57

SEX THERAPY: SOME ETHICAL CONSIDERATIONS

By RICHARD BURRIDGE

85p

Grove Booklet on Ethics No. 57

Sex Therapy:
Some Ethical Considerations

by

Richard Burridge

From June 1985, assistant curate of the parish of St. Peter and St. Paul, Bromley, Kent

GROVE BOOKS

BRAMCOTE NOTTS. NG9 3DS

CONTENTS

		Page
1.	Introduction	3
2.	What is Sexual Dysfunction and Therapy	5
3.	Ethical Background	10
4.	Ethics and Basic Techniques of Therapy	14
5.	The Wider Issues	19
	Appendix: Bibliography	24

Copyright Richard Burridge 1985

FOREWORD

I once asked a young Christian couple what was their biggest problem in their marriage. Without hesitation the wife said, 'sex'. She added: 'If you really want to know, that applies to many other couples in the church too.' But, to my knowledge, this couple had never reached out for help, even though the situation clearly caused considerable stress.

To whom *does* such a couple turn? If they plucked up courage to consult one of the leaders in the church, could they be confident that this person would listen sensitively, be competent to counsel, or would at least know where they could receive specialized help?

Because many of us would not know what to say, I believe Richard Burridge's booklet is an important break-through. His treatment of sex therapy is sensitive, thought-provoking, and clear. His carefully-spelt-out challenge to think biblically and compassionately is timely. And his concern both to break the conspiracy of silence which surrounds the word 'sex' and to bring healing to couples troubled by sexual dysfunction surely echoes the concern of God himself; the God who created men and women genitally equipped to enjoy bodily fusion in marriage.

Joyce Huggett

ACKNOWLEDGEMENTS

There are many to whom I owe thanks for their assistance:
to Mrs. Sonia Coats of the MGC who first introduced me to the ideas and methods of therapy;
to Dr. Francis Bridger and other members of the Grove Ethics Group who encouraged the writing of this booklet;
to the many people I interviewed and those with whom I discussed the ideas;
to those who read the manuscript, especially Dr. Rosalind Oliver, Dr. Glynn Harrison, Dr. David Cook and Dr. David Field who helped to reduce errors, those which remain being my own;
to Mrs. Joyce Huggett for her encouragement and kind foreword above;
to Mrs. Alison Anderson for her assistance and typing;
and finally to my wife, Sue, for her love and patience.

Richard A. Burridge, April 1985

First Impression April 1985

ISSN 0305–3067

ISBN 0 907536 90 5

1. INTRODUCTION

Despite two decades of the 'sexual revolution', sexual activity remains a source of misery to many. Indeed, the current myths of the ever-ready male and the constantly multiply orgasmic female only serve to accentuate the pain, and even guilt, of those who feel inadequate in their sex lives. Exactly how many people are affected is impossible to ascertain. Some estimates suggest that as many as 50% of marriages have sexual difficulties at some time.[1] What is certain however is that problems are not uncommon today. It is important to be clear that the term 'sexual dysfunction' refers to difficulties couples may experience in their lovemaking: we are not here concerned with questions about such things as homosexuality or criminal activities (such as rape, incest, or bestiality).

For most of this century, psychoanalysis was the main way of dealing with sexual difficulties; unfortunately it often met with little success. After World War II, Alfred C. Kinsey began his research into human sexual behaviour[2] followed quickly by Masters' and Johnson's research into how exactly sexual response functions.[3] This research led to their programme for treating sexual difficulties: their clinic handled 790 cases between 1959 and 1970. *Human Sexual Inadequacy*, the publication of their work, became the standard manual on sex therapy. Masters and Johnson claimed a success rate of 80% and this led other therapists to follow and modify their work. Masters' and Johnson's method relied heavily upon a behavioural approach, in which the immediate problem—difficulty in sexual behaviour—is dealt with, rather than upon the psychoanalytic approach to the underlying personality; others saw the need to complement it with psychotherapy.[4] There are various possible forms of sex therapy now available in Britain through NHS clinics, the Family Planning Association, the Marriage Guidance Council and many individuals, such as doctors or social workers. A major difficulty with this sudden proliferation is that there is no single professional body to oversee sex therapy, concerned for training and ethics. The sex therapy manuals never ask ethical questions. Nevertheless there are many ethical considerations which need to be discussed. While there have been some recent attempts at this[5] as yet they have had little widespread effect.

With its concern for marriage and for broken individuals, the church should be involved in this area. Unfortunately all too often a strict religious upbringing features strongly in the factors lying behind sexual

[1] Masters and Johnson *Human Sexual Inadequacy* (here called '*HSI*') p.369. For full details of books mentioned—see bibliography.

[2] *Sexual Behaviour in the Human Male* (1948) *Sexual Behaviour in the Human Female* (1953).

[3] *Human Sexual Response* (1966)

[4] See Kaplan (1974). Jehu (1979) discusses fifteen separate programmes published between 1970 and 1978.

[5] See *Ethical Issues in Sex Therapy and Research* (here called '*EI*') edited by Masters, Johnson and Kolodny (1977) and BAC Newsletter Feb. 1984 pp.17-20.

difficulties.[1] Clergy are involved with many couples in marriage preparation and counselling and are thus well-placed to assist. However ignorance about this field can lead to suggestions such as the problem being divine retribution, to be cured by certain amounts of churchgoing![2] Few Christian books on marriage mention sexual difficulties or therapy[3]; most imply that sex will be exhilarating and easy, compounding the pain of those whose experience is otherwise.

This booklet is an attempt to assist Christians to understand the questions arising from sexual difficulties. The church should be able to give informed advice and counselling, referring couples to professional therapists if needed. There is some evidence that the Christian tradition has contributed to the causes of sexual dysfunction—even if this is a result of a misunderstanding of the faith. On pastoral grounds at least, therefore, we have a duty to be involved with therapy. It is to be hoped that this booklet will bring sex therapy to the attention of clergy and those ministering to marriages. Christian couples who are experiencing sexual difficulties but who are worried about entering therapy may also find it useful, as will Christians who are already working in this field, but have questions about its ethics. It is also to be hoped that professionals involved in this work will begin to take ethical questions seriously. Even if the reader cannot share our somewhat traditional Christian base, nonetheless we can all agree that these questions are of real concern. So this booklet is offered as a starter to discussion. It deals mainly with the more behavioural approaches to therapy and attempts to describe the various possible ethical positions regarding each question. In so short a compass it clearly cannot be a final statement on the issues; the footnotes and bibliography are intended to assist further debate. Nor is it to be considered as setting out a 'Grove Books policy' on the matter; but we hope it will provoke others to tackle this neglected area.

[1] See below p.6 and note 2.

[2] Cases quoted in *HSI* pp.189-90.

[3] Wheat *Intended for Pleasure* describes some techniques for individual use—but not professional therapy.

2. WHAT IS SEXUAL DYSFUNCTION AND THERAPY?

Like many areas of medicine and counselling, sex therapy is beset by technical vocabulary and explanations. This chapter introduces these concepts and terms and thus acts as a glossary for the rest of our discussion.

