KAPITEL 8 / *CHAPTER 8* [8]
PSYCHOLOGICAL COUNSELLING ON SEXUALITY, SEX, AND GENDER

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Introduction.

Sex counselling is the most successful outcome of the integration of different theoretical models into a single technology of psychological help. According to the available statistics, sex counselling is the best way to treat 80-95% of various sexual disorders, e.g., impotence, premature ejaculation, and orgasmic dysfunction (in the absence of physiological problems). Firstly, this method of treatment is successful because sexual problems are solved by reaching insight and doing "homework." Secondly, it does not take a lot of time (3 to 10 sessions). And thirdly, the very strategy requires the counsellor to be flexible and pragmatic.

In order for sex counselling to be successful, couples must be willing to keep their relationship and go through psychotherapy. The basic plan to provide psychological help consists of 6 steps:

1. Clinical interview;
2. Checking physical state and studying the history;
3. Studying the relationship;
4. Exercises on the development of sensory sensitivity;
5. Special techniques;
6. Evaluation.

8.1. Special Techniques of Psychological Counselling on Sexuality

8.1.1. Clinical Interview

The counsellor thoroughly gathers information on family history, attitude to sex in childhood, religious influences, early sexual experience, and current attitude to various sexual practices in both partners together or separately. The examination includes conclusions about previous sexual problems, as well as the current difficulties and attempts to solve them.

When the working relationship is set, the counsellor can ask such direct questions as: "What do you think about during sex?"; "What would you like to do

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from what you do not normally do?"; "How do you begin an intercourse?"

8.1.2. Examining Physical Condition and Studying the History

In case of sexual problems, it is essential to confirm or exclude physiological problems prior to psychological intrusion. It is important to know which medicine the client takes: for example, some drugs used to decrease blood pressure can affect sexual activity.

Studying the history and examination can help detect some physical processes that can cause sexual dysfunction. Counsellors on sexual problems work in collaboration with medical specialists who conduct such studies. It is also important to work together with psychotherapists who have not only knowledge, but also sensitivity to work with those who are clearly confused and feel uncomfortable being aware of their difficulties.

8.1.3. Study of the Relationship

Sexual behaviour is a way of communicating with each other. Counsellors should also dedicate some time to trust and responsibility to work. Open and friendly atmosphere makes it easier for the clients to reveal their fears connected with failure, which often are the cause of sexual problems. They are asked to share with each other what they like and do not like, their fantasies, thus getting closer in a secure verbal way. Sometimes common sex counselling is not a necessity, because it is the attitude of the partners that is the root of problems. Therefore, before you work with more severe sexual problems, it is important to make sure that all deep conflicts have been resolved.

8.1.4. Exercises on the Development of Sensory Sensitivity

Here we use the methods of behavioural counselling, which the couple have to exercise at home. The initial tension is released through the prohibition for a couple to proceed with having sex, thus excluding the possibility of failure. These exercises are aimed at achieving and receiving not genital satisfaction through touching, which may sound selfish, but effective and unpretentious nevertheless. Then the couple add:

- Stroking each other on the back for one week;
- Non-genital touches and giving mutual pleasure in other parts of the body;
- Gentle genital simulation;
- Genital touches.

8.1.5. Special Techniques

Sex counsellors use many educational and psychotherapeutic tools to enhance other communications, awareness, and sexual responsibility. Films and books can also be used as visual aids.

There are also certain specific procedures, such as "compression technique" used for premature ejaculation. Working on various problems, a variety of sexual positions and certain mental exercises can be used to eliminate distracting thoughts.

8.2. Peculiarities of Counselling on Sex and Gender

How to start a conversation about sexual problems? Even if these problems are a major cause of seeking treatment, clients do not always speak about them directly. And counsellors may not always feel free to ask the client about intimate aspects of their life. Therefore, the study of sexuality of the client often begins with standard questions and answers or a kind of game between the counsellor and the client, "What could you tell me about your sex life?" – "Everything's fine" or "It's OK." The counsellor, however, should not be satisfied with such superficial response, thus asking clarifying questions, "What do you mean by 'fine'?", "What is OK for you in sexual life?" Thus, we let the client understand that a short answer is possible, but not enough. As mentioned above, even if the client did not come because of sexual disorders, most psychological problems are closely related to the sexual sphere.

