Peer Commentary

Sex Therapy Needs Building Not Deconstruction

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Without Abstract

In their attempt to deconstruct sex therapy and bury the remains, Binik and Meana (*2009*) ask "Will the 'real' sex therapist please stand up?" I am not sure about being "real," but I was a sex therapist for 40 years until my retirement. I have treated many couples and individuals and also trained many therapists in the use of sex therapy. These trainees have come from a range of professional backgrounds, including clinicians, social workers, and marriage guidance counselors. I am aware that the term "sex therapy" is used to describe a variety of approaches, but I will focus on my approach as I "stand up" in this commentary.

Binik and Meana start their piece: "The practice of sex therapy appears to be alive and well." In my view, it is close to being in crisis. We are in an "evidence-based" era of health care, and the most crucial problem facing sex therapy is the lack of evidence of its efficacy, which I will return to below. By the time I left the United States, it was becoming increasingly difficult to get sex therapy covered by health insurance and my impression was of a marked decline in the number of people training as sex therapists. On my return to the United Kingdom, where I had practiced as a sex therapist within the National Health Service (NHS) for most of my career, sex therapy clinics within the NHS remained few and far between and those that existed depended on the commitment of specific clinicians with an interest in sexual problems, rather than the policies of the health care system. At the present time, sex therapy in the UK is most available from Relate, what used to be called the National Marriage Guidance Council, provided by marriage guidance counselors with additional training in sex therapy.

There is no unifying theory of sex therapy, we are told. That is basically true, but it is, if anything, a strength rather than a weakness. When I first started treating sexual problems, I regarded myself as a "behavior therapist," guided by "modern learning theory." I struggled to fit this theoretical approach to the needs of my patients. Then came Masters and Johnson (*1970*), like a breath of fresh air. Yes, they were atheoretical, but they provided a framework for dealing with sexual problems in sexual relationships that immediately made sense to me and many other therapists with a range of theoretical approaches, Helen Kaplan, a psychoanalyst, being a notable

example. It was unusual and encouraging to have a treatment that permitted the use of a variety of theoretical approaches.

My basic approach has changed little since then. I view sex therapy as having two principal components—"behavioral" and "psychotherapeutic." The behavioral assignments have two crucial functions. By setting specific behavioral goals, described by Masters and Johnson as "sensate focus," one allows a graded approach to sexual interaction that is particularly effective in identifying the "obstacles" to a pleasurable sexual relationship. Once identified, such obstacles usually need the "psychotherapeutic" component in order to be resolved, and this is where a variety of approaches may be effective, depending not only on the specific obstacles but also on the specific skills of the therapist.

There have been two relevant changes in my approach in the last few years, which I have incorporated into my recent writing on the subject (Bancroft, *2006*, *2009*). The first is the impact of pharmacotherapy, in particular the "Viagra phenomenon." Whereas Viagra and other PD-5 inhibitors provide a method of improving erectile function, it has become increasingly apparent that such pharmacological treatment on its own is often ineffective in the longer term, and needs to be integrated with counseling or psychotherapy to help the couple to incorporate the pharmacological effect into their sexual relationship (Rosen, *2007*). Sex therapy, as I see it, is particularly effective in this respect. The early stages of sensate focus allow the therapist to decide whether a continuation with sex therapy will be sufficient or whether pharmacological treatment should be added. This emphasizes the extent to which "sex therapy" is a method of assessment as well as treatment. The assignments of "sensate focus" are such that one could reasonably ask any couple, with or without sexual problems, to do them, confident that they will provide valuable insights into the nature of that couple's sexual relationship. This is one relatively unique aspect of sex therapy. Second, and this has more to do with my increasing attention to theory than with sex therapy *per se*, I have come to see that the Dual Control Model of sexual response (Bancroft & Janssen, *2000*), in which sexual excitation (SE) and sexual inhibition (SI) are counterbalanced, and where propensities for SE and SI vary across individuals, is a constructive way to view the sex therapy process. If the problem results from increased sexual inhibition reactive to the dynamics of the current relationship, then the early behavioral assignments and the associated psychotherapeutic component may well result in reduction of the inhibitory component. If, on the other hand, the sexual problem is not a result of reactive sexual inhibition, it may persist in spite of the early stages of treatment. The clinical value of this specific theoretical approach to sex therapy has yet to be demonstrated, but it has potential.

