

Sexuality, Power, and Empowerment: One Man's Reflections on Sex Therapy

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Abstract

The focus of this paper is the understanding of and intervening in issues of human sexuality from a cultural/contextual perspective. Emphasis will be given to how society's sexual, gender, and relational assumptions "invite" a lack of expected mutuality in sexual relationship and, thus, set the stage for sexual problems to emerge. These problems often fall into the domain of "power" - power over the other, or powerlessness for oneself. Using what I have termed "the five words of sexuality", a "distinction between thought and action" and an experiential definition of violence, the paper outlines a highly effective contextual intervention strategy which can enable higher quality sexual relationships. This method has proven clinically effective in working with both opposite-gendered and same-gendered relationships.

Introduction

It is an honour to be asked to give this presentation to my peers and colleagues at the Canadian Sex Research Forum. When I was first asked to give this keynote, I felt somewhat reluctant, more out of anxiety and shyness than sloth or avoidance. I think it had to do with the fact that I am keenly aware of being primarily a clinician with academic interests in the application of theory to clinical service. As such, I do not feel I fit as comfortably with the more traditional "research" focus of the Forum, and so therefore was both anxious and flattered at the invitation. It is with this awareness that I offer my thoughts and reflections on the last 15 years of my clinical work along with those of my colleagues in the Human Sexuality and Family Therapy Programs in the Faculty of Medicine at the University of Calgary.

Over the years, I have come to reflect on the way in which I work and teach as being most a result of what I have been conditioned to by the culture at large, and taught by the patients and clients whom I have seen. These persons are the ones who have invited me into looking at sexuality and power from a perspective that is different from that which I, as a white, middle class male, trained as a psychologist, a physician and a psychiatrist, would traditionally have held.

In keeping with my narrative focus to work, the paper is divided into three narrative sections, each reflecting part of the title of the presentation. The first outlines my personal journey to being a sex therapist through our shared cultural labyrinth and is intended to highlight moments of distinction in my understanding sexuality. The second section briefly gives the stories of four patients, clients of distinction and what each taught me about the power of experience. Finally, the third section

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outlines four distinctions of use, the empowerment of clients and clinicians alike.

Moments of Distinction

A number of cardinal experiences come to mind in reflecting on my journey to the current epistemology and clinical perspectives that I use. The most important are pivotal clients and their experiences that helped me move beyond the “blindness” of my cultural rearing, however, the first meaningful experiences are, of course, the personal ones that lead me to becoming a sexual therapist (Sanders 1991b).

I see myself as being like most others when it comes to past experiences of understanding and experiencing sexuality. I was raised in a traditional Canadian family of two parents and four children. I was surrounded in my family by an older brother and two younger sisters. It was as a child within such a usual family that I began to appreciate sex as an experiential thing.

At about eight or nine, I remember standing in the back alley with a group of boys and girls from the neighbourhood, talking in conspiratorial tones about where babies came from. In the end, the group consensus was that they either came directly from the belly-button or out the anus. Either consideration was quite shocking since I had believed that they had magically appeared on the day of delivery from that huge human factory called a hospital. A few years after this incident, at the age of eleven or twelve, I remember pursuing girls for intimacy and sexual play. When my parents read the note from the teacher who found a girl and I in the nurse’s room sexually playing with each other, I was quite forcefully informed of the unacceptability of this type of behaviour. At around the same time, through rough-housing with my group of male friends, I found that sexual arousal could also occur with the same sex, but I very quickly learned that this was not acceptable either. It wasn’t until I learned about self-stimulation that I realized that there might be something that was acceptable only because no one else knew about it! Later, in my mid-teens, I became baffled by the neighbourhood’s and my peers’ reaction to a man who had moved in with his dying mother to look care for her during her last days. The ridicule and abuse that this young man was subjected to, from community centre to grocery stores, always perplexed me, for I did not understand that others thought of him as “gay,” and it appeared to me that he was doing such a benevolent and caring thing by looking after his widowed and ill mother.

It was in my mid to late teens that I became more aware of women as an oppressed group when, in fact, my own mother became severely depressed. I can remember that she would stay up all night trying to perfect the cleaning and polishing of the kitchen floor, folding laundry just right, or preparing endless lunches that none of us could ever eat. Mom would be crying and talking to herself about the burden of running the household without my father’s presence and how she must show him and her parents that she could do it. All of this with her 2 and 14 year old daughters and her 18 year old son at home; little money, bill collectors at the door, and nearest family three hundred kilometres away. Oddly, when my father heard of her having yet another admission, it seemed to invite him into being even more distant and away more often. It seemed as if he interpreted my mother’s upset as his not having done a good enough job of bringing home money and creature comforts for her, when in fact it seemed that she wanted to have more of an active, lived relationship with him. I remember that my parents were never seen together once by the physicians about the so called “illnesses,” nor were we as children ever consulted.

