

An Invitation to Escape Sexual Tyranny

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Introduction

Let's talk about sex! Do you remember when you were young and sextalk or sexplay was simple and fun? It was probably mostly because you had not yet crossed over the hormonal boundary into puberty and its consort — lust. Remember, though, when lust did become part of adolescence and suddenly sexual matters seemed to become all preoccupying, yet ever so unavailable either because it was forbidden or you didn't know how to do it? And then do you remember when love entered into sex and for the first time there was a feeling of limerance¹ — where lust and love fell together? How about the surprise of first sex with another? For all too many of us, however, first actual sex with another was met with an "Is that all?" experience. For many of us, our sexual hopes and experiences eventually lead to dysfunctional sex. It is these people who present to therapists for help with their sexual lives, whether the therapist is ready or not.

My intent in this article is to review some of the potentially restraining or constraining belief systems that therapists may find useful to help both themselves and clients escape when dealing with sexual issues clinically rather than write a review article on cybernetic sex therapy (see Sanders, 1986; Sanders and Tomm, in press).

Patriarchy and Sex

What is sex? Well, I believe that most of you, and most of your clients or patients, intuitively know what sex is. Yet, most of us reflexively think of certain behaviours as defining sex: sexual intercourse, orgasm, sexual touching, etc. There is, however, more to how we have come to define sexual experience than simply as an over-emphasis on behaviour. Overall, we are subject to common social assumptions and attitudes with respect to sexual activity. In general, it appears that men are socialized to have and accept the belief that sex is their right and that they are naturally more sexual or "horny" than females. Both men and women tend to be socialized to accept the belief that **real sex** must include sexual intercourse. Women are socialized more often than men to believe that sex is a necessary duty. Both sexes seem to be

¹ In *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.

brought up to believe that sex should follow one particular path, that is, an ever increasing arousal to the point of climatic orgasm where beds and windows rattle and then one drifts off into a loving sleep. Both men and women tend to believe that sex is a performance supported by the maxim "if at first you don't succeed, try, try again until you do". Many act as if one should be able to "will" a sexual response. This belief is in contrast to a more reliable understanding of the physiology of a sexual response simply being the emotional *disinhibition* of inborn biologic sexual reflexes.

These traditional attitudes and values, many of which have been discussed in recent books,² come from our civilization's social history of close to 5,000 years of recorded **patriarchy**³. *The "tyranny" of patriarchal assumptions is seldom seen more clearly or felt more acutely than in sexual activity.* It is these patriarchal assumptions held by both sexes, although perhaps more blindly so by men compared to women, that have continued to support a confusion between sex and context, between reproduction and sex, and even between sexual thoughts and actions.

Up until the increased influence of the women's movement which resulted in women's eventual reproductive freedom through effective and self responsible contraception, there was no need to separate sex from reproduction. Patriarchal assumptions, which both men and women have inadvertently colluded in maintaining, invite the belief that sexual pleasure is more for men than women. Most likely this assumption was derived from the simple biological fact that intercourse worked better for men than women as a sexual opportunity but equally well for both as a reproductive opportunity. However, the pervasive tyranny of patriarchal assumptions invites all of us to believe that, since intercourse feels physically best for men, it should be seen as **true sex**, despite the fact that women's sexual opportunities are relatively less than those of men when intercourse is offered as the routine "main course" of sexual relationships.

The patriarchal beliefs of sexual intercourse as being true sex and that men have the right to sex (i.e. intercourse), invite women into sexual submission and men into sexual dominance. All too frequently, I see clients who appear to think that a woman who does not find intercourse as sexually fulfilling as her mate is somehow "broken" and so requires "repair". Most often these women have been dutifully submitting themselves to intercourse with low or absent arousal in the belief that the man's sexual needs are somehow more important than the woman's. Comments I frequently hear include: "A man *needs* to have sexual release.", or "He may find another, more willing woman if I don't give him the kind of sex he wants." These statements invite the woman into further submission by helping her accept the patriarchal assumption that women are responsible for men's sexual gratification. The tyranny of patriarchy, for both genders, becomes very clear on such occasions. When the more usual modes of sexual therapy do not seem useful to couples struggling to attain a more mutual sexual relationship, the therapist can

² such as *Male Sexuality* by Bernie Zilbergeld and the Lonnie Barbach's books, *For Yourself* and *For Each Other*.

