Quickies

The Handbook of Brief Sex Therapy

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A Catalytic Approach to Brief Sex Therapy

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LAWRENCE AND TINA HAD BEEN ENGAGED for nearly a year, and their wedding day was a month away. Lawrence had recently lost all interest in sex, and thus they sought therapy with a sense of urgency. During the past month they had been interlocked in an intense conflict over sex, with no resolution. Like most couples, they had revealed their sex histories early in their courtship; they had both appreciated the openness of these discussions and had shared many details. As the wedding drew nearer, Lawrence suddenly became uncomfortable when he and Tina were making love. He explained that during their previous sex-history discussions, he had formed mental images of what Tina looked like when she was with former lovers. Recently, these images had begun to enter his head when he and Tina were making love. He had tried to deal with this on his own by telling himself that these ideas were silly. However, his attempts were futile; he simply would feel himself turn off whenever he and Tina started to become intimate.

When Tina discovered Lawrence's distress and asked him what was wrong, he reluctantly confessed and then asked Tina to describe more of what she had done with other lovers, wondering if she did things with the others that she hadn't done with him. Feeling very uncomfortable, Tina tried to brush these questions off, but this led Lawrence to secretly conclude that she had more of a past than she was revealing. When frustrated with her, the

word *whore* popped into his head. He tried turning his anger into sarcastic remarks, but this brought out more defensiveness in Tina, which, in turn, inspired more suspicions, not only of Tina's past, but also of her present.

They came to therapy with several concerns. Tina truly loved Lawrence but was afraid that he had a serious emotional problem. Lawrence realized that he was being irrational; however, try as he might, he was unable to stop the images of Tina with other sex partners. Conversations had only made things worse. Both admitted that they were emotionally and physically exhausted from staying up into the early morning on most nights, trying to resolve their problem. They were hoping that the therapist could help them get out of this "downward spiral," so they could get on with enjoying their relationship and wedding.

Alicia and Dave appeared for therapy with what they thought was an unusual problem—male frigidity. They reported that after 10 years of marriage, Dave had become completely uninterested in sex. He hadn't approached Alicia in 6 months, and he found excuses not to have sex when she made advances toward him. Dave was puzzled by his lack of responsiveness, as Alicia was extremely attractive, worked out regularly to stay in shape, and was wonderful with their two children. The couple did not argue or fight, although there had been a growing tension over Dave's lack of sexual interest in Alicia.

They initiated therapy after a discussion in which Dave had revealed that he was questioning the possibility that he had fallen out love with Alicia. Considering her more friend than lover, he was spending more time at work. In separate conversations with the therapist, Dave denied that he was having an affair or was interested in other women. Alicia suspected that because Dave was not having sex at home, he must be "getting it someplace else."

Nadia didn't like sex. Married to her husband, Ivan, for nearly 13 years, and mother of their two young boys, ages 4 and 5, she felt numb when they made love. Throughout their marriage she had tried to meet Ivan's needs; however, lately he was becoming increasingly frustrated with her over her lack of desire. Complaining that they did not have sex frequently enough, Ivan didn't like it when Nadia would "just lay there."

Nadia agreed that she wasn't interested in lovemaking and that Ivan was right about the frequency issue. Given her responsibilities with the children, she had been more tired lately, and, consequently, she was having more difficulty forcing herself to have sex with her husband. Not having

had intercourse in more than 6 months, Nadia said that as far as she was concerned, she could live just fine without sex; she loved her children very much and Ivan was a good husband who treated her well. If anything, she felt sympathy for his plight. However, several weeks earlier, they had had an argument about sex, during which Ivan threatened divorce if Nadia didn't get "her" problem solved. This was especially upsetting for Nadia because Ivan had never threatened to leave her before. Ivan always went by his word, so Nadia knew that if she didn't do something, he was likely to leave. Nadia consulted her gynecologist, who, unable to find a medical problem, referred her for psychotherapy.

Had the couples described in these vignettes gone to a sex therapist in the 1950s or 60s, they would have probably found themselves involved in long-term psychodynamic work, with their therapist going in search of the underlying causes of their sexual difficulties. Had they simply consulted some sex manuals, they probably would have encountered prescriptive techniques, heterosexual assumptions, and the idea that foreplay is a prerequisite to insertion and orgasm for both partners (the closer to simultaneous the better)—the universally desired end (Apfelbaum, 2001). The manuals, implicitly suggesting that sexual contact is a "performance" to be judged, would have inadvertently heightened the couples' performance anxiety.

Had the couples gone to a sex therapist in the 1970s, 80s, or 90s, they would probably have worked with someone influenced by Masters and Johnson's pioneering and widely influential work, *Human Sexual Inadequacy* (1970). As a result, their time in therapy would have been much briefer, and it would have been organized much differently. Their therapist would have known much about their sexual response cycles (Masters & Johnson, 1966), and he or she would have assumed that their difficulties were probably based on performance anxiety. As Masters and Johnson put it, "Fear of inadequacy is the greatest known deterrent to effective sexual functioning" (1970, p. 12).* The therapist would have had several techniques at his or her disposal—including "avoiding goal directedness," "sensate focus exercises," "intercourse prohibitions," "nondemand pleasuring," "receptive kissing," "start-stop methods," "squeeze techniques," "masturbation training and self-pleasuring," and "vaginal dilators"—and one or more of these might have been helpful in resolving their problems.

* Masters and Johnson (1970) themselves inadvertently played into these fears (among other problems) by the very title of their work, which focused on *inadequacy* rather than on difficulties or problems, assuming that there was some tacit norm of adequacy.

However, it is possible that the therapist's drive toward brevity and efficiency, along with his or her assumptions and biases, might have only exacerbated the couples' distress.

