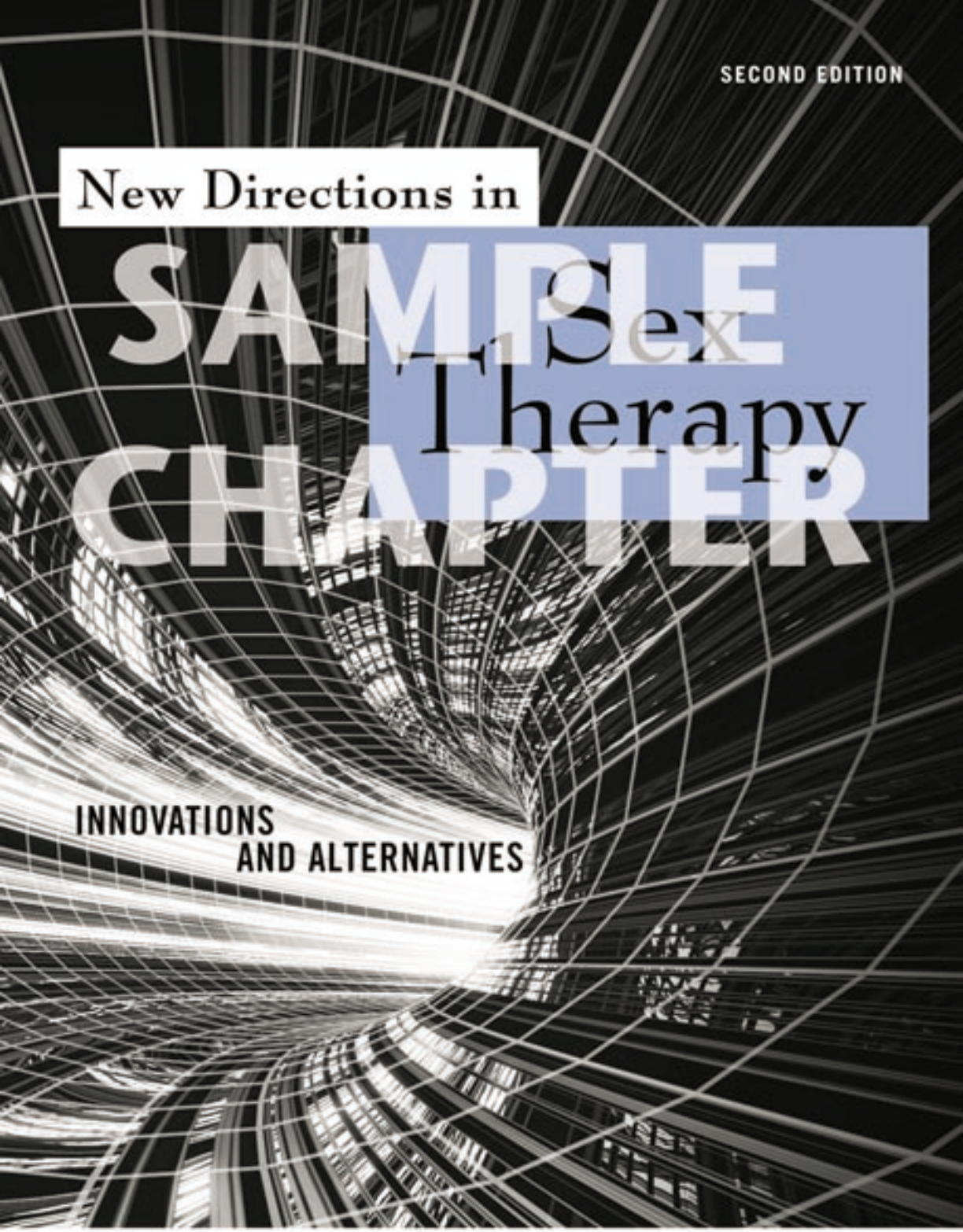

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SECOND EDITION

New Directions in Sex Therapy

INNOVATIONS AND ALTERNATIVES

Edited by
Peggy J. Kleinplatz

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Is That All There Is? A New Critique of the Goals of Sex Therapy

PEGGY J. KLEINPLATZ, Ph.D.

The most fundamental factor in determining the character of a given clinical approach is the nature of its goals. So it is with sex therapy. Over the last 40 years, the scope of our cases has changed, the clientele and their problems have become more complex, and our methods have become more discerning. Our objectives, however, remain the same. These goals involve the elimination of the symptoms of sexual dysfunction, the reversal of desire disorders so as to bring too much or too low desire into an alleged normal range, and the containment of paraphilic urges and behaviors.

This chapter will critique conventional conceptions of sexuality and sexual inadequacy and the goals that arise from them as limiting the potential outcomes of our work. Alternative goals will be recommended alongside a new direction, promoting optimal sexuality.

Sex Therapy Emphasizes Performance Rather Than Subjective Meaning and Experience

The goals of sex therapy emphasize performance rather than embodiment, connection, and integration. Correspondingly, "success" is measured in terms of objective, behavioral, and physiological indices rather than in terms of subjective meaning and experience.

