Handbook of Clinical Sexuality for Mental Health Professionals

Third Edition

Edited by
Stephen B. Levine

Candace B. Risen and Stanley E. Althof
Associate Editors

ROUTLEDGE

HANDBOOK OF CLINICAL SEXUALITY FOR MENTAL HEALTH PROFESSIONALS

Third Edition

The *Handbook of Clinical Sexuality for Mental Health Professionals, Third Edition*, builds on the authors' authoritative first-person voice on sexual matters of the previous editions. The work reflects the field's growing sophistication about sexual disorders and their therapies. The scope has been expanded to keep pace with new literature and research in the field, and eight additional chapters have been added. New topics include the politics of diagnosis, persistent genital arousal, asexuality, post-orgasmic illness, scientific findings concerning the origin of orientation, and partnering with the pharmaceutical industry. Easily accessible, the *Handbook* is divided into sections that touch on fundamental knowledge and skills, treatment, men's major sexual concerns, women's major sexual concerns, problems common to both genders, the diversity of sexual lives, and future and trending topics. Written in a personal, supervisory style, the book will help new therapists anticipate clinical contingencies and help experienced therapists refine their thinking and teaching.

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With gratitude to our patients and colleagues—past, present, and future

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PREFACE TO THE FIRST EDITION

Each mental health professional's life offers a personal opportunity to diminish the sense of bafflement about how health, suffering, and recovery processes work. Over decades of work in a mental health field, many of us develop the sense that we better understand some aspects of psychology and psychopathology. Those who devote themselves to one subject in a scholarly research fashion seem to have a slightly greater potential to remove some of the mystery for themselves and others in a particular subject area. But when it comes to the rest of our vast areas of responsibility, we are far from expert; we remain only relatively informed.

The authors of this Handbook devoted their careers to unraveling human sexuality's knots. Their inclusion in this book is a testimony to their previous successes in helping others to understand sexual suffering and its treatment. Since one of the responsibilities of scholars is to pass on their knowledge to the next generation, in the largest sense, passing the torch is the overarching purpose of this book.

We humans are emotionally, cognitively, behaviorally, and sexually changeable creatures. We react, adapt, and evolve. When our personal evolution occurs along expected lines, others label us as mature or normal. When it does not, our unique developmental pathways are described as evidence of our immaturity or psychopathology. Sometimes we are more colloquially described as "having problems."

Sexual life, being an integral part of nonsexual life processes, is dynamic and evolutionary. I think about it as having three broad categories of potential difficulties: disorders, problems, and worries. The disorders are those difficulties that are officially recognized by the DSM-IV-TR—e.g., Hypoactive Sexual Desire Disorder, Gender Identity Disorder, and Sexual Pain Disorder. Many common forms of suffering that afflict groups of people, however, are not found in our official nosology and attract little research. I call these *problems*. Here are just two examples: continuing uncertainty about one's orientation and recurrent paralyzing resentment over having to accommodate a partner's sexual needs. Problems are frequent sources of suffering in large definable groups of the population—e.g. bisexual youth and not so happily married menopausal women. Then there are sexual worries. Sexual worries detract from the pleasure of living. They abound among people of all ages. Here are five examples: Will I be adequate during my first intercourse? Will my new partner like my not-so-perfect body? Does my diminishing interest in sex mean that I no longer love my partner? How long will I be able to maintain potency with my young wife? Will I be able to sustain love for my partner? Worries are the concerns that are inherent in the experience of being human.

Sexual disorders, sexual problems, and sexual worries insinuate themselves into the therapy sessions even when therapists do not directly inquire about the patient's sexuality. This is simply because sexuality is integral to personal psychology and because the prevalence of difficulties about sexual identity and sexual function is so high.

Unlike the frequency of sexual problems and worries, the prevalence of sexual disorders has been carefully studied. Their prevalence is so high, however, that most professionals are shocked when confronted with the evidence. The 1994 National Health and Social Life Survey, which obtained the most representative sample of 18- to 59-year-old Americans ever interviewed, confirmed the findings of many less methodologically sophisticated works. In this study, younger women and older men bore the highest prevalence. Overall, however, 35% of the entire sample acknowledged being sexually problematic in the previous 12 months. There are compelling reasons to think that the prevalence is even higher among those who seek help for mental or physical conditions. Although people in some countries have unique sexual difficulties, numerous studies have demonstrated that the population in the United States is not uniquely sexually problematic.

To make this point about prevalence and, therefore, the relevance of this book even stronger, I'd like you to consider with me a retrospective study from Brazil. The authors compared the frequencies of sexual dysfunction among untreated patients with social phobia to those with panic disorder. The mean age of both groups was mid-30s. The major discovery was that Sexual Aversion, a severe DSM-IV diagnosis previously thought to be relatively rare, was extremely common in men (36%) and women (50%) with panic disorder but absent in those with social phobia (0%). The sexual lives of those with social phobia were limited in other ways.

I find this information ironic in several ways. This finding probably would not have shocked therapists who were trained a generation or two ago because it was then widely assumed that an important relationship existed between problematic sexual development and anxiety symptoms. Modern therapists, however, tend to be disinterested in sexuality and so are likely not to respond to these patients' sexual problems. Adding insult to injury, the modern treatment of anxiety disorders routinely employs medications with a high likelihood of dampening sexual drive, arousability, and orgasmic expression.

For most of the 20th century, sexuality was seen as a vital component of personality development, mental health, and mental distress. During the last 25 years the extent of sexual problems has been even better defined, and their negative consequences have been better appreciated. Mental health professionals' interest in these matters has been thwarted by new biological paradigms for understanding the causes and treatments of mental conditions, the emphasis on short-term psychotherapy, the constriction of insurance support for non-pharmacological interventions, the political conservatism of government funding sources, and policy to consider sexual problems as inconsequential.

As a result of these five forces, the average well-trained mental health professional has had limited educational exposure to clinical sexuality. They are neither comfortable dealing with sexual problems, skillful in asking the relevant questions, nor able to efficiently provide a relevant focused treatment. It does not matter much if the professional's training has been in psychiatric residencies, psychology internships, counseling internships, marriage and family therapy training programs, or social work agency placements. Knowledgeable teachers are in short supply. The same paucity of supervised experiences focusing on sexual disorders, problems, and worries applies to all groups.

In my community, Cleveland, Ohio, there happens to be a relatively large number of highly qualified sexuality specialists. Most moderate to large urban communities, however, have no specialists who deal with the entire spectrum of male and female dysfunctions, sexual compulsivities, paraphilias, gender identity disorders, and marital relationship problems. Although many communities have therapists who deal with one part of this spectrum, the entire range of problems exists in every community.

A remarkable bit of progress occurred in the treatment of erectile dysfunction in 1998. Since then, primary care physicians, cardiologists, and urologists have been effectively prescribing a phosphodiesterase-5 inhibitor for millions of men. But, despite the evidence of the drug's safety and efficacy, at least half of the men do not refill their prescriptions. There is good reason to believe that this drop-out rate is due to psychological/interpersonal factors rather than a lack of the drug's ability to generate erections. This fact alone has created another reason for mental health professionals to become interested in clinical sexuality. Most physicians who prescribe the sildenafil are not equipped to deal with the psychological issues that are embedded in the apparent failures. The non-responders to initial treatment need access to us. But mental health professionals need to be better educated in sexual subjects. So there are three reasons for developing this Handbook: (1) to pass the torch of knowledge to another generation; (2) to better equip mental health professionals to respond to sexual disorders, problems, and worries as they appear in their current practice settings; and (3) to help patients to take advantage of the emerging advances in the medication treatment by helping them to master their psychological obstacles to sexual expression.

Stephen B. Levine, MD

You Can Do This!