Despite the many improvements to sex therapy offered by Masters and Johnson and others, current approaches are still burdened with significant problems. Peggy Kleinplatz (2001) articulated a telling critique:

- There is no unifying theoretical base for sex therapy.
- Sex therapists' fundamental assumptions are laden with sexual myths and stereotypes (e.g., about gender and "normalcy").
- Current sex therapy practices are based on gender-biased, phallocentric, and heterosexist assumptions. For example, rapid ejaculation in males is seen as a serious problem, whereas rapid orgasm in females is seen as reason for celebration (Reiss, 1990).
- Sex therapy's basic conception of sexuality remains biologically based, rather than offering equal attention to personal and interpersonal processes, cultural norms, and gender bias.
- The field continues to focus on body parts, rather than on the persons attached to them.
- Sex therapists are least successful where the greatest needs are—in problems related to desire.

We concur with these criticisms. The sex therapy field has, historically, paid too little attention to cultural, contextual, theoretical, and interpersonal competence. As Apfelbaum (2000) pointed out, the societal enthusiasm that has greeted the introduction of Viagra highlights a continued emphasis on sustained erections. Delayed ejaculation is considered a blessing, enabling sustained intercourse rather than the troubling dilemma it can often present for those who experience it. Sex for pleasure is left out of the picture, in favor of intercourse-based, orgasm-mandated acts. Sex therapy writers rarely address the positive ways of expressing joyful and passionate sexuality or consider that many men and women prefer same-sex partners.

The treatments of vaginismus or erectile dysfunction mark two additional examples of this focus on performance. The fact that vaginal dilators are used with nearly 100% success to eventually enable intercourse is, on the one hand, good news. However, this news also supports the myth that intercourse is the ultimate desirable goal. The target of treatment is a set of parts in disrepair, and the context for the problem remains irrelevant. Similarly, the treatment for erectile dysfunction tends to be on the

penis, with frequency and firmness of erections taking precedence over understanding the contextual pressure of performance on demand. When the focus of treatment is on techniques to enhance performance, clients aren't given an opportunity to discover multiple ways of being in relationships or to understand the contexts in which sex disappoints them.

Too often, sex researchers and sex therapists have (literally) put on the white coat of medical lab researchers to assume an air of medical objectivity and neutrality in their work, to desensationalize their focus on sexuality, and to gain credibility for their research grants. In doing so, they not only have lost the broader contexts of sexuality, but also have overlooked the pure passion and pleasure that sexuality offers. Perhaps this has contributed to the field's limited success in helping clients presenting with low desire* to find the erotic intimacy and fulfillment necessary to fuel their sexuality.

In the face of such critiques, sex therapy appears to be caught in a cul-de-sac, where disjointed and ungrounded techniques are atheoretically applied in service of traditionally defined and medically driven performance criteria. This chapter offers a way out of this dead end. Drawing on the insights and practices of the strategic and systemic brief therapies, as well as the metatheories that have influenced them, we present a "catalytic approach" to brief sex therapy that honors the complexities and particular passions of our clients and their partners, attending not only to their struggles with performance, but also to their levels of desire. This is done with a contextual sensitivity to their cultural understandings, as well as to their sexual identities and expressions.

CATALYTIC BRIEF THERAPY

Before we can describe our approach to sex therapy, we must first explain our brief therapy foundations. We have been significantly influenced by both the strategic model of the Mental Research Institute (MRI) (Fisch, Weakland, & Segal, 1982; Nardone & Watzlawick, 1993; Watzlawick, 1976, 1984; Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzalwick, & Bodin, 1974) and the solution-focused model advanced by the Brief Therapy Center (de Shazer, 1982, 1985, 1988, 1991, 1994; de Shazer et al., 1986) and others (O'Hanlon, 1987; O'Hanlon & Martin, 1992; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992).

* Years ago, most clients presenting with this problem were women. However, more recently the proportion of males and females presenting with low desire has become essentially equal (Apfelbaum, 2000).

Although many would suggest that MRI and solution-focused approaches to brief therapy should be considered separate models, others have strongly argued that they are best considered two variations of the same process-based orientation (Fraser, 1995; Presbury, Echterling, & McKee, 2002; Quick, 1996). Adopting the latter perspective, we use the term "catalyst" to refer to a blending of the two (Cummings, 1995; Fraser, Morris, Smith, & Solovey, 2001, 2002).

A catalytic approach is organized with a simple focus—to introduce a small but significant shift in the relationship interactions or descriptions around a problem, and then to amplify the subsequent ripples in the system to foster change. Like MRI therapists, we view problems as vicious cycles of well-meaning attempts to solve a perceived difficulty. When the attempted solutions don't work, people tend to try them again and again, which makes the difficulty itself worse, or in fact *becomes* the problem.

Our basic interventions involve finding or creating significant exceptions to the problem pattern, or finding or creating small but significant differences in the vicious cycle of the problem. The first step involves identifying the vicious cycle pattern around the described problem. Like MRI therapists, we then initiate new action by redirecting solution attempts or reframing the problem. Like solution-focused therapists, we also identify and amplify already-occurring exceptions to the problem pattern and build upon them to support change.

Both components of the catalytic approach seek to introduce shifts in the action or conceptualization of the interaction around the identified problem. In this chapter, we describe some of the major ways brief therapists introduce such shifts in the "doing" or the "viewing" of the problem, but first we must elaborate on two metatheoretical ideas that inform this way of working—the systemic concept of *second-order change* and the social constructionist notions of *the coevolution and relativity of reality*, or *second-order reality.*

Second-Order Change

Although the concepts of first- and second-order change are based on rather complex theoretical premises (Watzlawick et al., 1974), they can be explained quite simply. *First-order change* refers to change within the normal definitions, understandings, premises, rules, and practices of a given system. It may be described as change in frequency, intensity, location, duration, and so on of a given practice or action.