In a sense, sex therapy has an advantage over other forms of psychotherapy. Most of the problems and solutions in our domain seem relatively discreet, well-demarcated, and readily identifiable. Whether or not one has orgasms or "erections sufficient for penetration" is more easily identified than the comparatively amorphous concerns of patients in general psychotherapy. It would seem that the goals in treating such patients would be clear cut (i.e., having orgasms or erections), especially relative to the goals in treatment of depression or anxiety. This makes it particularly easy for us to be trapped into defining the problem and the symptom as one and the same; it also means that the goal is typically defined in terms of remedying technical difficulties in performance. It makes harder for us to distinguish between the anorgasmia

and her feelings about it or his lack of physiological signs of arousal and the individual's subjective sense of being turned on. Zilbergeld and Ellison (1980) suggested over 30 years ago that the cognitive and affective components of sexual response ought to be included in our understanding of sexual function/dysfunction. Their innovation, the incorporation of subjective aspects of arousal and the sense of satisfaction into our models, has not been given its due. As such, our models still cannot account for problems in sexual desire when performance is intact.

The following vignette illustrates the gaps in the conventional model. The couple in my office have had a high frequency of sexual activity for years. They know one another's bodies cold. He brings her to multiple orgasms regularly within minutes of commencing genital stimulation. There are no component failures here, yet ironically, herein lies the problem. She is full of contempt as she says, "He plays my body like a violin, and I am growing to hate him for it." Her desire had disappeared as she began to feel that her body was the object of his expert manipulations while the person within lay untouched (Kleinplatz, 1996b).

One night of sex with a new partner may be exciting, if only because of the possibilities to be explored. It is when we quit exploring the person within, forgoing passion and focusing instead on the more expedient goal of orgasm, that, sooner or later, sexual problems begin. It is, paradoxically, in the act of repeating—relentlessly—the successes of the past that we ultimately become ineffective lovers. The consequences of participating in sex over a prolonged period without intimate, sexual connection, even when the mechanical aspects of sex are satisfactory, may be the loss of sexual desire or the ability to become aroused.

Technique had better excel when arousal is depending on it and it alone. One cannot afford any mechanical glitches when technical proficiency alone is intended to produce arousal. To create intense sexual excitement, skillful stimulation is not nearly as "effective" as eroticism. Eroticism can override an awful lot of lousy technique. In fact, erotic connection can generate sexual excitement in the absence of any physical contact at all. It seems so much easier to produce arousal by relying on both erotic contact and technical proficiency at physical stimulation. This requires more than hitting the right nerve endings.

When one complains about the other's technique, the partners may not be in the ideal mindset for giving and receiving stimulation with pleasure. "He's tweaking my nipples." We hear these kinds of complaints frequently and with them, the partner's exasperated response, "No matter what I do, I can't seem to get it right. I can't seem to please her." The reason he cannot please her is because they are not sufficiently attuned to one another for him to feel her responses or lack thereof. Because they are not on the same wavelength, she is not easily aroused to the point where whatever he does will please her.

Correspondingly, individuals who object to a given set of sexual acts may be less particular when they are so aroused that they are governed by their senses rather than by their sensibilities.

When a couple/individual is focused on erection or orgasm, we know that they are oriented at the performance level. We encourage clients to stay on this plane rather than to enter the erotic dimension when our solutions target symptoms alone. Treatments for mechanical problems that encourage clients to perform on automatic may engender feelings of disconnection and disembodiment. Men who can circumvent and proudly numb their intense feelings of arousal by focusing on repulsive imagery so as to "last longer", or women who can lubricate notwithstanding minimal subjective arousal, can perform, but they cannot be present. Sooner or later, either they or their partners sense it. That is when the emptiness begins and with it a lack of desire. When they are embodied within and connected to one another as erotic beings, performance becomes far less relevant for sexual fulfillment, which takes on a whole new character.

Our goals seem aimed at treating symptoms of sexual dysfunction. The alternative goal is to augment the ability to be present and sexually accessible, in which case concerns about functioning seem to recede, even if the performance has not yet changed. Perhaps we need to prevent the development of future problems by going beyond performance concerns, even when those are the presenting complaints, and focus instead on clients' inner and interpersonal experience.

Sex Therapy Promotes One-Size-Fits-All Goals at the Expense of Appreciating Individual Uniqueness

Sex therapy treats broad categories of dysfunctions and disorders rather than the particular individual who bears the diagnosis. Our field aims to eliminate the problem without sufficient regard for the individuality of the person within (i.e., the uniqueness of the client and the role, meaning, purpose, or value of the problem for the person). Goals are thus based on insufficient data about the nature of the client's sexuality (at present or in potentia).

Part of the problem with the goals of sex therapy is that they are macro, one-size-fits-all objectives when what we need are micro, individualized "interventions", highly sensitive to what lies within a given individual. Combinations of subjective, sexual/erotic meanings are as distinctive as fingerprints. They are intricate, complex, subtle, and powerful.

