

## **The Interview as Intervention in Sexual Therapy**

by

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## **Introduction**

Sexual issues brought to therapy are mostly related to sexual functioning and not to sexual development or identity. Patients are usually concerned about how they believe they should be performing sexually. They compare their performance to a past time, or compare performance with one partner to that with another partner. The symptoms people present with primarily have to do with the four phases of the sexual response cycle (SRC): desire, arousal and excitement, orgasm and resolution, and evaluation/pleasure. Such concerns can be either quantitative or qualitative. For instance, worries about the frequency of sexual activity or sexual intercourse are quantitative, while concerns about lack of sufficient stimulation for adequate arousal before coitus would be qualitative.

The purpose of this article is to focus primarily on the use of systemic (Milan) interviewing principles and practices as forms of intervention in sex therapy. Initially, a brief review of sex therapies will be provided, followed by outlining a recursive model of sexual intervention and finally, a more in-depth discussion of the application of systemic principles in sex therapy.

## **The State of the Art**

For more than fifty years there have been two major psychotherapeutic fields developing parallel to each other for the treatment of sexual concerns. The first is psychoanalytically oriented psychotherapy, to which most professionals in the field have been exposed. It is based on the theoretical belief that the failure to accomplish the childhood developmental tasks associated with resolution of the Oedipal complex results in arrested, delayed or distorted psychosexual development. Treatment usually consists of re-enacting the Oedipal situation in the transference relationship with the therapist and thereby completing those developmental tasks which were seen as not accomplished in childhood (Heiman et al 1981). Partly as a result of the failure of the analytic approach to effectively and efficiently deal with sexual problems, the second parallel approach of using common sense remedies became more prevalent. The use of common sense "folk medicine" remedies has been the oldest approach to sexual concerns, and reaches back into antiquity. Prescriptions such as deliberately entertaining anti-erotic thoughts during sexual intercourse to provide some distraction for men with rapid ejaculation have been suggested. Having an affair, or testosterone administration have been prescribed for men with erectile dysfunction. For female arousal and orgasmic dysfunctions, common sense suggestions have included faking orgasm, passively taking care of the husband's sexual needs no matter what the woman's state of arousal, or using lubricating gels to circumvent absent natural lubrication due to insufficient arousal.

In the last 20 years, other methods of dealing with couples' sexual concerns have been more prevalent in the mental health field.

After Masters and Johnson's (1970) work had been published, behavioral treatment strategies for sexual concerns became widespread. These approaches involve the therapist in educating about sexual information and functioning, in restructuring

maladaptive behavior patterns and cognitions, and in using anxiolytic and skill training techniques.

Today there are comparatively few people who practice strictly behavioral approaches. Instead, most of the common sexual therapies involve quasi-behavioral approaches. For instance, Helen Singer Kaplan (1974, 1979), and her "New Sex Therapy" uses many behavioral approach techniques, such as systematic desensitization, the construction of successive patient successes, and so on but her work is combined with a psychodynamic analysis of the individuals. The work of Price et al (1980, 1981) is also based on behavioral principals but tends to be more interactional in its' application. All 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 therapeutic principles by the Milan Team (Selvini Palazzoli et al 1978, 1980) brought another useful tool to the treatment of sexual problems. The use of systemic principles, however, does not mean that the other treatment principles are no longer useful. Indeed, when dealing with sexual symptoms, the therapist can add systemic understandings and methods to the other treatment resources.

### **A Recursive Model of Intervention in Sexual Issues**

When dealing with sexual issues, the therapist has to be concerned with more than just the interpersonal aspects of the relationship. Assessment of the patients' biological status, their informational resources, and their behavioural capabilities is required in addition to evaluating their interpersonal relationship. For this reason, a recursive intervention model based on being able to move from one level of intervention to another when appropriate will be described.

Since it is known that many over-the-counter medications (including alcohol and tobacco), numerous prescribed medications, a large number of medical illnesses and physical traumas can severely affect physiologic capability for sexual functioning, it is wise to evaluate areas of biologic concern, and treat them where indicated.