³ Patriarchy can be defined as "social organization marked by the supremacy of the father in the clan or family; the legal dependence of wives and children, and the reckoning of descent and inheritance in the male line; a society organized according to the principles of patriarchy *Webster's Ninth New Collegiate Dictionary, 1983*

choose to work directly with the tyrannical effects of patriarchal assumptions.

For instance, the knowledge that sexual intercourse is not an equal *sexual* opportunity for each of the genders appears little known, and as a result, I find that people often have trouble understanding this concept. Granted, if both men and women are socialized to believe that intercourse is the best or most erotic sexual activity, both could have an equal opportunity for intrapsychic arousal. However, intercourse is not of equal potential anatomically.

A series of questions can help bring forth this distinction more clearly:

Therapist (to the woman): "What part of a man's body do you think is usually felt as most sexual when touched?"

Woman: "The penis."

Therapist (to the man): "How well did she guess?"

Man: "Correctly."

Therapist (to the man): "What part of a woman's body do you think is usually felt as most sexual when touched properly?"

Man: "The vagina."

Therapist (to the woman): "How well did he guess?"

Woman: "Not very well, its actually around the clitoral area and my breasts."

Therapist (to both): "What part of the body does a man use for sexual intercourse?"

Both: "The penis, of course?"

Therapist (to both): "What part of the body does a woman use for sexual intercourse?"

Both: "The vagina, of course?"

Therapist (to both): "What happens to the clitoris during intercourse?"

Both: (A blank look) "Nothing!" she usually replies.

The therapist can go on to point out that whatever clitoral or para-clitoral stimulation *does* occur through intercourse⁴ puts the woman at a sexual disadvantage **compared to** the man. In fact, intercourse works so effectively, both erotically *and* physiologically, in releasing a man's sexual *and* reproductive reflexes that most men need to actively learn to delay their orgasms during intercourse. Most women, on the other hand, are unable to regularly be orgasmic during intercourse even with stimulation in addition to coitus. *If some other part of the male's body were the primary sexual organ leaving the penis solely for reproductive needs, or if the vagina had actually been the female sexual organ (as patriarchal assumptions lead us to believe) instead of, or in addition to being the reproductive organ the possibility of a more equal sexual opportunity from intercourse would have existed.*

However, the limits of our sensual and sexual experiences are determined by our anatomy and its evolution. Whereas a man's *sexual* response is

⁴ Masters and Johnson, in their now famous work on human physiological sexual response, showed that the clitoral nerve plexus mediated somatic (i.e. touch based) sexual feeling for woman, and the penile nerves (pudanal, pelvic and cavernosus) mediated the same touch for men. Their studies also showed that the female genital anatomy made direct or *sufficient* indirect clitoral area stimulation almost impossible for woman, compared to the direct and effective stimulation of the male penis during intercourse. What little sexual stimulation women are able to get from sexual intercourse compared to men is much more effective, by the way, in younger and childless women because of the more resilient labial tissue conducting the indirect stimulation from penile-vaginal thrusting to the clitoral hood. Unfortunately for couples dependent on intercourse, as a woman becomes sexually aroused, clitoral erection pulls the clitoris in under its hood and away from even the indirect stimulation in lower arousal states.

absolutely necessary to deposit the semen where it would be of most *reproductive* benefit, a woman's sexual response is *incidental* to pregnancy. One can imagine how evolutionary drift "restrained" intercourse to be the most effective sexual stimulant for males. If something else (e.g. masturbation) had felt better sexually for a man in the days before we knew how babies came about, he would have been more interested in those events instead of reproductive intercourse.

The influence of patriarchal assumptions does not stop only at obvious sexual issues. It continues, unfortunately, to other areas that confuse clients, and sometimes even the therapists, more so. There is much confusion for instance, in the area of violence and sex. The historical belief that men have the right to take sex by violence if unable to get it by other means, has been translated in our more "civilized times" to a confusion between sex and social responsibility as it deals with sexual behaviours.

