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THE SEXUAL NARRATIVE
A Story Waiting to Be Told

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Introduction

Last week a seventy-two-year-old man came to my office for the first time. He told me that he had mustered up the courage to seek counseling four months earlier and found a counselor with whom he immediately felt comfortable. In weekly sessions, they had discussed his anxiety, depression, and anger management problems that were interfering with his marriage. At his last session, he mentioned that he wanted to talk about a sexual issue that he was deeply ashamed of and had never discussed with anyone. Before he could continue, his therapist stopped him and said that this was beyond her professional expertise and suggested he see me. He was disappointed that she was not even willing to hear what he had to say as it had taken everything he had to even bring up the subject. He assured me that I must be a very nice person but that it was very hard to start again.

I was disheartened, but not surprised, to hear this. As much as my colleagues and I have tried over the years to encourage and support our professional mental health community in becoming more comfortable with and knowledgeable about sexual issues, sexuality remains a scary subject for many to address. I have to remind myself how nervous and uncomfortable I was in the early years and how I might never have gotten over this discomfort had it not been for my mentor, Stephen Levine, who encouraged me to forge ahead. As a result, I spent the next forty years hearing about a wider range of sexual experiences, feelings, thoughts, and struggles than I could ever have imagined. I am indebted to those countless patients who taught me through their sexual stories. In this chapter I will share what I believe are the necessary skills to acquire in order to develop professional sexual comfort and expertise. I will focus on the obstacles one must overcome in order to develop those skills.

Why do I Need to Learn This?

Everyone has sexual thoughts, feelings, and experiences that are integral to their sense of who they are and how they relate to the world. Sexual problems often manifest and mask themselves in the major symptoms that bring patients to treatment: depression, anxiety, failure to achieve, low self-esteem, and the inability to engage in intimate relationships. Yet patients are shy about revealing their sexual concerns. These feel so private, so awkward, so potentially embarrassing that many are reduced to paralyzing inarticulateness. They dread being asked; they long to be asked. They know for sure that they _need_ to be asked if their sexual concerns are to come out.
The Sexual Narrative

Why Don’t I Want To?

This is often the fundamental question behind “Why do I need to?” The reasons for not wanting to are many:

1. I’m not used to talking about sex . . . My discomfort and awkwardness will be obvious.
2. I don’t exactly know why I am asking or what I want to know.
3. I may be unfamiliar with and/or not understand something my patient tells me.
4. I won’t know how to respond to what I hear.
5. I may offend or embarrass my patient.
6. I’ll be too embarrassed to consult with my colleagues.

Most of us can recall having some of these concerns about a wide range of issues when we first began our clinical careers. Questions about what to ask, how, when, and why were the ongoing central focus of our early learning. Patience, persistence, and a sense of humor helped to get us through the processes of gaining experience. Over time, increasing comfort and expanding knowledge made the job that much easier.

The concerns about being perceived as nosy or intrusive or about offending or embarrassing our patients may be more specific to sexual topics. While patients may initially react as though you have intruded into territory too personal to be shared, they are usually settled by a simple explanation as to the relevance of the question.

Therapist: You’ve told me a lot about your ambivalence about marrying Joe . . . your concerns about his lack of ambition and his relationship to his family. You haven’t mentioned anything about your sexual life together. Can you tell me about that?

Jill: Well, uh . . . it’s OK, I guess (squirms). What do you want to know?

Therapist: Sexual intimacy is often a vital part of a relationship . . . It can really enhance it or can be problematic. How have you felt about your sexual relationship with Joe?

Jill is a little taken aback by the initial question. She doesn’t know how to respond because she is not used to articulating aspects of her sexual life. A simple statement by her therapist about sexual intimacy will help Jill get started.

Sometimes, however, it is the therapist, not the patient, who feels weird about or embarrassed by the exploration of sexual material. This is particularly true when the topic is something the therapist has never experienced (“My ignorance will show”), can’t imagine experiencing (“That’s disgusting!”), or has experienced with ambivalence and conflict (“I don’t think I want to go there!”). The therapist may unwisely avoid the subject if it threatens to bring up painful memories.

