Talking about sex:
NARRATIVE APPROACHES TO DISCUSSING SEX LIFE IN THERAPY

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How do we discuss sex issues in therapy with a narrative and post-structuralist, post-colonial approach? This paper discusses the ethics and practices of narrative approaches to talking about sex in therapy. It discusses ways to reduce the influence of shame and embarrassment, promote local knowledge and skills, and to minimise the impact of the gender and sexuality of the therapist.

Keywords: sex, therapy, narrative therapy, Foucault, ethics, externalising, co-research, outsider witness, scaffolding

THE PROBLEM OF VERBALISATION

> *I don't try to write an archaeology of sexual fantasies. I try to make an archaeology of discourse about sexuality, which is really the relationship between what we do, what we are obliged to do, what we are forbidden to do in the field of sexuality, and what we are allowed, forbidden, or obliged to say about our sexual behaviour. That's the point. It's not a problem of fantasy; it's a problem of verbalisation. (Foucault, 2000a, pp. 125-126)*

Sex is part of life, and the usual cause of it! And talking is part of life for most of us too. However, talking about sex, while common in TV, film, literature and the internet, is not so common for some couples and not so common in therapy. Perhaps, at times, it should be. In this article, I focus on the practices of talking about sex rather than sexual practices. I discuss how to ask clients if it is important to talk about sex, including when meeting with clients who may initially present with other problems; how to then add in a discussion about sex; and how to talk about sex in ways that decrease the negative influence and effects of embarrassment and shame, and that maximise people's own knowledge and skills.

To begin, I discuss various ethical considerations to 'talking about sex' from a narrative, post (non)-colonial and post-structuralist theoretical framework. Next I describe my preferred practice guidelines and their informing principles, and then I finish with examples from my work, two with white, heterosexual couples, and one with a gay man.

Before I begin, a note about terminology. In this paper I call the work I do 'therapy/psychotherapy' or 'counselling'; the people I work with 'clients'; our meetings 'sessions'; and 'sex' only refers to acts by and with consenting adults.

THE RAFT AND THE REASON FOR THIS ARTICLE

In narrative practices we acknowledge the importance of people's intentions, principles and purposes as major influences on what they do.

> … *actions were increasingly understood to be shaped by a raft of purposes, values, beliefs, aspirations, hopes, goals and commitments. (White, 2007, p. 101)*

What is my own purpose for this article and what is its history? My longstanding interest in talking about sex derived partly from a curiosity about sex when growing up, and partly from exposure to the tail end of the 'alternative culture' and 'sexual revolution' of the 1960s and 1970s which included an encouragement to talk about sex as a healthy, positive and 'liberating' thing to do. Though in the late 1970s, Michel Foucault (1978, 2000b) was to write about the simplicity of this 'sexual liberation' view and how it could also be understood as creating less obvious new conditions on sex.

In the early 1980s when I began doing psychotherapy work, I often wondered, 'Where could I discuss sex therapy with colleagues?' In the mid-1980s I discovered narrative therapy, although it had not yet collected that name. Since then I often asked myself, 'How and where can I discuss sex therapy with a narrative and post-structuralist framework?'

A few years ago, while looking after my second child, a toddler, in my backyard, I was chatting with a neighbour who mentioned her new job was office work for a sex therapist. I enquired further and discovered a national organisation here in Australia: ASSERT - Australian Society of Sex Educators, Researchers and Therapists.[1]

I joined a local monthly peer supervision group on sex therapy but was so nervous to talk about sex therapy that I don't think I spoke for my first three meetings. Drawing from the comfort and ease shown by the other group members and from my determination to develop some skills in this area, I gradually discovered my voice. As I slowly gained comfort in talking about sex therapy in this group, I started to wonder should I, could I, include 'talking about sex' more in my work with clients? Over time I began to introduce the topic more regularly in my psychotherapy work, especially with couples. I gathered greater ease and experience and began to try out a variety of narrative informed practices. This is a process that is continuing.

Recently, I became aware that Dulwich Centre[2] had launched a project re 'talking about sex in therapy' in the hope that narrative practitioners could be more approachable, comfortable and skilled in talking about sex with the people with whom they work. This paper is a contribution towards this shared aim.

PART ONE: ETHICS, THEORY, CULTURE, AND TALKING ABOUT SEX

Although I have taken a position of increasing the discussion about sex and its problems in therapy, I believe this position should never go unexamined. Talking about sex can be understood as a cultural practice: a practice that comes from culture, that operates in culture, and that makes culture. When thinking about introducing 'talking about sex' in therapy or elsewhere, it is ethical to consider when to respect culture and when to counter culture. And there are at least three cultures to consider whether to respect or to counter: the cultures of the professions, the cultures of the client, and the cultures in whichever society we live.

FOUCAULT AND THE PSYCHOTHERAPY INDUSTRY

'Let's tell the truth'

As a 'counsellor' it would seem normal practice to encourage people to tell the truth about themselves (and about each other if they can keep civil) and their problems. In therapy sessions, people telling the truth about their thoughts, feelings and experiences (including those related to sex) would usually be seen as productive. Dishonesty, hiding the truth or lying in therapy would usually be seen as counterproductive. Yet Michel Foucault, when he looked at the different types of truth-telling[3] over western European history from the ancient Greeks and Romans to the modern era, posed the following question:

> *How did it come about that all of Western culture began to revolve around this obligation of truth, which has taken a lot of different forms? (Foucault, 2000c, p.295)*

'Let's tell the truth to a therapist'

According to Foucault, in the ancient world of Greece and Rome the truth could be told in a public speech in the Agora or Forum, or it could be told more privately to one's tutor in life, i.e. 'an expert'. With the advent of the Christian era one's personal 'truth' could be told to one's confessor, the priest. In the 20th century, psychotherapy imitated and adopted the practice of 'the private confession of the truth for making oneself a better person'. Now people are invited/incited to confess to the expert therapist instead of to the expert priest (Foucault, 1978, p. 130). In the contemporary Western world, it is not just in psychotherapy that there is a popularity for 'truth-telling' about the self. A whole range of places and ways of talking the truth about oneself and one's problems are being propagated. The private space of a professional counselling room remains, but there is also the grand public arena of the daytime television talk-shows or evening reality television shows, plus internet social networking and video-posting websites.

'Let's tell the truth about sex'

Foucault further wrote that at certain points in history, including our own, telling the truth about sex is especially encouraged (Foucault, 1978, 2000b, 2000c):

> *Unlike other interdictions, sexual interdictions are constantly connected with the obligation to tell the truth about oneself ... the task of analysing one's sexual desire is always more important than analysing any other kind of sin. (Foucault, 2000b, p. 223)*

'Let's work on ourselves to become a better and freer person'

And according to Foucault, a key aspect of contemporary western culture, including that of professional psychotherapy and 'pop' psychology, involves people making an effort on their 'self', working on their self, in order to make a 'better' self. This is supposed to lead us to more personal freedom, a 'freer' self (Foucault, 2000b, 2000c). Foucault called these types of self constituting, self-producing techniques in society 'technologies' of the self. Declaring the truth about oneself and one's problems is, according to Foucault, a central technology of our times.

I find Foucault's ideas extremely interesting, but how is this relevant to us as therapists who might want to make it more possible for our clients to talk with us about sex?

If we consider a Foucauldian analysis, contemporary Western culture includes practices of:

- Working on the self, trying to better know and care for the self

One way of doing so involves:

- Talking truthfully about oneself and one's problems

This particularly includes:

- Talking truthfully about sex
- To an 'expert'

And these acts are seen as:

- Leading to becoming a free individual, to achieving personal liberation and freedom.

To me, this sounds like a definition of much of modern psychotherapy and sex therapy. Again, interesting but also very sobering! If we take note of Foucault, if we consider much of what we may try to do in therapy as cultural practices, then I believe these (our) practices should be examined in terms of their history, purposes, and especially their real effects.

For example, according to Foucault, this notion of seeking personal freedom through these particular technologies of the self can actually reduce personal freedom (Foucault, 2000c). This pursuit of 'self-improvement' however may be never-ending, there may be no escape. Out of concern and a cause to better 'know thyself' and 'care for thyself', people may devotedly do hard labour on and for the self, working hard to talk about one's self and one's truths. We may devote ourselves to a life sentence of 'self-production' packaged as 'self-improvement'. In the name of liberation, people may also work harder and harder to abide by certain normalising ideas as to what constitutes proper 'truth-telling' and appropriate 'self-care'. We constitute our selves through what Michael White (taking from Foucault) referred to as practices of 'modern power' (White, 2002).

What does this imply for those of us interested in talking about sex with our clients? Well, as therapists, when we encourage people to be able to talk more and truthfully about sex, our acts of trying to help 'liberate people' could inadvertently achieve the opposite. Our work may risk contributing to making people less free not more free. We can ask the following questions of ourselves:

- *Am I recruiting here to an 'industry' of 'talking about sex'?*
- *Am I selling the idea that truthfully talking about sex will 'set you free', will help free you of problems?*
- *Am I constructing a pressure to 'confess' and talk about sex?*
- *Am I just creating more work for already overworked people, of getting them to work hard at transforming themselves into 'talking about sex' type people?*
- *How much am I just a staff member of the 'Industry of Talk' competing for territory with the 'Industry of Pharmaceuticals' in the field of problems in sex?*

Perhaps we can ask the following questions of the people we work with:

- *Is talking about sex my idea, your idea, or just the 'fashionable' idea?*
- *Is talking about sex a necessity or a fad and fashion?*
- *In your experience, is 'talking about problems like sex' the 'new' pressure?*
- *Does 'talking about sex' end up telling you that you have even more problems than you initially realised and makes you feel worse?*
- *Does 'talking about problems like sex' make you feel free, or more of a failure? Does it reduce your burden or increase it?*
- *Does 'talking about sex' seem to have an end? Or is it just the beginning of a 'new' life-long chore?*

It's important to note that Foucault was not against seeking freedom including in relation to sex (Foucault, 2000d). In fact, he was very much for it. Foucault was not against self-improvement, social-improvement, self-care, or self-knowledge. But he believed that the cultural practices and pursuits that stake claim to offer self-improvement, social-improvement, self-care, or self-knowledge, should be looked at in terms of their social-historical and cultural origins and their real effects. It should never be taken-for-granted that contemporary practices claiming to be pursuits of freedom are actually representative of 'progress' (Foucault, 2000c).