1 What is sexual functioning?

Although it may seem like 'doing what comes naturally' in fact sexual response is a complicated mixture of mental and physical reactions. The basic cycle in both men and women goes through four phases[1]: the excitement phase of initial stimulation and arousal; the plateau phase of increasing sexual tension; the orgasmic phase—a totally involuntary response of maximum intensity; and the resolution phase—a lessening of tension and a gradual return to the normal state. These four phases are perhaps best understood as a two-stage system with each stage controlled by a separate physiological mechanism: thus the initial excitement and build up involves swelling of the genitals (through the filling of the blood vessels with fluid—called *vasocongestion*); orgasm involves muscle tension—between three and fifteen muscle contractions at regular 0.8 second intervals. Sexual dysfunction can occur separately in either stage: thus a woman may have a vasocongestive dysfunction which hinders actual intercourse, yet still be readily orgasmic; conversely she may respond easily in the initial phases but not reach orgasm through muscular dysfunction. A similar pattern may be found in men.[2]

Behavioural approaches to sexual functioning understand sexual response as a learned pattern—in much the same way as we learn to talk or read. Dysfunction is thus seen as a result of interrupted or inhibited learning—rather than an abnormality from birth or handicap. Therapy is an attempt to provide another opportunity for correct learning to take place. This can even be appropriate quite late in life, since sexual response continues right through the ageing process (if a little slower in some phases).

2 What causes dysfunction?

Only about 10% of dysfunctional cases are caused by something physically wrong.[3] Causes in such cases include medical conditions (e.g. diabetes), the use of drugs or alcohol, the results of surgery or aspects of the ageing process. By far the bulk of cases, however, have psychological causes; often there is a combination of many different factors—and it is rare that any one such factor can be identified as a sole direct cause. There are two levels of these factors: the immediate and the remote. The *immediate* are related to the present situation: the client's fears and anxiety, especially about the inadequate functioning; the state of the couple's relationship; the level of knowledge or the amount of stimulation. *Remote* factors are of several types: a learned

[1] See *Human Sexual Response* passim.

[2] Kaplan pp.13-15.

[3] Kaplan p.69. Other estimates range between 3% and 20%.

pattern of failure, perhaps beginning with an early traumatic sexual experience; marital discord leading to the sexual difficulties; or the individual's upbringing. Until recently girls were not led to expect to enjoy sex[1]; now the converse is true and very high expectations are formed. Both attitudes may contribute to difficulties. There is some evidence that strict religious orthodoxy plays a significant role among the factors contributing to most dysfunctions[2]: although we might wish to suggest that a negative 'sex is sin' ethic is a misunderstanding of biblical teaching, nonetheless it remains true that someone taught such attitudes in childhood may have sexual difficulties later when married—even if they have subsequently discovered a more positive tradition or have rejected religious beliefs altogether. On the other hand it is also true that over-casual attitudes in upbringing or promiscuity may contribute to later difficulty. Once any of these factors has produced some initial sexual difficulty, the individual finds himself in a vicious circle of failure and anxiety: 'What is wrong with me? Will I get it right this time? Perhaps I'm not a real man (or woman)?' Masters and Johnson stress:

> *'It should be restated that fear of inadequacy is the greatest known deterrent to effective sexual functioning; simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner.'*[3]

In this way, the anxiety causes the difficulty which in turn produces more anxiety and so the spiral continues until normal sexual functioning is made impossible.

3 What are the main dysfunctions?

Dysfunction occurs when there is difficulty with any of the individual phases or stages of sexual response. It may be either *Primary* (i.e. adequate response has never occurred) or *Secondary* (i.e. difficulty after previous adequate response). It may occur in all situations *(total)*, or in certain specific situations only, or at random.

. . . General dysfunctions:

Both sexes may suffer from *inadequate sexual interest*, a lack or loss of desire, and from *inadequate sexual pleasure*, a case of 'feeling nothing'. Painful intercourse, *dyspareunia*, in men is predominantly physical in origin (e.g. hypersensitive glans, infection) and medical remedies should be sought. In women it is much more complex: there are many possible physical causes[4] although it can also be psychosomatic.

. . . Male dysfunctions:

(a) Difficulty with erection *(impotence)* can be very distressing and prevents intercourse taking place. Sometimes erection may be possible

[1] *HSI* pp.217-218.

[2] See for example, *HSI* pp.175-179 (impotence), pp.229-230 (orgasmic dysfunction), p.252 (vaginismus) and Jehu p.33.

[3] *HSI* pp.12-13—their italics.

[4] *HSI* chap. 10 gives a doctor's checklist.

by self-stimulation; alternatively this may be total. There are some physical causes (e.g. medical conditions, drugs, alcohol) but more often psychological. Secondary impotence is more easily treated; but both are amenable to therapy, particularly if there is a very co-operative wife.[1]

(b) *Premature ejaculation* is very common, if difficult to define. The man finds he ejaculates almost immediately upon intercourse or even before entry, leaving his partner frustrated and himself feeling humiliated. It can be understood as a lack of voluntary control over the ejaculation reflex.[2] Psychological factors are the main contributors to this learned pattern of failure. Therapy offers a series of exercises to develop control and success rates are high.

(c) *Retarded or absent ejaculation* affects the second stage of response: erection and thrusting are successful but the man cannot climax or requires a very long time to do so. This is quite rare, usually with psychological factors such as trauma or upbringing in the background; therapy is reasonably successful.

(d) The involuntary discharge of semen back into the man's bladder *(retrograde ejaculation)* is uncommon and usually of physiological origin. It need not affect intercourse although conception may require artificial insemination of the husband's sperm.

. . . Female dysfunctions:

(a) *Vaginismus* is an involuntary muscle spasm of the vagina preventing the insertion of the penis. This distressing and painful complaint leads to non-consummated marriages. Causes are predominantly psychological and diagnosis requires medical examination. Success rates are high.

(b) Analogous to male erection difficulties is female inhibition of the initial lubrication and swelling *(vasocongestive dysfunction)*; thus it does not necessarily prevent orgasm. Usually of psychological origins, it is reasonably amenable to therapy.

(c) *Lack of orgasm* is probably the most common female difficulty. The initial stages may go well, but the muscle response is inhibited and thus no orgasm or resolution occurs. Exact definition is difficult since female orgasm response is varied, much more than society's current expectations imply: some women are often orgasmic in intercourse while others are less often so or require clitoral stimulation also. Causal factors can be quite complex, but are mainly psychological. Primary dysfunction can usually be dealt with through one form of treatment or another. Although orgasm can often be enhanced or increased through therapy, situational dysfunction is more difficult. Kaplan argues that intercourse plus clitoral stimulation to orgasm is normal for many women.[3]

[1] Impotence among men influenced by a strict religous upbringing produced Masters' and Johnson's least successful rates (*HSI* p.213).

[2] Kaplan p.290ff.

[3] Kaplan pp.379, 397-399, 407-409.

In some couples both partners may have difficulty. The most common pairings are premature ejaculation with orgasmic dysfunction or impotence with vaginismus. Such obvious connection emphasizes the need for treatment of couples, rather than individuals. Usually therapy tackles the most easily treated problem first, giving confidence to approach the other afterwards.

4 What happens to a couple in sex therapy?

Sex therapy aims to relieve the actual difficulty; it sets a limited contract with specific goals to be reached often in a relatively short period of time. Essential to sex therapy is the belief that the *couple,* if at all possible, must be treated together and not just the individual.[1] Although therapy conducted jointly by a man and a woman may be preferable, it is not always possible nor necessary.[2] Masters' and Johnson's full-time approach (fourteen days in a hotel) is too expensive for most people and few therapists follow this. Instead the couple are seen regularly (perhaps once a week), remaining at home and at work, and this will last usually between six and twenty-eight weeks. Therapy consists of a mix of behavioural tasks to be practised alone in the privacy of the home and of discussion sessions with the therapist. Resistance to the tasks or 'mistakes' are considered and often reveal underlying attitudes which feed the dysfunction; these can be handled in discussion and psychotherapy.

