

Systemic Rituals in Sexual Therapy

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INTRODUCTION

There are few human activities that occur so frequently and yet are so shrouded in mythology as human sexuality. Sexual ideas, expectations and activities vary greatly from culture to culture, from one geographic location to another, between religious denominations, from community to community and from one family to another. Human sexuality becomes even more complex by the expectation of it fulfilling a variety of personally felt different cultural and social needs. These can include reproduction, fulfillment of duty and commitment, expressions of interpersonal intimacy and uniqueness, and interpersonal bonding. With such complex demands being made of our sexuality, it is not surprising that we in North American culture, who all too often appear preoccupied with issues of sexuality and yet, paradoxically, remain highly constrained by social and family sexual taboos, end up having sexual symptoms and dysfunctions. These symptoms and dysfunctions are frequently brought to health care professionals in hope of finding a satisfactory resolution through therapy.

This chapter will examine the nature and use of systemic rituals as applied to the sexual aspect of interpersonal relationships. A clinical case and the discussion of its treatment will be used as the foundation from which an elaboration of the methodology and use of systemic rituals will be offered. In addition, a brief description of a recursive model of intervening in sexual concerns will be offered.

STATE OF THE ART

Before reviewing systemic rituals and their clinical application in sexual therapy, a word of caution is in order. 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 suggested to **first** 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 for either 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 interventions is not.

In all cases of sexual concern an adequate assessment of the bio-physiologic functioning of the individuals involved should be completed before one moves on to assume that the most useful method of intervening would be through non-organic interventions.

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?" "Have you noticed that these have increased or decreased over the last few months?" (*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 sense of arousal through the sexual actions you engage in?" "Do you have physical changes such as erection etc.(for males) or vaginal wetness and pelvic fullness etc. (for females) that accompany arousal?" "Are you usually able to maintain your arousal for the 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 or enjoyable as you would want it to be?" (*pleasure/evaluation phase*)

Given that the individual experiences sexual desire (i.e. a sense of sexual urgency, not just sexual curiosity) on some occasions and that within some of **these occasions** s/he is able to have a complete sexual response including physical indications of arousal and resolution, the likelihood of organic abnormalities accounting for the symptoms is extremely low. That is, if the neurological, vascular, and muscular reflexes involved in the physiologic sexual response are able to operate on some occasions (whether interpersonally or self stimulatory) when the individual is desirous, the sexual physiology is sufficiently intact for the response cycle to potentially operate in other contexts. The remaining questions seek the ability of an individual to modify their sexual response for interpersonal reasons. The ability of a man to influence the timing of his ejaculation, or the ability of a woman to reach orgasm are learned modifications of the ordinary physical sexual response capabilities. The appropriateness of learning these events depends on the socio-cultural context of the sexual activity. For instance, in North America and Europe, it is expected that men influence the timing of their ejaculation during sexual intercourse to enable a more mutual sexual event for each partner. In other cultures, such as Arabic countries (Katchadourian, 1985), this may not be an expectation. Cultures are not static in their expectations of appropriate sexual activity. Our own culture has only recently added the expectation that sexual contact between a couple be a mutual bonding and arousal opportunity. Indeed, it is as recently that we have added the expectation of female orgasm to interpersonal sexual activity.

If an organic abnormality is suspected because of a global inability (i.e. inability under any context including masturbation, dreams, as a simple reflex, as well as interpersonal sexual activity) to achieve a physical sexual response, evaluation by a physician competent in sexual assessment is indicated. On the other hand, if the above series of questions rules out a significant organic component by uncovering at least occasional full physical response, the therapist may confidently move on to work psychotherapeutically.

To date, most sexual therapy interventions have focused on common sense, psychoanalytic, behavioural, or simple interactional solutions. The application of systemic principles (by which the author means second order cybernetic principles such as applied in Milan therapy¹) to sexual issues is a relatively undeveloped area in the literature (Sanders, 1986).

Some concerns remain difficult to treat with the traditional or usual sex therapy techniques. The adoption of systemic therapeutic principles in treating sexual symptoms has brought another useful tool to the treatment of sexual issues. As an example, I have clinically observed that once vaginismus is resolved the partner often develops erectile dysfunction. Another example is the belief of a disorder of sexual desire residing in the individual presenting with lower desire for sexual intercourse or activity compared to their partner. This is most often

labeled *Inhibited Sexual Desire (ISD)* (Kaplan, 1979). I prefer to understand the symptom as indicative of a **discrepancy** in sexual desire between the two. This alternate understanding orients the therapist towards an interpersonal view of sexual desire rather than an intrapersonal linear view of something necessarily being "broken" within the individual. Such clinical symptoms may be understood not only in the domain of the couples sexual or marital relationship, but on some occasions, perhaps, even more clearly in some other domain. These domains of understanding could include rules about sex from the family of origin, or the couple's past history, or from a subculture or gender group, from popular sexual myths, and even from more deeply ingrained cultural and historical myths. It is when a larger and more connected understanding of the symptoms is indicated, that one may profitably turn to systemic methods. The use of systemic principles does not mean that the other treatment principles are no longer useful. Indeed, in dealing with sexual symptoms the therapist can add systemic understandings and methods as another of a larger number of treatment resources.

Common bonds between the more usual directive sex therapies and sex therapy conducted systemically include a behavioral orientation, the use of active prescriptive interventions, a focus on context construction and use of positive connotation (usually termed successive patient successes in traditional sex therapy).

