Sexological Systems Theory: an ecological model and assessment approach for sex therapy

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Current modalities of sex therapy, consisting of both cognitive-behavioral and systemic approaches, show moderate results. Yet the very fact that such results are at times inconsistent or incomplete indicates that something is lacking in treatment. The present paper suggests that such inadequacies may be a result of a lack of focus on all aspects of sexuality as biopsychosocially determined within current modalities. The Sexological Systems Model proposes sexuality as a developmental process similar to Bronfenbrenner’s Bioecological Systems Model. The Sexological Systems Diagram is introduced as an intervention for both assessment and psychoeducation for couples presenting for sex therapy. Information obtained through facilitating the Sexological Systems Diagram can be used by the therapist to determine the most appropriate treatment plan.

Keywords: sexual development; bioecological systems; sex therapy; Bronfenbrenner; marriage and family therapy; theory

Introduction

To date, human sexuality has been conceptualised in a myriad of ways. Whereas some authors focus on the description of the biological processes that occur over time (DeLamater & Friedrich, 2002), other researchers focus on the development of sexual scripts (Kimmel, 2007; Simon & Gagnon, 1986) or attitudes (Lefokowitz, Gillen, Shearer, & Boone, 2004), whilst still others focus on the life events that impact later sexual behavior (Sarwer & Durlak, 1996). In terms of environmental factors, DeLamater and Friedrich (2002) explain sexual development through the notion of the life stage conflicts defined by Erikson (1968) and they identify some of the interactional influences of parents on children’s developing sexuality. Also in terms of environment, Hogben and Byrne (1998) apply social learning theory to sexuality to suggest that an individual learns about sexuality through observing the interactions of others. Taken together, then, all of these differing approaches suggest that sexuality is determined by biological, psychological and environmental factors in combination.

Yet despite the fact that the research cited above indicates the need for a multifactorial approach to understanding sexuality, a comprehensive explanation for the development of sexuality, engulfing all of the psychological factors, life cycle stages and environmental influences, is lacking. Whilst some researchers have
applied a biopsychosocial approach to identify the many influences on the etiology of sexual dysfunction (e.g. McCabe et al., 2010), there has been a persistent failure in recognizing that sexuality encompasses more than just sexual behaviors. Sexuality, as defined by Weeks (2010), is a “product of social and historical forces . . . which brings together a host of different biological and mental possibilities, and cultural forms – gender identity, bodily differences . . . erotic practices, institutions and values” (p. 8). Thus, the development of one’s sexuality is the result of biological and psychological processes that are enacted within a socio-cultural context, which, in turn, shapes its expression.

Recent literature in the field of sex therapy (e.g. Leiblum, 2007) has advocated an integrated approach to the treatment of sexual problems. Undoubtedly, many clinicians already employ a comprehensive approach to treatment; however, an inclusive structured approach has not yet been formalized (Leiblum, 2007, p. 11). Attempts to develop such an approach include the Intersystems approach (Weeks & Treat, 1992), which aims to assess and treat the systems that might be impacting the onset, maintenance and/or resolution of the problem. This approach describes the process of assessment through which biological and psychological factors pertaining to the individual are explored as well as relational, familial, social and cultural factors (Hertlein, Weeks, & Sendak, 2009). Although holistic, however, the Intersystems approach fails to offer a cumulative perspective of all the impacting systems on sexuality. With this failure in mind, it is the goal of this paper to meet the need for a comprehensive model that explains the development of sexuality and sexual dysfunctions in an attempt to formalize the assessment and treatment of sexual issues. In addition, we propose an assessment and intervention tool that attempts to facilitate the clinical assessment and the creation of a treatment plan. The model we propose is based on Bronfenbrenner’s (2005a, 2005b) Bioecological Systems Theory (BST). In 1977, Bronfenbrenner explained the basis of human development in a model that he coined as Ecological Systems Theory (EST). This model was later expanded to incorporate biological processes and became known as the BST. These two models may be discussed interchangeably throughout this article, as various ideas were presented throughout the theory’s development from the EST (Bronfenbrenner, 1977, 1986a, 1986b) to the BST (Bronfenbrenner, 2005a, 2005b).

Bronfenbrenner’s model is a process-person-context-time model. In this model, in order to obtain an accurate understanding of human development, one needs to understand the dynamic relationship of individual and context, the person with their biological, cognitive, emotional and behavioral characteristics, the context or systems and the time, which is defined as an ontogenetic, family and historical time (Bronfenbrenner, 2005a, 2005b).