Many changes have occurred, particularly in the last fifteen years, in the biologic understanding and treatment of sexual problems. The work of Masters and Johnson filled in many of the gaps about the physiologic and anatomic basis to sexual activity, and other researchers have carried on their work (Hoon, 1976, 1977; LoPiccolo 1980). 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 been either for the implantation of erectile prostheses or the creation of artificial vaginas. Although these interventions are beyond the professional scope of most therapist working with sexual concerns, the assessment of the need for biologic interventions is not. For instance, a series of direct investigative questions used to explore a patient's sexual response cycle could be:

"Are there ever occasions when you feel sexually desirous, whether or not you act on them?" (*desire phase*)

"On an occasion when you do feel sexually desirous and you choose to act sexually, whether with self or another, are you able to increase your arousal through the sexual actions you engage in?" "Do you have physical changes such as erection etc.(for males) or vaginal wetness etc. (for females) that accompany arousal?"

"Are you able to maintain your arousal for what sexual purposes you want?"(*excitement/arousal 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?" (*orgasm phase*)

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

"Do you find sexual activity to be as pleasurable as you would want it to be?" (*pleasure/evaluation phase*)

The therapist must also be able to evaluate and monitor patient access to information about sexual topics. Our larger social context is relatively closed regarding sexual information when compared to other meaningful and important aspects of life. Because of restrictive societal values about sex, very few of our patients feel as free to access 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 information may then be indicated.

Judicious use of specific suggestions as to how a couple could improve their sexual relationship is sometimes indicated. Many patients who present with clinical concerns assume their sexual feelings should be goal directed. Sexual arousal is a sensually perceived event that is dependent upon an opportunity for heightened personal sensual awareness. By directing attention away from the self-perceived sensual feelings and toward the goal of performance or of pleasuring the mate, many people miss or lose what they would consider high quality sexual exchanges. What one shares with the mate is not so much one's sensual feelings (for how could someone actually perceive the feelings of another) but rather the interpersonal context. When this context is one of vulnerability and trust at a time of physical arousal, we usually think of it as sexual intimacy. If the interpersonal context is more one of competition or orientation primarily to the mate, directive therapeutic techniques may be indicated. Such suggestions as sensate focus exercises, the squeeze technique, self stimulation for orgasmic experience and so on fall into this directive category.

Using a recursive model of intervention, the therapist would be able to change levels of understanding by moving from one level of conceptual abstraction to a more complex and

comprehensive one when needed. This could entail moving from a biologic conceptualization through an informative one, then to a behavioral understanding, on to interactional one and then to a cybernetic formulation. This model would also imply the ability of the therapist to be able to move between the levels of complexity in any other direction when it would be most useful for the treatment of the couple's concerns. Implicit in this model is the need for the therapist to recognize when moving from one level of understanding (and therefore, acting) to another would be most useful.

One indicator 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 current level of therapist conceptualization and treatment. On occasion, disorders that most often respond well to the more usual approaches appear "resistant". These situations could benefit from a more complex understanding of the so called "resistance", thereby enabling the therapy to continue. A useful view of resistance may that of Steve de Shazer (1982) who says that resistance is a property of the patient-therapist relationship and not of the couple alone. He uses the therapist's felt experience of patient "resistance" as an indication that the therapist has, as yet, to understand the couple's symptoms and the system fully enough. Taking this perspective can aid the therapist in recapturing an inquisitive stance with respect to the "resistance" which may then help him in doing something other than "more of the same wrong solution" (the reader is referred to P.Luckhurst's (1985) article "Resistance and the 'New' Epistemology"). On the other hand, useful compliance with therapist suggestions and directions may indicate using a trial of more directive or informational interventions.

Another concept looks at utilization of resources. If a lack of resources available to the patients is perceived it may be best for the therapist to move towards a more directive, informative, or biologic understanding of the symptoms. If, on the other hand, inadequate use of available resources is seen, then it may be best to move on to a more complex frame of understanding and intervention in which the function of such inadequate use maybe understood..

