DEALING WITH SEXUALITY: ESSENTIAL IN AN ALCOHOL REHABILITATION PROGRAM

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SYNOPSIS

Sexuality and alcoholism have been linked since Shakespeare's time, but various studies have pointed out there is no simple direct relationship between the pharmacological effect of alcohol and its behavioral consequences. Both alcoholic and non-alcoholic people may use alcohol to be more comfortable with their sexuality. If this has been the case for an alcoholic, it underlines the importance of dealing with sexuality as part of an alcohol rehabilitation program. Sexual dysfunctions are commonly expressed by the recovering alcoholic and may have a direct relationship on his/her potential for recovery.

This paper reviews the nature of the drug, the nature of the illness, and the nature of the sexual response. It then discusses specific sexual dysfunctions in the alcoholic population and the implications for treatment.

INTRODUCTION

Sexuality and alcoholism have been linked since Shakespeare's time, but various studies have pointed out that no simple, direct relationship exists between the pharmacological effect of alcohol and its behavioral consequences. Society has a common belief that alcohol facilitates the expression of sexuality. In fact, both alcoholic and non-alcoholic people may use alcohol to be more comfortable with their sexuality. If this, indeed, has been the case for an alcoholic, this underlines the importance of dealing with sexuality as part of an alcohol rehabilitation program. At the Donwood Institute, sex is not regarded as a "taboo word" and, in fact, is a component of our treatment program. The film, "Sex, Booze, and Blues," is used in a group setting, and then the patients are asked to break into small groups of dyads or tryads for further discussion. They are presented with a bibliography and a list of sex therapists available in the community. In addition, two practicing sex therapists are on staff at the Institute.

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Before beginning a consideration of sexuality, sexual function, and alcoholism, I feel the necessity to discuss the effect of alcoholism on the family unit itself. The sexual relationship is just simply one aspect of communication within the family. The dynamics of the family unit need to be understood in order to comprehend the destructive force that alcoholism may have on the family and a couple's sexual relationship.

We all know that alcoholism is a family illness. If the treatment professionals wishes to help the family of the alcoholic, he/she must understand how family members react to this illness. Alcoholism is characterized by problem drinking on the part of one or more members of the family, and a predictable response on the part of other members of the family. The normal family responses which are beneficial in physical illness or injury work almost in reverse when applied to an alcoholic. The family does everything it knows how to do and attempts to help in every way possible, yet the alcoholic returns to drinking, again and again. These are normal family reactions, and produce normal emotional distress on the part of the spouse, children, and parents of the alcoholic. This is again followed by additional drinking. Alcoholism as an illness involves interaction of the alcoholic with members of the family and with others in society. Alcoholism is never an illness in one person. It cannot be treated under the standard medical model of doing something for the patient. The alcoholic drinks, others react to the drinking and the disrupting consequences, and the alcoholic responds by drinking again. This sets up a merry-go-round of drinking, reaction, response, and drinking again, which we term alcoholism.

"What's all the fuss about alcoholism?" That many think there is no problem is the problem. It's earlier to pretend there is no problem than to face up to it, and that is what is happening in our country. The family gets caught in the denial system as tightly as does the alcoholic. The pressure on the family to deny and to be part of a conspiracy of silence, maintaining "there is no problem," is a reflection of society's attitude of denying, covering up, and pretending there is no alcohol problem. Factors which contribute to the denial of a problem include the stigma of being labelled alcoholic, feelings of moral shame, and harboring of age-old myths.

Alcoholism draws people out of touch with reality: the family is locked into compulsive behavior and it begins to believe its own defenses to the point of becoming
delusional. The extent of delusion renders the family incapable of helping itself. It needs others. The defence system of the family begins to parallel that of the alcoholic. This behavior is unwittingly developed by the alcoholic. He adapts these defence mechanisms to cause the least amount of stress to himself, and in turn each member of the family reacts correspondingly. Note the following:

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<thead>
<tr>
<th>Alcoholic</th>
<th>Family</th>
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<tr>
<td>Denial of alcohol dependency</td>
<td>Denial of the alcoholic's disease</td>
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<td>Delusion/Control of his drinking</td>
<td>Delusion/Control of the alcoholic's behavior</td>
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<td>Obsession with alcohol</td>
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<td>Impaired thinking</td>
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The family is a system in which each member may work together for peace and harmony, or each may work against one another in a destructive way. Each family member finds a survival role to protect herself/himself from pain. This defence system can become the primary problem for each member of the family. The progression of alcoholism in the family is characterized by disturbances in behavior and by emotion of the family members. A family with a drinking problem usually experiences communication problems of varying degrees. The members take turns hiding, covering up the drinking, being afraid, searching for the answers, and blaming: all of which produce confusion and a loss of direction for each member and for the family as a unit. The family's history is one of varied feelings and unresolved problems. The members pretend and deny reality; believing things will be different they set unattainable goals for themselves and others. The relationships within the family unit are strained and tense with each person feeling lonely and isolated.