By contrast, if we begin with something as broad and nomothetic as a diagnosis, all we know is the name given to a rubric of behaviors, desires, urges, and fantasies, but it stays at that level—it is just a name. There is no opportunity to truly understand the nature of a given phenomenon with its corresponding label. If anything, the label may act as an obstacle by suggesting

that the clinician knows enough to proceed and that there is no need to delve deeper. If, however, we develop/employ more sensitive epistemologies, we begin to understand the vast array of ways of being, sexually and otherwise, that have been lumped together.

Therapists often act as if all individuals who fit a given psychodiagnostic category are alike; once they have been diagnosed with the same pathology, they will receive the same treatment, and that treatment will target the same goal. For example, in treatment of the paraphilias, the goal may simply involve controlling the unacceptable or compulsive sexual behavior, without distinguishing the significance of the desires for this particular client. In contrast, the literature by sadomasochistic participants distinguishes between sadism, dominance, and other motives for certain superficially similar behaviors. Those who participate in sadomasochistic activities at least try to clarify motives so that it is easier (to try) to find what they seek.

The approach to sadomasochism within sex therapy is markedly different from the approach of the actual participants. Sex therapy sees only the broad category of sexual sadism and sexual masochism as listed in the *DSM* (*Diagnostic and Statistical Manual of Mental Disorders*). Participants conceive of a wide spectrum of behaviors under this umbrella and an even more varied spectrum of underlying goals and purposes motivating these acts. While sex therapy focuses on what is on the surface, participants are interested in the meanings that lie at a deeper level. When a professional dominatrix or even a seasoned amateur undertakes a given scene, she must first investigate, inquire, and understand fully and thoroughly what her partner wants to experience, aims to attain, achieve, derive, or accomplish therein.

Telling your therapist that you have powerful and compelling cravings for bondage and discipline, that you would rather be engaging in your favorite form of sadomasochistic sexual relations than going to work in the morning, is enough to get you classified as a paraphiliac. In contrast, saying this to the dominatrix is useless. It does not provide her with nearly enough information to know how to proceed. She would be out of business very quickly if she were to provide the identical or even quite similar services to every man who requested bondage and discipline. To satisfy her customer, she needs to know the nature of his desires precisely. Does he imagine a determined and unyielding disciplinarian? Is she to be a loving, nurturing, almost maternal figure who knows just how to take care of him? Is she to be a wild, driven, sex-crazed woman who simply will not let go of him until she's had her fill? The devil is in the details. Saying that *her* client is masochistic or submissive does not begin to capture it.

The dominatrix may be the ultimate phenomenologist. She interviews her submissives to get at what they want *most*. Are they better interviewers than therapists are? Do they have higher, more sophisticated goals? Perhaps they

have simply validated that desires are surely more complex than what is seen on the surface, that motives are expected to be complicated, and so implicitly normalize the idea that "sexual" behaviors are embedded with particular, unique motives.

For clinicians, the alternative to treating the category is to develop more sensitive and subtle approaches to appreciating the uniqueness of each client and to tailor our goals accordingly.

Sex Therapy Opts to Promote Conformity to a Toxic Norm Rather Than Social Change

When we diagnose, treat, and assess outcome among our clients, we typically begin with normative performance standards as our reference points. It is deviation from these norms, defined in physiological terms, statistical norms, and conventional values, that serves as a major criterion for diagnosing disorder and determining the goals of treatment. We attempt to restore our patients to a level of functioning (or control, in the case of the paraphilias), which may neither be in their best interests nor those of our society. We tend to accept the social definition of the problem and treat it instead of combating it (Irvine, 2005). We aim to achieve conformity to a troubled norm (Reiss, 1990) rather than applying ourselves to changing the norm.

What is this norm? North American sex scripts may have toxic effects on sexual development, relationships, self-image, etc. The norms embedded in these scripts have become increasingly narrow, affecting our ideals even of genital aesthetics. Current messages undoubtedly engender sexual problems and yet go unchallenged. Sexologists recognize that definitions of masculinity centered on the belief that a man's worth is to be measured by his last erection can only impair his sexual functioning, not to mention his enjoyment; but we mention this in passing, just before we treat his erectile dysfunction. We treat the symptoms of lack of sexual desire and vaginal atrophy in menopausal patients without examining the context in which older women come to be seen as dried-up sexual beings. Our knowledge that these "symptoms" are related to cultural values is hardly publicized. Meanwhile, our society tries to eliminate the "symptoms" of aging, and clinicians meekly acquiesce rather than emphasizing how sexuality can actually flourish and be optimized in older couples (Kleinplatz, 2010b; Kleinplatz, Ménard, Paradis, et al., 2009b).

Every time we treat patients one-on-one, we inadvertently help to reinforce the status quo. That is, we take money to help this particular client resolve this presenting problem, perhaps even acknowledging in the course of therapy that our society has engendered her body-image problem or his preoccupation with his erections. However, by focusing our energies in this limited fashion, we keep this secret in our consulting offices (Irvine, 2005) and fail to devote

ourselves to changing society. We abet in maintaining the social context in which the problem exists.

