releasing of eggs.

2.4.1.2 Male sexual anatomy

2.4.1.2.1 External male anatomy

The male's external anatomy (Figure 4) consists of the scrotum, which contains the testicles, and the penis. (Compare King, Cameron and Downey, 1991:37; King, 1999:41 and Masters, Johnson & Kolodny, 1995:60.)

Figure 4: External male genital anatomy in King, *et al.* (1991:26).



The penis:

The penis is an external organ that consists primarily of three parallel cylinders of spongy tissue with a rich network of blood vessels. There is great variation from male to male in the size of the non-erect penis but with erection, size differences tend to diminish. The glans, or head of the penis, is covered by foreskin in the uncircumcised male, but is exposed in a male who has been circumcised. Although there is considerable debate as to the merits of the procedure, many males have had their penis circumcised during infancy. Circumcision has not been proved to have any effect, positive or negative, on sexual feeling or responsivity. An erection occurs as a result of the spongy-like tissues of the penis becoming engorged with blood. Although many men worry about penis size, the

vast majority of women say that it is not important (and greatly prefer the quality of the experience). Some people take drugs to enhance sexual desire or performance (aphrodisiacs), but, except for temporarily enhancing energy or relaxation, they do not work and usually have undesirable side effects.

The scrotum:

The scrotum is a sac of skin underneath the penis that contains the testes. Muscle fibres in the scrotum move the testes closer to or farther away from the body in response to temperature changes or exercise, in order to facilitate sperm production. Sperm made in the testes are carried by a long tubing system (the epididymis and vas deferens) inside the body. Sperm are mixed with seminal fluid from the prostrate gland and seminal vesicles to make up semen.

The testes:

The testes are paired structures usually contained in the scrotum. The testes are highly sensitive to pressure or touch. They have two separate functions: hormone and sperm productions.

The breasts:

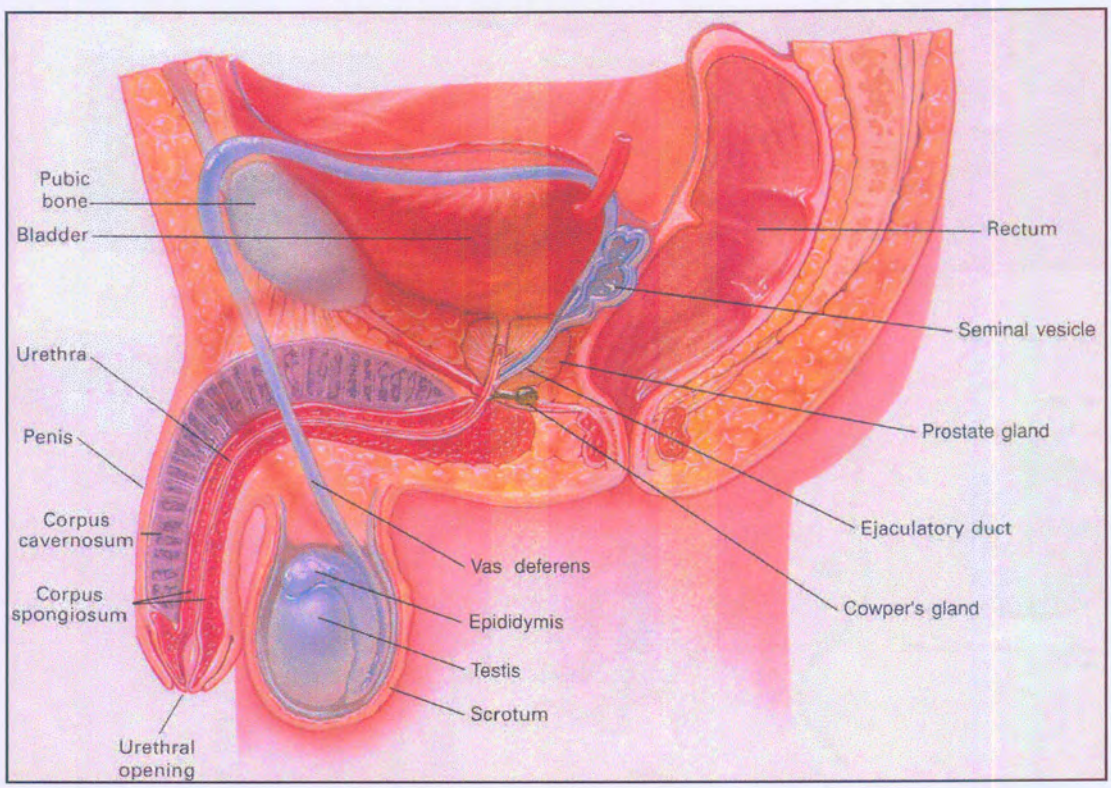
The breasts are basically modified sweat glands. The male breasts have a nipple and areola but have little underlying tissue or fatty padding. The male nipple and areola seem to be less sensitive to touch and pressure than that of the female.

The mouth, tongue, lips, thighs, buttocks, anus, and skin are other parts of the body often involved in sexual activity and can be a source of erotic arousal.

2.4.1.2.2 Internal male anatomy

The male's internal reproductive system (Figure 5) includes the testicles, which produce sperm and male hormones, and a four-part duct system (epididymis, vas deferens, ejaculatory duct, and urethra) to transport sperm out of the male's body. (Compare King, Cameron and Downey, 1991:38; King, 1999:42 and Masters, Johnson & Kolodny, 1995:61.)

Figure 5: Internal male sexual anatomy in King, *et al.* (1991:26).



During ejaculation, sperm are mixed with fluids from the prostate gland and seminal vesicles to form semen. The Cowper's glands secrete a small amount of fluid before a male reaches orgasm.

2.4.2 The physiological dimension

King (1999:72) refers to Masters and Johnson who observed and recorded physiological responses from hundreds of people engaged in sexual activity. This work led them to conclude that, contrary to previous beliefs, males and females are very similar in their responses. The physiological responses were divided into

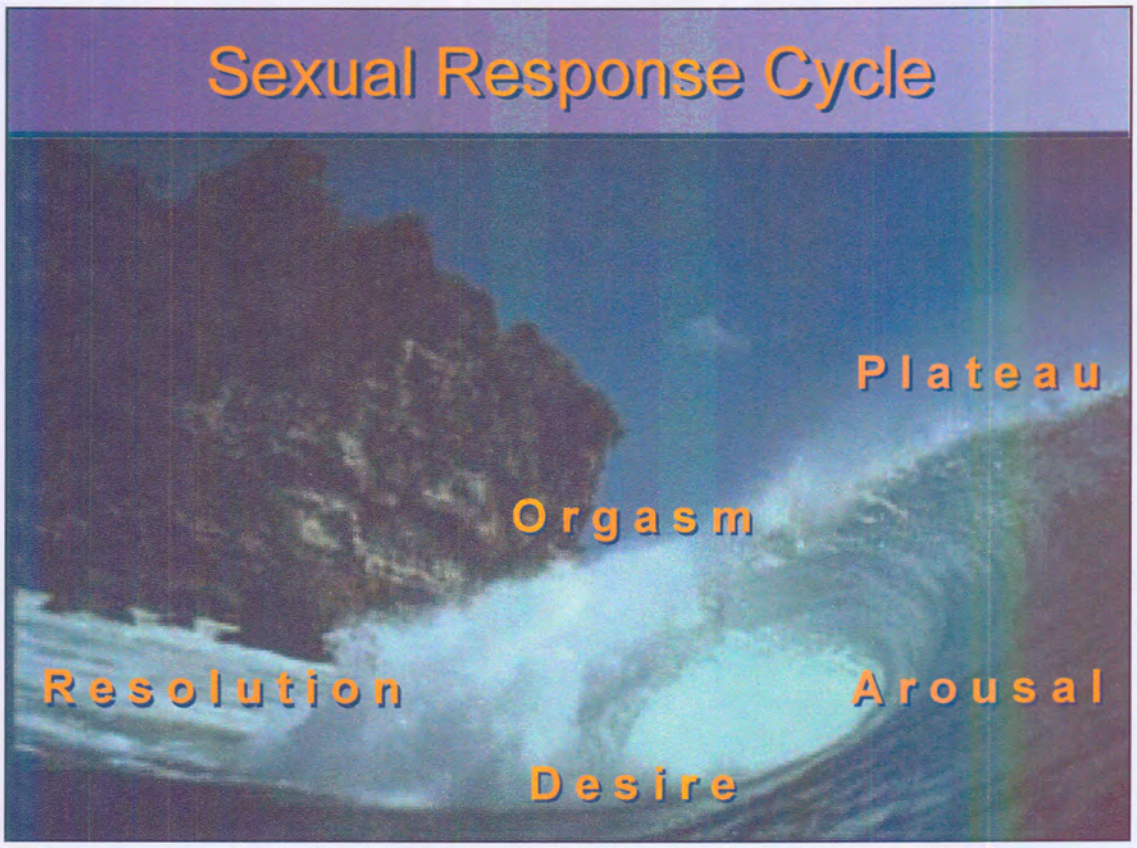
four stages: excitement (desire and arousal), plateau, orgasm, and resolution. Other researchers have organised the responses into fewer or more stages. Kaplan (1979:44) proposed a model for sexual responses that has only three phases: desire, excitement, and orgasm.

The physiological responses are the same whether a person is mechanically having sex or making love. It is the ability to include emotional and romantic feelings during sex that distinguishes humans from other species.

2.4.2.1 The sexual response cycle

The sexual response cycle (Figure 6 and 7) is a model used to illustrate physical changes the body goes through in responding to sexual stimuli.

Figure 6 - Illustration of the sexual response cycle from own personal collection, with acknowledgement to Dr. C. Hadders.



The cycle is a continuum, and can be seen as a series of stages. The body goes through the response cycle in the same way regardless of the type of activity engaged in (oral, manual, coital). A person may go through all, or part of the cycle. (Compare Masters, Johnson & Kolodny, 1995:73; King, 1999:72; Berman & Berman, 2001:54 and Masters & Johnson, 1966:3.)

The cycle, first described in modern times by Wilhelm Reich in 1930, is generally acknowledged to consist of four general phases, occurring along an unspecified timeline. Reich described these phases as mechanical tension, bioelectric charge, bioelectric discharge and mechanical relaxation (Clinical Sexology Course Material, 2000:96).

