SEX THERAPY

It's more than just being comfortable talking about sex

INTERVIEWS WITH FOUR SEX THERAPISTS:
DR. DANIELE DOUCET, DR. DAVID MCKENZIE, DR. TEESHA MORGAN, AND DR. PEGA REN

BY CAROLYN CAMILLERI

Let's say a woman tells you she has low libido or the quality of her sex life has diminished. As her counsellor, you start to ask questions and learn she has pain during intercourse. The next step illustrates a key distinction between couple therapy and sex therapy.

Dr. Teesha Morgan would ask, where is the pain located? What kind of pain is it? How often is it occurring? In her mind, Morgan would be assessing for vaginismus, dyspareunia, vulvodynia, clitodynia — medical terms to describe different types of vaginal pain under the broad category of Genital Pelvic Pain Disorder — and then she would provide specific suggestions to treat it.

"We can talk with a woman and empathize, but if you're just tackling it from an anxiety perspective or a relationship perspective, a safety or communication perspective — and those all might be important factors of what is going on — you may be missing a key component or diagnosis, that we're actually dealing with something such as vaginismus, and this woman needs specific guidance to heal, such as seeing a pelvic-floor therapist," says Morgan.

Pain during intercourse is just one common issue Morgan sees in her office.

"With women, it's predominantly low libido or pain during intercourse or a difference in a couple's sex drive," says Morgan. "With couples, much of the time, it's quantity and quality of sex — either one or both has become an issue, and they want to communicate around their sex life in a more effective way."

With men, the predominant problem is erectile dysfunction, which Morgan calls an umbrella term for a multitude of issues. When a client presents with erectile dysfunction, Morgan starts by referring him to, at the bare minimum, a GP to check testosterone, prostate, diabetes, blood pressure, and other possible causes that may be biological. She then addresses behavioural aspects by assessing the client's masturbation tendencies and their effect on his ability to get an erection and sustain it. Treatments for behavioural issues start with what Morgan calls "homework assignments." Once biological and behavioural aspects have been addressed, she assesses for psychological concerns, such as anxiety and depression.

"There are three things to look at: biological, behavioural, and psychological. If you're missing one of those three categories, you're dropping the ball on the whole thing," says Morgan. "You can't just look at one and hope that you've found it, because oftentimes, one is causing the other."

Her holistic approach comes from very specific training in human sexuality.

MORE THAN A DEFINITION PROBLEM

The term "sex therapy" is not protected nor are there official requirements for using it. Technically, anyone could say they are a sex therapist, even without training. "Sexologist" is another term that can be misused. Dr. David McKenzie offers clear definitions.

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Dr. Daniele Doucet (Nee Duplassie): www.shanti-centre.com/danielle-duplassie/ | Dr. David McKenzie: www.davidmckenzie.ca | Dr. Teesha Morgan: www.teeshamorgan.com | Dr. Pega Ren: www.smartsextalk.com

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"Sexology is simply the study of human sexuality, and sex therapy requires a counselling background," says McKenzie. "Sex therapy has a much broader perspective that takes into account the dynamics of couple relationships, of how to treat sexual problems, how to diagnose them, whereas a sexologist is somebody who could be studying the history of kink. That doesn't make them a therapist."

Nor does training as a couple counsellor make one a sex therapist.

"Relationship counselling has a lot to do with communication concerns, but that is just a piece of what sex therapy is," says Morgan. "Sex therapy is a specialization like trauma or addiction."

McKenzie, who has been a sex therapist for the last 13 years of his 43-year counselling career, began his career as an Anglican minister trained in pastoral counselling. A couple asked him for help with premature ejaculation.

"Medical doctors just have one solution: take Paxil and that should help, but it doesn't always, and I didn't know who to refer to. I certainly didn't know about it myself, and I felt sad about that, guilty even," says McKenzie. "Someone would come to me regarding issues around human sexuality, and I could be sympathetic, I could give suggestions, but I didn't have any training as to how to treat it, where to go, what to do. In my own training, which was extensive, I never got any kind of training in sexuality."

The issue goes deeper than not having training. McKenzie points out that many counsellors don't even ask about sexual issues. "They're uncomfortable. They're not in touch with their own sexuality, or they're just very nervous, because they don't know how to handle it."

