A Cybernetic Systemic Approach to Problems in Sexual Functioning

by
Gary Sanders M.D. and Karl Tomm M.D.

INTRODUCTION

There are few human activities that occur so frequently and yet are so shrouded in privacy, misunderstanding, and myth, as sexual activity. The privacy fosters misunderstanding and myth making and the mythologies in turn foster further misunderstanding and privacy. Despite the recent increase in the amount of public information about sexuality that is available in books, popular magazines, and newspapers, person to person exchange of information about sexual experience tends to be stereotyped, surreptitious, or altogether absent. Consequently, sexual ideas, values, expectations, and activities vary enormously from one individual to another, from one couple to another, from one religious community to another, and from one culture to another. Add to this the variety of purposes and meanings associated with human sexuality such as reproduction, physical attraction, attachment, sexual identity, sexual orientation, sexual preferences, the politics of male - female relations, morality, spirituality, - and the subject becomes extremely complex. In other words, sexual activity at any one moment may fulfill a variety of personally felt physical, psychological, social, and/or cultural expectations. These could include experiencing intense physical and psychological arousal, expressing interpersonal intimacy and uniqueness, fostering interpersonal bonding, producing offspring, seeking self affirmation, seeking personal power, or fulfilling conjugal duty and commitment. With such complex demands being made of one's sexuality, it is not surprising that adolescents and adults often seem heavily preoccupied with issues of sexuality. At the same time, however, because so many individuals remain constrained by the shroud of privacy and by family and social sexual taboos, it is also not surprising that they develop concerns about and symptoms of sexual dysfunction.

Increasing numbers of these people are now seeking help for their sexual concerns. In North America many of these couples seek such help from marital and family therapists, particularily when specialized sex therapists are not available. The issues brought to family therapy are mostly related to sexual functioning and less so to issues of sexual development or identity. Concerns about partner fidelity, sexual abuse, and the sexual activities of children or adolescents are also commonly presented but will not be addressed here. We will limit our discussion to therapeutic responses to problematic experiences of persons in a sexual relationship, that is, to problems of sexual functioning. Within this domain, clients are usually concerned about how they **should** be performing sexually. They compare their current performance to a past time, or to their performance with another partner, or to the performance of others (as imagined or as seen in print and movies) and regard themselves as falling short.

The majority of these complaints and symptoms may be mapped onto the five phases of the sexual response cycle: sexual desire, arousal and excitement, orgasm, resolution, and reflection. For instance, one partner may complain that the other is insufficiently desirous of intercourse. Others may report lack of physiological arousal, despite a strong desire. Still others may complain of early ejaculation or inability to achieve orgasm.

From our point of view, what is more important than the specific nature of the symptoms is the experience of and concern about these symptoms. These concerns could be quantitative, such as worries about the frequency of sexual activity or intercourse, or they could be qualitative, such as complaints about lack of sufficient intimacy for adequate arousal before coitus. These types of concerns are, of course, often interrelated in that one partner may complain about lack of frequency of sexual contact while the other may complain of lack of sensitivity to his or her feelings. The partners' respective experiences and consequent problem solving efforts often form a feedback system that tends to maintain or aggravate their problems, with increasing dissatisfaction for both. It is this interpersonal pattern of complementary experiencing, meaning giving, and responding that interests us

the most in organizing our efforts to facilitate therapeutic change. In other words, our focus is on patterns in the here and now. This does not mean that we are not interested in our clients' past sexual experiences. We are, but only insofar as that past is active and having effects in the present. In our view, an in-depth interview about past sexual experiences and events can be more pathologizing than healing. As therapists, we prefer to orient ourselves in therapy toward fostering a future-oriented self-healing process rather than a past-oriented analytic process. Because of this preference and our recognition of the applicability of cybernetic and systemic thinking toward this end, the primary focus of our chapter will be on the use of systemic[1] therapeutic principles in dealing with concerns about sexual functioning.

A PRAGMATIC DEFINITION OF SEX

Whenever possible we try to maintain a view of sex and sexuality as centering around persons' perceived experiences within a dyadic ***relationship***. Sex is not merely regarded as the physical encounter of sexual organs or any particular sequence of actions; it is regarded as a uniquely sensuous experience in an intimate relationship. The terms **sex**, **sexual**, and **sexuality** will refer to those conditions, both personal and interpersonal, that permit the creation of the experience of an interpersonal state of erotic sensuous mutuality. Thus, the term sex will not be used to refer primarily to anatomy, physiology, or those actions necessary to reproduce the species. Instead, we conceptualize sex as mutual sexuality.

The decision to focus on the experiential and relational aspects of sex rather than on the physical and reproductive is based on two factors. One is the nature of our clientele. The clients that present to us with sexual problems describe concerns about sexual functioning that takes place in the context of intimate personal relationships. Clients with genuine physiological sexual problems seldom present themselves to us for treatment. Furthermore, in contemporary North American culture, the vast majority of the population who engage in sexual activity take active measures to limit or obviate their reproductive possibilities. These measures may include anything from the “rhythm method”, condoms, diaphragms, and the Pill, and to surgical sterilization The second reason for defining sex as mutual sexuality is that it orients us as clinicians in a more therapeutic direction. If we were to focus on and to attend to primarily the physical and physiological aspects of sexuality in our treatment efforts, our clients would be invited to do the same. Doing so would be to contribute to a process of objectifying, mechanizing, and perhaps even trivializing a unique human event that has the potential to be experienced as wholistic, aesthetic, and spiritual. Shifting one's view from sex as a physical act to sex as a relationship process opens more possibilities for the latter potential to be actualized.

Our circumscribed definition of mutual sexuality includes four major criteria:

1. Each person in a dyadic relationship experiencing self as having desire (with or without physical arousal) to be sexual with the other person.
2. Each person in the relationship perceiving the other as also experiencing sexual desire and/or arousal.
3. Each person actively choosing to participate in whatever intimate interaction takes place and not being coerced to do so.
4. Each person experiencing this mutual desire, arousal, and/or activity is experienced in a context of emotional and physical vulnerability, with trust that one will not be taken advantage of by the other.

Please note that our definition of mutual sexuality does not *necessarily* include intercourse. Although coitus may be entailed in an episode of mutual sexuality, it is not considered a key criterion for a gratifying sexual

[1]The use of the term **systemic** throughout this chapter refers to those ideas and theories alternatively referred to as Batesonian, Milan, ecosystemic, or cybernetic. The common thread among these views is a focus on circular patterns of interaction triggered by "differences". This is in contrast to the physicalistic view of systems associated with general systems theory where interaction is based on mass, energy, and power. For a more detailed discussion of these differing systems views the reader is referred to Bradford Keeney’s book ***The Aesthetics of Change*** (1983).

experience. On the other hand, anything that does not fulfill the four conditions is considered something other than mutual sexuality. For instance, if one person is sexually desirous and/or aroused while the partner is not, but the latter participates willingly for social reasons, we might regard the activity as "sexual obligation" or as "sexual duty", but not as mutual sexuality. If one partner is aroused while the other is not interested or willing but the former tries to impose his or her desires upon the latter, we regard the activity "sexual assault" or "sexual harassment" depending on whether physical force is employed or not. If sexual activity is taking place between an adult and child, we consider the activity "sexual abuse" whether the child is interested and aroused or not. This follows from our cultural point of view that the adult is seen as not respecting the child's best developmental interests.

In evaluating different forms of sexual interaction from our particular sociocultural perspective, we have found it useful to make two basic distinctions. The interaction could be distinguished as socially responsible or socially irresponsible and it could be distinguished as violent or non-violent. It is important to note that for the purposes of this discussion we are using Maturana's rather broad definition of violence as **any attempt to impose one's will upon another**[2], whether by physical, chemical, psychological, or social means. The reason for using such a broad definition is that it invites us to recognize the violence being perpetrated in certain situations that we otherwise might not consider violent. At the same time, however, it invites us to evaluate whether this "violence" is socially responsible or not. In other words, Maturana's definition leaves space for some violence to be accepted as socially responsible; such as appropriate discipline of children, confrontation of adults who persist in problematic patterns, enforcement of social legislation, and control of criminal behaviour. However, the fact that violence may be involved in some situations not ordinarily considered violent stimulates us and our clients to try to think of alternative patterns of interaction that are not violent.