We use this exhortative heading for a reason. "You Can Do This!" is our way of saying that the *Handbook* provides coaching, encouragement, and optimism that aim to inspire others to turn their interests to clinical sexuality. Mental health professionals can learn to competently address their patients' sexual worries, problems, and disorders.

How We Created the Handbook

Once the editors decided to say yes to the publisher's invitation to develop a Handbook, we set our sights on creating a unique book. We imagined it as a trustworthy, informative, informal, supportive, and highly valued volume that would encourage and enable mental health professionals to work effectively with patients with sexual concerns. To attain this lofty goal, we knew that the book would have to be a departure from the usual excellent book on clinical sexuality.

We created the *Handbook* through seven steps.

The first step we took was to define the intended audience. We quickly realized, having valued teaching so highly during our careers, that it was the mental health professional with little formal clinical training in sexuality. While we thought some readers might be trainees in various educational programs, we envisioned that most of the readers would be fully trained, competent professionals. We thought that experienced clinicians would have already had many clients who alluded to their sexual concerns and might have already perceived how their sexual problems may have contributed to their presenting depression, substance abuse, or anxiety states. We wanted to help the general mental health professional think about sex in a way that diminished their personal discomfort, increased their clinical confidence, piqued their interest in understanding sexual life better, and increased their effectiveness. We wanted professionals to stop avoiding their clients' sexual problems. We also clarified that we were not trying to create a book that would update sexual experts. We were writing for those who knew that they needed to learn both basic background material and basic practical interventions.

The second step was to realize that since we were writing an educational text, our authors were going to have to be excellent teachers. Excellence as a researcher or a clinician would not be a compelling reason to put a person on the author list.

The third step was to define our strategy for making the *Handbook* unique. We decided it would be through our instructions to the authors about how to compose their chapters. We gave them 10 instructions:

1. Use the first-person voice—use *I* as the subject of some sentences.
2. Imagine when writing that you are talking privately to the reader in a supervisory session.
3. Reveal something personal about your relationship to your subject—how you became interested in the subject, how it changed your life, how your understanding of the subject evolved over the years.
4. Imagine that you are guiding your readers through their first cases with the disorder you are discussing. Do not share everything that you know about the subject! Try not to exceed your imagined readers' interest in the topic.
5. Keep your tone encouraging about not abandoning the therapeutic inquiry even if they are uncertain what to do next.
6. Discuss your personal reactions to patient care as a model for the appearance of countertransference. Illustrate how a therapist might use his or her private responses to better understand the patient.
7. Either tell numerous short patient stories or provide one case in depth. Do not write a conceptual paper without clinical illustrations.
8. Annotate at least half of your bibliography. Your reference list is not there primarily to demonstrate your scholarship; it is there to guide the interested supervisee.
9. Be realistic about the reality of life processes and the limitations of professional interventions. While we want the readers to be encouraged to learn more, we do not want to mislead them into thinking that experts in the field can completely solve people's sexual difficulties.
10. Be cognizant when writing that you are trying to prepare your reader to skillfully and comfortably approach the patient, to gain confidence in his or her capacity to help, and to rediscover the inherent fascination of sexual life.

The fourth step was the definition of relevant sexual topics. We did not want to deal with uncommon problems—e.g., there was not going to be a chapter devoted to females who want to live as men, female impersonators, or serial sex murderers. This book was to help with common problems, ordinary ones, the ones that are often lurking behind other psychiatric complaints. This task was relatively easy.

The fifth task was slightly more difficult: to decide what basic information was necessary as background preparation for dealing with the common sexual problems. After this we set about matching authors to the intended topics.

The sixth step was really fun. We had been told that it was often difficult to get people to write for edited texts and that it might take 6 months or more to complete the author list. The vast majority of our esteemed colleagues who were asked said yes immediately and thought that the idea for the book was terrific. A few needed several weeks to agree. Four pled exhaustion and wished us luck.

The final step—the seventh—involved the review of the manuscripts. It was during this 5-month process that we, the editors, more fully realized what modern clinical sexology is. While reading these 25 chapters, we realized that as a group we vary considerably in our emphasis on evidence-based, clinically based, or theory-based ideas. All of us authors, however, speak of having been enriched as we struggled to better understand and assist people with various sexual difficulties. All of us have seen considerable progress in our professional lifetimes with our specialty issues. Some of the chapters are stories of triumphs (treatment of rapid ejaculation, erectile dysfunction, female orgasmic difficulties), others of disorders still awaiting the significant breakthrough (female genital pain, sexual compulsivity, sexual side effects of SSRIs). A number of authors address essential human processes that are part

of life (boundaries and their violations, menopausal changes, love), while others are coaching their readers about how to think of their roles and attitudes (sexual history taking, diagnosis of women's dysfunction, transgenderism). Some chapters focus on grave difficulties (aversion, sexual avoidance, sexual victimizations), and yet others on hidden private struggles that tend to remain unseen by those around them (homoeroticism in heterosexuals, paraphilias, unhappy marriages). All in all, we find the field of clinical sexuality fascinating and hope that our readers will rediscover what they used to know: sex is very interesting!

We designed this Handbook with the idea that the vast majority of readers will look at only the few chapters that are relevant to their current clinical needs at one sitting. Those who are taking a course in clinical sexuality and reading the entire Handbook, however, will quickly discover some redundancy. In editing we objected to any redundancy within a chapter, we were reassured by it in the book as a whole. This was because it meant to us that teachers of various backgrounds focusing on different subjects shared certain convictions about the importance of careful assessment, how to conduct therapy, the limitations of medications, the possibility of being helpful despite not being expert, etc.

We are deeply indebted to the authors of the *Handbook* for their years of devotion to their subject that enabled them to write such stellar educational pieces. As editors, it was a privilege to have been immersed in their thinking. We hope that our readers feel the same way.

Stephen B. Levine, MD
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PREFACE TO THE SECOND EDITION

The field of clinical sexuality evolves in response to changing general cultural trends, scientific advances, shifting professional ideologies, and the personal maturation of its practitioners. In less than a decade much seems to have changed in how we think about and offer care for sexual problems. These usually slight, occasionally dramatic shifts are the main reason for bringing out a second edition of this handbook.

The purposes of this edition are both obvious and subtle. Writers were asked to imagine that they were directly addressing clinicians who are inexperienced in dealing with people with sexual problems. Their task was to try to replace their readers' natural anxiety with a quiet, confident eagerness to begin the work. Each of these 26 presentations has been designed to provide therapists new to these problems with what they need to know in order to be credible with their patients. This is the *Handbook*'s primary goal.

A more subtle purpose focuses on experienced therapists and teachers. The editors presume that these readers have sufficient immersion in clinical sexuality to anticipate that our distinguished assembly of authors would display no uniformity of ideology, agreement about etiology, or consensus about how to think about therapy. When they attentively plunge into a chapter, they are likely to differ with something being conveyed and to emerge with a novel concept that will refine their thinking or their teaching. Experienced clinicians already know that they learn from exposure to the richness of thought of their gifted colleagues. We hope that these readers will appreciate that the *Handbook* reflects the state of the art of clinical sexuality in 2010.

Another vital, although understated goal of the *Handbook* is to set a tone of respect for the unique challenges that every clinician faces. With almost each patient that they see, inexperienced and veteran therapists alike confront a separate new reality that is complex beyond any author's capacity to capture. While we clinicians aspire to base some of our decisions on well-established scientific evidence, it is apparent that most decisions require us to integrate a set of unique factors that no single study has yet addressed. This integration creates the challenge, the joy, and sometimes the disappointment of clinical work.