Dr. Pega Ren agrees.

"Marriage and family counsellors all deal with sexual issues," says Ren. "And I think most never mention it, don't know how to ask the questions, don't know how to respond when questions are asked of them, don't know how to incorporate sex therapy. And it makes sense to me that that is the case, because most psychologists have between six and 10 hours of training in sexuality. And many counsellors don't have any training in sexuality at all."

The lack of training comes from a lack of training opportunities.

"As it is now, there are no graduate programs requiring training in human sexuality; however, there are people who hang up their shingles as relationship therapists and talk about sex but don't have adequate training to do so," says Dr. Daniele Doucet, adding that most training opportunities are in the U.S.

To date, regulating bodies in Canada haven't made training in human sexuality mandatory. If it were, Doucet believes more graduate programs would offer it. It's an issue in the medical community, too. Ren facilitates a four-hour workshop for graduating medical doctors called Sex Therapy for Non Sex Therapists. She may be the only person who talks to them about sex.

"All I have time to say is, 'These are the things that can change; these are the things that can't change, and you need to know what's on each of those lists, because your first job is do no harm,'" says Ren. "And very well-intentioned people do harm. They meet issues with their own prejudices, their own ignorance, and do their very best to be helpful without the knowledge or training to handle it effectively."

Ethics are the root of the problem.

"We're not supposed to engage in therapeutic activities that are beyond our competence," says Doucet. "But people assume that if they took a basic course in human sexuality or if they took a marriage and family course and read a book on human sexuality, that it makes them qualified to do therapy related to sex, and it's dangerous."

GOOD INTENTIONS GONE WRONG

Ren says her clients contact her about a wide range of concerns, including

relationship issues, unmet expectations, disappointment with trying to follow the cultural script, erectile dysfunction, body issues, painful intercourse, infertility, and GAS: guilt, anxiety, and shame. Much of it starts with a lack of adequate and accurate sex education.

"People don't understand how their bodies work. And they don't understand when their bodies don't work the way they expect them to and whether that's a problem with their body or the expectation," says Ren. "And there are very few avenues for them to get accurate, non-judgmental information."

Sex therapists have comprehensive knowledge of sexuality in all its forms, behaviours, and lifestyles, and an arsenal of solutions to issues that may arise.

"We have to have the answers before we start giving them. We have to know what works and what is appropriate for the person sitting in front of us. And that may be very different from the next person who presents us with the same symptom," says Ren. "We need more than empathy."

Above all, sex therapists need to listen without judgment.

"People hold enormous shame about what they do sexually and can take it nowhere, because we, as a culture, hold negative judgment about sexuality," says Ren. "We slut-shame women. We make men feel guilty for being aggressive and make them feel guilty for being sissies, so they can't win. And being able to say to someone, 'I am a sex therapist so you can tell me anything,' means that for many, many people, the sex therapist is the first person they speak to."

While all counsellors are trained to be sensitive to bias, sex therapy may uncover bias you didn't know you had, despite your experiences professionally and personally.

THE MAJOR PROBLEM OF BIAS

When McKenzie started studying sexology and sex therapy, many of his assumptions were challenged.

"For instance, being an Anglican pastor, I was under the assumption that the only sex that counted, the sex that was good and healthy, all had to be within a committed or loving relationship," says McKenzie. "That's absolute balderdash."

Nor does love and commitment always connect to sex. Once McKenzie started in sex therapy, he found he had some couples coming to him who had very successful marriages, who communicated and loved each other but weren't having sex.

"There's a myth out there that the sex life is the barometer of the rest of the relationship," he says. "Well, that's not always true, though it certainly can point to difficulties in the relationship."

THE PLISSIT MODEL

Jack Annon's PLISSIT model is one of the most favoured approaches to sex therapy. It's an acronym for the series of steps a sex therapist can take to address a wide range of issues. P for permission, LI for limited information, SS for specific suggestions, and IT for intensive therapy.

1 PERMISSION
Counsellors who are comfortable with sexuality and gender give the client "permission" to express issues that may be attached to shame or be difficult to talk about or process. The counsellor accepts the person and the issue without judgment. For example, a client may say they believe they are masturbating too much. The counsellor gives permission by responding with "I'm glad you told me that" and then "What makes you think it's too often?"