Therapist: (This is making me very anxious . . . I don’t want to remember what I did to Jim in college . . . It was the end of our friendship . . . To this day I feel like a worm about it.) I’m sure everything will be OK. These things happen.

Alan is clearly upset by his behavior and wants to talk about it. The situation, however, reminds his therapist of a similar time in his life. In an effort to ward off his own feelings of guilt, the therapist cuts off the discussion and incorrectly reassures Alan that everything will work out.
Whom Should I be Asking?

*Everyone.* Unless the chief complaint is so specific and narrow in focus or the time spent together so short or crisis oriented, *every* patient should at least be offered the opportunity to address sexual concerns. How will we know whether sexuality is of concern unless we inquire? Because sexuality is a topic that is difficult for patients to bring up, the therapist must assume responsibility for introducing it as an area of possible relevance. If nothing else, the inquiry tells the patient that sex is OK to talk about: “I’m interested in hearing about it if you want to tell me . . . I’ll even help you talk about it by taking the lead.”

*Including the elderly.* Therapists are often especially reluctant to inquire about the sexual feelings and activities of the elderly (often defined as anyone as old as, or older than, one’s parents!). Our culture emphasizes youth and beauty, and there is a tendency to view aging people as asexual or, even worse, to make fun of their displays of sexual interest. Older adults, in turn, may be embarrassed to admit that they still have needs for physical affection, closeness, intimacy, and sexual gratification.

When Should I Ask?

Inquiring about sex when someone shows up in a crisis about his dying mother is not particularly relevant. Early and abrupt questions about sexuality will be off-putting unless the chief complaint is of a sexual nature. On the other hand, putting it off indefinitely or waiting until the patient brings it up reinforces the idea that sex is a taboo subject in your office. The situation that offers the most natural segue into the topic is the gathering of psycho-social and developmental information early on in the assessment phase. Sexual matters can be incorporated into your inquiry regarding childhood and family-of-origin events, issues, and problems.

Therapist: You were telling me about your male friendships growing up. . . . Do you remember when you first became aware of sexual feelings?

Jack: Do you mean liking girls? I didn’t think much about girls until middle school. . . . I had a crush on a girl in seventh grade. Her name was Judy. She was very popular and hung out with eighth-grade boys. She never knew how I felt. I was geeky. She wouldn’t have given me the time of day. I still feel geeky. Nothing has changed. That’s why I’m here.

Jack’s therapist made a smooth transition from the focus on growing up and friendships to a question about the emerging awareness of sexual feelings. The transition made sense to Jack and he easily picked up on the question. In this case, Jack thinks that the issue of sexuality may be relevant to his seeking therapy. That isn’t always so. The advantage of inquiring about sex in the assessment phase, whether or not a sexual problem exists, is that it gives permission to speak of sexual issues in the future. If, however, you have forgotten to do this, it won’t hurt to introduce it as a topic at a later date.

How do I do This Well?

*The right words.* Even when clinicians are convinced of the worthiness of inquiring about sexual matters and are ready to do so, they often stumble over the vocabulary. The task of finding the right words and pronouncing them correctly can intimidate the best of us; we realize that we are far more comfortable reading words such as *penis, vagina, clitoris,* and *orgasm* than saying them out loud.

Nevertheless, it is up to the clinician to go first—that is, to say the words out loud so that the patient can follow suit. Sometimes we may use a word that is confusing or foreign to our patient; sometimes they will use words we don’t understand. Over time you can build up knowledge of a large repertoire of expressions, some clinical and formal, others slang and street talk. You will gain a working familiarity with both kinds.
Allowing the story to be told. While it helps to have an organized approach to the questioning, you should not become an interrogator who is wedded to a predetermined agenda or outline. I have found that the most useful conceptualization for talking about sexuality is that of helping people tell their sexual story. Sexual stories, as with any story, have a pattern of flow and a combination of plots and sub-plots, characters, and meaning. Some stories unfold chronologically from beginning to end; others begin at the end and flash backward to illustrate and highlight the significant determinants to the ending. Either way, the events, characters, and meanings are eventually interwoven into one or two major themes that constitute the story. Whether or not one begins by asking about current sexual feelings and behaviors and then gathers history or begins by taking a developmental history depends on two factors:

1. The absence or presence of a current sexual issue that requires direct attention
2. The client’s comfort with addressing current sexual functioning as opposed to historical narrative.

