Clinical Updates for Family Therapists:
Research and Treatment Approaches for Issues Affecting Today’s Families

Volume 1

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PREFACE

Clinical surprises are no stranger to the family therapy practitioner. The troubled teen turns out to have an eating disorder. The case of the depressed spouse takes on a whole new meaning when infidelity is revealed. You discover that a couple with low sexual desire is grieving the loss of a child. Any case stops in its tracks when suicide is raised. You are called upon to be expert on all these topics and more, but is that practical?

Through the years the AAMFT office has taken countless calls from clinicians who, while quite experienced and competent, are being faced with a clinical issue they know little about. What is the latest research? What clinical approaches are known to work? What is the lingo, and where can I find the best resources? It was this need that led to the creation of the Clinical Updates. The Clinical Updates were designed as quick read resources for the busy professional—digests of the latest information about a topic, with references for more in-depth study. We offer no promise that one will be an expert after reading a Clinical Update, but you will certainly have a good foundation on the topic.

Since 1999, the AAMFT has produced a Clinical Update on a new topic every two months, to coincide with the publication of the Family Therapy Magazine. They are widely referenced and frequently accessed through the AAMFT’s online archive (www.FamilyTherapyResources.com). We have received numerous requests to make the collection available as a set, to serve as a handy desk reference, an educational text, and to be accessible by clinicians who are not members of the AAMFT. We are pleased to accommodate these needs with the publication of the first two volumes of Clinical Updates for Family Therapists: Research and Treatment Approaches for Issues Affecting Today’s Families. (Topics included in Volume 2 are listed in the back of this volume.)

Each volume of the Clinical Updates for Family Therapists: Research and Treatment Approaches for Issues Affecting Today’s Families contains three years worth, or 18 chapters, of Clinical Update articles. We asked the original author(s) of each article to review the text and update it as needed with research and references. This ensures that you are holding an up-to-date resource.

We thank the authors of the Clinical Updates for sharing their expertise with us. Thank you for your initial work in authoring a Clinical Update, and again for reviewing and revising it in preparation for this volume. To the clinician using this volume, we hope it will become a valued resource for you when facing the clinical surprises sure to come your way.

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Male Sexual Dysfunction
By David Schnarch, Ph.D.

OVERVIEW

Couples today expect more fulfillment from sex and intimacy than ever before. Partners are less willing to accept sexual dysfunctions in silent frustration, and even if they are, the negative impacts usually ripple throughout the family. Whether to enhance relationship satisfaction, or reduce instability and divorce, every marriage and family therapist (MFT) needs to know about common sexual difficulties. Some MFTs will want to explore this topic further because of the powerful ways resolving sexual dysfunctions can facilitate people’s overall emotional development (differentiation).

Resolving sexual dysfunctions is a worthy clinical endeavor in itself. Rapid ejaculation, erectile difficulty, and problems reaching orgasm can impact both partners’ self-esteem, and intimacy often declines. Family dynamics become distorted or amplified in ways that often go unrecognized. For instance, imagine a father trying to hold onto himself in the face of difficult-but-predictable challenges from his rebellious adolescent son. Now add in the possibility he is in his late 40’s, struggling with increasing difficulty with erections. A moment’s reflection reveals why MFTs need to stay abreast of state-of-the-art sexual health care.

New erection-facilitating drugs (e.g., Viagra®, Cialis®, and Levitra®) have thrust men’s sexual function and couples’ intimate lives into the limelight. These medications will be tremendous blessings to many men and women; they will also reinforce high hopes for sexual performance and satisfying sex and intimacy. Also consider an estimated 30% of Viagra-takers who do not respond to the drug, Viagra-enhanced men whose partners are not interested, and long-suffering wives whose husbands who will not renew their prescriptions. Even with advances in sexual pharmacology, MFTs can do a great deal to improve couples’ sexual and overall relationships.

Sexual problems readily become part of a relationship’s ecology. Changes in sexual function can upset the status quo and change how partners feel.

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about themselves and each other—for better and worse. Differentiation-based inte-
gerated sexual-marital therapy, (versus traditional sensate-focus based approaches) can resolve sexual dysfunctions, improve sex and intimacy, and harness the accompanying changes to enhance both partners’ differentiation. Approached this way, resolv-
ing sexual problems and enhancing intimacy can yield greater capacity to love and more stability for the entire family.