BASIC ORIENTATION TO SEXUALITY

Obviously in this merry-go-round of drinking, reaction, response, and drinking again, which is termed alcoholism, the sexual relationship between the couple "shrivels on the
vine" because sex does not survive in a hostile environment lacking warmth and caring. Because problems of sexuality are often one component of a patient's recovery from chemical dependency, treatment professionals must have a basic understanding of this complex field. We need to have an appreciation of the wide range of normal sexuality and a tolerance for attitudes which differ from our own. Our usefulness as therapists is greatest only when we recognize how our own attitudes influence our therapy. However, there are several cultural factors which inhibit many people, both therapists and clients, from expanding their awareness in the field of sexuality. Sexual anxiety is very high in our society, so high, in fact, that many people cannot deal creatively or constructively, or think rationally about relationships and intimacy.

Many factors may account for the high level of sexual anxiety in our culture:

1) We are sexually traumatized. We are constantly bombarded by sex for commercial, exploitive reasons; moreover, sex is learned as punishment/reward behavior.

2) We are sexually ignorant. Our cultural value is on ignorance. It is better not to know sexuality because, if we do, we may lose self-control and, subsequently, become promiscuous and insatiable.

3) We already know everything. We are victims of the myth of naturalism, that you automatically and instinctively know how to make love, how to relate intimately, and how to perpetuate a long-term relationship.

4) We are sexually secretive. Sexuality is so private, personal, and intimate that one should not discuss it with anyone. We are not brought up to do so and, furthermore, the jargon is either too profesional or too riddled with four-letter words.

As the individual nears adulthood, he/she approaches a time when he/she steps behind a barrier of silence concerning sexuality. Most adults, as children, were very open in their conversations. Children freely discuss their desire for information, request answers to their questions, and are ready to discuss their interest and concerns most of the time. Adults rarely discuss sexuality outside the context of a dirty joke. Most adults feel some sense of
taboo about seriously discussing their interests and concerns. To do so is to admit to some weakness or shortcoming or, worse, some perversion of their character.

Most adults think they know all that is necessary about sexuality. Most figure that as long as they know the names of the sexual organs and what to do or not to do this, is all they need to know. Unfortunately, such is not the case. There is little recognition that sex education is needed by adults in order to meet adult responsibilities and to adjust to adulthood as a period of life. It is acknowledged that sex education begins at birth, but there seems to be no corresponding awareness that it should continue throughout life. Adults need sex information for several reasons: to make their own sex lives and marriages more satisfying and creative; to provide the informed public opinion needed to support desirable changes in attitudes, education, and laws as they relate to sex; and to facilitate open communication within and across the generations. In fact, sometimes education is the only thing needed in sex therapy.

The term sexuality encompasses biological sex, gender identity, and sexuality activity. It is an identification and an activity, a drive, a biological and emotional process; it is an outlook, and an expression of self. There may not always be congruency between the biological self, gender identity, and sexual activity. The critical factor is not what a man or woman does, but whether the individual feels comfortable about her/his own sexuality. In sexual health, the somatic, emotional, intellectual, and social aspects of one's sexuality are integrated into one's identity and style of life.

Specifically, sexual health includes these factors (Masters & Johnson, 1968):

1) The conviction that one's personal and social behavior are congruent with one's gender identity, and a sense of comfort with the range of sexual behaviors.

2) The ability to carry on effective interpersonal relationships with members of both sexes, including the potential for love and long-term commitment.

3) The capacity to respond to erotic stimulation in such a way as to make sexual activity a positive, pleasurable aspect of one's experience.
4) The maturity of judgement to make rewarding decisions about one's sexual behavior that do not conflict with one's overall value system and beliefs about life.