For example, a man experiencing difficulties in attaining and maintaining an erection may (along with his partner or partners) initiate a wide

variety of actions that would fall under the heading of "first-order change." He and his partner(s) might, for example,

- try to have sex more frequently, while rating his "erection success";
- try to avoid or reduce sexual interactions, thus reducing the frustrating potential of "failure";
- try harder to produce and sustain his erections, while closely attending to the "success" of their efforts in terms of hard penises.

All such solution attempts are first-order changes that either maintain the status quo or exacerbate the very difficulty that the client and his partner(s) are trying to resolve. Based on the shared assumption that the way to solve the problem is to try harder and to attend closely to success and failure, the solutions themselves become the problem. With success measured by the degree to which a sustained erection facilitates an orgasm by the man, his partner, or both of them, the man will be caught up in performance anxiety and continual distraction from the intimacy and passion that leads to arousal.

Second-order change is a change of the premises, definitions, assumptions, practices, and traditions of a given system of relationships. It most often represents a counterintuitive stepping out—or a *reversal*—of the commonly held ideas on the nature of a situation and its logical and reasonable solutions. It has thus often been described as *paradoxical* or *ironic* (Fraser, 1984). Such change tends to alter the premises or corollaries of a given system or, building upon them, to evolve new, different, or opposite solutions.

The man with erectile difficulties could experience a second-order change in many different ways:

- He might question whether his difficulty was actually a problem, or simply a reflection of other circumstances, such as reduced interest in his sexual partner(s) or their sexual practices. In this case, there would be little reason to expect firm and sustained erections.
- He might realize that his difficulty was situational—a result, say, of fatigue, worry, distraction, or illness—rather than an indication of a more severe problem. This could allow him to stop trying to remedy the situation, thus reducing the very pressure and distress that was precluding resolution.
- In an effort to learn more about what was going on, he and his partner(s) might purposefully try to make him lose his erections.

Many of Masters and Johnson's most effective interventions—from "sensate focus" techniques to giving directions for going slow and not engaging in intercourse—introduce the possibility for second-order change. For example, in male-female couples, the therapist reverses compulsions for male direction by putting the woman equally or more in charge of portions of nondemanding pleasuring, or start-stop approaches to rapid ejaculation. The compulsion to reciprocate is reversed in the exercises of receptive kissing and nondemanding pleasuring. And redirecting women away from attempting to achieve orgasm and toward self-pleasuring often reverses their difficulty in reaching orgasm.

The Co-evolution and Relativity of Reality

Both MRI and solution-focused therapists have been significantly influenced by the constructivist and social constructionist position that all of our ideas and constructs are individually and interactively created; they aren't floating "out there" as truths to be discovered. Constructivism (Bateson, 1972; Gergen, 1985, 1991, 1992; Watzlawick, 1976, 1984) refers to the philosophical and epistemological viewpoint that individuals co-create their views of reality through interacting with the world. Social constructionism (Gergen, 1985, 1994; Hoyt, 1994; Mahoney, 1995; McNamee & Gergen, 1992; Neimeyer, 1993; Neimeyer & Feixas, 1990; Neimeyer & Mahoney, 1995) builds upon the constructivist premise by emphasizing the influence of the social context on the making of meaning.

These postmodern understandings emphasize that all interactions should be considered in terms of the contexts of language and culture (Gergen, 1991, 1994). Thus, our ideas of gender roles, sexuality, and normative sexual practices, for example, must be considered within the individual and cultural assumptions from which they have evolved. As the MRI group (Watzlawick, 1976; Watzlawick, et al., 1974) noted, any given action or situation can be described and understood within any number of useful realities or frames of reference. These frames, which both enable and constrain possibilities, are applied not only by clients, but also by therapists and theoreticians.

Such a recognition invites us to examine our implicit assumptions on sexuality and normative practices, reminding us that there are many entirely positive ways of defining and expressing sexuality that don't fall within culturally dominant norms. Further, if all views of reality are created through social interaction and the use of language, then they can co-evolve in new

ways through interaction with therapists and homework with partners. Slight shifts in interaction with therapists and others can have watershed effects in altering the path of formerly problematic patterns.

Influenced by these ideas, catalytic brief therapists attend to, respect, and accept their clients' language and conceptual frames (Fisch et al., 1982; Nardone & Watzlawick, 1993; Watzlawick, 1976, 1978; Watzlawick et al., 1974; Weakland et al., 1974), creating pathways to change with interventions such as the following.

Restraining Change

Restraining clients from moving too quickly, or prohibiting them from directly attempting their desired goal, is often a second-order change in and of itself. Catalytic brief therapists employ both "soft restraints," where they give clients the directive to "go slow" in their attempts to rush headlong into some resolution, and "hard restraints," which involve either prohibiting a goal-oriented action or offering challenges to clients.

For example, a catalytic brief therapist may, not unlike Masters and Johnson, recommend that clients refrain from engaging in intercourse or other kinds of sexual interaction. When the couples "slip up" and attempt or successfully engage in their desired sexual pleasure, the therapist may cautiously celebrate their unexpected success. When their slip-up doesn't turn out well, the therapist can use their experience to reinforce the go-slow message.

Normalizing

This intervention attempts to put clients at greater ease by contextualizing their difficulties as normal reactions, given the constraints of their situations. Allowing clients to relax their often-pressured efforts to solve a perceived difficulty, normalizing helps them depathologize themselves and whatever they are struggling with. Sex therapists often accomplish much the same thing through psychoeducation, outside readings, and direct explanations.