One can see, therefore, that within any interview situation, this model of intervention becomes a recursive interaction between various levels of therapist understanding and the patients' actions.

### **Systemic Sexual Therapy**

Some problems remain difficult to treat with the traditional or usual sex therapy techniques. For instance, it has been clinically observed that once vaginismus is resolved, the partner often develops erectile dysfunction. Problems such as desire disorders are often too complex to treat effectively and efficiently with the more usual methods. Such clinical symptoms may be understood, not only in the domain of the couple's sexual or marital relationship, but on some occasions perhaps even more clearly in the domain of the family of origin, or the domain of the couple's past history, or another alternative domain of understanding. Here one may profitably turn to the

Milan systemic method.

Sheila and Ted were a young couple in their thirties who had been married at 19 as adolescent sweethearts. They presented complaining of not having children. Through questioning a problem of primary vaginismus was uncovered. They had, for 12 years, cooperatively tried once or twice a week to effect penetration with not one success. After initial successes at a more informational and directive therapy involving Sheila learning to 'accommodate' objects intravaginally, a sudden set-back in therapy developed. The couple complained of increasing arguments and irritability. They began not completing their homework assignments calling them 'tests', and finally they began missing sessions. The therapist then moved from a directive method to a systemic inquiry of the process of therapy. Ted admitted that he wished things were as they were before the couple started their 'tests' because at least then he knew where he stood with respect to Sheila. Sheila spoke about her fears of losing Ted's affection to a new baby if they had children in the near future. The domain of parenting and spousal commitment was then explored in depth using circular questioning and specific systemic rituals prescribed. After a few sessions the couple prompted the therapist to get back to the specific sexual accommodation assignments which they completed until sexual intercourse was able to occur on a pleasurable basis.

The major difference between a systemic perspective of the problems and the more usual perspectives is truly one of epistemology, or the way in which we know what we know. The more traditional lineal epistemology, such as biologic understandings, informational understandings, or causative interactional understandings, have worked well and will continue to work well for a large number of sexual concerns, but they may become too limited when dealing with the more complex or "resistant" concerns. Here the cybernetic epistemology that temporarily abandons notions of causation, and looks more at the pattern and form of interaction than its' content or structure, may be particularly useful. The goal of therapy moves from one of a goal directed outcome of behavioral change, to one of increasing the opportunities of alternative interactional behaviours to include more than only the symptomatic ones. That is, the goal of therapy becomes metachange - a change in the couples' ability to change (Tomm, 1984b). From a cybernetic perspective, changes in the sexual relationship that occur during the course of therapy would be seen as a change in patterns of interaction attributed to the creation of new meaningful information. From here, the couple could make use of what biologic, informational, and directive resources are available in their own community.

### **Style of the Interviewer**

The interviewer's style may help or impede the felt experience of the patients in discussing sexual matters. Our social context generally places lower value on specifically preparing people for open and frank sexual experiences than the value placed on other human interactions. At the same time, however, we have a highly codified set of behaviour expectations dealing with how we should behave and feel sexually. Many patients enter the therapeutic context implicitly or explicitly addressing these "shoulds". They berate or blame one another for socially inappropriate actions

("If you were only more desirous of intercourse, I would not have had the affair", or "What is wrong with me that I can't control my ejaculation and give my wife an orgasm during intercourse?"). Many feel embarrassed or shy when sexually explicit material is talked about and subsequently become mute or avoid sessions. In systemic therapy the intent of the therapist's style is to be perceived as accepting and acknowledging the uniqueness of the patients' sexual experiences. Often, purposely constructing a context of permission to feel embarrassed or shy results in alleviating the monitoring of anxiety. Statements that include explicit "permission" to feel anxious, and then give direction such as:

"Most people have limited opportunity to be as open and frank in discussing sexual things compared to other important life events such as finances, child rearing, etc. 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 you being as frank as possible since it helps my understanding, and feel free to use whatever terms or words you are used to. Now, what do each of you see as the major concerns that have brought you here today?"

can go a long way toward setting up a therapeutic context of acceptance and openness while respecting the experiences of the participants.