More recently, Masters and Johnson (1966:3) re-labelled these phases: excitement, plateau, orgasm and resolution. In addition, they introduced the concept of a refractory period, the fifth phase of the sexual response cycle. Only recently, researchers such as Berman & Berman (2001:55) are expanding medically and physiologically on the Masters and Johnson model, using new technologies such as photoplethysmography and Duplex Doppler ultrasound to evaluate women's genital blood flow during arousal. Although the new research has confirmed many features of the Masters and Johnson model, it has also shown that a monolithic model of sexual response is much too limited in its approach.

PHASE I: EXCITEMENT (Desire and Arousal)

A person gets turned on through his or her senses – seeing, feeling, touching, smelling, tasting and hearing as well as through thought or fantasy. An impulse is generated within the body in response to something happening outside or in the mind. The body wants to act in some manner to express this impulse.

The physiological manifestations at Phase I of the sexual response cycle are: changes in blood pressure, pulse, and respiration rate; and vasocongestion or engorgement with blood and muscle tension. Sexual arousal is first noticeable as the blood supply to the abdomen and pelvic areas increases.

Female

In the woman, sexual arousal is usually manifested by vaginal lubrication, blood engorgement, and sweating of the vaginal walls. The clitoris (made up of a glans and shaft similar to the penis) swells. The shaft of the clitoris extends about an inch under the skin and is generally not seen. The glans of the clitoris is packed with sensitive nerve endings, and is covered with a retractable hood. The hood is attached to the inner lips surrounding the vagina. In sexual arousal, swelling of the glans and an increase in the diameter of the shaft of the clitoris occurs, and some swelling of the inner lips takes place. This swelling makes the vaginal barrel somewhat longer. Excitement continues. The walls of the vaginal barrel begin to balloon out and back.

Male

In the man an erection usually occurs. The penis fills with blood. The tip, or glans, becomes extremely sensitive and red. The scrotum and testicles pull up toward the body.

Other changes may occur in either sex: nipple erection, sex flush on the abdomen and spreading upwards, increase in pulse (or heart) rate, increased breathing rate, rise in blood pressure and the muscles continue to build up tension. Psychologically, at this point a decision is made for or against engaging in some sexual action. The decision to engage in some sexual action, either alone or with someone else, is made consciously.

PHASE II: PLATEAU

The person begins active sexual movements and feels the flow of pleasurable feelings centring in the genitals and abdomen. The entire body is gradually flooded with warmth, generally increasing in intensity and reaching toward a peak. In both sexes, heart rate, breathing rate and flushing (if it occurs) continue to increase. The tension in the musculature increases (in involuntary as well as voluntary muscles).

Female

During this phase in women, formation of the "orgasmic platform" in the outer third of the vagina occurs. Contraction of the vaginal muscles can grip the penis or a finger quite firmly. The outer lips swell even more at this stage, while the inner lips become even more deeply colour (red). The clitoris usually elevates or retracts and its shaft shortens so that the clitoris may be hard to find. The uterus is pulled upward into the abdomen (a few inches) enlarging still further the total vaginal space.

Male

The penis reaches fullest erection and enlargement of the coronal ridge occurs. The testicles have increased in size by 50 percent and are pulled up tightly by further shortening of the (internal) spermatic cords. Full elevation of the testicles is a sign that the man has reaches "the point of no return" where ejaculation is imminent. A few drops of clear liquid may appear at the opening of the penis, this is a secretion from the Cowper's gland. This pre-ejaculate may contain some live sperm although the main function of the fluid is to prepare the tube for the passage of the ejaculate.

PHASE III: ORGASM

Climax occurs. The tension is discharged suddenly, with great excitement and involuntary contractions of muscles, especially in the genital area. If ejaculation is to occur, it occurs now.

Female

The "orgasmic platform" has a noticeable spasm and a series of rhythmic contractions. The entire length of the vaginal barrel may ripple with contractions that begin in the farthest end of the uterus. The subjective experience of orgasm in women coincides with the first contraction of the outer third of the vagina or orgasmic platform. Effective stimulation needs to continue up to and through orgasm.

Male

Contractions in the man are differentiated into two stages. The first, which coincides with the experience of the "point of no return", is the contraction of the seminal vesicles and prostate gland. The semen is pushed out through the urethra by the next wave of contractions. The interval between the contractions is about eight-tenths seconds in both sexes.

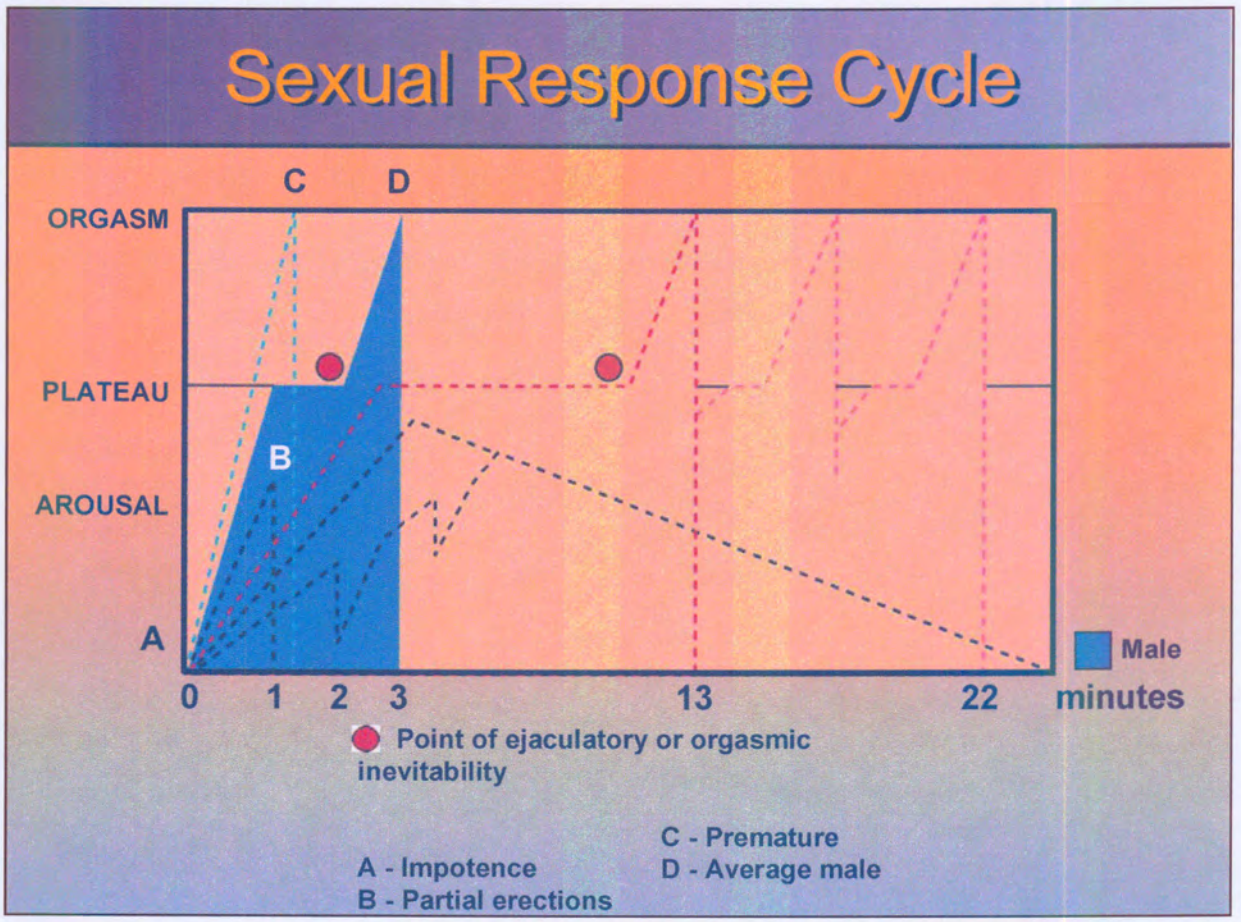
PHASE IV: RESOLUTION

The body now begins to return to its original pre-excitement state, a feeling of melting pleasure and calm. Sleep often occurs. Partners may feel especially tender and close. The expansion of orgasm is now integrated and appreciated.

PHASE V: REFRACTORY PERIOD

The time after orgasm in which little or no sexual excitement or charge is experienced, even if stimuli exist, is called the refractory period. According to the results of Masters and Johnson (1966:6) the refractory period occurs primarily in men but there is evidence that women also experience it. Some confusion results from the fact that many women are capable of experiencing multiple consecutive orgasms, while relatively few males have this experience.

Figure 7 - Graphic presentation of the sexual response cycle from own personal collection with acknowledgement to Dr. D. Renshaw.



The following is a summary of the male and female sexual response cycles in table format. (Compare Masters, Johnson & Kolodny, 1995:73; King, 1999:72; Berman & Berman, 2001:54 and Masters & Johnson, 1966:3.)

Table 1: The sexual response cycle - Males

Desire	Excitement	Plateau	Orgasm	Resolution
Specific sensations that move an individual to seek out or become receptive to sexual experiences.	Erection of the penis. Vasocongestion. Scrotum thickens and helps pull the testes toward the body Possible nipple erection.	Possible further increase in diameter of the penis. Testes become fully engorged with blood and increase in size by 50-100 percent. Cowper's glands secrete a few drops of clear fluid. Possible sex flush.	Emission-rhythmic muscular contractions in the vas deferens, prostate gland, and seminal vesicles force the sperm and fluids into the ejaculatory ducts. Contractions also in anal sphincter muscles. Expulsion-rhythmic muscular contractions in the urethra and base of the penis, force the semen from the penis (ejaculation). Subjective sensation in the glans.	Return to the unaroused state with loss of erection, decrease in testicle size and their movement away from the body. Disappearance of sex flush. A drop below the plateau level for a period of time (refractory period), before orgasm is possible again

Table 2: The Sexual Response Cycle - Females

Desire	Excitement	Plateau	Orgasm	Resolution
Specific sensations that move an individual to seek out or become receptive to sexual experiences	Vaginal lubrication due to vasocongestion; labia majora flatten and spread apart; walls of the inner two thirds of the vagina begin to balloon out; cervix and uterus begin to pull up; clitoris becomes engorged; nipples become erect.	Vaginal lubrication may slow down if plateau phase is prolonged; labia minora become engorged with blood and change colour; outer third of vagina becomes engorged and swells; engorgement of areola and breasts obscure nipple erections; Bartolin's glands secrete a few drops of fluid; sex-tension flush in 50 to 75% of women.	Single stage: rhythmic muscular contractions in the tissues of the outer third of vagina, uterus and anal sphincter muscles. Some women are capable of several successive orgasms without dropping below the plateau level of responsiveness.	After one or more orgasms return to the unaroused state with drainage of blood from the breasts, outer third of vagina, labia minora, and clitoris. Vagina shortens in length and width. Disappearance of sex flush.