Being flexible. Open-ended questions that encourage clients to tell their sexual story are ideal, but many clients are too inhibited or unsure of what to say and require more direction. When your open-ended questions are met with blank stares, squirming, or other signs of discomfort, do not give up. Patience and calm encouragement, along with the guidance of more specific questions, will usually get the ball rolling. Looking for an aspect of the client’s sexuality that is the least threatening—easiest to talk about first—may provide the direction.

Therapist: What is your sexual life like these days?
Joyce: I don’t know what you mean. . . . Like, am I seeing anyone?
Therapist: Sure . . . we can start there.
Joyce: Well, I’ve been dating this guy, Steven, for three months. We have been sexual . . . (long silence)
Therapist: Is Steven your first sexual partner?
Joyce: No. (silence)
Therapist: Tell me about the first one.
Joyce: I was fifteen and he was a year ahead of me in high school. My parents didn’t approve of him because he smoked and hung out with a crowd they didn’t like. But I wasn’t having a good year, and he was an escape for me. He had a car, and we would go driving around after school . . . I told my mother I had to stay after school for one thing or another.
Therapist: What were the circumstances that led up to your being sexual with him?
Joyce: I didn’t really want to, but he did, and I didn’t want to lose him. The first time was in his car . . . I didn’t really get anything out of it. We went together until he graduated and went to work. We were sexual the whole time, but I never really felt good about it. I didn’t trust him. Later, after he broke up with me, I heard he had been with others, and I really felt used and angry with myself. . . . I think it warped me or something. Sex has never been all that good. I don’t get much out of it. I think I just do it to stay in a relationship.

In this case, the therapist helped Joyce by being willing to start with whatever Joyce brought up, “Like, am I seeing anyone? . . .” Even so, Joyce was reticent and so, rather than push her beyond a question or two, the therapist switched gears and inquired about earlier experiences. Joyce easily responded to this question, and her response led back to the therapist’s initial question about her current sexual life.

The Use of Sexual Inventories

Clinicians often ask about the value of having patients complete sexual inventories either to obtain a general sexual history or to elicit detailed information about a specific dysfunction. There is certainly
an argument to be made that a scientifically validated sexual inventory can quickly and efficiently gather a wealth of information that might take a clinician a long time to ascertain. Inventories don’t “forget” key questions to ask, nor are they shy about delving into difficult topics. However, they can’t pick up nuance or follow themes as the patient presents them. Instead, the structure and flow of the inventory are superimposed on the patient’s sexual narrative, and key information may be lost in that process.

Some patients will be more comfortable answering questions on paper; others will prefer the interaction with another person to help them tell their story. While I acknowledge the value of such inventories, I have three suggestions. First, don’t use the inventory to substitute for the ongoing dialogue between clinician and patient that brings out the patient’s unique sexual story as the patient chooses to have it unfold. Second, establish at least the beginning of a therapeutic alliance with your patient before you introduce the idea of completing inventories. It is vital that patients feel comfortable and safe with the recipient of their sexual story, whether they share it on paper or in person. Otherwise, the information is not likely to be as accurate or complete. Finally, incorporate a discussion of their responses into the following sessions. It can be unnerving to share such personal information on paper and then never be given the opportunity to go over it. A partial list of inventories my colleagues and I have found helpful can be found at the end of this chapter.

Talking With Couples

Talking to a couple about sexuality requires sensitivity to three unique issues:

1. The absence of communication about sexuality in most couples
2. The distortion of facts that may occur when one or both partners fear correcting the other when telling their sexual story
3. The presence of private sexual thoughts, experiences, and secrets.

Many couples, even those who enjoy an active and rich sexual life together, may not feel comfortable talking about their sexual desires, needs, fantasies, or fears. Youth and good health enable them to be sexual without having to talk about it. Inviting them to describe their sexual life together may produce an embarrassment and inhibition that might not be present if either one was talking to you alone. Couples will usually giggle, look at each other helplessly, or in some other way convey an amused discomfort as they acknowledge, “We never talk about this!”

