

Let's Talk about Sexuality and Relationships

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Overseas research on sexual and relational disorders is varied and widespread. However, relatively little is known about such problems in New Zealand. The present study describes a cohort of clients seen by the Sex Therapy New Zealand service in one year, with a particular focus on the presenting symptoms in relation to existing models of sexual functioning problems. The therapists of the 46 clients who consented to participate completed a short questionnaire about the client and the therapy process. The key finding was that therapists identified relational problems as central to the sexual problem, while these issues were not identified in the referral. A larger study on sexual problems in New Zealand is needed to replicate and extend the results of this study, with a view to developing an integrated diagnostic, assessment, and treatment model for sexual and relationship problems.

Our understanding of sexual and relationship problems has developed over the last 60 years with models of diagnosis and treatment reflecting changes and advances in research. The earlier and more traditional models of sexual problems focus on biological aspects of sexuality, evident today in the current edition of the Diagnostic and Statistical Manual (DSM-IV-TR; American Psychiatric Association, 2000). The DSM model of sexual problems is based on the work of Masters and Johnson (1966). It identifies categories of sexual disorders in terms of problems with desire, aversion, orgasm, and pain (e.g., dyspareunia and vaginismus), as well as paraphilias and problems caused by a general medical condition or substance use. It is not intended as an aetiological model, but essentially describes sexual problems from a biological and medical viewpoint. The DSM has been used to establish the prevalence of sexual functioning problems. For example, male orgasmic disorder, also known as inhibited orgasm

or retarded ejaculation, is diagnosed when orgasm is achieved in intercourse only with great difficulty. Prevalence rates vary in different samples of men from 2% in its severe form to 6% in its milder form (Blanker et al., 2001; Frankel, Donovan, & Peters, 1998), with a lifetime prevalence of 1-10% overall (Spector & Carey, 1990). The DSM also includes diagnostic criteria for relational problems (e.g., partner, parent-child, sibling), which can be due to a mental disorder or general medical condition, and are similarly used to establish prevalence rates.

Other models have since been developed that incorporate a broader range of factors in efforts to theorise about the development and maintenance of sexual difficulties. These models are explored to provide background information on the nature of sexual difficulties and to highlight relevant points of each theoretical model. Tiefer (2001) established an Alternative Classificatory Model (see Table 1) that offers a different way of conceptualising

sexual problems from that provided by the DSM. The emphasis within this model is on the value of insight into the whole context, considering the influence of social, political, economic, partner, relational, psychological, and medical factors. This broader focus allows the consideration of factors that could otherwise be neglected when working from a primarily biological model. For example, it encompasses factors such as sexual problems that are related to one's partner and relationship or psychological factors, in addition to medical issues. However, the descriptions of these areas are relatively limited, and the medical factors are less clearly defined than in the DSM. For example, what is meant by a 'safe interpersonal situation' may vary for different people. In contrast, the DSM attempts to provide clearer criteria by identifying the specific symptoms and course of the problem (e.g., whether it is lifelong or acquired).

More recently, compilation of the Individual Sexual Response Model¹ by Robyn Salisbury offers an important shift in the development of understanding of sexual and relationship problems within a New Zealand context. As seen in Table 2, this model offers an approach that differs from that of the DSM and considers the requirements of a person's sexual response as opposed to simply focusing on the sexual or relationship difficulty (R. Salisbury, personal communication, July 13,

1. This unpublished model was compiled by Robyn Salisbury based upon the work of multiple authors as well as clinical experience and was developed to complement the existing models for training purposes. From here on, this model will be referred to as the Individual Sexual Response Model.

Table 1: Tiefer's (2001) Alternative Classificatory Model

Sexual problems resulting from social, political or economic factors
<ul style="list-style-type: none"> • Ignorance and anxiety resulting from inadequate sex education • Sexual avoidance or distress caused by not feeling able to measure up to cultural norms • Inhibitions caused by inner conflict • Lack of interest because of other obligations
Sexual problems relating to partner and relationship
<ul style="list-style-type: none"> • Betrayal • Discrepancies in desire • Not being able to ask for what you want • Resentment or conflict over other matters • Partner's health or sexual problems interfering with sexual desire
Sexual problems resulting from psychological factors
<ul style="list-style-type: none"> • Aversion or desire problems because of past abuse • Fear of actual sexual acts or the consequences of sex (e.g., pregnancy, disease)
Sexual problems resulting from medical factors
<ul style="list-style-type: none"> • Includes pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes • Reasons for this are numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body; pregnancy, sexually transmitted diseases, or other sex-related conditions; side effects of many drugs, medications, or medical treatment and iatrogenic conditions

Note: From E. Kaschak and L. Tiefer, 2001, *A New view of women's sexual problems*, pp. 5-7. New York: The Haworth Press.