The EST (Bronfenbrenner, 1977, 1986a) conceptualizes human development as a product of a dynamic and reciprocal interplay of systems. These systems are known as the microsystem, mesosystem, exosystem, macrosystem and chronosystem. The EST (Bronfenbrenner, 1977, 1986a, 1986b) has been previously linked to sexuality to explain adolescents’ sexual risk behaviors (Meade & Ickovics, 2005). In creating our proposed model, we took into account the EST and BST to explain the types of influences experienced by individuals and how these impact sexuality, sexual behaviors and the onset, maintenance and resolution of sexual dysfunction. The components of EST and BST are now more thoroughly explained in turn, with direct application to sexuality with the aim of developing from Bronfenbrenner’s account a Sexological Systems Theory.
Sexological Systems Theory

Following is a description of the factors that might impact human sexuality, as conceptualized through Bronfenbrenner's EST. It is important to recognize, however, these factors are illustrative and do not represent the entirety of factors that might influence sexuality.

Microsystem

A microsystem is any environment that directly contains the developing individual. A microsystem can be interactions with a daughter/son, sister/brother, friend or partner and includes the tasks that one performs in relationship with those people (Bronfenbrenner, 1977). There are innumerable microsystems that form throughout an individual’s life. However, certain microsystems have been identified as heavily influencing the development of sexuality, including the family (Fisher & Pollack, 1982), peers (Kinsman, Romer, Furstenberg, & Schwarz, 1998) and biology (Hertlein, Weeks, & Gambescia, 2009).

Microsystem interactions do not always directly relay information about one’s sexuality, but may involve issues including sexual desire, sexual ideals or morality. Interactions within a microsystem can also create stress, which might impact sexual desire (i.e., high couple conflict may lead to a decrease in sexual desire in one of the partners, which may in turn create more stress). Sexual dysfunctions of the acquired or situational types may develop due to interactions with another individual, especially with a sexual partner, but a lifelong type of dysfunction may have developed from very early interactions, including those with parents. In addition, microsystemic interactions promote the transmission of values about sexual behaviors. Experiences within each microsystem will contribute to the repertoire of personal scripts surrounding sexual behaviors.

Family

The family is a highly influential microsystem in terms of sexual socialization (Shtarkshall, Santelli, & Hirsch, 2007). Parents’ beliefs about sex are transmitted to children through exposure to parents’ attitudes about sexual behaviors and gender roles (Mischel, 1966; Thornton & Camburn, 1987). These ingrained messages might dictate how a person will act romantically and sexually with future partners, especially in terms of how they perform gender stereotyped behaviors within their sexual relations.

Parents’ communication of sexual values has shown to be determinant in children’s beliefs about sex (Fisher & Pollack, 1982) and adolescent’s sexual behavior (Romer et al., 1999). Adolescents who obtain sexual information from parents behave more conservatively (i.e., initiate sexual behavior at an older age) and are more likely to use contraceptives than those who receive information from peers (Fisher & Pollack, 1982; Lewis, 1963; Romer et al., 1999).

Peers

Peers play an important role as influences of sexual behavior, including impacting an individual’s decision whether or not to have sex. Perceived norms are often communicated through a network of peers which influences the sexual behavior of
adolescents (Buhi & Goodson, 2007). Those adolescents who perceive that their friends are not sexually active tend to not be sexually active either (Kinsman et al., 1998). Furthermore, normative sexual behavior among friends predicts the initiation of first intercourse during the middle adolescent years (Sieving, Eisenberg, Pettingell, & Skay, 2006). Adolescent beliefs about their friends’ values regarding sex are more important than the friends’ reported attitudes about sex. It seems that the perception of gaining friends’ respect influences the choice to engage in sexual activity or not.

**Partner/s**

Partners impact perspectives about sexuality and sexual behavior. Experiences with a partner will create a repertoire of how to behave within an intimate relationship. The quality of these experiences has a direct impact on the sexual satisfaction experienced with one’s partner/s (Holmberg & Blair, 2009). Thus, positive intimate and sexual experiences with a partner might influence the individual’s outlook on their own sexuality and the couple’s sexuality. Sexual communication with a partner is positively correlated with sexual satisfaction (MacNeil & Byers, 1997) and schemas formed in a current relationship will influence beliefs about sexuality, therefore impacting future sexual relationships (Davidson & Darling, 1988).

