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Existential Sex Therapy

Abstract

This paper considers what existential psychotherapy has to offer the ever-expanding field of sex therapy. First it considers the critical stance that existential psychotherapy takes towards diagnosis and categorisation, explaining why it is important for sex therapists to engage critically with notions of 'sexual dysfunction', and suggesting ways in which we might work with clients around the losses and gains of various labels. Following this, existential therapy is briefly outlined and applied to sexual issues, drawing particularly on the work of Peggy Kleinplatz and Irving Yalom, as well as the author's own client work. Three aspects of existential therapy are explored in depth: The focus on client's lived experience, the multiple meanings they may have around sex, and the importance of considering the various dimensions of existence. Throughout this latter half of the paper examples will be given where sex therapists worked with existential themes (including how to live a meaningful life, how to relate to others, mortality and the freedom to choose).

Keywords: individual therapy; sexual psychology; existential therapy; critical psychology; diagnosis.

Existential Sex Therapy

Introduction

We live in a sex-saturated culture. Sexual iconography has increased dramatically in advertising during the last decade, and images of entwined couples, arched backs and orgasmic expressions bombard us from billboards, cinema screens and newspapers (Gill, 2007). Women's magazines and 'lads mags' tell us the kinds of sex we should (and should not) be having (Attwood, 2005). TV stations attract viewers with endless documentaries on sexual practices. Porn is ever more freely available on the internet providing another mythologised version of sex. The overwhelming message is that 'everyone is always ready, willing and able to have sex' (Miracle, Miracle & Baumeister, 2002, p.101).

Alongside this hyper-sexualization there is an ever-increasing anxiety about sex and a concern with being unable to have 'functional' sex. Every morning my email spam-filter is full of advertisements for the latest sex-aid drug. I recently tried to explain the common sex therapy technique of 'sensate-focus' to a client. He responded that he was familiar with it having read about it in *The Sun*. Another client was reluctant to believe that the clinic could offer her partner and herself anything more than the myriad of sexual self-help books that they had already purchased. The prevalence of sexual 'dysfunctions', as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV-TR) (APA, 1994), is so high as to question whether it even makes sense to judge it a 'disorder' under the common normality/abnormality model: The 2000 UK national survey of sexual attitudes and lifestyles (NATSAL) found that 35% of men and 54% of women reported some kind of sexual 'dysfunction' (Mercer, 2006). Reviewing their US study with similar findings, Laumann, Paik and Rosen (1999) report that such people are 4-5 times more likely than others to be unhappy and dissatisfied with their lives.

Popular culture and psychiatric understandings also perpetuate anxiety about sex by defining what kinds of sex are and are not acceptable (both in definitions of 'dysfunctional sex' and 'paraphilias'). The popular TV programme (and then movie) *Sex and the City* specialised in 'freak of the week' episodes¹ which defined the kinds of hot, adventurous sex people should be having as well as policing the boundaries

¹ Following the popular 'monster of the week' format from sci-fi and horror shows like *The X Files* and *Buffy the Vampire Slayer*.

against bad sex as a the thing that was wrong with the boyfriend du jour (e.g. ‘erectile dysfunction’, wanting to be urinated on, or using baby talk). Sex shops like Ann Summers have a similar role in encouraging spicy sex and policing the boundaries against dangerous sex (fluffy handcuffs - yes, ball-gags –no, Storr, 2003). It is small wonder that the omnipresent call from clients at sex therapy clinics is ‘I just want to be normal’.

It is within this conflictual culture of sex that we operate as psychosexual therapists. Conventional sex therapy could be seen, to some extent, as reinforcing the assumption that it is good, natural and important to have a certain frequency of a certain kind of sex, whilst those who do not are ‘sexually dysfunctional’. One therapeutic approach which has rarely been applied to sex therapy, but which offers quite a different perspective, is existential therapy.

This paper considers what we could gain from taking an existential approach to sex therapy. First it outlines the implications of the critical stance that existential therapy takes towards diagnosis. Following this, it introduces what existential therapy itself involves, particularly exploring the focus on the lived experience of the client, and the importance placed on multiple meanings and dimensions of experience. As well as reviewing the small amount of theory and research on existential sex therapy (e.g. Kleinplatz, 1998, 2004; Adams, Harper, Johnson & Cobia, 2006) I reflect on my own thoughts having spent the last three years studying existential therapy and working in a sex and relationship problems clinic.