Hence when the client says nothing about their sexuality, the counsellor should lead them to this subject, "You are not saying anything about your sex life." This remark may be more valuable than a question. If the client answers with the question, "What exactly do you want to know?" the remark can be rephrased as a question "Why are not you talking about your sex life?" In case of resistance to discuss such issues, there should not be any pressure, but it should be noted that without such discussion it is much more difficult to understand the other problems.

Counselling clients with sexual problems can be of three kinds: sexual education, forming adequate sexual behaviour, and sex therapy.

Sex education and counselling tend to go together. Counselling adults refers to sexual education as changing attitudes towards sexuality. Problems often arise because of distorted ideas about sexual life, i.e., different kinds of pseudo-ideas and myths. Most people have a certain idea of what is normal and abnormal in sexual life,

and this understanding is often determined by myths. Many myths interpret sexual act and roles in it. Here are some of them:

- man always strives for sexual intercourse, while woman does not;
- man is aggressive by nature, and has a strong potency, while woman is usually passive;
- sexual intercourse must always be initiated by man;
- both partners must experience an orgasm simultaneously;
- man must always have an erection and ejaculation;
- man cannot influence a woman's ability to experience orgasm;
- sexual contact is possible only at a certain time and under certain conditions;
- there are acceptable and unacceptable positions in sex, etc.

Some people are guided by the sexual mythology and feel unhappy if their sex life does not match the stereotype. It is important that the counsellor was not under the influence of any kinds of myths.

Helping clients to get rid of myths and stereotypes is a very important aspect of counselling on sexual problems. Throughout the course of counselling, a psychologist works with the couple to overcome resistance. Acknowledging the fact that, when symptoms disappear, partners will be forced to seek other means of communication is a problem that needs to be discussed at the very outset of counselling. When sexual functions have been restored, the counsellor should help the couple to integrate all that they have achieved and continue their common growth and further development as a sexual couple.

Apart from counselling on separate sexual dysfunctions, sex counsellors call to give help to those suffering from sexually transmitted and chronic diseases, substance addictions, victims of violence, those who have had abortions and people with disabilities. In such cases, the counsellor should not only have a high level of training, but they have to work on their own views, feelings of discomfort, and prohibitions relating to this area.

In our society, as a result of the liberalisation of social norms towards sexuality, distribution of books and videos that promote sex and eroticism, sexual behaviour is becoming more and more uninhibited, but the problems remain, and in bigger amount, besides. For example, some people are confused or worried because of the inconsistencies in the standards of sexual behaviour they see on the screen or read in books. The main cause of sexual problems is mental tension, anxiety, and internal

conflicts, since sexuality is especially sensitive to emotional stress. Being uninhibited regarding sexual life enables people to freely turn to experts on sexual problems and discuss them during counselling.

The concepts of "sex" and "sexuality" are often used interchangeably, but their meaning is different. It is important to know when to use these terms in your professional work. Sex means mechanical implementation of sexual intercourse. Sexuality encompasses the full range of feelings, from sensory stimulation to intimacy. In psychological counselling, we often have to deal with sexual problems, although clients sometimes want to discuss the technical side of sexual life, too.

Counselling on sexual problems involves an understanding of the norm, pathology, and deviations in sexual life. Let us take a quick look at these concepts. [1]

According to our cultural norms, the purpose of sexual behaviour is a meaningful love relationship, delivering pleasure and a deep knowledge of another person, relieving sexual tension and enabling to have children. Normal sexuality covers a wide range of sexual behaviours. Sometimes it is difficult to establish the exact boundary between normal and abnormal sexuality. The location of this boundary depends on socio-cultural, moral, and legal norms. Which can often be quite archaic and conservative, by the way. Changing social attitudes to expressions of sexuality leads to a new definition of the sexual norm, which oftentimes depends on the partners' consent.

Many techniques of sexual relations are considered normal if they are accepted by both partners. The reasons for deviations in sexuality can be both psychological and physical. It should be noted that deviant sexuality reinforces other problems, which in turn intensify sexual disorders.

The most common sexual disorder in men is impotence, manifested in the inability to have a full erection during sexual intercourse. According to some authors, almost every other man quite often experiences impotence as a temporary dysfunction in certain periods of their life. With age the probability of such cases increases. Impotence causes acute distress, especially in young men. There might appear a disease caused by organic or psychogenic factors. In the first case, the pathogenic effects may take place due to taking hormones, some somatic diseases, or neurological disorders.