2 LIMITED INFORMATION
A counsellor who is quite knowledgeable in human sexuality can offer accurate factual information that puts the issue into perspective and makes the client feel more comfortable: statistics on erectile dysfunction or on how difficult it is for a woman to reach orgasm, how common a behaviour is in different populations or how a behaviour is harmless. For example, "Perhaps you would feel better knowing that there are no harmful effects of masturbation."

3 SPECIFIC SUGGESTIONS
At this stage, a counsellor would need to have good training in sexuality to go beyond empathy and offer guidance that does no harm. Morgan says it may be tempting to assume the sexuality-based problem is a symptom of something psychological, when it may be the root cause. Ren uses the example of helping a client manage masturbation behaviour so it doesn't, for example, become a threat to his employment, which could solve the problem and end the need for therapy. In other situations, specific suggestions could lead to treatments and continued therapy. It takes training to know what to offer in the way of specific suggestions for a wide range of issues.

4 INTENSIVE THERAPY
The final steps require an experienced sex therapist. However, Ren says fewer clients need sex therapy at this stage. More often, the issues are due to the client being frightened, ashamed, or uninformed, and once they have that resolved, they are finished sex therapy. "Then they can go back to their marriage and family counsellors, and do the rest of the life stuff because they've got the sex piece finished," says Ren.

One of his sub-studies was swinging, open, and alternate relationships.

"Many people think that people who have alternate sexual lifestyles are going to come apart, and they don't, and that was a real shock to me," McKenzie says. Further studies included kinks, BDSM, and sadomasochism. "It was a real eye-opener, but it doesn't mean the person's sick because they practise it."

Doucet says sex negativity is so normalized that people think it's normal. "Through a sexological lens, we see that sexual preferences are as diverse as food preferences. We don't pathologize people who like liver, even though a small portion of the population likes liver. When you live in a society that has these ideas that certain sexual activities are good and normal and certain ones are terrible, immoral, and abnormal, it creates a perspective that permeates all of us at a societal level."

Religion has long played a role in pathologizing sexuality. McKenzie has been a guest lecturer on the subject of sex, religion, and culture at the UBC School of Medicine, SFU, Trinity Western, UVic, and University of Northern B.C. in an attempt to educate professionals on the sexual assumptions and negativity based in religion.

Another pathologizing influence: DSM IV. The DSM V has been updated to recognize that unique sexual preferences in and of themselves are not pathologies, says Doucet, adding, "In my training, I learned how much bias I had based on sex-negative attitudes within our society. I didn't realize I had them."

The process of undoing bias begins with SAR — Sexual Attitude Reassessment. McKenzie describes it as a blunt, in-your-face experience viewing erotic material. "It's desensitization that gets a person used to the idea that there are all sorts of sexual proclivities and kinks," he says.

Sex therapists take SAR repeatedly; in Doucet's case, three times a year for three years. "We did a lot of process-oriented talking about our reactions — our judgments, our biases, our discomfort — and examined that in extreme depth, so we could see the ways sex-negative culture had influenced us," says Doucet.

Part of SAR's effectiveness is that it is done in a group setting with specially trained facilitators. Doucet says even sexuality students and counsellors find it challenging, but it is critical to get past bias to address even basic sexuality issues with clients.

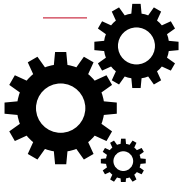
"How comfortable do therapists feel about asking clients about masturbation practices?" says Doucet. "Most are very uncomfortable, but it is so important to someone's sense of self as a sexual person. You need to ask about a client's comfort level around sexual pleasure and being comfortable in their bodies and with their body parts."

Unprepared counsellors can leave clients feeling distressed.

"I've had many clients tell me they didn't feel comfortable talking about sex and sexuality with their counsellors," says Doucet. "They couldn't have those important conversations."

Ren also talks about remedial work as a result of others' good intentions.

"It's unnecessary," says Ren. "There's enough good, valuable work for marriage and family counsellors to do without feeling they have to do it all."



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HOW TO BE TRULY HELPFUL

"Not all counsellors are couple counsellors," says McKenzie. "But anybody doing couple counselling who's not asking about the sex life should not be doing couple counselling, period."

