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10. Sex Therapy in Finland

How Did It All Begin?

The training of sex therapists in Finland began in the autumn of 1980. Forty family counsellors, theologians, physicians, psychologists, and social workers from all parts of the country were invited to the training centre of the Evangelic-Lutheran congregations of Tampere to study sexual therapy skills. Almost all participants were educators employed in the field of family work. The organisers had managed to obtain as the main trainers Alison and David Glegg from the British National Marriage Guidance Council. Their training framework was based on a modification of the Masters and Johnson sex therapy method. The organisations then supporting the training project were the Family Affairs Office of the state church, the Family Federation of Finland (Väestöliitto) and SEXPO. In later training periods, the organisers have also included the A-Clinic Foundation (which provides and develops services for people who have problems with alcohol and other addictions), Helsinki University Central Hospital, the Finnish Family Therapy Association, and the former National Board of Health as well as various individual therapists.

The first training of sex therapists in Finland some 20 years ago started with an intensive period of one week in the fall, supplemented by a three-day course in January and a one-week course later in the spring. Between these courses, trainees met in peer groups to continue their studies.

Many participants in the Alison and David Glegg courses experienced quite a shock when they could not evade matters but had to talk about sexual behaviour and parts of the body directly using real names. It was still more anxiety provoking to encounter one's own sexuality. The learning process began with film and video material on various aspects of sexuality, with group discussions. The films and videos, in addition to ordinary couple situations, dealt with the sexuality of pregnant women, disabled people and minorities as well as with masturbation. Alison and David Glegg considered it necessary that the teachers be able to face their own sexuality if they were to treat sexual problems of client couples and train other professionals. The Gleggs considered sexuality and its associated feelings and activities a central component of a relationship, believing that sexual feelings and activities ought to be handled in the same way as other aspects of the relationship. Therefore the sex therapist must have sufficient training in couple therapy and family therapy.

Participants in these early training sessions remember them as quite serious and dramatic. The same reactions surfaced again and again later when these new therapists began client work and began teaching people in the field. A sex therapist does not succeed without being totally familiar with his/her own sexuality. Although clients and students may blush and be unable to utter a word, the sex therapist must guide the conversation along unconstrained and reliable channels. The question always exists of how to create a confidential relationship when the topic is sexuality or the most intimate concerns of fellow human beings. Alison and David Glegg encouraged their students to acquaint themselves as broadly as possible with the entire field of eroticism and sexuality, including the commercial side of sexuality, porno stores and sex toys.

The training started in the early 1980s continued in 1984-1985 and 1987-1988. During this period, sex educators, including many of the same people who were in the 1980-1981 initial session, used skills obtained in their early courses to apply their knowledge for the first time in a sex therapy course organised totally with Finnish resources. Since 1980, considerably more than 100 sex therapists have been trained in Finland, and almost 300 people working in basic health care have received training as sex counsellors. The Jyväskylä Polytechnic has started to give specialised training in sexology for sex counsellors in the fields of social work and health care. The personnel working in basic health care are relatively well prepared for counselling work. Actual therapeutic training has so far been organised in various projects.

The demand for trained sex therapists has been much larger than the supply. One problem is that the couple relationship must be treated as an entity of which sexuality is only one part. Comprehensive therapy often requires expertise in traditional problem areas as well as in sexual problems. The traditional helpers for sexual problems — physicians, psychologists, and theologians — have indicated a need for further education in couple and family therapy, because these topics are treated very superficially in the basic education period. If a physician or theologian seeks family therapy training, he or she does not obtain sufficient knowledge and skills about sex therapy. The road to becoming a sex therapist usually involves (1) being trained as a professional social worker, psychologist, physician, theologian, and so on, (2) obtaining professional experience, and (3) then followed by three weeks of family therapy training and one week of training in sex therapy.

What Kind of Training?

The training in the pioneering phase during 1980-1981 consisted of three seminars (see above). The first seminar started by bringing trainees face-to-face with sexuality by compiling glossaries of sex words, viewing films and videos, and participating in small group work. The various levels of sex counselling were illustrated using the PLISSIT

model. The term PLISSIT comes from the initials of *Permission, Limited Information, Special Suggestions* and *Intensive Therapy*.