In the second case, there often reveals a disharmony in the relationship with the partner, increased anxiety, chronic feelings of guilt and shame; sometimes sexual

function is blocked in certain situations. Failure in sexual intercourse usually causes an acute sense of inferiority, which in turn provokes further failures.

Another disorder in men is a premature ejaculation, which is usually of psychogenic nature, often due to unresolved sexual conflicts, however, sometimes it may be caused by excessive tiredness. The dysfunction itself is a source of constant feeling of inferiority in men and sexual dissatisfaction in women.

The most common disorder of female sexuality is frigidity or sexual coldness, the most important feature of which is a partial or complete lack of sexual satisfaction. This disorder does not preclude the woman from the possibility of having sex. The aetiology of frigidity is mostly psychogenic and related to the negative feelings towards the sexual act (previous negative experience, unacceptable behaviour of the partner, etc.).

Frigidity may come with physical disorders. In both sexes a sexual disorder can manifest itself in the form of hypersexuality. In this disorder, a person is constantly tormented by thoughts and fantasies of a sexual nature, and overwhelming libido. Women's hypersexuality is sometimes called nymphomania, the man's one – satyriasis. Aetiology of hypersexuality is mostly psychogenic, but it can also be caused by epilepsy and other neurological diseases, as well as by the use of amphetamines and hormones. In some cases, hypersexuality can occur due to physiological changes during menopause.

Counsellors must be prepared to support clients of all ages. Kirkpatrick (1975) formulated nine rules of sex counselling:

1. Counsellors must not be burdened with their own sexual problems. This is a necessary condition for an adequate response to the related difficulties of the clients.

2. Counsellors should be able to freely and openly talk about sexual problems, i.e., not to overuse figurative language and follow sexological terminology.

3. Counsellors should sometimes be the first to start talking about possible sexual problems of the client, because the client may feel uncomfortable.

4. Counsellors should be able to interpret sexual problems when the client presents them in a disguised form.

5. Counsellors must be knowledgeable in various matters of human sexuality in order to provide the clients with the relevant information (anatomy, gender psychology, contraceptives, etc.).

6. When counselling adolescents and youths, counsellors must bear in mind that their knowledge about sexuality may be incomplete and distorted. Particular attention

should be drawn to early sex life, and so on.

7. Counsellors must limit their services and practices to those which are within their professional competence. They must not engage in sex therapy without special training.

8. Counsellors must be aware of the cases when they should refer their client to other professionals and must provide them with their contacts.

9. Counsellors must refrain from judgement of sexual behaviour and preferences of their clients.

The sex therapy proposed by US researchers Masters and Johnson (1970) is popular in treating sexual dysfunction. Although it is essentially designed for couples, but it has been used more recently as an individual and group method. This sex therapy is based on several principles:

- Responsibility for your own actions;
- Being sexually uninhibited;
- Studying different forms of sexual behaviour;
- Deep awareness of your own feelings and fantasies when communicating with the opposite sex;
- Structural behaviour change.

The terms heterosexual, homosexual and bisexual should be used as adjectives, not nouns, and in relation to the behaviour, not the people. In everyday language, however, someone is often called a homosexual or heterosexual, and people also call themselves like that. Inaccurate use of these words is associated with those whose regular sexual partners are people of the same sex and those whose homosexual contacts are rarer compared with heterosexual.

The term “homosexual” is best left to describe the behaviour of those who have sex exclusively or almost exclusively with people of the same sex, and the term “heterosexual” – the behaviour of those whose sexual partners always or almost always belong to the opposite sex; the term “bisexual” or “ambi-sexual” is better to be used towards sexual behaviour of those who more or less regularly have sexual contacts with people of both sexes.

Gender identity indicates why a person considers themselves a representative of a particular sex – male or female.

The internal conviction of this identity may both display and non-display physical appearance or the gender role assigned by society. These differences are

fundamental, particularly regarding transsexuality. In their real environment, transsexuals are identified by their anatomical sex. Transsexuals are raised according to how society sees them. Yet they consider themselves the opposite sex. Their appearance is in conflict with their internal sex.