CULTURE AND COLONISING

In introducing and engaging clients in the practice of talking about sex in therapy, it would be naïve to claim I am being culturally neutral. Talking is my trade. I 'scaffold' with conversation. It is difficult for me not to promote talking, otherwise it is difficult for me to do my work. Talking about problems, however, is not a universal cultural practice. Many problems in life are never discussed: some need not be, some should always be, but what about sex? Talking about sexual problems, or even just talking about sex, is not a universal cultural practice either. Should sex be talked about? If so, why necessarily with a therapist? Some people and sub-cultures love to talk about sex, and it's hard to get them to stop! They may like to talk about sex before, during, or after sex. There are whole realms and reams of literature, video and personal-professional knowledge on ways and styles to talk during sex with the aim to increase sexual pleasure. But other people and sub-cultures do not like to talk about sex. They may like to have sex but not to talk about it either before, during, or after. Talking about sex is not everybody's way of life.

I may be tempted to pronounce righteously that the cultures and sub-cultures that are not talking about sex are experiencing 'inhibition', i.e. the effects of psychological or political or religious prohibition or repression that needs to be challenged. Some worringly are, but some are not. I may be ready to claim 'I am not being colonising, I am being anti-colonial!' However, most colonial practices have been justified with a similar righteousness.

Guided by this concern, we can ask the following questions of ourselves:

- Am I introducing a cultural practice with this client/s of talking about sex where none existed? If so, have I discussed this issue with them?
- Is talking about sex their custom or am I starting, selling, a new custom?
- Are they coming here to learn my customs and culture, e.g. 'talking about sex', or to have their customs and culture respected and honoured?
- If they do not want to talk about sex with me, is there someone else, some other place in their life, context, community, where these conversations could take place?

We can ask also questions of the people with whom we work:

- Am I creating an issue to talk, or are we getting around to discussing something that needs discussion?
- Does 'talking about sex' fit with you or not? Does it fit with you as a couple? Fit in your background, family, or community, or your religious or personal values, etc., or not?
- If not, how would you like to proceed?
- If not, is it a practice you now wish to learn and adopt, or not?
- Is there anyone with whom you have found it helpful to talk about sex?
- If there is an issue related to sex that you do want to talk about, where could you turn?

COUNTERING CULTURE

The preceding discussion has invited us to respect pre-existing customs in relation to discussing or not discussing sex, and to tread carefully before we introduce a custom of talking about sex.

Conversely, 'counter' cultural critiques may invite us to challenge some accepted cultural ideas and ways of doing things. If, inspired by Foucault, we look at cultural practices as practices of power, there are two different forms of power that we may need to consider and challenge.

'CLASSIC' PRACTICES OF POWER & RESULTING ABUSE

Practices of power such as threat, punishment, 'guilting', and 'shaming', may have no consequences for a fortunate few, but for many they result in hurt and suffering. People who see us may have experienced these abuses of power in relation to sex, sexuality, and identity. They may have experienced violence and abuse and also discrimination and other forms of persecution. Unfortunately these abuses of power can be an everyday event in society and occur a lot more to those whose practices of sex, whose sexuality and sexual identity are not of the mainstream. If people have experienced being shunned, bullied, assaulted, harassed, or even arrested for disclosing, for talking about their preferred sexual identity and preferred sexual practices with consenting adults, this may obviously have significant negative effects on their relationship to sex and talking about sex. We can accept that it is our responsibility as therapists to acknowledge these as wrongs. To make it clear to our clients that we are willing to talk about these abuses, to name them, to discuss their effects and people's responses to them. (Waldegrave, 1990; White, 2011a)

FOUCAULT AND WHITE'S CONCEPTS OF POWER

'Classic' notions of practices of power are usually conceptualised as where someone with more power does something to someone with less - an external operation of power. There are other ways, however, to conceptualise practices of power, including where people are recruited to work on themselves - to engage in an internal operation. Foucault was interested in how knowledge works with practices of power to get persons to 'constitute' or 'make' themselves. He wrote (using only masculine pronouns!):

> *I would say if I am now interested in how the subject constitutes itself in an active fashion through practices of self, these practices are nevertheless not something invented by the individual himself. They are models that he finds in his culture and are proposed, suggested, imposed upon him by his culture, his society, his social group. (Foucault, 2000c, p.291)*

In other words: 'types of self are accompanied by formulas and recipes to build them'.

Michael White (2001a, 2002, 2011b), drawing on the work of Michel Foucault, formed his concept of 'modern power' and investigated the ways in which it operates in therapeutic conversations. Importantly, he described, how modern operations of power set up a whole range of norms for people's lives and identities, incite people to adopt and try to fit these norms, and then judge themselves as a success, or more often as a failure, at this task. This is a process particularly pervasive in relation to sexual identities and activities. Self-constituting processes

such as 'modern power', pervasive as they are, can be hard to spot as people may not be aware they are operating. If we as therapists are aware of them, we can externalise these knowledges and practices. Considering Michael White, we can 'make visible the invisible'. We can join in conversation with clients to name, expose, tease out and pull apart these 'norms', how they operate and their effects. We can identify and deconstruct the present-day 'truths', rules and regulations in relation to talking about sex and of sexual practices, then can make visible their history and evolution. We can ask about and list the unwanted effects of these on the person's life. We can enquire about and outline the ways a person is dutifully self-disciplining and self-shaping, engaging in operations of self-production, and then ask about the demands and costs of involvement in this process (Foucault, 2000b, 2000c). In simple words, we can explore how they are measuring, judging, and sentencing themselves influenced by these dominant ideas, attitudes and practices.

Here are just a few examples of the unwanted effects of 'modern power' (White, 2001a, 2002) that clients commonly introduce me to:

- A sense of personal failure and inadequacy as a sexual partner: Some people with whom I meet in therapy have a powerful sense of not being good enough in sex, of not being desirableness enough when compared and judged by cultural criteria of acceptable frequency, style and performance of sex, and/or of the shape, beauty and weight of their body.
- A sense of separation from and disapproval of one's own ideas and knowledge of what practices give pleasure in sex: Some people with whom I meet do not practice the forms of sex that give them pleasure because these are categorised by dominant cultural criteria as either unacceptable, abnormal and perverse, or inadequate, insufficient and not 'the real thing' (includes consensual adult-to-adult fetishes and solo sex). When they do engage in these sex acts, they are accompanied by a sense of shame or guilt.
- A sense of exclusion, isolation and disconnection from others because of a negative identity conclusion of not being 'good enough' for others by not meeting dominant cultural criteria: This has led to a feeling of being unlikable, left out, an outsider, alone, and worthy only of non-participation and of exclusion.
- A sense of exhaustion and burn out, or a constant demanding striving overload, or a simmering (or not so simmering) resentment, or all three: From relentless ongoing efforts to improve their sexual self to fit in with the dominant cultural criteria that prescribes what one should be doing in sex.

There are many ways we can respond to these problems in our work as therapists, some of which I will discuss later in this paper. Externalising conversations that name the dominating attitudes, ideas, norms and practices about sex and 'talking about sex' can be a helpful start.

We can ask:

- *What messages about sex and talking about sex did you pick up from your upbringing?*
- *What were your parents' family's attitudes and habits to sex and talking about sex?*
- *What beliefs are there in your cultural background about sex and talking about sex?*
- *What ideas/beliefs are around in your family and local community about sex and talking about sex?*
- *What ideas/beliefs within popular culture about sex and talking about sex are influencing you now?*

Similar questions can be asked in regards to sexual preference/orientation, gender and gender identity ideas, beliefs, choices, attitudes, and prejudices.

We can then use the Statement of Position Map (White, 2005a, 2007 chapter 1) to assist people to define their own position in relation to these ideas and their effects:

- *What is your name for those beliefs/attitudes/habits? (Naming questions)*
- *How have they affected you? (Effects questions)*
- *Are those effects good or bad in your opinion? (Evaluation questions)*
- *Why? How does that sit with your current principles? (Justification questions)*

This naming of dominant cultural ideas can assist people to then examine and question these ideas and, if they wish, to consider ways to counter their negative effects in their lives.

PART TWO: PRACTICE GUIDELINES AND PRINCIPLES FOR TALKING ABOUT SEX IN THERAPY

Talking about sex can be experienced as positive, negative, or mixed. It can be easy or difficult. It can be experienced as interesting, exciting, even arousing, or as embarrassing, humiliating, intrusive, and unwelcome. It can be longed for, like an overdue invitation that has finally arrived, a relief, like a heavy weight has been lifted. Or it can be baulked at like an onerous chore and duty.

It may provide a sense of liberation and increased sense of preferred self, or it may activate or aggravate ideas of personal failure. It may lead to greater connection or it may heighten a sense of isolation and loneliness.

Shame and embarrassment can be a big and frequent problem with talking about sex. Many people, although grateful for an opportunity to talk about sex in a session, find it too embarrassing to do. If they decide they do want to talk about sex in a session, then leading up to the session where talking about sex is planned, people may go through a sense of hopeful anticipation, or oppositely go through discomfort and dread. In the session, some people boldly bring up talking about sex. Some may subtly allude to it. Some may say nothing and silently wait and hope the therapist does first. After talking about sex while still in the session, people may feel they revealed too much. If not at the time, they may regret it later, after the session. They may feel they got caught up or were under pressure in the counselling discussion to 'reveal too much', or even forced to 'open up', psychologically naked with one's private thoughts on show and display. They may feel hurt, ashamed, and embarrassed. It may lead to not just feelings of shame and embarrassment but to a violated, exposed or dissected 'sense of self'.

Having considered some of the ethics, theory and cultural considerations in relation to talking about sex, I now describe my preferred practice guidelines and their informing principles to talking about sex in therapy. Amongst other aims, these aim to minimise people suffering shame and embarrassment when talking about sex, and to reduce the chance that this talking will adversely affect people's 'sense of self'.