Framing, Reframing, and Deframing

Framing involves placing a person, situation, action, or problem in a particular context. Reframing involves putting the same person, situation, action, or problem in an alternate but equally sensible and often more useful context. Deframing refers to deconstructing the context of a particular frame of reference to eliminate it as a cause for a problem, challenge its absolute reality base, or simply point out that it is but a point of view.

Positioning

Catalytic brief therapists adopt a position relative to their clients that is designed to facilitate therapeutic change. They might take a position of "cautious optimism," a "one-down" position, or a position that is significantly different from that of the clients or "helpful" others.

Prescribing Symptoms

Symptom prescription involves asking clients to engage purposefully in some variation of the described problem behaviors, allowing the therapist to learn how they think, act, or react during the problematic cycle, or to learn more about what brings the problem on or what makes it worse. Such prescriptions make the problem pattern less "automatic" or less out of the clients' control.

Predicting Difficulties or Relapses

This technique is often used to deflect clients from being discouraged at perceived setbacks or to encourage them to consolidate their gains by reencountering old perceived dangers. For example, clients might be warned that their first attempts at a new sexual exercise or technique is unlikely to produce instant success or pleasure and that the main objective is to learn something about themselves or their partner. Once they've achieved greater intimacy, they might be asked to see if they can reignite one of their old struggles. If they fail to fight, they further solidify their new patterns. If they succeed at fighting, they learn in what ways they are still vulnerable to the old pulls.

Finding and Amplifying Exceptions, Differences, and Positive Solutions

Once desired goals are identified, clients and therapists jointly look for times in the past and present when the problem hasn't happened. This process of searching for positives and identifying how they've come about is itself a second-order change, a reversal of the common client process of focusing only on problem-saturated stories. As exceptions to the sexual difficulty are identified, the contingencies surrounding them can be identified, and these positives may then be amplified, creating successive approximations of the desired goals.

Adopting a Goal-Oriented Future Position

Catalytic brief therapists help clients identify small, achievable, and relevant goals that are action-oriented and observable. The more clients orient toward a possible future, the more successful they become at realizing it.

With the theoretical framework of our catalyst approach established, we'd now like to discuss some cases. The first two demonstrate our method of working with clients who have medical concerns; the following three further elaborate on the vignettes presented at the beginning of the chapter, illustrating a way of dealing with level-of-desire problems.

"MEDICAL" PROBLEMS

As noted in the first section of the chapter, sex therapy has recently been critiqued for becoming overly biological in its approach to sexual problems and their resolution. Hormone therapies, surgical procedures, and medication have been seen as so successful that clients, physicians, and therapists have begun to view these paths to treatment as the ultimate brief therapy for sexual difficulties. This is despite recent resolutions by world health bodies, who recommend combined medical and psychosocial treatments even when biological interventions are most strongly indicated (Rosen, 2000). For brief therapy to be successful, therapists have a critical responsibility to approach *all* problems within the context of the clients' relationships and worldviews.

Beth and Tom came to therapy complaining that even Viagra hadn't helped Tom with his sexual performance problems. Married for 7 years, the couple had had a mutually satisfying sex life until the past year. This was Tom's second marriage and Beth's first; his first wife had left him for another man she'd met at work.

Tom seemed to have lost the ability to have or maintain erections, and he had recently stopped initiating sex or responding to Beth's advances. Their family physician had prescribed Viagra; however, Tom stopped using it when he found it to be inconsistent and rather strange and unnatural.

Two years earlier, Beth had quit her job as a secretary and returned to college to finish her bachelor's degree. Tom, the owner of an auto mechanic shop, thought that perhaps Beth's involvement with her studies had prevented them from paying more attention to their sexual relationship. If so, he would just wait it out until she was finished. Beth was distressed, fearing that either he had some physical problem or he no longer found her sexually attractive. When they had tried sexual encounters, they both had quickly responded to the first signs of an erection, rushing to insertion and attempts at intercourse. These efforts had all ended in failure, and Tom had withdrawn still more.

Respecting the couple's concern that there was some biological basis for their problem, the lead therapist, our colleague Mary Talen, invited

a physician (who was also a family therapist) to consult with them. His work-ups revealed some vascular difficulties that had probably initiated some of Tom's erection problems. The couple was relieved to learn of this, but they were also concerned, given that Viagra hadn't worked.

Mary and her colleague saw, in addition to Tom's biological condition, three other interrelated problems potentially contributing to the couple's difficulty. First, Beth's going back to college had resulted in her both withdrawing from Tom and potentially surpassing him in education and aspirations. Second, the couple had become locked in a vicious cycle of demanding and withdrawing. And third, overfocusing on the state of Tom's erections, they had pressed toward intercourse whenever they were apparent.

The therapists recognized that their interventions needed to attend to the biological component of Tom's condition, honor each of their views on sexuality and on each other, and reverse the demand/withdraw cycle. Working within Tom's worldview, they used metaphors of auto repair and maintenance, suggesting that he indeed needed a "new transmission" when it came to enjoying and having sex with his wife. However, he certainly needed instructions from his own "mechanics," or physicians, on what to expect of the new transmission and how exactly to break it in so he could eventually resume the pleasure of the driving experience.

Mary and her colleague told the couple to "slow down" when it came to having sex, avoiding intercourse for the time being. Tom was to learn how to utilize the effects of Viagra through masturbation and then gradually teach Beth what he had learned. In the past, the couple had found each other most attractive when they went out with friends and flirted with each other. The therapists thus asked them to go out on dates with other couples and look for each other's secret flirtations. Beth and Tom would be a little rusty, but it was important to get the "car back on the road." As they got aroused, they were to restrict themselves to some gradual pleasuring exercises, having intercourse only if they absolutely couldn't abstain.