This side of life exists separately from their sexual orientation as transsexual may be homosexual or transsexual. In everyday life, anyone can "identify" themselves as a homosexual or consider their "identity" homosexual. It is about the use of this term in affiliate (connecting) sense. Similarly, people could identify themselves as American, Indian, or Unitarian. [2]

The concept of gender or gender role is different from the concepts of orientation and identity, although it is associated with them. Gender and gender role are related to the public view on how boys and girls or men and women should behave and how they should be treated. Gender role is reflected in the behaviour of biological inclination of a person. The terms "boys" and "girls," "men" and "women" are social, and the terms "male" and "female" – biological. Gender applies to everything that man does in the community in which he lives, and may or may not have anything to do with biology. For instance, males can live like women and females – like men; a male may be raised as a boy, but live like a woman in adulthood. [3]

However, for most people their identity, orientation, and gender sound similar. A typical male considers himself as such, follows masculine behaviour (a combination of biologically and socially determined behavioural patterns), is accepted in society as a man, and prefers to have sex with females. A typical female considers herself as a woman, follows feminine behaviour (also a combination of biologically and socially determined behavioural patterns), is seen as a woman in the society, and prefers to have sex with males.

Deviations occur when an individual prefers erotic relationship with a person of the same sex (male and female homosexuals) or when a male person feels female.

8.3. Psychological Counselling on Intimacy

Establishing intimacy, as most people want, may appear hard to achieve due to such issues as obstacles to the development of intimacy, fear of intimate relationships, and pseudo-intimacy.

It is a well-known fact that some people easily enter into close relationships, while others find it very difficult to go beyond the small talk stage. There are clearly a lot fewer people that belong to the first category. Most people have to make a lot of effort to achieve intimacy, and often face the fact that all their attempts go unnoticed or rejected. The following are the common causes of the difficulties that arise at the beginning of close relations.

1. Shyness. People whose shyness makes them avoid communication and keep themselves to themselves, unintentionally limit their ability to create intimate relationships. Paradoxically, shy people often crave intimacy and friendship, but they obviously do not want or are not able to take the risk and overcome their shyness.

2. Aggressiveness. Aggressive people often scare away others or make them take a defensive position. Typically, they are concerned that "this man will take the upper hand over me," but few people are attracted to relationships in which they will have submissive role. Lowering the tone and aggressive behaviour can increase the chances of achieving intimacy.

3. Narcissism. People absorbed with themselves usually push the others away. Everyone knows the people who at all costs want to be in the spotlight; ignore the needs of others (not on purpose, but simply because they do not notice them); who speak only about themselves, not letting anyone else say a word, and do not want to do anything from what their partner wants, unless it coincides with their own desires. These people often initiate a sexual relationship by telling others a lot about themselves, but it is difficult for them to maintain a long-term relationship.

4. Egotism. Egotism stemming from narcissism can cause even more damage to the development of intimacy. Egoists often manipulate others and try to benefit from them to achieve their own goal. Selfish people care little about bringing anything good to their partner or relationship, and try to be the first to get their way.

5. Inability for empathy. People unwilling or unable to accept and understand the attitudes, thoughts or feelings of others might find it difficult to maintain intimacy. They often do not know how to listen to the other: they either interrupt their partner or do not hear what they are saying, being unable to look at the situation from the partner's point of view. Those who are capable of empathy, seek not only to understand, but also somehow help others.

6. Conflicts and unrealistic expectations. Many people have idealised pictures of intimacy. As a result, they expect the impossible, creating a situation that often leads to disappointment, frustration and even the refusal from intimate relationships.

In other cases, partners' purposes may be so different that the relationship is bound to fail. Thus, if one partner is mainly looking for the ability to share leisure and entertainment in friendship, while the other wants a deep intellectual communication, they are unlikely to become good friends.

Needless to say, this is not a complete list of all possible obstacles on the way to intimacy. There are other factors, e.g., depression, drug abuse or severe physical illness, which extremely complicate the establishment of close relations even if all other conditions are acceptable. [4]

It is important, however, to emphasise that intimacy is often extremely viable, making its way in spite of the unforeseen obstacles.

Fear of intimacy is rather common. Its main causes are distrust, fear of being abandoned or lose control. These are often accompanied by a negative view of oneself. People think that they do not have anything of value to contribute to the relationship, and question the fairness of the evaluation of the interested person because they feel uninteresting and not worth the attention.