Later, a close girl friend and I sat down and commiserated about the unfairness of life and people after one particularly harrowing night of family upset. My friend, was the first person to ever bring to my attention that men seemed to have a different experience and perhaps an easier one in some respects, compared to women. Although these were my truly first views of gendered differences, it would be some years before such a concept would help me see the world differently than how I had been socialized.

It was from these beginnings that I started to have more of an academic interest in helping people. When I started out to be a physician, I only wanted to be able to help people who were undergoing health problems free themselves from such oppressive experiences. However, I soon learned that modern medicine as practiced in Canada seemed to pay less attention to the person and more to their parts. As a physician, I was trained to bend patients to my will, believing that what I thought best would necessarily be best for them as well. However, since I longed for an interpersonal context for my healing intent, I became interested in psychiatry – that very discipline which had failed my parents. Here I was even better trained to have patients do those things that I wanted them to, but now with greater skill and secrecy. But it was not ordinary psychiatry that intrigued me, it was family therapy with its complexities, it's talking with more than one person at a time that beckoned me. It was here that I learned the difference between therapy and social control: one opens space for clients experiences and the other necessarily closes that space. It was here that I became more aware of how gendered lenses of experience altered people's intent.

During my psychiatric residency training in family therapy, I found that child-oriented presenting problems would often quickly result in seeing the marital subsystem alone. All too often, the marital concerns would revolve around those "secret" events which occur behind the closed (hopefully) bedroom door. I, just like the family, seemed to be de-skilled when it came to discussing such private events. However, being a good psychiatric resident, I quickly ran off to the medical library and read up on Masters and Johnson's (1970) and Helen Singer Kaplan's (1974, 1978) psychosexual treatments. Armed with brand-new "cookbook solutions," I went back to the couples only to discover that the therapy fell absolutely flat.

I elected to take a special training year at UCLA's Human Sexuality Program (under the auspices of Dr. Joe Golden and Dr. Susan Price (1980).) The decision was based on the realization that my therapeutic effect appeared of little use despite my interest and positive intent. This was to be an immensely pivotal year for me. Although the academic pursuit was very useful, it was the personal reflection that I found most useful. This was afforded me by living in a different culture. Although it may have appeared not obviously all that dissimilar from my hometown of Calgary, the differences became more marked and noticeable after a few months. It was from these "stereo" views of sex, gender and oppression – from holding a Southern Californian view and a Western Canadian view simultaneously, that I began to see human experience from a more comprehensive perspective. I now could see where we are all limited by social restraints against acting on our sexually *affiliative* intent. The most appalling of all was my realization that gay men and women were subjected to oppression simply for attempting to be loving and socially responsible! Additionally, the treatment of human beings as property, whether man or woman, was another shock to me. The notion of human property all too often was extended toward sexuality, such that an individual appeared to hold a belief that he or she

had a *right* to the body of another for sexual purposes.

As a consequence of coming to ‘see’ gender bias, of reflecting on my own family’s experiences through a lens of gender difference, for a number of years, I fancied myself a male feminist. However, I can no longer claim such a title. In part, my throwing off the mantle of feminism has to do with an effort to show respect for women’s leadership in the feminist field. As a man, I would not want to risk usurping women’s voices in matters that are fundamental to a woman’s experience. However, other reasons are more related to a personally experienced pragmatic reality. It appears that no matter where I would speak, the use of feminist language and concepts appeared to proffer an invitation to polarize that few people could refuse. This seemed true whether I spoke to a “Lesbian Mother’s Defense Fund”, a “Single Father’s Support Group,” an “Early Childhood Services” group in a rural or urban setting, or to academics. I was quickly disqualified by my audience. The “radical feminists” in the audience would disqualify my actions simply by the fact that I was male. I was classed as somehow being a “traitor” to the masculinist’s cause by my male colleagues. At best, I was seen as a well-intended but befuddled professional. Despite my good intent, the cloak of feminism didn’t appear to others as if it fit me. In addition to this pragmatic reason, however, there was an even more fundamental reason to abandon my effort at being a feminist — my experiences with my clients. It appeared to me that the popular notion that is bantered about in western culture where men are believed to be more interested in sex and women more interested in love (the “Men are from Mars and Women are from Venus” mentality) was in fact, mythology. For the couples I would meet as clients both the men and women appeared to want exactly the same thing: a mutually enjoyed, unique *experience* that defined their relationship as different from the others they were involved in. This most often included physical arousal, even to the point of orgasm, but as importantly, included emotional and physical vulnerability in the context of trust (both of which go into what we usually perceive as intimacy). It was the fact that both partners in a relationship, no matter their gender or affiliative orientation, indicated to me that each wanted exactly the same experiential thing that invited me to increasingly strive for a more mutualist perspective. In other words, I believe that it is my clients who have invited me into abandoning the personal title of “feminist” in favour of of pro-feminism and most importantly, mutualism.

