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Integrating Sex and Couples Therapy: A Multifaceted Case History

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Traditionally, sexuality has not been a focus in couples therapy training, research, or practice, although it is an important, often complex issue for many couples. This article tells the story of a couple presenting for sex therapy due to their unconsummated marriage, and is told to exemplify how sex therapy and couples therapy can be integrated in order to best meet the needs of couples. As the story unfolds, the multilayered facets of the presenting issue are revealed. The therapy incorporates and weaves together family of origin history, intrapsychic and cognitive issues, relational dynamics, patterns of interaction, and physiological/medical concerns into a postmodern couples therapy with behavioral interventions. This combined approach recognizes the value of each method on its own and their greater usefulness when blended together.

Keywords: Sex therapy; Couples therapy; Sexuality

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I was a second-year MSW student when I was invited to observe the first therapy session of a man presenting with lack of sexual desire for his wife. He began his story saying that he had been married for 25 years, but had not had sexual intercourse with his wife for the last 5 years. He spoke about a long history of ambivalence, resentment, lack of attraction, and guilt. He said that he and his wife had recently completed a year of couple's therapy in which their communication and parenting had improved, but in the course of that year, the issue of their sex life had not come up even once. Although his experience may not be the norm, it is not rare either. Traditionally, sexuality has not been a focus in couples therapy training, research, or practice (McCarthy, 2001), although without the comfort and skill to talk about sexual issues, therapists may neglect a significant piece of their clients' story. Over the years, I have found that an integrative model of couples and sex therapy that weaves together family history, intrapsychic and cognitive issues, relational dynamics, patterns of interaction, and physiological/medical concerns, to be a valuable and effective way to talk about sexuality (Althof, 2007; LoPiccolo, 2002). It is a privilege to hear the often complex and multilayered sexual stories that our clients share with us. The following case is one of those stories.

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An observant Jewish couple in their late 40s came to my office seeking sex therapy due to their difficulty with having intercourse. They had been married for almost 6 years but had never consummated their marriage. They wanted help achieving penetration to improve their sex life both for "normalcy" and because, despite their advanced age, they wanted to try to conceive a child.

When I first met Debbie and Lenny,[1] their self-conscious presentation was apparent. Speaking about sexual problems is difficult for many people, but I soon realized that even general self-disclosure and conversation were hard for this couple. Their language was self-conscious, clinical, or euphemistic, only worsened by Lenny's stuttering. Lenny suffers from Lupus; his mobility is noticeably impacted by joint pain and swelling, he experiences periodic dizziness, and he has difficulty keeping weight on. Lenny was the one who initiated the request for therapy while Debbie was skeptical about the efficacy of any psychotherapy, and whether she really wanted to fix their sexual issues anyway.

They began the first session by telling me about their problematic sex life. Debbie and Lenny were married when they were in their early 40s after having dated for 1 year. During that year they did not engage in any physical or sexual contact as per their religious mores; hence, there were no certain signs of what was to happen after their wedding. Once married, the couple found themselves unable to consummate their marriage for the first year and a half mostly due to Lenny's unreliable erections that often seemed to disappear in time for vaginal penetration. Debbie and Lenny were physically intimate during those 18 months, but Debbie grew increasingly frustrated as time passed and they were unable to have intercourse. She had been looking forward to being sexual after so many years of sexual inactivity, and had urged Lenny to look into taking Viagra. Debbie became upset when Lenny delayed speaking with his doctor, and then got angry when his psychiatrist was reluctant to give Lenny a prescription, saying that Viagra or other PDE-5 inhibitors were not likely to be helpful. This bit of information was probably the first clue that Lenny's erectile dysfunction was not solely due to organic dysfunction. Perhaps Lenny's psychiatrist was aware that drugs such as Viagra do not cause erections unless the man feels sexually excited (Levine, 2006).