For counsellors without adequate sexuality training, McKenzie's answer is clear: "As soon as the issue of sexuality is raised in the relationship as a problem, they need to refer out."

While there are many clear distinctions between couple counselling and sex therapy, there are some areas of overlap with respect to intimacy.

"Marriage and family counsellors can work with couples on communication and empathize with regard to problems with intimacy, especially if some of the major issues are 'We're not communicating. I don't know when my partner's in the mood. My partner doesn't know when I am, and my partner doesn't know what kind of touch I like,'" says Morgan, but cautions, "Even within that realm, understanding things like a person's sexual schema is important and is more into the sex-therapy realm. You might be helping with the communication but not understanding that the main reason they aren't connecting is because there's a differentiation in their schemas."

McKenzie believes strongly that, as Dr. Rosemary Basson of UBC's Sexual Medicine Clinic once stated, "Sex never stands alone. It is always connected to other issues."

"That is why family of origin is vital. We replicate our family-of-origin issues in our primary relationship and that has profound impact on our sex lives," he says. "Most of our sexual issues have both intrapersonal and interpersonal roots, and if these are not thoroughly explored, the sex therapist is only doing band-aid work."

Like any area of counselling, Morgan says, it's important to be aware of the limits of your own training and experience and refer out when progress seems stalled.

"We get to a point where we realize, 'Wow, I'm sinking,' and 'I'm out of my realm of expertise here,'" says Morgan, adding that she may refer once biological and behavioural concerns have been addressed — for example, if the client has severe issues with anxiety or trauma.

For Doucet, it is a question of training to avoid compartmentalized therapy.

"Ultimately, I think anybody doing relationship therapy needs to have some type of training in human sexuality, because our sexualities are an integral part of our everyday existence," says Doucet. "We don't wake up in the morning and say, 'Oh, you know what? I'm queer, but I'm going to put that in a box today and go live my life and then come home and put on my queerness again — or my sexual attractions or my sexual preferences.' Hopefully, humans aren't compartmentalized in that way."

The training isn't to turn every relationship counsellor into a sex therapist: it is to help counsellors manage discussions with their clients.

"We need counsellors to be trained in hearing clients ask for help," says Ren. "We need training so counsellors can hear their clients ask about something sexual without feeling they have to solve it but being able to respond without bias."

Doucet says counsellors who are interested in human sexuality can seek out training opportunities, such as courses and conferences. "Consult with experts who do have training. Learn how to integrate questions about sex and sexuality in intakes. Get supervision. All the things we would say therapists should be doing when they're practising in an area they're unfamiliar with."

Morgan, who is a co-founder of the Westland Academy of Clinical Sex Therapy, suggests the PLISS aspects of the PLISSIT approach to sex therapy (see page 17) are a good areas for counsellors to research, become knowledgeable on, and possibly incorporate into their practices. It's not a quick tool, but rather a framework, and learning how to apply the PLISSIT model for each sexuality-based dynamic requires training and supervision.

And Ren suggests putting together your list of experts. "Counsellors need to have the pelvic floor specialist on speed dial and the sex therapist on speed dial, just like they need the social worker and the person who knows how to get Mom into the nursing home without an eight-year wait list and someone who knows something about autism."

"All of us need the community of therapeutic interveners to do our jobs well. We can't all know it all," says Ren. "Sex therapists know the sex part, and we know it well, because we have doctorates in it. We don't dabble in sex. We come to it with a great deal of expertise and knowledge and not a whit of judgment." ■

Find information on sex therapy resources, training, and professional associations at the BCACC blog at www.bc-counsellors.org.

COUPLE COUNSELLING HOMEWORK

David McKenzie often gets calls from counsellors looking for input on their clients' sexual problems. The first thing he asks counsellors for is the clients' sexual history (he uses an eight-page form).

"You cannot begin to evaluate a couple until you've taken the sex history, relationship history of both of them."

He then asks about the clients' family of origin and depression inventory.

"Their relationship is driven by that family of origin, and depression is one of the leading causes of sexual shutdown in both men and women, especially men," he says.

"Without that information, which tells you about attachment and relationship styles, it's a case of the blind leading the blind. You need to get at the root of why the couple is together."

"That kind of work has to be done in the first session, and usually by the end of the first session, I can pretty well diagnose what the issues are and show them a plan for treatment," says McKenzie.