The effect that a mutualist focus has had for me as well as for some of my clients, has been a liberation from the socially constructed implicit adversarial nature of different thinking. It helps put us all on the same side of the fence, all striving toward the same thing — an affiliative human event which is perceived mutually as positive and wanted.

Clients of Distinction

These experiences have gone a long way towards liberating me from adversarial or dualistic thinking. It is as if I finally accepted my client’s invitations to more clearly realize their positive intent and purposeful striving towards a mutual relationship despite whatever the apparent gender differences and attempted methodologies.

For instance, one of the earlier cases that helped me look at sex as being more an experience than a set of specific behaviours was Christie, a 48-year-old banker who had transferred to Calgary from the USA, along with Julio, her husband of many

years. They had two children who were now in University and about to leave the nest, and had come as a couple to the sexual therapist because of increasing difficulty in her being orgasmic. In this particular woman's case, the orgasmic difficulty was secondary to a rather unusual chronic and increasingly debilitating neuromuscular disease that made coordination and reflexes difficult. Whereas at the start of our work together, she was able to walk with the assistance of one cane, by the end of our ten sessions 11 months later, she was wheelchair-bound. It was quite clear from the beginning that she would not be able to effectively rely on consistent genital orgasms from their usual practise of genital manipulation and intercourse. Julio, despite the fact of knowing that the neuromuscular disorder underlined the orgasmic dysfunction, found himself increasingly experiencing being abandoned, neglected, and rejected. Of course, we all know that part of this might have been related to his dealing with what could be seen as a significant and debilitating future for the woman he loved, but nevertheless, these were his focuses. After inviting Christie and Julio into refocusing their sexual intimacies to more experiential dominions rather than simple behavioural domains, I will never forget, as Christie was wheeling herself out after the last session, she stopped in the doorway, turned to me and said, "Dr. Sanders, if only I had known what I know now, I would give up my able-bodiedness of 30 years ago in order to have 30 years of this experience". I was quite astounded at the depth of her statement and that this apparently simple distinction, had had such great profundity for her. Christie and Julio were, therefore, essential in clinically inviting me to begin to explore my own cultural assumptions of what sexuality actually entails.

Another client, Darrin, clarified for me a another distinction useful in understanding sexuality – that thoughts and actions are not linearly predictive. Darrin was a 15-year-old youth who had been referred to an adolescent sexual offenders treatment program here in Calgary from a similar program in Ontario. This young man had been treated in a number of residential programs for the last 15 months but with only escalating problems. The particular symptoms that he displayed had to do with a fetish for soiled diapers; in fact, it had gotten to such extreme measures before he was referred to Calgary that while still in Ontario he was running away from his Program to steal soiled diapers out of trash cans and, if possible, off children themselves. This, of course, had severely alarmed not only the staff, but also the authorities in the community - to the extent that eventually permission was given by Child Welfare for him to have an entire Program to himself. That is, he would be watched 24 hours a day by his own staff who would rotate through the cottage which had been set aside in a separate facility just for him. Despite the herculean efforts on the part of the staff in the Ontario Programs, his fetishistic behaviour increased and multiplied to include now self-soiling and smearing of feces over himself during self-stimulation.

When I saw Darrin for assessment, he was a large and for his age somewhat overfat young man. He showed adequate intellectual capability and a wide range of emotional responses that were appropriate to situation and content. He had been put on Ritalin about two years previously and had recently been assessed for the possible use of an anti-androgen agent for chemical castration. After Darrin was sufficiently engaged in a therapeutic conversation, he easily told me that he found the *thought* of these diapers immensely arousing, and that he felt "compelled" to search out the diapers to use as masturbatory agents. He was able to espouse certain understandings that, for instance, he felt it comfortable to imagine himself being a baby and taken care of by a woman of his affection, or being cleaned after essentially

having soiled his “diaper” - again by a woman of his affection. Over the next six months, Darrin was helped to externalize the feelings of helplessness and hopelessness in relation to his fetishistic activities through becoming the “boss” of his thoughts rather than the thoughts “bossing” him. When he finally returned to Ontario, he no longer engaged in fetishistic behaviours, was fully able to influence his sexual activities appropriately, and was now medication free. He has remained well in follow-up living at home. This was accomplished by becoming very interested in what had cultural practices, no matter how well intended, had supported Darrin’s thoughts and fantasies becoming translated into specific actions rather than left where they seemed to be most effective, in his mind.