GUIDELINE 1: OBTAIN CONSENT TO (AND HOW TO) TALK ABOUT SEX

Obtaining client consent to talk about sex in therapy is a simple but important practice step (See box on page 32 for sample consent questions). This can include asking for information on how they would like to talk about sex, e.g. directly or indirectly, and whether or not they are okay with being questioned about sex.[4] During this process, it's also possible to check that you have let them know you are respectful and comfortable to talk about sex in therapy sessions.[5]

GUIDELINE 2: MINIMISE `PROBLEMATISING' SEX AND SEXUAL IDENTITIES

> *What I tried to do from the beginning was to analyze the process of 'problematization' - which means: how and why certain things (behavior, phenomena, processes) became a problem., for example, certain forms of behavior were characterized and classified as 'madness' while other similar forms were completely neglected at a given historical moment; the same thing for crime and delinquency, the same question of problematization for sexuality. (Foucault, 1985, pp. 65–66)*

In narrative therapy, we are aware of the all-too-common slippery slope of something in life being called a simple problem, then called a deficiency, dysfunction, disorder, or pathology, then called a problem personality trait, then finally called a problem personality. When this process takes over, the whole identity of the person is in the end called disordered or pathological. This is referred to in narrative practice as a 'negative identity conclusion' (White, 2001b, 2002, 2005b, 2007). Within professional discourse, people's lives can become so objectified that 'personhood' becomes 'casehood': *'I shall now present a case of ...'*

Sex quickly can become problematised. Sexual difficulties suffered by people become sexual problems or issues, which become sexual disorders and dysfunctions. These days people can have libido deficiencies, erectile dysfunctions, orgasmic dysfunctions, and so on. This pathologising can take over people's identities: *'He's a prem ejaculator'*, and oh so quickly the person has become a case: *'Can I discuss a case of orgasmic dysfunction?'*

I am a medical doctor by training and there are valid places for medical diagnosis and treatment. I am happy to engage in the medicalisation of sexual problems when appropriate. For example, sexual problems associated with post- prostate surgery and post-gynaecological surgery are areas where medical diagnosis and treatment may have a lot to offer people's sex lives. But if people are coming to talk with me, I take great care to ensure that the ways we speak about their lives do not contribute to 'problematisation' of their identities. Not only is there a risk of generating negative identity conclusions, there is another 'side effect' of medicalising and psychologising people's experiences of sex. If I as a therapist define and diagnose people's experiences of sex, this may take the understanding and solutions out of the domain of people's own knowledge and skills. It may leave them feeling more helpless to act on their own behalf. (White, 2011a, pp. 64–66)

In my work, to minimise these possible side-effects of problematisation and medicalisation, I tend to sparingly use the word 'problem' and I very rarely use terms such as 'dysfunction' or 'disorder'. Instead, I tend to ask:

- *How is your sex life? How is sex going?*
- *Should we include discussions about how you are going with sex in your relationship?*
- *Is sex something we should talk about?*

Sometimes I am more specific:

- *Erections? Foreplay? Types and ways of doing sex? Or anything else need talking about or not?*
- *Are there any sexual thoughts or feelings or fantasies or wishes or hopes, or anything else that you want to talk about or not?*
- *Are orgasms something you'd like to talk about or not?*

Perhaps also:

- *Any difficulties with sex?*
- *Any differing opinions or disputes about what you should do or not do in sex that you'd like to discuss?*

My preference for non-problematising speech is strong but it is not total, nor do I think it should be. At times I may use 'problem/issues' questions:

- *Any problems with sex? Any issues with sex?*
- *Any problems with how you go in sex?*

And if want to talk about what others might name as 'physical dysfunctions' or 'disorders', I tend to ask:

- *Any problems with sexual technique, performance, or orgasm etc?*
- *Any problems with how the sexual parts of your body are working?*

I then follow the lead of the client by naming the body parts in whichever style of language they are most comfortable with (e.g. 'street' words or more medical terms). And we generally talk about the types of common problems in ordinary language, using adjectives like hard, soft, wet, dry, etc.

It may be easy at times to use phrases such as 'intimacy' and 'marital relations' instead of sex, but I find using terms like those tends to lead to an obscurity about exactly what is being talked, so I tend to avoid them and instead speak as directly as I can.

If people in therapy wish to speak about particular problems, there are ways of doing this that minimise the chances of problematising their identities. One of the key principles in narrative practice is that people are always actively responding to problems in their lives. They are trying to understand, solve, endure, minimise or bypass problems. It therefore becomes critical to not only ask about problems but also to ask clients about their responses to these problems (Denborough et al., 2006; Denborough, 2008; White, 2005b):

- *Can I ask, are there any ways you have found to get around the problem a bit?*
- *Got your own fixes? Found other ways to make yourself or your partner happy?*
- *How do you stop it from getting to you as much as it could?*
- *How do you get yourself through the problem times in sex to enjoy sex as best you can?*
- *Did I hear you say at times you have some fun in sex despite the problems? How do you do that?*
- *You said you found your own ways to have or give some pleasure in sex? Is that right?*

My caution against the negative effects of 'problematisation' is a guideline not an absolute rule. I hope my reluctance to use 'problem saturated' language (White, 2001b), does not prevent therapists from judiciously asking clients about any problems they have with sex. This can be particularly important when clients are looking for clues to tell them whether or not their therapist is comfortable with talking about sexual problems.

If we're not sure clients want us as therapists to bring up the topic of sexual problems, why not ask them?

- *Do you need me to first ask about tricky sexual things to help you to talk about them too? Or would you prefer we don't discuss them until you bring them up yourselves?*
- *Would it help if I went through some common sex problems? Would that help you to talk about them, if that is what you want to do?*
- *Are you waiting for me to bring it up? Are you scared or reluctant to bring them up first, or do you really not want to talk about them at all?*

GUIDELINE 3: PREFER INTENTIONAL STATE DESCRIPTIONS RATHER THAN INTERNAL STATE DESCRIPTIONS

'Who' or 'what' we are interested in sexually is important, but irrespective of 'who' or 'what', how are we to describe 'how much' we are interested in sex at any one time? The 20th century was a period of the growth of the use of internal state notions for understanding sex. The notion of libido as an 'energy' became common. Sex 'drive' increasingly came to be equated with some deficiency or excess, some release or build-up of an

inner substance. These structuralist 'internal state' notions came to be used to describe people's sexual interests in terms of inner essences. 'Normal' and 'abnormal' levels of these essences came to correspond with 'normal' and 'abnormal' people (see White, 2005b, p. 15). Questioning these internal state descriptions, is not to deny that sexual interest can be experienced this way, nor that it does not wax and wane, nor that it is not affected by physical factors, e.g. medication, health, tiredness, etc. But, I believe confining ourselves to an understanding of people's sexual interest as an inner substance is incomplete and limiting. It commonly becomes problematised, e.g. couples argue: *'You have no libido!'* counter-argue with: *'Well your sex drive is excessive!',* then fall into a hurtful struggle about who is the most faulty person.

I believe that any level of interest in sex is influenced by conscious considerations: evaluations of self and of others, and the interactions with them. Values guide our assessments, e.g. of being used or respected, liked or disliked, wanted or unwanted. To me these considerations say that how much we are interested in sex reflects intentions, principles and beliefs, hopes, dreams, and so on (often in complex ways). Michael White (2007) referred to intentions, principles, beliefs, hopes as 'intentional states' to contrast them with internal state descriptions (pp. 100–107). I prefer in my therapy sessions to ask 'intentional states' questions. I prefer to ask about sex, interest in sex, or sex life, as I believe these terms more imply the existence of intentions and principles, and I am wary of using the terms 'drive' or 'libido' as I believe these terms mostly do not. I also tend to be cautious of using the terms 'desire' and 'lust' because of possible ambiguity, i.e., are we talking about intentions or internal substances.

GUIDELINE 4: FOCUS ON EFFECTS OF THE PROBLEM AND PEOPLE'S RESPONSES TO THE PROBLEM

If 'shame and embarrassment' make talking about sex difficult and distressing, externalising conversations can help minimise them and their effects. Other narrative approaches can assist too. A guideline to help mitigate the possibilities of 'talking about sex' adversely affecting a person's sense of self is to use the narrative approach to trauma of eliciting effects and responses. White (2005b) and Denborough (2008) have highlighted the significance of talking about the effects of the problem plus talking about people's responses either to the problem and its effects, and/or their skills in just getting through. As therapists, we double listen (aka doubly listening) and double question (White, 2003, p. 30). Our conversations have a dual focus: on the effects of the problem and on people's responses on their own behalf, to the problem:

> *[This] … provides double-storied accounts of people's experiences – accounts which richly describe the effects of the hardship that is being endured and also richly describe the ways in which the … [person] has been responding to this hardship … (Denborough et al., 2006, p. 21)*

In trauma work, this double inquiry can help people to speak of considerable hardship without disintegrating their sense of self. Through this process, we look to establish for people, an *'alternate territory of identity for … speaking of their experiences of trauma'* (White, 2005b, pp. 11–12). An important note is that when people talk to us about the effects of trauma, we may not necessarily hear or need to hear the details of *what* happened.

For people who experience increasing shame and embarrassment, the closer they are to discussing sex in general, and sex acts in particular, we can adapt and modify this 'trauma approach' to assist. This is especially relevant for those who report that talking about sex can be a trauma in itself. Instead of immediately asking and talking about the sex acts (or lack of) involved, we can ask how the sexual issues or problems are affecting them, and how they are responding to such challenges (White, 2005b; Denborough et al., 2006; Denborough, 2008):

Effects questions:

- *Can I ask not about the sex problem itself but how it is affecting each of you?*
- *What are each of you going through because of it?*
- *What is it doing to your relationship?*

Response questions:

- *You said you encouraged each other to feel a bit more comfortable to talk about sex. Can I ask what each of you did or said to help do that?*
- *What do you do to get yourself through the times when disputes about sex create difficulties?*

GUIDELINE 5: ELICIT WHAT PEOPLE BELIEVE IN AND WHAT THEY HOLD VALUABLE AND IMPORTANT

A third way to minimise shame and embarrassment and their negative effects, is to elicit and outline what it is that people believe in, what it is they hold important and value. There are two preferred ways I do this.

The first is to employ the Statement of Position Map 1 (White, 2005a, 2007 chapter 1). This involves four types of questions: questions to help people name and define the problem, questions about the problem's effects, questions on how people evaluate those effects, and

questions on how this evaluation flows from and fits with their principles. This map can focus the conversation more on the effects of the problem than the events of the problem. It can also focus more on the people and what they believe in, than on the problem. I often ask clients these four types of questions and then read back their answers. Here's an example of an 'edited' version of a person's responses that I have read back to them:

You told me your name for the problem is 'trouble initiating sex'. You said it is not directly bothering you so much, but it is indirectly, as it's leading your partner to tell you that they feel that 'you don't love them'. You said you don't like this at all. You want them to 'know you love them' because the type of sex life and relationship you want and believe in is where 'we feel and show each other love'. Did I get what you said right?