The actual course of therapy follows much the same direction for all dysfunctions. There is a careful history taking of both sexual experience and upbringing with each partner individually in confidence. Then a 'roundtable' discussion with everyone clarifies the issues and sets a *'contract'* to be worked for. Therapy begins with a total ban on all joint sexual activity except that directed by the therapist. This often comes as relief since it frees the couple from the vicious cycle of inadequate performance. Instead they are instructed in gentle caressing of one another, *sensate focus exercises.* This shifts awareness away from performance demands to a focus on touch and communication. Gradually this *non-demand pleasuring* is allowed to include the genitals as the couple learn to give and receive pleasure from each other. Specific exercises relevant to the dysfunction may then be introduced (such as the 'squeeze' technique to delay ejaculation). The appropriate sexual response is sought gradually: initially through manual stimulation, then transferred to coital expression. As the contract is gradually achieved, the couple are 'weaned off' the therapist's control, and arrangements for proper follow-up and aftercare are made.

5 What are the results of sex therapy?

After a five-year follow-up programme, Masters and Johnson had only a 20% overall failure rate, with variations over individual dysfunctions. Somewhat similar results have been recorded by others on programmes since.[3] Unfortunately little of the data is as yet statistically significant. Furthermore it may be argued that such programmes

[1] *HSI* p.195.

[2] Kaplan, pp.238-9; Jehu p.200.

[3] See Kaplan chap. 21 and Jehu chaps. 14-16.

achieve high success rates because of the highly-motivated clients used. However, while it may be true that one should expect somewhat less high success rates in routine therapy, it nonetheless remains true that the combination of behavioural exercises with therapeutic discussion has made a significant contribution to the treatment of sexual difficulty. Further analysis also provides interesting considerations. The good results are from healthy patients with basically reasonable marriages. The failures include those with severe marital discord, acute psychopathology, and sometimes excessively strict religious upbringing. Sex therapy seems to play a helpful role in building up marriages and preventing divorce[1]—another reason for the church to take it seriously.

6 An initial evaluation of sex therapy

Masters' and Johnson's behavioural method provided a useful corrective to approaching sexual difficulties purely from a psychoanalytic point of view. Yet one might criticize them for going too far in the other direction and laying too much stress on questions of function and performance. Sexual activity involves the whole of a person; attitudes and underlying factors are important. The functional approach, particularly if combined with expectations of high performance, needs to be counterbalanced with notions of love and caring commitment.[2] Now that the initial euphoria has died down, the contribution of Masters' and Johnson's work can be better evaluated and appreciated. The behavioural exercises and the idea of a learned pattern are a significant step forward. However, sex is a more profound experience than other bodily functions, like eating, and thus it is not surprising that many therapists use psychotherapy also. Sex therapy should combine behavioural exercises with dealing with the underlying context of attitudes. It should be placed in a setting which takes ethical—and, we would argue, spiritual—considerations seriously. For a couple who are healthy and have a basically stable relationship such therapy offers a good chance of alleviating their difficulties. We therefore turn to such ethical and theological considerations.

[1] *HSI* pp.368-9; Kaplan p.516.

[2] 'Love is a profoundly personal experience and hence completely foreign to Masters and Johnson's vocabulary and habits of thought'! (Szasz p.40).

3. ETHICAL BACKGROUND

It is difficult for a counsellor to start raising basic philosophical or ethical dilemmas in the middle of dealing with a specific case. An ethical framework should rather be based on principles which are the fruit of prior reflection. Thus before considering the specific questions of sex therapy, we need to consider a brief ethical background.

1 Ethical bases

Most people, including professional therapists, operate with some kind of baseline. Unfortunately it is rarely or consciously articulated. For some, it may be based on personal fulfilment, for others with reference to some external authority. The more clearly this is worked out, the more use it will be for ethical questioning. Most Christians would agree that biblical principles should play an important part in their ethical base, assisted by the Christian tradition and Spirit-guided reason. However, are biblical principles a set of rules, or just vague guidelines? Certainly some passages appear as legal rules, such as the Ten Commandments. Other passages direct one to the spirit of the law, not its letter—such as some of the prophets' or Jesus' teaching. 'Love is the fulfilling of the law' wrote St. Paul (Rom. 13.10). For the purposes of argument, there is a dichotomy between the extremes of *legalism* (everything dictated by laws) and of *situationalism* (assessing each individual situation separately).[1] There is a similar tension in moral philosophy between things being right or wrong in themselves *(intrinsicalism)* and their being right or wrong according to their consequences *(consequentialism)*.

In daily living, however, things seem more often like a spectrum upon which one moves up and down, attempting to balance both the extremes. On the one hand, situationalism can quickly slide into justifying practically anything; on the other, things are rarely as clear-cut as rules imply—often the choice may not be between good and bad but between two evils where the intrinsicalist can do neither. Thus one needs to find a balance between a prior set of principles and a loving compassionate response to the situation in hand.

2 A theological base

Christians will seek to find this balance in their theological base. Jack Dominian uses the criteria of sustaining, healing, and growth, as his base[2]; whereas Una Kroll derives the notion of Creating, Redeeming, and Sustaining Love, from her understanding of the Trinity.[3] While these may be an improvement on the situationalist's 'love', there is still need of clarification. An alternative approach can be constructed in terms of systematic theology—considering the implications of major Christian doctrines for sex therapy.

The doctrine of *creation* points out that the physical world is created by God and is thus 'very good' (Gen. 1.31)—and this includes our bodily

[1] See Joseph Fletcher, *Situational Ethics* (SCM, 1966) p.33 and *passim.*

[2] *Proposals for a New Sex Ethic* pp.37-40.

[3] *Sexual Counselling,* Appendix B, pp.178-181.

existence with its sexuality. Marriage and sex are 'a gift of God in creation and a means of his grace'.[1] In a created world we may expect to find basic principles of the Creator according to which life may be lived in the best possible way. The idea that the world is *fallen* alerts us to the reality that things are not always as we, or God, may wish. To deny suffering is unbiblical as well as unrealistic—and this applies equally to the pain of sexual difficulties. However, the *Incarnation* demonstrates that God is prepared to get involved with the mess of sin and suffering and to take the consequences of that involvement. So we too must get involved with the situation of sexual pain and difficulty in an attempt to bring the love of God to bear upon it. *Redemption* teaches us that God is concerned for salvation, for healing and transforming human shortcomings. Programmes for treatment and therapy are not outside his concern—and should not therefore be outside the concern of his people. Finally, *Sanctification* suggests that the wholeness of salvation includes holiness; there are therefore moral considerations to be applied to therapy.

This then is the theological basis for our consideration of sex therapy. It accepts that there are certain goods and evils intrinsic in the world, but also that living in a fallen world entails the evaluation of situations and consequences, difficult though that may be. While derived from Christian principles, such an approach need not be confined to specifically Christian discussion.[2]

3 Means and ends

Another important area which requires prior consideration is the relationship between acts and their motivation or intention, between *means* and *ends*.

Granted that the end of therapy is an ethical good, viz, the relief of the client's suffering, is therapy entitled to use ethically questionable means to achieve that good? This is where the discussion above comes into play. For the legalist or the intrinsicalist it is not permissible to break any moral rule to bring about the good end—even though not doing so will result in the suffering itself going unrelieved, which is clearly a bad outcome from the decision. However if one makes the decision on the grounds of consequences, then it may be the case that the loving intention to attain the ideal good at the end may permit certain means, dubious on their own. One has to weigh up which is the greater evil (leaving the suffering unrelieved or using the means) and which is the greater good (relieving the suffering or not using the means). Attempting to weigh up such decisions is notoriously difficult. A similar situation often occurs in medical prescription when a doctor needs to weigh up any negative side effects of a drug against the positive treatment it can offer. Clearly ends do not justify all means and there comes a point where a certain means cannot be used despite an intended good end. It would seem unwise to be breaking moral norms

[1] ASB Marriage Preface, p.288.