**DIAGNOSIS, ASSESSMENT, AND TREATMENT PLANNING**

To assess, diagnose, and treat men’s sexual dysfunctions, we need to conceptualize sexual function. The Quantum Model (Schnarch, 1991; 1998) postulates that people have two sexual response thresholds, one for genital arousal and another for orgasm. When the total level of stimulation reaches a man’s arousal threshold he begins to get an erection (a woman’s vagina lubricates). When the total level of stimulation reaches a man’s (or woman’s) orgasmic threshold, the most pleasurable reflex in the human body occurs.

Here is the important part: “Total level of stimulation” is not reducible to physical stimulation, or even friction plus fantasy. Our ability to bring meaning to sex makes human sexuality quintessentially human. We are meaning-making animals, and meanings present or absent during and surrounding sex drastically impact sexual function and satisfaction. “Total level of stimulation” is an interaction of (a) sensory stimulation, (b) our body’s ability to transmit and respond to these stimuli, and (c) our subjective emotional processes. Our current relationship, past relationships, and our relationship with ourselves greatly determine sexual meanings and emotional contexts. Early sex therapy emphasized sensate focus and physical techniques. For many people, however, meanings, thoughts, and feelings are stronger determinants of sexual (dys)function and (dis)satisfaction than sheer physical sensation. By considering these three components, MFTs can decipher male sexual difficulties and develop multi-systemic treatment plans.

**Erectile Disorders** (Male Sexual Arousal Disorder, DSM-IV 302.72)
involve persistent difficulty getting and maintaining an erection sufficient for completion of sexual activity. This can involve many different patterns: some men never get a full erection, while others get a good one at first but lose it at some point before they orgasm. Like all sexual difficulties, erectile disorders can be lifelong or acquired, and pervasive (generalized), intermittent, or situational. The onset of intercourse is the most common time for erection problems.

Erectile difficulties occur when the total level of stimulation drops below a man’s arousal threshold. This can result from combinations of (a) insufficient or intermittent stimulation, (b) difficulty transmitting that stimulus or responding to it (e.g., alcohol abuse, medication side-effects, neurological disorders, hormonal deficits, or penile vascular insufficiency or leak-age), and (c) meanings, feelings, and impinging issues that diminish enjoyment and arousal.

Treatment consists of increasing a man’s total level of stimulation (far) above his arousal threshold. This involves optimizing (a) physical stimulation, (b) physiological responsiveness, and (c) meaning frameworks, during and surrounding, sex. For example, the solution for one couple involved a wife tying her husband’s hands together before she rhythmically stroked his penis with oil while she looked him in the eye. This occurred one morning before work, when he was refreshed and not expecting sex. This couple did not need Viagra to renew their sexual relationship; others may find the pill a new lease on (sexual) life. Men who experience normal age-related decreased rigidity of erections may find Viagra and similar drugs helpful.

A long-term study of 225 patients found Viagra remained effective after 36 months of treatment, and long-term treatment additionally improved men’s emotional adjustment. Men’s erections, orgasms, intercourse satisfaction, and quality of life ratings (which improved early in treatment) were maintained, and erection problems became less bothersome. After 36 months, 75% percent of men never or rarely worried about erection problems, compared to 64% at the third month of treatment.¹

ED has a profoundly negative effect on the sexual experience of men’s partners. In one study, female partners of men with ED report significant declines in desire (72% before partner’s ED vs. 46% since partner’s ED), arousal (75% vs. 44% after), orgasm (65% vs. 34% after), and satisfied with sexual activity (82% vs. 45% after) after their partner developed ED. Overall, ED has a profound negative effect on the sexual experience of a man’s partner.²

Likewise, resolving ED has a corresponding positive impact. Other research studied the female partners of men with ED who received erection-improving drugs. Levitra significantly improved men’s ability to maintain erections long enough to complete sexual intercourse, and increased their partners’ satisfaction ratings. Desire, lubrication, orgasm, and satisfaction scores were significantly higher in the partners of Levitra-treated men, compared to the partners of men who received a placebo.³ Similar findings have been reported with other PDE-5 inhibitor drugs.