Permission means that client or patient obtains permission from the therapist to have sexual thoughts, fantasies, feelings, and needs. The client or patient is also assured that having such thoughts is permissible and common. Client questions may deal with masturbation, various forms of stimulation or sexual positions, sex toys, or sexually arousing material. A problem may also be that the client considers herself or himself to be deviant because of his or her activities or fantasies. It is also important to give the client permission to have feelings of anxiety, fear, shame, or guilt that may be connected with the activities or fantasies. Giving permission means the normalisation of the client's sexual thinking. This is sufficient for most clients. Asking for permission can be connected with various stages of life. Many young people may directly or indirectly ask for permission for their first sexual intercourse, and older people for continuing their sex lives. Permission must be given in relation to the client's readiness, not according to what the counsellor considers desirable. In conflict situations, permission cannot be given to one partner only.

Limited Information means giving information about matters that puzzle the client. These issues can be connected with genital anatomy, physiological reactions, pregnancy, childbirth, diseases, and medication related to sexually transmitted diseases and sexual disturbances, among others. Lack of knowledge often seems to be associated with anxiety and resulting sexual disturbance. Giving information may be greatly anxiety-relieving, especially for mild disturbances.

Problems related to sexuality very deeply concern the body. One's perception of one's own body, or one's masculinity or femininity may be problematic. One may feel one's own genitals are deviant, ugly, or dirty. It may be a relief for the client to see pictures of different genitals; for example, self-examination of her own genitals may be the first step a woman takes to accept her own sexuality. In men, the small size of the penis may be a problem.

Myths and disturbing beliefs concerning sexuality may be inadvertently internalised, and a clear source of these is not always obvious. They are promoted by the social climate or atmosphere, or from negative or controversial attitudes of parents or others. These influences are not always necessarily verbalised. A myth could be produced from a double message like "Sex is dirty, so save it for marriage when it will be clean" or "Sex is beautiful but don't talk about it in the presence of the children." Some sexual beliefs are used for making sex less dangerous and for trying to find a balance when one's own helplessness, fears, and disappointments are too difficult to handle. The purpose of these beliefs is to protect delicate areas in one's mind, to help avoid anxiety-producing closeness, and to keep threatening situations at a distance.

Special Suggestions (the SS in the PLISSIT model) refer to advice given to a client for improving his or her sex life, for instance, changing one's lifestyle, increasing interaction with one's partner, or carrying out exercises designed to reduce performance pressures. To give relevant advice requires therapists to understand the client's problems adequately and have detailed information about the client's sex life, life situation, and desires for change. In exercises aimed at reducing performance pressures, attention is focused on feelings instead of performance. One issue behind erection problems may be the fear of failure. If one is afraid that the erection may not last, anxiety connected with the fear may block the erection. Exercises can be given to the couple involving a prohibition on intercourse and on touching the genitals and breasts. The clients do not move from possibly arousing sexual feelings to sexual performing, but can instead enjoy their own feelings without pressure.

Intensive Therapy refers to a phase where the client or couple has decided together with the counsellor that counselling is not sufficient but that actual sex therapy is needed. This includes various exercises, homework and its follow-up, and analysis aimed at removing various disturbances.

In the training period from 1980 to 1981 training was based on cognitive therapy. The actual sex therapy training concentrated only on treating functional disturbances with the help of a solid theoretical basis, exercises, and supporting material (films, videos, pictures, sex toys). The two subsequent training periods (1984-1985, 1987-1988) were similar in structure to the first seminar. The goal was to acquaint trainees with short therapy models with an emphasis on problem solving according to behavioural and systemic approaches.

What Is Sex Therapy In Finland?