[2] 'It is the divergence between the world of reality and how we wish things might be that prompts the need for a discussion of ethics' (R. C. Kolodny in *EI*, p.52).

in a cavalier fashion, justifying this by the intended ends, so caution is advisable. Nonetheless a cautious use of consequentialism can help with the dilemma of choosing between two evils, neither of which the intrinsicalist may do.

4 Personal and professional ethics

The word 'ethics' is used to describe both personal moral behaviour and the appropriate standard of conduct expected in a profession. When discussing ethical issues in sex therapy it is important to realize the distinction. To illustrate: suppose a man and a woman, not married, have intercourse. In certain views of personal ethics, such as the traditional Christian teaching, this may be considered as unacceptable behaviour. The couple however may hold different views and consider it their own affair. Now suppose the man is a doctor and the woman his patient: intercourse between them is regarded as professionally unethical, regardless of the personal moral beliefs of the couple, and the doctor may be censured or struck off the GMC Register for such a breach of ethics. Thus it is possible to distinguish the individual ethical beliefs of both therapist and client from the professional ethical issues of therapy itself and its techniques. To date, the little discussion of sex therapy there has been has tended to focus only on the professional area. However both aspects are important and in the caring professions such compartmentalization between the personal and the professional is not easy. If the techniques of therapy offend the personal ethics of therapist or client there will be problems. Thus we shall be considering the question of therapy techniques and personal ethics in chapter 4 and the wider professional ethics in chapter 5. First however we will consider briefly the Christian ethics of sex and healing.

5 A Christian ethic of sex

Human sexuality and its expression in terms of gender and personal relationships is something good and God-given. This ethic is demanded by our doctrine of creation mentioned above (Gen. 1.27, 31). The Bible itself has this positive ethic: marriage is a delight not to be forbidden (Prov. 5.18-19; 1 Tim. 4.1-5), nor is sex to be refused (1 Cor. 7.5); there is even the erotic poetry of the Song of Solomon! Unfortunately Christian tradition has not always held this positive ethic: the contribution of strict religious upbringing to sexual difficulties has already been mentioned. Thus it is good to see more recent Christian books and teaching rediscover the positive attitude of the Bible.[1] Granted a positive ethic that sex is good and God-given, what are its purposes and context?

In Genesis two *purposes* may be discerned: the procreational (1.28) and the relational (2.18). In the past the former was stressed by the church; much modern emphasis is almost totally on the relational or unitive purpose. A Christian sex ethic must accommodate both purposes. Some sexual difficulties can prevent procreation (e.g. impotence, vaginismus, or ejaculatory problems); all the dysfunctions disrupt the loving relating of husband and wife. If the God-given

[1] See for example Wheat or Joyce Huggett's writings.

purposes of sex are hindered by sexual dysfunction, then a Christian's commitment to sex therapy may be seen as part of his being involved in God's redeeming of creation.

The *context* for full sexual expression in intercourse is seen by both scripture and tradition as marriage. Some recent Christian writings suggest that a relationship of love and commitment is sufficient[1], while others, including the present writer, prefer to see marriage as the normal context.[2] Given that the context of a stable relationship and the support of a committed partner are two factors which make the alleviation of dysfunction in sex therapy much easier, this too could be seen as further justification for the traditional teaching. Within the permanent relationship of Christian marriage, sexual difficulties can be faced and tackled in the best atmosphere of love and total commitment.

6 An ethic of healing

The doctrines of the incarnation and redemption together with the fact that Jesus spent much of his time healing, indicate that the alleviation of suffering, including sexual difficulty, is a good and ethical activity. God is the source of all health and healing and therefore it is right that those experiencing sexual difficulty should turn to him. It is possible that miraculous healing through prayer may occur. However since the causal factors are complex and God's concern is for healing of the whole person it is not unreasonable that God gives healing more often through therapy. There may need to be healing of past hurts or memories first; a too functional approach to therapy may miss this. Dealing with the sexual difficulty may be just part of the path to greater wholeness. Wholeness may include the opportunity to learn through the experience of suffering and difficulty to discover grace made perfect in weakness (2 Cor. 12.7-9)—for full healing is never possible in this life. Granted all this however, nonetheless it is right for a Christian to seek the help of a doctor for the relief of suffering and therefore to consult a therapist about sexual dysfunction.

[1] e.g. U. Kroll, p.180.

[2] e.g. J. Dominian, p.41, Wheat and Huggett *passim.*

4. ETHICS AND THE BASIC TECHNIQUES OF THERAPY

Christian ministry has a particular concern for those afflicted by suffering or trapped by anxiety. The ethical background above has suggested that the church should be involved with sex therapy as it attempts to alleviate sexual difficulty. However do the specific techniques raise ethical questions for the Christian?

1 The use of a therapist

Here the ethical question is whether it is right to admit someone else to the heart of a marriage and give them that control of 'conjugal rights' which belongs to the husband and wife (1 Cor. 7.4). We have noted the vicious spiral of anxiety, difficulty and failure which feed each other in sexual dysfunction. The introduction of a third party to direct affairs temporarily is a way of breaking this spiral. The therapist can assist the couple to face the difficulties and facilitate communication of their feelings, to enable them to understand each other's hurt and to express their continuing love.[1] The intended consequence is the full expression and restoration of conjugal rights, so the use of a therapist as a temporary means would seem quite appropriate.

A subsidiary question then arises as to whether the therapist should be a Christian. For a Christian couple a Christian sex therapist who would be able to pray with them as well as give therapy would be ideal—but such are few. The crucial issue is the privacy of one's inner life and the need for the couple's beliefs and values to be respected. In a similar way we may need to admit doctors, lawyers or psychologists whom we trust into our inner lives, even if not practising Christians. What is important is that the therapist should be sympathetic, or at least, not antagonistic, to the couple's faith and values.[2]

2 The temporary ban on sexual intercourse

Here the ethical question turns on how a ban on sexual intercourse can be acceptable, given that St. Paul forbids the refusing of conjugal rights (1 Cor. 7.3-5). The first thing to note is that he allows for a limited abstinence by agreement for a specific purpose, viz. prayer; the same principle may be extended to include abstinence for the purpose of therapy. Furthermore, neither partner is actually giving the other conjugal rights in a situation of dysfunction. The temporary ban is to facilitate the intended end of full conjugal rights of adequate sexual functioning to both partners and so this would seem justifiable. In fact, this is a good example of the benefit of the therapist's control: with the anxiety of intercourse removed, the husband and wife learn to communicate love and tenderness in non-coital expression.

3 Non-demand pleasuring

The sensate focus exercises are an expression of love through touch and thus raise no ethical problems. Touch is an important means of communication and one used expertly by Christ himself. Sometimes the client may feel uncomfortable about taking pleasure and starts to

[1] Mace p.48.

[2] See further page 19 below.

worry about being 'selfish'. This is particularly so for women with general sexual dysfunction: 'This is selfish. I'm sure I ought to be dealing with *his* needs'.[1] In fact this can be an avoidance mechanism to turn off the sexual response. The client needs to be encouraged to learn to accept her husband's loving touch; in her turn she can give pleasure back. In discussion with the therapist such emotional conflicts about erotic arousal can be discussed and worked out. The ability both to give pleasure and to receive that given by the partner is in full accord with our understanding of Christian love.