Rapid Orgasm (Premature Ejaculation, DSM-IV 302.75), the most common male sexual dysfunction, involves orgasm (and detumescence) with
minimal stimulation before either partner is ready. Unrealistic expectations aside, this definition underscores men's ability to develop voluntary ejaculatory control. Rapid orgasm in men demonstrates the variability of human sexual function: anxiety generally reduces total stimulation (e.g., creating erectile difficulty and delayed orgasm). However, in the case of PE, anxiety quickly spikes the total level of stimulation above the man's orgasmic threshold. Rapid orgasm, like delayed orgasm, is often specific to intercourse (i.e., before, upon, or shortly after intromission). Many men have better ejaculatory control when receiving manual or oral stimulation.

Like most sexual problems, PE has a negative impact on both the quality of life and sexual relationships of men and their partner. In another study of 1158 men, the 32% who self-reported ejaculating before they wished also experienced lower satisfaction with intercourse and their overall sexual relationship, and more problems relaxing during intercourse. Men who were more distressed by their problem also reported difficulty with arousal and avoidance of sexual issues with their partner.4

Another study of men with PE found 88% reported being moderately to extremely distressed by how fast they ejaculated compared with 15% of men without PE. Eighty-six percent of men with PE reported this caused relationship difficulty with their partner. Only 30% of men with PE reported good satisfaction with sexual intercourse (compared with 90% of men without PE). Men with PE had significantly lower confidence, greater personal distress, and lots of negative secondary impacts.5

However, acknowledging negative consequences of PE is difficult for many couples, in part because it is only starting to receive the same attention ED now enjoys. In one study of 152 couples, men's and women's reports on the man's ejaculatory behavior were only moderately correlated. In general, the women saw PE as less of a problem for the men than their male partners reported for themselves. Rapid orgasm generally diminishes sexual satisfaction for both men and women, but whether it affects their overall relationship and personal functioning—or the couple is willing to face this—is more variable.6

This is an important issue because it also strongly influences whether couples seek treatment. Research indicates seeking treatment is related to high levels of distress from PE, tension with their partner, reduced frequency of sexual intercourse, and being comfortable talking with health professionals about sex. Not seeking treatment is associated with "learning to live with it," disbelief PE negatively affects the relationship, lack of access to treatment or discomfort discussing sexual issues, and having additional sexual problems such as erectile dysfunction.7

Men with rapid orgasm often compensate by (a) reducing physical stimulation (e.g., refusing to receive during foreplay, cessation of thrusting), (b) reducing sensitivity (e.g., analgesic lotions or alcohol ingestion), or (c) reducing eroticism and intimacy (e.g., biting lip, ignoring partner, or self-distracting thoughts). These approaches rarely work because pleasurable sensations and emotions are small components of total stimulation compared to their anxiety. Worse, such methods predispose a man to erectile dysfunction.
Effective treatment involves (a) reducing both partners’ anxieties and increasing self-soothing, (b) raising (conditioning) the man’s orgasmic threshold through repeated intense stimulation, and (c) addressing relevant meanings and issues, which may not be about sexual performance per se. For example, a gay man initially developed better ejaculatory control by talking with his partner and confronting his own fears and self-rejections. Over the next several months he developed more control by repeatedly receiving prolonged manual and oral stimulation in a loving context, after bringing his partner to orgasm through similar methods. Their collaboration also quelled his fears about the breakup of their relationship.

Delayed Orgasm (Male Orgasmic Disorder, DSM-IV 302.74) involves difficulty reaching orgasm when one is desired, erection is solid, and stimulation has been prolonged and intense. Orgasm and ejaculation involve two separate but usually related processes: One can be impaired while the other remains intact. The term “delayed ejaculation” is often used synonymously with “orgasmic dysfunction” in men. Difficulty reaching orgasm may be occasional or pervasive but frequently is limited to intercourse. The incidence often increases with age. Numerous drugs (e.g., Prozac, alcohol) can delay ejaculation, raising a man’s orgasmic threshold beyond the total stimulation generated by the physical technique and emotional climate of his customary sexual style. Likewise, orgasm can be impaired by frantic thrust-
ing, fear of “failure,” loss of emotional contact, distraction, and interpersonal concerns. Some men fake orgasms in anticipation of their partner’s negative response. Orgasm and erection difficulties from drugs are usually reversible; however, some develop a psychological basis that remains after medications are discontinued.