There are differences between the directive sex therapies and sex therapy from a systemic perspective. First, of course, one is using a cybernetic or circular understanding in systemic therapy. Secondly, despite even the use of rituals, systemic therapy is non-directive in its intent whereas the intent of the traditional sex therapies is highly directional. Traditionally when a task is prescribed, the intent is "practice makes perfect", but in systemic therapies, rituals are prescribed with the intent of providing information that will make a difference in the couple's problem solving abilities. The therapist's intent often determines his/her response to the patient's subsequent actions. For instance, the patient's could be seen by the therapist as "failing" to practice toward perfection and thus resulting in the therapist taking an unintended blaming posture toward them. On the other hand, it is almost impossible for the actions of the patient's to not provide the therapist with **information**, thereby permitting the therapist and the patients more opportunity to avoid a blameful or pejorative stance to each other. Thirdly, systemic therapy is seen as non-expert. That is, the therapist does not assume to know better than the couple about their own experiences, their understandings of those experiences, or how they should feel and act in the future. This can connote a sense that the therapist respects the autonomy of the patients. Finally, the attribution of change is quite different. From a systemic understanding, the couple and their significant system are seen as responsible for determining any change that occurs. In this case the therapist is responsible for his own actions and the potential effect of those actions (and statements) on the patients, but not the actions of the patients' themselves. In more traditional sex therapies, either the therapy itself or the therapist themselves are seen as the responsible "change agents". When the therapist views his responsibility as the potential interpersonal effect of his own actions, it allows him more options in acting differently (and hopefully, helpfully) in the therapeutic process than if he focuses on the actions of the patients over which he has much less influence than his own.

SYSTEMIC RITUALS

In order to help the reader orient more fully to the application of systemic rituals in sexual concerns, a case example will be used. It deals with a long term history of primary (i.e. total) vaginismus. However, before going on to describe the case itself, an understanding of the clinical context in which the couple presented and were treated could be useful.

Clinical Setting

The Human Sexuality Programme (HSP), Department of Psychiatry, Faculty of Medicine, is a small professional training programme that operates within the auspices of the Family Therapy Program at the University of Calgary. Patient referrals come through family physicians, specialist physicians, mental health professionals in the community and nearby hospital institutions, and from the Family Therapy Program itself. Professionals involved are full time family therapists, psychiatrists, psychologists, social workers, and medical residents. Since there is no out of pocket user fee, the costs being covered by Alberta's universal medicare program, the patients referred are often those who are unable or unwilling to pay for non-medicare funded private practice sexual therapy provided by other professionals in the community. Because there are so few publicly funded therapeutic resources for sexual concerns, by the time most patients are first seen they have often been waiting anywhere from two to six months since initially requesting referral from their physician or mental health professionals.

Since the Programme operates primarily in order to advance the training of allied mental health professionals in the area of human sexuality, all patients are initially made aware that other professionals may be involved, usually on a team basis. It is explained to them that although members of the team are often professional trainees with respect to understanding clinical issues of human sexuality, they are all advanced medical or mental health professionals. The team is presented as an added resource of multiple minds. Additionally, couples are requested to permit video taping for the purpose of clinical review and professional training. However, as with all patients who come through the Family Therapy and Human Sexuality Programs at the University of Calgary, couples are given free choice to agree or not to videotaping and observation, without detriment to their treatment. This also occurs with respect to observation through one way mirrors.

Usually patients are seen as couples only, for one or two initial assessment sessions, at which time bio-physiologic information and resource assessments are completed. This may include the filling in of a *Derogatis Sexual Functioning Inventory* and a modified *Lock Wallace Marital Adjustment Inventory* by the patients.²

Case History

Sheila and Ted were a young couple in their mid thirties who had been married at 19 as adolescent sweethearts (see Fig. 1). They were referred by their family physician and presented complaining of not having children. By the time they were seen at the programme, both were quite hopeless about any solutions being found quickly but interestingly, both were highly motivated to continue seeking one out. Through questioning a concern of primary vaginismus was uncovered. They had for the entire 12 years of their sexual relationship co-operatively tried once or twice a week to affect vaginal penetration with not one success. The sexual ritual they had developed consisted of Sheila notifying Ted of her willingness to try sexual activity by prolonging a hug or caress, or sexually teasing him by making requests to be "caught" in a game resembling hide a seek. They would then permit personal arousal to the point where Sheila would motion for Ted to mount her in the missionary position (male superior). Ted would then try inserting his penis into Sheila's vagina and carefully watch her facial expression. As soon as her expression of discomfort turned to one of pain as evidenced by her showing her teeth as she tried to subdue the pain, he would withdraw. They then had a number of variations on the ritual depending on their general marital relationship state. If there had been tension or anger during the preceding few days, they would often make blameful recriminations against each other - she that Ted didn't persist long enough, and he that she didn't try hard enough to relax. If they were at peace with one another, they would go onto

complete their sexual activity in some other way. They had developed an alternative sexual style that included oral sex to orgasm for either or both, manual stimulation to orgasm, and inter femoral (between the thighs) intercourse. These activities seemed to meet most of their individual sexual needs, but both felt they were somehow inadequate as both spouses and individuals for not being able to have sexual intercourse. Now that age was prompting a more discerning look at forming a family, this sense of incompleteness and inadequacy became sufficient to prompt looking for outside help.

(Insert Figure 1. about here)

Although the couple agreed with each other that they were most concerned with not having children because of the vaginismus, they also reported increased marital arguing and less enjoyable coupled times together over the last few months.

Initial Treatment

After initial successes with Sheila and Ted using a more traditional informative and directive therapy involving sensate focus exercises³ for the couple and Sheila preparing to learn how to "accommodate" objects intravaginally, a sudden set back in therapy developed (see Figure 2). The couple complained of increasing arguments and irritability; they did not complete their homework assignments, and instead called them "tests". At this point in therapy, the therapist, noticing that he perceived "resistance" of the couple to doing the prescribed tasks, moved from a directive therapeutic method to a systemic inquiry into the process of therapy.