Finally, however, Lenny prevailed upon his psychiatrist to prescribe Viagra and it did help him attain better erections, although still not always reliably. But even when his erections were firm, penetration proved to be awkward and painful for Debbie. The couple tried, unsuccessfully, to have intercourse a few more times. A few months later, Lenny's medical condition worsened requiring hospitalization followed by months of physical rehabilitation. The decline in Lenny's health simultaneously exacerbated the couple's sexual problems and also forced the couple's sexual issues onto a back burner. Once Lenny's health stabilized, the couple sought help from a sex therapist, but they gave up after a few sessions. They found it too difficult and embarrassing to delve directly into the behavioral aspects of their sexual routines. They were discouraged when told that due to their particular anatomy, missionary position might not work for them, and that perhaps they should use a sling or special blocks to vary their sexual positions. They quit therapy after a few sessions. By that point anyway, Debbie had become resentful of Lenny for having taken so long to treat his erectile dysfunction

[1] Names and identifying information have been changed.

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and she had begun to lose interest in pursuing a sex life with him. As was their style, it was easier for them to avoid their problem rather than have to deal with their sex life openly. So they continued engaging in sexual activity without intercourse about once or twice a month, mostly with Lenny trying to manually stimulate Debbie and bring her to orgasm. Debbie rarely reciprocated and began to wonder why people say sex is so great, while Lenny quietly felt guilt and resentment.

In our first session, Lenny stated that he wanted a sex life with Debbie so that they could try to have children. Debbie said that she too had wanted to have children for the first few years of their marriage, but as time passed she had begun to have hesitations. Ideally, she wanted "a more normal" sexual relationship with her husband, but she had grown concerned about having a child with Lenny. Besides her advanced maternal age, Debbie had other concerns that were only more fully articulated as the therapy progressed. Debbie was worried that Lenny was going to become progressively more debilitated, and she would end up having to care for both her husband and their child while also having to be the sole wage earner for their family. On the other hand, she also felt guilty for holding back on something Lenny wanted so badly. She did not dwell on her own loss of the possibility of motherhood, although later on in the therapy she was able to address it. Lastly, Debbie also worried that given the combination of her age and Lenny's health issues, the possibility of having a child with health problems could be high.

It was during the first interview that I asked Lenny if his erectile dysfunction was due, at least in part, to his medical condition.

"My rheumatologist thinks so," he responded, "but my psychiatrist doesn't."

I was not expecting to hear the answer that I received from my next question, "What does your psychiatrist think?"

He responded, "He thinks it has to do with my attraction for men."

I immediately looked over at Debbie to gauge her reaction, and asked her if this was something she had known about. She responded that yes, Lenny told her about it 6 months after they had begun dating. She acknowledged that it had not been an easy thing to hear and remembered saying that she would need time to think about it. Added to Debbie's deliberations, I later learned, was her worry that perhaps this was her only chance at being coupled. She was getting older, had never made it past a first blind date before this relationship, and she was scared to give Lenny up. Ultimately, to Lenny's great relief, Debbie decided to continue with the relationship. The conversation about Lenny's same sex attractions was never brought up again, until our first therapy session.

LENNY'S STORY

Lenny is the oldest of four children in his family. He describes his childhood as rather lonely. He did not have many friends; his parents encouraged and praised his academic achievements but did not pay as much attention to his social or emotional life. Open communication about feelings was practically nonexistent in his home. Even Lenny's nonacademic activities tended to be solitary. He did not play team sports, and much of his spare time was spent alone practicing his musical instrument. Lenny's affiliation with Orthodox Judaism began in college, although he, like his family, always tended toward the conservative end of the social and religious

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spectrum. After college, Lenny pursued graduate studies, continuing to be a high academic achiever. He is now quite successful in his chosen field.

Lenny talked about his sexual history in an individual session that followed the first couple's session. After Lenny disclosed his attraction to men, I asked to see Debbie and Lenny individually. I wanted to give Lenny the space to speak more freely about the struggle that he had kept from Debbie for the past 6 years, and also to give Debbie the opportunity to talk about her feelings about the secret they were sharing. LoPiccolo (2002) speaks about the importance of having individual sessions after the first couple's session, especially in therapies dealing with sexual issues. This gives people a chance to share information, even information that both already know, without worrying about the impact it may have on their partner.

And so Lenny shared his sexual story with me, which he remembers beginning at about age 12 or 13 when he had become aware that he was sexually attracted to, and aroused by, muscular men. Superman and other action heroes were examples of what excited him. He recalls going into the basement of his home where he and his brothers kept their *Sports Illustrated* magazines, and he would masturbate to the photos. Lenny knew that he was different from the other boys, and he would try to participate in conversations or make comments about girls as best he could in order to fit in. During the summer months as a young teenager, Lenny found himself aroused by the well-built older boys he would see at the beach or the pool. As one might guess, he kept his feelings a secret.

