* Sex in Counselling:

An Introduction and New Approaches

Michael Pearson

COUNSELLOR RESOURCES

* Trigger Warnings

- ✓Sexual practices – some descriptions may generate explicit mental images.
- ✓Sexual assault – small amount of discussion
- ✓Shame – descriptive and in-depth discussion

COUNSELLOR RESOURCES

* Aims and Objectives

- ✓To empower you to explore sex more in therapy
- ✓To give you an introduction to sexual terms
- ✓To expand your views of sex and sexuality, away from a heteronormative model
- ✓To give you a brief introduction to cognitive behavioural, psychodynamic and person-centred approaches to sex in therapy
- ✓To offer you a greater understanding of areas of shame linked to sex
- ✓To give you a list of personal-development takeaways
- ✓To give you a list of therapeutic takeaways

* Overview

1. A large proportion of people experience issues with sex and sexuality (Laumann, Paik & Rosen, 1999).
2. Sex is underexplored in mental health and medical professions, and often absent from or lacking in training.
3. ‘Sexual problems can contribute to depression, anxiety, trauma, eating disorders, substance abuse, pain disorders, and so on; conversely, such problems can affect a person’s sexuality, yet remain unaddressed in the therapist’s office.’ (Buehler, 2016)

* Know Your Terms

Some of these are explicit:

- ✓Kink
- ✓BDSM
- ✓CBT
- ✓Ageplay
- ✓Furry play
- ✓Material play
- ✓Object sexuality
- ✓Voyeurism
- ✓Frottage
- ✓Pup play
- ✓Rubber play
- ✓Cottaging
- ✓Polyamory
- ✓Consensual non-monogamy

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* The Therapist

- ✓Therapists are rarely given the opportunity to explore sex in training.
- ✓One of the biggest reasons professionals do not discuss sex is because of their lack of knowledge and discomfort (Bray et al., 2010; Saunamäki & Engström, 2013; Saunamäki et al., 2009; Van der Stege et al., 2014).

* The Therapist

✓'Therapists' silence about sex in the therapy room sends many messages, but perhaps the loudest is please don't talk about sex!'

- 'Since the therapist never asked about sex, the client got the message loud and clear: Sex is not spoken here.'
- 'A couple … couldn't bring themselves to tell their "uptight" therapist that they had enjoyed swinging early in their marriage.'
- 'Because the couple had difficulty talking about sex, the therapist changed the topic from sex to finances because, explained Sam, "the therapist thought if we made more money, we'd be happier".'

Buehler, 2016

COUNSELLOR RESOURCES

* Discomfort Tolerance Exercise

Close your eyes, relax,
and be aware of your comfort levels
as I speak.

COUNSELLOR RESOURCES

* Sexual Wellbeing

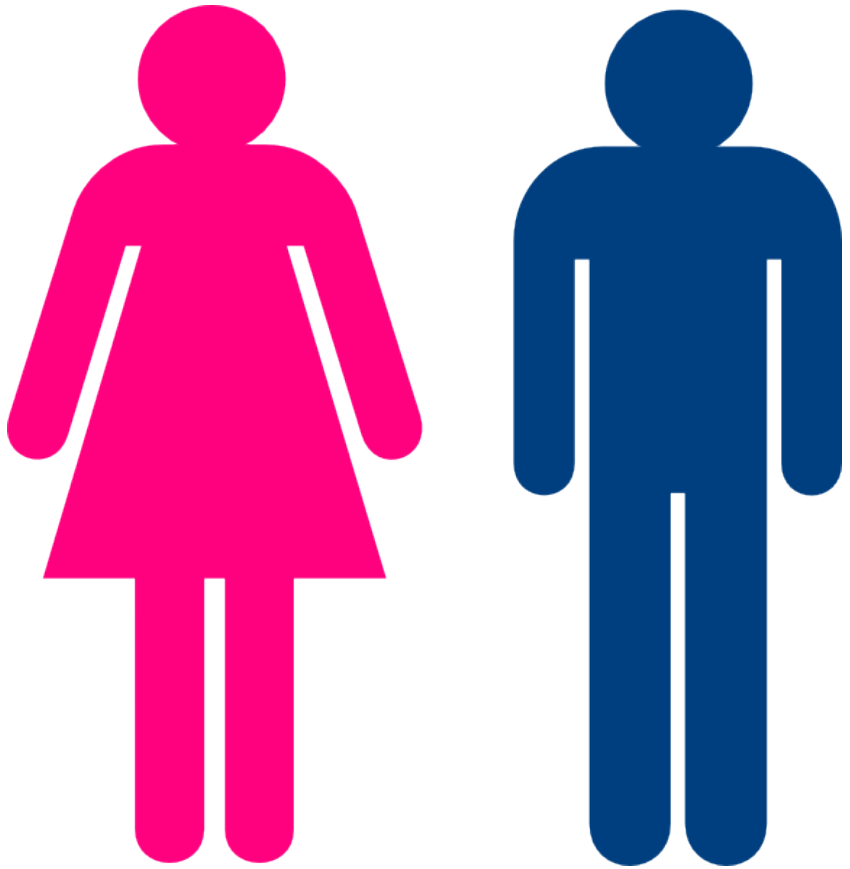
1. ‘Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of infection, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.’ (WHO, 2016, para. 4)
2. ‘Sex is influenced by biological, psychological, social, economic, political, culture, legal, historical, religious and spiritual factors.’ (WHO, 2016, para. 6)

* Sexual Wellbeing

1. Sexual well-being is an individual's perception of their sexuality, sexual self-esteem, sexual life and relationship (Foster & Byers, 2013; Kedde, van de Wiel, Weijmar Schultz & Wijsen, 2013).
2. Satisfaction with personal, emotional and physical aspects of sexuality, sexual awareness, clarity of sexual values, and comfort in sexual communication (Hooghe, 2012; Muise et al., 2010)
3. Physical and psychological, and the need for both – without poor sexual well-being (Martin, 2017).
4. These attributes are critical, as a deficiency in one can be linked to poor sexual well-being (Beckjord et al., 2011; Fitz & Zucker, 2014; Foster & Byers, 2016; Ussher, Perz, & Gilbert, 2013).