Anthony, who had been referred from the Plastic Surgery Clinic at the General Hospital after having reconstructive surgery to both his hands, helped me challenge my cultural assumptions of sex and social responsibility. At the time I first met Anthony, he was 26 years old, living on his own, and had been in the city only six months. He was recently out of a two-year relationship with a woman who was his senior by 15 years and who also had a chronic alcohol abuse problem. Nevertheless, he had found some satisfaction in the relationship, until towards the end when he discovered that she had been sexual with other persons. Anthony then left the relationship in order to strike out on his own, and in the ensuing six months, he found himself increasingly attracted to prepubescent children, both boys and girls, but primarily boys. In fact, in the church that he belonged to, he had found himself inviting one of the preacher’s sons into a compromising situation where Anthony exposed his aroused genitals to the boy and then invited the boy to touch him, which the boy did. Anthony in turn touched the boy genitally. The boy reportedly initially showed some pleasure in touch, but soon apparently displayed discomfort in the continuation of the activity. Nevertheless, Anthony repeated these events on two or three other occasions with the same boy, while the genital manipulations became increasingly complex and more involved. Eventually, Anthony retreated in great despair wondering what was wrong with him, and the more despairing he became, the more he felt the impulse to connect genitally with children to be irresistible - to the extent that before coming to see me, he had begun hanging around playgrounds and working out elaborate ways that he could try to get children alone. In a desperate effort to “control” himself, he had slammed his fists repeatedly against the wall, breaking most of the bones in both his hands.

I originally saw Anthony some years before, but I had an occasion to bump into him in the community a few months ago. He asked to speak with me privately for a moment, which was comfortable to do on that summer’s day, and as we spoke, he thanked me for the efforts that I had given him some years before. I was curious about his current state of experience and asked how life was going. Anthony said he was now involved in a long term relationship, that this had been a value to him although he and his woman-friend did not live together. I then asked what about the interest in children that he had talked about years before. He looked at me with a slight smile and stated “It’s funny, Doc, but I seldom, if ever, think of children anymore. How do you explain that?”

Perhaps the most profound clinical experience which I have had, helped me to see the difference between violence as an act and violence as an experience. It occurred a number of years ago when I was called to the Psychiatric Unit to see a young patient of 18. On this, the most recent of her many admissions to hospital, she had decompensated just prior to discharge. According to staff reports, Mary had been

doing well during her hospital stay; recovering from the schizophreniform symptomatology she had been diagnosed as having with the aid of medication and milieu therapy. However, just as she was about to be placed outside the hospital, Mary began to show symptoms of extreme anxiety, agitation, avoidance of interaction, and breakthrough anger. During one outburst, she apparently stated in anger that no one had ever asked her about her sexual history. If staff had they would know that she had been raped at the age of 12. The staff quickly inquired into this and as Mary began to settle with their support, interest, and changed medication regime, a tragic story unfolded.

At the age of 12, Mary and a similarly aged girlfriend, were walking across a city park on their way home when a man stopped them to ask them for directions. As they tried to explain to him the directions he was requesting, he pulled both off into the shrubbery and under threat of death, sexually assaulted each in turn. The girls, both just pubertal, were obviously terrorized and humiliated. Mary spoke of going home hoping to have some understanding and support from her parents. On blurting out the story, her parents responded to their shock and dismay by saying that she had no right to be in the park at that time of day, and that she knew better than to talk to strangers. Apparently Mary's girlfriend experienced a similar reaction from her parents. The event was hushed up and Mary was not permitted to go to the authorities. The girls were mostly left to their own devices as both families seemed best able to deal with the event through silence and secrecy. This, of course, invited Mary and her girlfriend into a special and unique friendship which blossomed over the next year or so. When Mary was 13, during a sleep over that she and her best friend arranged, the friend began to explore Mary's body sexually when she believed Mary to be asleep. This brought forth feelings for Mary that were similar to those she experienced when the man used her body without her consent. She became very frightened and broke off the relationship with her friend. A year and a half of personal isolation followed. At the age of 14 1/2, Mary fell in love with a teacher at school and began to write her love letters. The teacher, rather than dissuading Mary from experiencing these kinds of feelings at all, acknowledged Mary's feelings for her and gently helped her understand that these feelings could not be returned because of the teacher/student relationship. Mary remembers being very hurt by this, however, she came to accept it and subsequently, at about the age of 15, fell in love with one of her best girlfriends. After Mary realized that her love also had a sexual component, she experienced her first psychotic break and was diagnosed as having schizophrenia. Since that time she has been in and out of hospital on five occasions with average stays of three months. During this process she was also removed from her family and placed in a series of foster homes. After her current hospitalization, she was expected to move into an independent living situation.

