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Solution-Focused Brief Therapy for the Treatment of Sexual Disorders

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The purpose of this article is to describe the use of solution-focused brief therapy (SFBT) as an approach to sex therapy. SFBT has been used to treat most clinical problems and populations, but until now has not been offered as an approach to sexual problems. This article describes SFBT and discusses its applications to sex therapy. A case example is included.

KEYWORDS solution-focused brief therapy, sexual disorders, sex therapy

The history of approaches to the treatment of sexual dysfunction has, for the most part, paralleled the theoretical models in popular use at the time (c.f. Wiederman, 1998). For the first half of the 20th century, sexual dysfunctions were treated with the prevailing psychoanalysis (Levine & Ross, 1977). As behavioral interventions started to appear in the mid-20th century, they began to be applied to sexual dysfunctions (e.g., Lazarus, 1963; Lazarus & Rachman, 1957; Wolpe, 1958), culminating with the major defining work by Masters and Johnson (1970). Since then, a number of other contemporary psychotherapy models and practices have been applied, including cognitive-behavioral therapies (e.g., McCabe, 2001); systemic therapies (e.g., Schnarch, 2001); medical treatments including prosthetics and medication (Leiblum & Rosen, 2001); and models integrating cognitive, behavioral, systemic, and medical (Weeks & Gambescia, 2000, 2002). Most recently, postmodern therapies, which are a paradigm shift from the problem-focused, label-dependent, and pathology-based therapies, have begun to be applied to helping clients with sexual concerns (Green & Flemons, 2007). Solution-focused therapy falls within this group.

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Solution-focused brief therapy (SFBT; deShazer, 1985, 1988, 1991, 1994; de Shazer et al., 2007) is a strengths-based, resiliency-oriented approach to psychotherapy. SFBT reverses the traditional psychotherapy interview process by asking clients to describe a detailed resolution of the problem that brought them into therapy, thereby shifting the focus of treatment from problems to solutions. This small but iconoclastic shift has resulted in an approach that has become increasingly popular all around the world and is used not only as a therapy approach but also in education (Franklin, Biever, Moore, Clemons, & Scamardo, 2001; LaFountain & Garner, 1996; Litrell, Malia, & Underwood, 1995; Springer, Lynch, & Rubin, 2000), business systems (Berg & Cauffman, 2002), social services (Berg, 1994; Pichot & Dolan; 2003), and a myriad of other areas that benefit from solution-building. Within the psychotherapy field, SFBT has been used to treat most problems and populations, including family therapy (e.g., Campbell, 1999; McCollum & Trepper, 2001), couples therapy (e.g., Hoyt & Berg, 1998; Murray & Murray, 2004), and treatment of sexual abuse (Dolan, 1991).

With SFBT being as popular as it is among clinicians worldwide, and with a solid and growing research base supporting its use for so many varied problems and clinical populations (see e.g., Lambert, Okishi, Finch, & Johnson, 1998), it is surprising then that only one article on SFBT for the treatment of sexual dysfunctions and disorders appears in the literature (Ford, 2006).

The purpose of this article is to describe the use of SFBT as an approach to the treatment of sexual dysfunctions and disorders. Because it is a positive psychology approach that is resiliency-based that corresponds well to the human sexuality experience, SFBT is an ideal approach to use as the general framework for sex therapy.

While many sexual concerns can be ameliorated with SFBT as the primary approach, other specific interventions, either behavioral or medical, can be integrated with SFBT. Working within the paradigm of SFBT, individual, couple, dynamic, family-of-origin, and other important elements affecting a relationship are addressed in sex therapy via conversations directed by the couple.

THE SFBT APPROACH

SFBT is a paradigm shift from the long-established focus in psychotherapy on problem formation and problem resolution. SFBT therapists focus instead on client strengths and resiliencies by examining the client’s previous

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1 It is common convention for sexual dysfunctions to refer to the physiological-response-based problems that occur along the sexual arousal cycle, such as erectile dysfunction or vaginismus; and for sexual disorders to refer to the myriad of other sexual problems, such as paraphilias, gender-identity disorder, and problems related to the “coming-out” process. We believe SFBT is an appropriate approach for the treatment of both of these classes of sexual problems.
solutions and exceptions to the problem, and then, through a series of interventions, encourage the client to do more of those behaviors. SFBT is future-oriented, and goal directed. And while SFBT is often identified with its innovative techniques, the real story of SFBT lies in the belief that clients know what is best for them and to effectively plan how to get there.

What follows is a brief description of the SFBT tenets and general and specific interventions, as applied to sexual problems (for a complete description of the theory and practice of SFBT in general, see de Shazer et al., 2007). Descriptions of how other systems, such as individual, dyadic, or family of origin, affecting couples are illuminated within this framework.