I may then enquire about and expand upon these principles and hopes. In particular, I become interested in tracing the history of these principles and hopes (Carey & Russell, 2003a; White, 2007 chapter 2) and inquire about the people who contributed to these principles and hopes. These figures can be recognised, noted, and listed (White, 2007 chapter 3).

Can we talk for a while about these beliefs and ideas about the type of sex life and relationship you believe in and want? Maybe even get a history of the beliefs and ideas? Find out who contributed to their honoured place in your life?

My second preferred narrative practice to elicit and honour what valued beliefs people adhere to, is to use the narrative practice of the 'absent but implicit' (Carey, Walther & Russell, 2009; White, 2003, p. 30) or what I prefer to call the 'not stated but implied'.

If clients indicate what they don't like (or don't give value to), they may also be implying that they are thinking about, or have an idea of what they do like and give value to:

You both said that sex together is distressingly rare and unexciting. What could that be implying about what you want and hope for instead? What is it saying about the type of sex life you do want to share together? What is it saying about the type of togetherness you hope for and believe in?

These hopes and dreams, beliefs and values can then become the focus of our conversation:

Can we talk for a while about these beliefs, ideas and hopes of yours about the type of sex life and togetherness you would like? How long has this been important to you? Where and who did you learn this from?

GUIDELINE 6: SHARE LOCAL KNOWLEDGE (DE-CENTRE THE POSITION OF THE THERAPIST)

Narrative therapy differentiates between 'local knowledges' and those forms of knowledge delivered from experts (White, 1997; 2003 p. 52; Foucault, 1976, pp. 81–83). 'Local knowledge' is knowledge and skills that people in the community know, use and practice (See Epston, 2008; Denborough et al., 2006; Denborough, 2008). 'Expert knowledges' are those of the professional sciences that are dispensed by 'experts'. In narrative practice, we hope to promote and respect the use of effective local knowledges, not least as a way of helping people keep control over the way they address and solve difficulties in life. One of the mainstay practices of my narrative informed sex therapy involves collecting, collating and then sharing local knowledges. This includes making and sharing lists of local knowledges of sex and ways of talking about sex. Of course, it's important to do so in ways that bypass shame and embarrassment and that also respect privacy requirements.

One post-structuralist principle that I believe is that we are all positioned, historied creatures, and our positions contain biases and prejudices whether intentional or not, whether addressed or not. One of my favourite quotes from a feminist colleague is: *'It is a persistent error of powerful men to think their comments are objective, neutral, value and prejudice free'* (Rhodes-Little personal communication, date not remembered!). In recent years she has expanded this to write:

. .. knowledge is never neutral, never divorced from the person who produces it, nor from the broader structures which the representer produces or contests as they produce her/him. (Rhodes-Little, 2000, p. 285)

Similarly, as therapists, we are not objective, impartial, detached, or neutral (White, 2011a, pp. 65–66). Finding ways to collect and distribute local knowledge between clients can also assist to reduce the effects of the gender-centric and sexuality-centric bias of the therapist. In the next section I describe an example of collecting and sharing documents of local knowledge between women about sex in a way that I hope de-centres my position (Morgan, 2006) and reduces the risk of me as a male therapist participating in an age-old patriarchal practice of men deciding on what is best for women.

PART 3: STORIES FROM MY PRACTICE

Having explored a range of theoretical considerations and practice principles, I describe three accounts of my therapeutic practice.

ANNE AND BEN: WAYS OF TALKING ABOUT SEX

Anne and Ben in their mid-forties have been together for twenty years. They have one child, a daughter in late primary school years. Anne works part-time in an office and Ben works full-time in a small team of a very large company, in product distribution. I had worked with Anne many years ago, before she met Ben, helping her to reduce 'anxiety' and cease anti-anxiety medication, plus talking about getting on with her family. One day, Anne rang me as she discovered Ben had been using an online social-networking site late at night to 'chat' with women from his work. In her opinion, Ben's dialogue had not been sexual but inappropriately over-friendly.

I met them together but also gave time to each alone.. Ben said he realised now his 'chatting' was inappropriate. He said he was apologetic and that he had stopped it. They confirmed they loved each other and wanted to stay together. They added that they had drifted apart especially since the difficult time after the birth of their child. At that time Anne was diagnosed with post-partum depression and remains on anti-depressants prescribed by her family doctor (which Anne said did not affect her sex interest or function). I asked about their sex life. They said it was an important issue, sex was not occurring very often and they wanted to discuss it.

In our first sessions together we identified their preferred beliefs and hopes for their relationship. We discussed the negative effects on Anne (and also on Ben) of Ben's online activities, and how they did not fit both his preferred beliefs and hopes for their relationship, nor with his own preferred beliefs on how to relate to and treat women. We talked about how he, knowing such negative effects and guided by his preferred beliefs, could change his activities. In these initial meetings we'd usually run out of time to talk about sex but confirmed it was our aim to one day. Over the next year we met together every two or four weeks, though sometimes there were breaks of many months. Anne or Ben would commence each session with a significant topic they wished to talk about. These included 'couple issues' especially Anne's concern that Ben did not ask for anything from her and that rarely, he spoke with a 'temper' that scared Anne. We also spoke about some urgent and serious issues at Ben's work, Anne's suffering a resurgence of panic and anxiety, financial difficulties, health problems, aging parents issues, and other pressing concerns. About 12 months after our first meeting, one night while talking to Anne at home, Ben disclosed he suffered sexual abuse as a child. This became the focus of our next sessions.

Eighteen months after our first meeting, we reviewed the way these different pressing problems had understandably stopped us discussing sex. I then made a suggestion to dedicate a series of three sessions to solely discuss their sex life. Three sessions where we would not let other issues take the stage, whether these issues were deserving or not! Anne and Ben keenly agreed to take up my suggestion.

SESSION 1

At the first of the 'dedicated to talking about sex' sessions, despite our pre-session sacred vow, most of the first half was taken up by Ben talking about his outrage at the childhood sexual assault he had suffered. Thinking about 'talking about sex' had got him thinking about that abuse. Speaking out loud about his outrage was very new for Ben, so Anne and I were supportive that he have time and space to talk.

In the second half of the session we discussed 'talking about sex'. I mainly enquired and 'mapped' the influence of the problem (White, 2005a). They both reported that having sex once a month was too infrequent. Only Anne initiated sex, if they were both not too tired, late at night, after their daughter was asleep. Ben did not initiate sex, but never declined it. This matched the general pattern (above) in that he did not ask for anything from Anne. They enjoyed sex once it started. Neither felt inhibited or unsatisfied in their sex together. Either out of busy-ness, or habit, or discomfort, or all three (or other reasons) they did not talk about sex at home:

Anne: *Our communication is fantastic in every way, but when it comes to sex it is not. We had a discussion about it this morning. We decided we had to make a time (to talk about sex) at home - an appointment together!*

Ben: *Talking about sex adds to it ... (it would be good to) open up about it … but I am embarrassed!*

They finished confirming their earlier decision to make an effort to talk about sex at home and added a new decision that each would organise special child-free times to have sex.

SESSION 2

At the beginning of session two Anne reported she had organised a special day at home for sex together, which she enjoyed. She was puzzled though why Ben did not say anything about it afterwards and did not then organise a similar day. She said she found it hard to get Ben to talk about sex, including why Ben did not initiate sex. She did not know what he really thought of her and of sex. She was worried. She said she presumed she was unattractive or that he had no 'sex drive' or both.

I proceeded with externalising (White, 2005a, 2007) the effects of 'not initiating sex' plus the 'not talking about sex' problem. This externalising included encouraging a deconstruction of these problems' origins and histories, not just in their specific relationship but in modern couples more generally.

Anne: *I don't know … you do all the right things and it doesn't happen … I need then to talk about it (but) I'm too embarrassed to talk about it … I never talked about it … too hard to talk about … my mother and her two sisters talked about sex constantly … complaining, negatively … I went the opposite … I found it embarrassing … they never talked about it in a way that is loving or caring, the way it should be talked about. I don't know how to put it into words … I'd like to know how.*

Ben: *How does it come about that … after decades together … we end up not talking about sex!?*

Anne elaborated that she enjoyed the special day for sex a lot as it was full of the slow, sensual and caring sex that she really likes. She asked Ben how the special sex day was for him. His answer was a minimal 'okay'. Anne then voiced that indeed her old negative conclusions were true, i.e. that Ben did not like sex, or like sex with her, or like her at all.

I then referred back to Anne's earlier comment:

Ron: *Anne, you said: 'I don't know how to put it into words … I'd like to know how'.*

I checked with her that she was saying she wanted to learn how to put 'talking about sex' into words. She said that she was generally a good talker, but she wanted them as a couple to talk more about sex, and she especially wanted to help Ben talk more about sex.

Anne: *But I don't know how or know what to ask Ben.*

When Anne said she does not know how or what to do, I believed her. To me she means what she says.

I conceptualise that she is at the limit of what she 'knows how' to do. She is at the edge of what is familiar to her on how to 'put it into words', on how to ask Ben about sex. She wants 'know how', to 'know what' to say, to learn some new possible ways to talk and ask Ben about sex. Within narrative practice we 'scaffold' conversations[6] to assist people to move from the 'known and familiar' into what is 'possible to know' (White, 2006a; 2007 chapter 6).

I asked myself, 'why not get Ben and Anne to ask the same type of narrative questions of each other that I would ordinarily ask them?' In this case, I would 'scaffold' by offering questions. I would invite one member of a couple to ask the question that I would usually ask next. Instead of me asking their partner the question, I ask them to ask it of their partner. My name for this is scaffolding by 'offering questions' or 'borrowed questions':

Ron: *Anne, how about you again ask Ben, 'Ben how did you find the special day for sex?'*

Ben: *(before Anne could ask it) Well, it was okay.*

Ben said this in what I took to be an unenthusiastic looking and sounding way. Ben continued:

Ben: *No … umm … I really enjoyed the day.*

This was accompanied by a non-verbal expression[7] that both Anne and I read as something like *'but not completely …'*.