Given these two distinctions, it is possible to categorize a variety of sexual interaction patterns and contrast them with the sexual mutuality we strive to facilitate. Sexual harassment, sexual assault, and most sexual abuse are regarded as both violent and socially irresponsible. Sexual abuse of children may in some circumstances be seductive and not violent, but in our opinion it remains socially irresponsible because of the socially generated developmental view that the adult has failed to respect and protect the future of that child. Similarly, voluntary prostitution and other forms of sexual exploitation may not be violent, but they can be readily distinguished by many as socially irresponsible in that someone is being taken advantage of and/or the sacredness of sex is being trivialized. On the other hand, a sexual encounter based on obligation (as for instance, when one person concedes to the sexual requests or demands of another, not because he or she is desirous or interested, but because of prior commitments or other social circumstances) may be socially responsible, but it would be considered violent insofar as the second is imposing his or her desires upon the first. Likewise, some forms of sexual refusal following intentional invitations to sexual activity may also be regarded as violent. Based on our two basic distinctions, these and other kinds of sexual interaction are tentatively categorized in figure 1.

---

[2] I (G.S.) generally uss a more expanded version of Maturana's definition of violence. It is: **The holding of a view by one person or group to be true so that another person's or group's view is untrue *and* must change**. It is from the belief that others views **must change** rather than the difference of views that creates the interpersonal "mind set" that Maturana says all violence stems from. (personal communication)

	Violent	Non-Violent
Socially Irresponsible	- sexual harassment - coercive sexual abuse - sexual assault (including "rape") - coercive prostitution	- sexual exploitation - voluntary prostitution - pornography depicting violence or degradation - non-coercive sexual abuse
Socially Responsible	- sexual obligation or "marital duty" - sexual refusal after intentionally fostering expectations	- sexual and reproductive education - declining unwanted sexual invitations - mutual sexuality

Figure 1 Violence and Social Responsibility in Sexual Relations

What is interesting to note is that the sexual activity entailed in "marital duty", that is, one spouse (usually the wife) responding to the sexual demands of the other spouse, not because she or he wants to, but because they happen to be married, may be socially responsible but, given our framework, it still would be considered violent. Thus, many "normal" couples may be seen to be living a relationship of sexual violence (with episodes of sexual duty and/or sexual refusal) rather than a relationship of mutual sexuality. Unfortunately, much of this type of violence is considered socially responsible and hence tends to be perpetuated rather than presented for therapeutic intervention. Nevertheless, such relationship patterns usually become a chronic source of stress for both partners. The form of sexual activity that we consider mutual sexuality is non-violent, in that both persons are genuinely interested and desirous, and it is socially responsible, in that neither participant is being taken advantage of by the other.

EARLIER APPROACHES TO SEXUAL DYSFUNCTION

During the last century there have been two major therapeutic approaches to concerns about sexual functioning. The use of "folk medicine" remedies is the oldest and the most established. For instance, men with rapid ejaculation have often been told entertain anti-erotic thoughts during sexual intercourse. Having an affair has sometimes been prescribed for men with erectile dysfunction, while testosterone has been administered to others. For female arousal and orgasmic dysfunctions, "common sense" suggestions have included using lubricating gels, faking orgasm, and passively taking care of the husband's sexual needs no matter what the woman's state of arousal.

The second major approach has been psychoanalytically oriented psychotherapy, to which most professionals practicing in the mental health field have been exposed. This approach is based on the theoretical assumption that the failure to accomplish the childhood developmental tasks associated with an appropriate resolution of the Oedipus complex results in arrested, delayed, or distorted psychosexual development. Treatment usually

consists of re-enacting the oedipal situation in the transference relationship with a therapist and thereby completing those developmental tasks that were seen as not accomplished in childhood (Heiman et al 1981). Partly as a result of the failure of the analytic approach to deal effectively and efficiently with sexual problems, the first approach of “common sense remedies” once again became more prevalent .

In the last 20 years, more modern methods of dealing with couples' sexual concerns have been developed. A major milestone was Masters' and Johnson's (1970) pioneering work. Soon after it was published, behavioural treatment strategies became widespread. They involved the therapist in educating clients about normal sexual functioning, in restructuring maladaptive behaviour patterns and cognitions, and in using anxiolytic and skill training techniques. The work of Masters and Johnson filled in many of the gaps about the physiologic and anatomic basis to sexual activity. Other researchers (Hoon, 1976, 1977; LoPiccolo 1980) have carried on their work and many changes have occurred in the understanding and treatment of sexual problems, particularly in the last 15 years. Several behavioural treatment methods have been extended and elaborated.

Today, however, there are comparatively few people who practice strictly behavioural approaches. Instead, most sexual therapies involve quasi-behavioural techniques. For instance, Singer Kaplan (1974, 1979), in her “New Sex Therapy” uses many behavioural techniques, such as systematic desensitization, the construction of successive client successes, and so forth, but her work is combined with a psychodynamic analysis of the individual. The work of Price et al (1980, 1981) is also based on behavioural principles but tends to be more interactional in its' application. These therapists have pioneered the use of group treatment strategies for sexual concerns. All of these approaches have the following in common: attempts to reduce performance anxiety, use of sexual education, skill training, communication in sexual technique, and the use of a variety of attitude change procedures.

The elaboration of systemic therapy methods by the Milan Team (Selvini Palazzoli et al 1978, 1980) and others, (Hoffman, 1981, Tomm 1984a, 1984b) opened the door for another useful clinical tool to be applied to the treatment of sexual problems. Both of us (especially G.S.) have been involved in applying Milan concepts to sexual difficulties since 1980 (Sanders, 1986). The use of these systemic principles has been extremely gratifying in some cases. Nevertheless, we continue to use some of the quasi-behavioural treatment principles as well, remaining mindful of the systemic context in which they are being applied. Indeed, one of the things we have found is that applying quasi-behavioural techniques in the context of systemic understanding potentiates their effectiveness.

MULTIPLE DOMAINS OF EXPLANATION AND INTERVENTION

Despite our preferred focus on the experiential relationship aspects of sexuality we acknowledge the fundamental importance of our clients' biological status, knowledge base, and behavioural repretoire. At least some assessment of these aspects is required, in addition to reflection on the meanings our clients give to their sexual activity and to their interpersonal relationship. For this reason, an approach that uses a model with multiple domains of assessment and intervention will be described and briefly elaborated.

At any particular point in therapy, inquiries and/or interventions may be directed toward the biological domain of physiology, the informational domain of facts about sex, the behavioural domain of sexual actions, or the experiential/relational domain of meaning. We tend to organize ourselves by thinking of these domains as reflecting non-hierarchical levels of increasing comprehensiveness which are interconnected (by us as observers) in a circular fashion. The model is non-hierarchical in the sense that we assume bi-directional, rather than uni-directional, patterns of influence among the several domains. A basic feature of the model is the implied flexibility to move from one domain to another whenever this seems appropriate.

By moving from one level of conceptual abstraction “up” to more comprehensive levels and back “down” again to simpler levels recurrently, therapists should be able to change the nature of his or her explanations as needed

to guide his or her interventions (see Figure 2). Whenever possible, however, therapists remain mindful of the experiential/relational effects of any assessment or treatment initiatives while working at the biological, informational, and behavioural levels. For instance, if enquiring about certain aspects of biological functioning, about a person's sexual knowledge, or about specific sexual behaviours were likely to be experienced as humiliating (and not just embarrassing) in the presence of the partner, the therapist would refrain from asking in the conjoint context. Thus, the systemic relational view still provides the overall umbrella that contextualizes explorations in the other domains

With a complete assessment, movement in the model might proceed in a stepwise fashion up from a biologic focus through an informational and behavioural focus, on to an interactional and experiential one. At the same time, however, the model suggests that there are times when it might be appropriate to move back down to lower levels of complexity to generate more appropriate interventions. Implicit in this model is the invitation for therapists to recognize that it might be useful to move from one domain of understanding (and concomitantly from one domain of intervention) to another in certain circumstances. Before proceeding to focus our discussion on the emotional/experiential domain, which we are most interested in, we will provide some comments about the other domains and our movement from one to another.