During my first meeting with Mary, I chose rather than to repeat all the details of the history, to instead confirm that I had read the chart and understood her distress at having to talk with me. I then spent time personally engaging her. I found her, although sedated, to be highly forthright, easily able to follow questions and conversation, and more often than not direct in her response. She would, at times, show emotional upset particularly when approaching the subject of the early sexual assault. Eventually, I experienced our conversation to be sufficiently genuine and engaged to ask her the following questions.

"I am curious," I said, "after the events in the park where that man took advantage

of your body for his own purposes, how do you think others saw what happened when you told them of it? Did they see it more as a sexual event, or more as an event of violence?”

“Sex.” said Mary without hesitation.

I next asked, “How about the professionals that you have seen, such as here at the hospital? Do you think that now that they know these things happened to you, that they think of what went on in the park more as an event of unwanted sex, or more as an event of violence?”

Mary looked around the room, eventually her eyes landed on her primary nurse, who she had already admitted was a special strength for her recently, and then looked back at me with doleful eyes and said, “Sex. Didn’t they ask you, the ‘*Sexpert*’ to come and talk to me?”

Then I asked her, “Mary, how about yourself? When you look at what happened those six years ago, do you now see it as more a sexual thing that was unwanted and wrong, or more as an experience of violence?”

She looked at me with confusion on her face, obvious distress in her reflection and said “I have always thought of it as bad sex, but it always seemed so violent to me.”

I tell of these four cases since I believe they are able to offer an explanation both for the title of this paper and the four major points which I want to make.

Distinctions of Use

My theoretical and therefore clinically enacted focus has been in the tradition of writers such as Bernie Zilbergeld (1987) who wrote the trade book *Male Sexuality*, Michael Foucault in examining the cultural evolution of sexuality, Jeffrey Weeks (1986) with his experiential focus on sexuality, and, in particular, the focus used by gays and lesbians (Sanders 1992, 1993) in escaping cultural myths of penetration being sex and replacing it with sex as an emotional/erotic experience². Such emerging clinical traditions, garnered from my clients lives, buttressed by the above readings, have led me to a number of fundamental premises which I now use in my sex therapy work (Sanders 1986, 1988a&b, 1989). These are:

- Sex is an experience, not a set of specific behaviours.
- Thoughts are not linearly predictive of actions.
- Violence is essentially experiential, not a set of defined behaviours.
- Cultural drift, its stories of meaning and traditions of blindness, tend to be internalized and personalized rather than externalized and given to the cultural collective.

a. Sex as Experience

²... gays are in the vanguard of that final divorce of sex from conventional notions of sin; the divorce of sin from mythology and religion. If we can carry this off— if we can take sex out of the realm of sin altogether and see it as something else to do with personal relationships and ethics, then we can finally get around to another phase of Christianity which is long overdue. That phase is the one which deals with the question of sin as violence; sin as cruelty; sin as murder, war and starvation.
Writer Anne Rice

As Christie, the disabled banker helped me begin to understand, sex cannot truly be defined behaviourally as so many researchers and pundits have tried. Although genital behaviour may, at times, be seen as sexual, at other times it may be anything but as evidenced by Mary's experience. These patients helped me to genuinely question the assumption that sex had to do with certain behaviours such as intercourse and replace this assumption with sex as a mutual experience.

From listening more carefully to my patients, I distilled a series of five felt shared experiences between two people that appeared minimally necessary before the activities the two engaged in could be considered by our culture as mutual sexuality. Although I have described these "Five Sexy Words" elsewhere (Sanders 1991a), they are so fundamental that they bear repeating.

I will often orient clients to these Sexy Words in a reflective manner. As with clients, I will ask you to close your eyes after reading this paragraph. I would like you to privately remember, without acting on the memory or saying anything aloud, one of the better sexual experiences in your life. If this is difficult to do, then imagine how it would be if it could be. Now, I know as you bring this memory to mind that you will remember who you were with, where you were, and what you were doing, but I am more interested in you remembering what made this experience so special - what sorts of feelings, thoughts, and interactions did you have? When this is clearly in mind, continue to read.

