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ISSUES IN THE TREATMENT OF SEXUALLY DYSFUNCTIONING COUPLES OF AFRO-AMERICAN DESCENT

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Following the model of Masters and Johnson (1970), directive treatment programs have been developed for a variety of sexual dysfunctions, ranging from primary and secondary orgasmic dysfunction in women to premature ejaculation and erectile failure in men (Kaplan, 1974; Lobitz & LoPiccolo, 1972; LoPiccolo & Lobitz, 1973). Although many of the treatment procedures are amplifications of the general anxiety-reduction approach common to behavior therapy (Wolpe, 1969), other aspects of the treatment derive from cognitive, personality, and humanistic psychology (*viz.*, Lobitz, LoPiccolo, Lobitz & Brockway, 1974). Direct retraining approaches to treating sexual dysfunctions have been effective with a Caucasian population (Kaplan, 1974; Lobitz & LoPiccolo, 1972; Masters and Johnson, 1970; Obler, 1973), even where one partner has a psychotic diagnosis (Tanner, 1973). However, the treatment of Afro-American couples is a relatively new and unresearched area. Because of widely-held stereotypes about black sexuality, a number of factors must be considered in applying the above treatment programs to an Afro-American population. The present paper reviews the literature describing the myths of black sexuality and delineates the issues involved in the treatment of sexually dysfunctioning black couples by an interracial therapy team. A case history elucidating these factors is presented.

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Myths of Black Sexuality

Myths about the sexual practices of black Americans originated with the country's history. As early as 1550, African religion, skin color and behavior were perceived as inferior to that of the Anglo-Americans (Vontress, 1968). Missionaries who first traveled to Africa to convert "heathens" to Christianity were shocked by the "polygamy and diversity of sexual relationships" that they observed (Goldstein, 1948). African and Christian religions differed in their view of sexuality. Early American Christians believed that many sexual behaviors were offenses against God, whereas the African nationals followed a religious standard which did not include sexual morality. The violation of laws was perceived by the latter as an offense against a person and not against God (Staples, 1967).

The sexual prowess of blacks has been isolated throughout history as a dimension of special interest. Written accounts of Anglos' obsession with black genitalia and sexual abilities date back to the sixteenth century. (Thomas, 1972; Vontress, 1971). These myths have always been sustained in a negative context. Reported hypersexuality of blacks was often equated with their potential to be savage and bestial with their partners (Thomas, 1972). Credibility was added to these accounts by physicians who, fearing attacks on Anglo women, warned of black males' dangerous sexual potential (Thomas, 1972). To quote one early American physician, "A few emasculated Negroes scattered around and through the thickly settled Negro com-

munities would really prove the conservation of energy, as far as the repression of sexual crimes is concerned'' (Haller, 1970).

Although black males occasionally have been reported to be undersexed and unconcerned about their partner's sexual gratification (Kardiner & Ovesey, 1951), the myth of black hypersexuality is still the most widespread today. The recent abundance of ''black sexploitation'' films perpetuates this image of the black male's sexual prowess. Accounts of black female sexuality are more contradictory. A limited study of black women suggested that they suffer ''quite frequently'' from ''frigidity'' (Kardiner & Ovesey 1951). In the popular press, black females have been described as being sexually aggressive and having less sexual hang-ups about sexual role playing than white women (Young, 1974), while another comparison saw them as more sexually restrained and traditional in their sexual expression than white women today (Staples, 1974). The variety of myths that circulate in the lay press only confuse blacks about their sexual abilities and the overall importance of sexual expression in the total relationship. Many black men and women internalize the expectation that they have extraordinary genitalia and sexual prowess. This situation can create both identity and sexual dysfunction problems when an individual does not live up to these stereotyped images. These problems can be compounded by the highly competitive and exploitative attitudes which blacks have been found to have towards sexual relations (Rainwater, 1969).

There is little behavioral data to support any of the black hyper- or hypo-sexuality myths. For example, information gathered by the Kinsey Institute on penis length of black and white males revealed no significant differences in the length of the erect penis (Bell,1968). Similarly, black teenage women are reported to have a higher incidence of premarital sex than white teenagers (Zelnik & Kanfner, 1972), but these differences disappear at older ages (Hunt, 1974). In another study of adolescents, blacks and males were found to be more sexually permissive than whites and females (Reiss, 1967). The paucity of research on actual behavior only perpetuates confusion about the sexual behavior of black men and women. In addition, the absence of normative data handicaps professionals who attempt to help dysfunctioning black couples through re-education.