* Challenging Sexual Models

1. Partners
2. Sexual organs
3. Physical/non-physical
4. Penis/vagina
5. Relationships
6. Heteronormativity



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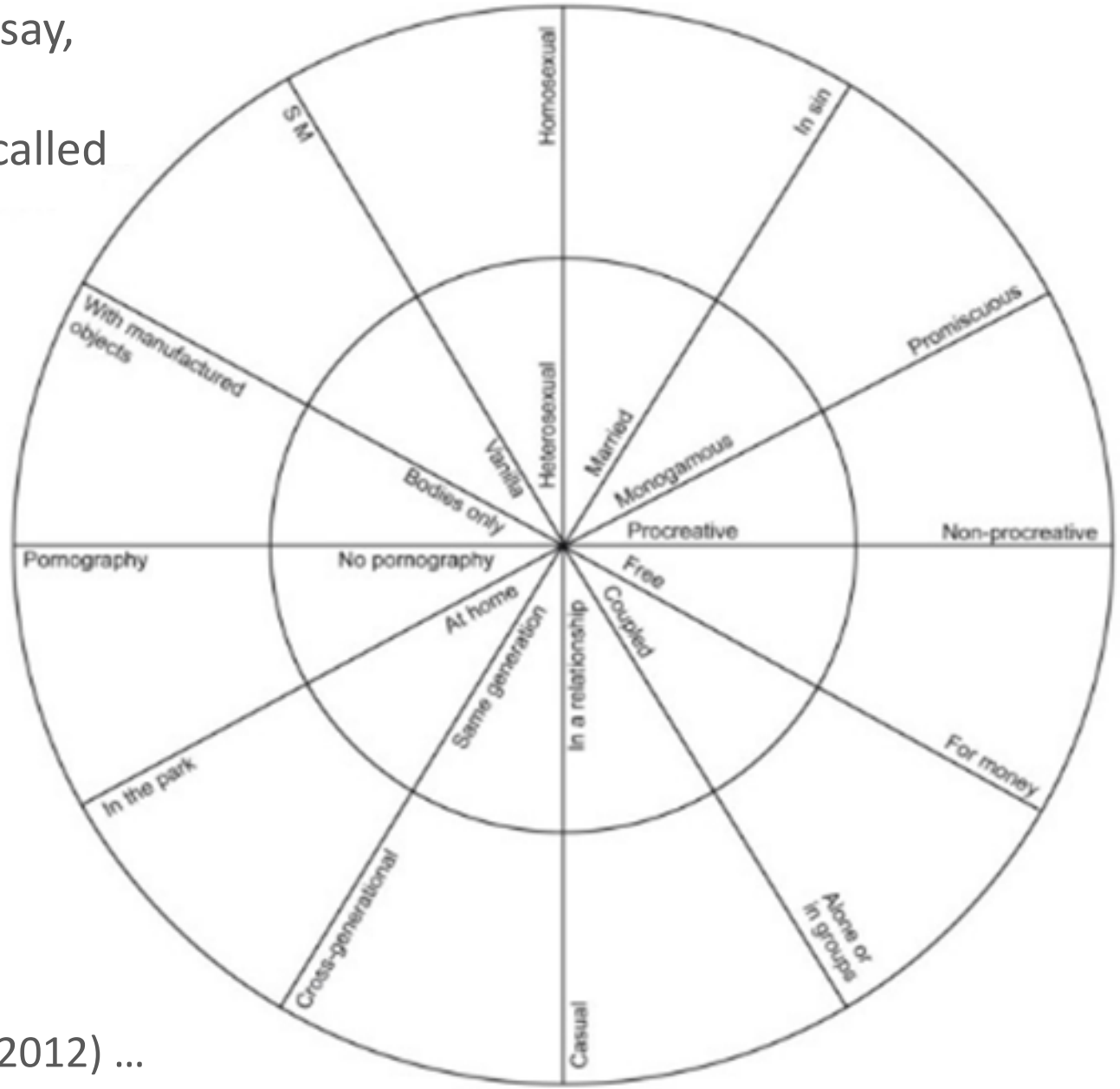
Gayle Rubin's 1984 essay, called 'Thinking Sex', introduced what she called the 'charmed circle'.



The charmed circle:
Good, Normal, Natural, Blessed Sexuality

Heterosexual
Married
Monogamous
Procreative
Non-commercial
In pairs
In a relationship
Same generation
In private
No pornography
Bodies only
Vanilla

The outer limits:
Bad, Abnormal, Unnatural, Damned Sexuality

Homosexual
Unmarried
Promiscuous
Commercial
Alone or in groups
Casual
Cross-generational
In public
Pornography
With manufactured objects
Sadomasochistic

Meg-John Barker, later (2012) …

COUNSELLOR RESOURCES

* Sexual 'Disorders'

- ✓Paraphilic Disorders DSM-5: (a) distress and/or (b) harm without consent:
  a. 'feel personal distress about their interest, not merely distress resulting from society's disapproval; or
  b. 'have a sexual desire or behavior that involves another person's psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent'.

* Sexual ‘Disorders’

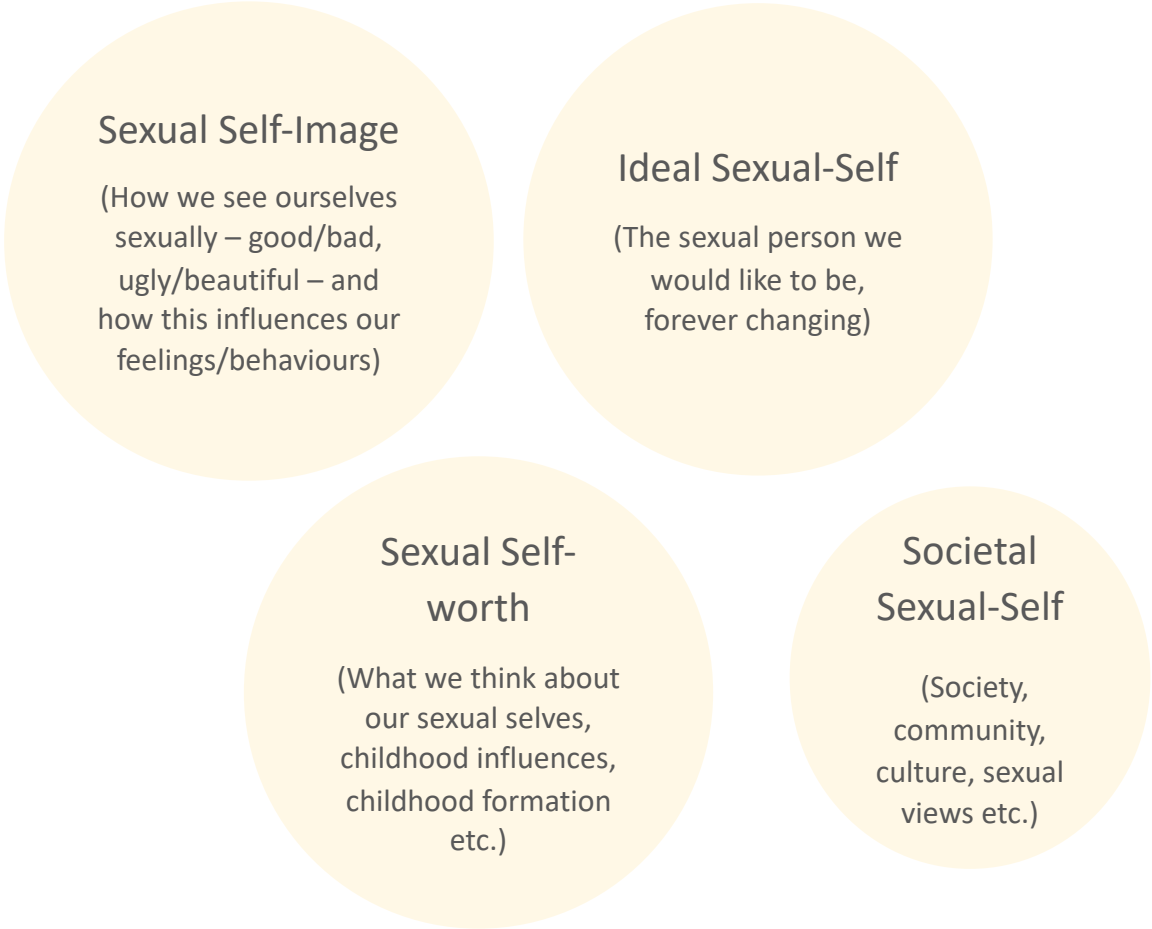
- ✓Exhibitionistic disorder
- ✓Fetishistic disorder
- ✓Frotteuristic disorder
- ✓Pedophilic disorder
- ✓Sexual masochism disorder
- ✓Sexual sadism disorder
- ✓Transvestic disorder
- ✓Voyeuristic disorder
- ✓Other specified paraphilic disorder