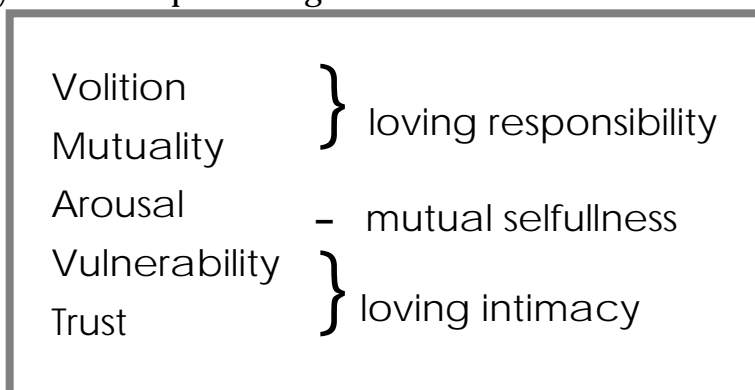
Your best sex (even if anonymous, or for only one occasion) probably included the following:

1. First, you and your partner recognized self and other as being involved together out of free choice, or **volition**. This freedom of choice was perceived by one for the other as well as for self. Indeed, the fact of each choosing freely helped invite a sense of special choice.
2. Second, you both were involved **mutually** in sex - i.e., you were both on the "same side of the fence at the same time". Again, knowing of both being on the same side of the fence "fed" rather than "starved" your desire to be with each other.
3. Third, both partners' experience was in the domain of **arousal** - both emotional and physical - the type of arousal that neither you nor your partner need worry about the other's - each seemed fully experiencing their own arousal. In fact, your partner's arousal helped feed yours and vice versa.
4. Fourth, these experiences and actions were occurring in a context of mutual personal **vulnerability**. Each could be as open with her or his physical and emotional experience as was valued.
5. Fifth, the vulnerability occurred within **knowing trust**; trust that one's partner would not take advantage of, make fun of, abandon, or be abusive of one's own openness.

How well did I guess? Most people find that these five words do describe their best and their hoped for sexual experiences.

These five words together make the personal events sexual or "sexy"; but if you and your partner do not experience all of them together, the sexiness is missed and the genital event becomes less than best or less than hoped for, in fact, can easily become

not sexual at all such as when all five words are missing in assault, or three are missing in duty. The words can be grouped (see figure 1) into *loving responsibility* - ensuring mutual free choice and that the activity, along with its intended experience, is mutual; *selffulness* i.e., that one takes personal responsibility for one's own arousal. I have come to call this personal responsibility and personal immersion into one's own experience while freely sharing with one's partner, selffulness, in order to distinguish it from selfishness - personal pleasure at the expense of one's partner; and finally *loving intimacy* - the emotional experience of mutual vulnerability coupled with valid trust. There can be other words added to these five to make the sex exceptional and more unique; for instance, when a sense of mutual love in a romantic sense can amplify the depth of the experience. A feeling of commitment in itself can also enhance the sense of sexual safety, as long as it is there for both. However, these latter two "words" are not truly necessary, although when present they do amplify the sexual pleasuring even more.



By thinking of people's intended sexuality from such an experiential frame, therapists can invite the clients into better being able to realize their intended lovemaking. If, on the other hand we simply continue using the age-old, worn-out, and most importantly, non-mutual behavioural definitions of sexuality, we risk inviting clients into simply trying yet again to perfect what thousands of generations of humans haven't managed - mutual sexuality based on an inherently non-mutual opportunity!

I then often invite clients into reflecting on these "five sexy words" as being more indicative of the experience which they seem to be after, than of the behavioural descriptions which they have traditionally been using. I help clients recognize that, for instance, genital activity between a prostitute and her 'john' entails only mutual choice and mutual judicious trust, but in fact they are not sharing the same kind of experience, since one is preoccupied with business and management of that business and the other with the illusion of sex. They are not having mutual arousal since the prostitute recognizes arousal takes time and time is money, and they are not equally open about these experiences, particularly the prostitute for fear that she would slow down her client's response and therefore the turnover of her business. Or, for instance, I invite the couple into recognizing that duty-filled obligation, even when done on a loving basis, has more in common with the business of body selling, than it does the experience of mutual sexuality. And finally, I help the client see the point even more clearly by inviting them to reflect on these words' application to the two experiences of participants in sexual assault. For instance, in Mary's case where she had no choice and he had all the choice. There is no mutuality. There is not similar arousal, nor similar openness, nor is there any trust. So, not one of the five words applies, and yet for eons people have thought of genital assault in some sexual manner.