We know all this. Sex therapists are quite aware of the deleterious impact of North American sex scripts on our society. We just are not doing enough en masse to fight it and thereby to prevent the development of sexual problems. This is not to say that we should stop helping those in distress; merely that in addition, we should be devoting more energy to prevention of sexual problems.

It can be done. In September 2010, sex advice columnist Dan Savage ("Savage Love") responded to the news headlines reporting a series of suicides among bullied gay youths by creating the "It Gets Better Project" on YouTube (www.itgetsbetter.org). Savage's video encouraged LGBT (lesbian, gay, bisexual, and transgender) youths to hang on in the face of harassment and alienation in the knowledge that a happier future with love and support awaits. In the months that followed, tens of thousand of other videos were posted by the LGBT community and allies. Within 6 months, phone calls to suicide prevention lines for LGBT youth had increased by 50% (www.itgetsbetter.org).

The alternative to reinforcing the status quo may involve increased advocacy for social change. If we are serious about not merely treating but preventing sexual problems, we have a responsibility to aim more broadly. We can intensify our support of sex educators and promote *comprehensive* sexuality education—not just classes on reproductive biology. We must resist leaving sex education in the hands of the right wing or those (e.g., media scandal mongers covering the sex addict du jour) who profit from keeping our sexual discourse salacious. We can revolutionize attitudes toward sexuality so that we no longer assist in reifying sexual dysfunctions and disorders. We will know that we have succeeded when we have made ourselves obsolete.

Sex Therapy Promotes A Priori Solutions Rather Than Change Generated From Within

The goals of sex therapy stop at the level of normative, standard functioning, whereas what lies within the individual is what ought to guide/direct what this person can become in therapy. We aim merely to restore clients to a predetermined, functional state, even though what this particular individual has the potential to become is not merely symptom-free: It is also unique and distinct from all other clients (Mahrer, 1996/2004). To the extent that our goals (and correspondingly, our methods) foreclose on the possibility of discovery of unknowns and of change generated from within the client, we will never discover all that our clients can aspire to and become. That is, the narrowness of our goals limits the extent of possible changes. If all we aim to achieve is symptom reversal, we will never discover all that each individual can become; we will be oblivious to how different the outcome of therapy can be, even though a series of clients may all begin with the same diagnosis.

Consider the differences in outcome in the following two clinical vignettes; although each man was referred for treatment of erectile dysfunction, the disparate kinds of change sprang from what lay within each individual.

> He enters therapy because of his erectile dysfunction and depression. His erectile dysfunction feeds his depression, while his depression feeds his erectile dysfunction. Is the therapist to treat the depression? Should the therapist target the erectile dysfunction? The alternative is to work with the whole person. We begin at a moment when he is aware of feeling despondent, hopeless, and never being good enough. All his energy is bound up in evaluating himself and not measuring up. It was at its worst that day she brought home the antique pocket watch she had recently inherited. Before she had a chance to put it away for safekeeping, though, he picked it up and examined it, appreciating the fine detail and getting lost in the intricate craftsmanship. It was when she entered the room that he became startled and dropped the watch, breaking it. As usual, he was overwhelmed by feelings of guilt, his sense of being a loser—impotent—and of ruining everything. In the process, he banishes the sense of fascination that had so enveloped him just moments before. But as he allows himself to revel in how it might feel to be entranced, to be in full reverie, to let go of self-consciousness and to focus all of his attention on something special and utterly compelling, a new possibility arises. (It is by entering this new way of being that emerges from within that change is effected [Mahrer, 2007]. In this instance, it is the ability to immerse himself in something or someone utterly fascinating.) He is transfixed by his wife. He lies between her legs, his face barely inches from her genitals, enraptured by her beauty. He is quietly fascinated by her. Every fold in her vulva is captivating. He is absorbed by the texture of her skin and how it shifts from coarse to velvety and delicate to slippery. "I've never really felt free to look at her this way before." As he says these words, he is no longer the depressed person he had been earlier, and his erectile dysfunction has conspicuously evaporated, too. The change was one that sprang from my client. The result was that not only the sexual dysfunction, but also the feelings of inadequacy, incompetence, and self-consciousness were gone. In their place was the capacity to lose himself in erotic union with his wife.
>
> A second client, too, comes to therapy because of his erectile dysfunction. He, too, is depressed. For him, the problem begins when they are in bed, ready to make love. The peak moment is when she says to him, "I want you inside me right now." For him, this is hell. His attention, however, is not on her—it is on his penis. In fact,

his penis is so riveting that it seems to have a life of its own. Be the penis, I suggest. Allow it to speak from its vantage point. Listen to its message. "Quit nagging me. You can't tell me what to do" is the response. "You are too busy performing to enjoy. I want attention. I want to be wanted." He had been in the habit of going through the motions even though his partner had been relatively passive and had expressed little overt desire for him. He begins to giggle as he imagines playing hard to get. The session concludes with the stirring of an erection. By the following session, he has given voice to his newly discovered capacity to bask in concerted sexual attention and the desire for pure pleasure (instead of being stymied by his formerly uncooperative, dysfunctional penis). He reports having had a great time in bed with his lover, who, much to his surprise, is absolutely thrilled to caress and stroke his penis, which now "functions" quite well. He also reports that his writer's block has dissipated.