Self-esteem, work, and sexuality are highly interrelated and operate by a feedback mechanism of one with the other. One has only to work in the field of addictions for a short time to realize that low self-esteem and lack of genuine involvement in life may be an important core in the process of addiction. This basic assumption emphasizes the importance of offering sex therapy to the recovering alcoholic in order to begin to improve the alcoholic's low self-esteem and increase his or her sense of involvement in life as the basis for recovery.

Sexual dysfunctions are commonly expressed by the recovering alcoholic and may have a direct relationship on his/her potential for recovery. In fact, sexual dysfunctions are becoming common complaints in the family practitioner's office with 15% of patients presenting with sexual problems. This figure increases dramatically in specialty areas. Sex researchers Masters and Johnson (1970) have estimated that 50% of marriages are sexually dysfunctional and that they do not provide adequate sexual satisfaction for both partners on most occasions. Sexual dysfunctions are defined as psychosomatic disorders which make impossible for an individual to have or enjoy sexual intercourse (Kaplan, 1974). This disorder may effect either the vagocongestive or the orgasmic component of the biphasic sexual response. For a man, this includes impotence and premature and retarded ejaculation. For a woman, it includes general sexual dysfunction, frigidity, vaginismus, and orgasmic dysfunction.

Evidence suggests that sexual dysfunctions may be caused by a great many factors and that intervention may be required on a great many levels. Although forces such as sexual guilt or severe marital discord, illness, or alcoholism are often responsible for erectile orgasmic dysfunctions, such problems may also exist in people who function well sexually. Only when deeper conflicts produce destructive sexual interaction between a couple, and so cause a person to feel anxiety and block erotic feelings at the moment of lovemaking, do they result in sexual dysfunction and the need for modification in order to restore sexual adequacy. By far, the great majority of sexual difficulties are created by experiential factors.
These include immediate causes, intrapsychic and cultural conflicts, and dyadic problems within the relationship. The immediate causes of sexual problems refer to the "here and now" situation, such as failure to engage in effective foreplay. Fear of failure is at the base of many sexual problems and is especially relevant to the recovering alcoholic who has usually experienced many sexual failures. Erotic feelings are frightening to many people, especially to the recovering alcoholic who has used alcohol to dull sensations in the past. The family unit as well as the alcoholic is in the process of recovering, and usually communication is poor. One needs feedback to develop a good sexual interaction.

Freud was the first to call our attention to the importance of sexual conflict in human behavior (Kaplan, 1974). He was so impressed by sexual conflict that he felt it was the root of all psychopathology, sexual and otherwise. According to Freudian theory the mechanism responsible for formation of sexual symptoms is the return of the repressed infantile sexual conflict. Unconscious conflict between enjoying sexual satisfaction and fear of punishment learned as a child is re-evoked by the present adult sexual experience. A common way of dealing with an unacceptable thought is by repression; this may be a common source of sexual anxiety. Conflict between the wish to enjoy sex and the unconscious fear of doing so has many sources which operate on immediate and, also, at deeper levels. Obviously, conflict resolution is important in the treatment of sexual dysfunction. Culturally, the interaction between the child's developing sexual urges and the experience of growing up in our sexually alienating society produces some sexual conflict in all of us. Such sexual conflicts are usually outside of a person's awareness, but, nevertheless, may have powerful, destructive effects on both the sexual and non-sexual aspects of the individual's life. The alcoholic is an individual who has learned to use alcohol to cope with various conflicts, including sexual ones.

Sexual problems are products of the interaction between the individual and his environment. Therefore, the couple relationship must come under consideration. This is an important dynamic in a recovering alcoholic's sexual dysfunction. Often the effects of alcoholism have destroyed the basic reason for the couple remaining together and so they may not be amenable to sex therapy, that is, one partner rejects the other. Marital discord is the rule rather than the exception in the recovering alcoholic's marriage. Two of the most important issues for a couple
dealing with sexual dysfunction are lack of trust and contractual disappointment; these must be dealt with in sex therapy. Communication is a key factor in dealing with sexual issues and may have a beneficial ripple effect on other issues as communication improves in the sexual arena. Many couples use the bedroom to prove who is in control in the relationship. Power struggles are a recurring problem in recovering family units of alcoholics as responsibility often had to be shifted and assumed by the non-alcoholic partner during the course of the addiction. Sexual sabotage by either partner is an important factor to recognize and deal with in therapy.