**SFBT Tenets**

**IF IT ISN’T BROKEN, DON’T FIX IT**

This is the major tenet of SFBT. As de Shazer puts it, “Theories, models, and philosophies of intervention are irrelevant if the client has already solved the problem” (de Shazer et al., 2007, p. 1). Sex therapists have long-recognized that many clients are doing quite well, and really only require short-term support or “permission” to continue doing or feeling what they are doing (Annon, 1976). It is very common in solution-focused sex therapy for clients to rate themselves quite high on their scale (see later) during the first session. To begin a full-blown sex therapy program would be inappropriate in these situations. Instead, offering compliments for the presession positive changes, support for their relationship, and encouragement for them to continue to do so well would be preferable and mostly likely lead to a brief therapy experience. To begin a session, a solution-focused approach would include inquiring into what the couple would like to maintain in their sexual and general relationship. At times, the couple will collectively identify behaviors, cognitions, and beliefs that both partners agree on that enhance their sexual relationship. Many times this includes descriptions of macro-systemic variables such as family-of-origin or dyadic issues.

**IF SOMETHING IS WORKING, DO MORE OF IT**

If the clients are already in the process of solving the problem, they need to be encouraged to do more of it. The SFBT therapist listens very carefully for examples of solutions to their sexual concerns, which are already occurring, and encourages the clients to continue doing what is working. Doing what works cuts across many dimensions and asking couples to describe details of successful sexual encounters as well as in their general relationship not only provides the therapist with information to use for encouragement but allows the couple to build confidence in their own abilities to solve their problems. Sexuality consists of different realms and the therapist in inquiring
about what has been working could focus on the following dimensions: part of a conversation would involve inquiring into each partner’s satisfaction with sexual technique since physically applying enough physical stimulation to bring a partner to his/her sexual threshold makes it possible to achieve orgasm; psychologically, each partner would define intimacy and how it has been affecting sex; how in-laws affect sex in a positive direction could be described. For example, if a woman notices that she is able to experience an orgasm when she and her partner make love in private situations (e.g., when their young child is visiting her grandmother), the couple might be encouraged to arrange for more “grandmother retreats” for the child or to organize their home in such a way as to allow for maximum privacy.

**IF IT’S NOT WORKING, DO SOMETHING DIFFERENT**

To complete the obvious first three tenets, this suggests that no matter how good it seems to be, if a “solution” is not working, it is not a solution. For example, couples “solving” their sexual problems by avoiding having sex is usually not a useful solution. In traditional behavioral sex therapy, if clients fail to do their homework, they are usually assigned the task again. In SFBT sex therapy, however, if a couple does not complete a homework suggestion or experiment, the task is dropped and something different is offered. This not only moves the couple away from what is not working but does so without creating self-doubt or self-deprecation on the part of the couple for “failing” a task. The therapist may also ask what the couple would like to change, seeking a description of their preferred future. At this time, the couple may mention behaviors that extend to other factors affecting their sex life such as family-of-origin issues, or making decisions together with shared meaning. Insofar as the couple is given the opportunity to identify these multisystemic issues, the therapist frames his or her questions based on the couple’s preferred solutions. Whatever the couple identifies as needing change, the therapist encourages the couple to try solutions and experience for themselves whether it will make a difference.

**SMALL STEPS CAN LEAD TO LARGE CHANGES**

SFBT is a minimalist approach where solutions are constructed through a series of small, manageable steps, assuming that once small changes are made, these will gradually lead to much larger systemic change without major disruption. Many changes begin internally for individuals whether it is a change in a way of thinking or a gesture towards a partner. A gesture, for example, can break a cycle affecting the couple’s dynamic and creates a feedback loop. In essence, they provide feedback, which can create a different dynamic. SFBT therapists listen carefully to minute yet milestone details, which may be easily overlooked in therapy, and ask for more details.
illuminating the change in dynamics. The descriptions often illuminate a larger story, leaving the couple to continue to create change within their relationship and around their relationship (with family, work relationships, etc.). Often, things like the process of coming to therapy, or making private time, or having a “cuddle night,” can lead to a sexual encounter, which will break the “avoidance cycle,” which will lead to one or both initiating sex more, and so forth. For example, the wife of a couple that our team worked with was experiencing moderate but inconsistent vaginismus prior to therapy. As a result of first session scaling, she noted that a small change would be for her and her husband to hold hands when they took their evening walk. She noted at the next session that when they made love that week, she felt more “relaxed” and did not have a vaginismus episode. The small change of hand-holding in some way allowed for more relaxed feelings, which contributed most likely to a better sexual encounter.