In college, Lenny became more religiously observant. He was dismayed that his homoerotic thoughts and fantasies persisted, and so he tried his own homemade aversion therapies such as pinching himself whenever he had an "errant" fantasy or became aroused by a man he had seen. He did not fantasize about women, and desperately wanted *not* to fantasize about other men. Nothing worked. In graduate school Lenny began seeing a therapist in hopes of eradicating his same-sex attractions, but that too was unsuccessful. He sought the advice of rabbis and therapists, but nothing helped rid him of his homoerotic thoughts. Because of his increasing Jewish observance, Lenny decided to stop masturbating in his early 20s, and remembers that he stopped having wet dreams around the same time. By the time Lenny came to my office, he reported that he had not been aroused by the visual stimuli of muscular men in several years.

Lenny was diagnosed with Lupus when he was 25, although at the time his symptoms were not as severe. Lenny managed his disease through medication and exercise; he said it could flare up and then go into remission, although some symptoms, like fatigue and joint pain, were more chronic. Lenny's cognitive functioning was not impaired in any way, nor was that a concern. However, the possibility of further disabling conditions involving his heart, kidneys, and joints worried Lenny. My guess, and what Lenny also assumed, was that his then-undiagnosed illness, particularly the vasculitis and the testosterone deficiencies associated with Lupus, probably played a role in facilitating his decision to stop masturbating and also contributed to his current erectile issues.

Disappointingly, despite the many years since his diagnosis and the various doctors he has seen, the issue of Lenny's sexuality and sexual functioning was never introduced unless Lenny broached the topic himself, which he rarely did. The phenomenon of health care providers avoiding discussions about sex with patients and clients is quite common, and is a recurrent complaint in the medical, nursing, and social work literature (Humphrey & Nazareth, 2001; Magnan & Reynolds, 2006; Marwick, 1999; Sandowski, 1993). This avoidance is often mirrored by couples' therapists who may

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feel uncomfortable or embarrassed asking clients about their sexual concerns. Many are worried about their lack of skill or ability to help their clients with sexual issues, and so they steer clear of the topic altogether. The burden to bring up sexual concerns is then left to the clients who, taking their cues from the professionals, often opt to avoid asking sex-related questions.

Lenny never had much luck with dating. Although he was struggling with his attraction to men, Lenny wanted to date women, be in a heterosexual relationship, and lead a conventional family life. He would get set up on dates, but after each first date, no one was ever interested in going out again. He was pleasantly surprised when Debbie agreed to a second meeting, not knowing that she too had felt delighted by the unusual occurrence of being asked out on a second date. It took Lenny 6 months to tell Debbie about his illness and then, a month later, about his homoeroticism. He was particularly anxious about telling her about his attraction to men, and worried that it would be too much for Debbie to accept. His motivation for telling her, which he shared with Debbie, was his concern about how their sexual life would be affected. Lenny waited anxiously to hear back from Debbie when she said she needed to think it over, and was enormously relieved when she said that she wanted to continue with their relationship. It still took Lenny several more months to propose marriage. Despite feeling that he had been honest about what he was bringing to the relationship, Lenny was still inwardly worried about how his attraction to men would impact their future sexual relationship.

DEBBIE'S STORY

Debbie, like Lenny, was also the oldest child in her family. She had two younger sisters with whom she was never close. Debbie was stocky while her sisters were thin; Debbie was more academically focused where her sisters liked to party. Debbie recalls her childhood as lonely, and speaks about the other children making fun of her. Her parents were not particularly critical, although neither were they praising or approving. She cannot recall ever being touched or hugged, although she assumes she must have been. There were times as a teenager when, after a fight with her parents, months could go by with only silence between them.

Debbie's family was not religiously observant. Like Lenny, Debbie found Orthodox Judaism while in college, after taking part in classes and events where she experienced a strong sense of community and belonging. Though ritual and observance were very important to her, Debbie's family never joined her in Sabbath or holiday celebrations. Whether in her parents' home where she kept a kosher corner, or later in her own home, Debbie's choice was either to be alone for religious holidays or to try to get invited to other people's homes in the community.