4 The use of tasks

Most of the tasks prescribed by the therapist are simple, for instance, the Kegel exercises to strengthen the pubococcygeus muscles around the vagina.[2] These raise no more ethical questions than being told to 'take this tablet twice a day before meals'. However is every form of sexual expression ethically acceptable between husband and wife, including manual or oral stimulation? It is true that at times in Christian history such acts have been condemned. The reason for this was the stress on the procreational purpose of sex and such acts have no procreational possibility. Even today if one asserts that every sexual act must have both a procreational and a relational intent, this would argue against non-coital sex. On the other hand, if every act is procreational in that it builds up the family unit,[3] or if the procreational purpose is satisfied in raising some children and need not be present in every act, then non-coital sex, like intercourse with contraception, is acceptable. From the point of view of the relational purpose, if such activity is helping the couple to relate better in expressing their love then this too justifies it. It is notable that the Bible, which is not slow to condemn certain sexual practices such as adultery, never forbids non-coital sex which was presumably practised as much then as now. Instead it teaches a total giving of one to the other in love. Thus there is no reason to condemn any practice undertaken by husband and wife to give pleasure to one another to build up 'the joy of their bodily union'.[4] Given this basic principle, let us examine certain specific tasks.

5 Manual stimulation

Stimulation by hand plays a prominent part in sex therapy. The initial exercises consist of gentle stroking or caressing; once those are completed, adequate sexual functioning is sought from manual stimulation—which is easier than the more demanding (and anxiety ridden) intercourse. In therapy for orgasmic dysfunction in women and for retarded or absent ejaculation in men, orgasm by manual stimulation alone is sought first, then together with the partner and finally in intercourse. Similarly the use of stop-start and 'squeeze' exercises for premature ejaculation involve the wife's stimulation of her husband by hand.[5] Some clients will have had a strict upbringing which condemned masturbation and this may awaken old fears: how can manual stimulation be justified in therapy?

[1] See Kaplan pp.369-370.
[2] Described in Jehu pp.166-7, Wheat pp.94-101.
[3] A modern Catholic view expressed by J. Dominian p.83.
[4] ASB Marriage Preface p.288; see J. White pp.24-25 for a similar view.
[5] Described in *HSI* pp.103-107, Kaplan pp.305-307 or Wheat pp.85-93.

While it is true that much of the church's teaching has condemned masturbation[1], the Bible does not, but is notably silent on the matter.[2] This fact, together with modern researches showing it to be an almost universal practice, should give Christians grounds for questioning the traditional condemnation.[3] However our concern here is not for masturbation itself, but for manual stimulation as part of therapy. This involves one partner bringing the other to orgasm outside of actual intercourse.[4] Our discussion above shows that this is only questionable if one holds that every act must have procreational possibilities; from the relational point of view such physical expressions of love are a perfectly acceptable part of the range of love-making. A client's resistance to this task may reveal an inability to cope with sexual arousal or a negative upbringing. In discussion the therapist will explore such underlying attitudes. Manual stimulation is an acceptable form of physical expression in marriage and also a way of developing sexual response as a means to the end of full sexual functioning.

6 The use of the imagination

Anxiety about the difficulty—'will I be able to do it all right this time?'—leads either or both partners to observe what is happening to them; such self-monitoring causes them to become detached from both the situation and their own feelings of arousal and thus to be unable to respond adequately. Such self-observation is termed *'spectatoring'*[5] and it occurs with many dysfunctions. It is particularly a problem for the client who has never experienced erotic arousal: in such cases the right physical stimulation may be received but her inability to handle it causes her to 'switch off'. In order for the caressing exercises to enable her to concentrate on experiencing her feelings, this 'switch off' mechanism and 'spectatoring' must be bypassed. One way to do this is via the imagination. Much counselling uses the imagination and 'fantasy journeys' to enable people to get in touch with their real feelings which the conscious mind is blocking. So in sex therapy, clients may be encouraged to re-live in imagination situations when they were aroused. Alternatively they might imagine totally fictional events. Practising such imagining while being caressed often enables the client to get over the mental barrier and to start receiving stimulation. It is thus a temporary means towards the end of enabling a patient to experience arousal and the wise therapist is careful to safeguard the client from becoming 'hooked' on any one fantasy. Once the client learns to experience arousal, the need for fantasy usually diminishes.[6]

Once again, the ethical question involves ends and means: the end of experiencing one's feelings is good, but what of the means?

[1] 'a grave disorder, an intrinsically and seriously disordered act' (Vatican Declaration on Sexual Ethics 1976).

[2] Gen. 38.8-10 refers to *coitus interruptus* not masturbation; further Onan is punished not for his sexual activity but for displeasing the Lord (v.10), which probably refers to his denying his brother offspring, thus transgressing the levirate laws.

[3] Dominian Chap. IV proposes a new ethic.

[4] See further Mace p.29.

[5] *HSI* p.65; Kaplan pp.119, 132-133.

[6] See Kaplan p.391 for further discussion.

Traditionally, Christians have been wary of sexual fantasy, condemning it as 'lustful thoughts' forbidden by Jesus: 'I say to you that every one who looks at a woman lustfully has already committed adultery with her in his heart'.[1] However does this verse condemn such a use of the imagination in therapy? The principle to which Jesus is directing us is that a man should love his own wife, not lust after someone else's, and so break the seventh commandment. The use of sexual fantasy in therapy is deliberately designed to enable husband and wife to fulfil their love for one another, and to prevent them seeking sexual relief outside the marriage, through alleviating their difficulty. It is thus in full accord with Jesus' intention to preserve a couple's relationship.

Often fantasy will involve one's partner in some exciting situation—but does Jesus' teaching apply against fantasy involving others? In fact the bulk of sexual fantasy does not involve real people known personally to the fantasiser: often they are completely faceless[2] or involve 'unobtainable' people such as film stars. Such fantasy is used as a stimulus to sexual arousal and is in turn fed by the partner's activity.[3] One may distinguish between the use of such fantasy to build up a marriage and the deliberate lusting after another person outside the relationship.[4] The latter is what is condemned by Jesus; it is also damaging to the couple's relationship and thus therapeutically useless. The former is a means of avoiding 'spectatoring' and helping a client to experience her feelings. Resistance may indicate underlying negative attitudes to be considered in discussion with the therapist.

7 Erotic literature and other aids

As with imagination and fantasy, so also the use of literature can help clients over the mental barrier of 'spectatoring' to reach their sexual feelings. There is a vast range of literature with sexually explicit content of course. One may start with the Bible and read the Song of Solomon; then there are classics of literature such as *Lady Chatterley's Lover.* Others may find pictures helpful, nude paintings or photography or even male magazines. Can such material be used in therapy?

If we take an *intrinsicalist* position, then the ethical acceptability depends on the material itself—whether it is intrinsically good or bad. Most intrinsicalists would draw a dividing line in this range—but criteria are notoriously difficult to define. One candidate might be method of representation—the written word is acceptable, but the photograph is not. However some pictures can be very tasteful, while writing can be disgusting. Are aesthetic criteria our guide then? The problem here is that one man's taste often differs greatly from another's. Another possibility is detail—how much is actually revealed. Unfortunately this too is a relative and arbitrary criterion; over the last two decades how much may be exposed, and in which contexts, has altered radically. Quality is also used in an attempt to distinguish art

[1] Matt. 5.28. See the commentaries for how this is interpreted as a ban on the imagination and certain books or films: e.g. F. Filson (A & C Black, 1960) p.86; R. Tasker (Tyndale, 1961) p.69; J. R. W. Stott (IVP, 1978) p.91.