2007). It outlines the transitional stages that a person needs to adequately experience to ensure satisfaction from a sexual relationship, such as willingness, desire, arousal, orgasm, and satisfaction. The model acknowledges individual diversity in that a person can experience varying amounts of feelings and responses at each stage, thereby considering problems from an individual point of view and including relational and individual factors. However, as with Tiefer's (2001) model, it is also limited by a lack of detailed description, despite allowing for consideration of the broader context and various sources of problem development. For example, willingness encompasses 'an adequate sense of wellbeing', which may stem from psychological factors but could also relate to physical factors, such as pain. Therefore, although the Individual

Sexual Response Model considers a broader and more flexible array of factors as relevant to sexual problems, it could also be too flexible and broad, with limited detail of a person's specific difficulties.

It is important to recognise that these two alternative models should not be used alone but alongside the DSM-IV-TR. Together, the three models identify the language and concepts used to describe and define sexual and relationship difficulties in New Zealand. However, no research has examined the applicability of these models in a local Aotearoa/New Zealand context. Furthermore, Brotto (2007) points out that the need has arisen for a more integrated approach to diagnosis and treatment that investigates the broad scope of relevant issues. In New

Zealand, Helen and John Conaglen have undertaken sexual and relationship research which has predominantly addressed the nature and treatment of sexual problems and sexual desire. For example, their research has examined the identification of sexual difficulties (Conaglen & Conaglen, 1997), with a focus on male problems (Conaglen & Conaglen, 2004) and erectile difficulties (Conaglen, Edemeades, & Conaglen, 1996). However, little further research on sexual difficulties has been undertaken in New Zealand. There is a need for local research exploring the types of presenting sexual problems and related factors, as well as the applicability of the three different models utilised in sex and relationship therapy with New Zealand clients. The present study represents a starting point to begin addressing this need, and is based on the services provided by Sex Therapy New Zealand.

Sex Therapy New Zealand (STNZ), directed by Robyn Salisbury, is a service based on a framework that examines sexual and relationship problems from all of the three perspectives outlined above. STNZ provides services for the diagnosis and treatment of sexual and relationship problems. The current study explores sexual and relationship problems in New Zealand amongst a sample of STNZ clients as part of an internal audit of the service. The study aimed to explore the nature and context of sexual problems, self-reported causal factors, levels of co-morbidity, impact on life, and the outcome of treatment, all as reported by each client's therapist, as well as the relevance of the different models of sexual problems.

Method

Participants

All clients seen by STNZ therapists during a one-year period from 2006 to 2007 were invited by STNZ to participate. Of 187 clients, 46 agreed to participate by returning a completed consent form, representing a response rate of 25%. Clients consented to their therapist providing anonymous information about their case in a brief questionnaire. The clients were 23 men and 23 women, aged between 24 and 74 years of age. The average age of the

Table 2: Individual Sexual Response Model

Willingness requires:
<ul style="list-style-type: none"> • Positive attitude towards self, partner, and sex • An adequate sense of wellbeing
Desire requires willingness plus:
<ul style="list-style-type: none"> • Drive – biological component occurs spontaneously yet is still subjective and can be affected by drugs, physical illness, emotional state, learning, stage of menstrual cycle • Motivation – comes from sexual identity or image of self as sexual being, quality of non-sexual relationship, reasons for sexual behaviour, transference from past attachments • Aspiration – wish to have/not have sex comes from beliefs about sex
Arousal requires enough of the preceding plus:
<ul style="list-style-type: none"> • Awareness of arousal in own body • Willingness and/or ability to refrain from self-distraction and to make arrangements to avoid external distractions • Positive expectations and past experiences • Sufficient stimulation
Orgasm requires enough of the preceding plus:
<ul style="list-style-type: none"> • An understanding of basic anatomy and physiology • Visual and tactile experience of own body's responding • Sexual skill competence
Satisfaction requires varying amounts of the preceding plus:
<ul style="list-style-type: none"> • A feeling of intimacy and closeness with partner that comes from feeling understood, valued, and cared for • Sexual self-esteem – feeling deserving of receiving and giving sexual and sensual love and pleasure • An 'enjoyable enough' sexual experience