By refocusing a couple's personal goals towards these shared sensual erotic experiences, rather than specific behavior, individuals in a couple have a much more potentially effective goal. It was on reflection of understanding these five words more clearly that I could restore the position of Christie and Julio, for they were eventually able to achieve this level of shared experience with each other despite, and perhaps even because of, their disabilities opening up the opportunity.

b. Thoughts do not predict actions

The second fundamental premise that I have found helpful is to have a clear distinction between the differences of thought and of action. Although this sounds quite simple initially, when it comes to the areas of sexuality, many of us, whether professional or lay persons in the community, act as if one is necessarily predictive of the other. For instance, this is often the case in pedophile fantasy. We, as a community and often as professionals, become sufficiently alarmed at persons' fantasies towards children that we have become more social control agents than therapists. This is certainly evidenced by Darrin, the young man with the diaper fetish, for as soon as the previous staff became aware of his "diaper thoughts" they became ever watchful for his "inevitable" action. By inviting both ourselves and Darrin into continuing to make the connection between the prediction of thought to the feared action, the action was, unfortunately, inevitably produced. However, when in fact we suggested he continue with the thoughts but redirect the action from actual use of soiled diapers or soiled underwear to the thoughts of the soiling while doing a different action, self stimulation in private, we found that over a period of two months, the dramatic behaviours began to recede just as dramatically as they had been present. This continued to the extent that now he is no longer involved in diaperism, or other fetishistic behaviour. Similarly, Anthony was able to come to accept his pedophilic thoughts as simply mindful events, without necessary follow through in specific action. He actually told me once quite clearly that the thoughts worked better when solely in mind than when they had ever been acted on..

c. Violence as Imposition

The third distinction that I have found particularly helpful is the awareness of an experiential understanding of imposition and violence in contrast to the experiential understanding of love. Humberto Maturana (1986), a neurophilosopher from Chile who started life as a biologist, has offered very helpful definitions of love and violence. He defines love³ as:

"the providing of space (a context of acceptance) for the experience of another even if there is some cost to self.

And he sees violence as:

³In *Love and Limerance (1979)* Dorothy Tenov introduced the word "limerance" to describe the state of falling in love or being romantically in love. As described by Tenov, the basic components of limerance include: 1) intrusive thinking about the desired person; 2) acute longing for reciprocation of feelings and thoughts; 3) buoyancy when reciprocation seems evident; 4) a general intensity of feelings that leaves other concerns in the background; and 5) emphasizing the other's positive attributes and avoiding the negative. Tenov includes sexual attraction as an essential component of limerance, but admits exceptions. Sexual attraction alone, however, is not enough to denote true limerance.

"the holding of an opinion to be true such that another's is untrue and *must* change."

It is important to realize that the holding of different opinions does not necessitate violence, but rather the holding of the belief that the other's opinion must change is where all violence stems from.

This is a broad and inclusive definition of violence, but as a therapist, I have found it particularly helpful because it defines as violence even those activities that sometimes cultures value, such as obligatory schooling for children against their wishes, or occasions of punishment at home where a parent's will is imposed over that of a child. By defining these current culturally appropriate interactions as violent, it invites us as parents or therapists to acknowledge our own violence and secondarily to develop that highly important therapeutic skill - the ability to reflect on our actions. As a therapist use of such a broad definition can invite us to reflect on whether we in fact are acting with *unintended* therapeutic violence in reference to our clients. And finally, this definition can also assist us help clients avoid unintended imposition in relation to the persons whom they care for and love.

The usefulness of this definition of violence as an experience can be seen in the work that I did with Mary, the young woman who had been genitally assaulted at age 12.

In the consult session, I looked at Mary and I asked, "Do you play baseball?"

She looked back obviously perplexed and perhaps even thinking, 'He's the one showing bizarre thinking and I'm the one diagnosed as schizophrenic.' "Yes," she replied.

"Well, please bear with me for a short while. Let's pretend for a moment that you are in a baseball game. You're the catcher and it's the last inning of the game with the last batter up. The batter has one more strike before being out and if this batter goes out, your team wins. Let's pretend that this is a fun game between two teams on a Sunday afternoon. Both teams have been enjoying themselves and are looking forward to the end of the game so they can move on to celebrate. As the pitcher throws the ball, the batter swings with great effort, misses the ball, and you, as catcher, catch it. You now know that the game is over, your team has won, and the follow-up parties await. However, before you can fully recover your balance from the catch, the batter turns and with full and mighty strength, swings the bat hard across your head. If this were to occur, would we call this baseball?"