If one thinks of love, and therefore loving sex as a positively experienced affiliative event, and one sees violence to be a non-positively experienced affiliative event, then the two do seem quite separate. However, we constantly confuse sex and violence through a collapse of the two understandings. For example, the notion of sexual abuse, even through the words used, confuses the two contexts. What we are actually talking about is abuse that has been mediated sexually rather than sex that has been mediated abusively. We are talking more of a violent act than an affiliative act, more a breaking of intimacy than a building of intimacy. This is true even in the notion of sexual assault (rape). How frequently do we read in the newspapers where judges somehow "blame the victim"? This blame can be obvious, such as blaming the woman for wearing a dress that is too tight or too short, or less obvious such as blaming her for inviting a man home (how dare she unleash his sexual lust - she must then deserve what she gets). Here we are talking about the patriarchal belief that a man has the right to sex if he so wants and a woman has *less* right to not have sex if she does not want it. If somehow the woman refuses, or doesn't agree with him, his self-righteous indignation then permits him to take it by force. What we are looking at here is not so much sex as it is violence through assault. When an assailant assaults a victim with the intent of robbery and uses a hockey stick, we don't call it "hockey", we call it assault. Therefore, when someone assaults another person with their genitals, we shouldn't call it sex or even rape but rather **assault** that was mediated sexually. Continuing to think of sexual assault as a sexual event invites still further submission to patriarchal notions of sex. Under patriarchal assumptions, it is as if the man simply used **too much** force to get what was **due** him.

Well, how is all this important for therapists? Not only do therapists have to be very aware of their own sexual values and attitudes but also, whether male or female, how **blind** they may be to their own **blindness** of patriarchy. To "see" where one has not seen before invites therapists to be more preoccupied with mutuality and the context in which people try to be sexual rather than the behaviours in which they engage as sexual.

The importance of this last point becomes more clear when one reflects on

therapeutic *intent* not necessarily predicting therapeutic *effect*. An example outside of therapy may help clarify this distinction. Most of you have probably been in the situation where you are trying to make a new acquaintance at a cocktail party or social gathering. The wish to meet this person may or may not have been based on sexual attraction. Most often it's more out of curiosity or interest. Your intent in starting up a conversation was to be sociable, yet your attempt appeared to have had the opposite effect, for you were quickly left by the person whom you had tried to meet. Your social intent did not have the desired effect. All too frequently therapists undergo a similar experience in therapy where the therapeutic intent does not have the desired therapeutic effect. When this is the case we often think of our clients or patients as "resistant" to our intent. In fact, it would probably be more *useful* (even though no more *true*) to use Steve de Shazers' (1982) view that we, as therapists, have "as yet failed to understand" how to transmit our intent in a way that would increase the likelihood of its desired effect.

In the area of sexuality the discrepancy between intent and effect becomes even more important. Not only must we be aware of how intent does not predict effect, but we must be aware of the origins of our intent in order to avoid *unintended therapeutic violence*⁵. If we are not aware of where the source of our intent originated, such as in patriarchal assumptions, then we may, without intent, promote potential misery and unhappiness in sexuality, intimacy and even family development.

Sex and Therapy

So what about sex? It seems to preoccupy our North American culture. So many of our direct and covert social morés seem to depend on sexual messages. Advertising, entertainment, socialization, and even much of education, seem to depend on some kind of sexual cueing. We appear to be a society preoccupied with sex and yet deprived of its qualitative experience. In fact, it seems uncommon for people, even lovers, to openly and honestly discuss their own sexuality. When open sexual discussion occurs, it tends to be either through the mental conversation of reading novels and books, or through a problem focus in interpersonal conversations. This focus is in stark contrast to a focus of admiration, love, celebration and enjoyment that appears to be most people's intent for their sexual experiences.

Are sexual matters of significant importance? Yes, very much so. Almost *everyone* at some point in life will engage in sex activity. In fact, most people will regularly engage in sexual contact with another person, and most often it will be the same person over a long period of time. Those people who do engage in sex regularly will often be more involved in sex than they will be in activities such as going shopping, pursuing recreational outings, attending church, or even in mutual family gatherings. It appears that, in our culture, sex is fundamental to interpersonal intimacy and, therefore, to the welfare of the fabric of our society. It is one of those things that brings us closer together,

⁵ Here I am using Humberto Maturana's notion of violence. He has stated that violence can be defined as "the holding of a belief to be true by one person or group such that another person's or group's belief is untrue **and** must change. It is the intent to change the different belief rather than the experience of difference that Maturana sees as the bases of all violence. Of course, such a broad definition of violence requires the social definition of appropriate and inappropriate violence. These later definitions change with changing social times.

keeps us close together and gives us hope of being close together in future. And yet, it seems that for a wide variety of reasons, there are many problems with sexuality as well. Frequently, whether a therapist wants to know or not, they will find that people have sexual problems.