Note: From R. Salisbury, personal communication, July 13, 2007.

sample was 47.92 years ($SD = 0.51$; 5 clients had missing data). An individual samples t test found no significant difference in mean age between men ($M = 48.45$, $SD = 14.05$) and women ($M = 47.38$, $SD = 12.90$), $t(39) = 0.25$, $p < .05$. The magnitude of the mean difference was very small (Cohen's $d = .08$; Cohen, 1998). There were 2 participants who were described as Māori, 1 as European Indian, 4 as United Kingdom European, 1 as Canadian, 29 as New Zealand European/Pākehā, and the remaining 9 as European. Individual therapy was sought by 12 clients (26.09%; 6 men, 6 women), 31 sought couple therapy (67.39%; 17 men, 14 women), and 3 sought both individual and couple therapy (6.52%; 3 women). A total of 34 (73.91%) were therefore in couple therapy. Of the total 46, 2 clients had

attended for an assessment only, 4 had just begun therapy, 10 were part-way through, 11 had almost completed, and 19 had completed therapy.

Procedure and Measure

The study was given ethical approval by the National Ethics Committee (MEC/07/15/ EXP). STNZ sent an information sheet about the study to potential client participants as well as to all STNZ therapists. The therapists of the clients who consented then completed a brief questionnaire about their client. This was processed and anonymised by STNZ before being given to the researchers for analysis.

The questionnaire consisted of 22 tick box and short answer questions and covered the following areas: client

demographics, type and current stage of therapy, initial presenting/referral problems and those identified by the therapist, applicable DSM-IV-TR categories, factors contributing to the problems, onset of problems, comorbid psychological and physical problems, impact of the problem on the client's daily functioning, and a narrative description of the client's progress in or outcome of therapy. Examples of the tick box questions are whether the client was seen individually or as part of a couple (two options: individual, couple), what stage was the client at with their therapy (just beginning, part-way through, almost finished, completed), what were the problems with which the client initially presented (early ejaculation, retarded ejaculation, lack of desire, erection difficulties, unpleasant/painful sex, sexual avoidance, infidelity, relationship problems, lack of capacity for intimacy, sexual abuse/trauma, abusive/risky sexual behaviour, orgasm difficulties, sexual addiction, paraphilia, infrequent intercourse, lack-loss of love for partner, need for psychosexual education, and sexual anxiety/fear), and at what stage did the problem/s develop (20s, 30s, 40s, 50s, 60s, 70s or older, or unsure). Examples of the short answer questions are what were the contributing factor/s of the problem/s, specify (DSM-IV or other) the names of the disorder/s identified, and briefly describe the current progress or outcome of therapy for this client.

Data Analysis

The nature of the study as an internal audit of a small sample meant that analyses were primarily descriptive and formal qualitative analysis methods were not used. Additional analyses were planned but could not be undertaken. For example, chi-square tests of independence were planned to examine gender and age group differences in variables such as the presenting problem. However, due to small sample sizes, these analyses could not be carried out. For the short answer items, including the narrative description of therapy progress or outcome, themes were established by looking for common responses and grouping them together into categories, in consultation with supervisors. The categories identified were checked for their appropriateness

or representativeness by the primary supervisor. Inter-rater agreement was assessed by the secondary supervisor who coded a list of responses representative of the themes determined by the researcher. In total, 10 discrepancies arose from 45 responses (21% discrepancy). In the case of six of these, discrepancies were due to inadequate explanation of the category headings, which were subsequently further refined. The remaining four (8% discrepancy) were discussed and altered.