Sex therapy can be defined as short therapy, the goal of which is solving the sexual problem or problems regardless of the therapeutic model or combination of models. Very often the basis is the short therapy method developed by William Masters and Virginia Johnson for the treatment of functional disorders. Before Masters and Johnson's model was developed, all sexual problems, including functional disorders, were approached using psychoanalytic frames of reference. Psychoanalysis usually means long-term work requiring several years. After psychoanalytic treatment, the client may understand the background of his or her functional disorder(s), but the symptom remains unchanged.

Sex therapy is considered to be one application of behavioural therapy. Although sex therapy has been developed for the treatment of functional disorders in clients' sex

lives, its exercises can also be used diagnostically, as part of other couple or familytherapy, and for enriching a couple's relationship. The exercises easily bring to the surface the couple's internalised feelings, concepts, and beliefs, and help focus on problem areas.

Sex therapy is primarily couple therapy, but attempts have been made to treat various functional disorders in group settings. A Finnish version of the developmental model of the sexual relationship called SEX-IMM has been created and has been carried out in group therapies, although relatively little thus far.

The sex therapy includes:

1) Treating functional disorders of sexual behaviour through structured behaviour-guiding exercises;

2) Giving information;

3) Helping both partners realise that the couple's functional problem is a "shared problem" and that both people are responsible for its treatment;

4) Creating an atmosphere where the client's attitudes can change from negative to positive;

5) Helping clients eliminate performance pressures;

6) Developing the client's interaction skills;

7) Lifestyle guidance.

Sex therapy based on the Masters and Johnson model combines psychodynamic understanding of sexual problems with behavioural guidance. Although therapy proceeds in a structured way, therapy does not apply the model in a mechanical way. Instead, throughout the whole therapy, there is open discussion of sexuality and its associated feelings and attitudes. Because the therapist encourages the expression of these feelings, an atmosphere is created in which change is possible. Therapy can be augmented according to client needs or the counsellor's training, for instance, by contact and relaxation exercises, massage, music therapy, or visualisation with the help of Gestalt therapy or the new form of short therapy gaining popularity in Finland, NLP (neuro-linguistic programming).

The sexual response sequence can be divided into three separate phases: 1) desire, 2) arousal, and 3) orgasm. Possible disturbances can therefore be placed within one of these three phases. Disturbances at different levels of intensity can occur in each stage, and treatment should be selected according to the quality and difficulty of the disturbance. Usually the first stage is most difficult from the perspective of treatment and the last is the easiest. Sex therapy can be used in the treatment of disturbances in all three phases.

However, this three-phase classification does not apply to involuntary spasms in the genital area, such as vaginismus in women. Such symptoms do not block desire or orgasm but can make intercourse painful or impossible. These symptoms also are very suitable for treatment with sex therapy. About 15% of problems connected with a lack of desire can be treated by means of sex therapy.

Sexual counselling provided by the basic social and welfare services concentrates on giving *permission* and *limited information* according to the PLISSIT scheme. The *special suggestions* part of PLISSIT belongs partially to sexual counsellors. *Intensive therapy* is, as its name indicates, expressly sex therapy.

What qualities are needed of a sexual therapist?

Sex counselling and sex therapy require that professionals being trained should have adequate knowledge of sexuality and have an attitude that prepares them for facing sexual matters.