Again the question comes up - what is sex? In a couple of paragraphs, I am going to invite you to use a definition of sex that may be very different from what you have used before.

First, however, I am going to ask you, the reader, to do a simple experiment. Once you finish reading the following instructions, close your eyes and do what they ask.

Without saying anything aloud or telling anyone around you, because this is very private, I would like you close your eyes and then to remember an occasion when you had one of the best sexual experiences ever.. Don't act on it, just call it to mind for a moment and when you have that memory and its associated feelings, open your eyes and begin reading again.

Now, since you are likely to be similar to most people when asked about what has been one of your best sexual experiences, that experience most likely included the following:

First, both you and your partner were desirous of sexual activity

Second, as an individual, you were physically and emotionally sexually aroused. That is, your body was experiencing events that were considered by you and evaluated by you to be sexual.

Third, it appeared your mate was sexually aroused as well. In addition, both you and your mate were sufficiently aroused and personally involved in that arousal to not have to be concerned about each other's arousal, and

Fourth, this arousal occurred in a interpersonal context of physical and emotional vulnerability as well as trust that each of you would not be taken advantage of or abused while in that vulnerable setting. These two components, vulnerability and trust are usually called intimacy.

How accurately was your "best ever" sexual experience described? Probably pretty accurately. Even for those people who remembered an anonymous encounter, or a sexual episode in a risky setting (parked cars anyone?), you and your partner collaborated in setting up trust and vulnerability for the duration of your encounter. This definition certainly would describe the better sexual experiences of your clients and patients. Notice there was no mention of any particular behaviour, nor any particular gender role activity? Where was the mention of sexual intercourse? Or of "foreplay"? Where was the statement of reproductive necessity, of pleasuring the other, or of sharing sexual thoughts? Although any or all of these could have been part of the *details* of your memory, they were not *necessary* for the quality of the experience. They are absent from the definition because sexual experience can be defined independently of any unique behaviours, such as those that historically are used to make babies.

With all this in mind, a circumscribed definition of sex could be:

Personally experienced, emotional and physical sexual arousal in an interpersonal context of mutual trust and vulnerability, (i.e. intimacy).

Or, more exactly stated:

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

I am so specific in defining sex as interpersonal and context dependent because I find that the meanings which people use to understand or define sex determine their later actions. This appears true for both clinicians and clients. For most people sex is equated with sexual intercourse. Of course, some will admit to "foreplay" being part of sex, and many may actually openly acknowledge that the emotional setting could also be important, but, by and large, most North Americans have an idea of sex being a certain group of activities — those required to get ready for sex (romance), those required to start sex (foreplay) and those that *are* sex (intercourse).

Clients usually come to professionals complaining they are having problems initiating or performing intercourse: They don't desire intercourse equally, they are unable to maintain erections in order to perform intercourse, they are unable to have orgasms at the right time during intercourse (if they can orgasm during it at all), they have pain during intercourse, and so on.

It is understandable that most people have an intercourse focus when they think or act sexually. After all, it has only actually been in the last fifty years or so that our social expectations of sexual activity have shifted from a male sexual "right" and a female reproductive "duty", towards a more mutual emotional experience that we call "making love". Unfortunately, our sexual practices have not kept up with our sexual expectations.

Defining sex from an interpersonal contextual perspective, however, invites a different personal experience compared to defining sex from a behavioural perspective. Rather than defining sexual experience based on particular activities (such as intercourse), it defines it as being based on a particular interpersonal context (such as **mutuality**). Such a definition can serve as an invitation to the sexual partners to share responsibility for the interpersonal context on the one hand and feel more free to take personal responsibility for their own sensual/sexual arousal on the other hand.