Treatment involves some combination of (a) less hurried and more varied patterns of non-goal-oriented stimulation, (b) removing physiological complications (e.g., physician-supervised medication changes) and (c) changing sexual style to reduce anxiety and create a more meaningful and satisfying reality. For one couple, this involved the man ceasing to force himself to orgasm. His wife mounted him from above, grinding her pelvis while supporting her weight with her arms on his chest. He watched her grind him as a pleasurable end in itself. This insight and his orgasm hit him at about the same moment.

Low Sexual Desire (Hypoactive Sexual Desire Disorder, DSM-IV 302.71). Human sexual desire is the most complex form of sexual motivation on the planet. The complexity that makes us capable of profoundly meaningful sex also makes low sexual desire the most common sexual complaint, and the one least responsive to conventional sexual and marital therapies. Low sexual desire involves a lack of interest in sex that is problematic for one partner or the other. In contrast, sexual aversion (repulsion or phobic panic response; DSM-IV 302.79) is relatively rare.

The DSM-IV may limit therapists’ understanding of low sexual desire by subtly encouraging an archaic viewpoint left over from early sex therapy (e.g., desire “phase”). It approaches low desire as an individual phenomenon (e.g., due to personal inhibitions or psychopathology), and reduces desire to a biologic drive, focused on genital contact, and manifested by initiatory aggressiveness or receptivity. These views, themselves, exacerbate pressure on “low-desire partners” and reduce sexual desire.

Sexual desire problems are far more diverse than “absence of sexual fantasies” and difficulty getting started. Low desire during sex is a pervasive problem too. Desire during sex has more to do with intimacy, passion, eroticism, respecting yourself, and liking your partner. Desire for your partner is often as important as desire for sex. Sexual desire is a component of sexual feelings and meanings, and thus co-determines total stimulation, and ultimately, other sexual dysfunctions and overall satisfaction.

Low desire can result from diverse combinations of physical and emotional causes. Clinically, “low sexual desire” is often a systemic phenomenon reflecting desire discrepancy and other relationship dissatisfactions. Common emphasis on “libido” and anticipatory “horniness” stifles appreciation of how emotional connection facilitates, and emotional fusion debilitates, sexual desire.

From the standpoint of differentiation, low desire is common, natural, and inevitable in emotionally committed relationships. Low sexual desire commonly surfaces during emotional gridlock, a midpoint in the natural processes of differentiation that permeate love relationships. Stop thinking about desire simply as biological drive and think of it as wanting.
Appreciating the strength and resilience required to love and want your partner underscores why differentiation is so important to sustained sexual desire in committed relationships (see treatment case example).

PDE-5 inhibitors are not much more effective than prior options. Their mechanisms of delivery and action make it unique. Penile injection therapy (e.g., papaverine) directly creates vasocongestion. It has high dropout rates and can cause fibrosis and prolonged erection after ejaculation. Efficacy of MUSE (prostaglandin-E1), inserted into the urethra of a man’s penis is lower than penile injections of the same drug. Viagra, Cialis, and Levitra work with vascular, “psychogenic,” and drug-induced erectile problems. However, they do not produce an erection directly. They require “effective stimulation” to work. As discussed, effective stimulation involves more than physical stimulation. These drugs reduce requirements for effective stimulation, but the emotional dimension is not obviated. Stress and anxiety (i.e., adrenaline) can reduce their effectiveness. Here’s where therapists may help some couples derive benefits from sexual performance-enhancing drugs.

As with Viagra, research demonstrates the effectiveness of Levitra and Cialis in treating ED (including with men who have other medical problems such as diabetes and hypertension). 8, 9, 10, 11
However, Viagra requires some planning for sex because effectiveness does not peak for an hour and wanes after four hours. Many couples engage in sexual activity with little or no advance planning, making newer drugs like Levitra and Celexa particularly attractive. (Cialis, for example, reportedly remains effective after 36 hours.) One study compared the efficacy of quick-acting Levitra taken immediately before sex, vs. long-lasting Cialis.