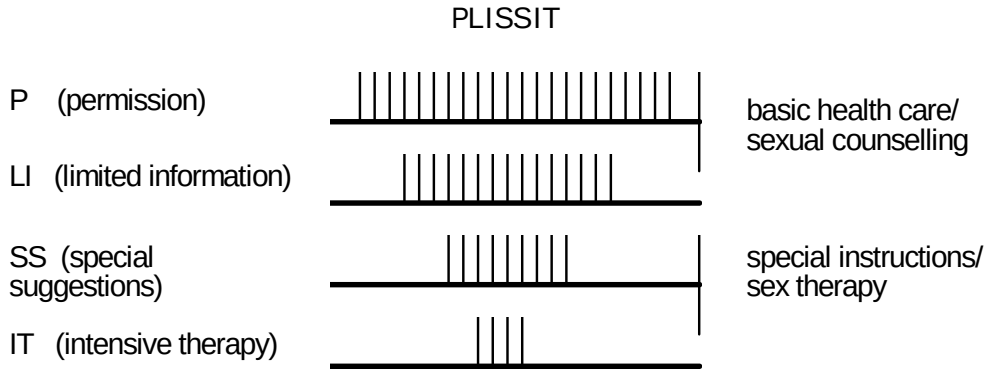
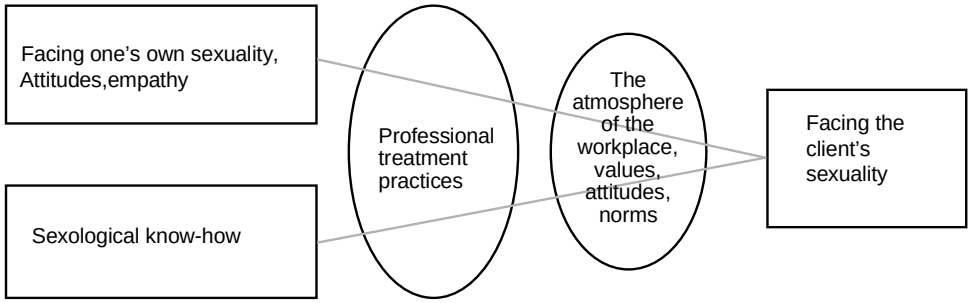


Figure 1. The distribution of client cases to the different levels of sexual work

The basis of a sex therapist's work includes his or her life experience, training, and a professional frame of reference as well as his or her view of the human being. It is difficult to measure results when working in human relations, but the essential concern is always with change. The therapist's attitude towards change affects his or her work, interpretations, and intervention methods. One may approach problems in a broad-based manner or in a focused way by opening up the bundle of problems layer by layer. The decisive issues are how the therapist defines the problem, what kind of a therapeutic

Figure 2. The subjective prerequisites of a worker



method the therapist finds possible, and whether the therapist approaches the problem from the perspective of the individual client and his/her personality structure and patterns of social interaction.

In working with sexual problems, the therapist's basic attitude is important: if the therapist him or herself is open and positive, he or she may use this positive attitude to build a new, positive model and give permission to experiment with new activities. The first step towards success centres on one's relation to one's own sexuality. After this, it is good to broaden one's own perspective and understand that what one feels is sexually significant for oneself is not necessarily the same as what another person considers significant.

A sex therapist is required to be neutral and objective as an educator and client worker. He or she should be prepared to deal with problems of gender and sexual identity, and with variations of sexual desire such as transvestism, fetishism, or sadomasochism. If the client has committed sex crimes, a larger network of authorities is often needed to deal with the situation.

Therapists and clients both have their own social and emotional background and surroundings that contain myths, taboos, values, and prejudices. Clarifying and understanding these myths in the context of problematic sexual situations is as important as clarifying the backgrounds of disturbances arising from functional factors, diseases, or medications.

Who Seeks Sex Therapy?

The couple seeking sex therapy is expected to have a basically stable relationship. Therapy can help those who do not have any organic reason for their sexual disturbances. The disturbances are classified in Finland mainly according to the Masters and Johnson schema. According to this, the functional disturbances in men include problems with erection or are connected with premature ejaculation or an inability to ejaculate. About 20% of men of ages 40-70 in Finland quite often have problems with erection. Only 5-10% seek treatment, although most could be helped with therapy and/or medication.

Smoking is the most common lifestyle reason for problems with erection. The next most common reason is being overweight, and the third most common is excessive use of alcohol. The reason behind erection problems is most often a disturbance of blood circulation (70%). The proportion due to psychological reasons is 10%, and the proportion due to hormonal problems is half that. Erection problems are being treated at various potency clinics throughout the country. Urologists also help. The best treatment results are achieved through co-operation between sex therapists and physicians. Physicians are seeking training in sex therapy more actively than earlier.

According to the Masters and Johnson classification, women's problems include vaginismus, painful intercourse, and disturbances in achieving orgasm in intercourse or while masturbating. According to an American study (Hite) 70% of women are bothered by a lack of orgasm. According to Finnish results, 5% of women never achieve an orgasm, one third have difficulties of some degree in achieving orgasm, and almost two thirds achieve orgasm fairly regularly. Lack of desire is a common disturbance of sex life for both women and men.