	Indications To Move To a More Complex Domain of Explanation	Indications To Move To a Less Complex Domain of Explanation
SYSTEMIC THERAPY		- Lack of available resources (information, finances etc) - Once able to use available resources again
INFORMATIONAL - BEHAVIOURAL SEX THERAPY	- Inadequate use of available resources - If therapy becomes "stuck" or regresses - If no or minimal response to usual therapeutic methods	- Sexual responses are independent of the context (i.e. global dysfunction) - Onset of significant bodily illness - Long term use of medications
BIOLOGICAL INTERVENTIONS	- individual patient responses to questions about physical functioning reveal episodic or context sensitive symptoms - if patients won't cooperate with treatment	

Figure 2 - Movement between Multiple Domains of Intervention

At some point early in the assessment it is important to inquire about the biological capabilities of each partner. Numerous prescribed drugs, some non-prescription drugs including alcohol and tobacco, and a large number of medical illnesses can severely affect the physiologic capability for sexual functioning. Although many marital and family therapists may not feel that they have the expertise to evaluate the biological aspects of sexuality, there is a series of simple questions that can be used to rule out any significant biological

dysfunction. These questions can be organized around the five phases of the sexual response cycle.

desire phase

"Are there ever occasions when you feel sexually desirous, whether or not you act on those desires?" "In other words, have there been times when you experienced an desire to be involved with someone sexually even though you may not have done so?"

excitement/arousal phase

"On an occasion when you do feel sexually desirous and you choose to act sexually, whether with yourself or another person, are you able to increase your arousal through the sexual actions you engage in?"

(***for males***) "Do you have physical changes such as an erection, testicles swollen and pulled up against the body, and the like that accompany arousal.?"

(***for females***) "Do you have physical changes such as a feeling of pelvic fullness, vaginal wetness, and so forth, that accompany arousal?"

"What about arousal associated with dreams in the night or on waking in the morning?"

"Are you able to maintain your arousal for whatever sexual purposes you desire?"

orgasm phase

"Do you get to a point where you feel the urge to release your arousal through a rapid rhythmic release usually called orgasm?"

(***for females***) "Are you able to be orgasmic most often when you want to be?"

(***for males***)"Are you able to influence the timing of your ejaculation?"

resolution phase

"About how long does it take for your body to return to normal after you have been sexually active - seconds, minutes, hours, or days?"

(***for females***) "Do you have feelings of pelvic fullness, aching, or pain afterwards?"

(***for males***) "Have you had the experience of prolonged aching of the testicles or an erection failing to subside?"

reflection phase

"Do you reflect upon the sexual experience you have had and evaluate and/or discuss it?"

"Do you find the sexual activity to be as pleasurable as you would want it to be?"

Any responses to these questions that are unusual should invite the therapist to explore further and could become a basis for requesting a complete physical examination. In particular, negative responses to the questions concerning the excitement/arousal phase in the presence of sexual desire could suggest some underlying medical problem, particularly if no drugs, alcohol or medication can be implicated. On the other hand, if the clients' answers to these questions suggest that their physiological capabilities are intact, it would be more appropriate to move on to explore the informational, behavioural, and experiential levels before proceeding further with physical investigations even if a client has predominantly biological concerns. The reason for this is that the client's preoccupation with biology may be limiting his or her capacity to become aware of relevant factors in the other domains and the therapist's continued focus on biological functioning may inadvertently foster rather than ameliorate the client's misdirected concerns.

Until the more recent interest in medical management (Morales et al 1982, 1981), specific sexually oriented biologic interventions have focused almost exclusively on surgical methods. These have consisted of the implantation of erectile prostheses or the creation of artificial vaginas. Although these interventions are beyond the professional scope of most therapists working with sexual concerns, the assessment of the need for

biologic intervention is not.

If there appear to be no biological problems (i.e. the “dysfunction” appears context dependent), the therapist would move up a level and ask a series of questions about the clients' knowledge about sex and their specific sexual behaviours to give the therapist some benchmark with respect to their sexual understanding and behavioural repretoire. One of us (G.S.) uses a modified version of the Derrogaits Sexual Functioning Inventory as a questionnaire in the form of a handout. A client's lack of adequate information may quickly become apparent in his or her responses on the questionnaire. Sometimes the judicious use of specific information or behavioural suggestions as to how a couple could enhance the quality of their sexual interaction is all that is required in treatment. In other words, some sexual problems have simple solutions. For instance, setting time aside for a sexual encounter and/or creating the conditions for intimacy such as being alone together after dinner or an evening out may seem obvious to most of us but may not be arranged because of the assumption that to do so deliberately would interfere with sexual spontaneity. Occasionally basic information is required to correct misunderstandings. For example, physiological arousal in females is not as obvious as it is in males and may take more time, especially when the male takes the initiative. Thus, if the male proceeds with penetration without realizing his partner is not yet ready, he is unknowingly risking inflicting physical and emotional pain. On other occasions, simply receiving “permission” from an authority figure to perform certain valued behaviours while being sexual is enough to liberate some clients from constraining myths. Some clients feel attracted to oral-genital contact but think it is abnormal. A clear statement that such behaviours are perfectly common and usual and are not unhealthy (provided both parties agree) may be all that is required.

The therapist could also evaluate and monitor client access to sexual information. Although there have been notable changes in the media during the recent years of increasing sexual openness, our community is still relatively secretive and closed regarding information about sexual behaviour and experience compared to other meaningful aspects of life. Because of these restrictive societal values, very few of our clients feel as free to search out useful information about sexual issues as they would about parenting, adolescence, marriage, old age, and similar events. Bibliotherapy, the prescribed reading and reviewing of specified information or use of audio visual materials may be helpful in situations in which clients need basic information or gradual desensitization.

Other clients appear to have the opposite problem. They have seen too many sexual movies and/or have read too many sexual novels or manuals. Consequently, they have given themselves so much “permission to perform” that they are unable to keep up to the level of their misguided or unrealistic expectations. For instance, many couples who present with clinical concerns assume their sexual behaviours and feelings should be goal directed, that they should achieve a particular end, such as a “spectacular simultaneous orgasm”. Their focus is on achievement. By directing their attention toward the goal of performance or of pleasuring the mate and away from self-perceived sensual feelings, these clients miss or lose what they could experience as a quality sexual exchange. The preferred focus in mutual sexuality is one's own experience of heightened **personal** sensual awareness while perceiving the other as also intensely aware of his or her own experience. What one shares with the mate is not so much one's own sensual feelings, but rather, the interpersonal context. When this context consists of mutual physical and emotional disclosure, vulnerability, and trust, at the same time as one experiences enjoyment and physiological sexual arousal, we think of the event as sexually intimate. If, however, the interpersonal context has evolved to become one of purposeful striving, such as toward some self-imposed performance standards for oneself or one's mate, the couple could benefit from some re-direction. Some directive behavioural techniques such as sensate focus exercises and self stimulation for orgasmic experience may be useful. Depending on how it is implemented the squeeze technique for early ejaculation could also fall into this domain. If it seems apparent that the couple has an adequate behavioural repretoire, it would be appropriate to move on to focus more squarely on the experiential meaning level. Continuing to focus on specific sexual behaviours could inadvertently promote further performance anxiety.

One positive indication for the need to move to a more complex or comprehensive level of understanding, would

be the therapist's perception of apparent “resistance” to the interventions based on an explanation at a “lower” level of conceptualization. For instance, when certain sexual problems that “normally” respond well to information or behavioural prescriptions, are not changing in the direction of resolution, these more usual approaches appear to be “resisted”. Such situations could benefit from an understanding of the so called “resistance”, thereby enabling the therapy to continue. A useful view of resistance is that held by Steve de Shazer (1982) who suggests it is a property of the client-therapist relationship and not of the client or couple. He uses the therapist's felt experience of client “resistance” as an indication that the therapist has, as yet, to understand fully enough the couple's symptoms and the system of interaction. Indeed, as therapists we prefer to take the pragmatic view that ***client resistance does not exist, but therapist resistance does***. Adopting this orientation helps us in using the experience of client resistance to evaluate our own position and recapture an inquisitive stance which may then enable an exploration of something other than “more of the same wrong solution” (see Luckhurst 1985, p4). On the other hand, when the clients comply appropriately with therapist suggestions and directives, this suggest that further trials of informational or behavioural interventions may be fruitful. In other words, if therapy appears to be progressing well, there is no need to change levels of explanation and intervention. It is such feedback in the therapeutic system that becomes the cybernetic “steersperson” guiding the course of therapy.