Ron: *Can I ask, 'I got the impression that your facial expression is something along the lines of "but not enough that you wanted to organise another day like that" …' Is that right or wrong?*[7]

Ben: *Yes, I wasn't going to organise another day …*

Anne is now looking at me with what seemed to be a mix of despair and annoyance.

Anne: *See, he does not like sex with me!*

Ron: *Anne, I believe when people say they don't like something, or not like something that much, they usually do that by comparing it to something they do like, i.e. something they 'give value to'. This concept is called 'absent but implicit' Guided by this idea, Anne can you try asking Ben this question: 'Ben are you implying that you have something else in mind you'd prefer to organise?'* [I often say the practice I use or name the type of narrative question I offer]

Anne: *Well you heard what Ron said! Ben what are you thinking?!! Okay, sorry Ron. Ron, what did you say to ask again?*

Ron: *Let's cut corners, Anne ask Ben: 'Ben, is there something else you wants to do sexually instead?'* (absent but implicit with corners cut!)

Anne: *Ben is there something else you want to do?*

Ben began to talk. He said he liked the slow caring sex but he also wanted:

Ben: *Sometimes I want it really fast ... really fast wham-bam-thank-you-mam type of sex … I think so . . . aggressive . . . vigorous . . . hard.*

Anne looked shocked, scared. I could address that or I could help Ben address it.

Ron: *Ben please ask Anne: 'Anne how has what I have just said affected you?' That's an effects question.*

Ben: *Anne, has what I have just said upset you?*

Anne: *I have never had aggressive sex. I have never thought about it, never wanted it.*

Ron: *Ben please ask Anne another 'effects' question: 'Anne please tell me more how what I said has affected you?'*

Ben: *Anne, please tell me more how you feel.*

Anne: *It scared me a little when you talked about it … to me you are being aggressive when you lose your temper . . . it pushes me away …*

Ben looked disheartened, crushed.

Ron: *Anne please ask Ben: 'Ben how has what I just said now affected you?'*

Anne: *Ben, how has what I just said affected you?*

Ben: *By aggressive, I did not mean hitting you . . . just not passive … fast and quick sex , then go to sleep … not a big production about it . . . that's what I am talking about.*

Anne looked less worried.

Ron: *Ben, can you ask Anne another question? How about: 'Anne, would you like to keep telling me more about what you are going through?'*

But, before Ben could Anne ask the question:

Anne: *Fast and quick sex is okay. Aggression is another matter. (*They later picked their name for the this type of sex as a *'quickie')*

I continued with offering them experience and effects questions to ask each other, with the aims of helping them help each other, and of helping them attend to and richly describe their experiences.

We then 'deconstructed' the two styles of sex *'slow, sensual and caring'* and *'fast, hard and vigorous'* by spending time looking at not just their personal opinions on the pros and cons of each type, but by discussing anything we had heard or knew about their place in history, different cultures and sub-cultures, genders and sexualities.

THEORY DETOUR: DE-INDIVIDUALISING PROBLEMS, CONCERNS AND ISSUES

I believe it is important to de-individualise problems[8], especially when they are first presented. People in isolation often think they are abnormal and weird in their concerns. I like to counter this through a Foucault-inspired review of the history of the topic, problem or issue being discussed. I like to look at the history of the particular issue and its effects on people, and the responses by people to this issue over history. We share a discussion exploring and deconstructing the various ways these problems have been viewed and considered by various cultures over hundreds or thousands of years. Externalising the various positions, opinions and solutions to the topic being considered by various cultures over hundreds or thousands of years lets people know that these problems are ones whole societies have looked at for a long, long, time.

For example, knowing the ancient Greeks and Romans incessantly argued for centuries over the best place and way and person to talk to about problems (Foucault, 1985) may help people feel not so strange that they took a long time to decide where to go to discuss what was going on in their relationship. Or, if people are struggling to work out what equality should look like in their relationship, perhaps it would be helpful to know that this notion of 'equality in relationships' is comparatively a

newly prevalent idea in world history. We have very few historical precedents to tap, so this may be why these efforts are so difficult at this time (and so important).

When the topics people are grappling with are placed in this broader social-historical-cultural context, people may recognise that they are a sensible part of a bigger social and cultural movement, as opposed to a freaky mutant individual exiled in isolation!

This approach to de-individualising problems, concerns and issues is sympathetic to, inspired and influenced by, but a slightly different approach to Michael White's (2011b) *'Bringing the world into therapy and subverting the operations of modern power'* approach.

End of theory detour. Now let's return to Anne and Ben.

By borrowing my narrative questions, Anne and Ben pioneered for themselves a new method for talking about types and styles of sex, bypassed old habits and ways of relating, and began to practice and experience a different way of talking to each other, a new 'technique' or 'technology' of relationship (see White, 2011c). Through using the questions I offered, Anne and Ben provided scaffolding to each other. They began to help each other move from the 'known and familiar' into 'the unknown but possible to know' (White, 2007 chapter 6).

Ben then talked on. A lot. He revealed he gets sexually aroused every day, e.g. at the sight of other mothers at his child's sporting events, when he is taking his daughter there. He then comes home and wants to have sex with Anne, but has never told her and hides both his interest and disappointment.

This news pleasantly surprised Anne and challenged and disrupted her fear that Ben did think about sex or want to have sex with her. They then shared the news that they found each other really desirable, plus both declared the disbelief each had that the other could ever find them desirable!

Ben kept talking. He revealed how the childhood sexual abuse he experienced had the effect of making him believe his sexual thoughts were bad and perverse and disrespectful of women, and that this added to his avoidance of initiating sex. Anne said the thoughts that he had shared with her seemed similar to most guys, and that she could not think of a time he ever acted sexually disrespectfully to her.

Without my prompting, Ben and Anne continued to 'scaffold' for each other. As they discussed how they could hold onto the practice of talking about sex and start doing this at home, they were *'developing proposals for proceeding in life'* (White, 2007, p. 276).

I finished Session 2 by asking Ben and Anne their opinion of my practice of offering them questions to ask each other:

Anne: *I like it ... I had to get used to it at first. Otherwise we just say what we always say by habit … and that wasn't working! I didn't know he thought so much.*

Ben: *It keeps me focussed, I don't drift off with my own thoughts, that's good. It helps me show her that I am interested, that I care.*

Another couple, Cath and Dave (who I discuss later) also reported on this approach of 'offered questions':

Dave: *They are good, they make me think about the question I am asking and take note of the answers I am about to get ... instead of me half thinking in another world, I focus fully on the question.*

Cath: *Because you hear the question twice ... you hear it and think about it and then you say it ... it keeps me focussed … pushes away other stuff* (thoughts).

Sometimes, at the end of a session, in addition to asking clients questions about their 'experience of the session' or asking them to evaluate the session in some way, I might employ one of three variations of outsider-witness style questions and responses (Carey & Russell, 2003b; White, 2005a, 2007 chapter 4)

OUTSIDER WITNESS VARIATION 1: THERAPIST OUTSIDER-WITNESS RESPONSE ON WHAT I HAVE HEARD

Ron: *Can I tell you some of things you said today that particularly got my attention? One thing you said Ben was 'How does it come about that … after decades together ... we end up not talking about sex!?'* [The expression that stood out].

I had an image of you becoming a detective, going searching for the answer. [The image this evoked]

I liked this comment, and it got me pondering too to be a detective for the socio-cultural reasons for this problem

besetting many couples, not just you two. A socio-cultural analysis is something I always like to do as I find it can be non-blaming. [Resonance: Why this expression was significant to the therapist]

I am going to ask and plot with other couples how the problem establishes itself in their lives, thanks. [Transport: The difference/contribution this will make to the work of life of the therapist]

OUTSIDER WITNESS VARIATION 2: I INVITE THE CLIENTS TO GIVE THEIR RESPONSES ON WHAT EACH OTHER SAID

Ron: *Ben, can I ask you is there anything positive Anne said when talking about sex that particularly caught your attention? Can you remember what her words were?*

Anne, was there anything that Ben said when talking about sex that has taught you something and perhaps got you thinking about something new you might like to try?

Ben, is there something Anne said when talking about sex that has changed the way you see things or yourself or Anne in a positive way? That has perhaps taken you somewhere? Taken you to some place new? Got you going?

OUTSIDER WITNESS VARIATION 3: I INVITE THE CLIENTS TO GIVE THEIR RESPONSES ON WHAT THEY SAID THEMSELVES

Ron: *Anne, is there anything you yourself said today about sex and talking about sex that particularly caught your own attention? Anything you said you are glad you said? Having heard yourself talk today about sex, is there anything you said that has given you some food-for-thought, or sparked up some ideas on what you might now try?*

Ben, when you heard yourself talk today about talking about sex, when you were listening to yourself talk, is there anything you said yourself that stands out in your memory? Can you remember anything you said particularly that has got you going?

SESSION 3

At the beginning of the third and last session dedicated to talking about sex, the update was that sex was not happening any more frequently. They said now, however, that they were not upset about this. They said the lack of frequency was due to the busy-ness and tiredness of daily life. They said they were not taking it personally.

Anne: *We are going pretty okay ... we are happy ... if we don't have sex as much as we could, it's tiredness … it's our decision.*

Ben: *It is not going to ruin or rule our relationship.*

I was stunned by Ben's eloquence

Ron: *Ben when you say something like that, when you coin a phrase like that, I want to steal it!*

I learnt that they now have the occasional 'quickie'. Anne was puzzled though about why Ben sometimes turned down a 'quickie' when she offered one.

Anne: *I say 'do you want a quickie?' and you sometimes say 'No'!? I do offer ... you often say no ... do you agree there is a contradiction?*

Ben: *Yes and there is a reason. I am happy to tell you. I don't want a quickie every time … just now and again … only about one out of 10 times* (you ask) *the other 9 out of 10 times I like to cuddle and feel your body without sex.*

Ron: *Ben are you asking Anne for sex at times now?*

Ben: *Yes, but it is not easy, I realise I am not asking very much.*

Ben said this looking sad.