The alternative to a priori solutions is to discover what each individual can become, respectfully enabling the client to grow in that direction and to expand the client's limits as far as he/she so chooses (Mahrer, 2007). This means not only a change in our goals, but will necessitate a shift in methods to meet these new objectives (Mahrer, 2008, 2009). Sex therapists will have to envision, borrow, and/or create techniques suited to accomplishing such goals.

Sex Therapy Stops Too Soon and Settles for Too Little

If many people have lousy sex lives, one reason for it is that so many settle for too little in bed. It is as though they come to the table intent only upon satisfying their hunger (Schnarch, 1991, 1997). Sex can be about so much more. Great sex can be like great therapy: They each involve aspiring high and not stopping for as long as each of the participants is ready, willing, and able to continue. Each can provide a means to touch, reach, play with, explore, probe, penetrate, and transform all that is within. Many people do not get what they want in bed because they are not really honest about it. They speak in vague generalities about the kinds of sex they want rather than acknowledging, aloud, to self and partner, what they truly crave. They are so afraid of having to look closely at and admit (as if it were a crime) what they really want. Their partners let them get away with it. Sometimes their partners do not know any better. We, as sex therapists, let them get away with it but should know better; we have no excuse. We know that individuals will not get any more out of sex than they are prepared to request. Part of our jobs is or should be to help clients figure out why they are dissatisfied, what they ultimately want, and what it would take to satisfy them. We are to help them figure out how to divulge what they want. Like many lovers, many therapists settle at the level of vague generalities and, as such,

do not gather the necessary information to keep the customer not just satisfied but happy.

Great therapy can be like great sex. The possibility is for utter transformation in the hands of someone who is willing to reach all the way inside and to help to bring forth all that one can be. This requires an enormous commitment to being not merely honest but also to be open/opened, transparent, genuine, authentic, vulnerable, and defenseless. Correspondingly, lousy therapy can be like lousy sex. Both are predicated on participants who are willing to stop too soon and settle for too little. They settle for effective functioning and bodily satisfaction. Many want more but dare not aspire to more or admit to their desires. But if they dare to be known and chance exposing the places that are most tender, sore, aching, or sensitive, they risk judgment, rejection, being misunderstood, or worse—being understood accurately and then rejected. They risk being hurt as well as the possibility of fundamental change.

We want to be touched, reached, felt, understood. If we conceive of bodies as merely physiological organisms, subject to breakdown and repair, we miss all the joy our bodies can experience, claim, and reclaim. Our bodies are the repositories for memories, fears, secrets, hopes, and dreams. If you touch me in my secret places, will I lie to you? Will I lay myself bare and let you feel my joy? Why stop at orgasm when we can aim for ecstasy?

Maybe we really ought to consider learning from those who aim high—from those who aim to get all that they can out of their sexual encounters and refuse to settle for perfunctory sex. They aim to use sex as a vehicle for personal growth and transformation and interpersonal intimacy. If the means they use are outside the conventions and constraints of ordinary sexual relations, so too are their goals extraordinary.

Instead, we aim to return dysfunctional clients to a hypothetical, biological norm—a regression to the mean. We promote sexual safety and stagnation rather than risk the dangers of all-out eroticism. We stay away from the potentially volatile, even though that is where the power for sexual change and growth lies. The transformative power of the erotic (Helminiak, 2006; Kleinplatz, 1996a, 1996b; Kleinplatz, 2006; Morin, 1995; Ogden, 2007, 2008; Rofes, 1996) is largely absent from our discourse.

This is never more so than in the case of incest survivors. In the face of their history of suffering, we help them to endure sex better rather than transform their pain. Much of the clinical literature on child sexual abuse is filled with cases of low sexual desire. Similarly, much of the literature on low desire is linked to histories of child sexual abuse. In the treatment of incest survivors, their sexuality seems almost an afterthought. We are to focus on anger, betrayal, trust, powerlessness, guilt, etc., but dealing with the client's sexuality is hardly a priority. Perhaps it is assumed that once all the other (presumably underlying) issues are dealt with, sexuality will take care of itself. Sometimes that is exactly the case. (The omnipresent assumption that sex is a natural

process that will assert itself once impediments to its expression are removed pervades even the incest literature.) However, in other cases, the client deals with all other issues and still feels no sexual desire.

Survivors are wounded in their sexuality. Common attempts to deal with sexuality in therapy aim to reduce clients' anxiety by heightening control. Therapists often support survivors in circumventing the triggers (i.e., setting, timing, positions) for flashbacks. However, this is not a solution; it is a way of not dealing with the problem. Each time some concession is made, another need for accommodation becomes salient: Kisses must be dry; no wetness is allowed; no moaning and groaning or other spontaneous exclamations of sexual passion. There are ways, of course, to avoid evoking the bad memories, but not without evoking a sense of the sexual world having been diminished, narrowed, in the name of taking control over the past.