An indication for movement downward in the hierarchical model could be any perception on the part of the therapist of the absence (or a deficit) of some important resource, be it financial, physical, physiological, behavioural, informational, emotional, or contextual. If a therapist, working within the relational/experiential domain, perceives a lack of behavioural capabilities, he or she might be well advised to return to that level of explanation. If, while working at the behavioural level, she or he noted insufficient knowledge about sexual behaviour, a move back to informational input would be appropriate. Likewise, if lack of physiological responsiveness became apparent, further exploration at the biological level would be indicated. The therapist must continually monitor the clients’ actual and experiential **access to basic resources** for adequate sexual functioning and try to open space for these resources to be obtained if they are not readily available. On the other hand, if *inadequate use* of **available resources** is perceived, it is usually best to move on up to a more complex framework of understanding in which the nature and effects of such inadequate use may be understood and challenged. Thus, one impetus for moment-to-moment changes in the nature of the interventions used is movement between domains of therapist understanding, which is triggered by the clients' responses to the therapist's actions.

THEORETIC BASIS OF A CYBERNETIC-SYSTEMS APPROACH

As noted earlier, some sexual problems remain unresponsive to treatment even when adequate physiological, informational, and behavioural resources are available. It seems as if some clients have a motivational problem of mobilizing and applying these resources to deal effectively with their sexual difficulties. When the usual sex therapy techniques are inadequate, some therapists rely on psychoanalytic methods to treat the “resistance” they distinguish. In a sense, the locus of treatment moves “inside the head.” When we encounter this kind of difficulty, however, we prefer to remain “outside the head” as much as possible and continue to explore the couple's human relationship systems, including our relationship with them. Indeed, we are currently often more inclined to explore relationship interventions even before trying behavioural methods. Desire disorders, for instance, are often too complex to treat effectively and efficiently with the usual methods. Furthermore, we have sometimes observed that once one problem like vaginismus is resolved, the partner often develops another problem such as erectile dysfunction. Thus, in these situations we find it more efficacious to use interpersonal systemic interventions from the outset.

There are two levels of complexity involved in applying an interpersonal systems approach. One may be regarded as based on first order cybernetics, the cybernetics of ***observed*** systems. The other is based on second

order cybernetics, the cybernetics of ***observing*** systems. The first entails the identification and description of reciprocal patterns of interaction between mates that generate, maintain, or aggravate, problems. In other words, the focus is on identifying pathologizing patterns of interaction between the members of a couple that are recurrent or circular. These problematic patterns may be classified as negative feedback patterns, as positive feedback patterns, or as disruptive or extreme oscillations from one pattern to another. Negative feedback in cybernetics entails a difference minimizing loop. For instance, a male with erectile dysfunction experiencing sexual insecurity might express sexual interest in a partner who responds by evaluating the size and firmness of his penis and, thus, inadvertently raises performance expectations which undermines his sexual arousal and maintains the insecurity. Such interaction minimizes the possibility of a change or a difference in the symptoms. The man continues to have erectile dysfunction which continues to invite a focus of interest and concern for the partner. In contrast, positive feedback in cybernetics involves a difference maximizing loop. For instance, when one person with low sexual interest is pursued incessantly by another with high interest, the sexual appetite of the first is blocked even further while that of the other is intensified out of frustration. The third type of cybernetic pathology, excessive oscillation from one pattern to another, may be manifest by periods of excessive sexual demands alternating with long periods of complete avoidance of physical contact.

Therapeutic interventions based on these kinds of assessments are oriented toward interrupting the pathologizing pattern. Because the pattern is interactional and circular the focus of the intervention can be on any link in the chain, that is, on the behaviour of the symptomatic person, on the behaviour of the partner, on both, or on their sequence in the interaction. Alternatively, the focus of intervention could be on the pattern as a whole, that is, on the meaning systems that organize the whole interactional process. Whenever possible we prefer to focus on the whole pattern, a more comprehensive intervention, which may be modeled after the Milan systemic methods of offering a paradoxical opinion (e.g. positively connoting the pattern of interaction in service of the relationship) or providing a ritual prescription (e.g. ceremoniously burning, freezing or thawing a symbolic representation of the experienced restraints to change).

The cybernetics of observing systems entails a greater degree of complexity. It includes a **recursion** which refers to the application of a process to the products of that same process. An example of second order cybernetics is the process of distinguishing the nature of the distinctions being distinguished. In other words, within the cybernetics of observing systems, the observing system observes and acts upon its own products and/or habits of observing. Thus, a man with performance anxiety may become anxious when noticing his own performance anxiety. A woman with vaginismus may become tense by trying to relax her own muscular tension. Indeed, “doubled emotions,” like fear of being afraid, guilt about feeling guilty, irritation about being irritated, being depressed about being depressed, etc., can become especially malignant. There is a much larger degree of interaction with the “self” in these patterns.

This self, however, need not be thought of as “skin-bounded.” Indeed, we find it more useful to think of the self as a socially defined unity that arises through, and is maintained and/or modified by, social interaction. In other words, the “autonomy” of the pathologizing patterns that entail self-observing may still be seen as a social process. Human beings see themselves through the eyes of other human beings. The interpersonal aspects of these second order patterns may not be obvious at first glance, but they become more apparent when we reflect upon the distinctions we make about the distinctions others make of us, and the effects these distinctions have on our patterns of thought, feeling, and behaviour. Take, for example, the ubiquitous blame-guilt cycle. If a woman distinguishes the man she is being intimate with as insensitive, and he distinguishes her as distinguishing him as such, he may concede and also see himself as insensitive and feel badly about himself and/or he may distinguish her as too judgemental and blame her for being unfair. She, in turn, could take either or both responses as validation of her original distinction. If he tries to defend himself and blame her for being unfair or in error, she may feel obliged to bring forth more evidence to support her view. At the same time, however, she may also concede to his view of her and begin to feel badly about herself. If he then distinguishes his behaviour as having triggered her into feeling badly, he may feel even worse and become more suspicious about his own sensitivity, seeing himself as preoccupied with himself, less sensitive and more irritable with

her, and so on. The “knot” of self-definition through mutual interaction begins to tighten. Talking about their views of one another becomes a process of blame inviting guilt and guilt inviting further blame so that they see each other and themselves more and more negatively. Then, distinguishing themselves in a painful pattern of talking, they begin a new relationship of talking about their relationship which also may become problematic with further blame-guilt cycles. In other words, sexual problems in couples often arise and are aggravated by their patterns of reacting to and/or talking about what they distinguish as a sexual problem.

However, inherent in this second order cybernetic perspective is also the potential of autonomous self healing. We are becoming increasingly interested in fostering this potential. If, for instance, the man referred to in the previous paragraph distinguished ***his sensitivity*** to his partner's criticisms of insensitivity (in relation to her), he could choose to redirect his emerging sensitivity to become a constructive resource for himself, that is to help him become more aware of her experience. Thus he could guide his own evolution in the direction of reducing the original insensitivity she distinguished. Similarly, if the wife of a man with erectile dysfunction noticed her own habits of noticing the turgor of his penis and noticed how her noticing invited him into feeling insecure, she could alter the focus of her noticing habits to attend to something that he felt more secure about such as the texture of his skin or his gentleness. Likewise, if a man noticed that his own pattern of taking note of his own level of sexual arousal (or of noticing his partner taking note of his arousal) raised his experience of performance anxiety, he could shift his focus of attention to something else such as experiencing the affection and caring of his partner. Therapy towards such self healing re-directiveness often entails a process of bringing forth descriptions (in the therapeutic conversation) of first order patterns so that they subsequently can be distinguished and acted upon in a second order manner by clients on their own.

Psychodynamic therapists might regard this orientation as one of offering insight. We are not very comfortable with the notion of insight because it is historically associated with intrapsychic phenomena and implies too much conscious awareness. The phenomenon we are interested in is more basic and general. It is a process of making new heuristic distinctions and perhaps new connections among them as a result of social interaction. Many of these distinctions take place in the coordination of therapeutic interaction and are nonconscious. Furthermore, we prefer to emphasize the interpersonal aspects of the process, and would thus choose the term “**outsight**” rather than **insight**. After all, the new recursive distinctions do arise in the interpersonal domain of therapeutic interaction. Our orientation towards “outsight” is consistent with our emphasis on the interpersonal contextual aspects of mutual sexuality; that is, rather than focusing on intercourse, we focus on “outercourse.” Indeed, we regard the whole phenomenon of observing as fundamentally social. Even descriptions of the experience of self, and of autonomy, depend on language that originally arises in the social domain.