I should acknowledge, however, before going further that existential therapy is not the only approach that takes a critical stance to diagnosis and dysfunction, or to work with lived experience and multiple meanings. Indeed, I am lucky enough to work on a multi-disciplinary team where such critical reflections are commonplace from therapists with backgrounds as broad as psychiatry, nursing, cognitive-behavioural psychology and psychoanalysis. Hopefully this paper will encourage readers to consider how critical perspectives, and the foregrounding of client meaning and experience might fit with their own approach.

A Critical Existential Approach to Diagnosis

The existential therapist Yalom (2001) states that therapists should ‘avoid diagnosis’ and suggests that diagnoses are often counterproductive because they diminish the ability of the therapist to relate to the other as a person. This resonates with my own

experience. It is very easy when faced with a client file or GP letter diagnosing ‘premature ejaculation’ or ‘vaginismus’ to form all kinds of assumptions about the kind of person you are about to meet, how easy they will be to work with, and so on. Yalom warns that diagnosis can mean that we attend too much to features that fit an initial diagnosis and not enough to those that do not but may also be important. He reminds us that sometimes diagnoses can become a self-fulfilling prophecy as people come to see themselves as ‘sexually aversive’ for example.

More fundamentally than this, existential psychotherapy follows the anti-psychiatry approach of Laing (1962) and Szasz (1974) in suggesting that diagnosis and treatment on the basis of symptoms misses the *meaning* of these symptoms and behaviours and thus dehumanize the individual. Spinelli (2005) argues that symptoms are expressions of attempts to defend against existential anxieties, so medical interventions and behavioural treatments can only offer a temporary amelioration. Kleinplatz (2003) concurs, saying that the goal of sex therapy is generally to eliminate barriers to sexual functioning so that ‘normal’ sex can resume, and that this focus on relieving symptoms neglects the vital intrapsychic, interpersonal, systemic and sociocultural meanings surrounding client experiences and behaviours. I will return to this consideration of meaning in more depth shortly.

Many sex therapists writing today agree with the existential distrust of medical and behavioural diagnosis and treatment. Leonore Tiefer writes that ‘it is never the wrong place to recommend ignoring the DSM’ (1995, p.54). There are several edited collections of sex therapy approaches which shun the conventional pathologising language of ‘dysfunction’ (e.g. Ussher & Baker, 1993; Kaschak & Tiefer, 2001; Kleinplatz, 2001; Green & Flemons, 2004). On the face of it, it may seem strange to critique an approach that has been so effective. As Kleinplatz (1998, 2004) herself points out, the PDE5 inhibitors have been very successful in providing men with erections and systematic desensitisation with dilators enables most women to engage in penile-vaginal intercourse², so why question these approaches? The answer is that these categorisations and treatments construct a problematic distinction between

² Kleinplatz does point out that, despite this, compliance levels with pharmacological and physical treatments for ‘erectile dysfunction’ are low (e.g. Althof and Turner, 1992) and many women are reluctant to follow the ‘vaginismus’ techniques, so there seem to be some limitations to these approaches even under their own definitions.

functional and dysfunctional sex which is, at best, limiting and constraining and, at worst, dehumanising and risks exacerbating rather than alleviating suffering.

Denman (2004) states that the DSM categories and conventional sex therapy treatments *construct* what 'normal sex' is as part of a dominant discourse which is also reflected and perpetuated in mainstream media, self-help literature and everyday conversation. The psychiatric/psychological construction is particularly problematic because it has a veneer of value-free scientific objectivity obscuring the 'intensely political and value-laden content of the discourse' (p275). As Fishman (2004) points out, the medical and psychological industries are idealized and have huge 'expert' power which means that their way of seeing things is often accepted as taken-for-granted fact rather than one, deeply problematic in this case, way of viewing the world. The DSM categories and medical treatments can be seen as part of a regulative discourse (Foucault, 1976) which is bound up in economic concerns (ViagraTM and co are big business) and conservative politics; for example, Boyle (1993) and others suggest that the recognition and treatment of 'female sexual dysfunctions' emerged when women's sexual dissatisfaction became a threat to heterosexual marriage and the nuclear family.