Debbie's dating history is replete with first blind dates but no call-backs. Debbie assumed that it was because she was overweight and had body image issues. She felt unattractive and undesirable, but also felt helpless to do anything about it. After her first date with Lenny, Debbie expected that her dating pattern would repeat itself and that he would not call her for a second date. When Lenny did ask her out again, Debbie was overjoyed. The issue of Debbie's attractiveness and desirability became a theme as the therapy progressed. It has been processed both in the context of Debbie's personal history as well as in the context of her relationship with Lenny.

Debbie began telling more of her sexual story in an individual session, 6 months into therapy. She remembers that when she was 11 or 12 years old she found some

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books about sexual fantasies in her parents' headboard. There were no pictures, just vivid descriptions of sexual acts that would excite her. She continued reading her parents' books well into adulthood, although she never accumulated a collection of her own. Debbie began to masturbate to these stories, and had a sense of what would arouse her if she had a boyfriend or husband. As time went on, Debbie began to use Internet pornography, but stopped using it after her marriage to Lenny. At first she was hoping to replace the need for it with the sex life that she was going to have with her husband, and later because her frustration, anger, and disappointment with their sex life made her shut down sexually. The issue of her pornography use resurfaced as our work on the couple's sex life progressed, which is when Debbie first shared this piece of her history with me.

As a couple, both Debbie and Lenny agreed that they were much better off together than alone; neither wanted to go back to being single. They talked about enjoying each other's company and the social advantages of being a married couple in their community. Both stated that even if their sex life stayed as it was, they wanted to stay in the marriage. When they came to my office, they often sat on the couch holding hands. Their handholding seemed to give comfort and courage to one another as they discussed sensitive issues, and gave affirmation that, although they were exploring difficult terrain, their relationship was not in peril.

INTEGRATED COUPLES AND SEX THERAPY

It took more than 3 months for Debbie and Lenny to decide to come see me regularly. Lenny was the one who thought therapy could help them with their sex life; Debbie was resistant, would cancel appointments or just not commit to scheduling a return visit. After our initial couple's session, I saw Debbie and Lenny each individually. I consulted with Lenny's urologist who had referred the couple for sex therapy once he realized that the couple had not yet consummated their marriage, and also with the psychiatrist who Lenny was seeing on a periodic basis for individual psychotherapy. The psychiatrist spoke about Lenny's history of OCD and depression. The depression, common in Lupus patients, had abated years ago, and Lenny was no longer being treated pharmacologically for either condition. The psychiatrist respected Lenny's desire to be in a heterosexual marriage, but always had concerns about Lenny's ability to perform sexually with a woman.

It was during their second couple's session in over 3 months that I suggested that unless they were willing to commit to a block of sessions, it would be difficult to get much done together or to know if I could help them. We talked about agreeing to 4 weekly sessions with the understanding that we would check in at the end of the month to see if they felt therapy was helpful and if they would want to proceed. They agreed to come to four sessions, found them to be productive, and then became motivated on their own to come to weekly therapy.

I already knew about the couple's previous history with sex therapy, and was aware that a frontal, directive approach had felt shaming and had been ineffective. I believed that Debbie and Lenny's sexual issues would ultimately be best addressed if the therapy could be what Harlene Anderson (1995) calls a "generative conversation," one in which people are helped through language to create and gain access to self-identities that are freeing. Hence, although sex therapy can be behavioral and therapist-directed, I stayed with my postmodern therapy values of not-knowing, respectful

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listening, and collaboration, trusting that my expertise as a sex therapist would come to use at the right time in the therapy.

Our work began in earnest with an exploration of Debbie and Lenny's process as a couple. I used circular questions (Checchin, 1987), asking questions such as what makes sensitive, or even not-so-sensitive, issues so hard to talk about; what would happen if they shared more of themselves? We began with examples of things other than their sex life that had been difficult to discuss or negotiate. Our collaborative conversations led us to talk about their families of origin and their patterns of interaction. We began our work in a gentle mode of shared inquiry, going at the couple's pace, focusing on their process versus the content of their issues and always being mindful to connect to their presenting sexual problem whenever appropriate.