2.4.2.2 Hormonal regulation of sexual function

The sex hormones, principally testosterone, estrogen and progesterone, are present in both sexes and are controlled by the hypothalamus and pituitary gland. The following description of hormonal regulation is a synthesis of literature by King (1999:52) and Masters, Johnson & Kolodny (1995:88). Testosterone has an important influence on sexual drive in males and females. Hormones are chemical substances that are released into the bloodstream by ductless endocrine glands. The ovaries and testicles are part of the endocrine gland system. In adult females, a new egg matures on a monthly basis. It is expelled from an ovary during ovulation and picked up by a Fallopian tube. If it is fertilised by a sperm, it implants in the endometrium of the uterus. If fertilisation does not occur, the endometrium is shed and discharged (menstruation), and a new egg starts to mature. The entire menstrual cycle takes an average of 28 days, but most women have cycles that vary in duration by a week or more. Some couples prefer to avoid sexual intercourse during menstruation, but this often reflects inaccurate and/or negative sexual information rather than good medical advice, for menstruation is a normal biological function.

Women sometimes suffer from menstrual-related problems, including emotional and/or physical changes in the days preceding menstruation (premenstrual syndrome or PMS) and painful cramps during menstruation (dysmenorrhea). PMS may be due to hormonal, social, and/or cultural factors. The major cause of

dysmenorrhea is an increase in prostaglandins, chemical substances that cause contractions of the uterus. In addition to these problems, some women have growth of endometrial tissue outside of the uterus (endometriosis), which can cause considerable abdominal pain.

A woman's last menstrual period (menopause) generally occurs in her late forties or early fifties. At this time, the ovaries shrivel up and there is a loss of estrogen. The loss of ovarian hormones however, usually does not affect sexual desire. Some women even show an increase in sexual desire after menopause. Evidence suggests that some minimal level of testosterone is necessary for normal sexual functioning by men and women. Sexual desire, however, is under greater control by the brain in humans than is the case for lower species.

The testicles manufacture and release testosterone, which is often referred to as the "male hormone", while the ovaries produce the "female hormones" estrogen and progesterone. However, testosterone is also produced in small amounts by the ovaries, and estrogen in small amounts by the testicles.

2.4.3 The psychological dimension

The psychological dimension of sexuality includes psychological factors such as emotions, thoughts and personalities, in combination with social elements. In other words, how people interact. According to Masters, Johnson and Kolodny

(1995:7), the psychosocial side of sexuality is important, because it sheds light not only on many sexual problems but also on how we develop as sexual beings. A person's gender identity (the personal sense of being male or female), is primarily shaped by psychosocial forces. Early sexual attitudes – which often stay with a person into adulthood – are based largely on what parents, peers, and teachers tell or show him/her about the meanings and purposes of sex. Sexuality is also social in that it is regulated by society through laws, taboos and family and peer group pressures that seek to persuade a person to follow certain paths of sexual behaviour.

2.4.4 The behavioural dimension

The behavioural perspective allows us to learn not only what people do but to understand more about how and why they do it (Masters, Johnson & Kolodny, 1995:8). According to them it is also important to avoid judging other people's sexual behaviour by our own values and experiences. Too often, people have a tendency to think about sexuality in terms of "normal" versus "abnormal". "Normal" is frequently defined as what we ourselves do and feel comfortable with, while the "abnormal" is what others do that seems different or odd to us. Trying to decide what is normal for others is a task doomed to failure because our objectivity is clouded by our own values and experiences.

2.4.5 The clinical dimension

Although sex is a natural function, many types of obstacles can lessen the pleasure or spontaneity of our sexual encounters. Physical problems such as illness, injury, or drugs can alter our sexual response patterns or knock them out completely. Feelings such as anxiety, guilt, embarrassment or depression and conflicts in our personal relationships can also hamper our sexuality. The clinical perspective of sexuality examines the solutions to these and other problems that prevent people from reaching a state of sexual health and happiness.

2.4.6 The cultural dimension

It should come as no surprise that people are different. Our own cultural attitudes toward sexuality are far from universal. Sexual topics are often controversial and value-laden, but the controversy is often relative to time, place, and circumstance. There is no comprehensive sexual value system that is right for everyone and no single moral code that is indisputably correct and universally applicable (Masters *et al.*, 1995:8). What is labelled as "moral" or "right" varies from culture to culture and from century to century. Cultures differ with regard to which part of the body they find to be erotic. People in some African tribes, for instance, carve holes in their lips, while other groups of people find it attractive to stretch their lips or necks. Many groups of people find body weight to be an important determinant of sexual attractiveness. There is a great deal of pressure

in our culture, for example, for men and women to be thin. What is considered to be sexually attractive can also change over time. Plump woman, for example, were also considered to be most attractive in Western cultures a few centuries ago.

What people consider as sexually attractive is also learned. Most heterosexual South African men find female breasts to be very sexually arousing, while there are many areas of the world where naked female breasts have no erotic significance at all.

Cultures also differ with regards to sexual behaviours and attitudes. In some societies, a man's special obligations to a guest or a friend are discharged by an invitation to have sexual relations with his wife. Ford and Bach in Masters, *et al.* (1995:7), listed eight cultural groups in which kissing were unknown. Foreplay during intercourse is entirely unheard of in some cultures. Intercourse is therefore often regarded as something positive by men, and painful and negative by women.

It is thus evident that it is very important to always consider cultural differences and culturally learned morals and values, especially when working in the field of sexuality. Sexual rights are applicable here. Sexual rights are human rights based in the inherent freedom, dignity, and equality of all human beings. The World Association for Sexology's Declaration of Sexual Rights (1999) states that

sexual health is a basic human right. The following sexual rights must be recognised, promoted and respected by all societies and especially by health care practitioners:

- The right to sexual freedom.
- The right to sexual autonomy, sexual integrity, and safety of the sexual body.
- The right to sexual privacy.
- The right to sexual equity.
- The right to sexual pleasure.
- The right to emotional sexual expression
- The right to sexually associate freely.
- The right to make free and responsible reproductive choices.
- The right to comprehensive sexuality education.
- The right to Sexual Health Care.

2.4.7 The historical dimension

Masters, Johnson & Kolodny (1995:8) state that sexual themes have been shown in art since ancient times. In certain respects, we are bound by a sexual legacy passed on from generation to generation, but in other ways, modern views of sex and sexuality differ drastically from past patterns. History teaches us that sexual attitudes and practices vary considerably over time and place. Masters *et al.*

(1995:21) state that religion has been a principal force in shaping sexual thought for more than 2000 years. In the past century, the advent of sexology as a science has also greatly influenced contemporary attitudes toward sex and sexuality.

2.4.8 The spiritual dimension

Masters, *et al.* (1995:4) and King (1999:11) agree that sexual attitudes and practises vary considerably over time and place. For more than 2000 years, religion has been a principal force in shaping sexual thought and still plays a major role in people's perceptions about sex and sexuality today.

2.5 Summary

In Chapter 2 a general overview of human sexuality and sex therapy was given. The historical development of sexology as a science was described and various definitions of key concepts were given. Different perspectives on human sexuality, namely the biological, physiological, psychological, behavioural, clinical, cultural and spiritual perspectives were also described.

The following points summarise the chapter:

- Sexuality is part of human behaviour and culture since ancient times, and is multi-dimensional in nature.

- The study of sexuality as a science started at the beginning of the twentieth century.

- The history of sex therapy as a discipline however, is relatively brief, and was essentially founded by Masters and Johnson in the late 1960's.

- Therapeutic approaches to sex therapy and sexual dysfunction have changed over the last few years.

- An integrative, holistic and post-modern approach to therapy for sexual difficulties has emerged.

- There is a movement today towards the combination of sex therapy and couple/relationship therapy. Many sexual problems are viewed as symptoms of more complex relationship issues, or problems relating to a lack of emotional intimacy.

- Sexual dysfunction is not merely viewed as a dysfunction of one individual, but it is seen in the context of the relationship between the couple.

- The purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems.

- The biological dimension of sexuality encompasses both sexual anatomy and sexual physiology of the male and the female.

- The physiological dimension of sexuality encompasses the sexual response cycle of the male and the female as well as hormonal regulation of sexual function.

- The psychological dimension of sexuality includes psychological factors such as emotions, the influence of different personality types as well as communication and conflict resolution.

- The behavioural dimension of sexuality allows for a better understanding of peoples reactions and behaviour.

- The clinical dimension of sexuality examines possible solutions to physical problems that alter sexual response, as well as possible solutions for negative feelings such as anxiety, guilt and embarrassment, which may hamper sexual functioning.

- The cultural dimension focuses on people's attitudes towards sexuality and on the influence of different culturally learned morals and values on a person's sexual behaviour and attitudes.

- The historical dimension focuses on the influence of past sexual views and attitudes on contemporary sexual attitudes.

- The spiritual dimension of sexuality takes the role that religious beliefs play in people's perceptions toward sexuality, into account.

Chapter 3 will deal with clinical sex therapy as well as with sexual dysfunctions and possible treatment options thereof.