Ron: *Anne how about you ask Ben 'What are you going through?'*

Anne: *Ben what is going on! Sorry Ron.* (Anne said smiling). *Ben, what are you going through?*

Ben: *If I ask you for sex and you say you are not in the mood, even if it is only half the times I ask you, I feel 'knocked back'.*

Anne: (to Ron) *I know, another experience question!*

Anne: (to Ben) *What else are you going through?*

Ben: *I think to myself, 'I won't ask you again because you will say no'. I am a sensitive guy. I am afraid to ask.*

Anne: (to us both) *It is already an issue, Ben asking for what he wants … he plucks up the courage and asks and I say no and it is a big issue for him … I need to be more open and listen ... I need to do something different.*

Anne looked like she was disappointed in herself.

Ron: *Ben ask Anne, 'Anne what are you experiencing now while we are talking?'*

We continued with 'offered' effects and experience questions. They got to know more about each other's experience more richly, more deeply. I then made a switch to questions on responses rather than effects. (Denborough et al., 2006; White, 2005a)

Ron: *Anne, ask Ben: 'Ben, how do you manage the sexual disappointment when Anne says no?'*

Anne: *Ben, how do you manage this disappointment?*

Ben: *The physical side, a long hot shower, or say to myself, 'It doesn't matter'.*

I checked with Ben and he confirmed 'the long hot shower' included masturbating.

Anne: (cheekily) *Do you think of me?*

Ben: *Yes*

Ron: *Ben, ask Anne, 'Anne, how do you manage sexual disappointment?'*

Ben: *Do you have your ... thing of ... of the long hot shower?*

Anne: *I'll be brave. Yes! I do. We have never talked about it. I was too embarrassed. Today is the first time. I have come a long way.*

Ben: (looking stunned) *I did not know ... you have never discussed it with me in 20 years. We have come a long way.*

Ron: *Well, that seems like a great place to run out of time to discuss things.*

As the session was almost over, we briefly drifted into a discussion about what they may do about another nemesis of modern couples that occasionally beset them. The dreaded 'I want to if you want to … Well I want to if you want to' conundrum!

We ended this third and final special 'talking about sex' session with evaluations from Anne and Ben about what these sessions had meant to them:

Anne: *It helped, these sessions, we can change, we have a method to change … I'm more comfortable with it ... I am scared we will go backwards though if we stop talking.*

Ben: *At least we talk here and on the way home in the car!*

They said in the future they plan to talk about sex in our sessions if time allowed after other issues were covered. They concluded by saying that they now thought they were going well in life, with no major crises, so they wanted to reduce the frequency of the sessions. The next session they wanted to talk about Anne's approaching new job.

CATH AND DAVE (AND THE PANEL): SHARING KNOWLEDGE

Cath and Dave came to see me as a couple for a mix of problems including how they were getting on. Cath is in her fifties and Dave in his forties. Married for about twenty years, they had one teenage daughter. Cath had two sons in their twenties from a previous marriage. Their problems included arguing, parenting issues, and financial worries. Cath revealed she had been a victim of child sexual abuse, further that her first husband was violent to her. She said she wanted to have a 'normal' life and that included in sex. She said she had decided it was time to do something to get over the child sexual abuse as doing nothing had not worked. Some of the effects of the abuse, as she saw it, were all types of anxiety and worry symptoms, social withdrawal, excessively criticising Dave, and few pleasant thoughts about sex. She did not want medication. Dave, a self-employed tradesperson, reported he was working too hard in his business, he was stressed, and that he needed to be firmer with his customers in what work he took on and how quickly he collected payment. I usually saw them together at their request but also saw them at times separately.

Cath wanted me to be aware that she wanted to talk about sex but that attempting to talk about sex, like having sex itself, invoked distressing memories of the abuse. She did not initiate sex. When Dave initiated it (infrequently), she did enjoy it. This enjoyment was helped by her 'choreographing' of positions so that they were ones that did not evoke the painful memories. Her difficult and reduced sex life was not the main factor for their attending therapy, but it was something Cath pointedly informed me she wanted addressed.

When I asked Cath about her beliefs and hopes in regards to sex, she stated firmly she believed it was her *'right to have a normal sex life'*. I appreciated Cath's words as making a 'human rights claim' to a *'normal sex life'* and as a clear statement of her principles.

The therapy proceeded with a mix of narrative techniques such as externalising problems and attending to unique outcomes, especially around Cath's anxiety symptoms and criticising habits, and Dave's work stress and work habits (White, 2007). Despite my best efforts, arguing was common in the sessions, so it was discussed. In this discussion we named and made visible various power and control practices. This included me informing them which of their comments they said to each other I would call abusive, and then exchanging ideas about if each agreed or disagreed with my naming and why.

Six months later Cath's anxiety symptoms were reducing and Dave was managing his work better - both helped by an overseas holiday. We joked that overseas trips should be available on prescription. Occasionally I asked about sex. Cath said it was unchanged, Dave said it was improving. Cath would then get fearful and ask to postpone any further discussion about sex. Slowly though she learned to tolerate a few minutes of discussion about sex each session. Over the next twelve months, if the topic of sex came up in that session, her tolerance increased to be able to talk about sex for up to 30% of the couple session time.

Cath then declared that she now wanted to start initiating sex. She said she wanted to claim that ability as a 'normal' part of her life. She asked me how could she do it? How could she overcome her fear of initiating sex and how could she initiate sex itself?

There and then I had a problem. Two of my principles were 'clashing'[9]. The first is that I am reluctant to engage in the 2000 year old (at least) practice of men being experts on what is best for women to do. In this example, on what women should do in sex. The second is that I also believe therapists should answer questions asked by clients and provide information if requested.

I conceptualised Cath's question, asking me how and what to do, as her conveying to me that she was at the edge of all she knows in relation to ways of overcoming fear and initiating sex. If I do not provide ideas, how then is she to get information on what is possible to know? Cath said she did not ask her female friends such questions as she did not want to risk telling them about the abuse she had experienced. Where was she then to get the information without wholly relying on expert advice or pop culture magazines?

In situations like this, I often consult people in the community from similar backgrounds to the person who has made the 'how to' enquiry. I compile a list of knowledge and skills from these consulted citizens and take this list back to the client who has the inquiry. This practice is linked to narrative co-research (Epston, 1999) and the gathering of 'local knowledges' (White, 1997, 2003), 'insider' knowledges (Epston, 2008, p. 118 & p. 190), 'wisdoms' (Ingram & Perlesz, 2004), the creation of collective narrative documents (Denborough, 2008) and community accountability & reference groups (Waldegrave 1990; White 2011a, p. 109).

Therefore to respond to Cath, I wished to ask some women about their knowledge in relation to ways of initiating sex. Somehow I needed to find women who would be comfortable to be asked about this and comfortable to reply. Where was I to find appropriate women to ask such personal questions? In my paid work I am in solo private practice or teaching in a context where I never have time to speak to close colleagues. The other half of each week I spend as a solo parent. This meant that the only women I felt I knew well enough to ask were two of my closest long term friends (who are both colleagues in the field but not sex therapists) and some of the mums at my kids' local primary school who I knew very well. I gently, tentatively, explained my purpose and, if they agreed, proceeded to ask them. Several were happy to contribute. Plus each month I also met with the sex therapists at our peer group supervision meeting, who coincidently were mostly women. I couldn't make the next meeting as it fell on a child care weekend, so I sent them an email (see below).

The peer supervision group members (sex therapists, sex educators, and sexual health practitioners) are always keen and enthusiastic to explain their expert knowledge and to provide advice. I have great respect for their knowledge and advice. I also greatly admire the way the women of that professional group tolerate and support each other, with their multitude of differing schools of therapy, knowledge and theory. I feel I am lucky to be at the meetings. They have given me more than I have given them. They kindly put up with me if I go on a post-structural post-colonial preaching prattle. In my email, I explained respectfully that, guided by my narrative model, for this situation I wanted their *personal* not professional knowledge, or alternatively the ideas/skills/stories from women with whom they had worked. This was a new practice for my expert colleagues but they kindly gave it their best and sent me several personal 'local knowledges'.

20 August 2010

hi friends/colleagues

can't make tomorrow's peer group supervision meeting, away with kids. sad as i have a great situation to present! perhaps you can bring it up in my absence and give me some feedback.

a 50 year old women in a long term relationship with a 40 year old man has come to the decision that she wants to initiate sex more. once initiated she gets into it & enjoys it.

at this stage I am not interested in the reasons why she lost/not developed initiation skills and knowledge. (been there done that) I want to feed back to her the personal accounts from 5 five women (names can remain anonymous) how they initiate sex in their own life

obviously this is a narrative co-research approach (also solution focus influenced) http://www.dulwichcentre.com.au/co-research-david-epston.html which (if I can say humorously) will frustrate those urges you may have to explore the problem and its history, or to give your professional advice!

but if you are willing to subdue those urges temporary, to delay gratification of those urges, I am interested in providing real women's accounts of their own 'initiating sex skills, knowledge and approaches', i.e. your very own or of women you know of from home or work

in return i will bring her feedback back to you on these compiled knowledge and wisdoms

cheers, ron

I put all the personal, local ideas and skills I received from the various women (who mostly but not all identified themselves as heterosexual) together in a list and then into a therapeutic letter. At the next meeting with Cath, I read this out to her. Later I emailed Cath a copy. She was very grateful for receiving such a gift from her fellow women, who I nickname 'the Peer Panel'.

20 September 2010
re Cath & the Panel

Dear Cath,

We have talked together in past sessions how 'the problem' affected your life and how you want to claim many aspects of a 'normal' life. By 'normal' you want to access the experiences and activities that ordinarily people can access. Events in the past helped set up your current problems but now, in the present, *you* want to have in life what you want, not what the problems dictate.

Due to many of the actions and steps you have been taking this year to (successfully) strengthen yourself, you now feel ready to keep adding more 'normal' experiences to your life. One thing you said you want is a more 'normal' sex life, i.e. to have a more active and enjoyable sex life with Dave.

One restriction you mentioned was that you currently never initiate sex, it is always Dave who does. We talked about how once sex was started you enjoy it and you said it was your decision now that you want to start to initiate sex. Certainly Dave would like you to and it would make him happier, but you said you want to do it for both him and yourself too.

You were very clear that part of the problem was:
A not knowing how to do it.

The other big part of it was: *B getting yourself to do it* (when you don't really feel like doing it but personally believe you should).

Your Ideas and Skills

With more time I could have asked you many questions to explore your own knowledge and skills, e.g., 'When you hold onto the wish to be able to initiate sex, what do you say to yourself to keep holding on?'

'Whenever you have almost initiated sex, if that has occurred, what did you do to get yourself that far?'