We can see how DSM categories and medical opinion are historically and culturally constructed when we consider times in the past when masturbation was discouraged or homosexuality was 'treated' (Kutchins & Kirk, 1997), or when we reflect that Masters and Johnson (1970) stated that 90% of sexual dysfunction was psychogenic in etiology and 10% organic, whilst post-ViagraTM statistics now put it at 80% organic and 20% psychogenic (Kleinplatz, 2004).

Kleinplatz (1998, 2004) also critiques the medical and behavioural psychology approaches for being goal- rather than pleasure-oriented. Despite attempts of more mainstream authors like Wincze and Carey (2001) to redefine the goal of sex therapy as mutual pleasure and to highlight the 'myth' that sex equals intercourse, the DSM categories and sexual response cycles they are based on (Kaplan, 1979) clearly construct the goal of treatment as enabling erections and orgasms, rather than exploring broader possibilities for enhancing sexual pleasure. The possibility that someone who is unable to have erections or to be penetrated may not be in need of treatment is seldom considered. As Denman (2004) argues, the promotion of sexual 'disorders' creates a limited notion of 'good', 'normal', 'natural' sex (Rubin, 1984), which people are expected to conform to, dampening their own 'erotic imagination'.

Several authors have argued that the model of ‘good’, ‘normal’, ‘natural’ sex promoted by the DSM and sex therapy is heterosexual, penile-vagina penetrative sex³ resulting in orgasm, where the man takes an active role and the woman a passive one. Ogden (2001) describes it as the ‘doing it’ theory of sexual normality and the ‘didja come?’ theory of sexual satisfaction’ (p.18). Despite Kaplan’s (1979) recognition that the sexual response stages may not be sequential, the implication of her model - and the DSM criteria that draw on it - are that there should be a linear progression from desire, through arousal/excitation to orgasm via penetrative intercourse. Adams (2006) points out that the existence of the categories of ‘vaginismus’ and ‘premature ejaculation’ reveal the prioritising of penetrative penile-vaginal sex. As Boyle (1993) asks, ‘premature for what?’ (p.79). This prioritisation is also revealed in the lack of categories relating to anal/oral sex (e.g. being unable to overcome the ‘gag reflex’) or a female version of premature ejaculation. Hite (1981) reports that some women do experience problems in orgasming too quickly, but of course this does not interfere with penile-vaginal penetration so there is not a diagnostic category for it. The category of ‘erectile dysfunction’, which is the most common presenting problem at many psychosexual clinics, gains its significance from the fact that sex is seen as complete when the man ejaculates (Denman, 2004).

This construction of a certain kind of ‘normal’ or ‘functional’ sex has been criticised for excluding same-sex sexual experience, or for assuming that this is equivalent to heterosexual experience (Boyle, 1993) and for implying that other forms of sexual contact are inferior (Adams, 2006). AIDS activists have questioned the focus on penetration as the only sex (Jackson, 2006). Sensate focus (Masters & Johnson, 1970) constructs certain kinds of touching as desirable whilst others, such as those involved in sadomasochistic activities, are still rendered pathological under the DSM (Langdridge & Barker, 2005). Although the DSM states that lack of sexual desire/arousal has to cause ‘marked distress or interpersonal difficulty’ in order to be diagnosed, there is still an implication that sexual contact is a necessary human activity, which excludes those who are celibate or self-defined as asexual (Scherrer,

³ This privileging of penile-vaginal penetration is also seen in the treatment of people who are born ambiguously sexed and are traditionally assigned as male or female by doctors based on whether they are physically able to penetrate a vagina or to be penetrated. ‘Corrective’ surgery carried out often deadens sexual sensation (Kessler, 1998; Fausto-Sterling, 2000).

2008). In the medical and psychological professions there is also a tendency to assume that sex only occurs between able-bodied people (Denman, 2004; Shakespeare, 2003). I saw a couple where one had multiple sclerosis. They came to the clinic as their last port of call having been told by all the other doctors and counsellors that they approached that they should not expect to continue a sexual relationship.