CHAPTER 3

CLINICAL SEX THERAPY

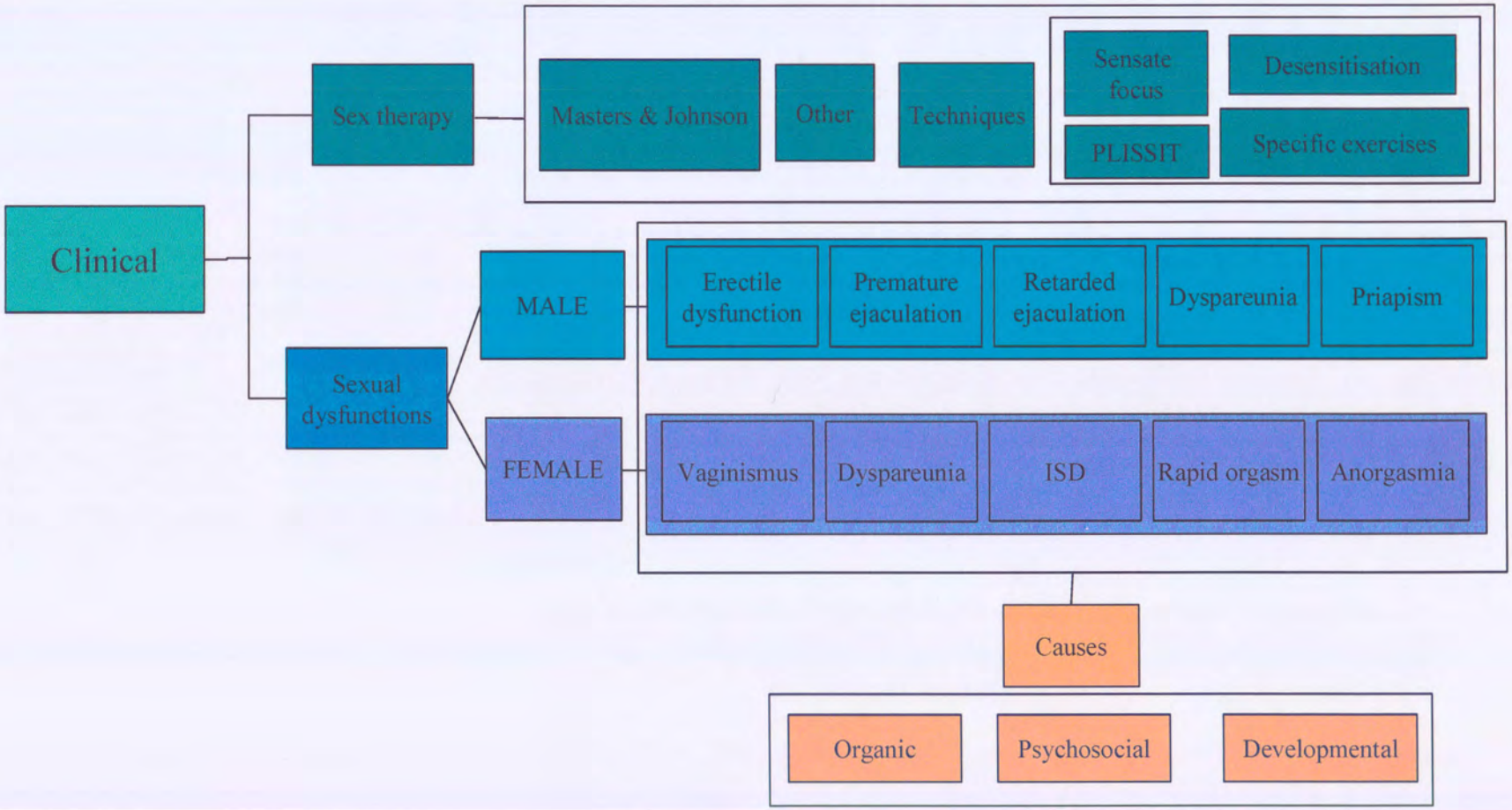
3.1 Introduction

Figure 8 contains a layout of this chapter. Shown are elements of the clinical dimension of sex therapy.

Wiederman (1998:88) asserts that studies indicate that a substantial proportion of the adult population will experience some sort of sexual dysfunction at some point in their lives. A specific field, commonly known as sex therapy, has evolved to address this growing problem of sexual difficulties, presented by clients. Wiederman (1998:88) defines sex therapy as a term that broadly refers to any systemic attempt by a health care professional to alleviate sexual dysfunction or difficulties experienced by a specified client.

Rosen & Leiblum (1995:877) are of the opinion that marked changes have however occurred in the formulation and treatment of sexual disorders since the publication of Masters and Johnson's, *Human Sexual Inadequacy* in 1970. Masters & Johnson (1970:98) proposed a treatment model based on a parallel, four-stage sequence of physiological arousal in both male and female – the so-called sexual response cycle described in chapter two. They were also of the opinion that psychogenic factors such as learning deficits and performance anxiety were part of the etiology of sexual dysfunction and they adhered to a brief, problem-focused treatment approach.

Figure 8: An outline of chapter 3 – The clinical dimension of sex therapy



Rosen & Leiblum (1995:877) state that since the 1980s however, research and practice in sex therapy have focused increasingly on the role of organic and biomedical factors. Other notable trends include a greater emphasis on sexual dysfunction in the elderly and chronically ill or disabled, as well as a focus on problems of hyper-sexuality.

Several authors have advocated an integrated approach to therapy, including elements of psychodynamic, cognitive-behavioural and systemic treatment approaches. (Compare Wiederman, 1998:96; Rosen & Leiblum, 1995: 885 and Berg & Snyder, 1981:291.)

3.2 Historical overview

The history of sex therapy as a discipline is relatively brief. From the start of the twentieth century until the late 1960's, sexual dysfunction was typically treated within a psychoanalytic framework. Wiederman (1998:88) asserts that from such a psychoanalytic perspective, psychological and sexual problems were viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one's parents.

Rosen & Leiblum (1995: 877) agree that sexual problems were seen as symptoms of greater "core" psychopathology. As such, treatment consisted of long-term, individual psychotherapy. In contrast to this dominant perspective, Wiederman (1998:88) mentions that a few clinicians like Lazarus, Obler and

Wolpe explicitly applied behavioural principles in the treatment of sexual dysfunction, but that such approaches were not the norm prior to the 1970's.

Sex therapy as it is known today, was essentially founded by Masters and Johnson. Their report on a "new" therapeutic approach to sexual problems that was published in 1970, revolutionised what health professionals saw as the appropriate treatment for such difficulties. In contrast to psychoanalytic approaches, the "new" sex therapy was relatively brief, problem focused, directive, and behavioural with regard to technique (Wiederman, 1998:89). Masters & Johnson (1966, 1970) emphasised social and cognitive causes of sexual dysfunction. They were of the opinion that a large majority of sexual difficulties ultimately arise from a sexually restrictive or religiously conservative background. Such a personal history appeared to result in decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequently anxiety and preoccupation over performance during sexual interactions. Masters & Johnson (1970:189) therefore used a learning model with the objectives of treatment consisting of effectively achieving alleviation of performance anxiety and re-educating clients regarding human sexuality.

Helen Kaplan followed Masters and Johnson in 1974 and introduced her version of the "new" sex therapy. Kaplan's model included an initial emphasis on immediate symptoms. If the direct approach to symptom treatment worked, the case was closed. If, however, the "new" behavioural techniques met with resistance, the therapist relied on psychodynamic theory, or consideration of

"deeper" issues, to understand the possible intra-psychic and interpersonal roles the sexual dysfunction might be serving. (Compare Wiederman, 1998:89; Berman & Berman, 2001:55; Kaplan, 1974:165 and Woody, 1992:35.)

Several authors (Masters & Johnson, 1970:190; Kaplan, 1974:167 and King, 1999:320) agree that the new sex therapy included short-term but intensive work with the couple as well as detailed information about relevant human anatomy and physiology. Additionally, the intervention consisted of direct behavioural exercises, including prescription of non-demand pleasuring, or "sensate focus", wherein the objective was to experience sexual pleasure in the absence of anxiety from perceptions of performance demand or excessive self-monitoring of sexual performance. Essentially, clients were aided and encouraged to discover their own and their partner's bodies. This was accomplished through a series of specific behavioural directives that resulted in pleasurable sensual and sexual experiences in the absence of anxiety. As reported by Masters and Johnson (1970:132) success rate of the new sex therapy was remarkably high. Overall, it appeared that their failure rate was only 20% for all sexual dysfunctions combined.

In the 25 years subsequent to Masters and Johnson several changes have taken place in sex therapy. Sex therapy in the 1970's was an outgrowth of an earlier cultural shift toward greater focus on increased gratification and discussion of sexual issues. Rosen & Leiblum (1995:878) state that accordingly, anorgasmia in women and premature ejaculation in men, were

the most prominent sexual dysfunctions presented to therapists in the early days of contemporary sex therapy. At the same time as the birth of contemporary sex therapy, there was a noticeable increase in mass media attention to issues of sexual enhancement.

Wiederman (1998:90) is of the opinion that the types of cases commonly seen in sex therapy clinics have changed dramatically over the last few years. As the proportion of the clients who simply needed education and direction dwindled, the proportion of clients with more pervasive and chronic sexual problems increased. Accordingly, instances of erectile failure, low sexual desire and compulsive sexual behaviour have become an increasing part of sex therapists' caseloads.

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. Wiederman (1998:90) states that the systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists, with increasing frequency. Greater attention has also been paid to the role of early sexual trauma in subsequent sexual dysfunction. In general, a more complex, integrative, or post-modern approach to the conceptualisation and treatment of sexual dysfunction has emerged.

3.3 The state of theory in sex therapy

All sex therapy approaches appear to share the underlying assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client. Wiederman (1998:90) state that beyond this global belief, a primary distinction among approaches to sex therapy has to do with the underlying assumptions regarding etiology of sexual dysfunction. There is a major split among therapists based on whether the sex therapist views sexual dysfunction as having primarily physical (biogenic) or social/psychological (psychogenic) causes.

Wiederman (1998:92) is further of the opinion that the primary psychogenic perspectives in sex therapy share some common assumptions about the etiology of sexual dysfunction. Psychodynamic, behavioural, cognitive, social scripting, and systems approaches are all based on the notion that the individual's past plays an important role in his or her current sexual difficulties. Psychodynamic and psychoanalytic perspectives, however, place strong emphasis on unconscious processes and unresolved conflicts from childhood. Other psychogenic approaches however share a strong social learning perspective. Sexual difficulties are thus seen as arising from current problematic thoughts and beliefs that are in some way a result of past learning experiences. The etiological assumption of the biological perspective is that some medical or physical factor is the root of the current sexual dysfunction.