I remember the first time Debbie cried in the therapy. It was the first time she expressed her emotional experience without trying to cloak it in intellectual terms. She began to talk about her deep pain in never feeling attractive or desirable. She spoke about how being with Lenny confirmed her worst fears, although she knew on some level that his same-sex preferences played a role in their lack of sexual chemistry. Her honesty, together with Lenny's ability to hear her, seemed to pave the way for more openness and exploration. We began to reflect on the meaning of having children and what it would mean not to have children. We explored the resentment that was already brewing as that decision seemed to be being made by default rather than by choice. Debbie talked about her fears of raising a child alone while having to care for Lenny as he would potentially become more debilitated. Lenny spoke about his profound desire for a child, but understood and even shared Debbie's concerns. They came to a decision that they would not use measures such as in vitro fertilization or artificial insemination to try to conceive a child as that would feel like tempting fate. But if Debbie conceived naturally, they would see that as a sign that it was supposed to happen. We discussed the possibility of adoption, but neither Debbie nor Lenny was interested. They knew that the chances of conception were low and that there was risk associated with Debbie's age, but this was their mutual decision. It was not religiously motivated; it was more about either having a genetically related child or not having one at all. Of course their inability to have intercourse would prevent them from conceiving without intervention, which made this therapy all the more pressing.

The couple's emotional and psychological intimacy deepened as they navigated this uncharted territory and at the same time, they were also growing more comfortable with and trusting of me. I began to weave discussions about the couple's sexual relationship into the therapy, including discussions about the couple's sexual routines and how those had become problematic. They described their previously unarticulated understanding that Lenny was responsible for initiating sex, since the initial erectile problems had been his. Lenny would spend almost an hour massaging Debbie, slowly making his way to her breasts or clitoris when she would allow it. His hope was that she would become aroused and want a more mutual sexual experience. Debbie liked the massages, but only rarely allowed Lenny to go further, and on the occasion when she did Lenny's erection would be long gone. At the end of those long, drawn-out sexual episodes, Debbie would sometimes offer to manually stimulate Lenny's penis. But it was too little too late, and Lenny would be silently resentful.

Both Debbie and Lenny agreed that their sexual routine was not good for either of them; it was neither mutual nor satisfying, and they both knew it needed to be changed. But they also expressed fear that Lenny would lose his erection if they

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attempted penetration, and so in some way this routine had spared them the anxiety and likely disappointment of more failed attempts at intercourse.

About 4 months into the therapy, I had an idea that I thought might be timely to introduce. I had attended a sex therapy conference where there had been a discussion about the use of intracavernosal penile injections (a therapy which involves injecting drugs into the side or base of the penis to produce a hard erection that can last 30 minutes or longer). I began to wonder whether penile injection therapy might be of use to this couple by helping Lenny attain erections independent of arousal. I brought the idea back to our therapy, and they were both interested and eager to try it. Given the varied layers of their sexual issues, it was imperative that their medical/pharmacological, psychological, and relational realities be addressed through a multifaceted approach to therapy (Daines & Hallam-Jones, 2007). But timing was of the essence. The medical/behavioral interventions would have the greatest chance of success if introduced in the larger context of addressing the couple's psychological and relationship issues.

With his permission, I conferred with Lenny's urologist about introducing penile injection therapy, and he thought it was a great idea. At the same time, I referred Debbie to a medical practice specializing in issues of female sexuality. Debbie's age and sexual inexperience were likely to result in anxiety, tightness, and/or dryness if penetration was attempted, potentially making for an unpleasant or even painful experience. I shared my thinking that if Lenny could sustain an erection independent of arousal, and if Debbie's concerns about penetration could be alleviated through learning to use lubricants, dilators, and/or lidocaine, the couple's chance for successful penetration could increase exponentially.

The sexual aspects of this therapy really came together following our conversations about Lenny's homoeroticism. During the first months of our work I was concerned that Lenny's disclosure was not being fully explored in therapy. The issue was clearly one that had to be addressed, but the conversation could only happen when the couple was ready. I did not want to rush the process; neither did I want to collude in their silence. Personally, I struggled with Lenny's decision not to act on his sexual orientation. I wondered how to remain respectful of Lenny's request to become sexual in a heterosexual marriage when his attractions were really only to other men.[2]

Hence, I did some soul-searching and reading to grapple with my questions about treating men with unwanted homoerotic attraction. One author (Rosik, 2003) posited that psychotherapists often lean toward the liberal end of the social and political spectrum, tending to believe in the Ethics of Autonomy where people have the right to do what they wish as long as they do not hurt others. However, when we work with

[2] There are several articles written on the topic of gay or bisexual men married to heterosexual women. See for example:

Alessi, E. J. (2008). Staying put in the closet: Examining clinical practice and countertransference issues in work with gay men married to heterosexual women. *Clinical Social Work Journal, 36*(2), 195–201.