But what if the survivor is seeking freedom from the past? What if he/she does not want to exist in a world that is no longer dangerous—it is now dreadfully safe—but is not yet free? In the name of empowerment rather than only control; in the name of freedom, not safety; and in the name of eroticism rather than tolerable sex—there is an alternative. What if we, as therapists, accompany the client to precisely the places where it hurts and touch them, stroke and play with them until they provide an avenue toward transformation? Why not use the power embedded in these memories to open a pathway to change and erotic freedom? Then the solution may involve going directly into whatever scares her and confronting it fully rather than avoiding it (Mahrer, 1996/2004, 2002, 2007, 2009).

> Ms. Walsh presents for sex therapy with anorgasmia and a history of incest. She has been in various forms of therapy for 15 years. During this time, phobias seem to dominate increasingly large chunks of her life, becoming debilitating and narrowing her world along the way. The goals of therapy had been to deal with the effects of the abuse on her sexuality and to produce orgasms. It had also involved traditional cognitive-behavioral exercises designed to treat anorgasmia. The problems persisted because the goals (and methods) aimed merely to make sex possible (i.e., mediocre) rather than to create an avenue for healing and the full flowering of her own eroticism. The guiding assumption had been that the incest had left her afraid, unable to let go, even or especially in bed. Making her surroundings and sexual relations increasingly safe had become stultifying rather than liberating. It is only by entering her inner world that we discover that it is not the victimization per se that stands in her way. It is the unacknowledged, buried peace she experienced after each assault ended, when she lay with her ear against his chest, feeling the peace of listening quietly to the rhythm of his heartbeat as it slowly

> returned to normal, feeling the safety in being Daddy's little girl again and the certainty that all was well in the world. It is when she begins to tap into the powerful, life-affirming memory of intimate connection in an absurd, horrific context that she is enabled to reappropriate her own sexuality. As a consequence, her world begins to open with sexual and other choices, and she is freed to experiment with new options, springing from within.

The alternative to promoting safely mediocre sex is to go to the core of our clients' pain and joy, the sources of hope and despair, and to aim for optimal and transformative sexual experience.

Sex Therapy Opts for Controlling Paraphilic Behavior Rather Than Aiming for Fundamental Changes in Desire

For the last 25 years or so, the major approach to the treatment of the paraphilias has involved pharmacologic treatment, primarily with anti-androgens and the SSRIs (selective serotonin re-uptake inhibitors) in combination with cognitive-behavioral therapy. The goal of such treatments is to control the unacceptable behavior and to reduce the frequency of the associated impulses or compulsions. The individual is taught to keep the fantasies at bay and to stay away from whatever stimuli might trigger his/her (typically his) behaviors. The pharmacologic component is intended to lower his overall level of sexual desire or response. In parallel with the treatment of sexual dysfunctions, the prevailing treatment approach to the paraphilias targets the symptom while leaving the source of the problem unexplored. The focus is on reducing the impetus to act on unacceptable urges, but the nature of the desires themselves is left unchanged. A series of review articles on the treatment of the paraphilias cites reports of patient non-compliance, high dropout rates, long-term treatment failures, and the need for treatment to continue indefinitely, if not life long (Berlin, Malin, & Thomas, 1996; Gijs, 2008; Gijs & Gooren, 1996; Greenfield, 2006; Guay, 2009; Rice & Harris, 2003). These difficulties may be related to the emphasis on behavioral management rather than profound change in the underlying fantasies.

The longer fantasies are hidden away and kept remote from conscious exploration, the more monstrous, dangerous, and taboo they seem to become When they are kept distant, they become increasingly ego alien, removed, strange. Unfortunately, this may be the result of the conventional attempts at containment of paraphilic desire. The paradox is that for as long as therapists (or their patients) do little more than attempt to keep symptoms in check, they grow like mushrooms in the dark. To the extent that we are successful in controlling behavior, we may help to fuel the alienation from within and thereby make the sexual desires, shrouded in secrecy, seem more compelling and menacing. It is only by entering into the heart of it that there may be

any hope for transformation. The closer one gets to it, the more it becomes understandable, takes on a human face and softens, becomes less obsessional in character, less burdensome and frightening, and instead, more friendly and alive, albeit no less intense.

Certainly, as a society, we are entitled to deem certain conduct unacceptable. Those who engage in such behaviors, particularly when they violate others' rights, are to be incarcerated. However, as therapists, we can go beyond attempts to regulate behavior. Instead, we can help individuals who so choose to change their underlying desires. Such a goal involves more fundamental shifts than merely reducing the frequency of the fantasies or even their intensity or the ability to enact them. Interestingly, recent evidence suggests that new alternatives are emerging in the treatment of high-risk sex offenders that involve more substantive personality change and a new focus on well-being and community support rather than isolation (e.g., Marshall, Marshall, Serran, & O'Brien, 2011; Wilson, Cortoni, & McWhinnie, 2009). Strikingly, none of these new alternatives originate from sex therapists. (For an illustration of fundamental change in a priest, previously diagnosed as a pedophile, see Chapter 14.)

The alternative to aiming merely for containment of the paraphilic symptom involves fundamental change in the client's desires. Paraphilias involve highly stigmatized and often illegal behaviors; by fostering deep-seated change, the therapist is better positioned to support the client without acting as an agent of social control.