Human sexuality is a multi-determined phenomenon. The need to take a multivariate approach to theorising and model building is especially important to sex therapy. Levine (1995:3) is of the opinion that there is a great need to consider the complex interplay of multiple biogenic and psychogenic factors that may underlie sexual dysfunction. Wiederman (1998:96) agrees with this statement stating: "Current sex therapy frequently consists of an integrative synthesis of the primary perspectives regarding sex therapy". This "post-modern" approach to sex therapy has evolved in response to the increasing complexity of the cases sex therapists and marriage counsellors encounter.

3.4 Classification of sexual disorders

Sexual and gender identity disorders are currently classified into four major categories, according to the Diagnostic and Statistical Manual-IV (American Psychiatric Association: 1994). These categories are: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified.

Several authors discuss these categories extensively. (Compare Grazioli, 1998:31; Rosen & Leiblum, 1995:878; King, 1999:322 and Kaplan, 1997: 211.) The following is a synthesis of the classification of sexual and gender identity disorders as described in the DSM-IV (American Psychiatric Association: 1994) and as it is discussed by previously mentioned authors.

3.4.1 Sexual Dysfunctions

According to the DSM-IV (American Psychiatric Association: 1994), a sexual dysfunction is characterised by psychological and/or physiological disturbance in the four phases that characterise the sexual response cycle (Desire, Excitement, Orgasm, Resolution).

According to Grazioli (1998:31) clinical judgement about the presence of a sexual dysfunction should take into account the individual's ethnic, cultural, religious, and social background, which may influence sexual desire, expectations, and attitude about performance. The disturbance causes marked distress or interpersonal difficulty.

The disturbance is not better accounted for by another Axis I disorder (except if it is another sexual dysfunction) as described in the DSM IV, and is not due exclusively to the direct physiological effects of a substance (e.g. drug abuse, medication) or a general medical condition.

According to Renshaw, Bancroft & Mulhall (1997:25) the major female sexual problems are sexual orgasmic problems: primary (never ever had an orgasm), and secondary (could at some point have an orgasm, but not at the present). Hypoactive sexual arousal disorder is another prevalent problem.

3.4.1.1 Hypoactive sexual desire disorder

The essential feature is persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity (taking into account the effects of aging and the context of the person's life).

3.4.1.2 Sexual aversion disorder

The essential feature is the aversion to and active avoidance of all (or almost all) genital sexual contact with a sexual partner.

3.4.1.3 Female sexual arousal disorder

The essential feature is persistent or recurrent inability to attain, or maintain until completion of the sexual activity, an adequate lubrication response of sexual excitement.

3.4.1.4 Male erectile disorder

The essential feature is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

3.4.1.5 Female orgasmic disorder

The essential feature is persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. This diagnosis should be based on clinical judgement that the woman's orgasmic capacity is less than reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

3.4.1.6 Male orgasmic disorder

The essential feature is persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that, taking into account the person's age, is clinically judged to be adequate in focus, intensity and duration.

3.4.1.7 Premature ejaculation

The essential feature is persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity, must be taken into consideration.

3.4.1.8 Dyspareunia (not due to a general medical condition)

The essential feature is recurrent or persistent genital pain associated with sexual intercourse in either a male or a female. The condition is not caused exclusively by vaginismus or lack of lubrication.

3.4.1.9 Vaginismus (not due to a general medical condition)

The essential feature is the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted with penis, finger, tampon or speculum.

3.4.1.10 Sexual dysfunction not otherwise specified

This category includes sexual dysfunctions that do not meet criteria for any specific sexual dysfunction. Examples include the following:

- No (or substantially diminished) subjective erotic feelings despite otherwise normal arousal and orgasm.
- Situations where it is not clear whether a sexual dysfunction is primary, due to a general medical condition, or substance induced.

3.4.2 Paraphilias

According to Masters, *et al.* (1995:449) defining abnormal behaviour consists of several different components: social deviance, frequency and persistence, psychological dependence, and the behaviour's effect on psychosocial functioning.

The paraphilias are conditions where sexual arousal becomes dependent on an unusual type of sexual behaviour or fantasies of that behaviour. The paraphilias are much more common in men than in women and often do not cause any form of personal distress.

The focus in all paraphilias involves intense sexually arousing fantasies, sexual urges, or behaviours generally involving either nonhuman objects, the suffering or humiliation of oneself or one's partner, or children, or other non-consenting persons, that occur over a period of at least 6 months. The behaviour, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Compare Masters *et al.,* 1995:449; Grazioli, 1997:32; DSM-IV: 1994 and King, 1999:340.)

3.4.2.1 Fetishism

The focus involves the use of nonliving objects. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in transvestic

fetishism), or devices designed for the purpose of tactile genital stimulation (e.g. a vibrator).

3.4.2.2 Frotteurism

The focus involves touching and rubbing against a non-consenting person.

3.4.2.3 Paedophilia

The focus involves a pubescent child or children. The paedophile must be age 16 years or older, and at least 5 years older than the child. This does not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year old.

3.4.2.4 Sexual masochism

The focus involves the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

3.4.2.5 Sexual sadism

The focus involves acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting.

3.4.2.6 Transvestic fetishism

The focus involves cross-dressing. This paraphilia may or may not be associated with gender dysphoria (persistent discomfort with gender role or identity).

3.4.2.7 Voyeurism

The focus involves the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

3.4.2.8 Paraphilias not otherwise specified

This category includes paraphilias that do not meet the criteria for any of the other specific categories, e.g.

- telephone scatologia (obscene phone calls)
- necrophilia (corpses)
- partialism (exclusive focus on part of the body)
- zoophilia (animals)
- coprophilia (faces)
- klismaphilia (enemas)
- urophilia (urine)

Masters, *et al.* (1995:450) also mention hyper sexuality (nymphomania in females, satyriasis in males). The core features seem to be an insatiable

sexual appetite, fairly impersonal sex, and low or nonexistent sexual satisfaction. Many therapists find the addiction model useful in understanding and treating compulsive sexual behaviour. (Compare Masters *et al.*, 1995:451; King, 1999:340 and Rosen & Leiblum, 1995:881.)

3.4.3 Gender identity disorders

To make the diagnosis of gender identity disorder there must be evidence of a strong and persistent cross-gender identification, which is the desire to be (Criterion A), or the insistence that one is (Criterion B), of the other sex.

This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasia).

There must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning

In children, Criterion A is manifested by four (or more) of the following:

- Repeatedly stated desire to be, or insistence that he or she is, the other sex.
- In boys, preference for cross-dressing or simulating female attire. In girls, insistence on wearing only stereotypical masculine clothing.
- Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
- Intense desire to participate in the stereotypical games and pastimes of the other sex.
- Strong preference for playmates of the other sex.

In children, Criterion B is manifested by any of the following:

- In boys, assertion that his penis or testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of stereotypical toys, games and activities.
- In girls, rejection of urinating in a sitting position, assertion that she has, or will grow, a penis, or assertion that she does not want to grow breasts and menstruate, or marked aversion toward normative feminine clothing.

3.4.3.1 Gender identity disorders not otherwise specified

This category includes disorders in gender identity that are not classifiable as a specific gender identity disorder, e.g.

- Intersex conditions (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasis) and accompanying gender dysphoria;
- Transient, stress-related cross-dressing behaviour;
- Persistent preoccupation with castration or penectomy, without a desire to acquire the sex characteristics of the other sex.

3.4.4 Sexual disorders not otherwise specified

This category includes disturbances that do not meet the criteria for any specific sexual disorder and is neither a sexual dysfunction nor a paraphilia, e.g.

- Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity;
- Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used;
- Persistent and marked distress about sexual orientation.

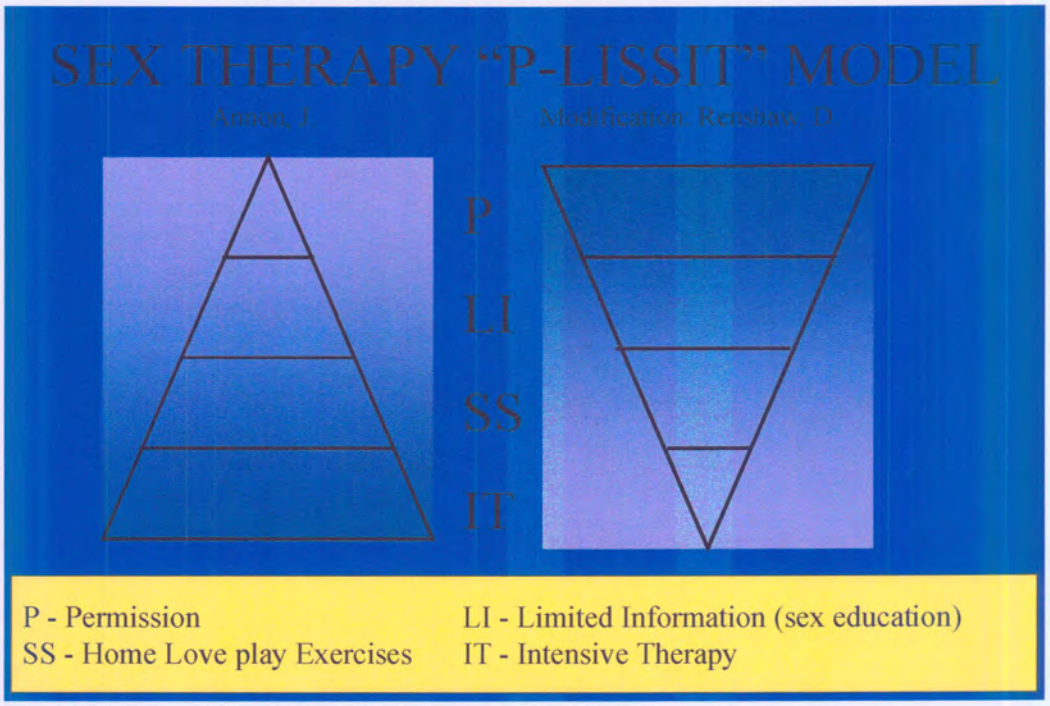
3.5 A model to treat sexual distress

Renshaw, *et al.* (1997:28) regards sexual response as a fundamentally psychosomatic phenomenon in which the interaction between psychological processes and physiological processes is absolutely basic. Remarkable

changes have been seen in the field of sexology. There have been developments in both assessment and treatment.

The PLISSIT model is widely used as a foundation for sex therapy (see Figure 8). (Compare Annon, 1976:89; Stahmann, 1997:67; Renshaw, 1995:72 and Woody, 1992:55.)

