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SEX THERAPY WITH LDS COUPLES

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Presented at the AMCAP CONVENTION
2 October, 1981

Recently, Allen Bergin in his President’s Message in the Spring 1981 AMCAP Newsletter presented a statement of his views on sex therapy suggesting that it merely represents “modern sensual technologies” which “too frequently offer sensual substitutes for genuine intimacy” (1981a, p.1). It is our belief that Dr. Bergin has presented an extreme view which some members may have misinterpreted as an AMCAP position paper rather than an individual’s opinion. The authors, having specialized in the treatment of sexual dysfunction as well as in marital therapy, will present an alternative viewpoint on the value and need for sex therapy among LDS couples.

The Need for Sex Therapy

Sexual dysfunction is an exceptionally common marital problem, and one that is often neglected in the treatment of troubled couples. In studying 750 couples receiving marital therapy, Greene (1970) found that 80% were sexually dissatisfied; and Sager (1976) estimated that 75% of couples in marital therapy have a sexual dysfunction. In a sample of 142 family medicine patients, Moore and Goldstein (1980) learned that 21% identified a problem with inhibited sexual desire. In their sample, 13% reported being unable to achieve orgasm, 13% rated their partner as having premature ejaculation, and 13% experienced dyspareunia (pain with intercourse). It has been Masters and Johnson’s estimate that one of every two couples struggles with a sexual dysfunction.

A widespread myth exists, however, in LDS culture. The myth is that sexual problems are only a manifestation of marital discord and conflict. Therefore, if the relationship is enhanced, the sexual dysfunction will automatically resolve itself. Bergin (1981b) has subscribed to this premise and expressed his belief in the superiority of a relationship-oriented therapy over sex therapy in treating sexual concerns. This is reminiscent of an outdated psychoanalytic concept which, for example, approaches alcoholism as only a symptom of historical conflicts and underlying pathology. According to this position, if historical conflicts are resolved, the alcoholic will automatically stop drinking. Operating on this assumption, the psychoanalyst has traditionally not focused directly on the drinking itself, with disastrous consequences. In our experience, both alcoholism and sexual dysfunctions require direct attention to the “symptom.” Unfortunately many counselors, due to personal inhibition or lack of professional knowledge, avoid discussing sexual issues. Even more seriously, some counselors refuse to refer patients to competent professionals, or merely “educate” clients with their personal folk concepts and biases.

It is very true that some sexual problems originate from marital discord. Many couples seeking sex therapy also need marital therapy, which we employ prior to focusing on the sexual dysfunctions. However, in most instances, sexual dysfunctions will not resolve themselves even if the marriage relationship improves. This has been documented by various prominent sex therapy authorities (Masters & Johnson, 1970; Kaplan, 1974) who have noted that once the vicious cycle of fear of sexual failure is set in motion, the original cause of the sexual dysfunction need no longer operate to cause the problem to be perpetuated in a marital relationship.

One of the authors recalls a middle-aged LDS couple who requested sex therapy because the husband was experiencing erectile dysfunction. They had been in therapy for almost four years with four different therapists, and each therapist had offered them the same opinion: “The sexual problem is just symptomatic of relationship problems, and as you improve the relationship and communicate better it will resolve itself.” The presenting complaint was never dealt with directly. The couple felt that they had a moderately good relationship to begin with, but after four years of therapy they agreed that their relationship had improved and was even better. Nonetheless, the sexual dysfunction was even more severe and was the cause of great frustration and pain to the couple.

Another young couple sought sex therapy after only a few months of marriage because the husband was unable to ejaculate during sexual relations with his wife. They were deeply in love, had been married in the temple, and essentially were still on the honeymoon. Nevertheless, a dysfunction existed. He had come from an LDS home, but his two older brothers had gotten their girlfriends pregnant and had to get married. He recalled vividly the anguish of his mother, and her threat to disown and never speak to him again if he followed in their footsteps. Throughout his dating and courtship he was very proper, and he also never indulged in masturbation. However, after marriage he was unable to dispel overnight his previous limits. Furthermore, his wife experienced serious pain during intercourse, which also caused him great concern and preoccupation. Part of her dyspareunia appeared to be caused by the “horror”
stories she had been told by her recently married girlfriend about how painful sex was for her. Gynecologic evaluation also revealed an organic problem which required minor surgery. Conjoint sex therapy followed the surgery and was successful in less than three months. Emotional intimacy and personal righteousness had not safeguarded them against dysfunction.