Talking with a couple about their sexuality requires a respect for each partner’s private feelings, wishes, and behaviors. These are probably best addressed in an individual session. Many therapists include conjoint sessions with the couple and at least one individual session with each partner in the initial evaluation to cover all bases. Routinely presenting this format at the first session reassures each partner that this is not being suggested because the therapist has gotten the indication that there are big secrets being withheld.

The difference between private and secret sexual feelings and behaviors is an important but sometimes confusing one. Private sexual thoughts include a myriad of images, fantasies, and attractions that do not impact on one’s real sexual relationship but that one might not want to share with one’s partner because to do so would be unnecessarily hurtful and serve no useful purpose—for example, “I think my neighbor is cute” or “I had a dream last night about an old boyfriend” or “I found myself flirting a little with that woman at the sales meeting last week.” It is not as if our partners don’t know that we have private sexual feelings, fantasies, or thoughts. They just don’t know the specifics, nor do most of them care to. Secret sexual thoughts or behaviors are those that are negatively impacting the relationship or would have a negative impact if discovered, or those which represent a betrayal of a vow, agreement, or seemingly shared value system—such as having an extramarital affair or avoiding
sex with a partner because of a persistent sexual fantasy that interferes with lovemaking. Partners may not know that these thoughts or behaviors exist although they often sense that there is something pulling our attention away from them. Some behaviors fall somewhere in the middle. Masturbation, for example, in some couples is a shared and openly accepted behavior; in others it is a private behavior that one or both partners engage in but do not discuss. When it is experienced by one of the couple as a secret, it is usually because it is a breach of a shared value system that prohibits it or because it is accompanied by a persistent and compelling unconventional fantasy that is unacceptable to the partner.

Amy: I walked in on my husband and found him masturbating with my panties on. I was at first shocked and then furious. I don’t know why it feels like such a betrayal of our marriage. I’m not sure how I feel about his masturbating, but wearing my panties is sick! He has kept this from me, and I don’t know if I can ever trust him again!

This distinction between private and secret sometimes poses a dilemma for the therapist who hears personal and undisclosed sexual information from one or both partners that may be negatively impacting their sexual relationship. Making the correct determination whether that information can harmlessly remain private, or whether maintaining its privacy will undermine a successful outcome, is never a certainty. A frank discussion with the holder of the information is the proper first step in making the difficult determination.

Therapist: You’ve told me about seeing another woman right now. Yet you want me to see you and your wife in marital counseling and concentrate on your sexual relationship.

Sam: I’m hoping that if our sex life improves, it will be easier to give up seeing Janet. I think I continue to see Janet because sex with my wife has never been good.

Therapist: Marriages usually have little to no chance of improving while there is an affair going on. And it would not be right for me to counsel the two of you while withholding this information from your wife.

Sam: I’ll take your word for it, but I can’t tell her. I know she will leave me, and I’m not ready to end my marriage. What do I do now?

In this case, Sam’s secret from his wife becomes something private between Sam and the therapist. If the therapist respects Sam’s right to confidentiality, he joins in the secret, which becomes, in essence, a betrayal of his wife. To be true to his wife, the therapist must break confidentiality with Sam. When I’ve reached this impasse with the holder of the secret, I explore the options: tell your partner, stop the affair without telling your spouse, leave your marriage, or take a time-out and get some individual therapy to sort out ending one relationship or the other before you work on the one remaining. None of those options are without cost.

The Components of Sexual Expression

Demonstrating interest, asking friendly questions, and being relatively accepting of what clients have to say will go a long way toward helping them tell their sexual story. But that is not enough. Sexual stories are made up of three components of sexual identity and three components of sexual function that cannot be readily expressed unless facilitated by the educated listener. Just as physical distress is more accurately described only after the physician has guided the patient through a series of questions that reflect the physician’s knowledge about what might be wrong, so it is with sexual distress. Obtaining the complete sexual story requires that the therapist have a professional conceptual framework of the six multifaceted aspects of sexuality.
Sexual Identity