(Insert Figure 2 about here)

Ted admitted that he wished things had remained 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 future. The domain of parenting and spousal commitment was then explored in depth using circular questioning and specific systemic interventions were then elaborated.

Theory

As has been stated earlier in the book, rituals describe prescriptive behavioral events of multiple meanings which express and, therefore, permit definition of social realities (Imber-Black, 1986). They are specific tasks that the patient system is requested to carry out which are carefully prescribed with respect to details and the sequence of actions, and are usually offered as an experiment, trial or symbolic gesture, or a transient rite. Rituals are often prescribed as temporary without any implications that they are, in fact, the way things should be. In this light they are quite different from the more usual sexual therapy "tasks" such as sensate focus, which are expected to be carried out on a "practice makes perfect" basis. Rituals are an attempt to introduce something new, unusual, or unexpected.

When working with rituals, the interviewing principles outlined by the original Milan associates are particularly important. Of the three original guidelines, hypothesizing, circularity, and neutrality, perhaps that of neutrality is most important when dealing with issues of sexuality. Neutrality is not intended as a strategic stance that can be used to increase the likelihood of the therapist's will being done, but rather a direction of interpersonal perception that is perceived by the patients as non-judgemental, non-favoring, and non-expectational. The goal of systemic interventions, including rituals, therefore, is quite different from how we usually think of outcome goals. As opposed to a specific behavioural

outcome, the goal is to enhance the patient systems' own ability to create non symptomatic solutions as it continues on its path of evolution through the life cycle. This comes about, hopefully, through a shift in the way couples are able to change. (see Tomm, 1984 for a more complete discussion of systemic theory and its' clinical application).

The purpose of rituals as applied to sexual issues can be seen as the provision of increased opportunity for mutually satisfying and need fulfilling couple sexual activity, without defining what the sexual activity *per se* will be. When a therapist intends to use therapeutic rituals, I believe it necessary to examine the larger social (or meta) context in which we as therapists are working in order to avoid unintentionally promoting other problems or symptoms. No where is this examination more necessary than how sex is defined and therefore expected to be experienced and enacted. A brief examination of some of these issues often proves clinically helpful to therapists working in the area of sexuality.

Interestingly, in order for individuals to experience what our society calls **good** sex a number of different conditions or contexts must be met. First, personal physical and emotional arousal would have to occur in a context of one's partner being nearly, or equally as aroused emotionally and physically. Second, the opportunity of experiencing one's own arousal without having to monitor the partner's arousal must be present. Finally, an interpersonal context (usually thought of as intimacy) of emotional and physical vulnerability along with sufficient trust the vulnerability will not be abused, must exist. If all these conditions are met, the experience is considered to be a sexually meaningful one.

Therefore, a pragmatic definition of sex according to the North American meta context that the author uses is:

the personally felt experience of sexual arousal in an interpersonal context of mutual emotional and physical vulnerability and trust (i.e. intimacy) occurring within socially permitted relationships.

Anything other than this our society deems something other than sexual. For instance, if one person is sexually aroused and the partner is not and this state occurs within a context of violence, society deems this activity as sexual assault. If on the other hand, only one partner is aroused and the other is not, then we deem the activity "duty", or taking care of ones needs. Whether or not both partners are sexually aroused, if the context is one of child-adult, society considers this to be sexual abuse.

Rituals are designed, therefore, to enhance the likelihood of a couple bringing forth sexual experiences that will meet the individual, interpersonal, and societal needs of what is culturally defined as "good sex". The design and potential enactment of a ritual may in itself be an enhanced method of sexual satisfaction over the couple's usual practices. However, the **intent** of the ritualized alternative is to provide an informational opportunity for **any** alternative to the usual more symptomatic sexual behaviours, not just that of the ritualized behaviours.

Indications for Use of Systemic Rituals

A number of indications for the use of systemic interventions and rituals in sexual therapy can be outlined. First, for those couples who have somehow continued to make inadequate use of available social and interpersonal resources, employing a systemic ritual can help orient them towards and enable their use of such resources. Additionally, rituals may help those couples who show an apparent lack of clarity, or a high degree of confusion with respect to the nature

of the problems, gain a more clear definition. Also, those people who are likely to express their concerns non verbally may respond well to rituals. Others such as those who have had numerous other forms of therapy and not found them useful (i.e. “therapy wise” persons) may show benefit from the use of sexual rituals. Finally, members of cultures embedded in a larger one, (for instance Orientals in an urban “China Town”, or North American Native Peoples living on reserves), can often find rituals oriented towards their own culture more helpful in accessing their personal sexual feelings than those oriented to the dominant culture.

Using Systemic Sexual Rituals

Part of the intent of therapeutic rituals is to create an emotional and physical experience that is an alternative to that which supports the patients’ symptoms and thereby produce news of a difference (Keeney, 1983). This is accomplished through the utilization of the couples reported history of their own life experiences. It is from this clinical wealth that the ritual details are generated, which allow unique application to that particular relationship. This accounts for, as a stated in earlier chapters, rituals being unique to one, and only one, specific patient system. Although, the ideas or concepts behind different rituals can be used repeatedly with different cases, the exact ritual itself is only applicable once.

In specifically looking at setting up sexual rituals a number of areas in addition to the usual form of sexual assessment need to be reviewed. The interpersonal context of the couple’s being sexual and the actual methods of sexual activity used should be examined as to whether or not their current ritual activities appear under ritualized, rigidly ritualized, skewed to one member’s family of origin, flexible in creating and perhaps amplifying rituals, or empty and hollow without an interpersonally meaningful experience (Wolin and Bennett, 1984).