When applied to the therapeutic system, this second order perspective also enables the therapist and/or team to monitor its own behaviour and to note whether it is actually guiding the session in a therapeutic direction or not. It enables a therapist to distinguish his or her own resistance to considering alternative interventions when distinguishing the client as resistant. That is, the autonomous self corrective potential of the therapist is enhanced as well. If the therapist notes a lack of progress when working with a woman presenting with low sexual desire, the distinction of low desire as the problem could be distinguished as problematic. Perhaps both she and her mate are under the influence of excessive expectations for her. Perhaps her mate could be distinguished as having a problem of excessive desire. Or perhaps the discrepancy between them regarding sexual desire and the attempts of each partner to impose his or her preferences upon the other could be a more coherent distinction of the problem. The nature and consequences of these differing distinctions could be explored in the therapeutic conversation. Finally, the power politics entailed in determining which distinction should prevail could be brought forth for examination. The man or the woman may be embedded in seeing the problem as her low desire operating from to patriarchal assumptions. The woman might experience validation in distinguishing the problem as his excessive demands and control efforts. Both might be able to recognize the violence entailed in imposing each of their views upon the other. Consequently they might agree to accept a discrepancy distinction and proceed from there to a greater understanding of each other's experience and

explore ways of escaping constraining assumptions. This process enhances the flexibility and autonomy of the therapeutic endeavor.

The major difference between a second order cybernetic perspective of sexual problems and the more usual perspectives is one of epistemology, that is, the way in which we as therapists and clients know what we know about problems and solutions. The more traditional lineal views associated with biologic, informational, behavioural, and causative-interactional understandings (and even a first-order cybernetic understanding) are based on the assumption of objectivity, that is, we assume that. we know what we do about problems through lineal perceptual input from the world out there. This lineal epistemology works well for a large number of sexual concerns, but it may be rather limiting when dealing with the more complex or “resistant” concerns. With these, the second order cybernetic epistemology may be particularly useful since it temporarily abandons notions of objective truth and causation, and looks more at the coordination of interaction that brings forth distinctions, the process of distinguishing rather than the distinctions alone, and the pattern rather than the content. The intent of therapy moves from one of achieving an outcome of specific behavioural change, to one of increasing opportunities for alternative distinctions and behaviours. It is assumed that when people genuinely experience alternative behavioural options they will spontaneously select those that lead to more mutual pleasure and less pain. The goal of therapy becomes what has been dubbed “metachange” - a change in the couples’ ability to change (Tomm, 1984b). From this perspective, change in a sexual relationship that occurs during the course of therapy is seen as a change in patterns of interaction attributed to the co-creation of new distinctions and meanings. The couple could make use of whatever biologic, informational, and behavioural resources they have, in new ways that lead to their own experiential solutions.

CLINICAL ISSUES IN A CYBERNETIC– SYSTEMIC APPROACH

Therapist Style and Stance

The therapist's choice of interviewing manner and style may vary in its, therapeutic quality. It may facilitate, or impede, the ease with which clients disclose and explore sexual matters. Obviously, it is incumbent upon the therapist to take leadership in establishing a pattern of interaction with clients that fosters healing. At the very least this implies developing an acute sensitivity to the personal vulnerabilities involved in talking about sexual experiences. Few of us are as carefully prepared for our sexual lives as we are for other human interactions such as meeting strangers, going to school, finding employment, parenting, and so forth. Our society generally prohibits preparing people for open and frank discussion of sexual experiences. At the same time, however, we tend to pick up a complex set of behavioural expectations pertaining to how we ***should*** feel and behave sexually. Clients enter the therapeutic context under the influence of these “shoulds.” They may feel that they should not even talk to an outsider about their sexual concerns and so they may experience themselves as breaking implicit social rules in coming to therapy. If the therapist recognizes this, it is useful to comment on explicitly and express appreciation for their personal strength and courage in challenging these constraining assumptions by initiating treatment.

To acknowledge and accept the uniqueness of the client’s experience enhances the possibility that the therapeutic context will, in fact, become healing. Often clients feel embarrassed or shy when sexually explicit material is talked about. Sometimes they even become mute and subsequently avoid sessions. Deliberately constructing a context of permission for embarrassment or shyness may alleviate the anxiety that could retard or prohibit the formation of a therapeutic relationship. This permission may be adequately conveyed with an accepting attitude, or it may require specific statements about the usualness of feeling anxious in such situations. For example, the following introductory statement could go a long way toward creating a therapeutic context of acceptance and openness while respecting the experience of the participants:

"Most people have limited opportunity to be as open and frank in discussing sexual issues compared to other

important life issues such as finances, child rearing, and so forth. Usually, when we talk about sexuality, it is either about someone else's, as a joke, or with a detached air. If you feel some embarrassment or shyness as we talk today, that is perfectly usual and expectable. I would appreciate your being as frank as possible since it helps my understanding of your situation and my ability to be helpful to you. And please feel free to use whatever words or terms you are used to. Now, what do each of you see as the major concerns that have brought you here today?"

The covert cultural injunction that "one should not talk about sex" is challenged with this invitation to be frank and open and is further weakened by a coherent rationale for why disregarding it would be helpful.

Another series of "shoulds" that constrain the clients' ability to find solutions are moralistic injunctions that trigger guilt and blame. Clients are often quick to blame and berate one another, as the following examples show:

HE: "As a wife she should be more affectionate with me. She hardly ever wants to have sex anymore."
SHE: "You shouldn't be so demanding!"
HE: "If you were only more willing to have intercourse, I wouldn't have become so demanding."
SHE: "How do expect me to respond to you when you're bugging me all the time?"

Or they blame themselves:

HE: "What is wrong with me that I can't control my ejaculation and give my wife an orgasm?"
SHE: "I should be able to satisfy my husband, why can't I relax enough for him to make love to me?"

In responding therapeutically to these "shoulds," we have found it extremely useful to separate the moralistic expectations from the clients themselves. White's (1986) cybernetic methods in family therapy have been particularly helpful in this respect. The problematic expectations are attributed to cultural influences rather than to persons. In applying his method we ask questions about how in which certain expectations have influence over the clients and how these expectations "push" them into problematic patterns of behaviour and experience. Then we ask questions about occasions when they might have been able to "escape the tyranny" of these expectations. When clients begin to experience the problematic expectations as something apart from themselves as persons, their guilt feelings and patterns of blame begin to abate. This externalized view of problems (in this case, the problematic sexual "shoulds" prescribed by our culture) is consistent with our orientation towards a social interactional basis for the mental phenomena with which we are dealing. What we try to introduce in the therapeutic conversation are increased possibilities for heuristic distinctions (e.g. between "self" and "not-self") and more space for choices in the direction of healing patterns of interaction.

To develop greater expertise in a cybernetic systemic understanding that might cultivate more healing interviews, it is useful for therapists to work with colleagues in clinical teams and to practice adopting certain principles or conceptual postures in relation to clients. Our own evolution as therapists was significantly enhanced while employing the ritual five part session of the Milan team (Selvini et al 1978) for a few years and adopting their three guidelines for the conductor of the session: hypothesizing, circularity, and neutrality (Selvini et al 1980). One of us (K.T.) has summarized the Milan approach elsewhere (Tomm 1984a, 1984b) and more recently has redefined the three guidelines as conceptual postures while adding a fourth, ***strategizing*** (Tomm 1987a). The reader is invited to review these earlier publications for a more comprehensive description of the Milan approach; only certain aspects of the conceptual postures will be presented here as they apply to sexual concerns.

Strategizing refers to the therapist's deliberate decision making in order to respond therapeutically to whatever emerges during the course of the interview. The therapist is continually making choices about what

to attend to, what to do, what to say, and what ***not*** to do or say. The process of strategizing is organized by the overriding goal to have a constructive, healing influence. For instance, as previously suggested, a therapist may choose to attend to the clients' initial embarrasment. The therapist may deliberately strive to maintain **neutrality** which allows more space for spontaneous healing to take place. Skills in systemic **hypothesizing**, such as conceptualizing circular interaction patterns, are sometimes necessary to establish and maintain such a neutral stance. Thus, certain aspects of the conceptual postures of strategizing, neutrality, and hypothesizing are synergistic in enabling a therapeutic process. However, all of the activities involved in these postures are ultimately based on the **circularity** of recurrent interaction between therapist and client in the therapeutic system.