Sexual identity consists of three elements: gender identity, orientation, and intention. The gender component refers to both biologic sex (i.e., male or female) and the more subjective sense of self as either masculine or feminine. A small but increasing number of people are appearing in clinicians’ offices asking for assistance in obtaining hormones, surgery, and/or psychotherapy to help them correct what they believe is a gender mistake; that is, they do not identify with their biologic gender and instead identify with the opposite gender or with an identity that falls outside of the binary stereotype. Unlike previous generations, today’s transgendersed young adults don’t consider complete physical transformation a prerequisite for identity. Some use hormones only; some biologic females have their breasts removed but forgo phallic surgery; some biologic males augment breast size but retain male genitalia. New terms have come upon the scene such as gender queer, trans-man or trans-woman, and gender flexible. Those who experience gender dysphoria may present with a host of symptoms such as cross-dressing, body dysmorphia, mutilation of breasts or genitals, and efforts to prevent, delay, hide, or reverse aspects of sexual development, such as binding or hiding the male genitals or breasts. Often there is an accompanying depression and failure to fit in with peers.

More frequently, however, gender issues involve a subjective sense of inadequacy and failure to live up to some yardstick of femininity or masculinity. Males express this in a number of ways: dissatisfaction with their body (I’m too short, thin, fat, soft), athletic ability or lack thereof (I am slow, uncoordinated, clumsy, weak), personality (I’m too sensitive, passive, shy, easily intimidated), interests (I am not interested in sports, cars, tools), or sexual prowess (I don’t know how to make the move, won’t be able to perform, won’t satisfy my partner, my penis is too small). Females will also express this in terms of their body (I’m too tall, big, flat-chested) and concerns about sexual desirability and performance, but Western culture allows for a much wider range of behaviors that, while not strictly feminine, will not damage a feminine self-image.

A negative gender identity sense can lead to low self-esteem, avoidance of partner-related sex and intimacy, and social and emotional isolation. Gentle inquiry about a client’s gender identity that focuses on body image, gender preferences, and gender role will reveal areas of gender conflict.

The orientation component refers to the linkage of sexual feelings with a preference for one gender over another for sexual and romantic purposes. Knowledge of one’s orientation does not require sexual behavior—that is, one often knows that one is homosexually or heterosexually inclined long before one is ready to participate in partner-related sexual activity. However, the terms heterosexual and homosexual are often used to indicate either subjective interest or actual behavior or both. This is not a problem if both the subjective and objective aspects of orientation are congruent, but it can be confusing and misleading if the two are not. For example, if a married man has sexual fantasies exclusively about males even when he is making love to his wife, is he a heterosexual because he is engaged in sex with a female or is he homosexual because the objects of his sexual attractions are exclusively male? The following use of language may help differentiate the objective and subjective components of orientation:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Subjective</th>
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<tr>
<td>Contact with opposite-sex partner (heterosexual)</td>
<td>Fantasy about opposite sex (heteroerotic)</td>
</tr>
<tr>
<td>Contact with same-sex partner (homosexual)</td>
<td>Fantasy about same sex (homoerotic)</td>
</tr>
<tr>
<td>Contact with partners of both sexes (bisexual)</td>
<td>Fantasy about both sexes (bierotic)</td>
</tr>
<tr>
<td>Contact with neither sex (asexual)</td>
<td>Fantasy about neither sex (anerotic)</td>
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The Sexual Narrative

Therapists need to be clear that the subjective and objective aspects of orientation are distinct from each other and cannot be assumed from one another. When talking about orientation, inquire about fantasies and behaviors with both opposite- and same-sex partners. It is best not to assume a heterosexual orientation by asking questions that steer in that direction such as asking a male, *Who was your first girlfriend?* Instead, one should say, *Tell me about your first sexual experience.* After a client has described his sexual experiences or feelings with one gender, it is appropriate and wise to inquire about the other. While there is a slight risk that your client may be offended, that reaction can be managed by a matter-of-fact reply, *Well, many people have feelings and experiences with both sexes, and it's always better to ask.* The goal is to give clients permission to speak about sexual feelings or behaviors that they may fear revealing.

The *intention component* refers to the idea that sexual behaviors are motivated by a certain intention. The decision to behave sexually, whether made after one night or twenty years, almost always conveys something about how the person feels about the other person, as well as the role sexual behavior will play in conveying that feeling. The meaning of the behavior can range from “I’m horny and you are available. Let’s have fun” to “I like you and want to be closer” or even “I love you” in one direction to “I will exert dominance and control over you” or “I’m angry and want to hurt you” in another.