Results

Nature of Sexual Problems

Multiple problems were identified for all clients by the referrer, which was either the client or their general practitioner. The most frequently identified problems according to the referrer were lack of desire ($n = 25$, 54.34%) and infrequent intercourse ($n = 24$, 52.17%; see Table 3). Relationship problems were identified for 16 clients (34.78%), followed by sexual avoidance ($n = 11$, 23.91%) and sexual anxiety or fear ($n = 10$, 21.73%). Therapists were asked to give a diagnostic label for the problems identified by the referrer using relevant DSM-IV-TR or other diagnostic terms, and categories were formed from these narrative responses. Desire-related diagnoses were most frequent, with hypoactive sexual desire disorder described for 30% of clients and desire discrepancy for almost 24% (e.g., not having sexual intercourse as often as desired, incompatible desire for sex with partner, and partner's problems impacting on desire and regularity in intercourse).

In the case of 14 clients, the therapist identified the same presenting problems that the referrer had identified. However, for 32 clients, more than two-thirds of the sample (69.56%), the therapist's description of the problems was different to that provided by the referrer (see Table 3). Although no statistical comparisons were possible due to the lack of independence of these frequency counts (more than one problem was identified for each client), some trends were apparent in the patterns of problems identified by therapists as opposed to referrers. These same patterns were evident when the diagnostic terms

used were compared. Problems related to desire and infrequent intercourse were identified less frequently by therapists, while relationship problems were more frequently identified by therapists (30.43%) than referrers (10.87%), as were issues related to capacity for intimacy.

For 14 clients (30.43%), other psychological problems were also identified as comorbid with the sexual problems. Of these, therapists identified that seven clients had depression, four had anxiety-related problems, two had substance-related disorders, and one had a mood disorder. In specifying a diagnostic category for these co-morbid problems, five clients had a form of depression, one had post-traumatic stress disorder, and one had an alcohol- and drug-related addiction. A diagnosis was not appropriate for the remaining seven clients because full diagnostic criteria were not met. Physical problems were also identified for 11 clients, including age-related physical difficulties (8.51%; e.g., post-menopausal vaginal dryness, and some decline in erectile functioning, likely to be due to age), sexual pain (6.38%; e.g., pain due to tension and wanting to say no but withstanding sex, and initial pain with sex), back pain (4.26%), paraplegia (2.13%), and visual problems (2.13%). There were 34 clients who had no comorbid physical problems (73.91%).

In terms of problem onset, therapists noted that the sexual and relationship problems developed at varied stages from adolescence to older adulthood. Problems were evident most commonly before 50 years of age (84.78%), and none developed after 70 years of age. According to therapists, the sexual and relationship problems identified were impacting on everyday life to varying extents for 43 (93.47%) clients. For more than half of the sample, the therapist identified that the problem did impact on the client's life, but not every aspect of it (54.34%). For 4 clients (8.69%), the problems impacted on their life completely, for 6 (13.04%) only slightly, for 8 (17.39%) not really, and for 1 (2.17%) not at all (impact was unknown for two clients).

Contributing Factors

Factors contributing to clients'

sexual difficulties were described by therapists and coded into 11 categories based on similarity of content. The most commonly described contributory factors were lack of communication and lack of psychosexual education (9 clients or 19.56% each). Sexual pressure and early trauma were each identified for 5 clients (10.87%), followed by attachment issues and relationship boredom (4 clients or 8.70% each), ejaculation problems (3 or 6.52%), addiction and anxiety (2 or 4.35% each), and desire discrepancy (1 or 2.17%; this was not applicable for two clients). Therapists identified internal factors as relevant to the establishment of sexual problems for 12 clients (26.09%), such as being anxious or fearful or having a belief that the problem stemmed from family history. External factors, which related the cause of presenting problems to either the partner or society, were identified for 14 clients (30.43%). For the remaining 20 clients (43.48%), the therapist identified both types of factors as contributory.

The client's childhood was identified by therapists as a causal factor of sexual problems for 22 clients (47.82%; more than one factor could be chosen, and the total number of responses exceeds 22). Most commonly, avoidant attachment was identified for 10 clients and childhood sexual abuse for 7 clients. Ambivalent attachment and history of familial abuse were each considered contributory for 4 clients. Childhood physical abuse and disorganised attachment were each described for 2 clients. Other childhood issues were identified for 6 clients, such as lack of parental modelling of close relationships, punitive and repressive parental views of sexuality, and loss of mother, not allowed to grieve.