SEXUALITY: AN IMPORTANT CRUCIBLE FOR COUPLES THERAPISTS

Take a moment to consider four key aspects of differentiation: (1) maintaining a clear sense of self in close proximity to an important partner, (2) soothing your own fears and anxieties, (3) non-reactivity to your partner’s anxieties, and (4) tolerating discomfort for growth. Now imagine a troubled, anxious couple struggling to make sex more passionate, erotic, and intimate. These four factors greatly determine what happens in bed and how they feel about it. Likewise, these factors determine if, and how, you, the therapist, will broach the sanctum sanctorum of their sexual union. They also control intimacy, eroticism, passion, and desire in your own bedroom. Differentiation has everything to do with sex and intimacy from every perspective therapists must consider.

Couples with sexual difficulties often enter therapy displaying the worst in themselves—their insecurities, inhibitions, and what they do not like about their partner or themselves. They do this, in part, because that is what they think therapists look for. In truth, that is what modern psychotherapy often calls forth. As a therapist, it gets hard to keep talking to the best in people, and hard to keep talking from the best within you. Your differentiation determines how much you can do this.

Does professional training prepare us to have better marriages, better sex, or better intimacy than the clients we treat? Is it our graduate education or our differentiation—clear sense of self, self-regulation, non-reactivity, and tolerating discomfort for growth—that determines our ability to conduct differentiation-based sexual-marital therapy? Self-confrontation may be good for the soul, but such challenges to one’s professional and personal integrity are not easy.

Sexual problems present couples (and therapists) with “crucibles”—severe tests and trials which measure their mettle, enhance it, and shape their destinies—situations in which “who they are” responds and becomes “who they create themselves to be.” The realities from which people respond are as important as what they do or do not do. They encounter entirely different journeys and destinations when operating from what is good and solid in themselves, as opposed to what is frightened, self-rejecting, narcissistic, and immature. Therapists must talk to the best in people at times when couples usually lead with their worst. Beyond the arena of sex, you will find this a powerful approach to MFT in general.

In-depth training in treating sexual problems can be harder to come by today than two decades ago, and not enough MFTs have it. Two decades ago it was enough to be “comfortable talking about sex.” Today’s therapists must be more sophisticated about sex than ever before. Must we also be well differentiated, too? That is a lot to ask of ourselves, but can we offer any less?
administered 24 hours prior. In a four-week study of 614 men with ED, subjects receiving Levitra experienced more success maintaining an erection to completion of intercourse at one hour post-dose, compared with those who took Cialis 24 hours in advance.  

In another study, 367 men with ED were given prescriptions of Viagra for 12 weeks, followed by Cialis for 12 weeks, or vice versa, followed by an eight week extension phase where they could select the drug they preferred. Viagra and Cialis were equally effective, and men did not differ in erection frequency or ease, penetration ability, intercourse satisfaction, or overall satisfaction with the two drugs. In the extension phase, 29% of men chose Viagra and 71% chose Cialis.  

Subjects also reported firmer erections, more confidence in their erections, more episodes of successful intercourse greater sexual self-confidence and spontaneity, and less sexual time concerns with Cialis.  

The most frequent reasons for choosing Cialis was being able to get an erection long after taking the drug, firmness of erections, ability to get an erection every time, had erections the next morning, short time between taking drug and first erection, and partner preference for this treatment.  

In a three-way comparison between Viagra, Cialis, and Levitra, 585 men received four-month trials with all three drugs. Overall effectiveness and satisfaction was approximately the same with all three drugs, and partners reported increased overall satisfaction with all three. However, differences user preferences emerged: Levitra had the quickest onset (5 to 17 minutes) and gave men their most rigid erections. Diabetics preferred Levitra. Some subjects preferred Viagra because of greater ease dividing pills into smaller pieces. Younger patients between ages 40 and 55 strongly preferred Cialis, presumably because they were more likely to have sex a second time during its 36-hour window of opportunity.  