* Sexual 'Disorders'

- ✓**Person-centred**: looking at current, experiential feelings of distress and learning to experience these from a place of acceptance, thus reducing distress; and exploring other ways to increase present satisfaction
- ✓**Psychodynamic**: exploring stages of sexual development, unresolved and suppressed infantile perversions, and possible fixation stages; and connecting experiences to key carer relationships in an attempt to resolve these
- ✓**CBT**: focusing on the behaviours and emotional impact of such behaviours, and possibly exploring triggers and subsequent reduction, thus reducing behaviours

* Person-Centred Approaches

- ✓ Personality development (Rogers, 1959) – self-image, ideal self, self-worth
- ✓ Sexual personality development



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* Person-Centred Approaches

Five characteristics of the fully ‘sexually’ functioning person (Rogers, 1961):

1. ‘**Open to experience**’: Being open to lean into positive and negative feelings, and therefore being able to recognise when they occur; understanding what sexual experiences are positive or negative, and pleasurable or not
2. ‘**Existential living**’: Not judging our own and others’ sexual experiences; being able to enjoy sexual experiences in the present and in the moment, and not necessarily always looking back at past sexual experiences or forward at future sexual experiences

* Person-Centred Approaches

3. '**Trust feelings**': Noticing the subtle and non-subtle sexual experiences to inform us of what is OK for us, enabling and trusting ourselves to make the right sexual choices, and to trust the sexual choices of others
4. '**Creativity**': Being able to be sexually creative, and taking positive-risks with informed decision-making and consent, in order to understand our sexual selves whilst also understanding that others' experiences will be different from ours
5. '**Fulfilled life**': Being happy and satisfied with our sexual choices, which include no sex and different forms of sex

* Psychodynamic Approaches

1. Oedipus – male Oedipal aggression as a consequence of sexual desires for the mother – poor evidence (Friedman, 2002)
2. Societal influence on gender, the role of men and the use of violence more relevant
3. Gendered roles taught by caregivers and their roles, and how they interact with one another: binary view of boys and girls

* Psychodynamic Approaches

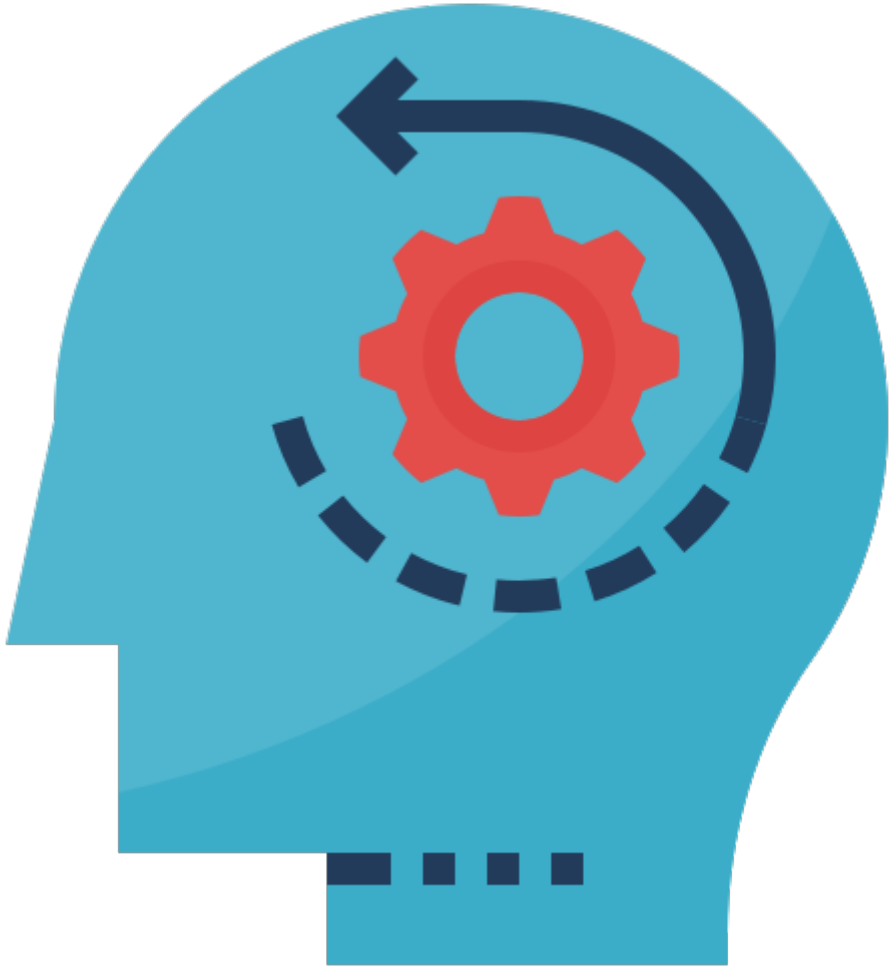
1. Human sexuality is disturbed.
2. It is often libido-led.
3. Young children experience sexual desires.
4. Infantile sexuality becomes repressed into genital sex, and adult sexuality emerges (i.e. taught by societal/heteronormative norms).
5. Infantile sexuality can become the dominant driver of sex, and lead to ‘perversions’ i.e. voyeurism/being watched – infantile form.
6. We cannot clearly distinguish between normal and abnormal, and we have traits of both (society is complex).