The Influence of Race in the Therapy Process

There has been relatively little research on the issues involved when the therapist and patient are of different races. Furthermore, the majority of studies have described interracial practice in the more traditional psychotherapies. The largest proportion of the studies has examined the social and economic disparity between white therapist and black clients (Oberndorf, 1954; Kardiner & Ovesey, 1951; Bernard, 1972; Sager, 1972), and the resulting problems that appear to influence treatment (Hollingshead & Redlich, 1958). Much of this research has involved documenting the value and life-style differences between the middle class therapist and the lower class client. However, life-style differences and similarities between white therapists and middle to upper class Afro-Americans has yet to be examined.

A second major focus has been the emerging black consciousness and the attendent antagonism toward whites (Bernard, 1972). This has been explored both in terms of the client's distrust and anger toward his white therapist (Kennedy, 1952; Schachter & Butts, 1968) and the therapist's reactive fear and lessened sense of competence as he receives, or expects to receive, hostility and rebuffs from his black clients (Bernard, 1972; Reiss & Bernard, 1971; Schachter & Butts, 1968).

The third issue, raised by only a few studies, is that of the therapist's own racial attitudes and stereotypes (Bernard, 1953, 1972; Goldber, 1973). Schachter and Butts (1968) suggest that this is not only a problem when encountered in the form of prejudicial discrimination, but is equally destructive when the therapist is *too* racially conscious. This leads to the therapist over-emphasizing the existence of racial conflict, thereby depriving the patient of working through the nonracial aspects of his difficulties.

Although there has been little research on interracial practice in the more traditional psychotherapies, even fewer such studies have developed from a behavioral perspective. This is particularly true regarding behavioral approaches to sexual dysfunctions. It would appear that cross-racial treatment considerations in a behavioral modality emphasize the individual's conscious control of his own behavior and minimize the role of the unconscious. As a re-

sult, transference and countertransference reactions are not the primary focus of therapy. The most salient dynamics in this form of treatment exist within the client couples, rather than between the therapists and clients. Thus, the therapist's role is based more on the expert-technician/educator model than on the analytic modes. (LoPiccolo & Lobitz, 1973). Sexual dysfunction therapy, by its very nature, focuses explicity on sexual behavior, thoughts, and feelings. Because of the myths surrounding black sexuality and their partial acceptance by both the black and white populations, such an emphasis may increase the already emotionally charged nature of the relationship between client and therapist.

In view of these special factors involved in a behavioral approach to sexually dysfunctioning black couples, as well as the literature regarding interracial therapy in general, the following three issues should be considered: First, the distrust and anger that Bernard (1972) suggests black clients often feel toward their white therapists may well be exacerbated by the specific focus on sexual difficulties, particularly because this has stereotypically been the black individual's area of strength. In addition, the behavioral approach places the therapist in the role of sexual expert, thus accentuating both the disparity between the client and the therapist and the attendent antagonism. Secondly, as previously noted, for centuries black sexuality has generated strong emotions in the white population. It is reasonable to assume that such responses may continue to occur even within the therapeutic relationship. The therapist's attempt to compensate for such stereotypic reactions may also cause treatment difficulties of another nature. In this instance the therapist, in attempting to present a liberal bias, may tend to dilute the power of his presence, thereby reducing the effect of therapy. A third major issue that is often overlooked is the effect of cultural variables on treatment. What white therapists may assume is sexually deviant may in fact be accepted as normal within the client's culture. In addition, the therapist's unfamiliarity with differences in cultural values may lead to unrealistic expectations regarding the client's attitude toward therapy in general and sex dysfunction therapy in particular. Such a lack of awareness may also cause the therapists to attempt to mold marital relationships in accordance with their own expectations rather than allowing the clients to choose on the basis of their own needs and desires.

Case History

Sarah and Nick (pseudonyms) are middle class Afro-Americans in their early thirties who sought treatment at the Sexual Dysfunction Clinic, NPI, UCLA. Nick was experiencing premature ejaculations, which restricted his ability to bring Sarah to orgasm through intercourse, resulting in frustration for both of them. The couple was having intercourse slightly less than once a week with both partners describing their sexual relationship as "extremely unsatisfactory." Approximately 75 percent of the time Nick had difficulty maintaining an erection prior to intercourse. His latency to ejaculation was reported to be less than one minute with only minimal foreplay.

Sexual Histories: Sarah had been raised in a predominantly black community in another state. At an early age, she became aware of the sexual mores, expectations and stereotypes of her culture, especially the myths regarding black male and female roles. She had been previously married and had a child, age 8. Prior to meeting Nick she experienced no sexual problems in the marriage or any other relationship in which she was involved. Based upon her past experiences and background, she maintained high expectations of spontaneous sexual relationships where both partners could perform genital intercourse with mutual orgasm without prolonged foreplay.