[2] N. Friday *My Secret Garden—Women's Sexual Fantasies* (Quartet, 1976) p.8.

[3] *Idem* p.28.

[4] See J. White p.94 for a similar distinction.

from pornography—but what of poor art or quality pornography?[1] These criteria are difficult to evaluate but it is by their use that the intrinsicalist must decide what is intrinsically acceptable. The *consequentialist* on the other hand considers the intention and the consequences. What makes sexually explicit material acceptable in therapy is the intention of alleviating suffering and the consequences of achieving normal sexual functioning.[2] Of course he must regard other consequences and side-effects: the replacement of one difficulty by another (such as enslavement to pornography) is of little benefit.

Both approaches would seem to accept the therapeutic use of well-produced good quality material designed to assist clients experience their sexual feelings. However there is difficulty in obtaining such aids. Other aids include prosthetic aids for the disabled and the use of dilators to overcome vaginismus.[3] Some have tried other aids, such as energiser rings or penile implants for erection difficulties[4] but have won little medical support. Probably the most common aid is the massager or vibrator for orgasm difficulties. By providing intense stimulation, the vibrator often provides clients with their first experience of a climax; they are then encouraged to transfer this experience to manual and eventual coital stimulation. As with the imagination there is a danger of the client becoming 'hooked' on the vibrator and so it is a temporary measure with the ultimate aim as intercourse.[5] The use of such aids raise no more ethical questions than similar forms of medical assistance. However problems do arise in obtaining these aids. Vibratory massagers for muscle relief and cramp can be obtained from high street stores and chemists and these can be used. More specifically sexual vibrators and other aids can usually be obtained only from back-street sex shops which are often opposed by Christians' and women's groups as immoral and exploitative. If such places are to be avoided on ethical grounds, where are the healthy outlets for good quality sex aids and literature? Una Kroll argues:

> 'There is still widespread ignorance about the proper use of sex aids and many people in western society seem to associate them with pornography rather than with therapy and healthy sexual intercourse. Those who are concerned with sex education need to identify and clarify the differences between healthy interest, therapy and pornography so that sex shops, film producers and publishers can offer a wide range of interesting educational material without recourse to unpleasant "soft" or "hard" pornography or making use of children.'[1]

The main tasks and techniques in therapy can be justified within the ethic of sex as God-given and of the need to alleviate suffering.

[1] Pornography does raise many other issues, e.g. its production, profiteering, exploitation, and the effect on society. Cf. the Longford Report on Pornography (1972) and J. H. Court, *Pornography: A Christian Critique* (Paternoster, 1980).

[2] See J. White on pornography and treatment, pp.124-125.

[3] *HSI* p.263.

[4] Jehu p.168.

[5] Kaplan p.389.

[6] *op. cit.*, p.153.

5. THE WIDER ISSUES

Unlike the previous chapter, the following issues are beginning to be discussed in certain parts of the therapeutic profession. [1] They can be raised here only briefly; for further discussion see the report of the 1976 Reproductive Biology Research Foundation conference, *Ethical Issues in Sex Therapy and Research* (here called *'EI'*).

1 Therapist's and client's sexual value systems

It was suggested above[2] that the therapist should not be antagonistic to the client's sexual value systems. A couple's moral or religious beliefs will affect their sexual attitudes and are part of the history-taking.[3] In counselling, the classic position of the counsellor is to be neutral; in practice this is hard to achieve[4] and so couples might like to discuss the therapist's own values before starting treatment.[5] Masters and Johnson are very clear that therapy should operate within the clients' own system and this was agreed by many others at their conference.[6]

Unfortunately this is not always possible: for example, suppose a woman with orgasmic dysfunction is asked to engage in manual stimulation for her therapy, but considers this to be 'sinful' or 'dirty'. In discussion of these attitudes, the therapist may challenge the client's values since they contribute to the difficulty and hinder treatment. This need not be considered unethical so long as such an attempt to challenge or modify clients' values is limited to those connected with the dysfunction.[7] A therapist should think carefully about such occasions and only proceed with the client's full and informed consent. It may be that some would find alteration of their values even more intolerable than the actual dysfunction itself.[8] Therapists should be careful to avoid too much emotional pressure when clients are vulnerable and to allow them a free choice. Nonetheless we argued in chapter 4 that none of therapy's techniques need be considered immoral by Christians: clients worried about such techniques may benefit from considering such arguments or discussing it with their minister of religion.

2 Is therapy for married couples only?

Masters' and Johnson's original programme dealt mainly with 'marital units',[9] but much therapy is offered to 'couples' without specifying that they should be either married or heterosexual, for example, by the Marriage Guidance Council. The Christian therapist needs to decide whether she will treat only Christians or everyone, only married people or all couples, and only heterosexuals or include homosexual couples also. The dilemma here concerns to what extent Christians can expect their ethics to be shared by an unbelieving world. Some values, such as

[1] See BAC Newsletter Feb. 1984.
[2] See page 14 above.
[3] *HSI* pp.25-26.
[4] *EI* p.49.
[5] Kroll's suggestion, pp.130-131.
[6] *EI* p.168; see also pp.147-148, 157-158, 214-215.
[7] *EI* p.158.
[8] *HSI* p.26.
[9] *HSI* pp.353-354.

the prohibition of murder or of stealing, we may have in common; others, such as Sunday worship, we do not. Sexual and marital values fall into an area where the Christian may have to work with others who do not share her views, while at the same time maintaining a prophetic witness to them. Such difficult decisions occur in other caring professions, such as whether a Christian doctor should prescribe contraceptives for unmarried girls. The Christian therapist must decide in advance whom she will treat: if it is married couples only, she should be respected by the counselling profession for her integrity to her beliefs and not dismissed as 'narrow-minded'. Alternatively, if she decides to treat all who are in need, the church should support her concern, not criticize her for laxity.

3 Those without partners and the use of surrogates

The next question concerns those who are not part of a couple at all, married or otherwise. Masters and Johnson treated 54 single men and three single women in their original programme. Some brought their own 'replacement partner' but 41 men were supplied with female surrogates. No women requested a male surrogate, so none were used.[1] The use of surrogates did not go uncriticized[2] and by 1976 Masters and Johnson had discontinued the practice for legal and therapeutic reasons: the surrogates were coming to regard themselves as therapists and litigation threatened.[3] In Britain surrogates have been used at the Institute of Sex Education and Research in Birmingham under Dr. M. Cole.[4] Surrogacy continues to be a live issue in America, especially since large sums of money are involved in 'sex-clinics' using surrogate-prostitutes.[5] There are, of course, legal questions here of pimping or prostitution.

The ethical question however turns on what to do about a single client, usually a man, who is suffering from a sexual dysfunction (such as impotence) which has made him so anxious that he is incapable of forming any relationship and subsequently entering therapy.[6] The intention of using a surrogate in such cases is that the client, relieved of both difficulty and anxiety, will be able to go on to form normal relationships. What do the differing ethical approaches have to say to this question? Both the *intrinsicalist* and the *legalist* may argue that sex with a surrogate outside any loving relationship is totally wrong and cannot be undertaken, whatever implications not having therapy may entail for the client. The *consequentialist* will attempt to weigh the consequences of not having therapy against the consequences of the presumed immoral act of using the surrogate. Unfortunately neither set of consequences is easy to determine or evaluate and therefore this approach may advise against surrogacy, if at all possible, on the grounds of caution. Another approach is to consider whether the *end,*

[1] *HSI* pp.154-156.

[2] *EI* p.31; it provdes Szasz with one of his major lines of attack on sex therapy—pp.46-61.