Subsequent actions of the interviewer are based on both the five part session and the three guidelines for the therapist of the session, hypothesizing circularity and neutrality. (The reader is referred to Selvini et al (1980) and Tomm (1984a,1984b) for a more in depth review of these concepts.) Only the guidelines will be reviewed here.

Therapists utilize hypotheses at all times whether or not they are consciously aware of them. Hypotheses are, after all, simply statements used, without reference to their 'truth', to organize information. Most often, for most of us, the initial hypotheses are lineal in nature (for they describe only one part or segment of the interaction) and these serve as excellent starting points for moving toward the more neutral epistemology of circular cybernetic hypotheses. The use of circular hypotheses helps the therapist consciously move toward a more complex understanding of the process events when necessary. This will allow multiple frames of therapist conceptualization including lineal and circular ones. Having alternate conceptual frames enables alternate therapist actions with respect to the couple's problems.

Perhaps the most important of the three guidelines when dealing with issues of sexual concern is neutrality. It must be remembered that neutrality is not a static position that is attained, but rather a direction towards which the therapist attempts to move. Neutrality is very important in sexual issues because of the larger context in which our understanding of sexuality has been imbedded. Traditionally, in Western society, sexual issues have not been discussed as freely, or as in depth as other significant life events. Our "social mind" therefore suffers a restriction of potential alternatives compared to

other human interactions, and is therefore more likely to judge from an egocentric perspective. The shortage of explicit open discussion and modeling about sexual alternatives leads to fewer useful distinctions being available to many people.

For instance it is commonly believed in many Western societies that sexual intercourse and sexual activity are interchangeable events. From a social and more importantly physiologic basis, there is much more to sex than the events leading to and the act of sexual intercourse, particularly for women for whom it is at best a moderate physiologic stimulant. Sexual intercourse is only one form of sexual activity, yet for most it is thought of as the 'true' or ultimate, therefore, only form.

Another area of lack of distinction has been evident in the failure of many to see the difference between assault mediated sexually, and sexual behaviour. Although, this is becoming increasingly distinct in Canada (the legal system now no longer calls sexual assault rape, but rather puts it under the legal context of violence), many health care professionals and the lay public in general, have yet failed to make this distinction.

An egocentric perspective of sex is subsumed under the belief 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. Such views crippled many professionals' therapeutic impact for years. For instance, psychoanalytic views of 'normal' sex were based on the then prevalent male view of sex being intercourse. Women who did not have 'vaginal' orgasms (ie through vaginal containment of the penis) were considered psychosexually immature. These professionals, because of their egocentric sexual views, never looked at what was, indeed happening for people, let alone possible. We see similar but more subtle egocentrism today in the attempts to have patients sexual lives conform to what the therapist considers better. Neutrality helps move the therapist away from potential egocentrism within the therapy room and thereby helps to avoid a moralistic stance. By aiming towards a more neutral view about the patients' sexual lives, the therapist becomes increasingly free to observe the relationship events as information about pattern and process. One is less likely to fall into the age old trap of trying to move the patients' activities towards what he considers sexually normal and preferable.

The therapist has potentially more impact on helping the couple alter symptomatic actions by freeing them to take an observer position of themselves and thus seeing the impact of his or her actions and beliefs on others. If, instead, the therapist is perceived as being a non-neutral observer, the individual patients are more likely to observe the effects of his observation. There would then be an increased likelihood of attempts to have the therapist's observations match the patients' own pre-therapy concepts of the symptoms. Therefore, the direction of neutrality can be particularly useful in helping the couple examine the impact of gender beliefs, beliefs about alternate sexual lifestyles, and other larger system issues that are often difficult to pursue from a less neutral perspective.