Distrustful people, who fear that they might be deceived, are resolute to avoid intimate relationships, preferring to have many random relationships instead of one that requires taking on a serious commitment; such people protect themselves from trouble, but rob themselves emotionally. Others enter into intimate relationships, but protect themselves by limiting the degree of closeness. Once there is a risk that the relationship can become too close, they start a fight, become indifferent or plunge into work; they protect themselves from the commitment of the relationship, and soothe their fears by keeping intimacy under control.

Oftentimes, fear of intimacy remains throughout the entire life. Sometimes it is rooted in the traumatic relationship with parents in early childhood; in other cases there is a gap after the intimate relationship that brought not only mortification, but deep disappointment, too.

True intimacy as a positive self-developing process should be distinguished from pseudo-intimacy which is more pretence than openness, more manipulation than empathy. Pseudo-intimacy is characterised by the following features:

1. The desire of one partner to shift most part of the hassle and responsibility on another rather than to take them over.

2. A huge gap between what is said and what is done.

3. Lack of mutual trust between the partners or deliberate and repeated breach of it by one of them.

4. One-sided or illusory obligations imposed by this relationship.

5. Selfish behaviour of one partner and their inattention to the interests of another.

6. One-way communication (one partner either takes up all the talking, or does not have talk at all).

7. Directive communication style, when one or both partners give instructions and criticise each other for not following them.

8. Permanent conflicts and disputes that consume a lot of time and energy, but hardly lead to solving significant problems.

The intimacy issues also include homosexual problems. The term "homosexual" refers to personal behaviour, while the term "gay" refers to public behaviour and shows the connection with the subculture. Homosexually oriented individuals openly declare their sexual preferences and can be identified by their activities and demeanour.

This is reflected in the feminised style of behaviour in men and masculinised in women. This style can be a natural expression of self, or part of rather formal codes denoting group identity. Many of the social signals that are used to give a sign of sexual interest are the same for homosexuals and heterosexuals. Certain behavioural codes may be useful for the homosexuals in heterosexual circumstances, e.g., subtle changes in tone of voice, posture and manners, keywords, visual contact and frequenting famous places for dating.

Bisexual (ambi-sexual) behaviour in 1990s was also discussed more openly than in the past. And there is no evidence that was more wide-spread than in any other previous period. Ambisexuals more openly communicate with homosexuals than heterosexuals, but they consider themselves a separate category of people. Just as lesbians did before them, they demand their recognition as a separate from homosexuals community, with its own specific group needs and interests.

Women who prefer to have erotic and loving relationship – exclusively or occasionally – with the people of the same sex were called "romantic friends" in the Victorian era. In Western culture, they were a minority even more hidden than men; the public learnt of their existence only after the Second World War. Up until the 1960s, they were mixed in the same group with men, being called "female homosexuals" or "gay women." Later, for political reasons, they agreed to be called lesbians because it gave them an identity as a group.

Although homosexual men and women have many common needs, lesbians

have their special needs, too. In particular, they are extremely concerned by the stereotypes about them in society. As representatives of any other orientation, they may be feminine or "macho-like," conservative or liberal, believers or atheists, interested or disinterested in getting an orgasm, prone to promiscuity or monogamy, reserved or sociable, attractive or plain. Their motives or reasons for identification with the lesbian community are often wider than among male homosexuals. Some women engage in sexual intercourse with the people of the same sex for political reasons, which is very rare or non-existent among men.

Any culture sees clothing as a symbol of belonging to the male or female gender, and expresses being a part of a certain group or excluded from it. Clothing is a means of providing evidence of gender division and accurate gender identification. It objectively reflects a range of mental, social, and many other aspects. People react negatively to violations of the norms related to clothing, and, therefore, to the preferred group identity.

Conclusions.

Sex consultancy is a specialised area, which often uses behaviourist methods to reduce the symptoms. It is often applied within the marriage counselling after processing the main problems in communication. In order for sex counselling to be successful, couples must be willing to keep their relationship and go through psychotherapy. The basic plan to provide psychological help consists of 6 steps: clinical interview, checking physical state and studying the history, studying the relationship, exercises on the development of sensory sensitivity, special techniques, evaluation.