[3] *EI* p.176; Jehu p.184.

[4] Jehu p.184; Szasz p.54.

[5] See *EI* pp.154-155; Jehu p.184; Szasz pp.49-61.

[6] See for example Kroll's 'Peter', pp.154-155.

relief of the difficulty and anxiety, is sufficiently good to justify the *means,* using a surrogate; yet another would lay out all the possible options and choose the *lesser evil.* All these latter approaches are beset by difficulties in evaluating and weighing up relative claims. It is not therefore surprising that many professional therapists are reluctant or even unwilling to use surrogates: instead other ways are sought such as giving the person individual psychotherapy to alleviate the anxiety together with reassurance that the sexual difficulty can be handled as and when he has a partner.[1] Quite clearly the traditional Christian teaching that sex is for marriage will not permit the use of surrogates. Granted that this is not available however, it may be argued that the church has a pastoral opportunity to assist such impotent or anxious individuals. It may offer sacramental confession or healing of the memories but above all it can provide an environment for the person to discover that he is loved just as he is, anxieties and difficulties notwithstanding, both by God and by others in the church; through that love he should grow into greater wholeness to make his own decision whether to remain single or form relationships.

4 Therapist's sexual involvement with clients

Some clinics, particularly in America, include sexual activity between therapist and client or observation of the clients' own love-making. Most professional opinion is agreed that such practices are ethically unacceptable as well as therapeutically damaging.[2] It is professionally unethical since this exploits the clients' vulnerability and dependence on the therapist—an irresponsible abuse of one's position.[3] As regards observation, it would place intolerable strains on clients in an already anxiety-ridden situation; it is suggested that anyone proposing this is doing so for his or her own sexual gratification.[4]

Genital examination is however a little more difficult. A physical examination by a doctor was part of Masters' and Johnson's history-taking.[5] When treating vaginismus it may be appropriate for a doctor to demonstrate the severity of the vaginal muscle spasm to both husband and wife in a medical examination. Any genital examination should be done only by a doctor.[6] Marriage Guidance counsellors will refer clients to their own G.P. or Family Planning Clinic doctor if necessary. Unfortunately some non-medically qualified therapists do include practical teaching or examination of the genitals. Since this is open to abuse, it is best avoided: unlike doctors, sex therapists have no professional code of ethics to protect their clients.

[1] Kaplan's approach, pp.237-238; see also *EI* p.154.

[2] Kaplan's sole use of the word 'ethics' in 544 pages is to attack this! (*op. cit.* p.204).

[3] 'The Counsellor or Sex Therapist should not engage in sexual activity with a client' (Principle 11, ethical code of BAC PSMF Division: BAC Newsletter Feb 1984, p.17). See also *EI* pp.149-151, 158-160, and *HSI,* p.389.

[4] Jehu p.2; *EI* pp.153, 159-160.

[5] *HSI* pp.57-60.

[6] Genital examinations where necessary to exclude abnormality should be done by a doctor. Genital examinations for other purposes, e.g. educational purposes, should be under direct medical supervision. (The legal position in this area is uncertain)' (PSMF Code, Principle 12, BAC Newsletter Feb 1984 p.18).

5 Codes of professional ethics in sex therapy

Sex therapy is now practised by many individuals from many disciplinary backgrounds, such as doctors, social workers or Marriage Guidance counsellors—all with varying amounts of training. There is no one professional organization with a code of ethics to oversee therapy, as is the case for doctors (the G.M.C.) or lawyers (the Law Society). The British Association of Counselling: Personal, Sexual, Marital and Family Division Code is presently held in abeyance; the Association of Sexual and Marital Therapists has yet to produce a code. There are important questions about training, selection, trustworthiness, and confidentiality, which need to be tackled. The lack of professional qualifications and of an ethical code is unsatisfactory and worrying to many therapists themselves.[1] It was for such reasons that Masters and Johnson convened the 1976 RBRF Conference.[2] No decisions were actually made, but Carl Shultz suggested the following:[3]

> '200 hours of supervised training; no nudity in one to one relationship; the therapist not to be judgemental or propagandize his sexual point of view; the client's right to his own sexual values; no genital examination to stimulate a sexual response; no bodily contact for erotic stimulation; total confidentiality; traditional professional forms to be used to announce practice; unethical to pronounce judgment on another therapist without research or data.'

Until such a code is widespread among sex therapists in this country, questions of professional ethics must continue to be raised.

6 The ethics of research

Adequate sex therapy depends on proper research: Masters' and Johnson's therapy programme built upon their own research into sexual functioning. Sex research also raises its own crop of ethical questions: for example, whether observation of sexual activity is justified for the purposes of research; the subjects' willing and informed consent; total confidentiality; the avoidance of certain activities such as the use of children. Such questions are important but beyond our scope.[4] However it must be said that if sex therapy is desirable and justifiable through an ethic of healing and redemption, the careful research it requires is also acceptable provided such questions are tackled.

7 Christians and sex therapy

Christians may be involved with therapy at various levels. First, Christian marriages are not immune to sexual difficulties. The present conspiracy of silence and the myth of 'marriages made in heaven' only add to suffering and anxiety: 'we must be abnormal or sinful; no-one else has these problems'. Such couples need to be reassured that sexual difficulty is neither uncommon nor sinful. Therapy offers the

[1] See for example Mace p.49; or Dr. Elphis Christopher BAC Feb 1984, p.18.
[2] *EI* p.181.
[3] *EI* pp.191-192.
[4] See *EI passim* for full discussion.

opportunity for healing and learning together afresh the God-given joy of sexual relations in marriage. Therapy need not be considered unethical nor avoided by Christians. A Christian therapist would be ideal, but there seems no reason to refuse treatment from any therapist who takes the professional ethical issues outlined above seriously.

Second, clergy have many opportunities with couples in preparation before marriage and counselling afterwards. They should have a basic understanding of sexual function and dysfunction since many couples' problems can be solved by basic information and an opportunity to discuss things openly. It is however important to be aware of one's limitations. To undertake intensive therapy requires professional training; so the wise vicar will have good contacts with local doctors, FPA or MGC counsellors to whom he can refer couples needing therapy.

Third, there are opportunities for Christians to be involved in the profession itself. William Masters invited and welcomed theological contribution to the ethical debate[1] and the church should respond to this invitation. Christian therapists need to consider the various ethical questions. They need to have thought out their own sexual value system and to be happy with the ethics of therapeutic techniques. They need to decide whom to treat and within what context—as individuals or within organizations such as the Marriage Guidance Council.

Lastly, it might be remarked that there is a particular opportunity for Christian counselling in this area. If fear, negative upbringing or initial sexual trauma are factors underlying dysfunction, the Church can offer healing in these areas. The positive attitude of the Bible can be a revelation to someone brought up with a 'sex is sin' ethic. The knowledge that God loves each individual enough for Jesus to die for each one is precious when dealing with fear and inadequacy. The use of prayer therapy to heal painful memories through the accepting love of Christ may have a significant contribution to make to healing past sexual trauma.

Ethical, theological, and pastoral, considerations all suggest that Christians may not only receive or practise therapy, but have a real ministry to offer to those in sexual difficulties. Sex therapy does not have all its ethics worked out satisfactorily as yet. Clergy and lay people will wish to continue to raise ethical considerations but they also have a contribution to make to the therapeutic process.

[1] *EI* p.208; chapter 2 pp.20-51 contains theological papers and discussion.

APPENDIX: BIBLIOGRAPHY

British Association of Counselling *Newsletter* Feb 1984
(The retiring chairman of the Personal/Sexual/Marital/Family Division expresses concern over the ethics and training of therapists pp.17-20).

