SEX AND SEXUALITY

QUESTIONS & ANSWERS FOR COUNSELLORS & THERAPISTS

GLYN HUDSON-ALLEZ

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Questions and Answers for Counsellors and Therapists

By

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For Brian
Whose constant love and support
made this book possible

and

Darren, Sarah and Liz
Don't you just hate it when
your mum talks about sex!

Foreword

If there is one area in the training of counsellors and psychotherapists that gets short measure it's the subject of sex and sexuality. This has been the case for more years than I can remember, and there seems little evidence that this has changed. There is no doubt that attention has been paid to improve curricula. Training courses now include the study of the impact of sexual abuse, sexual orientation and even deviant behaviour in our society, but what seems still to be missing is help for practitioners, who need to be able to work with and value the whole of their client's experience, including their sexuality – in other words, common human sexual behaviour.

I have always believed that the most important quality that any counsellor or therapist can offer clients when talking about sexual concerns is their own comfort with the material. This doesn't come naturally for most of us and won't improve if we duck the subject. If counsellors and therapists want to be fully available to their clients, this is the book to assist that process.

Through the medium of commonly asked questions, Glyn Hudson-Allez offers a clear and wise guide, which is both informative and thought provoking. She does not invite the reader to think they need the skills of a psychosexual therapist to engage in exploring sexual material but rather suggests that it is possible to have a normal conversation and that clients may feel mightily relieved to do so.

The questions asked are ones that practitioners will recognize as the ones they wanted to ask but maybe didn't dare. The answers are here and easily accessible. Dr Hudson-Allez has brought her years of experience together and produced a work that manages to offer accurate information while at the same time expanding our understanding of the human sexual condition. This is not another book about sexual problems but one that sets out to have real practical relevance to enhance counsellors' work with clients. As such it should become essential reading for all counsellors and psychotherapists.

Marj Thorburn MBE
Chair of the Professional Standards Board of the
British Association of Sexual and Relationship Therapy 2005

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Chapter 1
Introduction

When I first trained as a counsellor in the late seventies and early eighties, counselling courses were not as formal and structured as they are today. Much of the learning was done via supervision, peer review and personal reading. In those days, there was very little to read regarding normal sexual activity. Of course, there were seminal works on sexual behaviour, like Kinsey et al. (1948, 1953), Masters and Johnson (1966), Hite (1976), Rosen and Rosen (1981), Apfelbaum (1983) and Bancroft (1989), but these were considered speciality texts for sex therapists and not necessary reading for a general counsellor. When reading counselling texts, if it was mentioned, sex was usually related to Freudian theories that essentially focused on male supremacy and female subjugation. But discussion of what people did, how they enjoyed themselves and whether they could make it better was not part of the accepted texts.

When I reflect back to those days, sex was rarely mentioned in any depth, even in seminars. We were taught the PLISSIT model (Annon, 1976) of allowing clients the permission to discuss their sexual difficulties (see Question 7.1), but there was little movement on from that first stage. We could not even give limited information about sex, because the assumption was made that we should take such knowledge from our own behaviour. If we were respectable people in a heterosexual marriage, it was assumed that we had the requisite knowledge to impart. Homosexuality at that time was illegal, and any form of deviation from 'normal' vaginal penetrative sexual intercourse in the missionary position was considered to need specialist attention. Yet in the counselling room, we would receive questions like 'How much masturbation is too much?', 'How often do other people make love?' and 'Why can't I have an orgasm with my husband when I can have one on my own?' Without specifically going on to train as a sex therapist, this kind of information eluded us counsellors. I found exactly the same avoidance when I later did my psychology degrees.

When Pfizer first started conducting clinical trials on their new drug sildenafil, later to be called Viagra, there was a huge interest in the press

that bordered on hysteria. Headlines in the tabloid press like 'PILL FOR IMPOTENCE OUTSELLS PROZAC' shouted the outrage that men (and even, dare I say it, women) wanted to take the drug not just to cure erectile insufficiency but also to enhance their sexual performance. How dare they want to enjoy themselves, possibly at the nation's expense, cried the indignant civil servants in Whitehall! The Government hurriedly put forward prescribing criteria to prevent GPs prescribing Viagra for erectile dysfunction (ED), unless the man had one of a discrete list of physical illnesses, thereby limiting the potential expense to the purse of the NHS. And, even if they were given prescription help to enhance their erections, the patients may have been given only one dose for a week. Similar rationing of sexual activity by GPs was found in the prescribing of Caverject injections; and, if you messed up your weekly injection, that was the end of your sexual enjoyment until the next week. Thus GPs became the gatekeepers to many patients' recreational sexual activity.