Within the next 3 weeks, Tom had adjusted to using the Viagra, he and Beth had made time to socialize, and they not only had learned more about each other's pleasure, but also had rediscovered both intimacy and intercourse. By reversing the couple's solution attempts, the therapists were able to resolve Tom's biologically based difficulty and help put the couple's relationship back on a firm foundation.

Couples often hope that there are biological causes and cures for their sexual difficulties, but this is often not the case. Bob and Cheri had enjoyed a passionate sexual relationship until moving in with each other, at

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which point, much to Cheri's puzzlement and dismay, Bob started to sexually withdraw. He, and all the other men in her life, had always found her "hot," so Cheri figured that he must be experiencing a testosterone deficiency. When this proved not to be the case, they came for therapy, with Bob feeling singled out and accused of being the one with the problem.

The therapist, again Mary Talen, had the couple share some of their sexual history. Bob, when he was young, had walked in on his father cross-dressing. After that, he'd strongly affirmed his own heterosexuality in vigorous sexual relationships with women, while remaining sensitive to what might happen to him in a long-term committed relationship. Cheri had a history of drug abuse and prostitution, during which she'd come to believe that her main value was her sexual attractiveness to men.

Mary normalized the changes the couple had been experiencing, mentioning the transition in their living situation and pointing out how it had kicked off a problematic spiral. This reframing helped them attach new meanings to their recent difficulties, allowing them to simultaneously take a step back and draw closer to each other. Bob told Cheri that it was her love of life that made him want to be with her, and she told him that he was the strongest and truest man she'd ever been with. They reaffirmed each other's attractiveness and acknowledged the stresses of moving in with each other.

Mary asked them to make lists of what each wanted to retain of their separateness, while evaluating what they wanted together. During this time, they were to refrain from sexual contact and reinitiate dating, only returning to lovemaking as their transition to living together settled in. These gentle changes gradually got their sexual relationship back on track.

LEVEL OF DESIRE PROBLEMS

As noted earlier, several recent sources have critiqued mainstream sex therapy for not having an adequate way of treating what has now become the most frequent sexual complaint in the offices of sex therapists; differences in desire among partners (Apfelbaum, 2000, 2001; Kleinplatz, 2001). Indeed, "low sexual desire" has been called the sexual dysfunction of the 1990s (Pridal & LoPiccolo, 2000), affecting men as often as women and both heterosexual and same-sex couples.

As we return to the opening vignettes, notice how deframing "low sexual desire," shifting the pattern of relationships, and disrupting solution patterns become the keys to "reawakening desire."

Recall that Lawrence, Tina's fiancé, had lost all interest in sex after learning of her prior sexual experiences. The more he thought of her with other men, the more distracted and distressed he became. When Tina realized why he was withdrawing from intimacy, she was reluctant to share any more information with him. This aroused his suspicions, and they were off on a "downward spiral."

With accuser-defender vicious cycles, one partner typically accuses the other of some type of infidelity. The defender denies the infidelity, but does so in a tentative or defensive manner, which fuels the insecurity of the accuser, leading to more accusations, followed by more defensive denials, and so on. Lawrence's accusations had begun with concerns about Tina's former sex partners, but they'd quickly escalated to speculations about current betrayals as an explanation for her loss of interest in sex.

Catalytic brief therapists seek to interrupt this type of cycle, helping the accuser to stop accusing, or helping the defender to respond in a more definitive way to the accusations. In this case, the therapist, Scott, selected the latter approach. Honoring Tina's concerns about Lawrence's emotional well-being and respecting her frame of reference, he sought to use her language while reframing the situation and normalizing Lawrence's behavior.

Scott explained that the couple had fallen into what some might refer to as a "gender trap," which was being maintained by their deep love and strong passion. Deep love often brings out primitive emotions and a need to mark the relationship as something very special and exclusive. Men and women sometimes do this in different ways. A competitive man may want to be viewed by his woman as the greatest of all lovers. He feels secure, knowing that his virility and skill will keep his woman from wandering, given that the sexual experience he offers is beyond comparison.

In contrast, a passionate woman may like to mark the importance of her relationship by forgetting previous sexual experiences and pretending that her man is her only real lover. Lawrence and Tina's conversation about the past, although understandable, was interfering with their ability to complete their somewhat separate tasks before the wedding. The more that Lawrence brought up the subject of previous relationships, the more Tina was reminded of the past that she was trying to forget. On the other hand, her tentative responses were not providing Lawrence with the assurance that he was seeking.

Scott told Lawrence that he could offer him a strategy for dealing with his unsettling questions, but before proceeding he wanted to answer any questions they might want to pose to him. Tina asked how he could possibly have known exactly what was going on inside of her. Lawrence said he

hadn't realized what Tina had been trying to do. Scott acknowledged these reactions, explaining that "love makes us all a bit crazy."

Scott then turned to Tina and explained that there was a good "antidote" for Lawrence's condition. The next time Lawrence asked her about her past, she could simply give him a big Hollywood-style kiss, regardless of where they were—the mall, a family gathering, in bed, or in a restaurant. After the kiss, she should tell him the truth, which was that she didn't want to think about sex with anyone but him, that he was the only one she was interested in.

Upon hearing this, Lawrence burst out laughing. Scott looked at Tina, and, with a smile, told her to "make sure to give Lawrence some tongue with that kiss." They both left the session laughing, excited about the "antidote."