Overall, the therapist attempts to avoid "more of the same wrong solutions" that the patients have been applying to their sexual concerns. Almost inevitably these errors

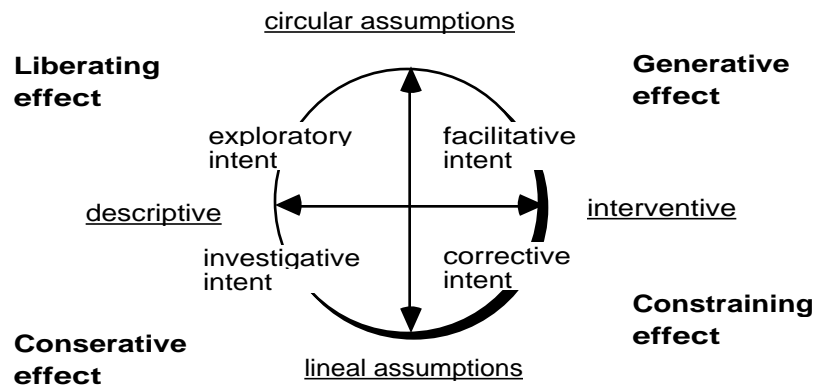
are ones of making judgements according to what is believed to be sexually normal. Unfortunately, the common beliefs of what is sexually normal tend to be the social context's myths and beliefs. By holding a neutral stance to peoples' beliefs while being intensely curious about the effects of holding one belief compared to another, an opportunity for the patients to gain a new and more useful perspective of their sexual lives is provided.

### **Therapeutic Use of Questioning Formats**

In traditional sexual therapy the therapist works for the most part by asking descriptive lineal questions in an attempt to get the 'real picture' of what is going on. Much time is devoted to getting detailed behavioral descriptions of the sexual symptoms, as well as to the physiologic context in which the problems could be occurring. Further detail goes towards outlining the impact of other life events on the symptoms through their course in past history. Additionally, effort is expended in understanding the problem from the patients' explanatory perspective, which is almost always lineally based. From these types of questions the therapist traditionally prescribes a behavioral prescription, which the patients are expected to follow in detail and then report back to the therapist. The same process of questioning, would then be repeated using descriptive questions based on lineal assumptions, to further exact the behavioral outcome and measure its closeness to anticipated positive outcomes.

Cybernetic oriented sex therapy also relies heavily on descriptive and the more strategic questioning formats but, in addition, uses questions based on circular assumptions and intents. A high use of behavioral effect and difference questions, can produce a liberating effect for the patient system since it frees them to consider alternate actions and more comprehensive understandings of the symptom than those from before. Additionally, using reflexive questions can have a great impact on the generative effort of the patients by introducing potential new cognitive connections and potential alternate personal actions.

Tomm (in press), has recently outlined a diagrammatic representation of his circumplex model of circular interviewing. When the interactions between the therapist and the patient system are observed, the horizontal axis refers to the primary target for whom change is intended. The asking of a question can be primarily directed toward descriptive information which implies change in the therapist's understanding or action, or it can be primarily an interactive question, with the primary target of change being the patients. The vertical axis refers to the underlying assumptions that the therapist's questions are based on, that is the therapist's epistemology. The assumptions may be lineal, which the majority of the assumptions of the larger social context are, or they may be circular. Fig 1 uses Tomm's diagrammatic form to outline what effect the therapist's desired intent in asking a question has on the patients' understanding and therefore actions around their symptoms..



Effect on Family of Therapist's Intent

**Fig. 1**

By understanding the intent of asking certain types of questions and then examining the impact on the patients, the therapist can purposely maximize his therapeutic impact through positive use of the questioning format.

A clinical case example may be useful at this point.

Bill, aged 27, and Marie, aged 28, presented with a complaint of Marie's lack of sexual desire compared to Bill's. This problem had persisted since the birth of their first child, a girl, now 2 years of age. Prior to this child's birth, the couple had reported that things had been more mutually satisfying sexually. When first seen, he was employed as a full time child care worker, and she was employed as a part time teacher's assistant, and full time homemaker. Both of the couples families of origin lived approximately 4,000 km away. They had been in this city for almost three years.