**Biology**

The impact of biology upon one’s sexuality can be characterized as a predisposing factor that influences an individuals’ sexual interest and sexual response. Examples of predisposing factors are genetic, hormonal regulation and vascular and neurological characteristics (Althof et al., 2005). In addition, sexual encounters can create a learned response as experiences become classically conditioned (van Lankveld et al., 2006). This can result in a biological response (e.g. contractions of the vaginal muscles) or psychological response (e.g. a woman will not allow touch in a specific area). Moreover, traumatic sexual experiences (e.g. humiliating first intercourse) can also impact one’s sexual behaviors (Althof et al., 2005). Therefore, both biological and psychological processes are closely linked to sexual behavior. The impact of predisposing factors on the sexual cycle is largely unknown, yet research has shown that it can enhance or hinder sexual performance and satisfaction (Althof et al., 2005).

Still within the biological milieu, precipitating and maintaining factors can impact sexual desire and arousal such as medication (Hertlein, Weeks, & Sendak, 2009) and psychogenetic disorders (e.g. depression [Althof et al., 2005]).

**Mesosystem**

A mesosystem is composed of the interactions that take place between the microsystems within an individual’s life (Bronfenbrenner, 1977). As multiple microsystems have impacted the development of an individual’s sexuality, two individuals engaging in sexual behaviors do not exist in isolation. Instead, the sexuality of each partner blended together becomes a mesosystem. Although the couple may be one microsystem, their sexuality as a couple should be considered a mesosystem.

Patterns of behavior are reinforced by experiences in school, with friends and within other systems. The mesosystem of sexuality also includes stressors which impact the sexual microsystems (e.g. sexual desire). Some sexual dysfunctions of the
acquired type may develop due to outside stressors which are not directly involved in the sexual interactions. For instance, stress has a direct effect on sexual desire, but not necessarily in genital responsiveness. Many variables can affect the quality of the couple’s interaction such as toxic pollutants, diet, stress, as well as social, situational and cultural factors (Bancroft, 1993).

**Exosystem**
An exosystem includes institutions that influence an individual’s daily settings but are not part of the individual’s immediate environment (Bronfenbrenner, 1977). The exosystems of sexuality have stirred a public debate over the propriety of sex education (Olsen, Weed, Ritz, & Jensen, 1991) and the ethics of providing or allowing contraception (Pinney, Gerard, & Denney, 1987). Exosystems, including the media, also impact sexuality by promoting a dramatized depiction of sexually active individuals (Ward & Friedman, 2006).

**School system**
When available, sex education in schools is often the first time that many individuals receive factual information regarding sex. The different approaches to sexual education influence the attitudes that children have toward sexual behavior (Olsen et al., 1991). Consequently, various modalities of sex education have been shown to impact views about sex, marriage and condom use (Rogow & Haberland, 2005). The quality of sex education and the knowledge received can shape sexuality either positively or negatively (Rogow & Haberland, 2005). For example, some sex education programs operate on an abstinence-only basis and do not teach about contraception or safe sex practices. For those students who end up sexually active, not knowing this information can lead to negative consequences and therefore negative sexual experiences. For others, learning this information may lead to positive and responsible sexual choices and therefore positive eventual sexual experiences.

**Healthcare and community**
The effectiveness of contraception has been proven to be a contributor in (primarily heterosexual) women’s sexual satisfaction (Pinney et al., 1987) due to sexual pleasure often being affected by a preoccupation with negative consequences of unprotected sexual activity, such as a pregnancy. Therefore, having reliable contraception often removes worry which may block sexual pleasure. Access to contraception for women is often a matter of availability of healthcare depending on the resources available, including the school system, community family planning clinic, private physicians or Planned Parenthood organizations. If these resources are not available through the community or healthcare system, it can impact sexual choices and sexual development.

**Media**
Many people receive a large amount of sexual knowledge through the media. The media frequently depicts sexual encounters as excessively passionate and erotic,
which is known to increase the amount of anxiety associated with sex (Cook, 2006). The misinformation found on television and/or magazines can also leave individuals feeling as though they are sexually defective (Kim & Ward, 2004).

Adolescents often cite the media as the second largest source of information they receive about sex, behind their peers (Ward & Friedman, 2006). Individuals who reported using television for companionship were likely to agree that sex is recreational, that men are sexually driven and that women are sexual objects (Ward & Friedman, 2006). Exposure to unrealistic views of sex and sex roles might have negative impact on sexual development.