Lawrence and Tina were married on schedule. When they came back for a follow-up interview after the wedding, Tina said that she had followed the prescription once. Lawrence had laughed and dropped the subject, and he hadn't brought it up since. With their sexual relationship back on track, they moved on to discuss other challenges, such as where they were going to live and when they were going to start a family.

By reframing Lawrence and Tina's interaction and by using humor to invite passion, Scott was able to help them interrupt their vicious cycle, moving them beyond jealousy and fear.

Alicia and Dave, the second couple presented at the beginning of the chapter, were also trapped in an escalating cycle, in their case between a pursuer and a distancer.

Earlier in their 10-year marriage, Dave had had what Alicia considered to be a voracious sexual appetite. No longer. They hadn't made love in 6 months, and Dave seemed to have lost all interest in sex. He considered Alicia more a friend than a lover, and he was concerned that he had fallen out of love with her. Alicia, in turn, suspected Dave was having an affair, despite his sincere denials to her and Andy, the therapist. Their relationship was becoming more and more polarized.

Andy made note of how hard Alicia had been working to attract Dave's interest. She had waited up for him when he was late from work, arranged candle-light dinners, worn sexy lingerie to bed, given him long suggestive kisses, and asked him about what he was thinking and feeling about her. When he'd failed to respond in an assuring manner, Alicia had become tearful.

The more eager Alicia had been for Dave's attention, the more he'd withdrawn, at one point talking about suicide. Convinced he was suffering from

depression, he'd obtained an antidepressant prescription from his family doctor, but the medication didn't change the problems with the relationship. He felt especially guilty that Alicia was going out of her way to make the relationship work. Wondering what would happen if his feelings for her didn't return, he considered the possibility that he would have to leave his marriage.

Pursuit-flight cycles may kick off when something tips the delicate balance of initiation in a couple's relationship. When one partner, feeling unwanted, pursues the other partner for affection and validation, it can inspire attempts for him or her to flee or withdraw. Just as pursuit stimulates flight, flight stimulates insecurity and more pursuit. The fleeing partner may read this cycle as a sign that they are no longer in love. If this fear is spoken, the situation is further complicated and may lead to an extramarital affair or divorce.

By the time Dave and Alicia entered therapy, their cycle had become a full-time endeavor. Alicia, spending most of her day dwelling on her fears of Dave's leaving her, had quit her part-time job to concentrate on the relationship. Dave was also devoting considerable time to worrying about his marriage, and his job performance was declining.

Andy's therapeutic objective was to interrupt this cycle by having one or both partners stop or even reverse their part in the cycle. If Alicia were to stop pursuing Dave, he might rediscover his interest in her. Alternatively, if Dave were to reverse his participation and pursue Alicia, she might feel less compelled to pursue *him*.

Dave didn't consider himself capable of making changes, given his loss of feelings, so Andy met with him separately, validating the difficulty of his position and praising his willingness to stay in the relationship. Andy reframed the nature of long-term relationships, talking about how sexual interest naturally waxes and wanes, and normalizing his loss of interest.

Meeting alone also with Alicia, Andy validated her concerns and assured her that Dave's lack of interest did not mean she was unattractive. He explained that sometimes people withdraw in relationships when their partner becomes too predictable or loses some of the uniqueness and passion for life that originally drew them together. He wondered with Alicia about ways that she might make herself a bit more mysterious to Dave, while recapturing her own interests. They agreed that unpredictability should be expressed in subtle yet honest ways. Certainly, she wouldn't want to hurt him.

Alicia had a habit of kissing Dave at bedtime, telling him that she loved him and, when he didn't respond, asking him if he loved her. Because this

had sparked recent arguments and bad feelings, Andy suggested that she could forget to kiss him or kiss him and forget to say that she loved him. She might also dress for bed in a way that downplayed her interest in sex. When Dave came home late, she might be so absorbed in some activity that Dave would have to seek *her* attention. Because the renewal of Dave's interest in her couldn't be forced, his free will would need to be given time to express itself by Alicia's getting more involved in her own life, going back to work or, as she was an avid reader, joining a book club.

The outcome of this shift did not appear until two sessions later. Initially, Alicia found it difficult to disengage from Dave in the way they'd discussed; Andy validated her struggle by acknowledging the challenge of trying something different when the stakes are very high. Disengagement came easier after this, as did reengaging in the things that interested her. At the next session, Alicia described what happened after a few nights of not giving Dave a kiss. Coming home late and finding Alicia reading a book, he tried to get her attention. However, she really was absorbed in what she was doing, and when she stayed engaged in it, Dave felt uneasy. Later that evening, he initiated sex.

Reengaged in her own life again, Alicia returned to work. She continued to feel more energy and assurance of her love for Dave and of his for her. Dave reported that his feelings for Alicia were starting to come back, and soon their sexual relationship rekindled. They both admitted that they had fallen back in love with each other. In essence, they had gotten out of each other's way, allowing themselves to rediscover each other.

Sometimes low desire is related to a history of sexual abuse. Such was the case with Nadia, who, you may recall, felt either numb or nothing at all when having sex with her husband, Ivan. Not having had sex in 6 months didn't bother Nadia, but Ivan was threatening divorce, so, after her gynecologist had told her that there was nothing physically wrong, she came to Scott for help in solving "her" problem.

Nadia realized that saving her marriage would entail her having sex more often with Ivan, but until Scott asked, she hadn't considered the possibility of actually enjoying it. She said that if pleasure was possible, then, yes, she'd like to feel it.

In gathering a sex history, Scott asked about what the couple had tried to make sex a pleasurable experience. This discussion was initially difficult for Nadia, but she was eventually able to reveal some very important details. From ages 13 to 16, she was sexually assaulted frequently by an adult male cousin who was living with her family. Entering her bedroom and forcing intercourse on her, he threatened to hurt her if she ever told her parents.