The success of Viagra, which was interestingly the unexpected side effect of researching drugs for cardiac problems, was to produce another side effect. It gave British men, hitherto notorious for their inability to speak about things emotional or sexual, the permission to speak openly about sex. As celebrities publicly confessed to struggling to achieve erections when they wanted to, and their willingness to try Viagra, the ordinary man in the street became more willing to say that he had trouble too. I was working in primary care at the time, and I remember that the incidence of clients coming to speak about sexual difficulties increased threefold. Furthermore, as the demand for sexual information, sexual counselling and sexual psychotherapy increased, the number of training places available for health professionals to undertake courses in psychosexual therapy halved. Many valued training courses accredited by the British Association of Sexual and Relationship Therapy (BASRT) and the Institute of Psychosexual Medicine (IPM) disappeared, not because there was a lack of demand for the places but for financial reasons in the training institutions.

With the number of suitably trained psychosexual therapists, or sexologists, dwindling, the knowledge that other health professionals, like counsellors, psychotherapists or psychologists, had to offer was vital. One would have assumed therefore that counselling training, now structured with fixed curricula, would fill the gap. But this does not appear to be the case. In a polemic published in a counselling journal, Clarkson (2003: 9) argued:

> . . . my research work over the last couple of years has proved to me that the literature on sexuality in the fields of counselling, psychology and psychotherapy is (a) conspicuous by its absence (b) factually wrong (c) focused on disorder and dysfunction – negative psychology – and (d) often plainly destructive and damaging.

This is an extreme view, but in the training of health professionals (GPs included) there is a paucity of training about normal functioning sexual behaviour. GPs may only have one or two seminars in their medical training regarding human sexuality, yet, when couples find their sexual activity is not working, their GP is usually the first person they turn to. In my experience of working alongside GPs, although there are some that take an interest in sexual difficulties, there are some who are deeply embarrassed when a patient raises a sexual issue, and there are others who feel they have neither the time nor the interest in getting involved in what may be considered as their patient's recreational behaviour.

Of course, the lack of input on sexuality on training courses for the health professional merely reflects a similar lack of input in British society. The lack of appropriate sex education is an example, as parents predominantly abrogate responsibility for this, for whatever reason, to the schools. Provision of a few classes here or there is inadequate to give children the knowledge and skills that adolescents require when their hormones drive them to start practising a sexual repertoire. There are few schools that provide consistent and repeated classes about sex, and not just about the mechanics of reproduction and the pragmatics of contraception but the physiological understanding of why the person's body is responding the way it does, how to enjoy and stimulate your own arousal systems and how to determine whether one's relationship is appropriate to consummate. Even writing this, I anticipate objections regarding teaching adolescents how to enjoy their own bodies as asking for trouble. Yet it is only by giving adolescents appropriate knowledge about themselves that are they able to make informed choices before sharing in the experience with others.

As a normal part of sex therapy, we undertake a full sexual and developmental history. It never ceases to amaze me how little real education people have had about sex, and how misinformed couples are. This is especially so in heterosexual relationships, where men and women have little knowledge and understanding of how their own body works and tend always to use this information (and sometimes misinformation) to expect their partner to work in the same way. Although there are some similarities between the sexes, their differences, especially in sexual arousal and enjoyment, are greater. Some of this misinformation is not trivial either. I have seen couples struggling to conceive who did not realize that the anal intercourse they enjoyed would not lead to pregnancy. I have seen many men who did not know that women do not urinate via their vagina. These were not ignorant people, but ordinary working- or middle-class folk who had fumbled their way through their relationships and wondered why sex was not as exciting as others made it out to be.

Yet things have changed since my initial counselling training. Twenty years on, clients in the counselling room are much more open to asking