Authors discuss the scientific work that justifies some of their decisions. They recognize that there are limitations inherent in these studies as well as in their preferred theories and ideologies. As readers move from chapter to chapter they will notice a differing emphasis on clinical processes and on scientific findings. This is also reflected in the lengths and annotations of the reference sections. While all authors are trying to integrate their clinical approaches with seminal work in the literature, they combine science, theory, and clinical experience in individual ways.

After using the *Handbook* a number of times, we hope our readers will feel that numerous authors have facilitated their understanding that sexuality is an integral part of the ordinary processes of life and that sexual concerns spring directly from these same processes. If our readers are able to approach patient care with a heightened awareness of patients' hopes for their therapy, of the limitations of modern interventions, and of their professional obligations, we will deem ourselves to have been successful.

Welcome to the second edition.

Stephen B. Levine, MD
Candace B. Risen, LISW-S
Stanley E. Althof, PhD

PREFACE TO THE THIRD EDITION

This book has a distinct editorial strategy. It is not a typical clinical science book because these are constructed in the passive voice, employ no first-person pronouns, and by design obliterate the presence of the writers. Such texts focus on facts gleaned from studies. We have gone out of our way to enable our readers to realize that our authors, whom we imagine as supervisors of the readers, are real people with definable personalities, capacities, allegiances, belief systems, and life experiences. This departure from the time-honored writing style was undertaken because we understand that the treatment of sexual disorders does not depend only on established facts. In the last analysis treatment is an amalgam of previously established facts and personal art. Clinical sexuality is a niche psychotherapy field, even when a medication is prescribed to diminish a problem. Every form of psychotherapy relies on person-to-person interaction, mutual assessment, and the timely artful transmission of ideas that address the patient's private psychological or physical concerns. We did not want the voice of any author to be hidden behind transient facts or theories. We encouraged the authors to share what they thought was important for their supervisees to understand as they encountered specific sexual difficulties. It is up to the readers to judge our editorial strategy.

Certain themes recur in many of the *Handbook*'s chapters. Although authors enunciate these themes in different ways, a collective experience is being reflected in them. Here are some of the themes that we have discerned: Sexual problems have multiple determinants. Therapists rarely have a simple problem to treat; the typical case involves a complex person or an even more complex entity—the couple. Problems are not typically completely resolved by therapy. Optimism about improvement and honesty in our efforts are necessary. There are few data sets that demonstrate the effectiveness of clinical interventions. Therapists grow professionally by maintaining their interest in a particular problem. What such themes mean, we surmise, is that there are different ways of knowing. Behavioral science, clinical science, pharmacological science, clinical experience, intuition, political ideology, and personal experience interact in unknowable ways to generate our concepts of what is therapeutic. This is the fascinating, humbling, and sometimes confusing state of our art in 2015.

This third edition of the *Handbook* documents the maturation of its returning authors. The new authors provide readers with topics that fill in some of the gaps in the second edition. Many authors comment on powerful new cultural changes that have affected or will affect sexual patterns and their treatment. The overarching goal of this edition is to provide valuable guidance for therapists to approach their patients with interest, knowledge, and confidence. Some of our readers will be new to the field, while more seasoned therapists may be new to a particular problem.

It is no easy task to write a chapter, even for those who have written many. Professionals are busy individuals with multiple life demands. Writing does not come easily to many otherwise accomplished people. The reward for carving out many weeks to prepare and refine a chapter is neither money, fame, nor academic promotion. Rather, it is the knowledge that one's efforts will be helpful to readers and that the readers will, in turn, benefit patients. Thus, although the names of the authors may soon be forgotten, the writers' reward is to be able to help individuals they will never meet. It is difficult to express our gratitude in words to the 37 professionals who contributed to this volume. We honor the professional altruism that generated their fine contributions.

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May 2015

SECTION ONE

Fundamental Knowledge and Skills

Introduction

Traditionally, a handbook is not intended to be read from cover to cover by most of its readers. It is a book to be kept at hand for times when clinicians encounter a problem they would like to better understand. As all clinicians begin with inexperience, the chapters provide the eager reader the benefit of seasoned clinician-authors' views on the problem and reasonable approaches to its treatment. This first section of the handbook does not address any particular problem. It discusses four vital aspects of professionalism. The quality of the clinician's behavior distinguishes the professional helper from a well-meaning intelligent acquaintance.

Section One provides sequential essays to enable the young professional to understand the big picture, to provide comforting conversations that illuminate the patient's unique life complexity, to maintain the integrity of doctor–patient relationship so that patients' chances for improvement are maximized, and to skillfully use language to approximate the ineffable aspects of the sexual experience. Unlike the rest of the handbook, we editors recommend that this section be read in its entirety as preparation for relying on the rest of the book.

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1
GRASPING THE INTUITIVE
Why Sex Is Important

Stephen B. Levine, MD

Introduction

I am fortunate to have had four decades to be professionally preoccupied with sexual problems. This has afforded me an opportunity to study their sources and to consider how clinicians are helpful to individuals, couples, and families. Initially, I viewed these interests through the lens of medicine, conceptualizing sexual problems as diseases. Today, I am far less likely to imply that sexual variations, functional limitations, and relational disappointments are symptoms of diseases. Even when they have strong physiological bases, I am hesitant to glibly refer to them with the same terms I might use for schizophrenia, bipolar disorder, asthma, or psoriasis. Beyond pathophysiological factors, sexual suffering is also created by education, attitudes, individual experience, relationship quality, and social circumstances. I still hold fast, however, to medicine's idea that the careful study of dysfunction can illustrate the processes of mental and physical health. This chapter focuses on sexuality's potential to advance the quality of life. Awareness of this form of health is largely intuitive rather than scientific. To evoke and explain the intuitive, I answer 11 questions that it has taken me years to pose. But before I begin, I need to establish a few academic-sounding concepts.

Our current preoccupation with sexuality and its problems is not new. The classification and theories of the causes of sexual problems and their means of treatment date to the earliest of medical writings.[1] Today, the sexual patterns that attract the most clinical attention involve two broad categories:

Sexual Identity: transpositions of gender identity, variations in orientation, and paraphilic patterns of arousal within and outside of a sexual addiction pattern

Sexual Dysfunction: lack of sexual desire, incapacities to maintain sexual arousal, inabilities to attain orgasm, orgasm without pleasure, premature ejaculation, painful intercourse, and unwanted sexual arousal.

Modern psychologists, psychiatrists, relationship therapists, sex therapists, counselors, urologists, gynecologists, infectious disease specialists, and physical therapists each stake out their territories within this broad array. Our individual professional turfs are relatively narrow, no matter how esteemed by others we may be. Each of our fields has a somewhat unique take on etiology. All of us have a tendency to overlook a vital basic principle.

All sexual behavior—solitary or partnered, normal or dysfunctional, morally acceptable or socially disapproved of—is constructed from four general sources: biology, psychology, interpersonal relationships, and culture.

I refer to this as the First Principle of Clinical Sexuality.[2] As sexual health care professionals we are forced by our education, knowledge, and skills to oversimplify this ordinary complexity.[3] The sexual lives of our patients are rarely as simple as professionals conceive them to be, and while the First Principle is an antidote for professional arrogance, it does not help us understand why sex is important, which is the ultimate goal of this chapter.

Verbalizing the Intuitive

How Are Adults Nurtured in Sexual Relationships?

Adult sexual relationships are well known to have the potential to stabilize and enrich individuals and to make them happy with their interpersonal status. *Psychological intimacy* and *partner sexual behavior* are the two behavioral systems that nurture adults. Partnered sexual behavior can exist without psychological intimacy, just as psychological intimacy can occur without partnered sexual behavior. When they are successfully integrated, however, a positive feedback between them creates a greater degree of mutual nurturance and results in maximization of sexual functional capacities. Psychological intimacy motivates partnered sexual behavior, and sexual behaviors create a new degree of psychological intimacy. In sexual health, the two interlocking systems function as one.