For instance, the rituals of time management and prioritization of couple events including sex must be further evaluated. Many couples want to be sexual without providing time with which to access sensual and sexual experiences. It is almost as if some couples expect the bi-physiologic reflex of sexual arousal to be as responsive in being turned on or turned off as their television set, and hope that somehow they will be able to manage a quick interpersonal bonding event during a commercial break. Additionally, a number of couples seem to get caught up in prioritizing other life events as more important than the spousal relationship. Many young couples will always put their children’s needs or the family’s financial needs ahead of their own couple needs. Couples who do not provide quality spousal exchanges often have sexual troubles since the sexual contacts often become rigidly ritualized in an attempt to take the place of otherwise unattended intimacy needs. This area can be quite important when assessing a couple’s sexual potential since in our society intimacy is defined as being necessary for mutually enjoyable sexual experiences. Our society has, since women have had reproductive choice through use of effective of birth control, increasingly had expectations of a couple’s sexuality as being mutually bonding. Couples who share this expectation yet do not take time for creating an interpersonal context that supports intimacy and bonding seem to put all the burden for maintenance of their spousal relationship on their very quick and often unsatisfying sexual encounters.

The assessment of how well couples are able to differentiate between affection and sexuality is another useful area of exploration. Many couples appear to have elaborated rituals that do not take into account this distinction. The author uses a definition of physical affection as those physical activities between couples that have as their primary **intent** a message of caring, and any sexual feeling or display as secondary. Sexuality on the other hand, is where the **intent** of shared physical arousal and its experience in an intimate context is primary and the affective display is secondary. As Zilbergeld (1978) has pointed out, males and females in our society

have great difficulty differentiating between affective display and sexual actions. From an early age both women and men struggle with the expectation that if a man is physical then it means that he is sexual. When he becomes involved in an affective relationship and displays his feelings physically, he and his mate may understand them more as a sexual request than simply an expression of deep feeling. Frequently, women will complain that their men only seem to want genital sex. The men on the other hand, will state that their women appear to want only affection. When the man approaches the woman with what he intends as an affectional display but does so with a sexual behaviour, she often withdraws thinking him only after intercourse. On the occasions that she may be horny and approaches her man with an affectional behaviour that she intends to lead to sex, he may not respond for fear of being seen as only after sex.

If indeed there is a hypothesis that some of the sexual symptomatology may be related to other, often more encompassing, interpersonal events but the couple somehow can not be oriented towards resolving them more easily, devising a clarifying therapeutic ritual may help to provide them with the opportunity to "discover" the issue and resolve it.

Ritual construction does require that the ritual fit with the systemic hypothesis. Rituals, as one form of systemic intervention, must also fit in with other methods of intervening systemically. In order to elaborate a systemic hypothesis it is best to temporarily abandon the non systemic ideas and understandings. To demonstrate some of these ideas, discussion will return to Sheila and Ted.

The therapist used the perception of resistance as a cue to move into a more complex conceptual posture. The first step after the therapist noticed his experiencing the patients as "resistant" was to enquire about the process of therapy from a systemic perspective. This changed the nature of the therapy. The patients' reaction was one of renewed curiosity about their own experiences with subsequent re-engagement in the process of therapy. Part of this reaction could probably be attributed to the increased neutrality of the therapist who became actively engaged in a genuinely curious reformulation of the couple's behaviours and statements from a systemic perspective. The newness and novelty of therapist's actions could also have played a part in the patients' response.

Initially, the therapist used systemic opinions that split his understanding of how best to comprehend the "slowing down" in therapy. The couple was asked to help the therapist understand if the upset in therapy was simply one of those ordinary events where things slow for awhile and which occur in any therapy or was it indicative of the therapist making an error in using sexual therapy when in fact their "real" problems were more to do with becoming a family. The couple's response was to come back to the next appointment and discuss their fear of parenting and of losing each other. This appeared anchored in the early formation of their relationship and was alluded to by Sheila as an early event that she "could never discuss and never forget".

At this point in therapy, the therapist gave an opinion putting them together as victims of the **idea** of marriage in that when they married in their youth, they appeared to give up being lovers. A ritual was prescribed where they were then asked to come up with individual lists of the most important past events, either as individuals or as a couple, that were interfering with their being a couple as they would want to be in the present. Each was asked to keep a sheet of paper with them at all waking times. On this paper, they were asked to list those past events that seemed to interfere with how each wanted the relationship to be in present and in the future. They were asked to jot down as many things as they could think of as soon as they left the session, but to also keep the list available for the occasions where just living life brought

other events to mind that belonged on the list. They were told not to preoccupy themselves with trying to fill up the list, but rather alternate between times where the list would be on mind and times where other events of life would be on mind. Each was also asked to research their listed items as to how important they might be in interfering with the present. This research could take the form of casual conversations with the people involved, discussing the event either openly or covertly with friends or family, or reviewing what acquaintances might think in a similar circumstance. Before coming to the next therapy session, each was asked to choose a quiet private place where s/he could sit down in the evening and prioritize the items they had listed from least to most important in its having an interfering effect on the present relationship. This ritual of making and prioritizing a list of past events that each believed were continuing to interfere with their present relationship was designed to provide an opportunity for the couple to take an observer perspective with respect to their own contributions to the couple's current symptoms. It included in its design and delivery, notions of ritual construction such as: alternations between thinking of and researching the listed items, prioritizing relationally interfering past events, and acting "spontaneously"; repetitively evaluating the relative importance of each remembered event; the prescription of a time and place for the ritualized behaviours to occur, and the use of very specific instructions on how to do the ritual, yet open instructions on what events in specific would be ritualized (see also Chapter ___ for further discussion on ritual design).