Conventional approaches to sexual 'dysfunction' have also been critiqued for perpetuating the construction of the naturally sexually active and initiating man, and the sexually passive and penetrated woman which is also present in the everyday language of sex (penetrating rather than enveloping, euphemisms like 'nail', 'fuck' and 'screw', and the lack of positive words for female genitalia; Weatherall, 2002). The multi-million selling self-help text, *Mars and Venus in the Bedroom*, explicitly states that women should sometimes lay there 'like a block of wood', that sex is a natural male need, that ends with the man's orgasm (Potts, 2002). Jackson (2006) argues that such polarised views of men and women prevent us from seeing similarities between, and variations within, each gender category. It completely excludes much trans experience (Kessler & McKenna, 2000) and is also constraining, limiting and pressurising for both women and men: disempowering women (Jackson, 2006) and pressuring men to act as unemotional machines, focused purely on their 'performance' (Potts, 2000; Marshall, 2002, 2006; Tiefer, 2006; Grace, Potts, Gavey and Vares, 2006; Vares and Braun, 2006; Croissant, 2006).

Under this model, women are not supposed to be sexually active, and their need for clitoral stimulation to reach orgasm is viewed as something 'additional' because the clitoris is not as easily stimulated by penetration as the penis (Boyle, 1993). Ussher and Baker (1993) critique the categorisation of 'vaginismus' saying: 'that this is a description of a woman who cannot (or does not want to) have sexual intercourse could easily be overlooked in the discussion of peri-vaginal muscles and reflexes of the thighs' (p.27). Bass (2001) and Potts (2002) point out the potential negative impact of a 'performance perfection' approach to male sexuality on men's identities and well-being. Zilbergeld (1999) states that the image of 'natural' masculinity in our culture is of men who are every-ready for sex, hard and able to go all night long. The construction of soft penises as 'dysfunctional' reinforces such stereotypes (Kleinplatz, 2004). Many men attending the clinic where I work are terribly anxious about whether

their penis size and performance is adequate, and locate much of their distress and relationship problems in this area.

There is, however, a problem when we come to work with clients from a more critical, or existential, perspective, and that is that diagnostic terms and ideas of 'sexual dysfunction' are dominant understandings which many of them may, themselves, draw on. I would be very wary of overtly deconstructing such categories which may be a vital part of the client's way of viewing their issues. However, clients often express some reservations themselves and I have found open engagement with these to be useful, particularly in relation to the losses and gains which come with embracing a diagnosis. For example, the following client, Steve, brought the possible label of 'sexual addiction' into the room (as yet not categorised under the DSM, but no less problematic for that, see Keane, 2002; Irvine, 2005).

Steve: My partner was looking online and she came across some stuff about sex addiction, you know?

Me: Mmhm

Steve: So I ordered a book on it, here (gets a book out of his bag)

Me: And how did you find it?

Steve: Like phew. It was pretty intense. I mean there's a lot I recognise in there. About the kind of background I have, and how it feels so out of control once you get online.

Me: Sounds like it was useful to see that this might be an experience you share with others?

Steve: Yes... it was a relief in a way [sounds doubtful]

Me: You don't sound completely sure

Steve: Well there was also stuff in there that didn't fit me so well. But... maybe I should just accept it.

Me: I think it can be useful with any new word, or idea, like this to think about both what you gain from it, but also what might be lost.

Steve: It does feel like I might lose something. I mean, thinking about what I was doing online in therapy was really useful to me. It helped me to realise that I wanted to be more creative, have more of an impact, in my life. The stories in the book are kind of simplistic. They don't get into that kind of thing.

Me: Any other gains or losses?

Steve: (pauses) Well a major gain is the fact it gives me a story: something you can say to other people and they are like 'oh well that's not really your fault'. But on the other hands that feels a bit out of control. And it has changed over time. It's not something I do so much now. I don't like to think it's something I'll always be.

An Existential Approach to Sex Therapy

As well as working critically and openly with diagnosis, what else might an existential approach have to offer and what kind of framework for sex therapy would such an approach involve?