How Is Psychological Intimacy Created?

I conceptualize three ways:

By Conversation. The usual way to attain psychological intimacy is through talking.[4] One person speaks; the other person listens. In order to achieve a moment of psychological intimacy, the speaker has to meet three requirements. The speaker must talk about his or her inner subjective psychological self. The speaker must be able to trust in the safety of sharing this with the listener. The speaker must possess the language skills to express his or her thoughts, feelings, perceptions, and history in words. Psychological intimacy will not occur, however, unless the listener is able to evidence the following characteristics: provide undivided, uninterrupted attention to the speaker; make noncritical comments that reflect an accurate comprehension of what is being said and felt by the speaker; and construe the opportunity to listen as the privilege of learning about the inner experiences of the speaker. By this standard, most conversations, even between established lovers, do not create psychological intimacy.

Psychological intimacy is a transformative moment of connection that occurs simultaneously in both the speaker and the listener. It is a bonding process that creates or reinforces the sense of belonging to one another. Psychological intimacy exists in two forms. The first is the two-way psychological intimacy that ideally recurs in a couple's life. Each member of the couple, of course, takes a turn being a speaker and a listener to potentially re-create moments of connection. In one-way psychological intimacy, however, a particular person is almost always the speaker, and the other person is predominantly the listener. Mental health professionals create a one-way psychological intimacy with patients, as do parents with their young children. Psychological intimacies are part of the landscape of numerous kinds of relationships, ranging from friendship to sibling bonds to lawyer–client relationships. Unlike this wide array of psychological intimacies, psychological intimacy within a sexual relationship possesses a special power to repeatedly ease the way to sexual behavior.

These bonding moments of connection have profound consequences for the speaker. The moments strengthen the bond to the listener, causing pleasing thoughts such as "I am accepted," "I feel more stable," "I am happier," and "I feel healthier." They erase loneliness, create optimism, and cause the speaker

to look forward to the next opportunity for connection. After repeated moments of psychological intimacy, the speaker generates interest in sexual behavior with the listener. Psychological intimacy is a powerful erotic stimulus. In certain contexts it is the most reliable and safest known aphrodisiac.

These moments have positive consequences for the listener as well. The listener gains a deeper understanding of the speaker and experiences pleasure in being of value to the speaker. The listener demonstrates an increased willingness to think about his or her own subjective self and comes to realize how important he or she is to the speaker. These subjective experiences reaffirm the bond to the speaker.

By Shared Intense Experiences. A second way of creating psychological intimacy does not require much conversation. An intense bond can readily be established or reestablished through shared intense emotional experiences. For example, enduring a frightening febrile illness in an infant with a partner, caring for a dying friend together, being together in combat, and being on an athletic team all produce psychological intimacy by virtue of shared intense emotional experience.

By Sexual Behavior. The third way of attaining and maintaining psychological intimacy is through sexual behaviors. These, too, are largely nonverbal shared emotional experiences. Sex creates emotion in multiple ways. The sight of the partner's naked body is a powerful experience of knowing the person, particularly early in the relationship. To this is added the perception of what the naked person feels about his or her naked body. One learns of the partner's interest in and attitude toward specific sexual behaviors. Each person witnesses the other in arousal, a pleasurable knowledge that is augmented by facilitating, listening to, and watching the partner's orgasm. These intensely private subjective experiences create the sense of knowing the partner in a way that others could not. This is a privilege. In these ways, sex creates a profound degree of connection.

The unmodified word *intimacy* is used to describe shared conversations about private experiences, nonverbal emotional experiences, and sexual pleasure. All three avenues promote the sense of loving and being loved.

What Is Learned Over Time Through Sex?

Over time, individuals discover their partner's range of sexual comfort. They witness the changing nature of this comfort. They come to discern their own and their partner's variations in desire, arousal, and orgasm. They appreciate some of their partner's motivations for sexual behaviors. Over months, years, or decades, sexual behavior may deepen the couple's bond such that each has a rich, nuanced conviction of the sensual capacities of the other and how best to relate to them.[5]

What Accounts for the Pleasures of Sex?

The pleasures are physical and psychological. Sex can create novel delicious sensations and pleasant emotions before, during, and after orgasm. A person experiences the sense of power in giving the partner pleasure. The ability to give and to receive pleasure increases interest in the other, adds to the knowledge of the other, and creates the sense of being intertwined with the other. These are the means of creating a sense of oneness. The seamless interplay of physical and psychological pleasure during sex attenuates the sense of time as the individuals transport one another into the realm of sensation.

The psychological pleasures of sex involve personal meanings. These meanings, however, are often either closely held, kept private even from the partner, or relatively inchoate. "I feel it, but I can't describe it. It just is!" "I love you!" is the occasional summary of this complexity.

Why Is Sex Important?

Sexual behavior stabilizes our sexual identity. Sex allows us to feel that we are confident as a man or woman. It helps us to refine and stabilize our identity as a heterosexual, homosexual, or bisexual

person. It clarifies the nature of our intentions as consisting of peaceable mutuality or varieties of sadomasochism or fetishism.

Sex is the vehicle for early romantic attachment at every stage in life—among the never attached, the divorced, the widowed, and those having affairs. It can facilitate the vital process of creating an entity from two individuals. Romance conveys the hidden quest for a safe, secure, comforting lasting unity. It is typically accompanied by an intense desire to bring the partners' unclothed bodies together.

In established relationships, sexual behavior reinforces the sense that one is loved and capable of loving. It strengthens the sense of oneness, enabling individuals to perceive themselves as an integral part of another. Sex has the capacities to erase the ordinary angers of everyday life, to elevate one's mood, and to increase resiliency for tomorrow. It improves our capacity to withstand extra-relationship temptation. And, of course, it is vital to our reproductive ambitions.

Sex remains a vehicle for self-discovery throughout life. It begins in adolescence when eroticism is dominated by fantasy, attraction, and masturbation and continues to reveal private aspects of the self during the many decades of partner sexual behaviors and into the wistful final years alone.

Why Is Sexual Experience Unstable?

Men tend to be a bit more constant in their sexual function than are women, but this point should not be overemphasized because *sexual experience is a dynamic, ever-evolving process* for all. This concept can be thought of as the Second Principle of Clinical Sexuality. Sexual experience changes in the short and in the long term in response to numerous biological, psychological, interpersonal, economic, and social factors. Individuals change psychologically, physically, and sexually over time as they mature, take on new responsibilities, and experience loss, personal dilemmas, and illness.

What Is a Couple's Sexual Equilibrium?

The Second Principle explains why the sexual fate of an individual entering into an exclusive relationship is not determined by his or her pre-commitment sexual capacities. What he or she experiences in the new relationship will heavily depend on the interplay between the person's and the partner's component characteristics (see Table 1.1). The interaction of these components determines how frequent sexual behavior is, what sexual acts they share, how orgasm is attained, and what level of sexual psychological satisfaction they achieve. I call this interaction the sexual equilibrium. Each couple has unique sexual equilibrium.

Some individuals come to know over their lifetime that different levels of satisfaction occur with different partners. Some choose to live their lives within two separate sexual equilibria: one with the spouse and another with a paramour. These men and women typically have a more satisfying

Table 1.1. The Interaction of the Sexual Components in Any Sexual Equilibrium

Partner A		*Partner B*
Gender identity	➔➔	Gender identity
Orientation	➔➔	Orientation
Intention	➔➔	Intention
Sexual desire	➔➔	Sexual desire
Ease of arousal	➔➔	Ease of arousal
Orgasmic pattern	➔➔	Orgasmic pattern
Pain-free penetration	➔➔	Pain-free penetration

sensuous functional sexual equilibrium with the paramour. In some instances, the spouse is aware of the other sexual partner.