Buxton, A. P. (2001). Writing our own script: How bisexual men and their heterosexual wives maintain their marriages after disclosure. *Journal of Bisexuality* 1(2–3), 155–189.

Higgins, D. J. (2002). Gay men from heterosexual marriages: Attitudes, behaviors, childhood experiences, and reasons for marriage. *Journal of Homosexuality, 42*(4), 15–34.

Higgins, D. J. (2006). Same-sex attraction in heterosexually partnered men: Reasons, rationales and reflections. *Sexual and Relationship Therapy, 21*(2), 217–228.

Ortiz, E. T., & Scott, P. R. (1994). Gay husbands and fathers: Reasons for marriage among homosexual men. *Journal of Gay and Lesbian Social Services, 1*(1), 59–71.

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clients who are inclined toward the more conservative end of the spectrum, they often include two other influential dimensions in their evaluative framework: the Ethics of Community and the Ethics of Divinity. Rosik says that the Ethics of Community might involve concerns about respect, duty, integrity, social roles, fear of social decay, and the proper state of social order, while the Ethics of Divinity might focus on concerns about purity, sacredness, and living a life in the image of God. Those psychotherapists who believe that sexual fulfillment is a primary means of evaluating healthy adjustment are potentially disregarding the client's Ethics of Divinity and Community, and may be biased against those who do not subscribe to the Ethics of Autonomy as a moral domain. And hence, I was left to challenge my thinking that a person's self-actualization and personal identity should center on one's sexual orientation. I have always felt supportive of the people I have known both personally and professionally who felt the need to abandon religious observance because their homosexuality was not consonant with the strict religious communities in which they grew up. Why then should I take issue with Lenny's desire and request to remain in his faith community at the expense of his sexual orientation? Lenny had spent considerable time in individual therapy grappling with these issues, and he was clear about what he wanted. By the time I met Lenny, he was no longer looking to change his sexual orientation, nor could I have agreed to be his therapist had that been his request. He simply did not want to act on it. He seemed to have accepted himself as he was, yet still wanted to find a way to live within his religious community in a heterosexual marriage that included a sexual life with his wife.

I wanted to make sure, however, that we did not avoid talking about Lenny's homoerotic thoughts and fantasies and the role that they played in preventing the couple from being able to consummate their marriage. And so, when the timing seemed right, I opened up the conversation about Lenny's sexual history the next time it came up. I began by talking about talking: How would it be for Lenny to share his sexual story with Debbie, and how it would be for Debbie to hear it? They were both open to doing this, although somewhat anxious too. Besides his disclosure to Debbie while they were dating, Lenny had never shared this part of his life with anyone other than a professional, and certainly never with someone who was part of his day-to-day life. As Lenny began to share his sexual story with Debbie, he spoke hesitantly but poignantly about what it was like for him to grow up attracted to men when he so desperately wanted to be "normal." He talked about his attraction to muscular men, and the way he would sneak into the basement to masturbate to the *Sports Illustrated* magazines. He talked about his loneliness. He shared his failed efforts to rid himself of his homoerotic thoughts, and his difficulty in seeking help for them. For her part, Debbie listened quietly and respectfully, although it certainly brought up a wide array of emotions for her. She did not ask questions, but was happy when I did. Lenny's ability to share his story and have it witnessed and accepted by Debbie was a powerful experience for both of them, as well as for me. It seemed that Lenny's readiness to share something so private and Debbie's willingness to listen and accept what he had to say were critical factors in paving the way for the successful sexual outcomes that they were seeking.