THE NATURE OF THE DRUG

Shakespeare, that well-known scientist, is still the leading authority on the effects of alcohol on sexual activity: "It provokes the desire, but takes away the performance" (Macbeth, Act II, Scene 3, line 34). His words have the quality of expressing both lay and scientific opinion regarding the interaction of sex and alcohol. The sexual response people have to a given drug is determined by their personalities, cultural backgrounds, and their expectations and feelings about the drug, as well as the pharmacological action of the drug, the dose, the person's set, the mental state, and the relationship with partner.

Whether sexual desire is or is not increased by alcohol is difficult to answer because of the sexual concurrence of alcohol use with the potentially ambient sexual opportunity and stimulation, for example, the cocktail bar. Certainly, alcohol is used as a social lubricant with the effect of the drug serving to lessen inhibitions, facilitate conversation, and decrease self-consciousness among others. Alcohol is a central nervous system depressant. Its first point of action is the reticular activating system in the brain stem thereby releasing inhibitions, verbal and behavioral. Although, alcohol may take sexual overtures easier, it is at the same time reducing sensitivity in the very centers essential for sexual performance. Therefore, a fine line exists between enhancing sexual response and interfering with sexual response. The dose varies with the drinker.

Alcohol has been regarded by some as an aphrodesiac. The supposed aphrodesiac effect of alcohol may be attributed to reducing the culturally-imposed anxiety about sexual behavior and the feelings accompanied by muscle relaxation,
which may both allow the sexual act to occur and prolong its duration. Most of us grow up with a certain amount of anxiety about sex; some of us learn that alcohol will relieve that anxiety, thus establishing a complex bond between sexuality and alcohol. If a sexual act is successful while one is under the influence of alcohol, this type of learning may reinforce a person's belief that he cannot achieve the same results without alcohol. Often the alcoholic attributes his success to the bottle, rather than to himself. Increased consumption by such a person will eventually result in failure and, possibly, in subsequent psychological impotence with or without alcohol. Wilson and Lawson (1976a) determined that, indeed, expectations play a large role in determining the effect of alcohol on sexuality.

Some of the medications to which the recovering alcoholic may be exposed may have an adverse effect on his/her sexual response. The effect of drugs on male sexuality is far better documented and understood than is their effect on female sexuality. This is partly because the male sexual response is more visible and quantifiable—erection and ejaculation. By analogy, if lubrication and swelling in females are governed by cholinergic nerves, then the anti-cholinergic drugs (e.g., Probanthine) prescribed for peptic ulcer, which may adversely effect erection in males, may also impair the excitement response in females. Since there is no ejaculation phase in the female orgasm, antiadrenergics (e.g., Aldomet) prescribed for hypertension, which may impair ejaculation in the male, may be expected to have no particular effect on orgasm in women. Anti-androgens, (e.g., estrogen replacement in post-menopausal women and birth control pills in younger women) may decrease the libido by opposing the stimulating action of androgen on the brain and on the sexual organs. Anti-alcohol drugs (e.g., Antabuse) occasionally have impotence reported as a side effect. The mechanism is not understood; again, it is difficult to rule out the functional overlay completely, because these drugs are being used in men recovering from a powerful addiction.

Some drugs may enhance human sexual response. Hormones (e.g., androgens) may be used for the treatment of impotence, and will stimulate the sex centers. A neural transmitter, L-dopa, used in the treatment of Parkinson's disease may have the side effect of increasing libido, presumably by a direct central affect. The use of amphetamines as a stimulant or appetite depressant has been
reported to enhance libido; however, in chronic usage stimulants diminish libido and sexual functions as well as causing general debility. Hallucinogens (e.g., LSD, THC) disrupt neuro-transmission in the limbic system and reticular activating system. They have been reported to have a varying effect, enhancement or impairment, emphasizing again the importance of the patient's expectations. In general, the sexual effect of psychotropic medications are non-specific. Patients on anti-psychotic, anti-anxiety, or anti-depressant drugs may experience an improvement in their sexual function; however, this is a reflection of the drug's favorable effect on the psychic state. The anti-psychotic drug, Mellaril, causes dry ejaculation, supposedly by way of internal vesicle sphincter paralysis, causing semen to flow into the bladder. Haldol has been reported to reduce libido and potency, and cause retarded ejaculation in some men by some unknown mechanism (e.g., central or peripheral anti-adrenergic effects). Generally, the anti-anxiety drugs cause an increased sexual interest as anxiety diminishes, but muscle relaxing effects may account for the rare orgasmic dysfunction reported. Sex drive and performance may improve as depression lifts with the use of anti-depressants, but they may have some peripheral autonomic effects which rarely cause impotency and ejaculation problems in men.