Why Not Just Do What Works? What's the Catch?

If the PDE-5s (phosphodiesterase type 5-inhibitors) and vaginal dilators work, why object? These treatments have been proven to be highly effective, at least short-term, in reducing or eliminating the symptoms of erectile dysfunction and vaginismus, respectively. A useful tool is just that—a fine thing to have available in our arsenals. Whether and when to use these tools is a decision to be made by clinicians and their clients.

It is a question of which approach would this individual or couple find most helpful in meeting his/her/their wishes. These wishes may very well be for symptom reversal or control, in which case either brief, cognitive-behavioral treatment or medical intervention may well fit the bill. However, if we present our patients with only these options, we may well miss those who seek entirely different kinds of resolutions to their problems. Perhaps they would prefer to refrain from intercourse, or to refrain from sex with their current partner(s); perhaps they prefer same-sex partners or a time of celibacy; perhaps they would prefer to be assertive enough to decline sexual intercourse verbally and directly rather than with their seemingly uncooperative bodies; perhaps they would prefer to focus on the dysfunctional relationship, in which case "normal" sexual functioning would constitute a betrayal of the self; or perhaps they would prefer to use the symptom, regardless of its origins,

as an opportunity for individual or interpersonal growth—to deepen the relationship or to heighten the chance for inner change, or to optimize sexual (or other) potential. Not all patients would choose to avail themselves of these options. Some just want the symptom to go away. That choice deserves to be honored. But it is not much of a choice if it is the *only* possibility offered. We owe it to our patients to present them with more and, for some, better options.

It is incumbent upon us to put forth alternative, broader agendas that aim to keep the best possible solutions and most satisfying outcomes at our disposal. Otherwise, we will lose access to the highest goals when they are most appropriate.

A New Direction: Promoting Optimal Sexuality

What might an alternative set of goals include? What kind of objectives might we aspire toward? Is it only our patients who dream about the farther reaches of human erotic potential? In the years since the first edition of *New Directions in Sex Therapy*, I have continued to wonder about the farther reaches of human erotic potential. As such, my research team and I have devoted the intervening years to the study of optimal sexuality (Kleinplatz, 2006, 2010a, 2010b; Kleinplatz & Ménard, 2007; Kleinplatz, Ménard, Paquet, et al., 2009; Kleinplatz, Ménard, Paradis, et al., 2009). As a field, sex therapy has spent considerable time and energy focused on the assessment and treatment of sexual psychopathology with little understanding of the entire spectrum of sexual possibilities. Even our understanding of "normal" sexuality has been limited to physiological models of sexual response. We have had virtually no idea of what we might aspire toward as lovers and as a field. That has left the lay public open to the distortions and unrealistic expectations found in the mainstream media and in pornography. Our clients often seem unaware that they are viewing entertainingly pure fiction.

In order to fill this lacuna, we endeavored to discover the components of optimal sexuality. We interviewed "key informants", that is, individuals who had experienced wonderful, memorable sexual intimacy over the course of a lifetime to find out about the nature of such experiences and whatever lessons we might learn from these experts (Kleinplatz, 2010b; Kleinplatz & Ménard, 2007; Kleinplatz, Ménard, Paquet, et al., 2009; Kleinplatz, Ménard, Paradis, et al., 2009). Eight major components were identified (Kleinplatz, Ménard, Paquet, et al., 2009). Optimal sexual experiences involved:

1. Being present, focused, embodied, and utterly immersed in the experience
2. A sense of connection, alignment, being in synch, merger with the partner
3. Deep sexual and erotic intimacy characterized by mutual respect, caring, genuine acceptance
4. Extraordinary communication, heightened empathy, and sensitivity

5. Interpersonal risk taking experienced as an adventure, a journey, an ongoing exploration
6. Authenticity, being genuine, uninhibited, transparency
7. Being vulnerable, getting "swept away", reveling in the sensation, and surrendering to the partner
8. A sense of transcendence, bliss, peace, awe, the feeling of utter timelessness in encounters that had been transformative and healing

Just as interesting were the two minor components, characterized as such because they were mentioned by only a minority of participants and were not emphasized or valued to the same degree as the major components: intense physical sensation and orgasm and secondly, lust, chemistry, attraction. Such findings turn our understanding of sexual relations on their head, let alone the caricature of them put forward in mainstream depictions of hot sex.

One of the major lessons was that optimal sexual experiences in no way resemble functional sexual interactions. Participants were dumbfounded when we asked about the role of sexual acts and activities in optimal sexuality, as if they were incredulous at the irrelevance of the question. Although sexual functioning is expected for ordinary sexual activity, it is neither necessary nor sufficient for extraordinary sex. That is at least, in part, because it is not sexual "acts" that make for optimal sexuality, but rather one's way of being with partner(s).