When Sheila and Ted returned to the next session with lists in hand I implemented an in session ritual was used. Rather than look at the lists, they were invited to read them to themselves, to intrapsychically recreate the emotional tone that accompanied the original event, and then say good bye to the event as an active influence in their current lives. They readily agreed to my "invitation". If they had shown reluctance or had not completed the listing ritual, I would have responded by accepting whatever was presented and using that as the information on which my next therapeutic action would be based. I would **not** insist or constrain them to do what I had intended. Upon completing the intrapsychic re-creation, I then suggested they burn the memories one at a time. This appeared more difficult for Sheila to do. She began crying and by the time she came to the item she had prioritized as most influential in disturbing her current life, she found it difficult to burn. Finally, with an air of bravado, she tossed the paper into the fire and the act was completed. The burning of these prioritized events was designed with the intent of creating an opportunity to place a marker in time for each of the couple. That is, each would have the option of escaping the paradox of the past, present, and future appearing collapsed in their experience of time. The rituals provided an occasion of demarcating the past from the present and the present from the future. The choice of an in-session ritual was made for a number of reasons. The first reason was to utilize surprise and the unexpected since I had not used in-session tasks or activities before. The second reason involved engaging the couple through the use of novel therapeutic events. Finally, an in-session ritual was chosen so that I could fill the role of "witness" to the "putting of the past in its place".

The next session was one week later and included a burying ritual. The couple was instructed to bring a container that symbolized their relationship to date yet that one that could also be given up. This was done in order to use a couple specific object of familiar symbolism. Interestingly, for a couple who could be hypothesized as having difficulty "consummating" their relationship, they brought the container that their wedding rings originally came in. The ashes from the burning session were then "interned" in the box. Sheila and Ted were then told to find a private burial site for these past events that were being "given up" and to "lay the memories to rest". A brief discussion of potential emotional reactions to grief ensued and the couple was scheduled to be seen in 6 weeks. The therapeutic intent here was to use a familiar and socially acceptable symbolic act to create an opportunity for a different way of

interacting as a couple compared to their usual method of “more of the same wrong solution” (the reader is referred to P. Luckhurst’s (1985) article “Resistance and the New Epistemology”). The intent was **not** to truly “put the past in its place” through the enactment of the ritual. The intent was to create potentially more useful distinctions about the past, present and future being distinct, rather than the notion of collapsed time and experience that each seemed to be operating under for many years.

When they returned, they appeared almost transformed. Sheila stated that she had to take a week off work following the burial since she would break into tears the first week. During the week’s leave, she would find herself thinking almost constantly about the past. She recalled that one day, about two weeks following the burial, she suddenly brightened and began planning her future. Ted described a different experience. He said that at first he believed the sessions of burning and burying were ridiculous. However, about two weeks after the couple had buried their wedding ring box filled with ashes, he found himself getting increasingly angry at nothing in particular. After an occasion at work where he cut himself on one of his butcher knives, he suddenly realized that he was dwelling on the past and began speaking with Sheila about how their relationship would be in the future if they had children. Subsequent to this, Sheila decided to persist in her vaginal accommodation exercises only to find them much easier than before. When asked how their sexual life had been over the last six weeks, they sheepishly admitted to having sexual intercourse on a number of occasions. This had occurred in a context of mutual pleasure and with relative ease. At first, in fact, Sheila could not believe Ted had actually entered her.

Interestingly though, they stated that intercourse was not all they had expected it to be. Both agreed that their previous sexual activities (oral and mutual caressing) were more enjoyable. They asked the therapist if it would be all right if they continued having sexual intercourse in order to try for a pregnancy. The therapist suggested instead that they go slow and practice mostly what they knew best.

On an eight month follow up (the couple kept postponing their appointments), Sheila and Ted had not had a pregnancy and had initiated adoption proceedings. They stated they were occasionally having intercourse but relied most heavily on their usual sexual practices. Sheila had received a promotion at work and Ted had left his job to go to school for computer technician training.

Case Discussion

In reflecting on the treatment of Sheila and Ted, a number of inferences about the therapy can be made. It appears that at a point when they were having great difficulty in utilizing the available therapeutic resources of directive sex therapy, the interpretation of this “resistance” as an event in the therapeutic relationship, and not a property of the individuals involved, led to different actions and understandings on the part of the therapist. This may then have freed both the therapist and the patients from the constraint of each trying to get the other “to see it their way”. This freedom could then be acted on by the therapist in creating new and novel interpersonal **opportunities** for the patients that relied more on a systemic view of events than the more usual cause and effect perspective. The rituals themselves, could be seen as providing an apparent concrete course of events that permitted these opportunities. Through the making of, and prioritizing of lists, the notion of separating their experiences of past, present and expected future in time could be indirectly and experientially examined. Through the burning and burying of these written symbols of past emotional events, both Sheila and Ted had an opportunity to demarcate time experienced personally in a more interpersonal manner. With the increased interpersonal permissiveness generated from such novel distinctions, the

behavioural and experiential options of the couple could be greater and new experiences then brought forth while still keeping past events, which were personally experienced, coherently understood.