Existential therapy is hard to pin down because there are many different branches which emphasise different elements (Cooper, 2003). Broadly speaking it sees people as meaning-constructors who are actively involved in making sense of their worlds. Existential therapists aim to engage phenomenologically with clients, bracketing off their own ways of seeing the world as much as possible in order to gain a full picture of the client's unique lived experience and the worldviews which shape this (Spinelli, 2005). Clients are encouraged to explore the assumptions underlying these worldviews to see how they may have become rigid and fixed and to consider what alternative ways of understanding may be possible (and potentially more useful). Obviously this creates the opportunity for working more openly with cultural assumptions around sex and how clients engage with these, as in the example above.

Clients are particularly encouraged to see how the existential 'givens' of human being may be involved in their difficulties, and to face up to these. The givens include the fact that we will all die (and do not know when), the fact that we are free to make choices in life, the fact that we are alone despite our being thrown into a world where we are inevitably connected to others, and the fact that life has no inherent meaning: we create it for ourselves (Yalom, 1991). In the remainder of this paper I illustrate how many such themes emerge within existential therapy for sexual difficulties.

I will consider what existential therapy has to offer sex therapy under three main headings: Exploring how existential therapy prioritises the lived experience of the client (Spinelli, 2005); how the focus is on the meaning of the experience for the client (Kleinplatz, 1998, 2004); and how it may be useful to explore the different existential dimensions with clients (Van Deurzen, 1997, 2002; Adams, et al., 2006).

The lived experience of the client

Kleinplatz (1998, 2004) is one of very few sex therapists to explicitly address existential themes, drawing on Frankl (1978), Laing (1967), May (1969) and others in

her existential-experiential approach to sex therapy⁴. Kleinplatz emphasises the need to listen to the client's lived experience and to use this as a way in to exploring their worldview and what is meaningful and important to them.

In her (1998) paper Kleinplatz describes her work with Ms. Smith who was terrified of vaginal penetration. Ms. Smith had a background where sex-talk was taboo and had had an 'awful' relationship with a man who pressured her to let him penetrate her, before she embarked on a much more positive relationship with her now-fiancé. Rather than attempting the standard desensitisation treatment, Kleinplatz encouraged Ms. Smith to describe her lived experience of being orally assaulted by her previous partner. This resulted in her confronting her feelings of powerlessness in many relationships and exploring feelings of anger and ways in which she could take control. Over six sessions her feelings of shame around her body disappeared and she reported a new-found sense of freedom. In follow-up she reported that her 'vaginismus' had disappeared.

In her (2004) paper Kleinplatz reports on a man who came to see her because of his 'erectile dysfunction' and his feelings of being flawed because he was taking a PDE5 inhibitor. Rather than treating the 'erectile dysfunction', Kleinplatz chose to work with the 'whole person'. Instead of focusing on his erections, she asked him to talk about whatever scene was compelling his attention at the present time. He described being in bed with his partner the previous night and her saying 'I want you inside me right now'. He reported his tense, desperate response and his focus on his penis. Kleinplatz suggested that he listen to the message his penis was giving him: a common idea in existential therapy that difficult feelings or sensations may have valuable messages. He realised that, in contrast to his own desire to be accommodating, the penis was angry at being expected to perform and wanted prior attention. He gave voice to these desires with his partner and she was very happy to caress and stroke his penis, as well as exploring other desires with him which he had previously tried to ignore.

Yalom (1991) describes one case when he worked with someone presenting with sexual problems. Like Kleinplatz, Yalom started with the lived experience of the client, but also attempted to bracket both his own, and his clients' assumptions about

⁴ Although the related form of 'experiential psychotherapy' referred to by both Kleinplatz and Mahrer (Mahrer, 1996; Mahrer & Boulet, 2001) should also be considered in relation to existential issues.

what was going on. The client, Marvin initially suggested that he was a therapist's dream because his problems were so clearly sexual: he had problems gaining and sustaining an erection. He commented that 'sex is at the root of everything. Isn't that what you fellows always say?' (p.230). However, by exploring Marvin's dreams with him, Yalom discovered that Marvin's problems were much more about dread of impending death than they were about sex per se. Marvin was nearing retirement age and part of him was very aware of all that he had not done with his life (e.g. having children or a meaningful career). Sex was a way in which he tried to soothe himself but it did not always work and then the anxieties crept in. Yalom (p.240) writes:

I believed that Marvin was entirely wrong when he said that sex was at the root of his problems; far from it, sex was just an ineffective means of trying to drain off surges of anxiety springing from more fundamental sources. Sometimes, as Freud first showed us, sexually inspired anxiety is expressed through other devious means. Perhaps just as often the opposite is true: *other anxiety masquerades as sexual anxiety*.