Mary looked at me, eyes wide, obviously thinking and said "No."

I said, "I'm curious, why would it be that if a man uses his genitals *against* a woman, we would call it sex?"

It was Mary's response to this question that has prompted my talking about this in professional circles. She looked at me, silence in the room. Initially I could not read her expression but slowly tears began to roll down her cheeks, softening her stony look.

On many occasions since this session, I have asked professionals what they believe Mary was emotionally experiencing at the moment of her tears. Many women say,

perhaps relief. Many men state, perhaps sadness at the time lost. But, in fact, when I asked Mary to tell me of her tears, she looked at me, and angrily said, “You mean I had to wait all these years to learn this?”

It was this anguished cry of a youth who had spent six years of personal turmoil and torment following an act (that was clearly experientially violent) with confusion as to its sexual implications. I have found the fact that the implications had taken on a larger influence for her own personal development to be especially poignant.

Once I validated her anger and her right to be upset that this had taken so long, I then began to inquire of her ability to work with this concept over time, particularly with her primary nurse. I asked, “If the professionals also thought this way, would you find it helpful in coming to experience yourself as more healed around the events that occurred those six years ago or would it make little difference?” “A big difference!” was her response.

The issues of violence, sex and social appropriateness were not all that Mary was struggling with. Her many years of hospitalization, family disruption, and difficulty accepting her lesbian orientation and its meaning, when taken together were significant and powerful invitations to disruptive behaviour and experience. Nevertheless, this simple *baseball metaphor* permitted Mary to both cognitively and experientially recognize and begin to internalize more useful distinctions of the sexual assault than that which society had offered her. The intervention also became available for professionals - those who would read the consult, who would talk with the primary nurse in attendance, and who would talk with Mary herself.

Although I saw Mary on one or two more occasions and her clinical status improved dramatically and remarkably over a short time, I am not sure exactly what happened to her later. I did see her in a store a year or so after our first meeting. I do not think she saw me, however, from across the store, I saw her interacting like any other shopper - buying a Walkman from a salesperson. I do know that for other women and men and their spouses the baseball metaphor has served as a concrete and identifiable foundation from which to start meaningful healing after the traumas of sexual assault and sexual abuse.

d. The tyranny of cultural conditioning

The final distinction that I have found particularly helpful is recognizing that in the end, all these distinctions are culturally based, and contrary to these less common understandings, the most common way of understanding problems is to internalize them to persons. For instance, even the English language orients people this way. The phrase “you made me...” gives attribution to the internal experience of another’s intent, or the phrase “you are too horny” implies that horniness is internal to the person as opposed to a product between the two. Michael White (1986) has been a pioneer in using externalization techniques primarily with families and children; however, I have found it exceptionally useful to use externalization techniques of certain culture practices that have “victimized” couples and thwarted their intent for a more mutual experience of sexual engagement. For instance, I frequently use the concept of patriarchy or traditionalism having “gotten hold of” the couple in ways that are, of course, gendered, but nevertheless limiting of their intent. This is what I chose to do with Julio in inviting him to a more respectful understanding of Christie’s experience. By inviting couples to work together in

standing up to the traditions to patriarchy's bossing them about, I have found couples to work more mutually, more effectively, and with delight.

Conclusion

Sex has traditionally been thought of from two major customs. The first and most traditional way has been as "sex" providing the means for procreation. The second tradition has been sex as sexual activity - this is what most persons in our culture now consider sex. When one looks to see the accepted cultural definition of sexual relations, as Webster succinctly puts it, the term is described only as "coitus". This behavioural distinction is, in my opinion, a root source of much of the difficulty in our understanding, enactment, and therapy of sexual expectations. So, in using "Sexuality" in the title, my first invitation to you has been to rethink sex as primarily and fundamentally experiential and relational, rather than individual and behavioural. The second word of the title "Power" means less about the power one holds over another, but rather the power that one has over one's self. Here, I am interested in the postmodern constructivist position of developing effective reflective skills and respectful distinctions, both as therapists and as persons with sexual lives. And thirdly, the term of "Empowerment" is an invitation, particularly to clients, to experience ones' sexual lives more fully and more completely by privileging mutuality rather than selfishness, and choice rather than imposition in the context of intimacy.

As I look down the road of future therapeutic interventions, it's my belief that the greatest opportunity for professionals to aid future sexual healing will come from a congruity between the therapists' intent and practice. This congruity will certainly include an orientation that is accepting, comprehensive and reflective. More importantly however, a healing perspective would also clearly encompass the synergistic possibilities of mutualism.

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