Nick's father was a career army enlistee; consequently, Nick was raised and educated in predominantly white areas surrounding army bases where his early social contacts and dating experiences were minimal. His first sexual encounters took place while in the armed forces in Germany. Nick was reluctant to admit a prior history of premature ejaculations because he was quite conscious of the stereotyped image of the hypersexual abilities of black males. He finally revealed that he felt inadequate that he "couldn't do his job" of performing up to the stereotyped expectations for his culture. This performance anxiety served only to heighten Nick's sexual dysfunction.

The couple was highly achievement oriented: Sarah was a college student, and Nick was in a competitive executive training program. Both individuals had well-defined conceptions of each other's sexual role in the relationship. Yet, there was little discussion of the growing discrepancy between Nick's expectations for himself and his current performance level. In addition, Sarah failed to directly express her disappointment with the sexual aspects of the relationship.

Nick and Sarah were seen one hour a week by a female-male, black-white co-therapy team for a total of 13 therapy sessions. Therapy followed the general format prescribed by Masters and Johnson (1970) as modified by Lobitz and LoPiccolo (1972), in which the couples were given "homework" assignments of sexual activities to be carried out in the privacy of their own home. Concurrent with the general directive approach of therapy, several treatment issues emerged which were pronounced for black couples.

Issues Related to Black Sexual Stereotypes

Myth: "Black males are 'naturally' sensual lovers."
Example: Nick felt inadequate and inferior because his body build and sexual performance did not "naturally" match the hypersexual black image. His resulting anxiety inhibited him from experiencing physical pleasure during sexual relations.
Management: Nick was assigned self-pleasuring sessions in which he explored his own body through the tactile, visual, and olfactory modalities. These sessions were designed to increase his acceptance of his body and awareness of those parts from which he could experience pleasurable sensations. Secondly, he was instructed to explore areas of his body which increased his sexual arousal in order to make him aware of body areas, in addition to genitalia, which could be aroused. Thirdly, during the couple's mutual sessions, he was encouraged to communicate the methods of pleasure and arousal that he had discovered. This was designed to increase Sarah's appreciation of Nick as a sensual person and to help her to realize her role in awakening that sensuality in him which previously had been dormant. She was also instructed as to how she could lessen her partner's performance anxiety by supportive verbal statements and by attempting some of the methods that Nick described as arousing in their mutual sessions.
Myth: "Black women can only be satisfied through intercourse."
Example: Sarah perceived herself as a highly sensual individual who had an increasing need for sexual satisfaction through intercourse. This placed a great deal of performance pressure on Nick. In spite of her self-image, she was not aware of her body's response to physical stimulation other than genital intercourse.
Management: Sarah was assigned individual pleasuring sessions in which she explored her body visually and tactually. This was expanded to include masturbation. Her self-image as a highly sensual individual was enhanced by her developing a means of sexual satisfaction in addition to genital intercourse with her partner.
Myth: "Black men and women do not require sexual foreplay before intercourse."
Example: Sarah perceived spontaneous, immediate genital intercourse as the "ideal" form of sexual expression. Her early learning history included sexual mores which proscribed sexual contact other than intercourse.
Management: The couple was given assignments which broadened their range of foreplay skills. They were also instructed in means of genital stimulation, in addition to intercourse, which they incorporated into their repertoire. During the course of therapy, Sarah discovered that genital stimulation prior to intercourse greatly enhanced her arousal.
Myth: "Black men have unusually long latencies to ejaculation."
Example: Prior to treatment, Nick denied that he had prematurely ejaculated, attempted to demonstrate longer retention abilities than he had, and refused to admit that there was a history of the dysfunction.
Management: While Nick was given support in understanding his frustrations, he was also made aware of the frequency of this problem among men and how his denying the problem only served to exacerbate it and further alienate him from Sarah. He was told to expect premature ejaculations to occur from time to time during the step-wise desensitization procedure of the program. Both partners were instructed to reinitiate sexual contact if a premature ejaculation occurred. The therapists stressed the importance of verbally supporting each other at this point. In a step-wise fashion Nick mastered the "squeeze technique" (Masters and Johnson, 1970) in individual sessions, which increased his awareness of the phase prior to ejaculation and heightened his self-confidence over his control. He then taught Sarah to apply the "squeeze" during intromission. Her perception of his ability to overcome the premature ejaculation problem increased as Nick exhibited more self-control.
Myth: "All black males are sexually aggressive and highly physical partners".
Example: Nick failed to be as sexually demonstrative and aggressive as Sarah desired.
Management: This problem was handled with a two pronged approach: Sarah was encouraged to note the aspects of Nick's personality and approach toward her that she liked, as well as to communicate those things she wanted him to change. Secondly, Nick was encouraged to respond to Sarah's requests if he felt he could comfortably change his behavior. He also worked on understanding the sexual, non-verbal

cues from his partner. Sarah learned to provide more verbal and non-verbal cues to increase the likelihood that her partner would understand when and how her sexual needs could be met. As a means of illustrating to the couple how increased communication should take place, the therapists role-played simulated conversations in which both partners expressed their desires and yet attempted to compromise with each other.