Client meanings

One strong message that I have taken from my existential training is that anything can be a way in to exploring how a person makes sense of their world and what is valuable and meaningful to them (e.g. dreams, fantasies, the way daily life is structured, how people engage with food). Sexual issues are no exception to this, although I have found, even within existential circles, that people often see sex therapy as something very specific rather than another way of gaining entry into client understandings, ways of being, and existential issues. As we can see in Yalom's example above and my own example with Steve, sex is often a handy existential barometer, and explorations of it within the context of the client's whole lived experience can be very revealing about what they regard as meaningful, and how they relate to others, themselves, and their own mortality.

Psychological and medical models of human experience often search for one universal cause-effect explanation for human experiences and behaviours in a reductionist fashion. Existential therapists would instead see any experience or behaviour as having many possible meanings for different individuals (and even within the same individual on different occasions). For example, I have worked with two men who were unable to orgasm during penetrative sex. One linked this very

much to his inability to express himself in other aspects of his life, whilst the other was fearful of letting go of control and being made fun of.

It is important to be aware of the multiple possible meanings of having/losing an erection, being penetrated, having an orgasm, and all other aspects of sex which may vary between people and even within the same person on different occasions. An orgasm, for example, can be experienced as: a mechanical release, a demonstration of one's masculine or feminine sexuality, a relief of stress, a loss of control, allowing someone to see you at your most vulnerable, a display of intimacy, the height of physical pleasure, a transcendent spiritual experience, a performance demonstrating prowess, a giving of power to another, an exerting of power over another, a form of creative self-expression, a humorous display of our rather-ridiculous humanity, an unleashing of something wild and animalistic, a deeply embodied experience, an escape from bodily sensations and pain, and/or a moment of complete alive-ness or freedom.

Mitchell (2006) interviewed heterosexual women and their partners about how they saw their ability to orgasm. Women regarded it as: 'important but not essential', as signifying their partner's commitment, being about *mutual* enjoyment, and being important for their partner's sexual confidence. Their partners saw women's orgasms as: very important, vulnerable to relationship difficulties, a complicated skill they had to learn ('it's like the Bermuda triangle down there', one said), and an unlevel playing field, since it was perceived as being more difficult to get a woman to orgasm than a man.

Given the multiplicity of possible meanings, Kleinplatz (1998, 2004) warns against focusing on 'dysfunctional' penises or vaginas rather than exploring client's own meanings. She suggests that PDE5 inhibitors might restore performance to a man whose wife has died, or who is sensing a rift between his own desires and those of his partner, or who does not feel comfortable with his new girlfriend, leaving him feeling alone and empty because his loss, tension or anxiety has not been addressed. She suggests instead that we ask what the meaning of a non-penetrable vagina or soft penis is for the individual, and what they might gain from it. For example, she points out that it can be 'against the rules' for men to say that they do not want sex (because they are expected to be always 'up for it' and to prove their partner's desirability through it; Zilbergeld, 1999). Being unable to 'perform' may be the only way to get out of sex. Similarly 'vaginismus' may be a way of saying 'no' to unwanted sex.

Within this consideration of meaning it is important to take account of the wider subcultural and cultural meanings surrounding sexual practices. Milton (2000) particular emphasises the need for existential therapy to be 'lesbian and gay affirmative', and indeed lesbian, gay, bisexual and transgender (LGBT) clients I have worked with so far have had both similar and different meanings to heterosexual clients (for example, many gay men have open relationships where trust and sexual fidelity are not tied together, and there may be various meanings surrounding different practices such as oral sex, anal sex and mutual masturbation and the positions taken within these). Hall (2001), a lesbian sex therapist, argues that 'the meanings attributed to sexual encounters are...fluid' (p.161) and suggests that clients 'map' their sexual territory, giving them permission to move between different 'zones' at different times (e.g. zones for 'earthmoving sex, silly sex, mood-elevating sex or sorrowful sex...sex for intimacy and sex for distance...sex-free zones...mechanical sex...once-a-month-if-we-feel-like-it-or-not sex...only-if-I-don't-have-to-lift-a-finger sex...and...maybe I'll feel like it after we start sex', p.174-176).