Using a context based definition of sexuality can also invite people to make a distinction between the sexual behaviours and the context of those behaviours. For instance, when a man is having a genital examination by his physician, the physician, male or female, may manipulate his genitals in much the same way (hopefully unintentionally!) as his sex partner would when beginning sexual play. However, the likelihood that the man will become aroused during a physical examination is very low compared to him becoming aroused with the same touch occurring in the context of mutual sexual expectation and desire shared with his mate. It is therefore the interplay between action and context that determines whether the experience is sexual or not, and not so much the behaviour itself. Of course, this interplay is individually experienced as a sense of arousal, horniness, or lust, but this personal experience is brought forth by a mutual context or suppressed by a mutual context. Additionally, this definition orients people towards those experiences that make up the sexual context: *shared arousal in an interpersonal setting of trust and vulnerability.*

A Clinical Vignette – “Sexual Liberation through Outercourse”

The family physician’s referral letter was brief and, unfortunately, not really to the point:

“Please see Mrs Lori Bryant in consultation. She has been a patient of mine for two years and recently came in complaining of problems in the bedroom. She apparently no longer has interest in marital sex with her hard working physician husband. She told me that matters are now beginning to severely affect her marriage.”

Lori turned out to be a well dressed attractive 31 year old woman who had been married to Ian, 32, for eight years. Ian had recently finished his residency and had been working in a local emergency department and quite enjoying it. They married while Ian was in first year medical school and Lori help put him through by supporting the family until he began earning money in his internship. The couple had two children, a 3 year old girl and an eight month old boy. When I asked what concerns brought them to see me, Ian spoke up first and stated: “Lori is no longer interested in me sexually. She just lies there while we make love and is now beginning to avoid it.” I then asked Lori directly what she saw as the concerns for the couple and she stated: “I just don’t seem to be sexually interested anymore — it’s as if I just “click off” when we go to make love”.

As it turned out, their physical sexual response cycles worked just fine when in the context of sexual desire, but it was the desire that seemed to escape Lori. Although the couple admitted that Ian had always been “hornier” than Lori, what they both saw as Lori’s problem had begun during her most recent pregnancy and persisted to date. Lori, at one point, quickly reminded her husband that she had not totally abandoned him, that she had, in fact, continued to be sexual with him even though she was not desirous. I asked why she would choose to be sexual when she was not desirous and she responded: “He works so hard, and he enjoys sex so much, I would feel terribly guilty if I did not.”

Exploration around the other aspects of their marital and family relationships showed that Ian was more content than Lori. As a full time home maker, Lori found herself stretched to the limit looking after the kids (especially the newest one and his frequent night awakenings), running the home, cooking meals and helping Ian relax from his work schedule of four 10 hour shift days on and four days off.

Here, then, was a couple who presented believing their life problems centred

on sex. How to help them? Some therapists might tackle such a case by helping the couple protect time for self and sensual/sexual exchange (e.g. sensate focus exercises), others might skip the sexual symptoms and instead address marital roles and sharing of family responsibilities, hoping that once they had a more mutual relationship, they would "find themselves" sexually happy. Still others might try to support Lori in standing up to what they may see as Ian's excessive expectations of her both sexually and non-sexually. With this case, I chose to focus on the sexual arena while also exploring the effects of their marital situation on their sexuality. As is my custom, after making sure they were capable of a physiological sexual response in the presence of desire, I explored their responsiveness to useful sexual information.

I quickly found out, however, that this couple seemed almost immune to informational and directive behavioural interventions such as the need for protected time, mutual arousal before attempting any penetration, etc. It seemed that no matter what intervention I used, they always found it less than useful. For instance, I prescribed an exercise I call "Time Outs". This is a simple directive exercise where the couple negotiate a time where they can be together for a couple of hours without interruption. They are told that each time out will be centered on one person's interests and that person will alternate from one time out to the next. I then suggest that whose ever time out it is, decide on an event that s/he is interested in, *without consideration for the partners likes or dislikes*, and then invite the partner to come along (of course, one not should pick an event that the partner's participation in is vital for their own enjoyment). The partner is told that s/he cannot refuse and must take over the instrumentals of the outing, such as babysitters, driving, tickets (if needed) etc. The person whose time out it is simply enjoys themselves as much as the event allows. The partner who is the "obligatory date" can, of course enjoy the activity if it is of interest, but not to the exclusion of their primary task: *observing their mates enjoyment* and reporting back in the next session on their observations. The object of the exercise is to recreate the interpersonal climate that occurs when people date. The enjoyment comes more from sharing the partner's experience than it does from the event itself.