What Is Sensuality?

Satisfying functional sex requires the abandonment of ordinary daily preoccupations and the substitution of a focus on bodily sensations. Sensuality is not how a person looks; rather, it is what a person is capable of doing and feeling during sex. Sensuality has two faces. The readily appreciated face is the capacity to experience the preoccupying sensations of a kiss, a lick, a touch or a breast or genital caress and of penetration. The subtler face of sensuality is the person's interest in transporting the partner to this realm where pleasure predominates.

Is a Life of Sexual Pleasure Possible?

High on the list of personal expectations of life is to have, at least for an extended period of time, a diet of emotionally satisfying sex.[6] It is as though individuals collectively know that sex can be wonderful and that it is a vehicle to feel and express love. In the final analysis, sex may be the easy way to access the much more difficult to describe subject of love.[7] Particularly in clinical medicine, where the topic of love is avoided, sex may be a surrogate topic for love—that is, we discuss sexual dysfunctions rather than impaired processes of loving that may have created the sexual problems.

A satisfying sexual life diminishes the sense that one has been cheated by fate. Wonderful sex creates a comforting, stabilizing sense of happiness. People learn from it that in being a part of someone else, they do not lose their individuality by loving. They come to realize that their individuality is essential to their blissful sensual excursions. Satisfying sensual sex prevents envy of other people's sexual experiences because people sense that "It could not get better than this."

While sexual pleasure can last a lifetime in some couples, the psychological and physical components of that pleasure intersect in differing proportions over time. Many couples over 70 have retired from partnered sex but are pleased to know that they had their share of wonderful sex when they were younger and healthier and had more sexual drive.

What Is Sexual Health?

It may seem out of place to pose this question at this juncture. I place it here so that you can readily appreciate that recurrently satisfying sensuous interactions represent a developmental achievement—the mastery of numerous forces that block the way to sexual health for others. Sexual health is not guaranteed for men or women by their biological normality, their sex-positive attitudes, or their past history of sensuality. Sexual health is a potential that is realized by individuals who intuitively understand that sex is important and want to be part of the process. I hope that you will now be able to make explicit what the sexually healthy person understands intuitively: sex has the capacity

1. To please
2. To stabilize
3. To physically satisfy
4. To emotionally satisfy
5. To improve self-understanding
6. To improve understanding of the partner
7. To heighten the experience of being loved and loving
8. To enhance life through reproduction.

What Are the Sources of Distress About Sex?

You can assume that your patients with sexual difficulties are currently lacking in the attainment of these potentials. Some have never attained them, even briefly. Many have attained and lost them. Sexual distress is a requirement for the diagnosis of any sexual dysfunction. While rating scales can be used to quantify distress, the resultant numbers explain the intensity but not the sources of the distress.[8] You need look no further than the eight items above to understand the sources. When sex does not please, stabilize, or satisfy physically or emotionally, when it fails to improve understanding of the self and the partner, when it does not enhance the experience of love or create desired reproduction, sex is distressing. It is often distressing even when the patient does not initially appear distressed.

How Do These Concepts Facilitate Therapy?

Mental health professionals have important advantages over nonpsychiatric physicians. We tend to function closer to the two principles of clinical sexuality than doctors who intervene biologically while paying only lip service to the psychological, interpersonal, and cultural contexts of a patient's life or who expect improvements to be well received and lasting. These biological-only interventions have a tendency to disappoint the patient and the doctor. Many a physician wonders why many of their prescriptions for oral treatments for erectile dysfunction are not refilled despite the drugs' reputation of providing a cure. We mental health professionals tend to be aware that there is more to erectile dysfunction than an uncooperative or unreliable penis. We know that changes in one person invariably impact on the partner. Therapeutic interventions can be immediately effective because of the rebalancing of the delicate interactions between two individuals' sexual identity components and sexual function characteristics, and they can fail because of unappreciated sensibilities emanating from the partner.[3] But I am getting ahead of myself.

Even though our contact with the patient begins with our eliciting a history of the presenting sexual problem, the initial evaluation is actually a mutual process. The clinician is evaluating the sexual complaint by searching for the correct diagnosis and beginning to ascertain the pathogenesis and factors that dictate an approach to therapy. The individual patient or the couple is assessing the clinician's warmth, interest, empathy, and understanding of their distress. Some pleasant initial evaluations are not followed by treatment. Some treatments are not continued for a reasonable duration. When this happens to you, as it invariably will, consider the possibility that you flunked the patient's evaluation. The goal of the sexual history taking from the patient's perspective is the establishment of a hope-generating trusting alliance with the clinician. There will be no therapy, despite an accurate diagnosis and a state-of-the-art treatment plan, if you fail your unspoken audition. We all have times when we fail our auditions.

To increase the odds of establishing patient trust, I recommend rejecting the idea of a complete sexual history. The specifics of the sexual history vary with the presenting problem, the specialty of the clinician, presumptions about the likely sources of the problem, and the patient's capacity to talk about the matter. Despite the inherent pressure younger clinicians feel to gather a lot of information at the first encounter, there are other tasks to achieve. This task, the creation of a therapeutic alliance, is a hopeful agreement to work together to attain an agreed-upon goal. The sexual history and the doctor's ability to formulate the pathogenesis of the problem are evolving processes. Eventually, the history should reveal the individual's sexual identity components and sexual functional capacities (Table 1.1). It should then be able to clarify the partner's capacities how the component capacities of each interact to contribute to the couple's problem. It is asking too much of any clinician to obtain a picture of all of this by the end of the first meeting.

Understanding the patient's distress and disappointment with their sexual problem, although it takes only a brief moment or two, generates moments of empathy and one-sided psychological intimacy. This is how many clinicians pass their auditions with very high marks.

This book is brimming with important information about dealing with problems. It is my hope that by considering the potentials of sex—understanding why sex is important—these chapters can be put to better use because you understand the intuitive. I am optimistic that with time you will be increasingly skillful in succinctly putting into words what your patient is thinking and feeling. This ability is a vital ingredient of clinical competence. Clinical competence, however, has another important subtle ingredient—skepticism. We all must be careful about the intuitive. Science has a long history of demonstrating that the obvious, the felt, the intuitive is not always correct.

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2

THE SEXUAL NARRATIVE

A Story Waiting to Be Told

Candace B. Risen, LISW-S

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.

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.

> Alan: I can't believe I slept with my roommate's girlfriend! Now she won't speak to me and my roommate will be back tomorrow. What can I do?
> 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 transgendered 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:

Objective	*Subjective*
Contact with opposite-sex partner (heterosexual)	Fantasy about opposite sex (heteroerotic)
Contact with same-sex partner (homosexual)	Fantasy about same sex (homoerotic)
Contact with partners of both sexes (bisexual)	Fantasy about both sexes (bierotic)
Contact with neither sex (asexual)	Fantasy about neither sex (anerotic)

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), frotteruistic 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 nongenital 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.

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3

BOUNDARY CROSSINGS IN CLINICAL PRACTICE

Candace B. Risen, LISW-S

I Am a Boundary Crosser

I became acutely aware of boundary issues in therapy early in my career because of my work in the sexual dysfunction clinic at University Hospitals of Cleveland. There, sexual feelings and behaviors were the main topic and the predominant force in the room. I could not ignore the subject. As time went on, I began to see professionals who had been sexual with their patients, clients, employees, parishioners, or others with whom they had related from a position of trust and authority. I spent countless hours attempting to understand how and why they came to do what they did. I came to appreciate sexual exploitation of a patient as a boundary violation that occurred only after a long series of other less egregious boundary crossings, sexual and nonsexual, that were never acknowledged or addressed. Some examples were seeing a patient for longer periods or after hours, not charging for sessions, engaging in excessive disclosure, exploring intimate details with no apparent relevance, commenting on the patient's attractiveness, accepting personal comments without exploration, hugging, and having contact outside the office. I eventually realized that these events were often in response to intense feelings, on either side, which were acted on without awareness, acknowledgment, or scrutiny.