Sexual Dysfunction in Happy Couples

In the authors’ experience, sexual problems are often not a manifestation of marital discord and conflict. It is not at all uncommon for dysfunctions to be present in otherwise happy marriages. At the Sex & Marital Therapy Clinic at the University of Utah Medical School, we have seen many relatively newlywed LDS couples as well as several members of stake presidencies, numerous bishops, and stake high councilors. In the vast majority of instances their overall marital relationship and communication were very good, but they still suffered with sexual dysfunctions. They were grateful to receive sex therapy and enthusiastic about its results.

In the New England Journal of Medicine Frank, Anderson and Rubenstein (1978) presented the results of a study of well-educated, white, middle-class couples--volunteers from church and community groups who were not involved in therapy. The couples felt that their marriages were working and they were definitely above average in marital satisfaction compared with the general population (83% rated their marriages as “very happy” or “happy”). Despite the high degree of marital happiness, 63% of the women and 40% of the men reported a sexual dysfunction, and sexual “difficulties” were described by 77% of the women and 50% of the men. Among the women, 48% had difficulty getting sexually excited, 33% had difficulty maintaining excitement, 46% had difficulty reaching orgasm, and 15% were unable to experience orgasm. Among the men, 7% reported difficulty getting an erection, 9% had difficulty maintaining an erection, 30% ejaculated too quickly, and 4% had difficulty being able to ejaculate. In regard to sexual “difficulties,” 47% of the women and 12% of the men were unable to relax during sexual involvement, 35% of the women and 16% of the men expressed disinterest in sex, and 28% of the women and 10% of the men described themselves as “turned off.”

The Frank, et al. study illustrates that a sexual dysfunction does not always have to cause widespread disruption of the entire relationship and marital dissatisfaction. Where there is emotional intimacy and high satisfaction in other areas of the marriage, some couples are successful in tolerating sexual problems with minimal disruption by compartmentalizing and insulating them from the rest of the relationship. However, sexual intimacy and fulfillment are important and valued by most couples, and in the authors’ experience, dysfunction can over a period of time frequently cause deep resentment, emotional distance, and deterioration in the marriage.

Sensual Substitute or Catalyst for Intimacy?

Bergin (1981b) made what seems to us a misleading and generally inaccurate statement that, “We have hastened to turn people into sensual acrobats with criteria for judging success being established mainly on a physiological base” (p. 13). He then quoted from Levine and Agle (1978) only a portion of their criteria for sexual improvement and reaching, in our opinion, an unjustified conclusion: “Such criteria mislead therapists and clients into targeting their efforts on sensual performances rather than upon the relationship qualities that are necessary for positive and lasting intimacy. It has been assumed by many therapists that either (a) the relationship in which sex occurs, its permanence or moral quality is not the therapist’s business since he or she is a technician, or (b) the quality of the relationship is important; but that improving sex will improve the relationship” (p. 13).

Unfortunately, in selectively quoting from Levine and Agle (1978) their criteria were misrepresented. In the paragraph immediately prior to the one quoted by Bergin, Levine and Agle (1978) stated, “There are at least two sets of distinct standards for success in therapy for any sexual dysfunction.” Their first standard, also cited prior to that which Bergin quoted, was: “The patient or couple should become problematic in the areas of desire, performance and emotional satisfaction” (emphasis added) (p. 236). Furthermore, in the results of their study, they found that “Of the 30 spouses, 24 reported significant gains in nonsexual areas. These included freer communication and mutual understanding, increased closeness, more self understanding” (p. 241). Furthermore, the couples they selected for study felt they did not have marital problems which were causing erectile dysfunction, and expressed that they were committed to their marriages.