Lori and Ian did not seem to find these exercises as helpful as some other couples. They both reported on the next visit that they found it to simply be a repeat of their usual shopping trips and visits with friends. I then decided to work more systemically with the couple. My therapeutic goal was no longer to simply enable specific behaviours such as physical arousal, or specific experiences such as desire. Instead, I became more interested in aiding **both** Ian and Lori to interpersonally reflect on and subsequently "escape" as many as possible of the unwanted or non-valued restraints and constraints⁶ that kept them from a happy and fulfilling sexual life. I chose to do this by examining, in the interpersonal domain (as opposed to an intrapsychic domain), their belief systems around sex and sexuality. This can be done by "externalizing" a problem that has restrained their positive intent from being experienced by the other positively⁷ (I prefer to externalize a problem that is

⁶Constraints can be thought of as internalized events that are originally experienced as interpersonal restraints or "should nots". For instance, the shame or guilt associated with self stimulation acts as a constraint against self stimulating but most probably originated from parental, school and/or church restraints against masturbation.

mutual). Through careful examination of the relative influence the externalized problem has over each of the couple and the relative influence each has over the problem, a therapeutic direction of clients experiencing a sense of personal mastery and fulfilled intent can begin.

Once Lori's description of her over-work and excessive sexual expectations became more clear, I enquired more actively (in a non-judgemental or neutral manner) about Ian's personal experiences. To my enquiries about how much they shared parenting and household duties, he responded that he had too much work, what with shifts and committees, to be of much help to Lori. He went on to state that his sleep was essential since he had to work long shifts at the hospital. As such, he could not get up with the baby. He did try, however, to share in the housework and kitchen duties, although his cooking was of such low calibre that Lori excused him from it. In fact, Ian saw himself, as did Lori, as being feminist in orientation. He stated that women have often commented on his sensitivity to their concerns and his emotional accessibility. He further stated that one of his superiors at work was female and he held no prejudice because of this; nor did he believe that Lori should stay at home with the kids if she would rather be out working. It was just that they didn't have enough money at the moment to hire a nanny.

I chose to externalize the problem of patriarchal assumptions "tyrannizing" their relationship by seeming to distort their good intentions. I suggested that it appeared as if both were victims of the tyranny. I chose patriarchy as a potential problem since both limited their sexual actions and expectations to events more fitting with reproduction and male needs than mutuality and sexual needs. Lori seemed to be tyrannized by trying to put her husbands sexual, personal and work "needs" ahead of her own feelings and body responses. Ian, I suggested, seemed victimized not only by patriarchal assumptions, but also by his own blindness. He seemed blind to the extent that patriarchy still covertly influenced him through his inadvertent invitations to Lori to subjugate her needs to his own. I acknowledged that, despite the apparent victimization, both appeared to have laudable intent with respect to the other - they loved one another and truly seemed to want a solution to the pain of their coupling.

I asked the couple if they were ready to try to escape the tyranny of patriarchal assumptions. I suggested that it would not be easy since our society is still organized patriarchally (simply look at whose name is used by default on marriage, who makes up the ranks of politicians, religious leaders, business leaders, educational administrators, etc.). To defy such an organization, even though it may invite couple happiness into their lives, might set them apart to some degree from friends and family. Mothers may wonder why Lori is not "fulfilling her wifely duty", male friends and colleagues of Ian's may wonder why he "lets Lori get the best of him" etc. Despite such cautions, both were interested in the opportunity that "escape" seemed to provide for more couple mutuality both sexually and generally. I had to caution them, of course, that true escape would not be toward the parallel tyranny of 'matriarchy' - which is simply the flip side of the the tyranny of patriarchy, but rather toward true mutuality and celebration of differences.