Or questions to Dave:

'Can you tell me about a story when Cath did something new but difficult that she believed in?'

I will try to ask these type of questions next session.

Ideas and skills for similar people

In the therapy model I am trained in we talk about 'co-research' or a very similar concept of 'collective narrative documents':

www.dulwichcentre.com.au/co-research-david-epston.html

www.dulwichcentre.com.au/collective-narrative-practice.html

This involves collecting accounts from people of what they do that helps them solve or manage a problem or at least get through. This is deliberately about ideas/solutions/skills from the 'person in the street' not expert ideas or recommendations.

In response to the part A of your question *how to do it*, I have collected seven accounts from women in long-term relationships (or who have in the past been in long term relationships) like yourself on how they initiate sex. Two female friends who felt comfortable to give their own preferred techniques happily contributed. One personal account I found in a book. As for the other four 'how I do its', these were kindly provided by women at a monthly peer supervision group of sex therapists that I attend. They have offered ideas either from their own life or from women they have spoken to in their work. Although they are 'professionals or experts', their comments are from their own or other women's ordinary daily experience.

For fun I am calling them all, colleagues and friends, 'the Peer Panel'.

I have not got it exactly word-for-word, but I did my best (names have been changed too):

Amy: *Sometimes I just ask him for sex.*

Bea: *Once recently, when he was in the lounge room, I acted really dominating and aggressive and demanded sex from him. That worked but was pretty scary for both of us. I don't think I will do that again.*

Celia: *If I kiss him, not just a peck, then it is going to happen!*

Denny: *When we are lying in bed I start to rub his back. Then I move my hand around and touch his penis …*

Evie: *I don't like sex at night because I am too tired. But if I go to bed naked (I normally wear pyjamas) he knows it is on in the morning. Means he thinks about it all night too!*

Fi: *If he is in the shower I stand against the doorway in a suggestive pose …*

Gabby: *When he comes back from the shower I will be on the bed naked.*

As these local techniques only address Part A *what to do*, I will try to make another list on Part B *how women get themselves to do it too.*

If you like, I could also make another list from men about how their wives/partners initiate sex and another list on how the men would like their partners/wives to initiate sex. This is just a start. Please let me know what you think of and take from the list, both good and bad! The 'Panel' are keen to hear what you take from their accounts too if that is okay with you.

Ron

As the sessions proceeded, this became a semi-regular practice. Cath would send me on a mission to get more peer knowledge, and the peer panel, especially the peer supervision group, eagerly looked forward to the next question. The peer supervision group women contributed about half the knowledge I collected, my colleague and neighbourhood 'mum' friends the other half. In relation to the first question, I composed an entire therapeutic letter (above). Compiling that letter occurred during a child-free weekend. With the later questions, to save time, I wrote only a point-form list of replies. Also to save time, sometimes I collected fewer 'entries' for the list. Compiling these briefer lists usually occurred on busy child care weeks or weekends. There was not a list for every session, but I probably created one for every four sessions, one every three or four months. The following example is a list written up during a child-care weekend.

Cath to the Panel
May 2011

Cath: *From not having sexual thoughts I am having them but about other men. Is it normal to think of having sex with other men than your husband? What do you do with that thought?*

The Peer Panel's Answers:

Abby: *For sure I have those thoughts … I use them for arousal … a flick (on) switch … to think about sex more … for masturbation … and to initiate sex with my partner.*

Bea: *I use them to do a role play with my husband.*

Celia: *I set up blind dates with my partner* (he acts out the other men).

Denny: *It is very common, you are not alone, I want to let you know that. I write out the fantasies, sharing it with my partner, great fun ... share it together … he'd be part of it, inclusive as another man ... inclusive not exclusive* (of him)

Evie: *If it can be used it can be positive … I don't tell my lover them tho … I use it to keep my desire up … it is normal okay … I don't feel guilty … I use it to keep things going …*

Fi: *I point out to my husband great looking guys … I intrigue him with what I find attractive.*

The lists can be archived and distributed to other clients who ask the same questions or have similar inquiries.

The most recent question from Cath is a work in progress:

Cath: *How do you feel sexually attractive without losing weight?*

Preliminary contributions so far are all from one friend/colleague & mum:

Jane: *Make sure you have different size underwear, always wear ones that fit properly whatever size you currently are. Don't think about how you see yourself, think about how your lover sees you … And have sexy underwear.*

These lists and our discussion in relation to sex in Cath and Dave's relationship continue to only take up about one third of our session times together. Some sessions we may not talk about sex at all, other issues such as work and family and their relationship continue to be the mainstay of our conversations.

EVALUATIONS OF THE PROCESS

In my experience, this process is mostly well liked by clients who eagerly await the next instalment! Interestingly, people report that they rarely copy the co-researched knowledge and acts, nor does hearing other people's ideas immediately spark them to invent their own solutions. Instead, people report that what is most significant about receiving other people's ideas is that this undermines or dissolved negative sexual trait or 'negative identity conclusions' (White, 2005b, p. 11; 2007, pp. 26–27). It assists them to refute negative ideas of the self such as: *'I'm weird, there is something wrong with me'.* They are also used to reduce isolation: *'I am not alone, others go through that'.*

Cath: *It's good that they all think along same way … it's comforting to know ... then I don't feel like a sicko.*

For the 'panel' members the process was more complex. Some of the mums found that thinking, talking and writing about sex excited them when this was not what they wanted from the discussion. Others reported that their husbands/partners did not want them talking more to me than to them about sex. When the husbands/partners next bumped into me they were nervous about what I knew (or they imagined I knew) about their sex life. As a result, over time and explanation the panel came to be comprised of people who enjoyed the process as others sensibly withdrew. The neighbourhood mum friends who are continuing members of the panel, report that they really like to see the compiled lists for their own interest too, as do the peer group colleagues.

For me, compiling the lists and undertaking therapy in this way has not been a neutral activity. Some friends have criticised my interest in sex and talking about it. One colleague and friend said, *'You talk too much about talking about sex'.* Initially I was hurt and angry. Later, I realised that I may probably have offended my friend. I realised this was perhaps telling me I needed to improve my skills at picking up earlier who and when people are getting upset by these types of discussions. Other friends supported the process but cautioned me to take care. While others thought it was a great idea and regularly ask for updates. Several friendships have been significantly strengthened through the process. I continue to be amazed at the answers from the Peer Panel: how useful they are, how different they are to textbook knowledge, and how I would never have thought of most of them. The answers of the Panel greatly increase my knowledge.

GEOFF THE TEACHER

Geoff, a teacher in his late thirties, came to see me to discuss 'coming out' as 'gay' (his words) both to himself and to others. Despite my confessing that I have little experience or knowledge of such issues, he said he deliberately wanted to see me as someone not in the gay community. For fifteen months he discussed his sexuality and its effect on him and his world. He then decided to explore the world of sex with others, which to that date was unknown to him. Within our conversation, Geoff would not bring up sex overtly, rather he would allude or briefly touch on a sexual topic and then we would tend to move into discussing the other aspects of life, e.g. health, work, family, finances, friends, relationships, and internet dating.

I would have to remind myself to ask questions:

- *You have mentioned sex briefly, does that mean you want to talk about sex?*
- *Is sex something you would like to discuss now? Should I ask you about sex now?*
- *Were you wanting us to talk about sex now or not?*

Geoff would then discuss sex. He would mention a myriad and multitude of fears: about performance; about first time nerves; about his physical appearance and looks;

about how to tell what someone wanted to do; about how to tell someone what he wanted to do; about whether his sexual interests were perverse or abnormal; and about health risks like sexually transmitted illnesses. When I tried to use narrative therapy techniques such as externalising conversations, enquiring about unique outcomes, or re-authoring practices, Geoff mostly politely ignored them. I gave up such attempts. On the other hand, Geoff did respond more enthusiastically if I expressed a positive attitude to talking about sex as well as my provision of a safe place to speak.

As Geoff gained some sexual experience, he talked about the various sexual practices he was checking out. He spoke about his fears, worries, likes and dislikes. He described 'ordinary' sexual practices and also about differing and diverse sexual practices found especially in certain diverse gay sub-cultures: all of which I knew little about. I confessed to Geoff that I felt a bit lost and useless, that I had little or no knowledge or experience of these sexual practices. He replied with a half smile, that he wanted to keep seeing me, as it was *'easier than starting with a new therapist'*.

As Geoff talked he would often look at me as if to enquire if I found the sexual practices and terms shocking, weird, abnormal or fascinating. Sometimes he would ask me outright if I thought his curiosity and interest in them implied anything perverse or faulty about him. My attempts then to critique western notions of personal failure (White, 2002) and 'negative identity conclusions' (White, 2005b, p. 11) again met with his disinterest and were mostly dropped. And he was not interested in any co-researching of how other men, gay or straight, went through the similar experiences re sex.

Often I would look up the sexual terms and practices he mentioned later in Wikipedia, as Geoff was always ahead of me in this area of sexual knowledge. He was bringing it back, telling me what he was learning and discovering. My classic narrative therapy techniques were politely tolerated and ignored. Gradually I realised I just had to sit back, listen and learn. I had to drop narrative therapy techniques and just try to show narrative therapy principles and ethics in action. Ethics like taking a position of restraining myself from talk that centres the discussion on what I know (see Morgan, 2006), and disciplining myself to listen to him and centre the discussion on what the client knows (this is not so hard when you don't know much!).

Talk about sex never took up more than about a quarter of our sessions together. Narrative conversations about his employment, friendship, family, dating and relationship concerns always took the majority of our time. My contribution to 'talking about sex' was to simply, intermittently ask something along the lines of: *'Were you wanting to talk about sex for a while now?'* and back up this offer with some time for Geoff to talk about sex and me to listen.

With Geoff, when it came to talking about sex, I did narrative therapy based on narrative therapy ethics and principles, without doing any narrative techniques. A therapist with narrative 'attitude'!?

DISCUSSION

In bringing this article to a close, I want to emphasise again how nervous I was at starting to 'talk about sex' in therapy. My start was not in isolation. I began with the support of the peer supervision group and trusted friends. I persisted and my knowledge, practice and comfort improved. The fear that comes with 'talking about sex' has reduced, but it hasn't gone away. I revisit the ethical cautions in relation to this work whenever I can, but not as often as I should.