* Psychodynamic Approaches

7. Stages: Oral (sucking, swallowing), anal (withholding or expelling faeces), phallic (penis or clitoris – intrigue, masturbation), latency (little or no sexual motivation) and genital (penis/vagina intercourse)
8. Psychodynamics will work on exposing the dominant infantile desires to make sense of them, look at emergence, and possibly resolve these.

* Cognitive Behavioural Therapy

- ✓ CBT will explore the interactions of thoughts, feelings, physical sensations and behaviours – negative thoughts and feelings can form cycles, 'stuckness', repression and distress
- ✓ **Example**: Male dysfunction
- ✓ Understanding when the issue began
- ✓ Exploring the links between events/triggers, resulting in behaviours and negative feelings
- ✓ Goal setting – small immediate goals and an end goal



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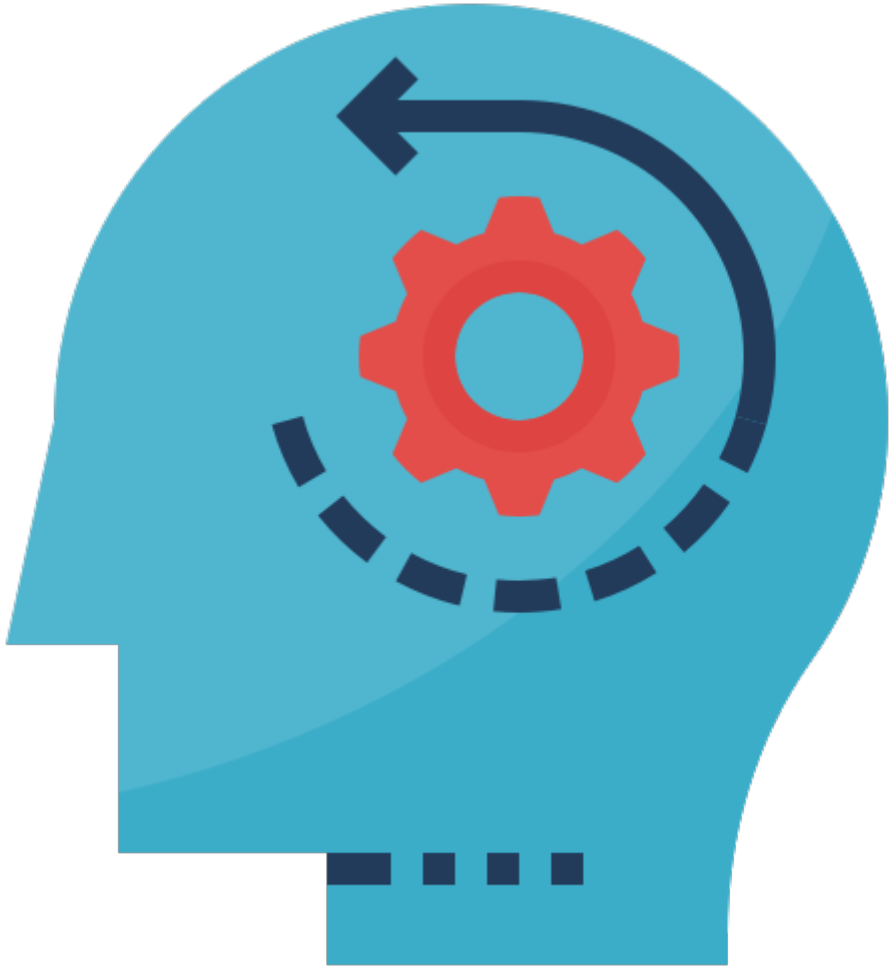
* Cognitive Behavioural Therapy

- ✓ Tools and exercises – for example, sexual activity that involved body contact and intimacy but not penetration or necessarily orgasm
- ✓ Reducing avoidance/self-soothing behaviours that reinforce thought cycles
- ✓ Self-monitoring
- ✓ Relaxation techniques



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* Cognitive Behavioural Therapy

- ✓ **Example**: Female dysfunction
- ✓ Fear-avoidance model of Vlaeyen & Linton (2000):

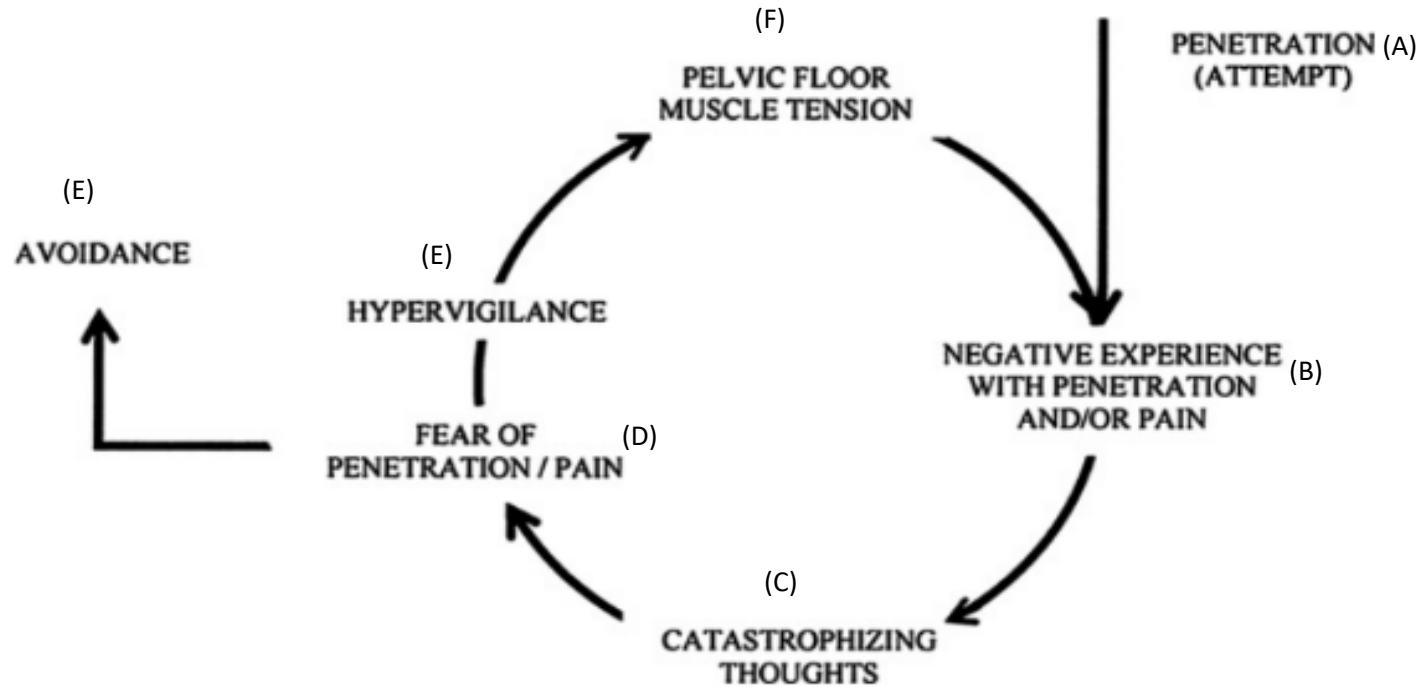

Fig. 2. Circular fear-avoidance model of vaginismus.