THE NATURE OF ILLNESS

Masters and Johnson (1970) cited an oft-quoted clinical observation that alcoholics are devoid of sexual tension. Whether the alcoholic's time and tension are so completely focused on the addiction so as to cause a loss of interest in sex or whether arousal is impossible, even if the alcoholic could be distracted from the addiction, is not known. Reduction of sexual capacity, both interest and ability, in alcoholics may be another symptom of physical deterioration. The same physical impairment can have vastly different effects on individuals depending on their immediate past histories, their relationships with their partners, and their ego integrations. Few organic disorders destroy sexual responses completely. More commonly, sexual function is only partially impaired by, for example, alcoholism, diabetes, neurological damage, anti-hypertensive medication, or advanced age. However, the patient or partner's alarmed or discouraged response to partial impairment may then produce complete dysfunction by virtue of these emotional reactions.
Some organic causes of sexual dysfunction may occur in recovering alcoholics. A person who feels ill and debilitated or is in pain is not usually interested in pursuing erotic matters. Hepatic and renal disorders which impair detoxification and excretion of metabolic products and estrogen are especially likely to be accompanied by diminished sexual interest. In hepatitis loss of appetite and/or libido are sensitive indicators of the disease. Diabetes and multiple-sclerosis may be responsible for erectile difficulties. Diseases and surgical procedures which interfere with the nerve supply to the reproductive organs will obviously effect the sexual response. Depression, stress, and fatigue are common presenting complaints of recovering alcoholics that can damage their sexuality profoundly.

THE NATURE OF THE SEXUAL RESPONSE

It is not possible to treat sex as a simple process simply affected by another simple process, drinking alcohol, primarily because sex isn't simple. Any behavior whose neural substrate is more than a single process has the possibility of being affected by the amount of drug taken in a complex manner. Successful sexual intercourse depends upon a complex sequence of hormonal and physiological events which are highly vulnerable to the effects of both acute and chronic stress, and the effects of both acute and chronic alcohol intake.

The detailed research by Masters and Johnson (1968) has depicted the four parts of the sexual response cycle: excitement, plateau, orgasm, and resolution. These are accompanied by anatomical and physiological reactions throughout the body as well as in the sex organs. The female sexual response is more variable than the male, presumably because it is far more susceptible to psychological and cultural determinants. These phases provide a wide range of possible action for alcohol; it is important to point out that a drug will act differentially on males and females, depending on its site of action. The aspects of sex which may be affected by alcohol use include libido, erection, orgasm, and ejaculation.

SEXUAL DYSFUNCTIONS IN THE ALCOHOLIC POPULATION

The effects of alcoholism are wide ranging with respect to sexual functioning and sexuality, having both physiological and psychological ramifications. Some of these effects may be initially masked, but as the alcoholism
progresses there will be a decrease in both the ability to function adequately and also in the desire to engage in any sexual activity at all.

The sexual dysfunctions of the female alcoholic may include general sexual dysfunction, orgasmic dysfunction, and vaginismus. General sexual dysfunction is otherwise known as frigidity, and is due to inhibition of the general arousal aspects of the sexual response. "Physiological" means that such a patient suffers from an impairment of the vasocongestive component and, therefore, does not lubricate. "Psychological" means there is a lack of erotic feelings. For the recovering alcoholic woman, general sexual dysfunction is a common complaint and may be due to the depressant effect of the drug or the devastating depression that is usually her lot (Wilsen & Lawson, 1976b). Actual physical changes from the increased consumption of alcohol and lack of proper food can result in bloating, weight gain, coarsened skin, alcoholic breath, and reddened eyes. The major problem that a woman alcoholic has to deal with is the damage to her self-esteem; this has a very negative effect on her sexual response, leading to general sexual dysfunction.

Orgasmic dysfunction is the most prevalent sexual complaint in alcoholic and non-alcoholic women. As a rule women who suffer from this dysfunction are responsive sexually, that is, they may experience erotic feelings, lubricate, and show genital swelling, but they cannot reach orgasm. Kaplan (1974) has described a hypothetical distribution of the female orgasm on which differences in the ease with which women achieve orgasm run along a continuum. At one end are women, approximately 10%, who suffer from total inhibition of orgasmic expression; at the other end are those women, rare indeed, who can fantasize to orgasm. Most women tend to move back and forth along the continuum in different sexual situations and at different times in their lives.