The circularity inherent in a therapeutic conversation (that is, in therapist questions triggering client answers, triggering questions, triggering answers and so on.) is easily taken for granted. Fortunately, one of the idiosyncratic features of a second order cybernetic systemic approach is to emphasize this circular process. Attention is drawn to the therapist's contributions to the distinctions being drawn by clients through the questions asked. It is not assumed that the clients' distinctions are offered spontaneously to the therapist as if clients were in an unbiased vacuum. Certain kinds of questions invite certain kinds of reflections and responses. For instance, questions based on patriarchal assumptions ***("Does she respect your sexual needs as head of the household?")*** elicit different experiences and answers than questions based on feminist assumptions ***("Does she respect herself as fully equal in your sexual relationship?")***. In other words, through their interaction in the clinical conversation, therapist and client tend toward becoming coupled in their assumptions and patterns of drawing distinctions.

Indeed, they become coupled in an emotional domain as well as a linguistic one. The dynamics of emotional interaction between therapist and client in the therapeutic system makes an enormous difference in the quality of the relationship. The therapist who adopts a posture of ***caring circularity*** (interacting primarily on the basis of human affection) is more likely to offer clients an experience of empathic understanding than a therapist who adopts a posture of ***obligatory circularity*** (interacting primarily on the basis of the professional need to obtain information) who is more likely to give clients an experience of penetrating scrutiny. The latter can be especially problematic when exploring sexual concerns which include the experience of one's person being violated by another. That is, the penetrating scrutiny of the interviewer may inadvertently aggravate the problems being presented.

There is probably more room for the therapist's own feelings of affection to emerge when working with couples oriented towards enhancing their mutual sexuality than in other kinds of therapy. Emotions are “infectious” and the therapist's affection for his or her clients as persons can enhance a couple's affection for one another. However, in our opinion there are ***no*** circumstances in which it would be appropriate or justified for a therapist to become sexually involved with a client. To do so violates our cultural understanding about the nature of therapy and would be socially irresponsible. A therapist taking advantage of clients for his or her own needs for intimacy or sexual gratification also would be contradicting the fourth criterion of mutual sexuality (as defined earlier). The best way in which a therapist's affection can be expressed is in the form of humour. To use humour effectively the therapist must continually ***listen to the clients' listening*** (to the therapist) so that she or he can be assured that they experience him or her as laughing together with them, not at them. In other words, developing skills in the conceptual posture of caring circularity requires the ability to monitor the moment-to-moment effects of the therapist's behaviour on the clients, to compare these effects with what is intended, and to make changes accordingly.

The other conceptual posture that we have found extremely useful in guiding our interviewing style is neutrality. Adopting this posture implies accepting all persons as valued and equal, and not taking the side of one person against another. Sometimes this is not easy, particularly when both members of a couple agree in their descriptions that only one of them is the problem, such as both confirming that one partner is very inhibited or “frigid”. In these situations, externalizing the problem from the person (without projecting it onto

another person) makes it much easier for a therapist, without jeopardizing neutrality, to agree that certain aspects of the situation are problematic. Useful questions include: “*How did these inhibitions get such a hold on you?”, “In what circumstances do these childhood prescriptions take over?” “When they do, what happens to you?”, “Have there been some moments when you have been able to escape them?”* . These make it possible for the “identified patient” to experience the problem increasingly as separate from her as a person and alien to her personhood (which is affirmed and valued). Later the therapist could shift the focus to interactional elements by asking her partner “*When she is in the grips of her family view that 'nice women are not sexual' what do you do to help her become a stronger person and free herself to make her own choices rather than caving in?”, “What kinds of things do you do or say that might invite the inhibitions to take over her, without you intending this?”,* (similar queries can be addressed to the “identified patient") “*Have you noticed some things that he (or she) says or does that inadvertently feed the inhibitions and strengthen their power over you?”* In this manner, the woman as a person is separated from her inhibitions and her partner is invited to consider which of his or her own actions may support or challenge the pattern. Subsequently, the problematic contributions of the partner may also be externalized. This technique makes it easier for a therapist to remain more neutral with respect to persons but still take a strategic position against the continuation of problems.

We believe that the enactment of neutrality during the course of an interview has a general healing effect. It counters the ubiquitous tendency to blame the personhood of others when there are problems and it opens space for clients to take a fresh look at one another as persons who mean well. Perhaps one of the most insidious enemies of neutrality is egocentrism, an orientation in which one is self centred and in which one's views and oneself are collapsed to constitute a single entity. Thus, if someone were to challenge our views we could experience them as challenging us as persons. Such an egocentric orientation leaves us extremely vulnerable to reacting to any difference from our preferred views as threatening to us. The typical response would be to protect ourselves by defending our views and to judge the other as incorrect or wrong. A commitment to neutrality helps us escape such egocentrism in ourselves and facilitates a similar orientation in our clients. To be neutral with respect to persons (including ourselves) when they manifest differing views and apparently differing contributions to problems, therefore, requires an ability to separate persons from their views and the consequent behaviours.

Neutrality is particularly important when dealing with sexual issues because of the vulnerability of persons who hold idiosyncratic and/or stereotyped views that are maintained by the cultural shroud of secrecy over personal sexual experience. As already noted, sexual activities are not discussed as freely, or as deeply, as other significant life events. Because there is less open discussion it is less obvious that our sexual views are derived from our social context. Hence, they are more likely to be directly associated with the self and tend to become egocentric. Furthermore, because of the shortage of explicit open discussion and modeling about sexual alternatives we have fewer useful distinctions available to us to make comparisons and reflect upon our circumstances. One stereotypic belief, for instance, is that sexual activity and sexual intercourse are one and the same thing. On an experiential and even a physiological basis, there is much more to sex than the act of sexual intercourse (particularly for women for whom the latter is often only a moderate physiologic stimulant). Sexual intercourse is only one form of sexual activity, yet for many it is thought of as the 'true' or ultimate, and therefore, only form.

An egocentric perspective of sex entails the presupposition that what one as an individual understands to be most normal sexually (i.e. usual, reasonable, and acceptable) is, in fact, a true picture of sexual normality. Egocentric views have crippled the therapeutic impact of many professionals for years. For instance, psychoanalytic views of 'normal' sex were based on the early 20th century male view of sex as intercourse. Women who did not have 'vaginal' orgasms (orgasm through vaginal containment of the penis) were considered psycho-sexually immature. These professionals, because of their egocentric orientation, tended to impose their views rather than look at what was, indeed, happening for people, let alone what was possible. We see

similar but more subtle egocentrism today in the attempts to have clients sexual lives conform to what the therapist considers appropriate. We are not neutral about this process. We are against such "therapeutic violence," that is, the imposition of the therapist's views upon the client. At the same time, however, we try to remain neutral with respect to the personhood of such therapists and see them as being under the influence of misguided patriarchal ideas or egocentrism. We also apply the same perspective to ourselves as we try to escape the lingering grip of patriarchy and egocentrism and try to escape temptations to impose our views of mutual sexuality on our clients. We do, however, have our preferences. But acknowledging our positions as preferences keeps us mindful that they are personal and that we do not have any "objective authority" to impose them on others. This guides us to try to remain open to discussion and to altering our views as we interact with clients and colleagues. In other words, neutrality helps us move away from potentially restrictive egocentrism within the therapy room and thereby helps us reduce the inadvertent negative impact of judgemental or moralistic attitudes of which we may be unaware.