Figure 9: PLISSIT model from own personal collection with acknowledgment to Dr. D Renshaw.



Stahmann (1997:67) describes the PLISSIT model as a model for sex therapy. Annon originally developed this model in 1976. It conceptualises the different levels of intervention that is required in helping couples with sexual dysfunctions. This so-called PLISSIT model identifies four different levels of expertise and intervention. This model is very useful in sex therapy and it also

works well as a framework for providing feedback in clinical consultation and supervision.

3.5.1 Annon's model

Stahmann (1997:69) describes Annon's model as it applies to sex therapy. The four levels of expertise and intervention conceptualised are represented in the word PLISSIT. "P" represents the "Permission" level and consists of the therapist simply feeling comfortable enough to convey a sense of permission to clients so that they feel free to bring up sexual matters. The next level, which often blends with permission, is providing "LI" or "Limited Information". Many couples and individuals can be helped through providing some basic information such as an overview of the sexual response cycle. This is the sex education the client never had. The third level of intervention is giving of "SS", "Specific Suggestions," which can be viewed as the sex counselling level. Here suggestions to deal with specific sexual problems may be offered or exercises such as sensate focus are introduced. The fourth and most complex level of intervention is "IT" or "Intensive Therapy". This is the level of intensive sex therapy.

3.5.2 Stahmann's addition

Stahmann (1997:68) identified an important missing ingredient in this model, namely the expectations about therapy that the therapist and the client may

have. According to him all clients have some sort of preconceived expectation or idea about therapy as a process, or some expectation about the therapist as a person. Therapists whether they are family or sex therapists also have expectations that guide and direct their interventions. Thus with the addition of "Expectations", the model has become the EXPLISSIT or EX-P-LI-SS-IT. Stahmann consequently uses the EXPLISSIT model for conceptualising, designing and delivering marital and family therapy interventions. He first looks at the expectations of both the client and the therapist. What does the client expect about the therapy process? Why are the clients here? What might be indicators to the clients that therapy is successful? What does the therapist expect? What does the therapist expect about the therapy process with the client and what does the therapist expect about the possible outcome of therapy? In supervision and case consultation, what does the supervisor expect about the process and outcome? What are the expectations of the supervisee about the supervision process and outcome?

3.5.3 Renshaw's modification

Renshaw (1997:40) modified the model further by turning the triangle around. The permission given to the client by the social worker or therapist, to experiment with his or her own sexuality, as well as to communicate about sexual issues in a comfortable manner are seen as the most important and largest part of sex therapy. Limited information about sexuality in general and the specific sexual difficulties are then given. This phase can be described as the sex education the couple never had. Home love play exercises are then

given to the couple and the feedback on these is discussed at the beginning of the next session. The smallest part of sex therapy according to the revised PLISSIT model is then intensive therapy for specific and complicated long-term problems.

3.6 Treatment modalities for sexual dysfunctions

3.6.1 Male erectile disorder

King (1999:325) describes erectile dysfunction (ED) as a sexual problem in which a male has difficulty, or an inability to get and maintain an erection. EDs can be *primary* (i.e., a male who has never had an erection) or *secondary* (i.e., the individual has not had erectile problems in the past), and *global* (i.e., it happens in all situations) or *situational* (e.g., a man who can't get an erection with his wife, but can with other women).

Masters, *et al.* (1995: 523) describe an erection as the result from the spongy-like tissues of the corpora cavernosa and corpus spongiosum of the penis becoming engorged with blood (the penile arteries dilate and valves in the veins close). This response is under reflexive control by two centres in the spinal cord (the lower one responds to touch and the upper one responds to erotic thoughts). They normally work together, and depend on the presence of testosterone (the male hormone) and other chemicals. Any number of things

can upset the balance and impair functioning, including fatigue, stress, alcohol, and drugs.

According to Rosen & Leiblum (1995:879), the difficulty in achieving or sustaining an erection is currently the most prevalent sexual disorder in men seeking sex therapy. The frequency of ED is strongly age related. Studies have also showed a high incidence of illnesses and medication use in men with ED. Renshaw, *et al.* (1997:28) regards sexual response as a fundamentally psychosomatic phenomenon in which the interaction between psychological processes and physiological processes is absolutely basic. There have been many developments and changes in both the assessment and treatment of especially ED. In 1988 the term impotence was changed to erectile dysfunction. According to Renshaw, *et al.* (1997:29) there are several treatment possibilities for ED namely:

- penile self-injection therapy;
- oral medication;
- vacuum erection device;
- couple and sex therapy.

Rosen & Leiblum (1995:880) stress the fact that in keeping with the focus on biomedical causes of ED, medical and surgical approaches to treatment have escalated in recent years. These include surgical prostheses or penile implants, intracorporal injection or vasoactive drugs, constriction rings and vacuum pump devices and oral medication. King (1999:325) mentions that circulatory problems (e.g., arteriosclerosis, sickle-cell anaemia, or beta-

blocking medications used to treat blood pressure and heart disease), neurological disorders (e.g., accidents, pelvic surgery), and hormone imbalances (primary abnormalities or secondary complications due to diabetes) often result in ED. Eighty percent of alcoholics suffer from ED. It is important, therefore, that a client with an erectile problem have a complete medical exam before treatment begins.

Renshaw, *et al. (1997:30)* describe **intracavernosal or penile self-injection therapy** as it is sometimes referred to, as a very effective tool in the management of ED. It is a process whereby medications that are primarily vasodilators, are injected directly into the erectile chamber. Five to ten minutes later, the patient has an erection that is usable for intercourse. Many men overcome needle phobia to go along with this therapy.

The **vacuum device** is the oldest form of therapy for ED. It is a very simple mechanical device that entails a cylinder that is placed over the penis. A vacuum is created in the cylinder, drawing blood; passive congestion of the penis occurs and a constriction ring is placed over the penis that traps blood within the penis itself.

Rosen & Leiblum (1995:879) agree that psychological and interpersonal factors are also associated with ED. Renshaw, *et al.* (1997:29) stress the importance for sex therapists to indicate to the patient that even if he is unable to achieve an erection, it is still possible to enjoy sexual intimacy with one's partner. The difficulty in obtaining an erection often becomes a barrier to

sexual intimacy, and the man is very reluctant to embark on any type of affectionate interaction with a partner. This, therefore, often results in the couple becoming detached from one another and having less intimacy. Such a man can be helped to see, particularly with the partner's help, that the erection is not the only, or the most important part of lovemaking. Therefore, there is an important role for **counselling**. For many men, it is intercourse or nothing. To request that, at least for a few weeks, the couple only receive pleasure and forget about the erection can make a dramatic difference in the way the man's body performs. The client is then achieving the result of relaxation using the mind, the most important aphrodisiac, namely, fantasy, and letting the body take over naturally and have the erection.

Rosen & Leiblum (1995:880) mention that the communication between couples should also be improved during sex therapy. Effective communication is profoundly important in sexual relationships, and improving communication can often produce dramatic improvements in the relationship and the sexual dysfunction. Therapy can help clients to understand the meanings that they have attributed to their sexual lives. This can often be very important in reducing guilt and anxiety.

King (1999:325) and Masters, *et al.* (1995:581) agree that if the cause of ED is determined to be solely psychological, the success rate during therapy depends largely on whether it is a primary or secondary dysfunction. Men with primary erectile dysfunction are often found to have had a strict religious upbringing in which sex was equated with sin and guilt. They may have had

very few social experiences with females during childhood and adolescence. For men with a secondary ED due to psychological factors, the most common cause is performance anxiety. Performance anxiety is a fear of failure. Nearly all males will experience an erectile dysfunction sometime in their life, often due to stress (e.g., school, career), fatigue, drugs (e.g., prescription, antihistamines, and illicit drugs), or just too much to drink one night at a party. Having sex with a new partner can also be very anxiety producing. Although dysfunctions in these situations are normal, many men are not aware of this and begin to worry about being impotent. The next time they have sex the anxiety caused by fear of failure can result in what is called spectatoring – observing and evaluating their own responses rather than experiencing the sexual pleasures. Spectatoring is distracting (a loss of intimacy) and can lead to loss of erection, which results in even greater anxiety the next time. The behaviour becomes a vicious cycle, and what started as a normal response to fatigue, alcohol, drugs, or other factors can become a chronic psychological dysfunction.

Renshaw, *et al.* (1997:30) mention the **psychosomatic interface** as being intensely interwoven in the area of sexuality. It is important for the clinician of any discipline to see whether the ED is global or whether it is specific to the partner. If the man is having morning erections and is masturbating the therapist needs to understand what is happening between the couple.

There is also the **pharmacological approach**. The most recent development is the use of a phosphodiesterase level five inhibitor, Sildenafil, more

commonly known as Viagra. It blocks the effects of phosphodiesterase, which has a very local effect in the penile tissue. By blocking the enzyme effect, you prolong the effect of sexual stimulation. The drug has no effect without sexual stimulation. This is a very new approach to the pharmacological treatment of ED. (Compare Rosen & Leiblum, 1995:879; Renshaw, *et al.,* 1997:31 and Masters, Johnson & Kolodny, 1995:581.)

Few studies have addressed the impact of treatment in the partner relationship, and limited attempts have been made to integrate medical and psychological approaches to treatment.

As far as psychological treatment for ED goes, several authors have emphasised the importance of cognitive interventions. (Compare Masters, *et al.,* 1995:583; Renshaw, *et al.,* 1997:31 and Rosen & Leiblum, 1995:870.) Males with chronic ED typically harbour distorted cognitions about the nature of sexual arousal, sexual skills, and their partners' expectations regarding sexual satisfaction. These dysfunctional beliefs and expectations are a potentially important focus for treatment.

A number of treatment interventions for single men with chronic ED exist and have also been described by Masters, *et al.* (1995:582). Treatment strategies include sexual attitude change, masturbation exercises and social skills training.

Rosen & Leiblum (1995:881) agree that psychological and interpersonal approaches have been relatively neglected in the face of increasing medicalisation of ED. Recent studies in contrast have highlighted the importance of the integration of cognitive and interpersonal factors as well as pharmacological treatment in this highly prevalent disorder.