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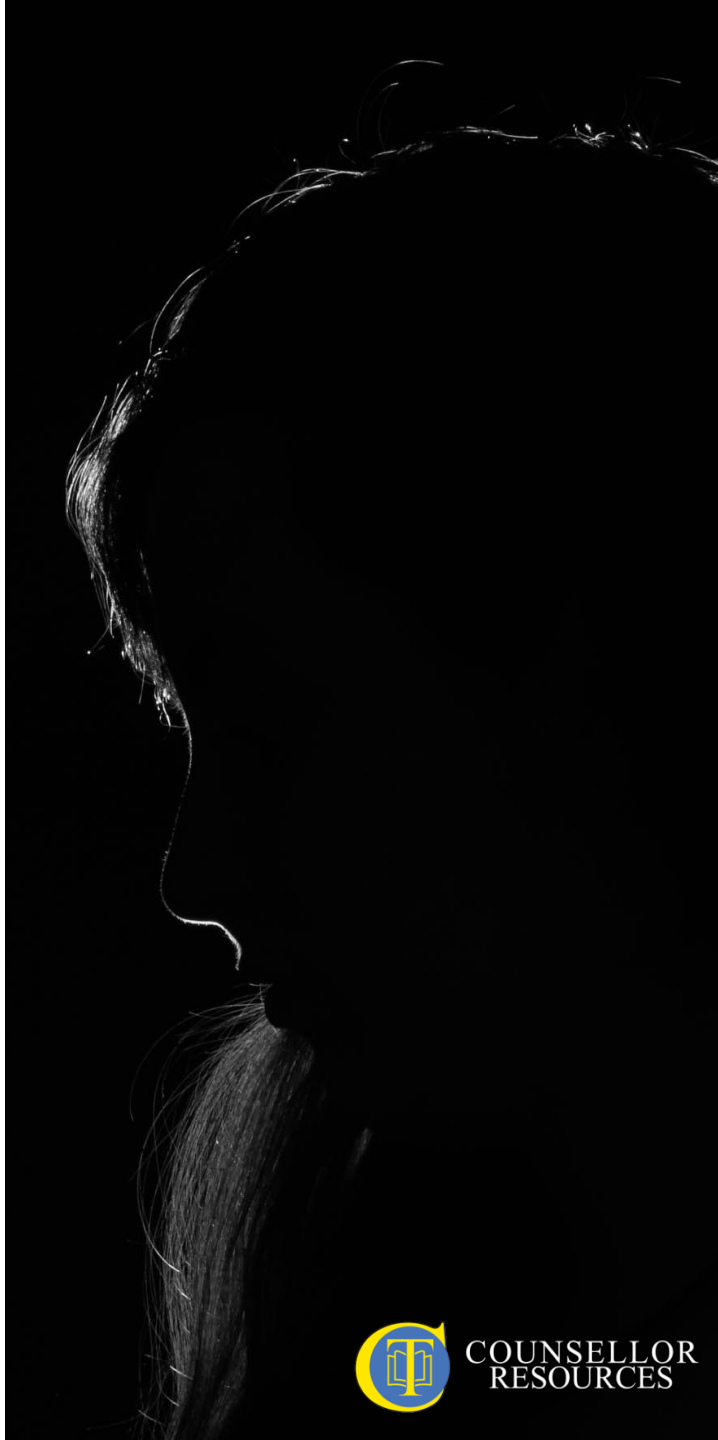
* Shame and Sex – Memorable Messaging: Women

1. Early messages that are embedded in societal norms, families, culture, education etc. (Gunning et al., 2020 – note heteronormative bias in article)

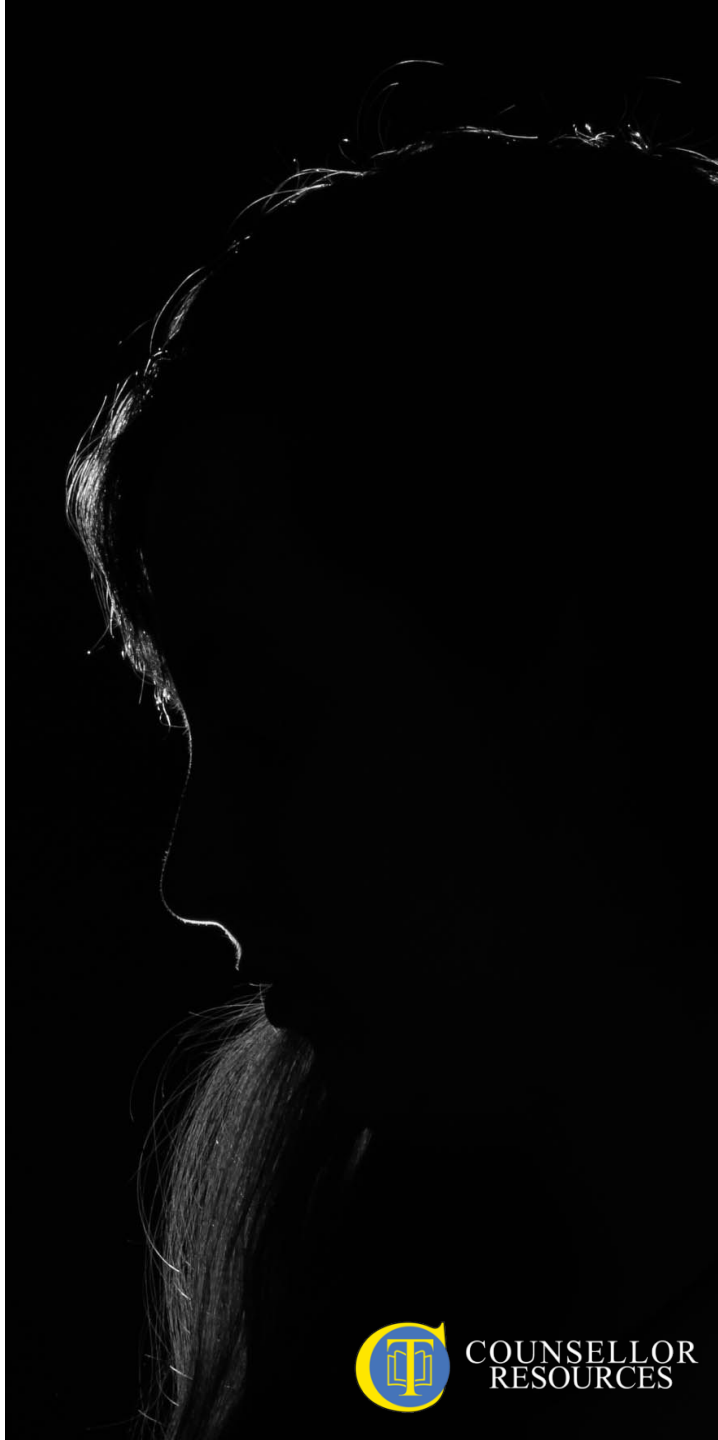
2. Messages women receive have ‘lasting implications on their identity development, conceptualisation of sexual activity, and relationships with their bodies’ (Rubinsky & Cooke-Jackson, 2017a, 2017b).