**Macrosystem**

Some of the prevailing beliefs and messages regarding sexuality come from the much larger systems operating in society. These broader influences are called the macrosystem. A macrosystem is comprised of cultural and societal principles which create contexts and patterns within the outmost setting (Bronfenbrenner, 1977). Since the macrosystem is present and influential from birth, it is expected that it is a prevalent factor in the formation of lifelong or generalized types of sexual dysfunctions. Its impact might not be as explicit as are other systems, however. As society evolves, it continues to dictate values and ideals concerning sexuality, namely ideas about (ab)normal sexual practices (e.g. BDSM behaviors being considered a sexual disorder in the DSM-IV-TR: American Psychiatric Association [APA], 2000). Additionally, cultural differences in how people express sexuality constitute a macrosystemic influence implying the necessity of identification of specificities of sexual development in cultural minorities (Leiblum, 2007).

**Gender**

One of the most salient aspects of how the macrosystem affects sexuality is through gender role socialization. Gender is socially constructed and gender roles serve to guide men and women about what is expected of them, including sexually. Gender role socialization is pervasive throughout the life cycle and often begins before a child is born. Gender roles can greatly influence the development of sexual schemas, sexual scripts and overall sexual functioning (Hynie, Lydon, Coté, & Weiner, 1998).

In the USA, socio-sexual norms dictate that men should pursue sex under all circumstances and women should participate in sexual encounters for emotional or relational reasons, but resist encounters that will not fulfill those needs (Hynie et al., 1998). Internalizing these scripts can lead to various outcomes, such as a woman feeling guilty or shameful if she engages in casual, non-relational sex or a man engaging in certain activities to prove his masculinity to himself or others. Another example of gender roles is that autonomy is seen as a masculine trait, while communication and a relational focus are associated with females. By applying these gender roles to sexuality, typical beliefs are that men tend to be proactive and assertive during sex, while women adopt a passive role; however, if either wanted to adopt behavior that is associated to the other gender, it might create a sense of discomfort if they think they are going against their gender expectations. Due to a gradual change of roles in society, sex scripts have also adjusted and will most likely continue to do so. Women today may feel more able to be sexually assertive and expressive than they were in the past (Siegel, 2001), for example, a study conducted
by Saunders and Kashubeck-West (2006) found that women who self-identified as having a feminist orientation generally displayed more androgynous or stereotypically masculine traits, which may improve sexual satisfaction or lead to a more positive body image for women.

Culture/ethnicity

Culture provides general guidelines regarding all aspects of sexual behavior, including who it is acceptable to be attracted to, how sexual relationships should be and the appropriate time and places for sexual activity (Hynie et al., 1998). Cultural messages regarding sexuality are often passed down to children from parents who learned them from society and culture.

Religion

Many of the dominant values surrounding sexuality in the USA stem from various religious traditions. Despite religious orientation, most have rules regarding which context sexual intercourse is appropriate and for what purpose. Many faiths do not approve of sex before marriage, homosexuality or sex outside of procreation purposes, which, in turn, affects the premarital sexual behavior of young adults (Uecker, 2008). Religious beliefs may enhance sexuality or detract from it. For example, an individual may experience sex guilt if an individual participates in sexual practices outside the framework of what is approved by their faith tradition (Cowden & Bradshaw, 2007).

Chronosystem

The Chronosystem involves temporal changes, or changes throughout the lifespan, that influence a person or their environment (Bronfenbrenner, 1986b). These temporal changes can be any change related to the lifecycle including age at sexual initiation, menopause, aging children, aging parents etc. The chronosystem is unique in that it contains the entire set of systems in a person’s environment and also encompasses life events that either impact one’s desire and psychological processes surrounding sex (e.g. abortion or miscarriage) or directly impacts their experience of sex (e.g. sexual abuse). Sexual abuse can be a chronosystemic influence on sexuality. Depending on the developmental stage of the victim and the duration of the abuse, the degree of dysfunction will vary (Hartman, Finn & Leon, 1987; Phillips-Green, 2002; Rudd & Herzberger, 1999). The emergence of sexual dysfunction (e.g. whether lifelong or acquired type) can be related to the time line associated with sexual initiation and behaviors.

As a couple, for example, begins to share and merge their lives, their shared chronosystem also begins to merge. The chronosystem continues to change and evolve over time. The sequential order that each system influences a person’s life will modify the sexual scripts they ascribe to. For example, a child who is warned by their parents that sexual intercourse is “bad and dirty” prior to receiving a biological approach to the sex education may not absorb the message about sexuality as a natural process.