As clinicians, we have found that in fact the majority of relationships do improve when sexual functioning improves, although if there appear to be marital conflicts which are causing sexual problems, we always employ marital therapy before proceeding with sexual counseling. Of the dozens of sex therapists the authors have professionally associated with, the vast majority emphasize and work to enhance both emotional and sexual intimacy for the couple.

Bergin (1981b) further made what we perceive to be an extreme statement, “Sex therapy with married couples can induce such concentration on bodily sensations and excitement that the broader issues of kindness, selflessness, patience, and loyalty are lost. In narrow eagerness to obtain sensations, a married couple may lose those feelings which compose a broader and deeper relationship” (p. 14). We consider this a generally distorted perception of the field of sex therapy and seldom find this to be true. Naturally, there is more to an eternal companionship than sexual expression. A skilled sex therapist will not treat the sexual relationship in isolation, but always attend to the overall emotional relationship of the couple. Sex and marital therapy are often done in combination.

We are pleased that what have been derisively called “sensual technologies” have been developed because many couples lack skills, both emotional and sensual, to
sensitively and tenderly convey love to their eternal companions instead of just “having sex.” In many couples, we find that sex is perceived as coitus alone; there is relatively little touching and affection exchanged in the marriage. These couples seem to only know how to relate in crude, sexual ways rather than with tender gentleness. In these couples, we might refer to this unrefined sexual expressiveness and lack of affection as “sexual substitutes for sensual tenderness and genuine intimate expression.”

It is vital for us to acknowledge that sexual intimacy is also an integral part of marriage. True, many couples need to learn to be less selfish, and achieve emotional intimacy through improved communication skills. At the same time, however, many of these same couples also need to learn how to achieve sexual intimacy and fulfillment. What about those persons who are so unknowable that they are unable to please their partners and whose partners are too shy to guide them? For example, we have seen many relationships where the woman feels taken advantage of and believes that her pleasure and fulfillment are unimportant to herself and her mate. She ends up feeling that it is her duty and obligation to “service” him, and feels unloved because he is unable to show love tenderly.

Our goal must be to assist couples in achieving both sexual and emotional-spiritual intimacy. Sexual expression is for more than just procreation, as taught by Joseph F. Smith:

The lawful association of the sexes is ordained of God, not only as the sole means of race perpetuation, but for the development of higher faculties and nobler traits of human nature, which love-inspired companionship of man and woman alone can inspire (Smith, 1917, 20-30).

Sexual intimacy creates a deeper and closer intimacy and is one of the most powerful ways of communicating love, affection, and support. President Spencer W. Kimball has addressed this issue on several occasions. For example, in the April, 1974 General Conference, he quoted with approval the following statement from Billy Graham:

The Bible celebrates sex and its proper use, presenting it as God-created, God-ordained, and God-blessed. It makes plain that God himself implanted the physical magnetism between the sexes for two reasons: for the propagation of the human race, and for the expression of that kind of love between man and wife that makes for true oneness. His command to the first man and woman to be “one flesh” was as important as His command to “be fruitful and multiply” (Kimball, 1974, quoted in Burr, Yorgason, and Baker).

In 1975, President Kimball stated that:

We know of no direction from the Lord that proper experience between husbands and wives be limited totally to the procreation of children (Kimball, 1975, p. 11).

Respect & Ethical Practice

Bergin (1981b) observed that sex therapy can produce deterioration effects, but this is not different from all other forms of therapy (Bergin & Lambert, 1978). Naturally, one who has suffered from impotence for years will be depressed if therapy is unable to alleviate the problem, and his spouse may be even more unhappy and depressed if treatment is unsuccessful. In some cases, a marriage may even dissolve because of a partner’s unwillingness to continue living with severe sexual frustration.