**The solution is not necessarily directly related to the problem**

SFBT spends little or almost no time focusing on the origins or nature of the problem. While almost all other psychotherapy models and approaches have problem-leading-to-solution sequences, SFBT reverses this. Instead, the SFBT therapist and clients works backward to accomplish the goal by carefully and thoroughly examining the client’s experiences to find times when at least a portion of the desired solution exists or could potentially exist in the future. Solutions traverse many dimensions that have little to do with the problem, mainly being the sexual issue. The couple may speak about adjusting their schedules to provide time for intimacy, more reliance on friends or neighbors, seeking information to enhance pleasure as possible solutions.

Couples often assume incorrectly that the solution to their sex problem has to do with sex directly. For example, a partner may buy sexy underwear for his mate, but this may lead to her feeling pressure and to be more sex-avoidant. At the same time, some seemingly unconnected solutions to low sexual desire and sex avoidance that we have seen emanating from clients include a partner helping with the dishes, arranging for a babysitter every Friday night, taking evening walks, starting an exercise program together, and taking dancing lessons. As can be seen, none of these idiosyncratic solutions would seem at face value to have anything to do with the “problem” directly. These solutions utilize the strengths of the couple as a unit because the couple is identifying and executing the solutions together.

**The language for solution development is different than that needed to describe a problem**

The language of problems is different than the language of solutions. “Problem talk” tends to be negative and past-focused and often suggests permanence of a
"Solution-talk" is usually more positive, hopeful, and future-focused and suggests that problems are transient (McGee, Vento, & Bavelas, 2005; Tomori & Bavelas, 2007). For example, the diagnosis of hypoactive sexual desire disorder does little to help the therapist or the client discover solutions a couple may have stumbled onto but “forgotten.” And understanding the “dysfunctional relationship patterns” or “attachment issues” of one or both partners may be interesting but not ultimately what will lead to solutions to the problem.

No problems happen all the time; there are always exceptions that can be utilized

This tenet follows naturally from the tenet of problem transience and suggests that people almost always display exceptions to their problems, even small ones. Most clients with any of the sexual dysfunctions or disorders do not have the problem all of the time. (There are exceptions to this, such as in the case of physiogenic erectile dysfunction.) For example, a client with premature ejaculation was able to recall a number of times when he was able to control his orgasm by slowing his thrusting or changing his positions. He agreed to an “experiment” where he did these self-discovered techniques the next times he and his partner made love.

The future is both created and negotiable

This tenet suggests that people are not locked into their diagnoses but instead are the architects of their own destiny. To this end, the future is a hopeful place, one filled with sexual pleasure and contentment. A very important and useful tool in identifying solutions is through couples speaking of their preferred or ideal future sexually. The preferred future inevitably includes how each partner individually influences the other partner and how the couple comes together as a unit to achieve success. The couple and relationship is the point from which solutions are identified and the couple’s unique dynamic itself fuels solutions.

Ongoing Interventions

A positive, collegial, solution-oriented stance

Sex therapists typically present a fun, sex-positive, playful stance. This fits well with the SFBT general tenor of being positive, respectful, and hopeful. In addition, the SFBT sex therapist offers a collegial, rather than expert stance. Also, the SFBT sex therapist assumes clients are motivated, successful, resilient, and full of previous positive sexual experiences that need to be learned about, nurtured, and encouraged. They believe that the client has the capacity to understand the multiple dynamics that might play into
the maintenance of sexual problems. SFBT considers what other models view as “resistance” as either natural protection, a realistic desire to be cautious and go slow, or a therapist error in suggesting interventions that do not fit the clients situation. The SFBT therapist “leads from one step behind” (Cantwell & Holmes, 1994).

LOOKING FOR PREVIOUS SOLUTIONS AND EXCEPTIONS
Most clients have had, what they would consider, great sex at some time in their relationship and/or have had recent times when their specific problem did not happen, or was less serious. SFBT therapists are trained to listen attentively for any small evidence or memory of a previous solution and to set up the therapeutic environment to nurture those memories. From the first session on, the SFBT therapist asks about, listens for, and encourages detailed discussion about previous solutions and exceptions to the problem. Clients come to learn to pay attention between sessions to such small changes and solutions across all areas of their experience (i.e., physiological changes, relational changes, etc.) so that they can report on those the next session.

QUESTIONS VS. DIRECTIVES OR INTERPRETATIONS
Questions are obviously an important element of communication and are an important part of all models of sex therapy. In SFBT, however, questions are the primary communication tool, and as such, they are a major intervention in and of themselves. Most models of sex therapy offer directives or interpretation. The SFBT sex therapist generally uses questions to elicit previous solution and exceptions and to encourage detailed discussion about past successes, previously great-sex times, and even recent experiences that were a little better than before. Such questions can help the client to focus on changes made across several areas of their lives, such as individual biology, psychology, dyadic issues, and so forth.