Analysis of patients' responses to use of therapeutic rituals is always difficult. This difficulty relates mostly to the notion of attribution of change. It appears that we can never really know what events contributed to a difference in interaction between people, we can only infer what we suppose promotes change. To say that "therapeutic events" are responsible for couple change is really only an inference. Although patients react differently to different therapist actions, a useful assumption may be that the reaction is determined by the patients themselves and not the therapist. We as therapists, therefore, would be seen as responsible for our actions and the **probable** effects of them on our patients, but not directly for the actions of our patients. (see Tomm in press).

Sex Therapy and Therapeutic Rituals

There are a large number of potential rituals as applied to sexual issues. They are limited only by the therapist's creativity and the ritual's social appropriateness. For instance,

Action rituals such as using the actual freezing of a relational symbol at a time when the introduction of time is thought to be needed can be useful. Each member of the couple is instructed to remove the object and let it defrost when they perceive events to be getting out of control (arguments, sexual expectations, etc.). They are instructed to not continue the behaviour being interrupted during the defrosting period but rather to reflect or act upon a systemic distinction that the therapist sees as potentially useful for them (for example, are the arguments more in service of each person's affectional or sexual needs). After the object has defrosted, it is suggested that the couple go on with their lives until time needs to be introduced again. The burning and burying rituals used with Sheila and Ted are also action rituals.

Thought and feeling rituals such as the prescription of odd/even days to examine the experience of a relationship event as being either more in the service of personal and couple intimacy needs or more in the service of personal and couple sexual needs can be used along with prescribed "be spontaneous" times of acting naturally. The ritual with Sheila and Ted of listing important events from the past that were deemed as negatively influencing the present is an example of a thought ritual.

Many sexuality rituals fall into the action category. The use of sensate focus exercises as a ritual (as opposed to the practice makes perfect notion of a task) to highlight the distinction between a self sensual focus and an other person performance focus is another form of action ritual. Other forms of rituals that can be used to describe the distinction between sexuality (as a sensually based event) and performance (of self, of other, of genitals, etc) can include use of what are usually thought of as sex therapy tasks. Some of these are: role playing orgasm, first privately, and later in the presence of her mate, for the pre orgasmic woman; prescribed sexual intercourse alternating with intercourse occurring only when both mutually desire it for the couple with a discrepancy in desire for intercourse; and the use of prescribed self stimulation in the accepting presence of the mate as an alternative to duty bound taking of responsibility for the partner's orgasm. The intent of the therapist and therefore his/her response to the prescriptions is the primary distinction of these events being ritualized as opposed to simple tasks.

Context rituals can be used to promote opportunities to meaningfully distinguish different contexts and respond more appropriately. For instance the prescription of *time outs* could be used. Here, one partner is prescribed the finding of an activity he or she would potentially enjoy attending and to arrange to go to it. The other partner then accompanies in an “obligatory” manner. The outing time is limited and the events constrained by the therapist to those that do not require the participation of the partner for the first’s enjoyment (e.g. dancing or playing cards are out, but eating dinner or going for a walk are not). The “task” for the partner whose time out it is, is to enjoy themselves as fully as the event permits. The “task” for the other is to observe the enjoyment of the first. For the next time out, the partners reverse roles. Rituals such as this, and others like celebration rituals, help to distinguish contexts of personal opportunity from duty to others, gender roles from couple events and so on.

Mixed rituals are those that mix the intended distinctions, say between action and context, such as a sensual dinner or sensual bath ritual. In using a sensual dinner ritual, the opportunity for co-creating an intended context through specific actions is prescribed. The partners are told to negotiate a menu for a special dinner. When the menu is decided upon, they are instructed to go together to the grocery store and shop for the ingredients. Once supplies are purchased, they are to prepare the meal together, even if one acts as the “lead hand” to the other’s being “foreman” in the kitchen. They are instructed to eat the meal in an unusual place compared to their everyday meals. Finally, the couple is told to not use utensils nor to feed themselves, instead relying on their partner to feed them. Further suggestions can be made depending on the intent of the therapist and needs of the specific couple such as a directive against any verbal communication and instead relying only on non-verbal methods of influencing the pace of eating. Rituals of this type can promote opportunities for couples to construct an interpersonal language of sensuality and fun as distinct from performance and duty.

CONCLUSIONS

Human sexuality is a complex interpersonal activity that presents a great challenge to the helping professional. It is often useful for the health care professional to reflect on the nature of sexuality in our culture. The sexual response cycle (Masters and Johnson, 1970) is an ordinary biological reflex that is socially constrained in action, and to some degree, in thought from early life on up. Sexuality frequently exists under confused contexts of reproduction, pleasure, and bonding. Because of these larger system constraints, our sexual perception and expression often requires the use of specific rituals of fantasy and/or action in order to access the sexual response cycle and thereby permit interpersonal sexual activity.

Often the simple provision of information is all that is necessary to “kick start” the patients’ own problem solving mechanisms. This could allow them access to personal physical functioning in a mutually enjoyable interpersonal context. For example, a re-married couple in their forties was referred because of escalating fights over their unsatisfactory sexual relationship. Since beginning their sexual activity with each other three years prior to referral, the woman had been unable to achieve orgasm during sexual intercourse. Although she had never experienced coital orgasm with her previous relationships, she did not consider it a major problem. Her new husband, however, felt that he would end up losing her as had the other men in her life unless he could **give** her an orgasm. The fact that the difference in genital anatomy between the sexes is important for achieving mutual sexual satisfaction was discussed. It was pointed out that females have a separate reproductive (vagina, uterus, fallopian tubes, ovaries) and sexual (clitoris, mons pubis, breasts and other sensual areas) systems whereas men have both their sexual and reproductive systems in one genital structure (penis, testicles,

scrotum). It was also pointed out that women did not need a sexual response for reproduction but men did (in order to deposit the semen where it would do the most reproductive good). The information that sexual intercourse does not promote an equal sexual opportunity for men and women (even though it is an equal reproductive opportunity) helped this couple to refocus their sexual efforts toward mutual sexual pleasure regardless of **how** it was obtained.