Upon initial assessment many descriptive lineal questions were asked, such as:

"What is the main problem now?"

"When did each of you first notice the lack of desire for intercourse?"

"Have the symptoms changed at all over time?" If so: "When did you notice them getting worse? Getting better?"

"What ideas do each of you have as to how come these symptoms are present at this time?"

"What attempts have each of you made in order to try and overcome the problem?"

However, descriptive circular questions could also be asked, and these may have a liberating effect on the couple. For instance, in asking the question,

"Who is more desirous in sexual intercourse?"

and following it with the question

"Who is more desirous of sexual intimacy other than intercourse?"

one introduces through the questions, a distinction between intercourse and sex. This distinction may be new to the couple as indicated by an inability to answer the question, or the questions may bring forth and amplify a pre-existing distinction. The distinction may sufficiently pique the couple's curiosity that they enquire (now or later), more about its applicability to their own thoughts and actions. By following up with a reflexive circular question such as,

"If intercourse were temporarily impossible, and this was accepted by both for the moment, would Bill believe that Marie would be more or less desirous of sexual intimacy?"

then one can help actually open the issue of the couple potentially not having made a distinction between intercourse and sex. Additionally, strategic lineal questions can also have their place if the therapist responds to the feedback neutrally. For instance, one could state,

"I am curious as to how come in this relationship, the person with less sexual desire as opposed to the person with more sexual desire is identified as the patient?"

This would be a strategic lineal question if it is based on the assumption that the patients should also define the male as symptomatic and the therapist's intent in asking the question is to change the patient's views to match his own.

Prescribed homework tasks are given in order to maximize certain distinctions that the therapist hypothesizes may introduce new useful information to the patient system. Of interest to more traditional sex therapists is the fact that the patient's do not even necessarily have to do the tasks either as prescribed or at all in order to generate useful information from the prescription. Problems that may have come up in attempts to do the tasks or in considering them, are then examined again through use of circular questioning. For instance,

"If you were able to complete the sensate focus exercise, who do you think would have been most able to focus on their own sensual experiences more than on observing their partner's responses?"

A partial transcript of the sixth session with Bill and Marie follows. They were reporting a "set-back" in their sensate focus sessions since Bill interpreted their not currently having sexual intercourse as Marie having "won". The therapist's questioning intent is in brackets following his questions.

Marie: Our homework didn't go very well because Bill thinks I am winning.

Bill: I'm not saying she won.

Marie: (interrupting) That was the phrase you used.

Bill: I never said 'won', I don't think.

Marie: "Your winning..."

Bill: Winning, yeah.

Therapist: Winning? What is Marie winning? (*Intent: investigative - clarify therapist understanding*)

Bill: I thought we'd come to a 50 -50.....Nothing like this.

Therapist: 50 - 50 about....? (*Intent: investigative*)

Bill: About the amount of sexual sessions or encounters we'd have but I don't think its becoming 50 -50, its still 75 - 25.

Therapist: Meaning? (*Intent: investigative*)

Bill: She gets her way 75% of the time and I get mine 25%.

Therapist: With respect to actually having a physically intimate encounter or with what is done during the encounter? (*Intent: exploratory - drawing a distinction*)

Bill: No, no, - having an encounter.

Therapist: So, was Marie incorrect earlier in her impression that you want more intercourse - that you are losing the intercourse race? (*Intent: corrective - confrontational*)

Bill: No, I'm not losing the intercourse race, I'm just not winning....

Bill &

Marie: (Both laugh)

Bill: I try to control my urge to caress my wife but I still do it and I get turned down a hell of a lot.

Therapist: Well let me ask, do you think that if Marie were assured that every time you became sexually aroused you would not request intercourse, do you think that she would be more, less or just as interested in sexual sessions? (*Intent: facilitative - highlighting future possible distinctions*)

Bill: I don't think it would make any difference.