“What were some small, positive changes you noticed since the two of you decided to come in for therapy?”
“What were some times recently when your sex life was just the way you would like it to be?”
“Did you know that she really liked it when you touched her that way?”
“Would you be willing to try an experiment this week?”

PRESENT AND FUTURE-FOCUSED QUESTIONS VS. PAST-ORIENTED FOCUS
One of the cornerstones of SFBT is its focus on the present and future rather than the past. Questions that focus on clients’ present successes and plans
for future maintenance are more useful and lead to better outcomes than questions that focus on the past. Focusing on how they want their future sex life to be allows clients to maintain hope, which will in turn drive continued positive change. The therapist can ask the client to identify positive changes across many dimensions of the individual’s or couples’ life, including physiology, interpersonal changes, and so forth.

COMPLIMENTS

Supporting what clients are already doing successfully and acknowledging the difficulty of their problems encourages change while communicating that the therapist has been listening, understands, and cares (Berg & Dolan, 2001). SFBT sex therapists spend a good deal of time in complimenting clients about their hopes, their specific goals, and their successes. Compliments serve not only to make partners feel good about themselves but to help their partner see their strengths and good intentions. This indirectly serves to break negative-feeling cycles, suspiciousness, and ultimately avoidance. The therapist can use compliments across many areas of the couple’s lives. For example, the therapist can compliment the clients for better self-care strategies, which may address physiological limitations complicating the sexual picture. Sex therapists often compliment each partner individually illuminating each partner’s strengths within the relationship (as the therapist ties the compliment to the relationship dynamic) and the couple as a unit. Compliments may focus on how the couple works as a team to set up boundaries therefore increasing intimacy and cohesiveness or how the couple tackles financial issues reducing the stress on an individual partner.

GENTLE NUDGING TO DO MORE OF WHAT IS WORKING

Once a positive framework has been created, and some exceptions and previous solutions have been revealed, the SFBT therapist intervenes with gentle questioning, encouragement, and soft “nudging” to do more of what is working, via some of the specific interventions that follow.

Specific Interventions

PRESESSION CHANGE

The purpose of this intervention is to allow the SFBT sex therapist to punctuate, explore, and get details about the positive changes that may have occurred before therapy began. This is the first topic of conversation to be about changes and solutions and exceptions, rather than problems. The therapist might say: “We have found that many couples, once they decide to
come in for therapy, begin to see changes. I am wondering what changes you have noticed, even small ones, since you called for your appointment.”

There are two possible answers to this question. First, the clients may say that there were no changes, that things were still bad. In this case, the therapist asks “How can I be helpful to you today” or “What might need to happen to make this a really useful session?” or even “How have you managed to keep things from getting worse?” This would lead to a discussion that would elucidate some resiliencies, strengths, and hope. Each individual brings his or her own experiences to therapy and an example of hope is in the mere fact that despite ambivalent or negative feelings about therapy, each partner is in therapy to support each other. An example of strength is the willingness to divulge personal information in a genuine and honest way to a stranger. It is a powerful statement to the therapist and each partner of the couple’s commitment to change. It is also a powerful statement to others affecting the couple’s dynamic that the couple is constructing boundaries around their relationship and privately with solidarity enhancing their relationship.

Second, the clients may say that there are some changes that have happened and/or that things have improved. In this case the therapist explores at length those changes, uses them as the basis for therapy goals, and encourages more of those changes.

SOLUTION-ORIENTED GOALS

It is possible the “presession change” questions will lead to clear and specific goals, in which case the therapist can ask “So if all of your times were like it was last Friday when you made love and it was ‘great’, would that be how you would like it? Is that your goal?” Even if no changes were noted before the first session, the therapist can obtain goals the same way, by asking about how their sexual relationship once was, or a recent exception, perhaps months or even years ago. Of course, the clients could also be asked “How can I help you make this a great session today?” or “What would make this a great relationship” or some version of this.

Goals in SFBT are usually offered in the more of the positive rather than less of the negative format. If couple has trouble offering any more than less of the negative (e.g., “I want him to stop pressuring me to have sex”) ask “What would he (or the two of you) be doing instead?”