Initiation into sexual behaviors emerges at different times, depending on a variety of factors, and can be the result of experimentation or forceful coercion, whether
physical or psychological. Young children commonly discover the pleasure associated with touch of their genitals and will continue to do so at the dismay of their parents; boys generally start this practice before girls (Oliver & Hyde, 1993). Earlier onset of coitus is related to less sexual dysfunctions later in life (e.g. erectile dysfunction or anorgasmia) more so for the male population (Koch, 1988).

**Rationalization for use of sexological systems**

When a couple or collective (in the case of polyamorous relationships) presents for therapy, they may pinpoint the relationship/s or sexual relationship/s as being the presenting problem. Due to this, the therapist may often conceptualize and treat the presenting problem as a microsystem, with a main focus of therapy being the relational interactions. However, sexuality can never be separated from current and previous sexual influences and interactions. We suggest an approach to sexual problems based on our model, Sexological Systems, in which the sexual relationship is conceptualized as its own systemic structure that interacts along with all of the different systems referenced in the (Bio)ecological Systems Theory (Bronfenbrenner, 1986a, 2005a) (see Figure 1).

Historically, behavioral approaches (i.e., sensate focus) have been the preferred treatment of sexual dysfunction (Masters & Johnson, 1970). The use of primarily cognitive-behavioral treatments for sexual dysfunctions (e.g. vaginismus) has shown success rates as low as 14% (van Lankveld et al., 2006). Moreover, behavioral interventions that are prescribed are often incongruent with religious beliefs (McCarthy, 1995) an example being the prescription of masturbation. Behavioral therapy involving one partner who is not committed or comfortable with sexual techniques can be counterproductive to the progress of the relationship and even detrimental to their self-image and levels of anxiety. As McCarthy (1995, p. 38) notes:

Cognitive-behavioral sex therapy is most efficacious with primary sexual dysfunctions; where there is a lack of information or self-defeating attitudes; with committed couples; with single people who are open to masturbation retraining, fantasy rehearsal, and social skills interventions; with couples motivated to implement sexual exercises and function as an intimate team; with patients who are comfortable with a gradual, step-by-step approach to change; or with a specific sexual dysfunction.

![Figure 1. A couple's mesosystem of interacting sexological systems.](image-url)
Sex therapies that focus treatment on few of the systems described above that
influence sexuality find only moderate success rates (Hawton, Catalan, Martin, &
Fagg, 1986; Hawton, Catalan, & Fagg, 1992, 2005; Sarwer & Durlack, 1996; Wylie,
1997). Considering the numbers of patients for whom treatment is not successful, there
may be a more effective approach to the treatment of sexual problems in therapy.

The systemic treatment of unconsummated marriages, or relationships involving
disorders such as vaginismus, has proven to be a more efficacious approach (Gindin &
Resnicoff, 2002). For this reason, systemic approaches (e.g. Intersystems approach)
for the treatment of sexual dysfunction is suggested as a complement to the use of
behavioral approaches, including sensate focus (Hertlein, Weeks, & Gambescia, 2009).
As previously mentioned, systemic approaches to the treatment of sexual dysfunctions
aim to include diverse information from the many systems conceptualized in
Bronfenbrenner’s BST. Although many therapists undoubtedly focus on the impact
of diverse systems in case conceptualizations and treatment plans, some systems
influencing sexual development and dysfunction may be overlooked.

Yet despite the utility of incorporating a systemic approach, empirical evidence
for the efficacy of systemic sex therapy has scarcely been published and literature
regarding this consists of primarily case studies (Hertlein, Weeks, & Gambescia,
2009; Hertlein, Weeks, & Sendak, 2009; McCabe, 1999). There are gaps in the
efficacy of current modes of sex therapy, justifying the need to continually seek to
expand treatment approaches. An approach incorporating and assessing all elements
of the Sexological Systems may prove to be effective, even though the treatment has
not been empirically tested at this time.

More recently, the Intersystems approach has been implemented within the field
of sex therapy and has proven to serve as an innovative and needed expansion to
case conceptualization and in organizing therapists’ assessment approaches
(Hertlein, Weeks, & Gambescia, 2009). Yet as Lowe (2010, p. 199) notes:

There is an implied presumption that if all these areas of assessment have been
adequately explored, there is a high probability that the subsequent treatment plan will
be successful. However, little specific instruction is provided to clinicians (or students)
on the step-by-step process of obtaining information in these various realms of
assessment.

Again, then, Sexological Systems theory is intended to expand further upon the
assessment process and include areas within the mesosystem, exosystem and
chronosystem of Bronfenbrenner’s BST. These systems host many other influencing
factors on sexuality, such as the timeline of events and interaction of the
microsystems, which is not encompassed within the assessment by the Intersystems
model. The Sexological Systems model helps to fill this gap in literature and provides
a more complete and specific approach in the assessment and conceptualization of
sexual problems.