Outcomes

Therapists gave a narrative description of the outcome for each client based on their current stage of therapy, and these descriptions were coded into eight categories. For the majority of clients (30.43%; $n = 14$), the identified outcome was an increase in two intimacy-enhancing sets of behaviours: communication and consideration. The following quotes

from therapists are examples of these categories:

- (client) formed new beliefs about sex and self and willingness is increasing as new ways of relating are developed, and intimacy has improved,

- relationship now very strong and intimate, clear acknowledgement has developed that one partner's lack of willingness to commit to marriage impacts on other, and

- progress and issues covered include emotional exploration, exploration of expectations of self and partner, masturbation exercises, alternatives to intercourse/penetrative sex, anxiety management strategies and communication with partner.

A range of other primary outcomes were described as occurring less frequently, such as increased intimacy ($n = 8$, 17.39%):

- intimacy and trust have been rebuilt and client is not able to be emotionally intimate,

- gradual change in capacity for intimacy through education and obtaining new ways of understanding the sexual problems,

- couple now have worked hard to work through the rape and gradually rebuilt trust and intimacy and have risked becoming sexual again, and

- this client is more able to be sensual with their partner, including sexually.

Other outcomes described included: a better match in desire between partners ($n = 4$, 8.70%), decrease in anxiety and increased ability to explore own desires ($n = 4$, 8.70%), and decreased relational pressure ($n = 2$, 4.35%). For seven clients (15.21%), only an assessment had been carried out at the time of the study, and the outcome was unclear for a further three (6.52%).

Power Analysis

Where statistical analyses were possible (i.e., comparing average age between men and women), the effect size was extremely small (Cohen's $d = 0.08$). The analysis of mean differences where the effect size is less than .10 (determined to be a small effect size according to Cohen's guidelines) would only yield 11% power where $N = 47$

(Cohen, 1988).

Discussion

The present study aimed to explore sexual and relationship problems in a sample of 46 STNZ clients as part of an internal audit, with a view to examining the relevance of the existing models of sexual problems. Theoretical models were presented in the introduction to highlight the different classifications and types of sexual problems that are currently being used. Their relevance will be explained in conjunction with the following discussion of results. Multiple presenting problems were identified by both the referrer and therapist. In a study of 592 people in the United Kingdom, Roy (2004) found that there was more than one problem either for the individual or in the relationship in over 33% of cases. In the present study, lack of desire and infrequent intercourse were identified most commonly by the referrer as a presenting problem for clients. This finding is in line with the literature which specifies hypoactive sexual desire disorder as the most common sexual complaint for women (Basson, 2007) as well as for 16-17% of men (Mercer et al., 2003). Early ejaculation has been identified as the most common orgasmic disorder for men (Jannini & Lenzi, 2005; Laumann et al., 2005; Montorsi, 2005; Rosen, Porst, & Montorsi, 2004), but was relevant for only one male client in the present study. In contrast to the problems described most often in the referral, the most common presenting problems according to the therapists were relationship problems and lack of desire, as well as lack of capacity for intimacy and relationship problems. These results also indicate that there were differing views regarding the core nature of the sexual problem with which the client presented, with therapists considering some of the broader contextual and relational factors as key to the sexual difficulty, such as those identified in Tiefer's (2001) model and the Individual Sexual Response Model. Much of this relational richness would be lost with the use of a solely DSM-based model. Therapists considered that a diverse array of factors contributed to the development and maintenance of sexual problems, such as lack of

communication, lack of psychosexual education, sexual pressure, early trauma, anxiety/fear, attachment difficulties, and societal issues, which is consistent with the broad range of causal factors identified by Tiefer (2001). These varied results and their relationships with different components of each of the models highlight the importance of understanding and describing difficulties utilising components of the three models described. The study has identified a diverse array of sexual problems evident in a New Zealand sample, which are not entirely captured by any of the three existing classification models. Although the present study was not designed to specifically address how to combine these models into a more complete theory, this would be extremely useful for further research.

Limitations

The present study was based on a small sample of clients seen by STNZ in a one-year period, and was made up of clients who could afford to attend therapy, were older on average (49 years), were willing to articulate their problems, agreed to have their information shared, and whose problems may be more socially acceptable than those potentially identified by a younger population. Furthermore, only 26% of clients sought individual therapy only, and the majority of the clients involved in the present study were seen as a couple. The findings could have been more varied if the majority of clients were seen for individual therapy, were of a different age group with potentially different difficulties, and if the sample size was larger, selected over a larger timeframe, from varied services, with a higher response rate.