MIRACLE QUESTION

One of the most common and important interventions in SFBT, the Miracle Question (de Shazer et al, 2007, pp. 37–60) can be helpful for clients who are having difficulty setting goals or who can articulate a desired feeling but not the concomitant behaviors (e.g., “I just want to feel more”). The Miracle
Question can lead to a clear, specific, and scalable goal. It can also lead to clients feeling more hopeful about their future. The basic question can be asked like this:

Suppose tonight you were to go to sleep, and during this sleep, a wonderful, deep, restful, peaceful sleep, a miracle were to happen. And this miracle is that your problem is solved, over. Now, you wake up in the morning, and you don’t know this has happened, and because you were asleep you didn’t know this miracle had happened. Without you saying a word, what would be the first small thing partner would notice that was different. What would be the first small thing you would notice was different.

Another reason SFBT therapists ask the Miracle Question is that the very description of the miracle often leads to the emotional reaction of experiencing the miracle. For example, clients’ body language usually relaxes (if previously tense), or their facial expressions lighten up, or with sexual miracles, they show signs of sexual interest. In all sexual response models, desire precedes physical sexual change. For couples who have had a long hiatus in sexual activity and intimacy, a pique in sexual interest may be all that it takes to initiate intimacy and/or a sexual encounter.

Scaling

Scaling is both an SFBT approach to assessment and a format for using solution-oriented language. Some SFBT therapists use scaling as the primary intervention in sessions. Part of the beauty of scaling is its deceptive simplicity, which allows all manner of clients to benefit, and all types of problems to be addressed. It may be used at any time in the process, but best asked first during the first session, using some version of the following:

On a scale of 0–10, let’s say a 10 were as good as you could ever hope your sex life could be, and 0 as awful as it could be. I would like to know, from each of you three things: Where do you think it is now (pause to get answer from each); where was it at its worst (pause to get answers); and where would you be happy for it to be at the end of counseling.

Having this scale gives the therapist a great deal to work with. The therapist might say: “So you are at a 3 now, and it was a 2 at its worst. What has changed to move it up the scale a whole point?” This leads to a discussion of small changes the couple has already noticed in their sex life and/or relationship. Also, the therapist can ask: “What would it take for you to move up from a 3 to a 4?” This leads to small, observable, behavioral changes that can be “assigned” for the next week. These assignments are
preferable to the therapist-initiated ones most common in behavioral sex therapy, since they emanate from the client. It also makes change feel incremental and manageable. The advantage with scaling is that the couple may use multiple scales addressing different dimensions in their lives. There are times when each individual has described a unique miracle and the couple together has described their miracle. In scaling, each partner is asked how each might move up the scale with the help of the partner or outside resources such as medication, renewed relationships with important others, and so forth.

“Instead” questions

This intervention is useful when clients offer a goal or a description of their problem that is a reduction of a negative behavior (e.g., “I want her to stop avoiding sex so much”). The therapist, using a small but significant shift in the language, asks: “What would you want for the two of you to be doing instead?” This may lead to an answer like: “Maybe talking more, maybe being romantic more,” which could lead to the question from the therapist: “What would ‘being romantic more’ look like?” Now the talk has morphed into “solution talk” and a more positive view. Systemically, the instead question inevitably leads to less defensiveness between partners, because it is about the hope for the future, offered in a constructive way, rather than about a complaint about the past.

Listening for and punctuating solutions and exceptions

This is a basic, ongoing intervention that fundamentally differentiates SFBT from traditional problem-focused approaches. The SFBT therapist listens continuously for small bits of information from the couple suggesting a previous solution that may have been successful but that was forgotten, or for naturally occurring exceptions that have gone unnoticed. These changes might have occurred throughout several areas of the client’s experience, such as within the couple’s relationship, each person’s individual psychology, and so forth. These are then punctuated by (a) repeating the clients’ words; (b) being surprised, very interested, the classic “Wow!” response; and (c) having the couple give details about the previous solution or exception.

For example, a couple in the course of describing all of the times he has failed to get an erection, casually mention that when she one time playfully teased him orally, he not only got an erection, he had sex with a certain vigor that he had not shown in a long time. As this was said in passing, while explaining why things were “so bad,” it might have been easy for the therapist to miss this exception. Instead, the therapist responded with interest and fascination, having the clients describe it in detail, and shifting the focus from that of failure to that of success.
“How” Questions

This is another basic and ongoing intervention that differentiates SFBT from traditional problem-focused therapies. The SFBT therapist tries to ask questions that ask “how” rather than “why.” There are many reasons for this small but important linguistic shift that are beyond the scope of this article (for complete discussion of the philosophic-linguistic origins of SFBT, see de Shazer et al., 2007, pp. 133–141). Suffice it to say, the question “how” organizes the discussion around actions, descriptions of successes, which solidify and punctuate those successes, making them more likely to occur again. Examples of “how” questions in sex therapy might include

“How were you able to keep from coming longer last night?”
“How were you two able to spend so much more time in making love?”
“How did you decide to buy that sexy outfit for yourself?”