These experiences forced me to confront the knowledge that, in my years of practice, I too had crossed boundaries without recognizing it as such or understanding the implications of what I was doing. I didn't necessarily think that these occurrences were all bad. In fact, I often felt that the crossing of a particular boundary was therapeutically indicated and perhaps even essential to fostering my relationship with the patient. But when I was in doubt, I rarely sought advice from a colleague or supervisor because of embarrassment, fear of sounding stupid or naïve, or reluctance to reveal my private feelings. However, I was lucky to be working in a setting that placed great emphasis on individual and group supervision. During our twice-weekly case conferences, patients' and therapists' feelings and behaviors were frequently brought up. Discussing the intricacies of managing intense erotic, romantic, or hostile feelings was encouraged, without fear of reprisal. I discovered that articulating *why* something seemed wrong was difficult, especially when it was suggested that I eliminate *wrong*, *bad*, and *inappropriate* from my vocabulary. It seemed that all of us leaned on the concept of something being "inappropriate" in our training, but I came to see that word as fostering shame without increasing understanding.

I was challenged to defend responses as therapeutic or anti-therapeutic and learned to argue both sides before drawing a conclusion. This reinforced the idea that, with a few exceptions, the way to proceed was not an absolute. My strategy for this chapter is to repeatedly illustrate this process.

What Is a Boundary?

Intense nonsexual and sexual feelings arise in all therapies, not just those focused on sexual concerns. And yet, in most settings, they are rarely directly discussed. The rules for the conduct of therapy, what I am calling boundaries, are often addressed only as a set of policies and procedures. What a therapist can and cannot do is shaped by law, the ethical standards of one's profession, agency policies and procedures, and local custom. I hope to convince you, however, that ultimately decision making within the privacy of therapy must be a reflection of our own good judgment.

A boundary is a line drawn between two spaces. It may be associated with safety; for example, a child may not cross the street alone, and the sidewalk is his boundary. It may be associated with ownership; for example, the property up to this boundary is mine, and beyond the line is yours. Or it may be associated with limit setting, a set of rules designed to foster socially acceptable behavior.

The unseen supportive structures of therapy, that is, its frame, are constructed with a set of boundaries. Two or more people come together in a therapy to achieve a negotiated goal to enhance the welfare of the patient(s). This frame has been characterized in various illuminating ways: an unbalanced power relationship (Hoffman, 1981), a trust-based relationship (Plaut, 2010), or a one-sided intimacy (Levine, 1998). We professionals hold power over our patients. "The power we have is the power they give to us; it is not necessarily power that we assume on our own. We are very likely to have influences on our clients far beyond our intentions or awareness" (Plaut, 2010, p. 24).

When we examine the main frame of therapy more closely, other structured edges become apparent. These define what is acceptable behavior in the clinical setting (Gutheil & Gabbard, 1993). These edges include expectations for where, when, and why therapy takes place; what may or may not go on while it is occurring; and how the therapeutic goals are to be accomplished. Each of these structured components protects the welfare of the patient and enables the work to proceed. There are further seemingly minor substructures of the frame: how we decorate our office, what we wear, what times of day or days of the week we see patients, whether we contact patients through emails, telephone chats, or text messages. The patients can feel our internalized boundaries by what we choose to talk about. Do we chat about sports, or do we readily focus on the client's conflicts? Do we share personal information? If so, when and for what purpose? Perhaps, without realizing it as such, the frame of our work, our unique interpretation of boundaries, reflects our professional ethics and our personal values. And, without realizing it, we also frequently cross some of these conventional boundaries.

Boundary Crossings Versus Boundary Violations

A boundary crossing occurs when the therapist or the patient says or does something that falls outside the structure of the prototypic therapeutic relationship. The therapist shares something about her personal life, or accepts a gift, or loses his temper. The patient reaches out to hug the therapist, invites the therapist to a celebration, or calls the therapist at home. Boundary crossings occur—sometimes purposefully, sometimes inadvertently, and sometimes out of a confusing loss of control of the situation.

Boundary violations are crossings that are not well thought out, gratify a patient's immediate need without consideration of long-term consequences, gratify a therapist's need at the expense of the patient, harm the patient, or risk harming future work. A boundary crossing with one patient might be a boundary violation with another, for example, hugging an elderly depressed person versus hugging a recognized survivor of sexual abuse.

The Concept of the Slippery Slope

It became apparent to me over time that most of the professionals who had committed major sexual infractions described increasingly blurred boundaries over a long period of time. Gabbard in 1989

described this as the "slippery slope," a process by which the crossing of small and seemingly harmless boundaries, without obvious negative consequences, could result in making it easier to indulge in increasingly significant and harmful boundary violations. Subsequent research supported the idea that almost all harmful boundary violations were preceded by minor boundary crossings (Zur, 2007). Several authors took this further and asserted that these mini–boundary crossings (self-disclosure, gifts, hugs, etc.) *inevitably* led to boundary violations and were therefore to be avoided at all costs. This created controversy between the idea that therapy should be characterized by a rigid rule-bound process and the idea that timely boundary crossings could have high clinical utility and a positive effect on the therapeutic alliance and outcome (Zur, 2007). Most clinicians take the latter position and believe that a positive therapeutic alliance is a key factor in predicting a successful outcome. Maintaining a rigid and rule-bound stance is often viewed as coldly and uncaringly anti-therapeutic.

Whether a particular boundary crossing is helpful or harmful may vary by patient, therapist, theoretical orientation, setting, and, most important, whether or not its significance is ever acknowledged and discussed. This relative position has one vital exception, however. No therapy should include the possibility of patient–therapist sex. Sexual contact changes the goal and process of therapy and risks profoundly harming the patient and the therapist in the long run.

What Is the Role of the Therapist?

A therapist's role is to initiate and orchestrate a series of verbal interchanges with the goal of enhancing agreed-upon growth needs. The therapist and patient roles are not equally balanced. The therapist is there to be helpful to the patient. The patient is under no obligation to be helpful to the therapist. The therapist's role is to question, probe, and challenge the psyche of the patient in an effort to interpret, clarify, and affirm the patient's needs and wishes. Inherent in the role is the belief that such objective and helpful intervention is possible only if the therapist's private needs and wishes are not gratified. This has been known as the rule of abstinence—the therapist is entitled to a fee and the gratification that derives from the sincere attempt to be helpful, but nothing more!

The goal of therapy is to help the patient live better in the outside world. The therapeutic relationship is made up of bits and pieces of the client's past relationships, often referred to as transference, mixed in with the real-time interchange between the therapist and patient. It is the therapist's first-hand experience of how the patient relates in everyday life. It is *not* meant to be a substitute for real life. Therapists cannot and should not try to be the substitute good parent, the better partner or friend, or the answer to the patient's prayers, although we sometimes wish we could. While patients may long for this and pressure their therapist to take on this role, yielding to their wishes ultimately leads to difficulties. The better a therapist is at being this substitute parent, partner, or friend, the less reason the patient has to make the necessary changes in the outside world in order to meet those needs. Unfortunately, however, it is often hard to delineate between a patient's legitimate needs for warmth, understanding, and affirmation and the person's irrational needs for the therapist to become a parent, partner, or best friend.