The most common questions from couples seeking help deal with "How, When and How Often?". It has been noticed that routines make sexual relationships stale. Foreplay, intercourse and afterplay, if repeated according to the same pattern, may disturb the functioning of one's sex life. Men tend to be more straightforward in their approach than women. In deciding on the frequency of intercourse, problems could be solved, for instance, in such a way that the partner desiring more frequent sex can decide on two days per week and the partner wanting less frequent sex on, for instance, five days per week. A different daily rhythm of the partners can produce other difficulties besides stress. People living in a couple partnership must get the courage to demand privacy and time for themselves in spite of work, children, or grandparents possibly living in the same household. It is very common that either one of the partners is still dependent on his/her parents and does not have the courage to demand an independent and stable sex life. The attitudes of the childhood home, inhibitions, and secrecy can have a long-term effect. Sexuality can also be used to dominate, blackmail, reward, and humiliate. Both partners of couples entering therapy are required to want change and to be motivated to

work toward it. They also have to be motivated to seek therapy by reserving enough time for the treatment (therapy visits and home exercises). Starting therapy also requires that both partners refrain from outside sex relationships and avoid excessive alcohol use during the treatment.

In sex therapy, the therapist first attempts to create a positive atmosphere in which it is possible to change attitudes. The responsibility for treatment is divided between both partners. The goal of treatment is to abolish pressures to perform and to increase interactive skills. A central part of treatment consists of exercises carried out at home and their analysis in therapeutic sessions. The preconditions for beginning sex therapy are clearly delineated.

The criteria for beginning the treatment are the following:

1.The couple relationship is basically stable. Both partners want to continue the relationship, and both partners obtain some kind of satisfaction from it. This can be checked by asking clients about the following:

- Opinions about positive and negative aspects of the relationship;
- Information about the use of common leisure time and satisfaction with how that time is used;
- Opinions about the ability of both partners to act independently;
- The frequency of quarrels and the method of settling them;
- To what extent each partner considers the other partner as physically attractive, i.e., approves of the other one's physical appearance.

2. The disturbance can be classified according to the Masters and Johnson classification (with the addition of dysfunctions in the arousal phase of the female partner).

3. No organic cause underlies the disturbance. The therapist must clarify effects of possible illnesses and of medications, disabilities, or surgical operations. Furthermore, it is important to clarify the use of alcohol and other intoxicating drugs. If there is even the slightest reason, it is necessary to consult a physician or refer the client to one for a more detailed examination. Such referrals are always needed in cases of painful intercourse (dyspareunia) and vaginismus or other cramps of the perivaginal muscles.

4. Neither partner is deeply depressed. The problem is not the type of depression but whether or not enough energy remains for the treatment.

5. Both partners want change and are motivated to work. This is the most important of all criteria. Additionally, it is important that one partner does not bring the other one to treatment but that both are able to perceive the problem as a common one and affecting both.

6. Both consider the problem as sexual. If partners disagree about what their problem is, it is necessary to help the partners to reach an agreement or to choose the problems they want to work on first.

7. Both are ready to reserve the required time. It is very important to clarify with clients the extent of their commitment. Sometimes it is necessary to clarify in detail the home conditions of partners and help them find the time for the exercises (3 times per week).

8. Secrets between the partners must not become too great an obstacle for the therapist to treat the client couple. Individual interviews may reveal facts that the other partner does not know. It is important to ask the client for information about these kinds of secrets, and encourage the client to discuss them with the partner.

9. Neither one has an outside sexual relationship during the treatment. This point is important to emphasise because as the treatment progresses step by step, an external sexual contact may destroy the progress made.

10. Neither partner uses too much alcohol. Too heavy drinking may block all sexual response and directly affect erection and the ability to reach an orgasm.

Several different modes of work have been created, from therapy sessions on the Internet, to weekly meetings, to open care based on exercises. We will next explain the method of working in open care.