When the intention is based on a wish to have fun and/or show affection and a genuine desire to be with the other person, hopefully the meaning of the sexual exchange will lend itself to emotional satisfaction and a sense of connection. When the intention is based on a need to avoid intimacy, to prove something, or to dominate, control, or hurt the other person, the meaning of the sexual exchange may be experienced by the partner as empty, uncomfortable, or frightening, even if there is no actual coercion. You can gain access to your client’s intentions to be sexual with a partner by inquiring directly and by asking about the sexual fantasies that the client relies on during self-stimulation or with the partner. However, fantasies and the intentions imbedded in them are intensely personal, private aspects of a sexual history and must be approached in the most gentle, non-judgmental manner. Here are some questions about intention:

*What determines when you feel ready to be sexual with a partner?*
*What are you feeling when you wish to be sexual with your partner?*
*Why do you not feel like being sexual with your partner?*

Here are some questions about sexual fantasies:

*What do you usually fantasize about when you masturbate?*
*Do you ever find yourself fantasizing about something else while engaged in sex?*
*What imagery in pornography are you most drawn to?*
*Do you ever fantasize about sexual behaviors you would be reluctant to do?*

The more conventional the imagery, the easier it will be for the client to reveal it. If, however, the fantasy contains elements of aggression or fetishistic preferences, even the gentlest approach will not necessarily elicit an honest, accurate response. With time and patience, trust may build up enough for the client to be willing to reveal more. Periodically revisiting questions about the more personal and private aspects of sexual fantasy and behavior helps this process.

**Disorders of Intention**

When the sexual interest is directed toward some activity or person other than genital stimulation or preparatory fondling with physically mature, consenting human partners with an intensity and persistence beyond normal sexual interest, we use the term *paraphilia.* When the paraphilia is causing
distress or impairment to the individual or entails personal harm or risk of harm to others, it meets the criteria for a paraphilic disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. Defining persistent, intense, and normal is of course subjective and open for controversy. The manual lists the eight most common paraphilic disorders as voyeuristic disorder (spying on others in private activities), exhibitionistic disorder (exposing the genitals), frotteristic disorder (engaging in unwanted touching/rubbing), sexual masochism disorder (undergoing humiliation, bondage, or suffering), sexual sadism (inflicting humiliation, bondage, or suffering), pedophilic disorder (being attracted to prepubescent children), fetishistic disorder (specific focus on nonliving objects or non-genital body parts), and tranvestitic disorder (cross-dressing for erotic purposes).

Many of the paraphilic themes are experienced as part of more conventional sexual behavior. For example, an interest in and arousal in response to silky lingerie is hardly noteworthy unless it is so narrow in focus and intense that there is no real interest in the person wearing the lingerie. Who hasn’t experienced some voyeuristic interest in other people’s sexual behavior? If no one did, there would be no audience for romantic/erotic movies. That interest, however, is quite different from the compulsive, intense need of a peeping Tom to spy on others. Likewise, a mutual enjoyment of sexual role-plays of dominance and submission or the use of props such as blindfolds, wrist restraints, and so on is quite different from the coercive infliction of pain or humiliation.

Many therapists recoil in disgust and/or anxiety when they are initially confronted with paraphilias, especially when the behaviors meet criteria for a paraphilic disorder. They are quick to say, “I don’t treat that!” and refer to a specialist. While seeking out an expert in paraphilic disorders may be appropriate, especially if the behavior involves legal consequences, the ideal first step is to discuss the topic in a helpful manner. The development of this skill increases the likelihood that the client will accept the referral to an expert. To attain this, we must suspend the anxiety and negative judgments that we have acquired over the years about these matters and put forth our intellectual curiosity. It helps to realize that many clients with these disorders are deeply troubled and ashamed of their behavior. Your willingness to discuss the subject will provide them with an opportunity to come out from hiding and get help.

Patients may voluntarily disclose a paraphilia, but typically such preferences and activities are not revealed unless the person is “outed” by the law, a spouse, or an employer. When the unconventional sexual focus is revealed by a spouse in a conjoint session, the therapist should offer additional individual time with the patient to explore the issue further.