> A female patient asks her female therapist to accompany her when she appears in court for a divorce hearing. Her husband was physically abusive, and she is afraid to face him in court alone. She has no friends whom she can ask to do this. Should the therapist go?

Pro:

The therapeutic goal was to foster enough strength and self-esteem to push forward with the divorce. This day in court is the culmination of the patient's hard work in therapy.

The patient truly has no one else, but she is moving forward with a new life and is determined to develop healthy relationships in the future.

The therapist has reassured the patient on numerous occasions that she is not alone, that the therapist is there with her as she confronts her fears. This is a concrete demonstration of that message.

Not going may leave the patient feeling abandoned and/or betrayed without the skills to work through these feelings and maintain the therapeutic alliance.

The therapeutic alliance will be strengthened by this concrete demonstration of support and lead to further growth.

Con:

The therapist sets a precedent for being available outside of the office setting, running the risk of increasing the patient's dependency and making it less critical that she reach out to others.

The patient may actually regress in the company of her therapist, that is, be less motivated to overcome her fears and assert her wishes.

The therapist's choice to go is motivated by her excessive need to keep the patient dependent on her in order to feel important.

If the therapist charges for this, the patient may feel shame and resentment for having to "rent a friend." If the therapist does not charge for this, the patient may see this as an act of "friendship," leading to future confusion.

Alternatively, the patient may feel indebted to the therapist and unable to express negative feelings in the future.

The therapist may resent the increased demands on his or her time and manifest this in some form of negative counter-transference response.

You may feel strongly about one position or the other, but I think either can be defended, depending on the particular patient, the nature of the therapeutic relationship, and the unique circumstances. Most important, a frank discussion of both sides of the matter with the patient, before and after the event, is critical. Even if the therapist or patient retrospectively concludes that the decision made was a mistake, that discussion can be a positive and meaningful part of the therapeutic process.

Does the Patient Role Also Have Boundaries?

Yes, although patients have much more latitude. In general, they are expected to sit in a chair, engage in purposeful discussion to the best of their ability, call if they have to cancel an appointment, pay their bill, and behave in a manner that does not jeopardize the relationship. This last obligation is tricky because we often tell patients they can say anything and we encourage them to be open and honest without fear of reprisal. At the same time we expect them to express what they are feeling in a manner that is not destructive and to be willing to process what they are expressing. But what if a patient continues to be verbally abusive and will not participate in a discussion of the meaning of his anger? What if a patient continues to express her longing for an intimate connection with the therapist in a provocative manner and is unwilling to examine the nature and motives of her longings? How long does the therapist allow the unfiltered expression of feelings before stepping in and containing it? The therapist must balance allowing enough expression of feelings that the patient feels heard while at the same time attempting to examine, understand, and explain the true meaning of the feelings. It is important during these times for the therapist to be in control of the process and to be able to explain to the patient why this cannot continue.

> I can see how angry you are with me. I am trying to understand why you feel as you do. But continuing to yell and swear at me makes it difficult for me to do that. I want to sort this out

together with you and help us both through it. Can you stop for a minute and allow that to happen?

I hear that you wish you could have a different sort of relationship with me and that you feel rejected when I don't respond in the way you wish I would. Can you consider that there might be a different way to understand what you are feeling? I would like to explore that with you.

Patients have greater or lesser ability to respond to such interventions, and there are times when a therapist has no choice but to stand firm on the boundary even if it means ending the discussion or terminating the session. But even having to terminate a session can be done in a helpful manner rather than in anger or anxiety.

Let's end this today and try to look at it again at another time. Perhaps we will be able to discuss it next time in a way that feels more helpful.

Summary

The role definitions for both therapist and patient form the overall boundary or frame for the work of therapy. Therapy is purposeful. Its inherent structure is more like parent and child than friend to friend because its emphasis is on the needs of one. In addition, it exists in relative isolation from the personal worlds of either party. Most often the therapist and patient did not know each other before entering into the therapy and do not have much contact with each other outside the therapy. Boundaries exist to enable the patient to obtain the maximum benefit from therapy, however great or modest this may be from patient to patient.

The Dangers of Dual Relationships

The term *dual relationship* in psychotherapy refers to any situation in which multiple roles exist between a therapist and a client (Pope & Vasquez, 2001; Zur, 2007). Dual relationships occur when either (1) friends, family members, colleagues, members of a group, and so on agree to enter into a therapeutic relationship; (2) therapist and client enter into a concurrent other relationship such as employer–employee, friend, or member of a group; or (3) therapist and former client subsequently form another type of relationship, that of friends.

Therapists often avoid taking on a client whom they already know in another familiar context, believing that they don't have the objectivity and professional distance to do their best work. Prospective clients often intuit this as well, asking their friend or family member for a referral to another therapist rather than asking to be seen. But this is not always the case. There are situations in which there is only one source of therapy and one has no choice but to seek help from a well-known and often seen member of the community. Examples of this are in rural communities where there may be only one practicing therapist or in close-knit ethnic or religious communities where members will seek out help only from one of their own. There are also circumstances involving substance or sexual abuse where patients may only feel comfortable speaking with someone whom they already know to be a fellow sufferer. In all these cases, the dual relationship will work best if both parties are mindful of and can discuss the potential conflicts that may arise.

Most therapists and patients avoid situations that will place them into another type of relationship. For example, a therapist would purposefully not hire his patient as a landscaper even if that patient was the obvious or optimal choice otherwise. A therapist and patient, both avid cyclists, might decide together that they will join two different cycling groups, at least while engaged

in the therapy. Why? Because being in a dual relationship puts a strain on the therapeutic process. Both patient and therapist are confronted with conflictual feelings that can undermine the therapy.

Therapist 1:

What if my patient does a lousy job on my lawn? How will I be able to tell him?
My patient will know where I live. He may run into my husband or children. He will see all sorts of details of my private life. That makes me uncomfortable.

Patient:

What if my therapist is disappointed with my lawn service? I'll be extra anxious about delivering extraordinary care.
I resent that I pay her XXX dollars for every therapy hour. She pays me X dollars for my lawn care. I feel inferior and it makes me angry, but I can't say that to her.

Therapist 2:

If we are members of the same club, my patient will see that I am a better/worse cyclist. I'll be anxious about forging ahead/keeping up.
I won't be able to talk as freely with my cycling buddies if my patient is around.
Will my patient feel rejected if I want to ride with others?
The group goes out for burgers and beer after the ride. I'll resent it if my patient joins us.

Patient:

I'm a better cyclist than my therapist by far. It makes him look weak, and I don't like seeing him that way.
My therapist is a much better rider. I already feel inferior, and this makes it worse. He must see me as weak and pathetic.
I feel as if we have a shameful secret when we are cycling in the group together. No one knows I am his patient, and I don't want them to. I just want to ride my bike.

Sometimes entering into another type of relationship cannot be avoided without great cost. An example of this is in academic settings where professional worlds often overlap and situations arise that pose a conflict. Mental health trainees or young clinicians often seek therapy from senior clinicians they come in contact with, need a course taught only by their therapist, or seek employment where their therapist works. In situations such as these, it is imperative that both patient and therapist maintain an active dialogue about the thoughts and feelings that potentially accompany the dual relationship.

Nonsexual relationships between therapist and patient that occur after termination may be more or less problematic depending on such factors as the duration and intensity of the therapy and the time lapse following termination. Entering into a social relationship a year after having met two or three times to discuss a specific crisis is less likely to cause difficulty than entering into a business partnership two months after extended psychotherapy has terminated. One must be mindful that establishing a second relationship may deprive the patient of the opportunity to return for further psychotherapy (Gabbard, 2005). It is also important to appreciate that the therapeutic alliance does not end with the termination of therapy. The patient's thoughts and feelings about the role his therapist and the therapy process played in his life remain with him forever. Decades after my own therapy ended, I was caught off guard when I met up with my therapist at a meeting. I was surprised at how

emotional that moment was for me as a rush of feelings returned—the memory of emotional pain and vulnerability mixed with affection and gratitude. It was as if it were yesterday.