At various points in their article, Binik and Meana suggest that sex therapy is not meaningfully distinguishable from other types of therapy. They state, for example, that "sexual dysfunctions are probably governed by biopsychosocial mechanisms very similar to those governing other life problems." In some respects, that is so. But the combination of the psychophysiological processes involved in sexual arousal, and their expression in sexual behavior, is unique, made more so by the involvement of a sexual partner. Furthermore, the study of sexuality in general, as well as the treatment of sexual problems, requires a cross-disciplinary approach, covering sociocultural influences as well as psychophysiological mechanisms, and how they interact. One of my early concerns as a sex therapist was that the behavioral component, in particular sensate

focus, might reflect middle-class values in relation to male-female relationships. I have become less concerned about this since, and have been encouraged by what Binik and Meana call “a hot export,” the use of sex therapy in other cultures. This illustrates further the adaptability of the sex therapy format, making it useful in cultures where male-female relationships differ in important ways from those in North America and Europe.

The cross-disciplinary nature of sex therapy as well as sex research, apparent from the variety of professional backgrounds of those who practice sex therapy, as well as those who attend sex research meetings, has always held considerable appeal for me. Sex therapists and sex researchers vary in their areas of particular expertise; some will be better informed about the psychophysiological, others the relational or cultural aspects. But they will all acknowledge the importance of the interaction of these aspects. While I am sure this is not unique, it is another way in which sex therapy is different, and why organizations of sex therapists have emerged. Why should this be regarded as a problem? And why on earth should this “perpetuate societal discomfort with issues of sexuality”?

Binik and Meana call for the incorporation of “sex therapy” into other treatment approaches, rather than see it as something “special” or “privileged.” I see no reason why elements of sex therapy can’t be used by therapists who have not had specific training in sex therapy. Quite often a sexual problem within a relationship can be resolved simply by getting the couple to go through sensate focus, as it often enables them to gain insight. Thus, health care professionals who are likely to encounter sexual difficulties in their patients or clients can be encouraged to explore this approach, with the understanding that if it is not helpful and the sexual problem continues, referral to a sex therapist is appropriate. A family planning clinic is an obvious place for sexual issues to be discussed, and in the fourth edition of the *Handbook of Family Planning and Reproductive Health* (Glasier & Gebbie, *2000*), I provided some basic information about sexual problems and encouraged the clinician to try simple behavioral interventions when such problems are encountered.

Many clinicians, however, are not comfortable talking to their patients about sex. This may have improved in the past 50 years, but it is noteworthy that the medical training curriculum now gives less time to sexual issues than in the past. Members of the medical profession, in particular, have a tendency to be evasive about sexual issues. For those seeking help for sexual problems, being able to talk comfortably about sex is crucially important. This is one reason (among many) why it is helpful to be referred to a clinician who the patient knows to be a specialist in sexual problems, such as a sex therapist.

“Why separate sex from relationships and the rest of life?” they ask. No sex therapist would suggest that we separate sex from relationships. Such separation was evident in the early stages of sexual medicine, principally involving urologists. Binik and Meana incorrectly state that the growth of the sexual medicine movement has been very recent. In fact, it got underway in the 1970s, initially with emphasis on surgical procedures for erectile dysfunction, such as penile implants, and later with the advent of intracavernosal injections. Not only was sex separated from relationships, the penis was considered independently of the man attached to it (Bancroft, *1989*). With the introduction of Viagra, there has been a substantial change, with surgery being much less involved.

I personally have no doubts about the value of sex therapy, but I recognize the need for this value to be systematically and convincingly demonstrated if sex therapy is to prevail. This, however, presents us with a considerable challenge. In the first two decades of Masters and Johnson-type sex therapy, there were a number of controlled studies assessing efficacy (for review, see Hawton, *1992*). But since then there have been very few (Heiman & Meston, *1997*). Having participated in a number of the early studies, my impression was that those in the field became disillusioned by a tendency to find no statistically significant difference between sex therapy and other methods. Warner and Bancroft (*1986*) proposed that an important reason for this was the considerable prognostic variability, particularly in couples receiving sex therapy. So far, little or no attempt to control for key prognostic variables has been employed, and in order to do so we need a better understanding of prognostic factors and a relatively large number of couples to be involved. All the earlier studies had involved relatively small samples. Furthermore, the relevant treatment outcomes are varied and complex. They are not simply a matter of eliminating a specific sexual dysfunction. The relevant changes involve a relationship, whether or not both partners are involved in therapy. Sex therapy, for example, can be beneficial to a couple where one partner has an "organic" dysfunction that cannot be changed (e.g., erectile dysfunction in a man with diabetes), the beneficial outcome being a substantial improvement in the experience of sexual pleasure and the quality of the sexual relationship. By improving communication and understanding between the couple, many useful sexual adjustments may result. How to capture such varied benefits in treatment outcome research requires careful consideration. Together, these requirements present the challenge. It is not an insuperable one, but will probably require a multi-centered treatment study with all the complexities that entails. Such research is also expensive and a further enduring problem is the difficulty in obtaining research funding in this area.

"Burying" sex therapy in the expectation that mental health or sexual medicine clinicians would fill the gap, would, in my opinion, be a serious mistake. We should be striving to build, not dismantle.

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