Issues Related to Cross-Racial Treatment

Issue: "Black couples may feel distrust and anger toward the white therapist."
Example: The therapists were concerned about Sarah and Nick's reaction to the directive nature of sex dysfunction therapy, since the structure and authority was emanating from a black-white therapy team.
Management: The primary means of dealing with this possibility was to emphasize collaboration with the clients as colleagues rather than maintaining a client/therapist dichotomy. Throughout the therapy process the treatment team attempted to maximize the couple's involvement in both developing future homework assignments and in understanding and resolving their own problems when they arose. The educational model used in this mode of therapy enabled the clients and therapists to work together through sharing information and discussing alternative means of alleviating the dysfunction, thus minimizing the directive/authoritative aspects of sexual dysfunction therapy.
Issue: "A white therapist working with a black client may often be so invested in maintaining a non-prejudicial stance that his normal style of interacting with a client is inhibited."
Example: The male therapist in this treatment team experienced initial difficulty in limit setting and assertive confrontation, particularly with the male client.
Management: This problem was resolved mainly through post-session consultation with the black co-therapist. She pointed out the male therapist's inhibited approach and reassured him that he could maintain his characteristically assertive style without jeopardizing his liberal attitudes. Subsequently, the male therapist was able to relate more openly with Nick.
Issue: "Cultural relevance is often overlooked in developing treatment goals."
Example: The co-therapists were aware of the pitfall of suggesting treatment goals to their clients which lacked continuity with their cultural experiences.
Management: Since Sarah and Nick had internalized certain sexual stereotypes, it was not the function of therapy to destroy these "ideal" images, but to broaden the couple's level of self-awareness and sexual skills. A great deal of the re-education process included discussions of how myths of black sexuality have been a means of focusing upon an aspect of the behavior of Afro-Americans which has led to exploitation but minimal understanding within and between races. The purpose was not only to dispel myths but to make the clients aware of how these myths affect the behavior of Afro-Americans.

Outcome

At the end of therapy, Sarah and Nick were having intercourse about three times a week. Nick's ability to sustain an erection increased from 25% to 90% of the time prior to intercourse. His latency during intromission ranged from 10 to 15 minutes before ejaculation occurred, allowing Sarah to achieve orgasm, frequently more than once per session. They reported feeling more comfortable with masturbation as a valuable asset to their sexual repertoires. Both partners verbalized their satisfaction with their improved sexual relationship and their ability to communicate their needs to one another during sexual and non-sexual contact.

Implications for Future Treatment and Research

Treatment programs for sexual dysfunctions have largely been staffed by white therapists and have treated white, middle-class populations. Recently in Los Angeles and in other urban areas, black couples have sought therapy for a variety of sexual dysfunctions. The above case is presented to highlight the management of issues which may arise in cross-racial sex therapy. Several implications for future treatment and research emerge.

First, the therapist's receptivity to working with individuals whose sexual behavior is influenced by their cultural background is believed essential to treatment success. It is difficult, if not impossible, to maintain an objective ap-

proach in the treatment of black couples without the therapist's commitment to accept aspects of the clients' experience which might be expressed in forms of sexual behavior different from their own.

Secondly, it is the therapist's responsibility to obtain information regarding the sexual myths which permeate the greater community and influence the self-concept of the Afro-American subculture. Prior to therapy, it is also important to examine how the myths of sexuality, culture and ethnicity tend to influence the therapist's attitude toward the clients. This kind of self-examination might lessen the likelihood of these variables interfering with the development of the therapeutic relationship.

Black clients may enter treatment with feelings of discomfort and even distrust and resentment towards white therapists, especially where sexual behavior is the focus. As Bernard (1972) has cautioned, these feelings may produce counter feelings in the therapist which could seriously jeopardize treatment outcome. The therapist needs to facilitate an open exploration of this possibility. The use of self-disclosure by the therapist can often allay the clients' apprehensions about revealing their feelings in the therapy session (Jourard, 1964). Therapist self-disclosure legitimizes the clients' expressions of discomfort when it becomes apparent that they are shared by more than one individual in the client-therapist relationship. In addition, interracial tension can be minimized by assuring that the clients set their own goals. Thus, the clients are enlisted as "therapeutic colleagues" in the treatment process.

In addition to descriptive research, there is a need for therapy outcome studies on sexual dysfunctions in black populations. In the present case, the black co-therapist facilitated resolution of several issues involving the interracial nature of therapy. The question remains as to how the race of the therapists affects the success of the treatment program. Systematic outcome research comparing white, black, and interracial therapy teams is required to provide a definitive answer.

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