F. Belliveau and L. Richter: *Understanding 'Human Sexual Inadequacy'* (Coronet, Hodder and Stoughton, 1971). (The official popular guide to *HSI*).

J. Dominian: *Proposals for a New Sexual Ethic* (Darton Longman and Todd, 1977) (An attempt to use modern psychology in Christian ethics)

D. Jehu: *Sexual Dysfunction: A Behavioural Approach to Causation, Assessment and Treatment.* (J. Wiley and Sons, Chichester, 1979). (An analysis of the material from Masters and Johnson onwards).

H. S. Kaplan: *The New Sex Therapy* (Baillière Tindall, London, 1974). (The classic manual for therapy).

U. Kroll: *Sexual Counselling* (SPCK (Care and Counselling Series), 1980). (A careful discussion of the area from a Christian viewpoint).

D. Mace: *Sexual Difficulties in Marriage* (National Marriage Guidance Council, 1972) (An introduction from the MGC's first General Secretary).

W. H. Masters and V. E. Johnson: *Human Sexual Response* (Little Brown, U.S.A., 1966). (How sexual functioning should be).

W. H. Masters and V. E. Johnson: *Human Sexual Inadequacy* (Churchill, London, 1970). (A description of their treatments).

W. H. Masters, V. E. Johnson and R. C. Kolodny (Editors) *Ethical Issues in Sex Therapy and Research.* (Little Brown, U.S.A., 1977). (Reproductive Biology Research Foundation Conference, Jan 1976).

T. Szasz: *Sex: Facts Frauds and Follies* (Blackwell, Oxford, 1981) (A critical look at sex therapy and education).

E. and G. Wheat: *Intended for Pleasure: Sex Technique and Sexual Fulfilment in Christian Marriage.* (Scripture Union, 1979). (A D.I.Y. guide to sex, its functions and problems, pregnancy and ageing, includes details of some exercises used in therapy).

J. White: *Eros Defiled, the Christian and Sexual Guilt.* (Inter-Varsity Press, 1977) (An attempt to handle sexual use and abuse from an evangelical point of view).

Useful Addresses in Britain

Association of Sexual and Marital Therapists, P.O. Box 62, Sheffield S10 3TS.

British Association of Counselling (Personal/Sexual/Marital/Family Division), 37a Sheep Street, Rugby, Warwickshire, CV21 3BX

Family Planning Association—see local Family Planning Clinic

National Marriage Guidance Council, Herbert Gray College, Little Church Street, Rugby, Warwickshire (or local office—see telephone directory)

GROVE BOOKLETS ON ETHICS

This series is published once a quarter, and each title has 24 pages and costs **85p.** Nos. 2, 3, 4, 6, 7, 10, 11, 12, 14, 15, 18, 21 and 23 are out of print. Asterisked titles have been reprinted.

1.* **THE CHRISTIAN AND THE UNBORN CHILD (Revised Edition)** By Oliver O'Donovan
5a.* **A CHRISTIAN CRITIQUE OF CAPITALISM** By Donald Hay
5b. **A CHRISTIAN CRITIQUE OF SOCIALISM** By Donald Hay (48 pages **£1.60**)
8.* **ONE FLESH: A Christian View of Sex Within, Outside and Before Marriage** By Paul Ramsey
9.* **THE HOMOSEXUAL WAY: A CHRISTIAN OPTION?** By David Field
13.* **USING THE BIBLE IN ETHICS** (20 pages) By Bruce Kaye
16.* **EVANGELISM, SALVATION AND SOCIAL JUSTICE** By Ronald J. Sider (with a response by John Stott)
17. **CULTURAL PATTERNS AND MORAL LAWS** By Greg Forster
19. **MEASURE FOR MEASURE: Justice in Punishment and the Sentence of Death** By Oliver O'Donovan
20. **CONSERVATION AND LIFESTYLE** By Klaus Bockmuhl
22. **MORAL EDUCATION IN A SECULAR SCHOOL** By David Kibble
23. **COURTSHIP** By Richard Griffiths
24. **SIN, STRUCTURE AND RESPONSIBILITY** By Greg Forster
25. **GENETIC ENGINEERING** By D. Gareth Jones
26. **MARRIAGE AND PERMANENCE** By Oliver O'Donovan
27. **ETHICAL DIALOGUE WITH OTHER RELIGIONS** By Myrtle Langley
28. **TRADE UNIONS: The Modern Problem and the Response of Christians** By David Attwood
29. **IN THE CIRCUMSTANCES** By John Gladwin
30. **SICKNESS UNTO DEATH: The Art and Care of the Dying** By Duncan Munro
31. **HUMAN RIGHTS: A Study in Biblical Themes** By Christopher Wright
32. **CHRISTIANITY AND DUE PROCESS OF LAW** By John Bullimore
33. **THE MORAL MAZE** By Eric Woods
34. **LAST ORDERS PLEASE: A Study in the Use and Abuse of Alcohol** By Philip Crowe
35. **CHRISTIAN ETHICS IN THE OLD TESTAMENT** By Greg Forster
36. **THE VALUES OF SCIENCE** By David Atkinson
37. **HARD CHOICES** By Richard Griffiths
38. **THE SPADE AND THE THISTLE: The Place of Work To-day** By David Attwood
39. **HAPPY FAMILIES!** By John Gladwin
40. **HONEST TO GOODNESS: Moral Experience and the Existence of God** By Vernon White
41. **PUSHING ASUNDER?** By John W. Bullimore
42. **LAST RIGHTS—Christian Perspectives on Euthanasia** By Stephen A. Wilcockson
43. **CHILDBIRTH: A Christian Perspective** By Jenny Cooke
44. **WORLD ENERGY NEEDS AND RESOURCES** By Peter Hodgson
45. **POLITICAL EDUCATION IN THE CONTEXT OF RELIGIOUS EDUCATION** By David Kibble
46. **THE HUMAN USE OF ANIMALS** By Richard Griffiths
47. **'TO LIVE GOOD'—THE POLICE AND THE COMMUNITY** by Greg Forster
48. **TRANSSEXUALISM AND CHRISTIAN MARRIAGE** By Oliver O'Donovan
49. **BANNING THE BOMB? AN ARGUMENT FROM THE 'JUST WAR' POSITION** By Colin Fletcher
50. **MEDICAL MATTERS—THE PATIENT'S CONSENT** (20 pages) By E. David Cook
51. **THE USE OF THE BIBLE IN SOCIAL ETHICS** By Christopher Wright
52. **ARTIFICIAL INSEMINATION BY DONOR** By David Ison
53. **THE CHRISTIAN CONSCIENCE AND JUSTICE IN REPRESENTATION** By Colin Buchanan
54. **VIDEOS, PERMISSIVENESS AND THE LAW** By Francis Bridger
55. **JESUS AND SOCIAL ETHICS** By Stephen Mott
56. **PEACE AND WAR: A DEBATE ABOUT PACIFISM** Between Ronald Sider and Oliver O'Donovan
57. **SEX THERAPY: SOME ETHICAL CONSIDERATIONS** By Richard Burridge
58. **TEXTS ON EVANGELICAL SOCIAL ETHICS 1974-1983** Edited by Rene Padilla and Chris Sugden (July 1985)

Send for Catalogue

ISSN 0305–3067 **ISBN** 0 907536 90 5

GROVE BOOKS

BRAMCOTE NOTTS. NG9 3DS (0602-251114)

Printed by Hassall & Lucking Ltd., Cross Street, Long Eaton, Nottingham, NG10 1HD Tel. L.E. 733292