Self-Disclosure

When I began my career I had been instructed to avoid self-disclosure. Self-disclosure was self-indulgent; it took up time that should be spent focused on the patient's life (*Enough about you; let me tell you about my suffering*); it interfered with the patient's projection of thoughts and feelings about the therapist because it filled in the empty space (*I didn't know you had no children; I assumed you did*); and it inhibited the patient's self-revelations (*Now that I know you are a Democrat, I can't tell you how Republican I am*). For many of us who were uncomfortable sharing aspects of our personal life, this rule was something we could lean on. In retrospect, this seems to have been an unfortunate introduction to therapy because self-disclosure, when done thoughtfully and purposefully, can be extraordinarily useful. If we are to believe that the positive therapeutic alliance is an important curative factor, than we must behave like real people coping with conflicts and dilemmas of our own, not therapeutic robots whose lives are problem-free.

Often self-disclosure issues come up before therapy has even begun. Prospective patients may have specific requirements for whom they want to see in terms of gender, age, marital status, religious background, professional discipline, modality of practice, and personality style. This is especially true of members of a minority culture or race such as Orthodox Jews or Afro-Americans, or people who are handicapped in some way such as those who are sight or hearing impaired, who may not trust that someone outside of their identity can be trusted and/or helpful. To a large degree, patients have a right to that information, and therapists usually choose to answer those questions so that the patient can make an informed choice. It is often helpful, however, to first inquire why the patient cares about a particular factor, because the reason behind it is not always rational or relevant to good care. For example, a patient might insist on seeing a psychiatrist instead of a psychologist or social worker or vice versa because they have pre-conceived ideas about who does better therapy. Or they may think that only a married therapist can do marital counseling or only a parent can do parent guidance. Gentle questioning can reveal their concerns and counter them if applicable with another point of view. Obviously, patients generally have the final word even if their choice does not appear wise.

By the same token, therapists disclose much about themselves from the very beginning of therapy by the location of their practice, their office decor, their manner of dress, and their interpersonal style. It is indeed a balancing act of being thoughtful of how we come across to patients (not dressing too casually or too formally, decorating one's office attractively but not making it a showroom of one's personal life), on the one hand, and being true to oneself and a real person, on the other.

In the therapy hour, self-disclosure can take several forms. One might tell a story about one's own life to demonstrate a personal understanding of the patient's narrative.

> Patient: (crying): I'm sorry I had to cancel last week, but my dog was sick and I couldn't leave her. I had to put her down the next day, and I haven't been able to stop crying.
>
> Therapist: I can imagine how awful you felt. I once had a dog I had to put down, and it haunted me for a long time.
>
> Patient: I'm so glad you said that. My husband thinks I should be over it by now, and even my friends don't seem to understand.

Notice that the therapist does not launch into a long story about the loss of her dog. This is not a discussion between mutual friends who share equal time in commiserating. The therapist's comment merely conveys an empathic response to the patient's grief.

Self-disclosure can also take the form of sharing one's reactions to something the patient is saying or doing. This can be therapeutic if it is expressed with the goal of wanting to understand what might be going on with the patient.

Therapist: You've made several offhand comments today that suggest you might be angry with me about something.
Patient: Really? Whatever I said, I was just kidding. Can't you take a joke?
Therapist: I think I can. But do you think you might be angry with me about something?
Patient: No, absolutely not. I think you are having a bad day!
Therapist: Well, last week was a rough session, and just before you left, you said you didn't know if coming here was worth it. I wonder if you were upset at my attempts to have you confront some pretty painful feelings. One way to make sure we don't go there today is to poke at me and keep your distance.
Patient: I was very upset last week. But I thought I got over it. How can I blame you for doing your job? You are right, though. I didn't really want to come today. I almost made up an excuse to cancel.

In this case, the therapist did not get defensive when the patient briefly turned it on him by suggesting he was having a bad day. Making this type of intervention, however, requires checking in with oneself first to make sure one's feelings are in response to something the patient is doing and not just the product of a "bad day" or something else going on in the one's own life or mind independent of the patient.

Who Has Sex With a Patient?

Most of us will never engage in sexual intimacies with a patient. It is also true that most therapists who do end up crossing this boundary never imagined that they would act this way. If there are personal characteristics or situations that we or our patients are experiencing that make us more vulnerable to crossing this type of boundary, it would certainly be helpful to know what these risks are. A word of caution, however: a retrospective view of the factors that may have contributed to a boundary violation cannot be used to formulate predictions of future violations based on current factors.

Risk factors that contribute to boundary violations have been discussed by several authors (Gabbard, 2005; Rutter, 1989; Schoener, 1995; Strean, 1993) who specialize in these problems. The agreed-upon risks include lack of training, mental illness, severe character pathology, and presence of a sexual compulsion or addiction. Most authors conclude, however, that the vast majority of therapists who violate boundaries do so in the midst of a personal crisis during which their own needs are neither addressed nor cared for.

It is a well-known adage that in order to effectively care for the needs of clients, therapists must have their own needs adequately cared for. But the truth is most of us will experience at least one period in our life that we would identify as a personal crisis: the break-up of a relationship, the death of a friend or family member, physical illness, or vocational failure. During those times, we may well feel that our personal life has become unmanageable and that we cannot get our needs met. Does that mean we should not practice during such a period? The answer depends on the severity of the situation and our ability to recognize and manage those unmet needs and personal vulnerabilities so as not to bring them into the office setting. In the acute phase of the crisis, it might be wise to take a few days off. But that is impractical in the long run. Self-awareness and self-care are crucial, that is, the ability to recognize one's vulnerabilities (loneliness, anxiety, depression, guilt, or low self-esteem) and to make sure those feelings don't spill over to the therapist–client relationship in a way that invites the patient to "lean in" and offer comfort. When that shift does take place, the

newfound mutual exchange of emotional intimacy can easily become eroticized, especially when the patient fits the therapist's "object of interest" in terms of age, perceived attractiveness, personality appeal, and sexual orientation. Likewise, to the extent that the therapist "fits the bill" for the patient, the potential for erotic feelings is greater. Thus, the dyad most at risk for a sexual boundary violation is the one in which the therapist and client meet each other's criteria for sexual interest and appeal and are each needy for affection, affirmation, and love because of current voids in their personal lives.

Conclusion

I have suggested to you that you will judiciously cross many boundaries during your career because therapy is a flexible, creative process that requires a constant re-evaluation of how best to serve the needs of the client. If a therapist rigidly adheres to a set of principles and rules and never ventures outside them, it is unlikely that the client will experience therapy as a humanistic, nurturing, and growth-promoting process.

There will be times when you will be tempted to cross boundaries you sense you shouldn't and will struggle with the conflict between your impulse and your larger wise understanding of what is at stake for you and the patient. Please do not be dismayed by your impulses and do not judge your colleagues for theirs. Our impulses, however misguided and uncivilized at times, are valuable sources of information about ourselves and our clients, if we examine them with intellectual curiosity and respect. Therapists who are early in their careers will become increasingly comfortable and skillful at this as clinical experience accumulates. It is part of the maturational process of professionalism. It is critical that you have a professional network of colleagues with whom you can periodically discuss these issues. Utilizing their perspective and guidance is the best way to ensure that you remain grounded in your commitment to provide the best possible care for your patients.

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