Biomedical solutions for rapid orgasm are also emerging. In recent years, orgasm-inhibiting side effects of selective serotonin reuptake inhibitors (SSRIs) have been harnessed in treating rapid orgasm. Paxil (paroxetine) generally creates the strongest ejaculation delay. This can be a useful adjunct in treatment, especially with men having lifelong PE. A complete treatment for rapid orgasm, offering short-term and long-term solutions, is available in Resurrecting Sex.  

As sex becomes increasingly bionic, MFTs will confront new relationship, social, and ethical/moral dilemmas. And MFTs can play an important role by asking an important question: Is this any more intimate, gratifying, or loving?  

**Case Study**  
Jason and Katie, a couple in their mid-forties married almost 20 years, sought treatment for his lack of sexual desire. Sex was reportedly “good” in their first decade together. Since then Jason demonstrated declining interest in sex with Katie. They had no sex together in the last six months, and only bi-monthly for the preceding several years. Jason agreed to treatment when Katie announced
her intention to leave him.

Katie was more sexually experienced than Jason, although neither considered themselves “beginners” when they met at college. Jason had several prior girlfriends, none lasting more than several months. Katie was in a serious long-term relationship with someone else when she first met Jason.

The lack of sex was a shock and disappointment to Katie. Jason rarely initiated and expected her to make all the approaches—except when he felt pressured to have sex. Jason still masturbated bi-weekly and medical evaluation revealed nothing. He still found Katie attractive and knew other men did too. This did not help conflicts over Katie’s growing career selling real estate. Jason had watched his mother eclipse his alcoholic father and leave him for another man. Katie’s salary now approached what he earned as a manager of a welding supply firm.

Early in treatment Jason suggested he simply was not as interested in sex as when he was younger. While agreeing this could be true, I proposed their “problem” could be a window into their relationship and each of them as individuals. Without further prompting, Jason described how he felt Katie controlled him, how she out-talked him in arguments, and how she was not as respectful (read “deferent”) as she used to be. Katie got defensive hearing this, and then Jason did the same. Tempers quickly escalated in session.

It would have been easy to treat Jason the same way Katie did: like an insensitive guy who could not relate to feelings or anyone’s needs but his own. I could have easily agreed with her that Jason’s sexual behavior was passive-aggressive. Jason had spent years guarding against his father’s explosive outbursts, and his mother’s manipulations.

But Jason looked more like a sensitive guy who could not stand his own sensitivity. Years spent stifling the part of himself that could still feel and care made Jason look oblivious to his emotions and the needs of those he loved. I viewed Jason’s sexual style through the lens of Bowenian differentiation: as his meager attempt to “hold onto himself”—daring not to give others the “use” of him as the price for being loved.

Rather than accepting Jason’s report of “no desire” at face value, I pointed out he had “no desire to want.” It was not that Jason did not want sex or did not want Katie, he did not want to want her. Wanting Katie made him vulnerable to what she might do to him, want from him, withhold from him, and what might befall her (and thus, him) if he cherished her. Jason knew the pain of wanting; wanting his father to stop drinking, wanting his mother to stop having affairs, wanting parents he could respect and admire. This was one of many aspects of treatment that surprised Jason and Katie.

Jason figured I would take Katie’s desire as the “gold standard” and try to increase his to match it. I refused to participate in any way that made his level of desire seem wrong, defective, or inadequate. Simultaneously, I encouraged Katie to maintain her own sexual agendas instead of deferring to Jason’s issues. When I questioned, “Who really chose whom?” Katie realized that Jason had never really chosen her. She chose him, and he married her because he did not have to choose. Her realization that she had never been “picked” pro-
voked difficult and productive self-confrontations about settling for being included instead of really being wanted.

Shortly thereafter, Jason and Katie’s emotional gridlock reached critical mass. Katie could not stay in the relationship as it existed and keep her integrity too. Likewise Jason would not violate his integrity by having sex to appease Katie, having realized how this replicated his own unresolved family issues. He had a “right” not to want his wife, just as she had a “right” to be with someone who wanted her. Pressure in the relationship rose although their arguments decreased; Jason and Katie focused on their own issues rather than blaming each other or expecting understanding and accommodation.