The 'talking about sex' work-in-progress I describe here may contain 'sparkling moments' but it doesn't include situations of 'cure' where the problems are banished forever and the promised land claimed. As to the preferred outcomes that these people are developing, they may build on them, they may hold onto them, or they may lose them and go backwards, and we start the work again. Narrative therapy can be hard work over a long time. Fortunately there is sharing and distribution of the labour. With Anne and Ben they helped do the work, with Cath & Dave, my friends and colleagues helped do the work, with Geoff, he did most of the work (give Wikipedia credit too). Such is the versatility of the narrative therapy approach!

The transcripts and letters enclosed are approximately 60% the clients' and my actual words, and 40% edited and reconstructed content, to make them clearer, to remove confidential information, and to leave out extraneous material. Everyone involved gave consent for their stories and contributions to be included if their names were changed.

To conclude, I look forward to reading further articles by narrative practitioners in relation to 'talking about sex' in therapy.

TWO WAYS TO REDUCE THE RISK OF 'TALKING ABOUT SEX IN THERAPY'

CONSENT QUESTIONS:

We can ask our clients clear consent questions:
Is it your wish to talk about sex or is it just my therapist-type idea?
Does 'talking about sex' fit your culture or not? If not is it a practice you wish to adopt or not
Can I double check, are you agreeable to talk about sex? Do I have your consent?
Do you want to think about it and not decide today? I don't want to put you on the spot. I don't want to pressure you.
Do you feel you can say no to talking about sex? Or that you can say no later if you change your mind?

THERAPIST RESPONSIBILITY AND ACCOUNTABILITY BEYOND THE THERAPY SESSION

Therapist responsibility and accountability are indispensible parts of narrative practice (White, 2011a, pp. 63-64). I am interested in developing forms of 'up', 'down' and 'across' accountability. This involves accountability 'up' to senior 'powerful' people and structures such as supervisors (peer, line, or external) and profession registration boards; 'across' to our peers; and 'down' to our clients and ex-clients. There is an old maxim that 'abuse lives on secrecy'. One way that I try to practice therapist accountability and responsibility in relation to 'talking about sex in therapy' is to present my work in this area to willing consenting friends, colleagues, and our peer supervision group. Not only do these presentations, critique and discussion lead to invaluable new ideas for practice, it is also a form of public accountability. By no means is this a guarantee of client safety, but it is a step in this direction.

For more about partnership accountability see the Dulwich Centre Newsletter 1994 Nos 2&3 which focuses on 'Accountability' in therapy, including in relation to relations of race and gender. See also the work of the Just Therapy Team (Waldegrave, 1990; Waldegrave et al., 2003).

NOTES

1. For more information about ASSERT see http://assertnational.org.au
2. For more information about the Dulwich Centre see www.dulwichcentre.com.au
3. Foucault equated this type of truth-telling with the Greek term parrhesia. For Foucault lectures in English on truth-telling and parrhesia see http://www.lib.berkeley.edu/MRC/foucault/parrhesia.html. The transcript can be found at: http://foucault.info/documents/parrhesia/
4. While trying to speak directly about sex, I realise that some people prefer to speak in less direct ways about sex. Also, some people do not respond well to direct questions (about sex or any aspect of personal life). People may be in an agreeable position to talk about sex but find being questioned as intrusive, interrogative, rude, and unpleasant. In considering this, sometimes I check in with clients by enquiring:

- *Am I firing too many questions at you about sex?*
- *Do you like questions at all?*
- *How are you experiencing my questions about sex?*
- *Am I 'over-questioning' again!?*
- *Are there questions about the theory and practice of what I am trying to do with you that you wish to ask me?*

5. We can ask similarly about talking more generally about sex in therapy:

- *Do you need me to let you know I am comfortable and supportive of you talking about sex and sex problems here, if that is what you want to do?*
- *Do I need to first let you know that I will show respect to what you say when you talk about sex and sexual difficulties, before you can do that talking?*
- *Are you worried what I will think of you if you talk about what you do in sex and what problems occur? Do you need to know I approve of you talking about sex and won't berate or shame you if you say what you really do?*

6. The term 'scaffolding' coined by Bruner (Bruner, 1974-1975 p. 277) is most commonly used to refer to the work of Vygostky (1962). Interestingly, Vygotsky never used the term.
7. The issue of translating a facial expression into a verbal expression, i.e. from gesture to speech, could be the subject of another paper in itself!
8. See Rose (1989) for a different Foulcauldian critique of individualising.
9. I often lean to the (post-structuralist?) view that life more involves accommodating differing honoured beliefs than the (structuralist?) view that it is about managing differing competing drives.

REFERENCES

Bruner J., (1974-1975). From communication to language - A psychological perspective. *Cognition 3*(3), 255–287.

Carey, M., & Russell, S. (2003a). Re-authoring: Some answers to some commonly asked questions. *International Journal of Narrative Therapy and Community Work*, (3), 60–71.

Carey, M., & Russell, S. (2003b). Outsider-witness practices: Some answers to commonly asked questions. *International Journal of Narrative Therapy and Community Work*, (1), 3–16.

Carey, M., Walther, S., & Russell, S. (2009). The absent but implicit: A map to support therapeutic enquiry. *Family Process;* 48(3), 319–331.

Denborough, D. et al. (2006). Linking stories and initiatives: A narrative approach to working with the skills and knowledge of communities. *International Journal of Narrative Therapy and Community Work*, (2), 19–51.

Denborough D. (2008). *Collective narrative practice*. Adelaide, Australia: Dulwich Centre Publications.

Epston, D. (1999). Co-research: the making of an alternative knowledge. In Dulwich Centre Publications (Ed.), *Narrative therapy and community work: A conference collection* (chapter 16). Adelaide, Australia: Dulwich Centre Publications. also at http://www.dulwichcentre.com.au/co-research-david-epston.html

Epston, D. (2008). *Down under and up over: Travels with narrative therapy*. Warrington, UK: AFT Publishing.

Foucault, M. (1976). Two lectures. In C. Gordon (Ed.) (1980), *Power/ Knowledge: Selected interviews and other writings* 1972-1977 by Michel Foucault (pp. 79–108). New York, NY: Pantheon Books.

Foucault, M. (1978). An introduction. *The history of sexuality, Vol. 1*. London, UK: Penguin Books. [Aka The history of sexuality Vol. 1: The will to power.]

Foucault (1985) Discourse and truth: the problematization of parrhesia. Six lectures given by Michel Foucault at the University of California at Berkeley, Oct-Nov. 1983 Edited by J Pearson. http://foucault.info/documents/parrhesia/

Foucault, M. (2000a). Michel Foucault: An Interview. In P. Rabinow (Ed.), *The essential works of Michel Foucault 1954–1984, Vol. 1: Ethics, subjectivity and truth* (pp. 121–133). London, UK: Penguin Books.

Foucault, M. (2000b). Technologies of the Self. In P. Rabinow (Ed.), *The essential works of Michel Foucault 1954–1984, Vol. 1: Ethics, subjectivity and truth* (pp. 223–252). London, UK: Penguin Books.

Foucault, M. (2000c) The ethics of the concern for self as a practice of freedom. In P. Rabinow (Ed.), *The essential works of Michel Foucault* 1954–1984, Vol. 1: Ethics, subjectivity and truth (pp. 281–303). London, UK: Penguin Books.

Foucault, M. (2000d). Useless to revolt? In J. Faubion (Ed.), *The Essential Works of Michel Foucault 1954-1984. Vol. 3* (pp. 452–453). Power. New York, NY: New Press.

Ingram, C., & Perlesz, A. (2004). The getting of wisdoms. *International Journal of Narrative Therapy and Community Work*, (2), 1–9.

Morgan, A. (2006). The position of the therapist working with children and their families. In A. Morgan & M. White (Eds.), *Narrative therapy with children and their families* (pp. 57–84). Adelaide, Australia: Dulwich Centre Publications.

Rhodes-Little, A. (2000). Life and death and law and art: (why teaching is more than imparting knowledge. *Alternative Law Journal,* 25(6), 282–287.

Rose, N. (1989). Individualising psychology. In J. Shotter & K. Gergen (Eds.), *Texts of identity.* London, UK: Sage.

Vygotsky, L. (1962). *Thought and language*. Cambridge, MA: MIT Press.

Waldegrave, C. (1990). Just Therapy. *Dulwich Centre Newsletter,* (1), 3–47.

Waldegrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. (Eds.) (2003), Just Therapy – a journey: *A collection of papers from the Just Therapy Team, New Zealand.* Adelaide, Australia: Dulwich Centre Publications.

White, M, (1997). Re-membering and professional lives, In M. White, *Narratives of therapists' lives* (pp. 53–92). Adelaide, Australia: Dulwich Centre Publications.

White, M. (2001a). Folk psychology and narrative practice. *Dulwich Centre Journal*, (2), 1–37.

White, M. (2001b). Narrative practice and the unpacking of identity conclusions. *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice,* (1), 28–55.

White, M. (2002). Addressing personal failure. *International Journal of Narrative Therapy and Community Work,* (3), 33–76.

White, M. (2003). Narrative Practice and Community Assignments. *International Journal of Narrative Therapy and Community Work,* (2), 17–55.

White, M. (2005a). Workshop Notes. Retrieved from http://www.dulwichcentre.com.au/michael-white-workshop-notes.pdf

White, M. (2005b). Children, trauma and subordinate storyline development. *International Journal of Narrative Therapy and Community Work.* (3&4), 10–21.

White, M. (2006a). Narrative Practice with Families with Children: Externalising conversations revisited. *In M. White & A. Morgan, Narrative therapy with children and their families* (pp. 2–56). Adelaide, Australia: Dulwich Centre Publications.

White, M. (2007). *Maps of narrative practice*. Adelaide, Australia: Dulwich Publications.

White, M. (2011a). *Narrative practice: Continuing the conversations* (D. Denborough, Ed.). New York, NY: W.W. Norton.

White, M. (2011b). Bringing the world into therapy and subverting the operations of modern power. In M. White, *Narrative practice: Continuing the conversations* (D. Denborough, Ed.) (pp. 4–26). New York, NY: W.W. Norton.

White, M. (2011c). Couples therapy: Entering couples into an adventure. In M. White, *Narrative practice: Continuing the conversations* (D. Denborough, Ed.) (pp. 149–156). New York, NY: W.W. Norton.