Other times, resolution of bio-physiological interference provides the physical freedom to create a useful and mutually satisfying sexual relationship. This may come about through simply allowing “nature to take its course” (e.g. healing after surgery or accident), or by the help of trained medical professionals for treatment of illness.

Frequently, directive therapeutic strategies can provide patients with enough impetus to find solutions to their symptoms (for example, the ban on sexual intercourse and the use of sensate focus exercises as a practice session). However, there are occasions where these strategies are not sufficient to help the patients continue evolving happily. It is here where the judicious use of creative and personally tailored systemic questions, opinions, and rituals may be applied to sexual relationships. Once the individuals appear more free or able to use the available resources, more directive or informational therapy may again be indicated. Using what I term 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 systemic 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 (see figure 3).

(Insert Fig 3 about here)

One indicator for the need to move between levels of conceptual comprehensiveness is **compliance** with therapist instructions. For the therapist to move to a more complex or comprehensive level of understanding, a perception of apparent "resistance" to the current level of therapist conceptualization and treatment would be experienced by the therapist. On the other hand, useful compliance with therapist suggestions and directions may indicate using a trial of more directive or informational interventions.

Another indicator for level shift deals with **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 observed, then it may be best to move on to a more complex frame of understanding and subsequent intervention in which the positive systemic 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. The specific use of rituals in sexual therapy can become an important addition to such a recursive model of intervention.

Footnotes

1. The use of the term systemic throughout this chapter refers to the collection of ideas and theories alternatively referred to as Milan, ecosystemic, or second order cybernetic. The common theoretic thread amongst all these views is a circular pattern view of interpersonal process. This is in contra distinction to the more physicalistic view of systems that has been promoted within general systems theory and the views that have been built on its original physical epistemology of force and power. For a more detailed discussion of these points the reader is referred to Bradford Keeney's book **The Aesthetics of Change** (1983).

2. The Derogatis Sexual Functioning Inventory is a fairly lengthy multiple choice questionnaire. It asks about sexual knowledge, attitudes, values, behaviors, fantasies, body image, general psychological symptomatology, and sexual relatedness. There are normative data available from the original publisher.

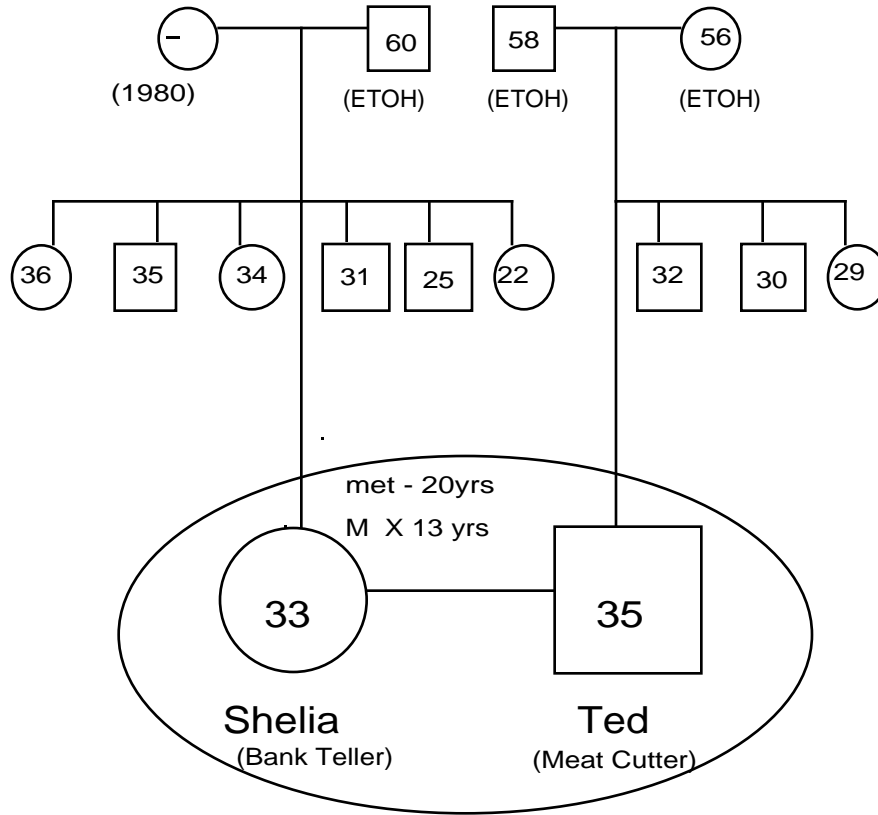
The Lock Wallace Marital Adjustment Inventory is a brief fill-in-the blank questionnaire that examines couples' marital relationship from interactive and role perspectives. The author uses this particular questionnaire to compare one spouse's response to that of the other. I have also modified the questionnaire to include live-in relationships and to be less sexist in its wording.

3. Sensate focus exercises were popularized by Masters and Johnson in 1970 and have formed one of the basic tenets of sex therapy ever since. These exercises are a prescribed couple session of sensual caressing and touching focussing on sensual *information* as opposed to sensual or sexual *performance*. Overt sexual activity such as intercourse is usually "banned" from occurring during these sessions. The intent is to reduce or remove performance expectations while creating a setting in which the couple can practice the basis of sexual arousal - the ability to focus sensually on one's own bodily feelings.