Integration of the sexological systems

The Sexological Systems Diagram (Figure 1) can be used as both an assessment tool
and a psychoeducational tool for therapists and clients. The Diagram can be used in
sessions by having the client, couple or partners examine each system in their life and
identify influential aspects on their sexuality. The therapist facilitates this process by
introducing the diagram to clients and educating them about the systems and
providing examples in each system that may impact human sexuality (i.e., the macrosystemic impact of religious views on sex guilt). Utilizing the Sexological Systems Diagram assists therapists in case conceptualization and informs them which treatment modality to follow. Therefore, the diagram structures the assessment process, increasing the likelihood that a complete history will be taken and used to inform the therapist’s approach to treatment. Some sexual difficulties may not require as extensive assessment as other complaints, so this process can be modified depending on the information the clients share. The presentation of the Sexological Systems Diagram is an idealized example and flexibility on the part of the therapist is needed in order to adapt the intervention to various clients.

As mentioned, the Sexological Systems Diagram can also be used as a psychoeducational tool to highlight the multiple systemic influences on any person’s sexuality and sexual relationships. This is a pivotal step in the therapeutic process as it enhances the client’s understanding of the factors that might strain the relationship, leading to an increase of self-responsibility in and for the relationship. The accountability that each partner adopts dilutes possible feelings of self-blame experienced by the identified patient, which might be a powerful resource used by therapists to promote healing.

The Sexological Systems Diagram is a dynamic tool that can be used at various moments in the therapeutic process. Therapists and clients can always revisit the Diagram when new insights or improvements arise. Moreover, therapists explain to the couple that as they continue to have experiences with one another, their systems will continue to change and influence all of portions of their sexuality. Being in therapy itself is an example of a chronosystemic influence and interactions will occur in the therapy room that will affect the couple.

**Implementation within sessions**

In many cases, it is difficult for an individual to recall all of the relevant life experiences at a moment’s notice. Therefore, in order to gain full benefits from this intervention, the Sexological Systems Diagram should be ideally conducted in therapy in a two part process over a minimum of two sessions. It should be recognized, however, that this is an ideal and suggested administration of the intervention. There will certainly be cases where the formalized assessment process may not be necessary, such as when the effect on the presenting problem is apparent.

The therapist begins the intervention by presenting the diagram and educating the client/s that sexuality is formed through a developmental process and explaining how different interactions or experiences can impact overall sexual functioning. Then the therapist may start by introducing the Sexological System (e.g. starting with the microsystem, for example) explaining potential influences and giving examples of how they may be interacting. Examples of systemic influences are: one’s biology (i.e., microsystem), a parent (i.e., microsystem), sexual education at school (i.e., exosystem), religion (i.e., a macrosystem), media exposure (i.e., an exosystem) or abuse (i.e., chronosystem). After explaining these systems, the therapist introduces the idea of their sexual relationship interacting with all the other systems. This part of the assessment must occur in one session and be built in collaboration with the clients. At this time, the therapist does not begin discussing the particular influences clients. Instead, the therapist assigns a worksheet as homework to be discussed in the following session. Each partner is instructed to reflect on the influences that all the
systems had on his/her sexuality and write them down on the worksheet (see Figure 2 for worksheet example). The main purpose of the homework assignment is to help the clients actively consider and understand the multitude of influences they have on their sexuality. Each individual should conduct the homework independently, but they can discuss their findings once they have completed it.

In the following session, the therapist will re-introduce the concept of the Sexological Systems and again present the Sexological Systems Diagram. The therapist should begin discussing the systems with the asymptomatic partner or the partner with a lesser number of symptoms. This order will help the identified patient understand that others have also had influences on their sexuality and will normalize and externalize (White, 2007) the effects of sexual dysfunction, thus reducing blame or guilt. The influences should be discussed in the order, or chronosystem, that they occurred within the individual’s life. This order will help the couple to focus and better understand the development of their sexuality and the chronosystem in which they developed. The first effect on the person’s sexuality could be contained within any system. The therapist should stop the individual who is explaining their sexual influences at the point where their partner/s were introduced as a microsystem within their life and sexuality. At this point the therapist should move on to address the systems influencing the life of the partner/s. This order will help focus the clients and will help them better understand the progression of their sexuality and the chronosystem in which they each developed. Once all partners have reached the point at the relationship has become an influence, the therapist will begin discussing how the clients have influenced each other and how subsequent factors have impacted their sexual relationship (see Table 1 for possible questions during the assessment process).