* Shame and Sex – Memorable Messaging: Women

3. This might be belief bias, religious bias, moral implications, gender assumptions, and assumptions about sexual gratification – often seen as protective factors.

4. Podcast – **menage à moi** – Numerous examples of masturbation shame that women experience



* Shame – Body Image

- ✓ Women disproportionally affected by body image issues
- ✓ Body image issues growing amongst men, particularly LGBT+ men
- ✓ CBT evaluation of body image in women (Quinn-Nilas et al., 2016):
  - Evaluative – cognitive assessment of own body
  - Affective – feelings about own body
  - Behavioural – how sexual behaviours are affected by thoughts about body (i.e. during sex might want lights off all the time, might not lie in certain positions because of effect on body fat)

Sexual Function:
Desire – i.e. libido
Arousal
Orgasm

Critical insight – this research is heterosexual women, penile-vaginal penetration, white

Research is often homophobic (Higgins, 2007).

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* Shame – Relationship Discrimination

- ✓ **Polyamory** is generally defined as 'the assumption that it is possible, valid and worthwhile to maintain intimate, sexual, and/or loving relationships with more than one person' (Haritaworn, Lin & Klesse, 2006, p. 518).
- ✓ Positive attribute associated with monogamy – 'more trusting, committed, passionate, and more sexually satisfying' (Conley, Matsick, Moors & Ziegler, 2017, p. 206)
- ✓ Therapists advise the return to monogamy (Weitzman, 2006) – clients must be damaged!

* Shame – Relationship Discrimination

- ✓ Assumptions about polyamory: lack of sexual health, emotional instability, negative personal characteristics (diminished trustworthiness), trauma (Cardoso, 2020)
- ✓ Asexuality – now viewed as normal variation rather than sexual dysfunction, and as self-identified

* Shame – LGBT+

- ✓ Increased maladaptive coping strategies to deal with internalised heterosexism, e.g. substance use (Hequembourg & Dearing, 2013)
- ✓ Differences in generations

COUNSELLOR RESOURCES

* Shame – LGBT+

- ✓ Differences in cultures/countries of origin/communities etc.
- ✓ Higher levels of shame, anxiety and insecure attachment; often leading to avoidant attachment styles (Brown et al., 2010) – unsupportive caregivers compound shame/internalised homophobia

* Shame – Men/Masculinity

How men experience sexual shame (Gordon, 2019) – increasing/continuously changing:

- ✓ Sexual experience distress
- ✓ Masturbation/pornography remorse, i.e. porn addiction or porn guilt – distress?
- ✓ Libido disdain
- ✓ Body dissatisfaction

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* Shame – Men/Masculinity

- ✓ Dystonic sexual actualisation (sexual self-image vs. sexual orientation)
- ✓ Sexual performance insecurity
  - Perceived high libido – shame/guilt
  - Sexual harassment stereotype threat
  - Homoerotic guardedness

COUNSELLOR RESOURCES

* Shame – Kink/BDSM

- ✓ Grace Millane murder – example of kink and women prejudice
- ✓ Concerns of being found out, rejected, risk to career (Bezreh et al., 2012)
- ✓ Self-acceptance; doing versus being, practice versus identity – 'doing' could be about self-shame, but it might not
- ✓ BDSM – bondage and discipline, dominance and submission, sadism and masochism – is often actually safer as a sexual practice; fewer transmitted STIs, consensual, planned (i.e. safe words) – ropes, whips, handcuffs collars, pain, power-play etc.

* Shame – Kink/BDSM

- ✓ Play, power, mind, sensation
- ✓ Some research suggests it can emerge at young ages, as early as 11 and earlier (Breslow, Evans & Langley, 1985).
- ✓ Stigma reduces a person's status in the eyes of society and 'marks the boundaries a society creates between "normals" and "out-siders"' (Goffman, 1963, p. 377) – i.e. charmed circle.
- ✓ BDSM considered unhealthy by therapy, assuming abuse/trauma (Bezreh et al., 2012)

* Fantasy and Trauma

- ✓ Women's sexual force fantasies (Shulman & Horne, 2006)
- ✓ Some evidence to suggest early sexual trauma may teach a young person to associate sex with force (Corne, Briere & Esses, 1992; Gold; Leitenberg & Henning, 1995).