Compliments in the Client’s Own Language

Compliments, while of course common in all psychotherapies, are a particularly important intervention in and of themselves in SFBT, since they serve to maintain the stance that the clients are the experts on themselves, support the positive and cooperative frame of the sessions, and serve to punctuate the small changes across many areas that clients have been making as they move up the scale. Compliments should focus on what the clients have done to maintain change and are best offered using the exact words the clients used to describe changes made, hopes, and goals. If possible, compliments should be used to remind partners of positive sexual changes, behaviors, and feelings that are occurring.

Experiments and Homework Assignments

In most models of sex and other psychotherapies, intersession assignments are given by the therapist. In SFBT, therapists often end the session by suggesting “experiments” the clients can do if they so choose. These are almost always based on something the client is already doing (an exception), thinking, or feeling that is in the direction of their goal. Sometimes, the client may ask the clients to come up with their own experiments. And since, unlike other approaches such as cognitive-behavioral therapy, homework is not required for change to take place, so clients not completing an assignment is not viewed as resistance, or really even addressed. It is merely assumed by the therapist to be the “wrong experiment.” To this end, resistance is not considered a relevant or useful concept.
USING SFBT WITH SPECIFIC SEX THERAPY INTERVENTIONS

We have found that SFBT is quite effective for a number of the most common sexual dysfunctions and often resolves these without other interventions. However, there are times when specific behavioral, skill-building, or medication interventions could be helpful or are necessary for the clients to reach their goals. How do SFBT sex therapists integrate SFBT with traditional sex therapy or medical interventions?

Following the first SFBT tenet, if the SFBT approach is working, that is, the clients can articulate their goals, and they are moving toward their goals, no specific sex therapy interventions would usually be needed. Following the second tenet, and common sense, if the approach alone is not moving the couple toward their goals, or they are moving toward their relational goals, but not their sexual goals, then it may be useful to include specific sex therapy or medication. Some of the ways that clients may be invited to think about including skill building or medication may include the following:

“Has anyone ever talked to you about Viagra or other medications for erection problems? (This type of question also addresses the factors within the intersystems approach in that it allows for the therapist to address biological concerns with the couple, which, for some couples, may be contributing to the maintenance of the sexual problem.)

“Some people have found doing more structured exercises to slow down their lovemaking to be helpful.”

“I have seen many couples who have found trying a few exercises, along with massage and touching, to help them with premature ejaculation. Do you think learning more about this may be helpful?”

In each of these examples, the couple is invited to think about including skill building or medication, rather than assigned it. While this may seem like a small distinction, it is not insignificant and usually leads to greater compliance and cooperation in therapy (Adams & Jurich, 1991). It is important that when the assignments are given, they are offered parenthetically as a part of SFBT. We usually use the following general protocol when offering skill assignment:

- Start the session with scaling
- Ask what is better or different, being sure to focus on individual, relational, and societal factors
- Ask if they still are interested in trying a specific new skill
- If yes, describe it; if not, continue with SFBT interventions
- Describe the skill or exercise. Often helpful to begin it with “Couples seem to really enjoy this exercise” then describe it, then say “What do you two think about it? Is it something you may want to try?” If they say no, or
hesitate, compliment them on wishing to go slow, and ask them to think about it during the week
• If they say that they would like to do it, ask how they hope the specific assignments and sex therapy focus they are going to work on today will help them achieve their goals
• Make the exercise an “experiment”
• When through, ask how what they have worked on will help them achieve their goals, move up the scale, and so forth
• Take a break, give compliments, make assignments

CASE EXAMPLE

Amy and Robert, a couple in their early 30s, were referred for sex therapy by her ob/gynecologist for low sexual desire. Amy, a stay at home mother, and her husband Robert, a laborer, had been high school sweethearts and got married in their early 20s. They now have three children ages 6, 9, and 12. For many years since the birth of their last child Amy had little to no interest in sex and had become increasingly concerned that lack of desire was eroding what was once a “happy marriage.” She explained that she would like the marriage to continue since other than the sexual difficulties, she and Robert have a strong partnership and friendship, albeit strained from current problems.

Amy explained that she experienced a lack of desire. She was often tired at the end of the day and not interested in sex with Robert. In fact she had become so distant that she rebuked any sign of affection in fear that it would turn into further demands for sex. From Robert’s perspective, he felt that she had completely “shut him out.” He, in turn continually questioned why she was so disinterested.