It is likely that some clinicians of questionable ethics and training will disregard client values and suggest things that would be offensive to LDS couples and other moral persons. However, this is not a problem unique to the specialty of sex therapy. Mormon couples must always discriminatingly choose therapists who work with respect for their values and beliefs. One of the characteristics that the authors most prize about Dr. William Masters is his extreme emphasis on respectful affirmation and acceptance of the patient’s moral values when engaging in the clinical practice of sex therapy. Because of his international reputation, Dr. Masters has worked with couples of many different cultures and religions from all over the world. He emphasizes very strongly the need to work within the value system of the patient and to “never get anyone in trouble with their God.” It is our belief that most mental-health professionals who have specialized in sex therapy adhere to this philosophy.

The Code of Ethical Standards of the American Association of Sex Educators and Therapists (AASECT) specifically states: “Sex therapists should be aware of the personal value system that they introduce into the therapy context and should disclose these values to the client when such information is relevant to treatment. Moreover, therapists should avoid gratuitously enunciating opinions or prescribing values that reflect their personal biases rather than being responsive to the needs and well-being of the client” (Masters, Johnson, Kolodny, & Weems, 1980, p. 415). In explicating these views, those specializing in sex therapy have taken a stronger stand on the importance of affirming client values than most other professional groups in their ethical codes.

We agree that it is a travesty when an unethical clinician urges clients to violate their values and stresses only physical technique and gratification without the perspective of emotional-spiritual intimacy and respect for the partner’s individuality and freedom. In considering destructive outcomes, however, is it any less a travesty for an ignorant or inhibited helping professional to cause iatrogenic damage to clients?

One of the authors recalls a young LDS couple, married in the temple. The husband suffered circulatory inhibition and was unable to ejaculate with his wife by any means. Seeming to operate on the assumption that sex is only for procreation, a physician unempathically told them not to worry. “There is always artificial insemination.” Similarly, we recall physicians telling men in their fifties and sixties that they should not be concerned with their loss of erection because “You can’t stay young forever.” Is it any less a travesty for an unknowable LDS counselor to tell a couple that if they continue to pay tithing, pray together and stay close, a sexual dysfunction will work out by itself? As clinicians it is heartwarming to see a young couple, in deep pain and turmoil because of vaginismus which has prevented the consummation of their marriage of over a
year, report that after brief sex therapy (8 sessions) they are expecting a child and fulfilling an important goal in their marriage. Vaginismus is a condition that may be cured virtually 100% of the time through "sensual technology." It is heartbreaking to see a couple unable to consummate their marriage because the 45-year-old husband suffers from primary erectile dysfunction and has never been able to maintain an erection sufficient for intercourse, although nothing is physically wrong. We see couples every week who have been frustrated by years of sexual rejection, whose temple marriages have gradually deteriorated through hurt, resentment, and deprivation. In utter hopelessness some divorce, while a few, although married, seek consolation in the arms of a lover.

Bergin (1981b) wondered about negative effects on children, saying, "The sex therapies become so preoccupied with pleasure that the consequences for marital stability and positive development in the child are lost sight of." (p. 14). We find that such a position cannot be supported. What about the potential impact of marital dissolution on the children if frustrating sexual dysfunctions are not treated? The couples we counsel have often had relationships deteriorate because of sexual frustrations until they are unable to model a healthy relationship for their children or educate them constructively about the sexual aspect of an eternal marriage. Our great concern is the negative impact on children of sexually dysfunctional couples who model aloofness and lack of affection.

The Specialty of Sex Therapy

Annon (1976) described a four-level PLISSIT model for conceptualizing the levels of intervention which are needed in treating sexual problems. The first level of intervention is Permission. It is our hope that all counselors, as well as all physicians and other health professionals, will acquire a level of personal comfort with sexual issues so that they can convey permission to discuss sexual concerns to their clients. The next two levels of intervention require more in-depth knowledge and training, and essentially comprise what we refer to as a sex-counseling level of work. Limited Information and Specific Suggestions can often be provided in a short period of time by the therapist who has studied sexuality and acquainted himself with factual information (Calderone and Johnson, 1981; McCary, 1978; 1973). This information may also include LDS philosophy. However, we express concern with what LDS counselors may present as Church doctrine. We have often heard of individual Church members passing on information which reflects their own opinion and inhibitions about what is acceptable instead of Church policy.