In relation to cultural differences there can be assumptions amongst therapists that people with certain cultural/religious backgrounds will be resistant to some of the standard 'treatments'. At conferences I have heard therapists and psychiatrists stating that women *must* be prepared to touch themselves, to insert objects into their vaginas, to mutually masturbate and so forth, otherwise there is no point them coming to therapy. Butler and Byrne (2007) argue that cultural differences should be celebrated rather than pathologised. Butler describes working with a Muslim couple who wanted to have penile-vaginal sex to become pregnant despite the female partner's difficulties being penetrated, and who were concerned that sexual self-touching was forbidden in their religion. In her explorations with them from a 'non-expert' stance, Butler found that sexual touching was permitted within a marriage if performed within the couple and not as masturbation, and that some laws of the Koran could be put aside if there was a medical justification. This created opportunities for the couple to explore different types of touching, and the female partner eventually became pregnant through the use of a syringe rather than penile-vaginal intercourse.

Embodiment and the existential dimensions

As stated earlier, psychological and medical models of sexual 'dysfunction' distinguish between psychogenic and organic aetiologies displaying the Cartesian

mind/body split inherent in much medical discourse and current Western thinking. Many clients come with similar notions of their problems as being *either* psychological *or* physical, generally wanting to be told that it is one or the other (e.g. physical because it can be quickly ‘fixed’ or psychological because it means they are not ‘sick’). I often work with clients around a possible alternative to this mind/body split based on Merleau-Ponty’s (1962) notion of embodiment. Psychological and physical processes cannot really be teased apart in any meaningful sense⁵. Kleinplatz (1998) warns that medical/behavioural techniques based on such a Cartesian split and focusing on physical performance can alienate individuals from their own bodies. The subjective experience of the individual as an embodied self is lost and the body fragmented into different physical parts to be treated. Treatments do not engage with the lived experience of what it means to have a penis or vagina and often train people to ignore their own images, feelings and sensations in favour of more ‘erotic’ ones.

Kleinplatz’s (1998, 2004) existential-experiential psychotherapy and Aanstoos’ (2001) phenomenology of sexuality are both predicated on the integration of mind and body with no primacy of one over the other. In a similar way to the way Van Deurzen (1997) regards emotions as reflective of what we value in life (jealousy as attempts to hold on to what is valued, guilt as a reaction to its loss, etc.), Kleinplatz sees embodied experiences as ways of expressing underlying experiences (e.g. the soft penis saying ‘no’ to sexual contact discussed above).

Linked to the concept of embodiment are the existential dimensions emphasised by Van Deurzen (1997, 2002). In their recommendation of an existential framework for sex therapy, Adams et al. (2006) draw on these dimensions suggesting that counsellors of new mothers who present with sexual problems consider the physical changes associated with pregnancy and childbirth and the need for the mother to come to terms with her new physical self (*Umwelt - physical*), the transition into new roles and identities accompanying motherhood (*Eigenwelt – personal identity*), the interpersonal relations between the mother and her partner, the mother and child and the mother in her wider social world (*Mitwelt - social*) and the way in which

⁵ Mental processes like emotions and memories occur on a physical level in the neural connections of our brains and relate to other aspects of our bodies (genitalia, etc.) through our central nervous system. Similarly, physical processes require certain psychological states in order to take place (e.g. comfort, desire, arousal, etc. for orgasm).

motherhood and sexual relations relate to the woman's wider meanings and values (*Umwelt* - *spiritual*). Adams et al. emphasise the importance of this latter dimension suggesting that therapists facilitate the new mother's exploration of her, often changing, values; Ogden (2003) highlights the spiritual aspect that many women feel is part of sexual experience at its best, which underlines the need to take account of this dimension in sex therapy.