Amy: Ken and I haven’t made love in a long time. Yesterday I went into his study to look for a bill, and I noticed the computer was on. Ken was upstairs with one of the kids. I looked to see what was on the screen, and I was horrified to see pornography. It was a woman tied up and a man standing over her. I looked further and there were dozens of photos of bondage. Our kids could have seen this!

Ken: I forgot to turn it off when I left. It’s no big deal. I just look occasionally.

Amy: It is a big deal! You’ve been spending hours on the computer lately. Last weekend you stayed up until 3 a.m. both nights and you overslept Monday morning and missed a meeting. You used to ask me if I would let you tie me up during sex, but it turned me off. You said it was no big deal then, but sex has been practically non-existent between us for a long time!

This interchange is typical in that Amy reveals Ken’s secret, which he then minimizes or denies. The therapist’s initial understanding of the problem comes from Amy’s observations, but the establishment of a therapeutic alliance with Ken will occur only if Ken is given the opportunity to explore his sexuality with the therapist privately. If this interferes with the therapist’s role as a marriage counselor, a referral to an individual therapist for Ken is in order.
Because all paraphilic disorders have a compulsive quality (recurrent, intense, sexually arousing fantasies, urges, or behaviors), by definition they qualify as a sexual addiction. However, not all sexual addictions are paraphilic. For example, although the man who is compelled to engage in online sexual chatting or multiple affairs may qualify or self-identify as a sexual addict, there is nothing about the content of his behavior that meets criteria for the unusual, hostile, dehumanizing, or coercive nature of a paraphilic disorder.

**Sexual Functioning**

Sexual functioning refers to the actual process of engaging in sexual behavior and the myriad of little and big things that can go wrong. Clients often present with complaints about some aspect of their or their partner’s ability to function sexually. We break sexual functioning into three separate but interwoven phenomena: desire, arousal, and orgasm. Desire and arousal can precede or follow each other. An increase in one usually augments the other—that is, the better it feels, the more I want it, and the more I want it, the better it feels.

Sexual desire is, in turn, composed of the interaction of three elements (Levine 1998):

- A biologic urge referred to as drive. This is experienced as a bodily tension or “horniness” that may or may not be associated with an anticipated partner.
- A cognitive wish to engage in sexual behavior. Cognitive wishes are reflections of internalized cultural values about the role of sexual behavior in our lives.
- A psychological willingness to allow one’s body to respond to a sexual experience. Psychological willingness requires a degree of comfort with one’s own body and sexual identity as well as trust in and comfort with one’s partner.

While men’s desire, especially for young men, is often most determined by drive, women’s desire is often more defined by their psychological receptivity to an external sexual overture. Desire is complex, and ascertaining the nature of a patient’s desire will take more than the question, *How often do you desire sex?* Asking several of the following questions will be necessary.

*How often does your body need a sexual release?*
*How often do you masturbate?*
*Do you think about making love with your partner when he/she is not around?*
*How do you feel when your partner initiates sexual contact?*
*How often would you have sex if you could?*

Sexual arousal is a bodily experience, a subjective horniness or excitement that may be described as a warm, tingling, and increasingly pleasurable sensation, often, but not always, accompanied by increased blood flow to the pelvic area, resulting in an erection and vulvar swelling and lubrication. Arousal, or the lack thereof, is usually easier to describe than desire. Questions might include:

*How does it feel when your partner stimulates you?*
*Do you experience a pleasurable sensation when your breasts and genitals are touched?*
*Do you get an erection when exposed to sexual stimulation?*
*Are you aware of lubricating when your partner stimulates you?*
*Does sensation build up as the stimulation continues?*

Orgasm, the rhythmic contractions and accompanying pleasurable sensations, is the culmination of sexual excitement. The word *climax* is often used instead, as is the more colloquial expression *to come*. It is rare to encounter a male who has never experienced an orgasm through self or partner
stimulation. Male complaints about orgasm usually center on their inability to control its timing. Either they climax too quickly to suit their or their partner’s needs, or they find it very difficult to accomplish. The former is a common complaint of young and relatively inexperienced males; the latter of males who may be taking medications that interfere with or delay orgasm. It is not rare, however, to encounter females who have never experienced orgasm. This is most likely due to a number of factors including females’ greater susceptibility to cultural taboos about self-exploration, less biologic urge, and greater internal conflict about expressing sexual longings. Females may or may not complain about their inability to build up enough arousal to reach orgasm. While many are distressed by this, others do not depend on achieving orgasm to feel sexually satisfied.