3.6.2 Premature ejaculation (rapid ejaculation)

Premature ejaculation is a common sexual dysfunction but is very often difficult do define. Masters, *et al.* (1995:582) define rapid ejaculation as the male who persistently ejaculates unintentionally during non-coital sexual play or while trying to enter his partner. King (1999:330) defines premature ejaculation as the recurrent and persistent absence of reasonable voluntary control of ejaculation. A man who is disturbed by his own inability to exert any control over when he ejaculates may develop performance anxiety. This, in turn, can lead to an erectile dysfunction. Many therapists believe that the early sexual experiences of some males actually teach them to rush during sex. Male masturbatory behaviour is generally orgasm-oriented anyway, but a male may hurry it even more in situations where he fears being caught.

Masters, *et al.* (1995:582) mention the fact that prevalence data suggest that approximately 25% - 40% of men in the United States of America experience difficulties with premature ejaculation (early ejaculation) at some time. A major difficulty has been the lack of a clear-cut definition or diagnostic criteria for early ejaculation. Masters & Johnson (1966:165) initially defined premature

ejaculation in terms of the male's inability to delay ejaculation until his partner had been sexually satisfied on at least 50% of intercourse attempts. Noting the lack of objectivity in this definition, other authors have emphasised the average duration of intercourse or number of thrusts following penetration. (Compare Kaplan, 1974:165; King, 1999:330 and Lopiccolo, 1978:135.) A third approach described by Renshaw (1997:30) has been to emphasise the degree of voluntary control that the man has over ejaculation.

Rosen and Leiblum (1995:883) quote the *Diagnostic and Statistical Manual of Mental Disorders, IV* who defines premature ejaculation (PE) as: "...persistent or recurrent ejaculation with minimal sexual stimulation before, upon, or shortly after penetration and before the person wishes it". The therapist must take into account factors that effect duration of the excitement phase, such as age, novelty of the sexual partner, and frequency of sexual activity. Psychological factors and early conditioning factors as causes of PE have also been emphasised.

Treatment approaches for PE include the traditional stop-start technique as well as the squeeze technique developed by Semans and Masters and Johnson (1970:165). Cognitive-behavioural interventions are also used as well as various pharmacological agents such as alpha-adrenergic antagonists or serotonin-uptake inhibitors (e.g. Prozac or Zoloft). Simply increasing the frequency of sexual stimulation may result in an increased latency to ejaculate. (Compare Masters *et al.,* 1995:582; King, 1999:331 and Renshaw, 1995:83.)

3.6.3 Male orgasmic disorder

Various authors describe male orgasmic disorder. (Compare Masters *et al.*, 1995:583; King, 1999:331 and Woody, 1992:66.) This is a relatively uncommon disorder and accounts for only about two to three percent of men who seek therapy. It refers to a difficulty (sometimes called retarded ejaculation) or a total inability (sometimes called ejaculatory incompetence) to reach orgasm and ejaculate in a woman's vagina, and it can be either primary or secondary. A few cases can be traced to organic causes (e.g., drugs, alcohol, neurological disorders). Most of these men, however, are able to reach orgasm either during masturbation or during manual or oral stimulation, which indicates that the usual cause is psychological and not physical. Masters & Johnson (1970: 165) reported that primary inhibited orgasm problems are often associated with a strict religious upbringing, a fear of getting a woman pregnant, negativity and hostility toward the partner, and/or maternal dominance. Secondary problems are often associated with some kind of previous trauma. According to King (1999:332) delayed or absent ejaculation may also be associated with a variety of medical or surgical conditions (e.g. multiple sclerosis, spinal cord injury, surgical prostatectomy), or the use of anti-adrenergic or neuroleptic medications.

Masters, *et al.* (1995:583) describe another disorder namely, retrograde ejaculation. This is a condition in which the semen spurts backward into the

bladder during orgasm because the bladder neck does not close off properly. It occurs in men with multiple scleroses and diabetes and following some types of prostate surgery.

Treatment interventions are usually aimed at reducing performance anxiety, in addition to increasing the level of genital stimulation. (Compare King, 1999:331; Masters *et al.*, 1995:583 and Renshaw, 1995:83.)

3.6.4 Priapism

King (1999:332) and Masters, *et al.* (1995:580) describe priapism as a condition in which the penis remains erect for a prolonged period of time due to damage to the valves regulating the penile blood flow. Medical attention is necessary to deal with this problem as this condition can be life threatening.

3.6.5 Female sexual arousal disorder (FSAD)

This condition refers to the lack of responsiveness to sexual stimulation in women and is defined as a "persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication response of sexual excitement" by the DSM IV as quoted in Rosen and Leiblum (1995:879). This definition emphasises the absence of physiological arousal, thereby paralleling the definition of erectile disorder. It is often difficult

to separate lack of arousal disorder in women from hypoactive sexual desire disorder or anorgasmia.

Masters and Johnson (1970:165) and Kaplan (1974:145) describe the use of biofeedback and fantasy training procedures for women with inhibited arousal and orgasmic disorders. Sexual arousal difficulties in women may also benefit from interventions to increase generalised autonomic arousal for example exercises, in addition to enhanced expectations of sexual arousal.

Psychological treatments included couples therapy, masturbation training, and sensate focus procedures as described by Masters & Johnson (1970:265).

3.6.6 Female orgasmic disorder

Female anorgasmia is generally regarded as the most prevalent sexual dysfunction in women. Some authors like Kaplan (1974:29) and King (1999:332) argue that the lack of experience with masturbation or inadequate partner stimulation frequently underlies the failure to achieve orgasm.

Inhibited Female Orgasm is defined by the DSM-IV as the difficulty or inability for a female to reach orgasm. Orgasmic dysfunction can be primary or secondary and situational or global. Many authors (King, 1999:332; Masters *et al.,* 1995:157 and Renshaw, 1997:60) agree that the key to reaching orgasm is the degree of stimulation to the clitoris. During intercourse, the penis only

indirectly stimulates the clitoris by causing the clitoral hood to rub back and forth over the clitoral glans. Fewer than half of women are therefore able to reach orgasm during intercourse without more direct stimulation of the clitoris. A healthy positive attitude about sex and pleasure is also very important. Masturbation therapy, sensate focus exercises and relaxation exercises are often used in treatment of anorgasmic women.

Masters, *et al.* (1995:586) describe the treatment of lifelong or primary anorgasmia as guided masturbation training and cognitive-behavioural sex therapy. Masturbation training procedures include manual or vibrator-assisted stimulation techniques, in addition to pubococcygeal muscle training procedures (Kegel exercises).

Secondary anorgasmia is more often associated with emotional or psychiatric disorders and with relationship conflicts.

Masters, *et al.* (1995:588) also describe a relatively rare condition called rapid orgasm. It is in essence the female counterpart of premature ejaculation, and is marked by characteristically having orgasm so quickly in a sexual encounter that it is distressful.

3.6.7 Dyspareunia

Painful intercourse does not only affect females, but may also affect males (Masters *et al.,* 1995:584). Most typically, the pain is felt in the penis, but it

can be felt in the testes or internally, where it is often associated with a problem of the prostate or seminal vesicles. King (1999:584) states that in men, the most common causes are a prostate or bladder infection, or the foreskin of the penis being too tight. In rare cases, fibrous tissue deposits can cause curvature of the penis (known as *Peyronie's disease)* and pain during erection.

Painful intercourse is a highly prevalent disorder in women, but is relatively rare in men. King (1999:325) describes etiological determinants as including a wide variety of physical factors, such as hymeneal scarring and pelvic inflammatory disease as well as psychological factors such as relationship conflicts or a history of sexual abuse. Dyspareunia may also be secondary to vaginismus or chronic lack of lubrication.

According to Masters, *et al.* (1995:588) painful sexual intercourse in women can present a major stumbling block to sexual satisfaction. This condition can occur at any age, and can appear at the start of intercourse, at the time of orgasm, or after intercourse is completed. Dyspareunia detracts from a person's sexual enjoyment and can interfere with sexual arousal and orgasm.

King (1999:325) asserts that in women, one of the most common causes of painful intercourse is vaginal dryness. If a woman is not fully lubricated when intercourse begins, the thrusting of the penis will severely irritate the dry vaginal walls. Lack of sufficient lubrication can be due to a partner who doesn't take his time, but it can also be the result of fear or anxiety, which

interferes with the vasocongestive process. Vaginal dryness can also result from hormonal changes (which occur at menopause), use of antihistamines and other medications, and even tampons. Use of a water-soluble lubricant can often substantially alleviate this problem.

Dyspareunia in women can also be caused by endometriosis (growth of the endometrium outside the uterus), pelvic inflammatory disease, vaginal infections, and urinary tract infections. Allergies to semen, feminine hygiene products (deodorants and scented douches), powders, and spermicides can also make sexual intercourse painful. Surveys generally show that about 40 percent of women have occasionally experienced painful intercourse. If the physical factors responsible for dyspareunia are not quickly taken care of, it can lead to other sexual problems. The anticipation of pain, for example, can become so great that it can lead to erectile problems in men, vaginismus in women, or loss of sexual desire in either sex.

Treatment approaches described by Masters, *et al.* (1995:588) include a variety of medical or surgical interventions in cases of specific organic pathology. In addition to medical approaches, however, most women require a course of cognitive-behavioural or sex therapy treatment. King (1999:332) mentions that for women with a long-standing history of painful intercourse the conditioned anxiety and lack of arousal associated with the disorder require additional treatment.

3.6.8 Vaginismus

Vaginismus is defined by King (1999:332) and Masters, *et al.* (1995:585) as involuntary spasms of the musculature of the outer third of the vagina and is the second major cause of penetration difficulties in women. The disorder is relatively common, occurring in 12% - 17% of women presenting to sex therapy clinics. Many authors (Rosen & Leiblum, 1995:884; King, 1999:332 and Masters *et al.,* 1995:588) distinguish between primary vaginismus, which refers to involuntary spasms in all situations, and secondary or situational vaginismus, in which some penetration is possible (e.g. insertion of a tampon).

According to King (1999:332) it is usually caused by psychological factors. Persistent and recurrent involuntary muscle spasms are often associated with the fear of injury to the internal organs or trauma like rape or abortion. It can also be due to a strict religious upbringing, hostility or fear toward men or medical reasons.

Vaginismus can also occur in association with dyspareunia, although it is more frequently caused by psychological or interpersonal factors. Masters, *et al.* (1995:585) agree that among the psychological factors most often associated with vaginismus are negative psychosexual upbringing, sexual fears and phobias and a history of sexual trauma or abuse.