There are definitely times when limited information is all that is necessary to resolve a problem or conflict for a client. One of the authors remembers receiving a telephone call last year from a young returned missionary. He was feeling very guilty and thinking he was over-sexed, "carnal, sensual, and devilish" because he awakened with erections several mornings a week. He had gone to a physician to discuss the problem, but had been given no information and was referred by the physician back to his bishop, who in turn referred him to the Sex & Marital Therapy Clinic. He did not realize that every male spends 20-25% of each night from birth until death having erections, and that this is a natural physiological occurrence for men during their life cycle. The pattern of having occasional morning erections simply meant that he was alive and aware, not depraved. This limited information greatly relieved him and helped him understand both himself and a natural physical occurrence.

The final level of intervention in the PLISSIT model is Intensive Therapy. Sex therapy requires the highest level of training and expertise. The Ethical Standard of Psychologists and the Standards for Providers of Psychological Services clearly stress the ethical obligation to recognize the boundaries of our competence and training as professionals. Practice in a new area of specialization such as sex therapy ethically requires both a base of thorough knowledge obtained through advanced coursework, and supervision in the new specialty area. We deplore the blatantly unethical trend among helping professionals to teach themselves how to practice sex therapy, usually by attending one brief workshop and then trying to stay a chapter ahead of the client couple in reading a sex therapy text.

The ethical practice of sex therapy particularly requires the non-medical mental-health professional to carefully master a complex body of medical knowledge relevant to conducting a thorough assessment. It is vital for the sex therapist to be knowledgeable concerning gynecological, urological, endocrinologic, neurologic, and vascular impediments to sexual function, as well as the effects of various illnesses and medications on sexuality. Without such a foundation of knowledge (Kolodny, Masters & Johnson, 1980) the therapist cannot differentially diagnose organic from psychogenic dysfunctions, and know when to have special medical consultants conduct tests and evaluations.

Dr. Bergin (1981b) noted that psychotherapeutic research in general shows "few differences in the effects of different techniques" (p. 3), and "in most cases, only a modest amount can be attributed to technical factors." In the psychotherapy literature, few differences are found in outcome rates between different technical and theoretical approaches, and most of the variance appears to be accounted for by client and therapist characteristics and relationship factors. This evidence does not appear to hold up as well, however, in much of the sex therapy research literature. In the treatment of vaginismus and premature ejaculation, for example, treatment programs using modern sex-therapy techniques typically have outcomes of 90-100% effectiveness, whereas traditional verbal therapies have been very ineffective (Stuart & Hammond, 1980; Hogan, 1978). Ovesey & Meyers (1968) describe a 30% effectiveness rate in treating retarded ejaculation by psychoanalytic therapy, while more recent sex-therapy completed on page 27
methods have produced successful outcomes in the 60-80% range on two and five year follow-ups (Stuart & Hammond, 1980; Masters, Johnson & Kolodny, 1977).

At the present time there is primarily one national organization which is providing certification in levels of minimal competence for practice as a sex therapist. The American Association of Sex Educators, Counselors and Therapists requires documentation of training, coursework, and specialty supervision for certification. They provide a national register of some 1300 certified sex therapists throughout the United States. AASECT certification does not insure competence, but it is making a helpful step in this direction by setting minimal standards of ethical practice. The ultimate responsibility for selecting competent referral sources in the area of sex therapy rests with counselors and clients. As in psychotherapy in general, we must counsel clients to question therapists as to whether they are willing to work respectfully within the client's value framework. LDS clients must further be educated to assertively speak up with therapists if they are insensitive to their values, and if this continues, to terminate therapy and seek help elsewhere. We do not believe, however, that AMCAP should be in the business of prescribing acceptable therapeutic approaches, either in sex therapy, psychotherapy or marital therapy. We hope that more LDS counselors will pursue specialty training and supervision in sex therapy, and that we will educate LDS clients on how to avoid disrespectful and psychonoxious therapists in any field of specialization.

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