Can sex therapists aspire to help those couples who are so inclined to reach these heights of erotic intimacy? Is it even possible? The good news is that in interviewing research participants about how they came to have extraordinary sexual experiences, each of them pointed out that the capacity did not spring fully formed in their youth but was acquired over time. None was born a "great lover". It required significant time and devotion for them to develop their potentials (Kleinplatz, 2010b; Kleinplatz, Ménard, Paradis, et al., 2009). It also necessitated jettisoning everything they had learned about sex while growing up in order to discover themselves anew in sexual encounters. Existing myths, often subtly reinforced by the methods, goals, and criteria for effective outcome in conventional sex therapy—including "sex should be natural and spontaneous", "real sex means intercourse", and "sexual satisfaction requires orgasm"—had to be discarded in order to revision themselves in sex. New, personalized visions of sexuality ultimately replaced the old one-size-fits-all norms that had never actually fit at all (Kleinplatz, 2010b). We, too, will need to examine and reject conventional notions about sexuality and sex therapy if we are to find ways to facilitate clients' attainment of their erotic potentials.

Is it *necessary* that we help couples aim beyond normative functioning? The answer may be embedded in the consequences of "success" in treating sexual dysfunctions. Rather quickly after Viagra™ was touted as a miraculous cure for erectile dysfunction, articles began to appear on patient non-compliance

(Althof, 2002; MacMahon, Smith, & Shabsigh, 2006; Perelman, 2000). Or as McMahon and colleagues noted (2006, p. 589), "Regaining potency does not necessarily translate into resuming sexual intercourse." A surprising number of prescriptions were never filled or refilled. This was not surprising to those of us who had seen women previously treated "successfully" for vaginismus (i.e., they were enabled to open and close their vaginal muscles around phallic-sized objects on command), yet they, too, showed little interest in intercourse. Or to put it more broadly, when the symptom of sexual dysfunction is eliminated/remedied only to be replaced with the new sexual desire "disorder", it is time to question what sort of conception of sexuality the clinician had prescribed and how it differed from what the patient may have envisioned. If we are to cease *generating* low desire in the course of our treatments, it will indeed be necessary to augment our visions of sexuality and aim for optimal sexual intimacy instead (Kleinplatz, 2004).

More importantly, what sort of picture of sex are we purveying in general? And what is the role of this picture in our well-known lack of effectiveness in treating the pervasive presenting complaint of low sexual desire? In 2008, Corty and Guardiani found that sex therapists considered 3–7 minutes of intercourse "adequate" and 7–13 minutes "desirable". By contrast, in our research, participants conceptualized their optimal sexual experiences quite differently from the sex therapists but in similar terms with one another: The same eight components described almost universally among individuals of different vocational and educational backgrounds, sexual orientations, and relationship histories. The sole outliers were sex therapists. We had interviewed sex therapists to flesh out development of the new model of optimal sexuality. Their perceptions were more negative, more focused on the role of erections, intercourse, and orgasm; highlighted differences, rather than similarities, between men and women; and were far less likely to value interpersonal risk taking during sex (Kleinplatz & Ménard, 2007; Kleinplatz, Ménard, Paquet, et al., 2009). (Yes, I know, some of my best friends are sex therapists, too.)

If we are to be effective in working with low sexual desire, we will need to acknowledge that the sex our patients are having is often dismal, disappointing, and lackluster (Kleinplatz, 1996a, 1996b, 2006). Rather than treating their desire "disorders" by encouraging them to lower their expectations, we will need to acknowledge that their low desire may be evidence of good judgment (Kleinplatz, 1992, 2010a). We will need to encourage them *not* to proceed with "sex" until they are full of desire (Kleinplatz, 2006, 2010b). Correspondingly, we will need to shift discussion of low desire with our patients and in the literature from counting frequency to evaluating quality.

If clients truly wish to experience "sex worth wanting", therapists need to aim much higher than merely returning their clients to adequate physiological functioning (Kleinplatz, 2001, 2006; Schnarch, 1991, 1997; Shaw, 2001). The new direction involves learning from the experts (c.f., Mahrer, 2008, 2009)

how to aspire toward and attain deep empathic connection, desire for and during sex, and ecstasy. We can help encourage clients to continue exploring one another emotionally and erotically that so that sexual intimacy cannot help but be exciting. By being vulnerable and authentic, embodied within and engaged with one another, the benefits may well be unlimited.

Conclusions

The focus of sex therapy is on sexual functioning/dysfunction and behavior rather than subjective experience. The predominant goal of our work is eliminating or controlling symptoms rather than understanding the person within, aiming for deep-seated change and enabling the individual to become all that he or she can be. We tend to settle for sexual mediocrity and stagnation rather than risking erotic transformation. Our field inadvertently maintains the status quo, supporting the conventional sex script by quietly treating its casualties, even though this set of norms engenders the sexual problems. Instead, we might intensify our work in social advocacy to change our public discourse, thereby preventing sexual problems. Sex therapists may wish to consider suspending the conventional objectives and to adopt an alternative set of goals. This would involve expanding our aims in depth; working with the whole person/couple, in breadth, for greater inclusiveness, and in height; and aiming for fulfillment of optimal erotic potential. A new direction could encompass learning how to help clients be fully present while engaged intimately, authentic while vulnerable, empathically and emotionally connected while taking interpersonal risks, and opening to ecstasy.

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