In the beginning, the couple and the therapist become acquainted with each other, and the couple defines the problem as accurately as possible in a common session. Next, both come to give their sexual histories in a meeting of about one and a half to two hours. These sexual histories can be taken also while both partners are present with the so-called focusing technique. In this, the starting point is the problem presented by the client couple, which is subsequently illuminated by the sexual histories.

After the initial discussions the therapist and couple discuss together their most important goals: what questions will be focused on, will an agreement be signed about the beginning of sex therapy, and what kind of exercises will be used to begin the treatment. Now almost without exception the sessions start with showering exercises, which help the partners become comfortable with nakedness and intimacy. A series of pictures about sexual reactions and anatomy are shown. Caressing exercises (Sensate focus I and II) are carried out at home afterwards according to the instructions and the results are analysed weekly in meetings. Sensate focus III is an exercise in caressing the genitals with an orgasm as its goal. It has proven to be a useful additional exercise for partners who are extremely anxious or who require slower progress. At the end, a decision is made about the start of symptomatic treatment if it is seen as necessary. There is a specific treatment for each type of sexual problem.

An example of the treatment of a symptomatic disturbance

One of the most common and most easily treated functional problems is premature ejaculation by the man. A man suffers from premature ejaculation when he would like to continue longer with intercourse but for various reasons is unable to do so. Therapists have rejected definitions based on the length of time between intromission and orgasm, or the frequency of orgasm. The disturbance can be treated with the squeeze technique and many other ways, but also by using masturbation. Marilyn Hahn and Jay Mann (University of California, Medical School) have developed an eight-point masturbation program that is also used in Finland.

In the first phase the man has to masturbate with a dry hand until he is able to continue for 15 minutes. After that, he masturbates using a moisturiser, again aiming at continuing for 15 minutes. In the next phase, the partner masturbates the man in a similar way. The partners proceed from genital caressing to intercourse and the woman takes a position above the man. The man is allowed to move only as much as is needed to maintain his erection for 15 minutes. When this goal has been reached, the man lies motionless under the woman and she moves gently until the 15-minute goal is achieved. If necessary, the squeeze technique can be taught to the couple.

In the penultimate phase, the same positions are maintained and both move gently until the man lasts 15 minutes. In the last phase, the couple attempts full sexual intercourse with the goal of lasting at least 15 minutes. The couple carries out the exercises according to their own time schedule and receives instructions from the therapist in sessions that are analysed together.

Where to obtain sex therapy

Sex therapists in Finland work in family health centres, church family counselling centres, A-clinics, rehabilitation institutions, and public mental health clinics as well as in prisons and prison mental hospitals. Private practitioners also offer sex therapy. A register of sex therapists is maintained by SEXPO, the Family Federation of Finland, and the Finnish Association for Sexology. The Finnish Association for Family Therapy also has a register of members with training in sex therapy.

What Does The Future Hold?

More and more physicians seek training in sex therapy, mainly gynaecologists, psychiatrists, and especially midwives from among the nurses. In other ways, too, co-operation between midwives and sex therapists has increased lately in a promising fashion. Through the Finnish program in sex therapy education, midwives achieve readiness for sex counselling and training in how to provide health services, and information in matters related to pregnancy, birth and child care. This sexual therapy and counselling seem to fit naturally with the other duties of midwives. The teachers of Polytechnics in the fields of social work and health care have also paid more attention to obtaining training in sex counselling. Through them, knowledge and attitudes about sexual questions are widely disseminated among practitioners providing basic health care in Finland. Some people with sex therapy training have organised additional training in various parts of Finland, thereby further increasing the availability of sex counselling.

There is a need to organise more sex therapy education for family and couple therapists who already have a degree in another field. Workers in mental health and psychiatric clinics as well as couple therapists in family counselling clinics (psychologists and social workers) have noticed how common sexual problems are. Thus far it has been usual to refer couples to professional helpers, but the need is quickly increasing for helpers in all these different areas to gain knowledge themselves about sex counselling and therapy.