She kept quiet, and the cousin continued to abuse her until he was killed in a car accident.

During these abuse episodes, Nadia would freeze up and go somewhere else in her head. She learned how to have sex without feeling like she was having it, but her cousin wasn't pleased with this. Trying to make her "get into the experience," he would tell her, while abusing her, how pretty or sexy she was, and he'd sometimes buy her sexy underwear and tell her to put it on.

After the death of her cousin, Nadia felt great relief. She started dating boys and became sexually active, but only because the boys seemed to like it. She continued to "go somewhere else," so for her, it was something of a "dead experience." Still, her lack of interest gave her a sense of power. While guys were losing control over her, she was able to remain cool and collected.

When Nadia met Ivan in her early twenties, his solidity and genuine caring for her made her feel secure. She wasn't sure if she ever really "loved him," because she never felt romantic and her feelings about sex had remained unchanged. Because of Ivan's disappointment in her lack of interest, she made an effort to warm up to the idea, reading romance novels that contained sexual material. They might have done the trick, had it not been for Ivan's habits in bed. When making love, he liked to talk to her and tell her how sexy she was. He'd also brought her sexy underwear, hoping it might spark her interest.

Nadia had told Ivan about being abused, but, afraid she might upset him, she'd never given him the full details. She had asked him to stop talking during sex and to stop bringing home sexy underwear, but he hadn't really responded. Recognizing that he seemed to enjoy these activities, she'd decided to drop the subject and try to make the best of it.

After listening carefully to Nadia's story, Scott reframed her numbness as a "secret power" for disconnecting herself from her feelings of sexual pleasure. This was not only an appropriate way to have handled the sexual abuse, but it also showed a keen sense of inner wisdom: It was her way of fighting back. In essence, she'd been able to say, "You can take my body, but you can't really have sex with me."

Now, as an adult, Nadia had a new need—the need to discover the power of sexual pleasure in a trusting and loving marriage. Scott, expressing his hope that this could be accomplished, suggested that Ivan's involvement in therapy would make it possible for them all to work together on helping Nadia in this discovery. The dilemma was theirs as a couple, not simply hers.

Nadia thought she might be able to convince Ivan to come to the next session, but she was uncertain about how it would turn out, because he didn't believe in "shrinks." Scott normalized Ivan's skepticism as a common reaction among men. He then asked Nadia if it would be okay for him to spend some time trying to help Ivan understand the impact of the sexual abuse as a way of helping her experience sexual pleasure.

Nadia brought Ivan for the next session. In an effort to put him at ease, Scott thanked him for coming and explained his reasons for inviting him: "Nadia has told me about the sex problem that she and you are having. My goal is to help her to experience more sexual pleasure so that you can have a more enjoyable sex life." Brightening up, Ivan said he would do anything to help, and he affirmed Nadia's description of his talking to her while they were having sex and bringing her sexy underwear. Yes, she had told him not to do this, but he figured she was just being modest. Because all women want to know that they are beautiful and sexy, he thought that telling her would turn her on. And if she, with her nice figure, could see how good she looked in the underwear he bought her, maybe it would be enough to get her going.

Over the years, Ivan had become impatient with the whole process of sex, so he'd gotten to jumping into intercourse without much foreplay. This seemed to be what Nadia wanted. He loved her very much, he said, but although he had adjusted to her lack of interest in sex, the frequency of their lovemaking had recently gone to such a low level that he just couldn't handle it. He'd begun thinking that maybe he just wasn't sexy enough for Nadia and that she needed another man.

After carefully helping Ivan to unfold his side of the story, Scott reframed their dilemma, drawing on the information that he had gathered over the two sessions: "Ivan, the problem that Nadia is experiencing is not about your ability as a lover. As you know, Nadia was abused as a young girl. As part of that abuse she became turned off to sex. This is not at all uncommon for women who have been abused, and in fact Nadia's reaction was quite expected. This business of being turned off has to do with the mental associations that Nadia has about sex. Mental associations include her fantasies and a sense that these fantasies are pleasurable. Pleasurable fantasies within a very trusting relationship with you are what Nadia needs to feel turned on. Unfortunately, as a couple, in your efforts to solve this problem, you have done some things that reinforce Nadia's negative images of sex. They set off her triggers. You may not be aware of this, Ivan, but when Nadia was abused, the abuser talked to her and told her that she was pretty and sexy. He also brought her sexy underwear. I know that you have done something

similar totally out of your love, but the problem is that these efforts may be too close to what happened to Nadia for her to stop the negative associations that she has with sex. I also know that Nadia's request to have sex without foreplay is well intended. She wants to please you and get the experience over with; however, this is also too close to what happened when she was abused."

Scott paused, and Ivan teared up and began to cry. Nadia, at Scott's request, placed her hand on Ivan, who said that he'd had no idea that his wife had been affected in this way. Scott explained that she had tried to protect him from her pain, which Ivan understood and appreciated.

Scott then proceeded to unfold a plan for therapy that included many elements of Masters and Johnson's work. He explained to Ivan that the course of treatment would involve a sacrifice from him. He was giving them an initial prohibition against intercourse while they engaged in a program of progressive pleasuring, and this could take a few months. It would be key that Nadia not engage in intercourse just to relieve his sexual tension, because this could reinforce her negative mental associations with sex. Masturbation would be perfectly appropriate, though, if he got too frustrated.