I gave Lori and Ian a series of what Michael White has called "complementary questions" (White, 1986b), designed to focus their reflections on their own intent and the observable effect of their intent. The following statement and questions were handed out to the couple:

⁷The concept of externalization has been described by Michael White in his work with families. Externalization is part of the process of double description where news of a meaningful difference for a family comes from the family's comparison of their traditional "internalized" view of the problem (e.g. Lori *has* a lack of desire), and the therapist's "externalized" cybernetic view of the symptoms (e.g. Ian and Lori appear restrained from their mutual intent for good sex) by the "tyranny" of patriarchal assumptions about what is sex). The process of externalization entails moving the couple from seeing themselves as only being influenced by their problem to having influence over the problem. The reader is referred to Michael White's writings (1986b) for a more detailed description of the externalization process and other useful therapeutic actions.

The following questions have been formulated to orient your reflections of present and future experiences in how the escape from the tyranny of patriarchy could continue. It is accepted that to reflect on one's ownership of certain assumptions is a rather unusual and sometimes difficult thing to do, yet it is also accepted that one's thoughts and assumptions guide the direction of life experience.

For Lori:

- 1. How does my submission to the tyranny of patriarchy invite a sense of lack of personal fulfillment?*
- 2. How does my feeling responsible for Ian's actions inadvertently invite him to come more under the influence of patriarchy?*

For Ian:

- 1. How does my belief that I have almost totally (90%) escaped the tyrannical effect of patriarchal assumptions inadvertently blind me to their continued influence?*
- 2. In what ways does my "habit" of leaving decisions up to Lori inadvertently invite her to accept the tyranny of patriarchy?*

For Both:

- 1. If each of us were to substitute either "to appear", or "to seem", for the verb "to be", in our descriptions of one another's behaviours, what would be the effect on the tyranny of patriarchal assumptions?*

On the next visit, two months later, the couple reported some significant changes. Ian had made a conscious effort to relieve Lori of her homemaking responsibilities for a couple of hours at least once or twice during the week. Lori had used this time to pursue personal interests rather than simply prepare for Ian. Lori had begun refusing sexual activity with Ian when she was not desirous (which was most often at this point) but made it clear she was not saying no to him as a loving person. My task, at this juncture, was to help amplify the positive changes of their "escape", help them build in some resilience for the almost inevitable "slips" or "hiccoughs" of the temporary re-emergence of patriarchy that lay in the future, and thereby help build more endurance for the positive changes.

My last contact with them, after a total of four sessions over six months (they seemed to set the times of meeting more than my suggested "a few weeks down the road" at the end of a session) showed them to be quite enjoying themselves. Sex had again become more enjoyable (they particularly liked to call it "outercourse" instead of intercourse since they no longer relied on intercourse as the "main course"), the couple had more intimacy and they were more able to share couple responsibilities according to desire and ability instead of gender roles. Of course, they had not "escaped" patriarchy entirely, but they were having a good time in their attempt to do so.

Conclusion

It now appears that our culture is increasingly leaning toward sex as a mutual event with significant emotional meaning - whether fun and uplifting and/or cementing the uniqueness of the love bond. I prefer to think of sexual activity as *sex play*, which can be thought of as inclusive of intercourse but

not dependent upon it. When sexplay fulfills the criteria of mutual arousal in an interpersonal experience of intimacy (i.e. trust and vulnerability), we tend to call it "making love". This experience appears to be preferred by both sexes all the time. In all my clinical experience I have seldom seen a man or a woman who prefers otherwise. When given a forced-choice question about which they would prefer as their life experience, sexual intercourse without intimacy or intimacy without sexual intercourse, all choose intimacy. Despite the frequent blind acceptance of patriarchal beliefs, North American men and women appear to aspire toward intimacy, and to escape patriarchy's tyrannical oppression. In our culture, the **primary** context of sexuality is positively experienced intimacy, and the experience of intimacy invites a freedom to be self, a liberation of sex as fun and enjoyment and an opportunity for celebration.

It is experiences such as these that become the therapeutic goals rather than enabling specific sexual activities such as sexual intercourse. No longer must a therapist try to measure his or her clients against an invisible, often poorly understood standard of sexual **activity**. The clients in fact, tell us what they want - **mutuality**. Our task as professionals, then, becomes to enable client's hopes through the necessary permission, limited information and therapeutic interventions that will help liberate or disinhibit their sexual feelings to fit those activities that they mutually value.

Imagine what the experience of interpersonal events could be if we, as therapists, managed to successfully invite our clients and patients to such a liberation from sexual tyranny. Just imagine.

Now, close your eyes.....

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