It is fundamental for the therapist to acknowledged negative and positive influences on sexuality. It is easy within sex therapy to focus solely on the negative influences as they impact dysfunction, but they are not the only influences. It could prove to be empowering to place an equal, if not a higher, focus on the positive experiences.
Examining influences from all of the different impacting systems allows for the accentuation of also positive factors in the development of sexuality. A subsequent session could focus on processing each partner’s reactions to the intervention.

**Case study**

Peter, a 54 year-old man, has been married to Theresa, 44 years old, for 15 years. They have two children, a girl who is 14 years old and a boy, 10 years old. This is Peter’s first marriage and Theresa’s second marriage. The two started attending therapy citing marital problems, which the therapist discovered were related to their sex life. After two sessions with the couple in which the therapist focused on joining, the therapist educated the couple on the Sexological Systems Diagram and assigned them to complete their individual diagrams as homework prior to the third session. In the third session, the therapist had the couple present their individual diagrams and processed them in session. The following is a summary of what Peter and Theresa shared regarding their sexual history and current sexual functioning.

Two years ago, Peter started complaining of low sexual desire and erectile dysfunction (ED). He saw an urologist who referred him to sex therapy because organic causes of ED were ruled out. Peter has been laid off of work for five years. Four years ago, he decided to start his own business as a painter but the business has not been profitable. He feels guilty because Theresa had to get a job and feels that he is not able to provide for his family. Peter regrets not obtaining higher education

<table>
<thead>
<tr>
<th>Sexological system</th>
<th>Relevant question</th>
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| Microsystem        | • How do you know physically when you are aroused?  
                      • Did your parents see sexuality as a positive or negative part of life?  
                      • Were your peers sexually active prior to you, the same time or after? |
| Mesosystem         | • How have previous sexual relationships affected your judgment of your current sexual relationship?  
                      • Does stress impact your desire?  
                      • Has hearing about your peers’ sexual experiences impacted your evaluation of your own? |
| Exosystem          | • Was sexual education a part of your schooling? If yes, was it abstinence-only education or comprehensive?  
                      • Has contraception been readily available to you?  
                      • What messages have you received from music, movies or television regarding what your sexual life should be like? |
| Macrosystem        | • What are your sexual roles as a man/woman?  
                      • What makes someone an appropriate sexual partner? Who is it okay to be attracted to?  
                      • What did you learn about the initiation of sexual behavior? Is it okay to have sex before marriage or for pleasure? |
| Chronosystem       | • Have you ever experienced sexual dysfunction prior to now?  
                      • Is there a prior history of sexual abuse? If yes, how long did it last and what did it entail?  
                      • What was your first sexual experience? Was this positive or negative? What was your first positive (negative) sexual experience? |

Examining influences from all of the different impacting systems allows for the accentuation of also positive factors in the development of sexuality. A subsequent session could focus on processing each partner’s reactions to the intervention.

| Sexological systems assessment questions. |  
|------------------------------------------|---
| Microsystem                              |  
| • How do you know physically when you are aroused? |  
| • Did your parents see sexuality as a positive or negative part of life? |  
| • Were your peers sexually active prior to you, the same time or after? |  
| Mesosystem                               |  
| • How have previous sexual relationships affected your judgment of your current sexual relationship? |  
| • Does stress impact your desire? |  
| • Has hearing about your peers’ sexual experiences impacted your evaluation of your own? |  
| Exosystem                                |  
| • Was sexual education a part of your schooling? If yes, was it abstinence-only education or comprehensive? |  
| • Has contraception been readily available to you? |  
| • What messages have you received from music, movies or television regarding what your sexual life should be like? |  
| Macrosystem                              |  
| • What are your sexual roles as a man/woman? |  
| • What makes someone an appropriate sexual partner? Who is it okay to be attracted to? |  
| • What did you learn about the initiation of sexual behavior? Is it okay to have sex before marriage or for pleasure? |  
| Chronosystem                             |  
| • Have you ever experienced sexual dysfunction prior to now? |  
| • Is there a prior history of sexual abuse? If yes, how long did it last and what did it entail? |  
| • What was your first sexual experience? Was this positive or negative? What was your first positive (negative) sexual experience? |  

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when he was younger. He realizes he is getting older and thinks he has not accomplished enough in his life. Peter has also been suffering from depression and anxiety for five years and has been taking selective serotonin reuptake inhibitors (SSRIs) and anxiolytics since then. Peter believes that men ought to be highly orgasmic and are responsible for their partner’s orgasm every time, as portrayed in the movies.