Amy: It feels good, but it doesn’t build up to an orgasm. . . . Ken keeps touching me because he wants me to climax. After a while I lose the feelings, and it actually gets unpleasant. I get frustrated and push his hand away. I would be fine without climaxing, but it seems way too important to Ken.

Concerns about absent, low, or high sexual desire; difficulties in achieving or maintaining arousal; and problems with the timing or achievement of orgasm are highly prevalent in the general population and are referred to as sexual dysfunctions. When they have always been present, we describe them as lifelong or primary; when they reflect a distinct change in sexual functioning, we describe them as acquired or secondary. When they occur in all situations (that is, with all partners and during self-stimulation), we call them global, and when they occur only in some situations (that is, with one partner but not another, or with a partner but not during self-stimulation), we describe them as situational.

Rosemary is a twenty-five-year-old single woman who has never been orgasmic with a partner. She is able to bring herself to orgasm through masturbation but shuts down when any partner attempts to stimulate her to orgasm. (lifelong situational anorgasmia)

John is a sixty-year-old married man who has not been able to achieve a satisfactory erection for five years. Morning erections are non-existent, erections via masturbation are floppy, and he is no longer able to achieve penetration during lovemaking. (acquired global erectile dysfunction)

Lifelong dysfunctions typically reflect some impediment in the development of a comfortable sexual self. Rosemary’s ability to stimulate herself to orgasm suggests a mastery of her own sexual sensations, but her inability to be orgasmic with a partner may represent her inhibition about letting go, a fear of being perceived as too sexual if she demonstrates what kind of stimulation she needs, or an unrecognized link between sexual arousal and being bad. Because this has taken place with all sexual partners, it will not be fruitful to spend too much time exploring the dynamics with a particular partner; it makes more sense to explore childhood and familial sexual experiences, attitudes, messages, and beliefs that may have negatively impacted her comfort level with any partner.

Acquired sexual dysfunctions suggest that the person successfully navigated the development of a comfortable sexual self before something undermined his or her success. The destructive force may be a physical change such as illness, injury, medication, radiation, or surgery or an emotional change as a result of personal, partner, or familial discord. Some acquired sexual dysfunctions can be traced to both physical and emotional changes. The emotions that most commonly interfere with sexual functioning are anxiety, guilt, fear, anger, and sadness. John’s erectile failure may reflect a change in his physical health, marital deterioration, depression, guilt over an affair, or other stressors. Therefore, the right approach would be to focus on what was going on five years ago, not on John’s early childhood and sexual development.
John reports that five years ago he was passed over for a promotion he was certain he was going to receive. At the same time, his physician encouraged him to lose some weight after a glucose tolerance test suggested borderline diabetes. He lost some of the weight, but it has been a constant struggle.

John’s failure to be promoted may have created depression, anxiety about his vocational future, anger at his employer, or guilt over his perceived less-than-stellar work performance. These feelings could negatively impact his ability to relax and receive sexual stimulation. The borderline diabetes presents two concerns; not only is diabetes highly correlated with erectile difficulties, but it may well have been a blow to his view of himself as healthy and vital. His ongoing battle to lose weight may be accompanied by feelings of deprivation, the sense of inadequate discipline, and a negative body image. All of these may have contributed to John’s acquired erectile problems. When clients such as John report multiple sexual difficulties, we must obtain an accurate picture of each one. Ultimately, we want to understand how they relate to each other.

Conclusion

The careful delineation of identity and functioning as they evolve and influence each other over a lifetime yields a sexual story; each one is rich and unique. You may feel at times that the book has been opened for you at chapter 10. Just as you settle into the story line, the pages flip to the beginning . . . or the ending . . . or just about anywhere. Relax. With your interest and guidance, the sexual narrative will come together. Your knowledge of the complexity of sexual impression and your willingness to help patients tell their sexual story will be forever appreciated.

References


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Sexual Indices