Since the birth of their first child approximately 12 years ago, Amy stated that she had felt a diminished sex drive. Initially neither partner was overly concerned and attributed the difference to an adjustment to motherhood that included intense involvement with her child and a depletion of energy. As Amy’s low desire continued, Robert increased his determination to “solve the problem.” Five years ago Amy was diagnosed with atrial fibrillation and began taking digoxin. Robert became convinced that the medication was causing or contributing to a lack of desire, and her physician did not rule out that possibility. Amy said she felt defeated by her “condition” and explained that she really didn’t know why she wasn’t interested in sex, although she did acknowledge that her medication seemed to slow her down.

Session 1

Amy and Robert were asked how the therapist might be helpful to them. Amy stated that she would like their sex life to be more like it was in the
early days of their marriage. When asked what that would look like, she said they would “get back our sex life.” She and Robert agreed that there are no set numbers to the amount of sex they would have, just “what works” for them. Robert’s goals were to not be afraid that he will always be refused sex, and to have Amy initiate sex “sometimes.” Amy spoke about what she enjoys sexually. She loved to “snuggle” and be affectionate without the pressure that it will “always lead to sex.” She admitted to missing this closeness and comfort, but didn’t like to “feel pushed.” The therapist then asked about exceptions, “Was there a time when things were different?”

Robert recalled a time in the last few years when he “got so tired of pushing” that he “gave up” and made a conscious decision to wait for Amy to be the initiator. For a while nothing happened. Then one night she snuggled up to him and “spooned” him. The next night she initiated intercourse. The therapist asked “If your sex life were like this all of the time, would that be what you would like?” Both agreed it would.

The therapist then asked each the Miracle Question. Both described, in detail, days that included intimacy. When asked to describe what that would look like, Amy said, “We’d be talking more. You know, just about ‘stuff.’ And he’d be listening, and I’d be listening.” She also said they would make love, and that she would feel close and safe enough to initiate sex. The therapist then asked her to describe in detail how she would initiate, what Robert would say and do, what she would do, and so forth. Robert’s miracle was filled with many “Well, she wouldn’t say” or “She wouldn’t do” statements. The therapist each time asked “What would Amy say instead” and “What would Amy do instead.” Robert soon was able to describe a miracle very similar to Amy’s, filled with both physical and nonphysical intimacy.

The therapist asked each to scale themselves based on three questions. First, “On a scale from 1 to 10, if 10 were your “Miracle” all of the time, and a 0 were the opposite, where are you are right now?” Amy scaled this a 6 and Robert a 5. Second, “Where were you each before you decided to come in to therapy?” Amy scaled this a 3, as did Robert. The therapist expressed amazement. “How did you two move up from 3s to a 5 and a 6?” This led to a short discussion about their commitment to each other, their love, and their optimism that things will get better. Third, “And finally, where would you two be content to be at the end of counseling?” Both rated that an 8.

The therapist ended the session by complimenting Amy and Robert on their commitment to each other, their articulateness, and their hard work. They were then asked to think about what they would need to do to maintain their relatively high scaled numbers (5 and 6), or may even move up even so slightly, like to a 5.25 and 6.25, and to pay attention this week to what each did (themselves and their partner) to maintain or move the numbers up.
Session 2

Amy and Robert began the session by talking about their success. They spent every night during the previous week snuggling on the couch while watching TV. As this was a change, the therapist expressed astonishment and delight at the change, and asked them to describe this snuggling in great detail. After that, they scaled their intimacy level for the past week, Amy rated herself at a 7 and Robert a 6. Again, the therapist responded with enthusiasm, and asked “How did you two go up a whole point each?” This led to discussion about how meaningful it was that each was trying, that they enjoyed the closeness, and ultimately both loved to touch. In addition, Amy said she really appreciated Robert’s “backing off” from asking for sex and instead appreciated that he seemed to “understand” her more.

Robert expressed concern that they had been through this cycle before and was concerned that by backing off and letting Amy take the lead that once the initial interest wanes, she would revert back to low or no desire. The therapist acknowledged his concern and asked what they both thought would help them maintain their “numbers.” Amy said that they need to continue doing what they’re currently doing so that she can continue not to feel pressured and become more comfortable in the initiator role. The therapist asked the clients to make their own “assignment” between now and the next session, and they both thought they should continue to do what they were doing. The therapist ended the session by complimenting Amy for noticing that Robert had listened to her, and Robert for being such a caring and attentive lover, one who “really listens” to his partner and tries to please her in a way that she wants.

Session 3

Amy and Robert again had what they described as a successful week and maintained their high numbers when scaled 7 and 6, respectively. When asked how they continued to remain so high, Amy said she thought that once the “pressure is off,” she feels safer, more comfortable, and in control. Robert when asked how he has been able to pay such good attention to Amy’s needs, explains that he knows it will make the situation better for Amy and that it takes the pressure off. The therapist asked how was for Amy having Robert make this “shift” and she explains that it “makes me go to him more.” She now felt that she could put her arm around him in bed without feeling like it would lead to sexual pressure.