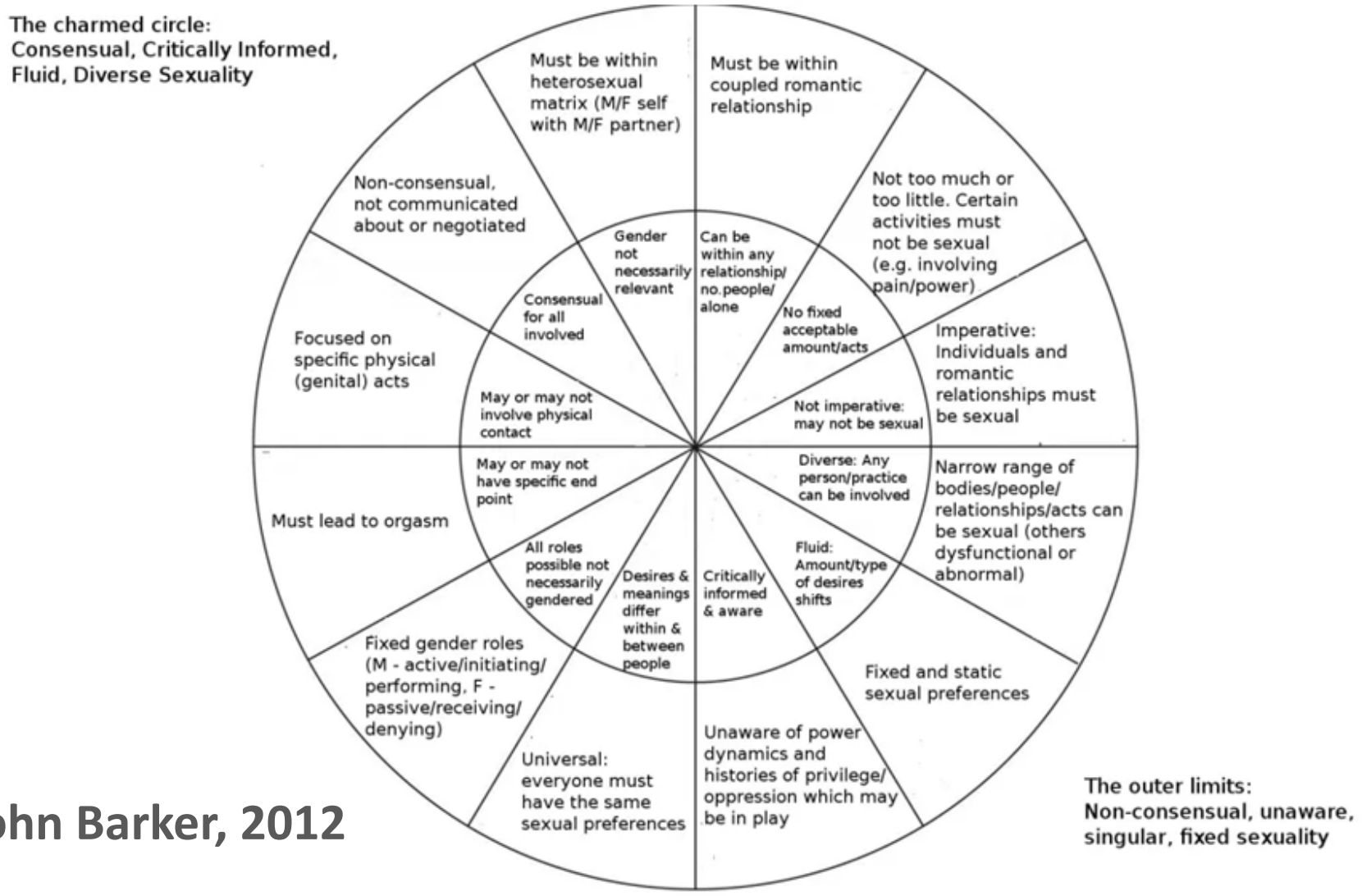
* Fantasy and Trauma

- ✓ However, early sexual trauma equally might not lead to this sexual development:
  - Is the sexual fantasy distressful to the person now?
  - Does societal/taught shame distress them?
  - Does connection to the childhood experience distress them?
  - Do they enjoy it and can they accept it?

* GSRD

- ✓ Gender, Sex and Relationship Diversity model
- ✓ https://www.bacp.co.uk/media/5877/bacp-gender-sexual-relationship-diversity-gpacp001-april19.pdf
- ✓ https://www.rewriting-the-rules.com/about-me/ – Dr Meg-John Barker
- ✓ Heteronormativity within sex therapy and sexual functioning
- ✓ Sexual dysfunction: is it?