It is useful to bear in mind that neutrality is not a static position that is attained, but rather is a conceptual posture that a therapist adopts to orient his or her behavioural responses in the interview. During the circular interaction of questions and answers, the therapist keeps moving his or her position in relation to answers because of the tendency for persons to become identified with their views. Indeed, a conceptual posture of affirming neutrality potentiates the posture of caring circularity. By accepting persons more fully and separating them from the distinctions they make, the therapist can move closer and be more affectionate in relation to clients. At the same time, both neutrality and circularity depend on the ability of the therapist to operate as an observing system within the context of the therapeutic system. The therapist, by coupling with clients, contributes to their capacity also to operate more effectively as observing systems. The opportunity for clients to gain a new and more useful perspective of their sexual lives is enhanced when, holding a neutral stance in relation to the people whose lives are guided by beliefs, we remain intensely curious about their beliefs and the differential effects of holding one belief compared to another. The therapeutic impact is derived from helping the couple to take an observer position in relation to themselves as persons and thereby seeing the impact of their own observations, beliefs, and actions on themselves and others. The acceptance of neutrality can be useful in helping the couple examine the impact of stereotypic gender beliefs, beliefs about alternate sexual lifestyles, and other larger system issues that are often difficult to explore without a neutral perspective. In contrast, the common pathology of "more of the same wrong solutions" is almost inevitably fed by judgements about what is believed to be sexually "normal" or "right". Unfortunately, beliefs about what is sexually "normal" tend to be ill-founded social myths.

The Therapeutic Use of Questions

We have already indicated how some questions may be used therapeutically in the course of an interview. This possibility has become a major focus of interest for us during the last few years. We also have become more sensitive to how some questions actually can be countertherapeutic. I (K.T.) have examined the issue of asking questions in clinical interviews in some depth and have devised a framework for classifying different kinds of questions that has proven useful in clinical work and teaching (see figure 3). This framework has been published elsewhere (Tomm 1988) but will be summarized briefly here with a few examples of questions that might be asked in an interview approaching a sexual problem.

Figure 3 illustrates the two basic axes or dimensions used in the framework. The vertical dimension has to do with the therapist's *assumptions about mental process* which underlie any particular question. At one extreme are lineal cause-and-effect assumptions. At the other are circular interactional assumptions. (These assumptions may be either ontological, concerning what kinds of sexual problems or solutions exist, or epistemological, concerning. how the client or therapist comes to know what they know about the problems or solutions that exist.) The horizontal dimension has to do with the therapist's ***intentionality*** with respect to asking a particular question or asking it in a particular manner. At one extreme is the intent to ask a purely ***orienting question***, that is, to obtain a response to orient the therapist. At the other is the intent to influence

the client deliberately in some manner through an ***influencing question***.

With the intersection of these two axes four quadrants arise with four different kinds of questions. ***Lineal questions*** are asked to elicit responses that orient the therapist to a lineal understanding of the situation. ***Circular questions*** are asked to elicit responses that orient the therapist to a circular understanding of the situation. The therapist's habits in the conceptual posture of hypothesizing will determine whether he or she will tend to ask predominantly circular questions or predominately lineal questions to generate the information required to formulate explanations to guide her or his therapeutic efforts. ***Strategic questions*** are asked when the therapist intends to influence the client to think, feel, or behave in a specific manner that the therapist regards as most appropriate. In other words, the therapist assumes that he or she knows better than the client on a particular issue and through the question tries to direct the client towards the "correct" thought, feeling, or action in a lineal manner. ***Reflexive questions*** are being asked when the therapist intends to influence the client in a general direction that the therapist considers therapeutic while remaining respectful of the client's capacity and autonomy to choose to move in that direction or not. In other words, the therapist facilitates the client's own capacity to make appropriate choices for himself or herself.

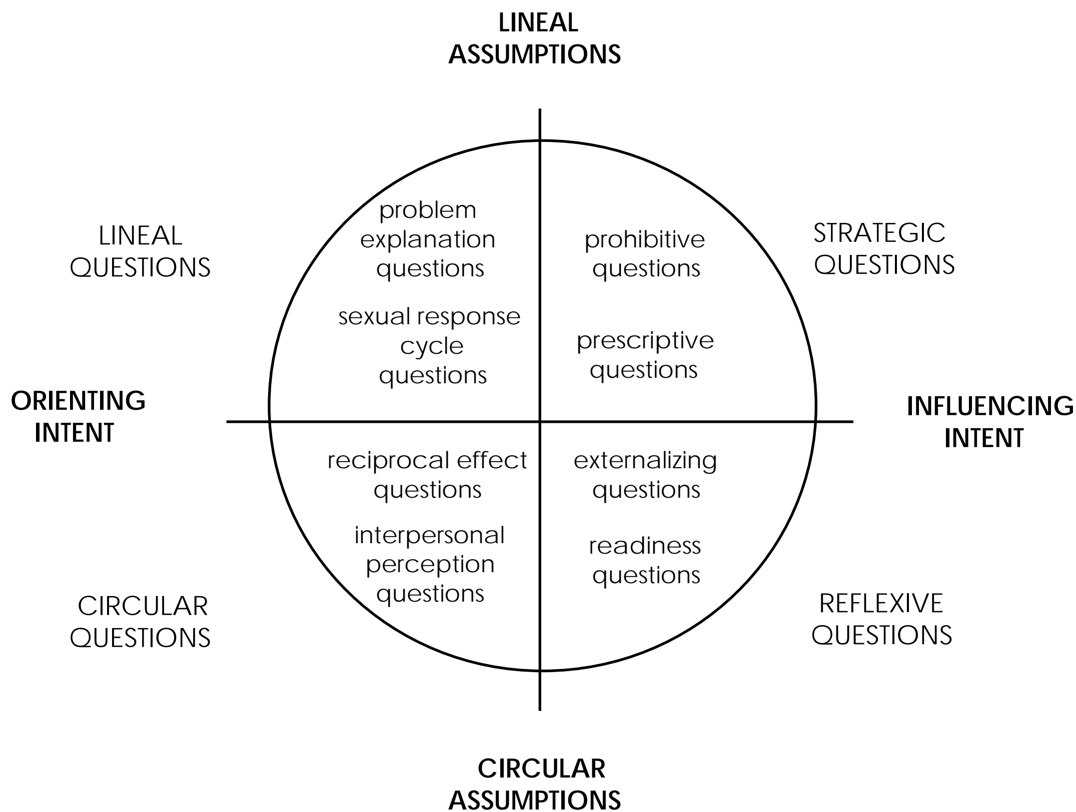

Fig. 3 A Framework for Distinguishing Different Kinds of Questions

In traditional sexual therapy the therapist works, for the most part, with lineal orienting questions. The primary intent is to attempt to get the 'real picture' of what is going on. Much time is devoted to getting detailed behavioural descriptions of the sexual symptoms and dysfunction. The questions for obtaining information about the five phases of the sexual response cycle that were suggested in the early part of this chapter are examples of such lineal questions. Further lineal questioning could be devoted towards outlining the impact of earlier life events on the development of the symptoms. The therapist would be oriented towards becoming familiar with the sequence of sexual experiences and developments in the client's past history.

Additionally, effort is expended in eliciting the clients' own explanations of the problem, which are almost always lineal. From the answers to these types of questions the therapist typically arrives at a lineal causal understanding of the problem. Consistent with this understanding the therapist then gives a behavioural prescription, which the clients are expected to follow and report back upon. The whole process is based on lineal assumptions about the nature of problems and of treatment.

Cybernetic systemic sex therapy may also begin with some lineal questions (to oriented the therapist to the problem and to engage with the clients in their lineal views) but soon circular questions soon enter the conversation. For instance, a series of ***behavioural effect questions*** may be used to clarify interaction patterns:

"When he approaches you for some sexual contact what do you typically do?"
"And when you try to put him off, what does he do?"
"And when he gets irritable what do you do?" ... etc.

A series of ***difference questions*** may be used to clarify reciprocities:

"Which of the two of you shows your disappointment about your sexual activities the most openly?"
"Who hides disappointment the most?" ... etc.

A series of ***interpersonal perception questions*** may be used to begin to develop a second order cybernetic understanding:

"Does she notice whether you are beginning to have an erection or not?"
"What does she usually think when you do not become physically aroused?"
"What do you think she thinks is going on in your mind?"
"Is that true?"
"What exactly do you think he pays attention to when he is unable to get an erection?"
"When you notice him becoming concerned how do you feel and what do you do?"

These circular questions are intended to help the therapist become oriented to the possible circular dynamics involved in the problem. Skills in circular hypothesizing are required to formulate these kinds of questions with ease. The answers provided may make it possible for the therapist to formulate a circular or cybernetic understanding of the problem. At the same time, however, the questions may have a liberating effect on the clients, since as they also begin to see the circular patterns they may free themselves from their original lineal understanding. They may begin to consider alternate explanations for their difficulty and formulate alternative actions on their own. In this way, circular questions are liable to have a therapeutic impact even when they are not specifically intended to do so.