Recently, Theresa has noticed a decrease in her sexual interest, but she still wishes to be close to her husband. Theresa has been suffering from depression for 17 years and has been taking SSRI’s for 10 years. Theresa has been preoccupied with a fear of becoming pregnant and her health insurance does not cover birth control at her age. In addition, Theresa’s parents are getting older and more dependent on her and she feels guilty because she cannot take care of them as she wishes due to the demands of her job. Theresa started this job two years ago due to family financial problems. She likes her job but she prefers to stay at home and spend more time with her family and Peter. In her previous marriage, Theresa had high sexual satisfaction with her husband.

The couples’ sexual activity has decreased substantially and they rarely have sex. When the couple came for therapy, Peter stated he would never have sex if it was not for his wish to please Theresa sexually. Prior to experiencing ED, Peter always initiated sex because Theresa thought it was the man’s responsibility. A year ago, on their anniversary, they tried to have sex. Theresa bought a sex toy hoping to turn Peter on, even though she felt very uncomfortable using them. They had some foreplay (kissing and hugging) and tried intercourse. Peter was able to have an erection but lost it because Theresa was not lubricated enough for penetration. They stopped the sexual activity immediately and since then they have not attempted sexual activity. The couple is highly religious and both were raised with strict moral values. Both of them are descended from Irish families and do not have a support network outside of their families of origin. Additionally, they have been concerned about their oldest daughter who has been a victim of bullying in school.

With the use of the Sexological Systems Diagram, the therapist was able to identify the systems affecting their sexual functioning (see Figures 3 and 4), and was able to inform her hypotheses pertaining to the case. In this scenario, the therapist chose to explore further the impact of culture, gender, the media and family life stressors. Additionally, the therapist chose to focus on their previous experiences with other partners and with one another and how it was affecting their interpretations of their current interactions. This multi-stage therapeutic process focused on each of their affecting systems. As a result, the couple was able to find ways to manage their stressors, understand better how their background and media exposure has affected their judgments of sexual behavior and how their experiences in the past affected what they currently judge as pleasurable. The couple was able to understand how the composite of influences has created their current sexual problems and was able to diminish the pressure that was created on them. They were able to manage their outside influences more appropriately and more successfully experience pleasure through sexual activity.

Discussion

Sexuality as a developmental process is similar to the development of an individual as a whole. This process of development can be described via Bronfenbrenner’s (1986a, 2005a, 2005b) BST. When assessing and treating sexual dysfunctions, the
Figure 3. Sexological systems diagram for Peter.

Figure 4. Sexological systems diagram for Theresa.
therapist benefits from a holistic perspective offered by the multiple systems in the Sexological Systems Theory, as it has the potential to integrate predisposing, precipitating and maintaining factors of dysfunction. Each of the systems is likely to have an effect on whether the sexual dysfunction is of the lifelong/acquired, generalized/situational and due to psychological/combined factors type (DSM-IV-TR: APA, 2000). For example, societal influences (i.e., macrosystemic influences) are present throughout a person’s life, so any dysfunction related specifically to that variable will likely be of the generalized and lifelong type. On the other hand, a partner (i.e., microsystem) and experiences with a partner (i.e., mesosystem) can emerge later in life and/or for a short period of time. For this reason, sexual disorders that emerge because of experiences with one’s partner are likely to be of the acquired and/or situational type.

An exploration of the multitude of systems influencing the sexual problem allows the couple to enlarge their understanding of the problem without blaming, which leads to an increase of self-responsibility in both partners for the resolution of the sexual problem. This experience is empowering as it depathologizes the sexual dysfunction and promotes a treatment based on understanding and not guilt.

The Sexological Systems Diagram, as outlined in this paper, was created as an intervention tool for the therapist to assess and educate their clients on the different impacting factors on sexuality. It can also aid the therapist in conceptualizing the multifactorial influences on the onset, maintenance and resolution of sexual dysfunction. By utilizing the Diagram early on within treatment, it will allow the therapist to construct a treatment plan that is customized to the clients’ current needs and experiences and may localize treatment to the most influential systems on the etiology of the problem. The Sexological Systems approach guarantees the assessment of diverse systems that might impact the sexual problem in a systematic manner. In addition, it is a culturally sensitive intervention, which promotes the discussion of these topics in treatment. This approach will be useful throughout couple therapy regardless of whether treatment is presently focused on sexual dysfunction.

Notes on contributors

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