There was low power to detect small effects where statistical analyses were possible (i.e., comparing average age between men and women). Unfortunately, further statistical analyses were not able to be conducted for a number of reasons. Comparisons of gender differences in the types of presenting problems were meaningless given that 74% of the sample were seen for couple therapy and, in such cases, the same problems were identified as belonging to the each person in the relationship. Comparisons based on

Table 3: Frequency of Presenting Problems Identified by the Therapist Compared with Referrer

Problem	Frequency	
	Therapist	Referrer
Lack of desire	19	25
Infrequent intercourse	13	24
Relationship problems	32	16
Sexual avoidance	13	11
Sexual anxiety/fear	12	10
Erection difficulties	2	5
Lack of capacity for intimacy	17	4
Sexual addiction	2	3
Unpleasant/painful sex	5	3
Lack/loss of love for partner	2	3
Need for psychosexual education	11	3
Orgasm difficulties	4	2
Infidelity	4	2
Early ejaculation	1	2
Abusive/risky sexual behaviour	3	1
Retarded ejaculation	1	1
Sexual abuse/trauma	8	1
Paraphilia	1	0
Other (e.g., grief)	11	6

age group were considered redundant given that the majority of the sample were aged from 30 to 70, and the sample sizes within age groups were relatively small (range 7-14). Analyses comparing the proportions of different types of problems were not appropriate due to the lack of independence of observations since, in all cases, multiple problems were identified for each client. Comparisons based on the diagnostic terms used could also not be done because of the small sample size in some of the cells. The same issue applied with any comparisons of the proportion that had the same or different problems identified by the referrer and therapist.

Implications and Recommendations

Despite the limitations noted above, the present study suggests the importance of drawing from the range of existing models of sexual difficulties in order to best conceptualise the development (including childhood factors and their relevance to the presenting problems), maintenance, and context of such problems to plan efficient and effective treatment. While the

DSM-IV-TR provides useful diagnostic categories and criteria for sexual and relationship problems (APA, 2000), it is also important to consider both the couple and individual relational capacity when working with people with sexual problems (Kaschak & Tiefer, 2001). The DSM alone may not adequately capture both of these capacities, and, although it outlines criteria for relationship difficulties, relational problems are not considered in the criteria for sexual problems. In comparison, Tiefer's (2001) Alternative Classificatory Model and the Individual Sexual Response Model consider a broader range of factors as contributing to sexual problems. An approach that encompasses all three models, identifying the relative relevance of their components, needs to be developed, validated, and utilised in research and therapy to ensure that assessment and formulation includes all relevant information for the particular client. Kleinplatz (2001) found that sex therapy in modern society not only focuses on physical aspects of sexuality and relating, but also encompasses relational capacity and behaviours. The nature of sex therapy in New Zealand should also reflect this. Although the

present study was not designed to develop a new theoretical model, it has identified the gaps between existing models and the problems experienced by clients, suggesting the need for what a new model should encompass. As this study was carried out in New Zealand, there are also culturally-specific factors which should be incorporated in a new model that are not readily apparent based on this study but are evident in the Individual Sexual Response Model (Table 1). In addition, existing cultural approaches to health and well-being would need to be considered and incorporated into this new theoretical model.

The discrepancies that arose in terms of problems identified by the referrer and therapist are an important issue for further exploration and highlight the relevance of psychosexual education not only for clients but also for the general population. Steps have been taken to reduce the existing taboo around sexuality, but there is still a long way to go before such issues can be completely accepted (Kelly, 2007). Promotion and normalisation of sexual concerns along with their rates of co-morbidity with other physical and psychological factors may encourage people to be aware of their own difficulties and seek therapy if necessary. Further research is needed to investigate the usefulness of an integrated theoretical model of sexual problems (Brotto, 2007). The three models explored in the present study highlight different perspectives from which to view sexual and relational difficulties. However, it is not clear which components of each model would need to be included, or whether other unpublished models exist. The assessment and treatment of clients with sexual problems would be markedly enhanced by the development of a more comprehensive theoretical model.

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