And so with a revitalized intimacy, with Lenny's sexual story out of the closest, and armed with penile injections and lubricants, Debbie and Lenny set out to try to have intercourse. Unbeknownst to Lenny or to me, Debbie had gotten the idea to look at erotic Web sites before engaging in sexual activity with Lenny in order to get lubricated. After a session in which we had discussed various sexual positions, Debbie went

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to the Internet to get other ideas, and ended up looking at the pornographic Web sites that popped up. As she became more lubricated looking at and reading the porn, she decided to try using the largest dilator she had gotten from her doctor to see if she could insert it. Sure enough, it slid in without a problem. The next night, Debbie and Lenny decided to attempt intercourse for the first time in several years. As Lenny was waiting for the penile injection to take effect, Debbie made some excuse to go onto the computer for a few minutes and secretly readied herself for Lenny by arousing herself with the pornography. When she returned to their bed, Lenny had a strong erection from the injection and Debbie was lubricated from the erotica. Lenny was able to vaginally penetrate Debbie for the first time in their $6\frac{1}{2}$-year marriage, and even ejaculated inside of her. Debbie excitedly called me the next day to tell me their news; they both felt incredibly thrilled and relieved.

Of course getting what you want is not always so simple. After our next couple's session, I met with each one individually to talk about how the experience was for each of them. Lenny admitted feeling guilty about his need for the penile injections to be able to penetrate Debbie. Although he loves Debbie and spoke tearfully about his appreciation of her as a partner, he wondered if it was selfish to have married her. The combination of his lack of heterosexual fantasy and the physical toll of his disease had made unassisted erections extremely difficult, and he wished it could be different.

Along with her excitement, Debbie felt both guilt and resentment about needing pornography to facilitate sexual intercourse. She felt both religiously impious, and guilty that she had done it behind Lenny's back. It was in this individual session that Debbie elaborated on her sexual story about finding the erotic literature in her parents' bedroom and her subsequent sexual fantasies, readings, and interest in pornography. In the ensuing weeks, Debbie told Lenny about her pornography use, both past and present. As Debbie did for him, Lenny listened with respect, compassion, and acceptance. He actually felt relieved, he said, as he saw a parallel in their hidden sexual stories. He was also happy to know that when Debbie logged onto the computer before they engaged in sexual activity, she was not prioritizing her Internet activities over having sex with him, as he had assumed. He was touched to know that, in fact, she was using the Internet to try to get her mind and body into the mood to make their sexual experience better.

Debbie and Lenny began trying to have intercourse whenever possible, given their religious constrictions and the recommended limits of use of the injections. Their first success was not readily repeated. There were issues related to the dosing of the injection, and worries about possible priapism (an erection that lasts over four hours, and a potential, though rare, side effect of the treatment). Sometimes the injections were not as effective as other times. Even when penetration did occur, ejaculation was not easy, and Debbie kept defining "success" as only those times when Lenny ejaculated inside of her. Part of our subsequent therapy has been to reassess that belief. Overall, they are coming to a place of acceptance that their sex life may be different from others, but it is theirs, it is "normal" for them.

Debbie and Lenny made great strides in their therapy. They recognized that although they had begun to have the sexual experience that they were seeking, their journey would not end with their ability to have intercourse. They continued to work on their nonsexual issues as well as on their nonintercourse-related sexual concerns. They both expressed great relief in the fact that Lenny's homoeroticism was no longer kept secret, and that they were able to discuss it when relevant. Debbie and Lenny

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came in with the request to work on their sex life, but part of our collaborative work was to expand their request to include their overall intimacy. Their work as a couple has helped them relate to their extended families differently, speaking more openly and articulating things that would have normally been left unsaid. It is not clear to me whether Debbie and Lenny's sexual intercourse will continue over time, but I sense that their new intimate intercourse will be something they continue to work on and incorporate into their lives for a long time to come.

Debbie and Lenny's story is one that illustrates an integrative, postmodern approach to couples and sex therapy that acknowledges the complex and multifaceted issues that are woven into the sexual stories that our clients bring to us. This combined method of practice encompasses a broad range of cognitive, intrapsychic, relational, behavioral, and medical interventions, recognizing the value of each approach on its own and their greater usefulness when blended together. The story of Debbie and Lenny also highlights the importance of taking a sexual history early in treatment, and the value of exploring sexual concerns in individual sessions. Their story reminds us that the possibility of same-sex sexual fantasies and behaviors should always be considered in an assessment, even with heterosexual couples, and that therapists must remain open to all possibilities through our stance of curiosity and not knowing.

Of course, Debbie and Lenny's contribution to the success of this therapy must be acknowledged as well. They brought an immeasurable amount of honesty, integrity, and courage to our work, for which they have my utmost respect and admiration.

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