As therapists begin to recognize the therapeutic impact of certain questions they usually start asking them intentionally to influence clients. In other words, statements can be introduced in the form of questions. Doing so adds complexity to the process of interviewing but enhances its therapeutic potential enormously. It also reduces the need for therapists to rely on instructions or to be directive. Whether a therapist's influencing questions are predominantly strategic or reflexive depends to a large extent on the degree to which a therapist is able to adopt and hold the conceptual posture of neutrality in his or her interviewing style. Reflexive questions require more acceptance of clients as autonomous persons. Strategic questions are driven primarily by a corrective intent and tend to reflect an urgency on the part of the therapist for clients to adopt his or her solutions. Because of this, these questions tend to have a constraining effect that limits clients to doing what the therapist thinks is good for them or not doing whatever the therapist thinks is bad for them. An example of each is:

"Why don't you spend some time together talking about your experiences of the day before beginning to express sexual interest?"

"Why do you proceed to penetration when you notice that she is not yet aroused and lubricated?"

Such prescriptive and prohibitive questions can easily be heard as judgemental and blaming; consequently, using a large number of them could invite clients to experience their therapists as manipulating or controlling them.

Our preference is to use reflexive questions as much as possible. These questions are based on a facilitative intent and tend to have a generative effect on clients. Clients are invited to consider an issue from another perspective and generate an alternative point of view. (Several types of reflexive questions are described in Tomm 1987b). The earlier example of externalizing questions that invite clients to separate problems from personhood are reflexive in intent. Other important groups of questions derived from White's (1986) approach that we use in a reflexive manner are dilemma questions, readiness questions, significance questions and reconstructed future questions. An example of a dilemma question is,

"Would you prefer to continue to drift in this direction of watching and worrying about your sexual performance or would you prefer to confront and escape this spectator habit?"

A readiness question is,

"How ready are you to confront the performance expectations that have such a grip upon you?"

A significance question is,

(After an improvement has taken place) "Do you realize how significant your initiative in escaping those old expectations really is?"

Finally, an example of a reconstructed-future oriented question is,

"Having turned a corner and embarked upon a new direction in your sexual relationship, in what way do you see your new future differ from your old future?"

It is important to note that these questions invite clients to make entirely new and novel distinctions. For instance, the dilemma question just given invites a new awareness of alternative possibilities and opens the choice for a new direction. The purpose of the readiness question is not for the therapist to determine the clients' objective state of readiness but to invite the client to reflect upon the issue and in so doing possibly generate greater readiness. The significance question brings forth and highlights constructive changes that have taken place, lessening the likelihood that the therapeutic gains will be overlooked and lost. The reconstructed future question invites further embedding of the constructive changes by connecting their significance to time. In these ways, reflexive questions enable self healing processes that are more likely to endure. The questions invite clients to bring forth new heuristic distinctions. They open space for more options and facilitate the experience of personal agency. They invite clients to evolve towards a future-oriented, proactive lifestyle.

It is, of course, important to bear in mind that the therapist's intent in asking any particular question never guarantees its effect. Whatever impact it does have on clients, if any, will depend on their own organization and structure as observing systems. Generally, however, lineal questions are liable to have conservative effects; the clients answer them but remain unchanged. As already mentioned, circular questions may have liberating effects and strategic questions are liable to have constraining effects. Reflexive questions are in our experience the most likely to have healing effects because they enable family members to generate new distinctions and to mobilize themselves into more constructive patterns of behaviour on their own. Thus, by becoming more observant of the assumptions and intent behind certain types of questions and making rigorous choices on the basis of ongoing client feedback in the circularity of the interview, the therapist may significantly enhance her or his therapeutic impact.

CONCLUSION

As clinicians we have evolved to the point where we now regard the interview itself as the major intervention when responding to problems of sexual dysfunction. We increasingly use second order cybernetic theory to guide us in recognizing the importance of the distinctions we make and in understanding how we work together with our clients in co-creating therapeutic realities. In other words, while we have our theoretical preference, we are continuing to explore.

At the same time, we still value and use the more traditional domains of understanding and intervention. We quite often provide information, suggest experiments, and readily utilize behavioural directives. We also occasionally use formal end-of-session Milan style interventions with paradoxical opinions and prescriptions. We feel that retaining this flexibility is important to avoiding becoming trapped within a single ideology and suffering from "therapist resistance".

REFERENCES

de Shazer, S., **Patterns of Brief Family Therapy: An Ecosystemic Approach.** New York: The Guilford Press, 1982

Hoffman, L., **Foundations of family Therapy: A Conceptual Framework for Systems Change**, New York, Basic Books, 1981

Hoon, E.F., Hoon, P.W., & Wincze, J. "The SAI: An Inventory for the Measurement of Female Arousal." **Archives of Sexual Behavior**, 1976, **5**, 208 - 215

Hoon, E.F., Hoon, P.W., & Wincze, J. "A test of reciprocal inhibition: are anxiety and sexual arousal in women mutually inhibitory?" **J. of Abnormal Psychology** 1977, **85**, 65-74

Kaplan, H.S. **The New Sex Therapy**, New York: Brunner/Mazel, 1974

Kaplan, H.S., **Disorders of Sexual Desire and Other New Concepts and Techniques in Sex Therapy**. New York: Brunner/Mazel, 1979

Keeney, Bradford P. **The Aesthetics of Change**, New York: The Guilford Press, 1983

Lopiccolo, L. "Low sexual Desire" in S. Lieblum and L. Pervin (eds) **Principles and Practices of Sex Therapy** N.Y., The Guilford Press, 1980

Luckhurst, P., "Resistance and the "New" Epistemology". **Journal of Strategic and Systemic Therapies**, 1985, **4**, 1 - 12

Masters W.H. & Johnson, V.E. **Human Sexual Inadequacy**, Boston: Little Brown and Co. 1970

Morales, A., Surridge, D.H.C., Marshall, P.G., & Fenmore, J., "Nonhormonal Pharmacological Treatment of Organic Impotence" **J. of Urology**, 1982, **128**, 45 - 47

Morales, A., Surridge, D.H.C., & Marshall, P.G., "Yohimbine Treatment of Impotence in Diabetes" **New England J. Of Medicine**, 1981, **305**, 1221

Price, S.C., Heinrich, A.G., Golden, J.S. "Structured Group Treatment of Couples Experiencing Sexual Dysfunction", **J. of Sex and Marital Therapy**, 1980, **6**, 247 - 257

Price, S.C., Reynolds, B.S., Cohen, B.D., Anderson, A.J., & Schochet, B.V., "Group Treatment of Erectile Dysfunction for Men without Partners: A Controlled Evaluation", **Archives of Sexual Behavior**, 1981, **10**, 253 - 268

Sanders, G.L., "The Interview as Intervention in Sexual Therapy" **Journal of Strategic and Systemic Therapies** Special Edition on Interviewing, Vol **5**, No. 1 & 2, 1986

Selvini, M. Palazzoli, Boscolo, L., Cecchin, G., & Prata, G. **Paradox and Counterparadox**, New York: Jason Aaronson, 1978

Selvini, M. Palazzoli, Boscolo, L., Cecchin, G., & Prata, G. "Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session." **Family Process**, 1980, **19**, 3 - 12

Tomm, K.M., "One Perspective on the Milan Systemic Approach: Part I. Overview of

Development, Theory and Practice" **J. Marital and Family Therapy**,1984a, **10**, 113-125

Tomm, K.M., "One Perspective on the Milan Systemic Approach: Part II. Description of Session Format, Interviewing style and interventions" **J. of Marital and Family Therapy**,1984b, **10**, 253-271

Tomm, K.M., "Interventive Interviewing: Part I. Strategizing as a Fourth Guideline for the Therapist" **Family Process**, 26: 1, 3-13, 1987

Tomm, K.M., "Interventive Interviewing: Part II. Reflexive Questioning as a Means to Enable Self Healing" **Family Process**, 26: 153-183, 1987

Tomm, K.M., "Interventive Interviewing: Part III. Intending to ask Lineal,Circular, Strategic, or Reflexive Questions?" **Family Process**, 27: 1988

White, Michael "Negative Explanation, Restraint, and Double Description: A Template for Family Therapy." **Family Process** 25:2, 169 –184, 1986