The couple's progressive pleasuring started with one-on-one talking, without touching, for 15 minutes a day, and it continued, with assignments given every 2 or 3 weeks, for sitting together and touching hands, then hair, and then face and other nonerogenous zones. They progressed to doing this without clothes on and then to giving massages, also without clothes. Scott stressed that Nadia should always take the lead so that she could feel in control and reverse the process that had brought on her negative sex images. She was to direct Ivan's hands when he was touching her and to practice touching him. Scott asked them to talk about which types of touches felt better and what they liked most. In subsequent sessions the three of them talked about the couple's attitudes and what kinds of sex they were most comfortable with.

Nadia began to enjoy sexual pleasure and sensation, but she also had an experience, for the first time in her life, of feeling intensely jealous. It came upon her as she watched Ivan talking to an attractive woman at church, and she didn't know what to make of it. Scott framed it as an indication of their budding romance, and he warned Ivan of the need to reassure Nadia of his love for her. Her jealousy meant that she was making herself vulnerable to him, and she would need protection so that she could continue opening up.

As a parallel development, Scott asked Nadia if she would feel comfortable exploring how to experience sexual stimulation, pleasure, and arousal

on her own. She would be in control, and, eventually, she could share her discoveries with Ivan, thus opening a new sexual relationship together. After some hesitation, Nadia agreed to take some steps in this direction. She was referred to the book and video *Becoming Orgasmic* (Heiman & LoPiccolo, 1988) and asked simply to review the materials and consider what it might mean to her to open this part of herself back up. She made excellent use of the materials and exercises, using them to slowly explore her sensuality.

Scott eventually suggested that they were ready to take the step into intercourse. Recommending that Nadia be on top, Scott directed her to be the one to insert Ivan's erect penis into her vagina so that she could feel the power of eventually reducing it to a withering pulp.*

The couple were doing well when they returned for a follow-up a month later. Nadia was experiencing pleasure with sex (both on her own and with Ivan) and Ivan was no longer contemplating divorce. They had two concerns. First, Ivan had noticed that Nadia wasn't consistently having orgasms with him. Second, they were wondering whether it would be okay to have intercourse with Ivan on top. Scott offered some ideas: "Sex usually goes better when the objective is pleasure. Orgasms will happen sometimes and sometimes not for Nadia. Trying too hard can have the opposite effect for her. There are many ways for you to reach orgasm with each other. As Nadia continues to discover these herself, she can help to guide you in helping the two of you to experience this with each other. The mark of a good lover is the ability to nurture a pleasurable experience for one's partner. Unfortunately, the movies rarely get this right."

Regarding their second concern, Scott said they were free to have sex in any way that they chose, as long as it produced mutual pleasure. They could also trade off on initiating. Scott ended with a caution: "You have done a wonderful job of learning to make love. Even so, you should expect that sexual interest will be stronger at times and less strong at others." He invited the couple to check out the women's magazines at the grocery store, noting that they all include features on how to spice up your sex life. Apart from any useful ideas these articles might contain, they attest to the fact that *all* couples ebb and flow in sexual interest from time to time, even when sexual abuse is not a factor in a person's life. Nadia expressed her gratitude to Ivan for helping her to open herself to him and to allow her to discover her own true sensuality. Ivan cried.

* This suggestion, taken from a case made famous by Milton Erickson, reflected a reversal of the abuse situation.

Although the guiding ideas for this case, as for all of our work, derive from systemic and social constructionist theory, the interventions were similar to those used by mainstream sex therapists working with desire problems (Pridal & LoPiccolo, 2000) and issues of sexual abuse (Maltz, 2001a, b). What was different in this case, as in each of the others before it, was the therapist's close attention to first- and second-order change and the respect given to the relativity of realities in social relationships. Nadia and Ivan had been locked in a solution-generated problem cycle of well-meaning attempts to negotiate their sexual relationship. The more they'd struggled, the worse it had become. With their worldviews honored in a therapeutic setting, they were able to make small yet significant shifts in their ideas, knowledge, and solutions, initiating the progressive resolution to their shared difficulty.

A CATALYST FOR CHANGE IN SEX THERAPY

The "new sex therapy" has always been a relatively brief therapy, but it has been criticized for lacking an underlying theory. In this chapter, we articulated and illustrated the social constructionist and systemic ideas that influenced the development of the MRI and solution-focused schools, as we believe that they can offer sex therapy the theoretical foundation it has been lacking. A social constructionist view honors clients' contexts and traditions, while also acknowledging the influence of the therapist's background. Such an appreciation helps therapists avoid the tendency to perpetuate dominant and implicit sexual myths, while also avoiding associated gender-biased, phallocentric, and heterosexist assumptions.

Because the theoretical framework of a catalytic approach is *fundamentally systemic*, its biopsychosocial set consistently places people in the larger contexts of their relationships. Thus, even biologically based difficulties and interventions are framed within the clients' social and interpersonal relationships. Instead of focusing on parts (a criticism, you may remember, that has been leveled at mainstream sex therapy), a catalytic approach to sex therapy considers the context of relationships to be of crucial importance. As can be seen from the cases we've discussed, such contextual sensitivity proves very helpful when therapists are addressing couples' problems with desire. The nature of the dilemma becomes clearer, making available a number of effective interventions.

This chapter has been a blend of both theory and practice. The editors of this book, Shelley and Douglas, told us that they wanted to "get inside our heads and our hearts," to learn how we work from our point of view. This

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chapter demonstrates our thinking and our passion. We believe that therapists who practice without a guiding theory risk losing their direction and abdicating their professional responsibility. Alternatively, theory that isn't grounded in effective clinical practice is lifeless and useless.

As we have demonstrated, the innovations of traditional sex therapy can be integrated with those from MRI and solution-focused therapy. We believe that in bringing the two fields together, using systems and social constructionist ideas as the bridge, practitioners from both can be mutually enriched. The result is an exciting catalyst for effective brief therapy for sexual difficulties.

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