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Key

- M = Married
- ETOH = Alcohol abuse
- ⊕ = Deceased (year)

Fig 1. - Clinical Case Genogram

SESSION	INTERVAL	MAJOR INTERVENTIONS
1.	3 wks	sensate focus (hands, head, or feet)
2.	4 wks	sensate focus (partial body) and self exam
3.	3 wks	time out, sensate focus (full body without genitals), accommodation exercises
4.	4 wks	time out and sensate focus including genitals repeat accommodation exercises
5.	4 wks	Systemic split opinion
6.	4 wks	Systemic opinion and list task of past events
7.	4 wks	burning ritual of past events
8.	1 wk	burying ritual of past
Follow up	6 wks	"go slow"

Figure 2 Clinical Case Therapeutic Summary

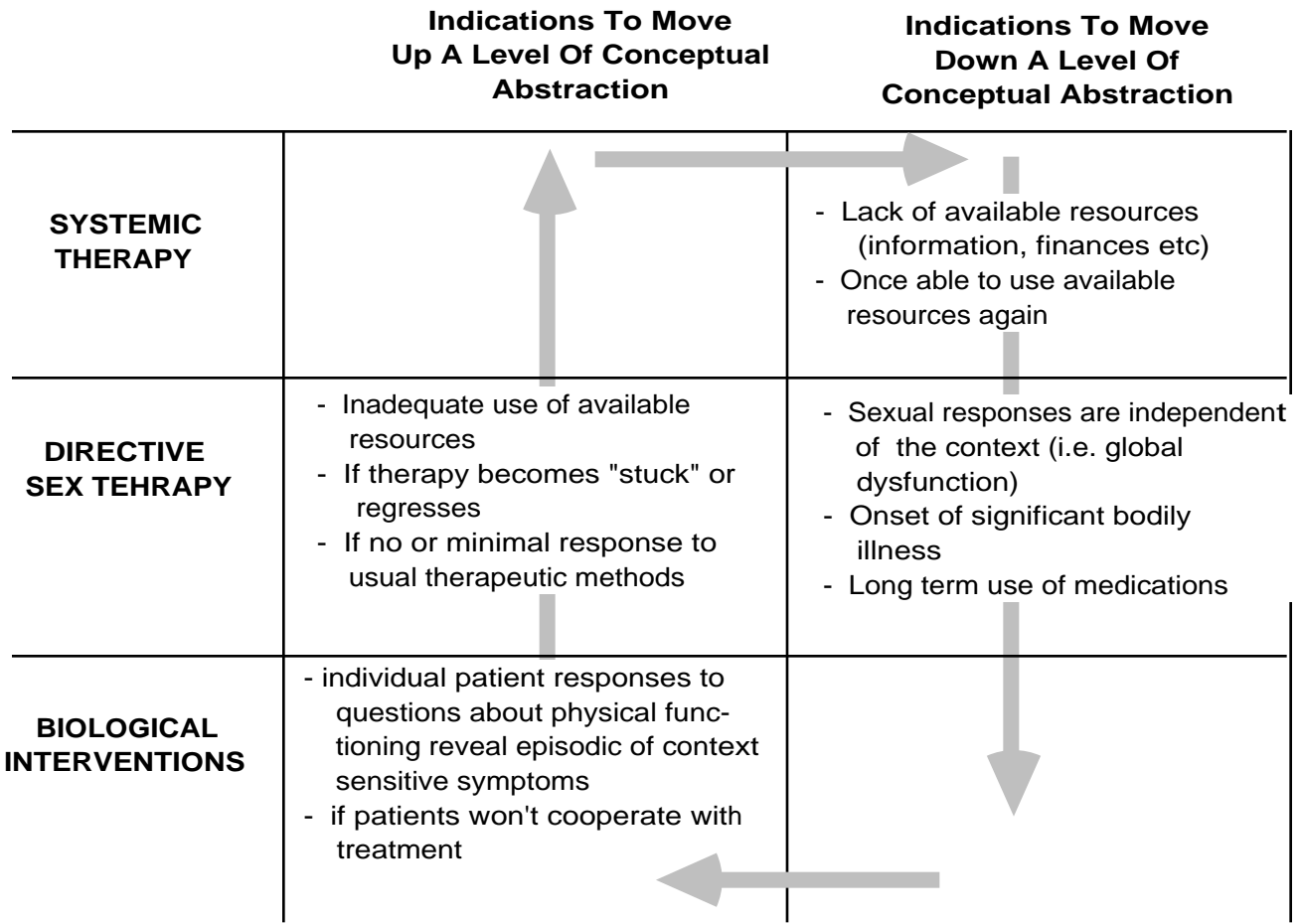


Figure 3 A Recursive Model of Intervention

On one occasion, a 13 year old boy was referred by Social Services to deal with his having sexually played with a 4 year old girl and a five year old boy when he was baby-sitting them. In both cases his actions were limited to constraining them against their wills and then touching them genitally and performing oral sexual activities on them. The parents of the younger children were so aghast, that they had the police take the boy to jail where that evening Social Services finally became involved. After finding out that he came from a single female parent family where the mother had no idea of how to educate him with respect to sexual functioning and appropriate sexual behaviour for his age (she simply assumed he would NOT be sexual), I provided him with a book that discussed sexuality from a non- judgemental but informative perspective. This had great impact on both the mother and the child. Not only did the boy find out a lot about sexual functioning (as did his mother who would clandestinely borrow his book to read up on sexuality), he became a resource of information amongst his peers. On six month follow up after the third session, the mother was now worried about her son's activity with a peer aged girl friend and if they were actually "necking" when playing in the basement. There were no more concerns or reports of the boy engaging in socially inappropriate sexual actions.