The couple, when asked what a slightly higher number on the scale would be each of them, they both noted that a little more “romantic time alone” would move the numbers up. They then discussed how difficult that is with children. The therapist asked about a recent time when this had occurred, and they recalled a “date” they had taken a few months earlier.
The therapist asked if they could, as an experiment, have another such date before the next session. They both agreed and finished the session by discussing how this could happen.

Session 4

The therapist began the session by asking them “What was different since I last saw you?” They shared that they had indeed gone on their date. The therapist again displayed amazement that they were able to actually do it, and asked for a detailed description. It turns out Amy was the one who initiated the date and planned for it. She had arranged for his parents to watch their children so they had their house to themselves. Amy spent much of the day thinking about Robert and becoming excited about the date. She also, unknown to him, secretly planned the evening’s date to end with lovemaking. She even lit candles and had rose petals on the bed as a surprise for Robert when they came home from dinner. They did indeed have sex for the first time in many months. They were both very pleased with the evening and Robert seemed particularly pleased that she had planned it and had taken the initiative.

After a long, detailed discussion of their date, the therapist asked them to scale themselves. They both scaled their “Miracle” at an 8. The therapist, after expressing surprise and delight with the very high scales, asked “How have you gotten to an 8?” Amy said that coming to therapy, talking about their situation, “feeling that Robert really hear what I needed,” seeing Robert try so hard, all allowed her to think about him more and in a “more sexual way.” The therapist, after complimenting them for being so romantic and fun, asked what would help them to maintain the 8, to which they both responded that they would like to do this again. The therapist asked when they would like to come back, and they thought 3 weeks would give them enough to time to have another date.

Session Five

Amy and Robert said that they were both talking more and that while spending more time together were holding hands more, cuddling, and kissing. They also had gone on two dates, which both ended in lovemaking, and had even had sex another time spontaneously before going to bed. The therapist asked them to scale their Miracles, and both scaled it a 9. The therapist noted that they had gone beyond their goal of an 8 and asked how they did this. They said that when everything is pushed out of the picture—kids, feeling tired, not feeling well, and so forth—they both greatly enjoy one another sexually. Robert also said that it seemed that for the first time in their marriage, Amy has begun to be more comfortable talking about her likes rather than just her dislikes sexually. She said that she had also been
more willing to let Robert touch her more intimately and engage in foreplay. The therapist complimented them for their willingness to open up to one another and experience so much pleasure. To the therapist’s surprise, when asked what they thought they should do to maintain the 9, Robert expressed an interest in working on a project with Amy that was nonsexual: He wanted to repaint their daughter’s room and wanted it to be a “team effort.” Amy was also surprised but quite willing to oblige.

The therapist asked what would be most helpful to them at this point. They suggested that they call the therapist if they felt themselves “slipping” and the therapist agreed. In follow-up phone conversations, Amy and Robert reported that they had sustained their high level of satisfaction with their intimacy, both sexual and nonsexual.

SUMMARY AND CONCLUSIONS

It should be noted that, from an SFBT point of view, this case example demonstrated a successful outcome, because the couple achieved the goals they had described. Since the SFBT approach does not deal with “issues” beyond the clients’ frame of reference, the couple’s goals are considered both valid and clinically sufficient. In this situation, the couple offered not only a cogent goal, based on their combined miracles, but also had exceptions to their problem, which could be incorporated into the therapy. In the course of the application of this approach, the couple had changed their “dysfunctional avoidant behavioral pattern” without ever having to have it described to them, which might have accidentally (and ironically) solidified this pattern further, by causing them to focus on the meaning of the “avoidance.” This is part of the elegance of the SFBT approach. It actually leads to the result that many problem-focused models end up with (or hope to end with) but does so more briefly and with less risk.

SFBT can be a useful approach for the treatment of sexual dysfunctions and is quite compatible with the interactional approaches described in this special issue. SFBT’s positive, collegial, supportive, and resiliency-based structure offers an ideal framework from which to work with the presenting problems treated by sex therapists. The use of medication (such as sildenafil citrate for erectile dysfunction) or other specific behavioral skills (such as the squeeze technique to reduce immediate orgasm for premature ejaculation) can be offered concomitantly within an SFBT framework if the client-initiated, exception based interventions do not result in the clients achieving their goals. Given the increased evidence for its effectiveness with many other clinical problems and populations, it is hoped that clinical research on SFBT will be expanded to empirically examine the effectiveness of SFBT for the treatment of sexual problems.
REFERENCES