One night as they lay together, Jason expressed a hope and intent to have more sexual desire. Previously this would have placated Katie’s fears that things would not really change. This time, however, Katie said Jason’s hopes and intent made no difference: All that mattered was what actually happened between them. She was resolved not to remain in a sexless marriage—but rather than saying this defiantly, Katie added, “I hope you never have sex with me again if that’s what it takes for you to feel good about yourself. The solution isn’t for you to sell yourself out to me, because I know what that’s like. I love you and I don’t want to be party to that.”

Jason and Katie lay together in the dark for several minutes, each alone with their thoughts. He did not like feeling pressured by Katie’s greater sexual desire, but her new position helped him realize how it had made him feel secure. That was when Jason rolled over and kissed her with his heart in his lips.

Katie had spoken from the best in her. Jason was moved by her willingness to see him as a separate person in the midst of her own turmoil; this was so unlike his picture of his mother. Jason kissed her from what was good and solid in him, as an act of self-definition and a statement of desire and respect for Katie. It was more than his fear of losing her. Facing his fears of her anger, expectations, manipulations, and rejection in preceding weeks, Jason showed himself it was safer to risk really wanting her. Tears and tongues were active that night as they talked, cried, and had eyes-open sex till dawn.

Jason became noticeably softer and less defensive in their daily interactions, and Katie became more aggressive and uninhibited in bed. Rather than feeling coerced or pressured, Jason reported a growing sense of mutual admiration and self-respect. Jason let himself be more erotic and sexually assertive than he had ever been before, and our discussions of his phallicness deepened his appreciation of experiences with his father and relationships with men in general. With the lens of his childhood in mind, Jason deliberately, finally, let himself relax and allow Katie to hold him. In the Crucible Approach® this is called “resolving the past in the present.” In this case Jason used a method called hugging ‘till relaxed (Schnarch, 1997).
REFERENCES


This extensive reference text thoroughly details the sexual impacts of pharmacological agents.


Edited textbook highlights leading sex therapists’ approaches to male and female sexual dysfunctions, including chronic illness, sexual coercion, aging, and therapy with gay men and lesbians. Offers research, conceptual formulations, and treatment vignettes.


Edited textbook featuring leading sex therapists’ approaches to problems of sexual desire. Diverse theoretical formulations and treatment vignettes.


Focuses on the current literature, research, and developments related to sexual dysfunction. Analysis of recent literature and findings, including a bibliography. 2 Audio Tapes.


Discusses sex therapy from different approaches, recently-released medication for erectile dysfunction, the impact on relationships, and how therapists can become valuable resources and referral options for medical professionals. (4 Audio Tapes.)


Case studies and clinical discussion of sexual desire disorders, sexual performance problems, and sexual addiction and compulsion.


A complete system for resolving male and female sexual problems in ways that enhance personal growth and repair damaged relationships. Full coverage of major causes of sexual difficulties, including medical and interpersonal issues. This book explains why normal healthy people have sexual problems, and how best to handle them.


A psycho-educational application of the Crucible Approach for clients and the general public. Good introduction for clinicians planning to tackle Constructing the Sexual Crucible. Using one detailed case history per chapter, this book explains how differentiation controls sex and intimacy in committed relationships. Five chapters of “tools for connection” offer specific ways to enhance intimacy, eroticism, and passion.


Often used as a primary text in graduate schools, this 600 page book (700 references) organizes major theoretical, clinical, and research issues within
Male Sexual Dysfunction

sex therapy. It then offers a radically new approach to integrated sexual-and-marital therapy, the Crucible Approach. Topics include the Quantum Model, differences between other-validated and self-validated intimacy, sexual desire, treatment of affairs, sex and spirituality, and the therapist’s role in treatment.

Videotape of Dr. Schnarch’s presentation at the AAMFT Annual Conference, recorded as part of the Learning Edge Series.

The classic book for men who want to understand themselves, their sexuality, and common emotions and dilemmas that come with being male.
Good self-help information about sexual dysfunctions.

ENDNOTES

World Congress of Sexology, Montreal, Canada (Session 3104).


ABOUT THE AUTHOR

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