Treatment usually consists of sensate focus and relaxation exercises followed by gradual dilation of the vagina. Treatment approaches described by

Masters, *et al.* (1995:585) typically consist of a combination of systematic desensitisation, pubococcygeal muscle training (Kegel exercises) and the use of vaginal dilators. The involvement of the male partner appears to be an important determinant of treatment efficacy.

Assessment and treatment approaches to sexual dysfunction have changed markedly in the more than 30 years since the publication of *Human Sexual Inadequacy* by Masters and Johnson in 1970. In particular the role of biomedical and organic factors have been emphasised increasingly.

3.7 Sex therapy techniques

3.7.1 Medical history

Sex therapists (King, 1999:320; Masters *et al.*, 1995:596 and Woody, 1992:60) agree that the vast majority of sexual problems are caused by psychological factors, but sexual dysfunctions are sometimes caused by physical or medical problems. Circulatory problems (e.g., arteriosclerosis), hormone abnormalities (e.g., low testosterone levels), or anything that causes central nervous system damage (e.g., diabetes, spinal cord injury) can cause a sexual problem. Alcohol and drugs often cause sexual impairment as well. One common cause of erectile dysfunction in men, for example, is some prescription medications used to treat hypertension and heart disease. It is important, therefore, that a therapist have a complete medical history of the

patient (and possibly have a physician do a medical exam) before beginning therapy in order to rule out any physiological basis for the presenting problem.

See Appendix A for an example of a medical history questionnaire.

3.7.2 Sexual history

Nearly all sex therapists will take a complete sexual history of the client before treatment begins. These histories are very thorough, and the length of time devoted to this will depend on how candid the client is about his or her past experiences. Some therapists like Masters, *et al.* (1995:594), prefer to work with couples because they are of the opinion that there is no such thing as an uninvolved partner. Renshaw (1995: 120) describes the goal of the taking of a complete sexual history as giving the client insight into his or her attitudes and beliefs about sex.

See Appendix B for an example of a sexual history questionnaire.

3.7.3 Systematic desensitisation

King (1999:350) states that many patients have severe anxieties about sex in certain situations. Therapists often attempt to reduce this anxiety through muscle relaxation exercises or stress reduction techniques. A series of anxiety-producing scenes is presented to the patient, and he or she is told to

try to imagine the scene. If this causes anxiety, the relaxation exercises are used until the scene can be imagined without anxiety. They then proceed to the next scene and repeat the procedure until the entire series can be completed without anxiety. Imagining a scene, of course, is not the same as a real-life situation, so a series of homework exercises are usually given as well.

3.7.4 Sensate focus

Masters, *et al.* (1995:596) and King (1999:320) agree that many people are too goal and/or performance-oriented during sexual relations (e.g., focusing on orgasm). Others have guilt or anxieties about enjoying sex. As a result, many people never really learn how to give or receive physical pleasure. Masters & Johnson (1966:176) created sensate focus exercises. The purpose is to reduce anxiety and to teach nonverbal communication skills. Most therapists, therefore, instruct couples to use non-demand pleasuring techniques when touching each other. They are instructed to go home, get undressed, and take turns touching each other without it immediately leading to the goal of having intercourse or having an orgasm. Touching of the breasts and genitals is forbidden at first, but all other areas of the body are to be explored. The receiver is instructed to focus on the sensations produced by the giver and to produce feedback as to what feels good and what does not. The giver learns what makes his or her partner feel good while simultaneously learning the pleasure of touching. The couple learns to be sensual in a non-demanding situation.

See Appendix C for an example of a sensate focus exercise handout.

3.7.5 Self awareness and masturbation

Several authors (Kaplan, 1979:231; Masters *et al.,* 1995:599; King, 1999:320 and Renshaw, 1995:42) use masturbation as a sex therapy technique. Renshaw (1995:43) states that research showed that a lack of sexual self-exploration and self-stimulation is a common feature of people seeking treatment for sexual problems. They give their clients instructions on how to masturbate because some people have never explored their own bodies. As a result, they are totally out of touch with their own physical responses. During masturbation, a person learns what kind of stimulation is pleasurable. It also helps them to learn how to relax during sex. Many therapists also consider it helpful to have a couple masturbate in each other's presence so that each can learn what the other finds most arousing and pleasurable.

3.7.6 Specific exercises

After the sensate focus exercises are successfully completed, therapists generally assign specific exercises to help with the problem for which the person came to treatment.

3.7.6.1 Erectile dysfunction

According to Masters, *et al.* (1995:597) it is important to help the man understand that he cannot will an erection to occur on demand. He can however set the stage for his own natural reflexes to take over by not trying to have erections and by moving out of his performance fears. It is also important that the therapist stresses the fact that losing an erection is not a sign of failure; it simply shows that erections come and go naturally. King (1995:325) advises that when intercourse is attempted after the man has gained considerable confidence in his erectile capacity and after he has been able to reduce his spectatoring behaviour, the women should be advised to insert the penis. This reduces pressures on the man to decide when it is time for penetration and removes the potential distraction of fumbling to "find" the vaginal opening.

3.7.6.2 The squeeze technique

Masters, *et al.* (1995:597) stress the importance of the couple approach in treating premature or rapid ejaculation since the condition may actually be more distressing to the woman than the man. In addition to discussing the physiology of ejaculation, the therapist can also introduce a specific method called the squeeze technique that helps recondition the ejaculatory reflex. Many authors describe the squeeze technique. (Compare King, 1999:330; Masters *et al.,* 1995:597 and Renshaw, 1995:197.) The woman puts her thumb on the frenulum of the penis and places her first and second finger just above or below the coronal ridge on the opposite side of the penis. A firm,

grasping pressure is applied for about fifteen seconds and then abruptly released. This technique reduces the urgency to ejaculate and usually ensures a 30% loss of the erection.

3.7.6.3 The stop-and-start technique

Renshaw (1995:83) describes this technique to utilise in the treatment of rapid ejaculation. The couple should engage in foreplay until the man almost reaches ejaculatory inevitability, then they should simply stop. They should relax, hug and hold and allow 30% loss of erection. Then loveplay continues to the same point again, and again let 30% loss of erection occur. Deliberate loss of erection can build confidence especially when loveplay returns the erection.

3.7.6.4 Kegel exercises

Several authors (King, 1999:37; Masters *et al.*, 1995:52 and McIntosh, 1997:2) advocate Kegel exercises to strengthen the pubococcygeus (P.C.) muscle. These exercises are designed to strengthen and give voluntary control over the P.C. muscle. The P.C. muscle is the support muscle for the genitals in both men and women and is the muscle that stops the flow of urine. There is a definite correlation between good tone in the P.C. muscle and orgasmic intensity. The Kegel exercises are the same exercises that physicians instruct women to do after having a baby in order to regain urinary

control. The advantages of Kegel exercises described by King (1999:37) and McIntosh (1997:1) are:

- Increasing the awareness of feeling in the genital area.
- Increasing blood circulation in the genital area.
- Increase in sexual responsiveness.
- Aid in restoring vaginal muscle tone after childbirth
- Increase control over orgasm.

See Appendix D for a program of Kegel exercises.

3.7.6.5 Vaginismus exercises

Vaginismus is treated by explaining the nature of the involuntary reflex spasm, by prescribing specific exercises and by using dilators if indicated. Masters, *et al.* (1995:599) and Renshaw (1995:85) describe specific exercises for women suffering from vaginismus.

See Appendix E for specific exercises in handout form to prescribe to clients.

3.7.6.6 Anorgasmia exercises

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Masters, *et al.* (1995:599) state that treatment strategies will vary widely depending on the cause of the anorgasmia. A woman with a poor body image may be helped to find various ways of regarding her body more positively. A woman who is distracted from high levels of arousal by disturbing fantasies might be taught thought-blocking techniques. Other common techniques

include encouraging a woman to explore her own body; dealing with performance anxieties and spectatoring; fostering sexual communications so that the woman is able to let her partner know what type of touch or stimulation she prefers and reducing inhibitions that limit her capacity for arousal or that block orgasm.

3.8 Summary

In Chapter 3 an overview of clinical sex therapy was provided. The historical background of sex therapy was followed by a description of the state of theory in sex therapy. The classification of sexual disorders followed as well as an explanation of the PLISSIT-model to treat sexual distress. Different treatment modalities for sexual dysfunctions were subsequently discussed as well as possible sex therapy techniques to utilise in treatment.

The following is a summary of the most important points:

- A substantial proportion of the adult population will experience some sort of sexual problem at some point in their lives.

- Sex therapy refers to any systemic attempt by a professional therapist to alleviate the sexual dysfunction or sexual difficulties experienced by a specific client.

- An integrated approach to therapy is needed.

- All sex therapy approaches share the underlying assumption that there is a healthy state of sexual functioning that therapists aim to restore for the client.

- Sexual and gender identity disorders are currently classified into four major categories: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified.

- The PLISSIT model is widely used as a model to treat sexual distress.

- Treatment possibilities for erectile dysfunction are:
    - Penile self- injection therapy
    - Oral medication
    - Vacuum erection devices
    - Couple and sex therapy
    - Penile implants

- Treatment possibilities for premature ejaculation are:
    - The stop-start technique
    - The squeeze technique
    - Cognitive-behavioural interventions
    - Medication
    - Increasing the frequency of sexual stimulation

- Treatment possibilities for female sexual arousal disorder are:
  - Fantasy training
  - Kegel exercises
  - Masturbation training
  - Sensate focus exercises
  - Medication

- Treatment possibilities for female orgasmic disorder are:
  - Masturbation training
  - Sensate focus exercises
  - Relaxation exercises
  - Cognitive-behavioural therapy
  - Kegel exercises

- Treatment possibilities for anorgasmia include:
  - Lubricants
  - Medical and or surgical interventions to treat the physical factors contributing to anorgasmia
  - Relaxation therapy

- Treatment possibilities for vaginismus include:
  - Sensate focus exercises
  - Kegel exercises
  - Relaxation therapy
  - Specific exercises prescribed for vaginismus

- Use of vaginal dilators

- A therapist counselling clients with sexual difficulties should always take a complete medical and sexual history from the clients.

Chapter 4 will deal with the important issue of the integration of sex therapy and relationship counselling. The role of the social worker in dealing with clients with sexual difficulties will also be addressed.