For someone who is experiencing problems attaining an orgasm, at the level of *Umwelt* we might ask whether the body is expressing something that is otherwise impossible (e.g. lack of trust in the partner, fear at loss of control or that degree of intimacy). At the *Eigenwelt* we can ask what orgasm means for the person's sense of self (e.g. does it signify being too enmeshed in someone else and losing oneself? Does it remind them of their physicality and the fact that this will end?) At the *Mitwelt* we can ask how orgasm is (or is not) involved in relating with others (e.g. Is it something to share, to give to someone else or to take from them?) At the *Umwelt* we can consider orgasm as a spiritually meaningful experience, the meanings given to it by the person, and whether sex is being made the ultimate source of meaning to avoid considering other possibilities.

Doan (2004), and Kleinplatz (2004) both warn that DSM diagnoses and conventional therapies often neglect the interpersonal dimension (*Mitwelt*). Doan reminds us that 'sex occurs *between* people' (p.152) but the DSM forces therapists to diagnose *one* of the people involved. Kleinplatz (2004) suggests that it is important to work within the relationship context and to be aware of the meanings that sex and sexual 'dysfunction' may have for everyone involved⁶. For example she suggests that 'erectile dysfunction' is often read as proof of undesirability by the sexual partner.

In my therapy with Helen, a young nurse who presented with 'vaginismus', our work focused very much around the *Mitwelt*, and the way in which her approach to sex related to her approach to people in general. Although sex was painful she would try to engage with it because she feared losing her boyfriend if she did not. After the first few sessions she shifted focus from her body and relationship to her relations with others much more broadly.

⁶ I say 'everyone' because it is important to remember that sex can occur between more than two people, for example in some forms of open non-monogamy (Barker & Langdridge, forthcoming 2009)

- Helen: Is it okay to have a rant? (laughs quite joyfully at the thought of it)
- Me: Absolutely. This is your space to be wherever you are today. And I'm keen to hear what's got you so stirred up.
- Helen: It's this doctor at work. He's always leaving extra work for us and yesterday, right at the end of my shift, he dumped down a load of files for me to go through. (her voice is slightly raised and fists clenched, although still seemingly amused with herself for giving voice to the anger)
- Me: You're fuming about this aren't you? (smiles)
- Helen: Yes I am. Because I just went ahead and did it. Again. It's just like everywhere.
- Me: Everywhere?
- Helen: At home as well.
- Me: At home?
- Helen: Yes because it's always 'don't upset your mum' (we've explored her childhood somewhat previously)
- Me: So everywhere you have to do things for other people?
- Helen: And I'm sick of it. I always have to be the good friend, the good nurse, the good daughter, the good girlfriend (she counts these off on her fingers as she enunciates each one)
- Me: And what's that like?
- Helen: (looks up at me and sighs) Knackering.

Over the course of therapy Helen challenged her previous assumptions that she had to make herself into what other people wanted her to be (a theme explored in depth by existential authors such as Sartre, 1943 and de Beauvoir, 1949). Letting go of the desire for other people to see her in certain ways, although by no means easy, meant that she was able to find a clearer idea of who she wanted to be. By the end of therapy she was able to be clearer about when she wanted sex and when she didn't, which resulted in it being much more enjoyable. Her fear of losing her boyfriend decreased as she realised that whilst she loved him, she was also okay on her own.

Conclusions

I began this paper with a rather negative view of the hyper-sexualisation of culture and concern with having 'good' sex. In their book Wincze and Carey (2001) present a more optimistic picture arguing that there is increased openness about sex and access to information and understanding since ViagraTM, meaning that people are more likely to engage with sex therapy and to understand what it can involve. Anxieties around sex mean that men, in particular, are far more likely to engage with therapy than they were in the past. Being about to perform sexually is so

intertwined with idealised masculinity that men are willing to engage with emotional and psychological explorations to address this (even though these are in opposition to ideals of 'rational masculinity', Connel, 2002). Psychosexual clinics, in the UK at least, are places where many people who would not normally have access to psychotherapy can come (those with little money, or from cultures where psychotherapy is unfamiliar, for example, because it is free and in a medical context). I would encourage sex therapists to critically and creatively engage with diagnostic categories, and to take up the opportunity to work with the lived experiences of clients, exploring multiple meanings surrounding sex at the various dimensional levels, and considering the relationship between sexual experiences and wider existential themes.

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