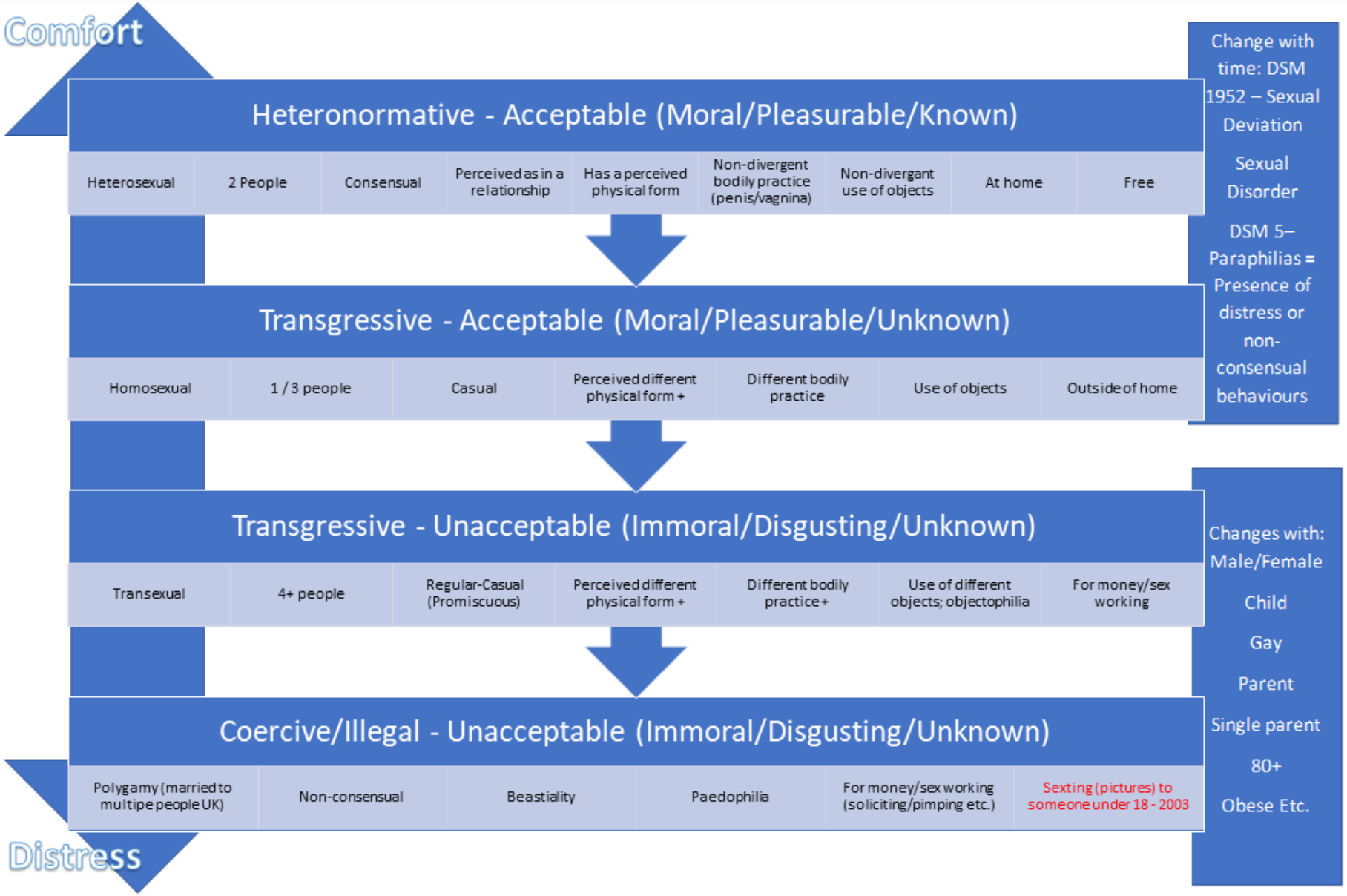
* Charmed Circle v.2



Meg-John Barker, 2012

COUNSELLOR RESOURCES

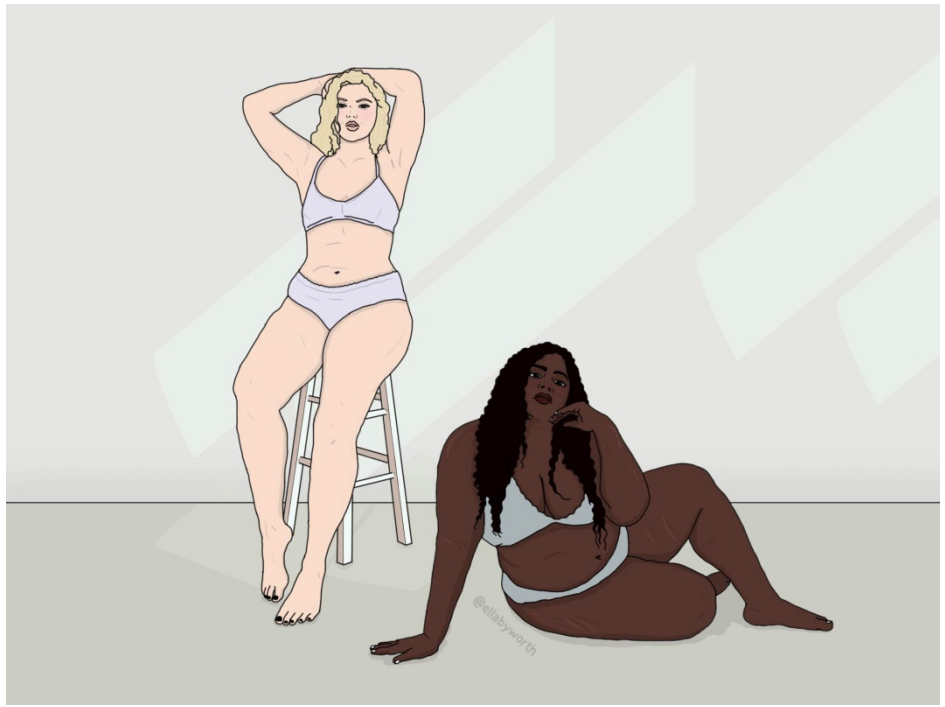
* Sexual Acceptability Model



COUNSELLOR RESOURCES

* Key Takeaways – The Therapist

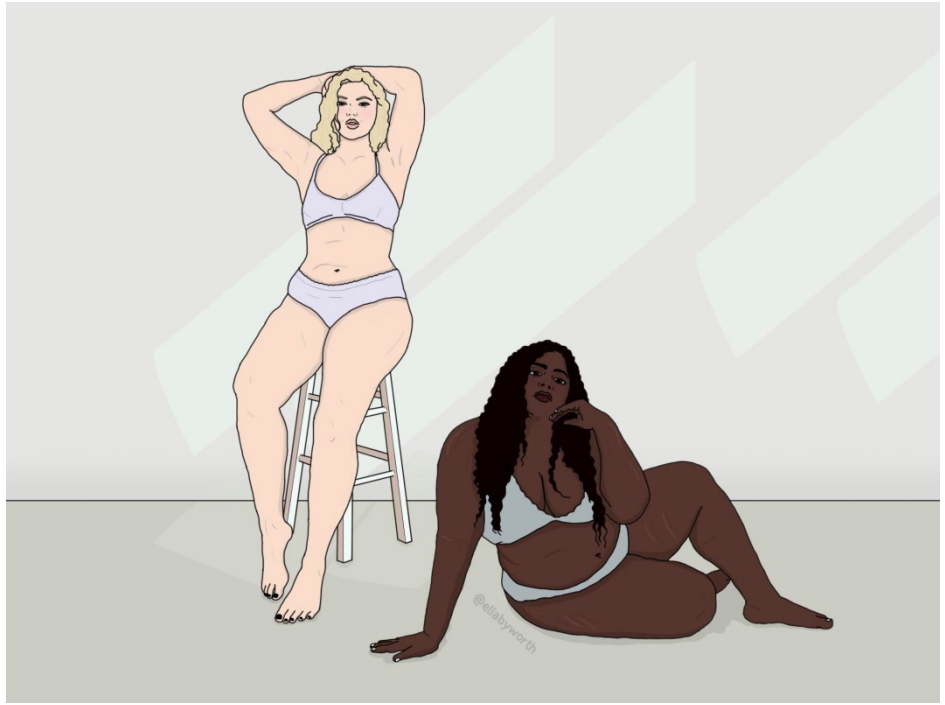
- ✓Expand your understanding of sex and sexuality, gain knowledge, don't expect your client to give you knowledge: sex is not just penis/vagina.
- ✓Explore your own sexuality: understand your discomforts, your boundaries, levels of disgust, body image, sexual efficacy – in therapy, on your own, with others.



COUNSELLOR RESOURCES

* Key Takeaways – The Therapist

- ✓Be honest about your phobias and isms – your assumptions, your lack of cultural awareness, your judgements – and discuss in therapy/supervision.
- ✓Look at the GSRD link on BACP – https://www.bacp.co.uk/media/5877/bacp-gender-sexual-relationship-diversity-gpacp001-april19.pdf



COUNSELLOR RESOURCES

* Key Takeaways – Clients

1. Sexual dysfunction = sexual communication
2. Explore memorable messaging around sex.
3. Ask your client about sex early on, once the relationship is comfortable (they probably want to be asked) – don't mistake your discomfort with theirs.
4. Be curious but relevant.
5. Normalise discomfort – yours/theirs.

COUNSELLOR RESOURCES

* Key Takeaways – Clients

6. Use their language if possible – dick means dick – or explain why you may not be able to use their language, but validate theirs.
7. Do not expect your client to educate you; educate yourself between sessions.
8. Normalise, normalise, normalise.
9. Gently unwrap shame.
10. Know your position on vulnerable adult, child safeguarding and sex/law.

COUNSELLOR RESOURCES

* CPD Certificate

Don’t forget to claim your CPD certificate.

This lecture and the additional resources, handouts and associated learning materials comprise 1.5 hours of CPD.

COUNSELLOR RESOURCES