Therapist: Is he reading you well Marie? (*Intent: exploratory - compare differences between observations*)

Marie: No, I thought we discussed this months ago. If I know that it wouldn't necessarily end in intercourse then I would definitely be more willing.

Bill: But it doesn't end in intercourse - we're not having intercourse now.

Therapist: My question was slightly different - not the knowledge that there wouldn't be intercourse but rather that it wouldn't be expected to end in intercourse? (*Intent: facilitative - drawing a potential distinction*)

Bill: I don't know - I can't read her well enough - well, probably she would be more interested.

Marie: Definitely!

Therapist: Let me ask you then Marie, if Bill knew that his sexual/sensual approaches to you

weren't going to always be turned down whether or not intercourse occurred, would he approach you more or less? (*Intent: facilitative - hypothetical future distinctions*)

Marie: (long pause) - I can't see him feeling that way.

Bill: In order for me to feel ready to ejaculate, I have to feel as if I am having intercourse. I

put my mind into that way of thinking.

Therapist: Do you always have to think of intercourse to orgasm no matter what sexual activity you are involved in? (*Intent: investigative*)

Bill: Always.

Therapist: Who between the two of you is most able to distinguish between thought and action? In other words, who is most likely to believe that if you think something you

will probably do it or should probably do it? (*Intent: exploratory - drawing distinctions*)

Marie: I don't know - well, maybe Bill:

Bill: I'd say Marie.

Therapist: Sexually, who between the two of you is most likely to believe if you think something you should do it? (*Intent: exploratory - difference question*)

Bill: Me.

Marie: Bill

Therapist: Well, who would be more, shall we say 'addicted' - Bill to the thought of intercourse or Marie to the belief that Bill wants only intercourse? (*Intent: facilitative - taking an observer perspective*)

At this time, a simple prescription was given that requested each to look for evidence of their own "addiction" and report back next session. No other specific homework was prescribed. On the next session, Marie opened by saying they had had mutually desired and enjoyable intercourse on one occasion and a couple of other sexual contacts that did not include intercourse. Bill stated he no longer thought Marie believed he always wanted intercourse and Marie agreed. Therapy continued for two more sessions by examining issues of pace and timing of change and how to understand relapses should they occur.

It is important, the author believes, that occasional lineal questions and statements be included in any interview so as to "connect" with the cognitive expectations and understandings of most individual patients. To be constantly related to on a circular or cybernetic epistemologic basis becomes somewhat other worldly for many people.

Systemic oriented sex therapy does not rely only on the interview session. It uses also opinions and rituals (tasks). These end of session interventions are used to either introduce a strategic distinction with respect to form and pattern (not behavioral outcome alone), or to fulfill the expectations of the patients in coming to a therapist and be "directed" toward improvement. These will not be covered in any detail here (see Sanders and Cairns, in press; Tomm 1984a, 1984b; Imber-Black 1985, in press).

The interview session itself is seen as a prime arena for the promotion of new

information that is of importance to the patients meaningful system. The interviewer's style, methods of practice and skill in utilizing a balance of questioning formats and techniques will predict the usefulness of the session as a therapeutic intervention. Most important, however, is the therapist's ability to use differing levels of abstraction for conceptualizing the sexual symptoms. The interview session as intervention will have most positive impact by relying neither on a purely lineal nor a purely systemic epistemology but rather appearing to move freely between the two when most warranted for introducing "differences that make a difference".

### Summary

This paper has discussed the use of the interview session as an intervention in sex therapy. In more traditional perspectives of sex therapy, the interventions are seen as what is specifically prescribed by the therapist usually at the end of the session. For the most part these traditional interventions are seen as either directive tasks or directive statements. In applying cybernetic epistemology and principles to sex therapy, however, the actual style of the interviewer can be used effectively as an intervention. In addition to the prescription of systemic opinions or rituals (tasks), a reliance on circular question design and use as therapeutically generative is a hallmark of systemic sex therapy.

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