Vaginismus is a relatively rare sex disorder that prevents penetration by the involuntary spasm of the pubo-coccygeal muscles surrounding the vaginal introitus. Treatment is aimed primarily at modifying the conditioned response.

The sexual dysfunctions of the male alcoholic include erectile and orgasmic dysfunction. Impotence is the impairment of penile erection; probably every man has experienced at least one episode of impotence, but for the alcoholic man it has become a pattern. Alcohol as a central
nervous system depressant interferes with normal reflexes and, therefore, may interfere with a man's ability to have or maintain an erection. Erectile problems may also be a result of peripheral neuropathy of the nerves supplying the penis. Drinking even small amounts of alcohol may lower serum testosterone levels in alcoholic men (Williams, 1976). Since testosterone has been connected to sexual activity in men, low serum testosterone is usually correlated with low sexual activity. If the alcoholic has developed cirrhosis, the following changes may occur: shrinking of testicles, loss of testicular function, low sperm count, and gynecomastia or breast enlargement in addition to loss of libido. These are all physical changes caused by alcohol that may dramatically affect the male sexual response. As well, the psychological damage done to a man's self-esteem with an alcohol problem may dramatically affect his sexual response. Premature ejaculation is a highly prevalent condition and, interestingly, seems not to be correlated with quality of marriage, specific sexual conflict, or non-specific psychopathology. It is often associated with secondary impotence. In the early stages of alcoholism this is one sexual problem that seems to be helped by the effects of alcohol, primarily because of the diminished CNS responses. Unfortunately, continued use of alcohol for these alcoholics will expose their bodies to the toxic effects of this drug resulting in the physiological problem of impotence.

Retarded ejaculation is the impairment of ejaculation while the erectile component remains intact. Physical and drug causes, particularly the use of Mellaril, must be ruled out. The aim of treatment is to extinguish the inhibitory response at high levels of sexual tension. This dysfunction may be indicative of relationship conflicts with which the alcoholic family units are commonly struggling.

Both men and women alcoholics may engage in sexual activities while drinking that leave them feeling degraded, used, and ashamed (Williams, 1976). Examples of these activities include:

1) Many sex partners, often with total strangers.

2) Homosexual activities. (Williams mentioned a study in which ¼ of the men reported such activity.)

3) Multiple sex partners, simultaneously in some cases.
It is important to stress that the most important, and most common type of sexual problem found in male and female alcoholics is the inability to form and maintain satisfying, intimate, and meaningful relationships. The alcoholic usually does not find himself very loveable, to say nothing of the remorse resulting from alcoholic behavior. This inability to deal with intimacy is probably related to the nature of the disease itself and to its consequences.

Burton and Kaplan (1968) surveyed several couples in which the husband was alcoholic. The survey dealt with their sexual relationships. When asked about the frequency of intercourse, husbands recorded intercourse approximately 1.6 times a week; their wives 2.1 times a week. Seven of the 16 couples were in disagreement on frequency, primarily due to the wives indicating more frequent intercourse than their husbands. One possibility for this discrepancy could be the blackout periods that are frequently associated with alcoholism. It is likely that intercourse was engaged in while the husband was in an alcoholic blackout and, as a result, had no memory of the event ever taking place.

One common pattern seems to emerge in these alcoholic relationships: the use of withholding sex as a weapon against the husband's drinking behavior. Certainly, this can be done reversely as well. The placing of contingencies on the availability of sexual intercourse is understandable. However, it is often ineffective and destructive. Such attempts are often met with anger, resentment, and engagement in extra-marital relationships. Levine (1955) has documented a high frequency of sex outside the marriage for the majority of alcoholics some time during their drinking career.

SEXUALITY AND RECOVERY: IMPLICATIONS FOR TREATMENT

Although abstinence has many healing aspects, it may create its own problems with respect to sexual functioning and sexuality. Sexual problems may have been occurring all along during the addiction; abstinence may take them more visible. Sometimes people expect abstinence to heal all problems, including sexual dysfunction.

In our experience at Donwood most recovering alcoholics who complain of a sexual dysfunction do not have a clear-cut organic basis for their problem. Certainly they have been exposed to a powerful depressant that has controlled their thoughts and actions and, generally, has put a damper on
their family life and sexual interest. Physically, the recovering alcoholic needs time to recover. Psychologically, early recovery is fraught with performance anxiety re: job, family, sex, and life in general. If performance anxiety re: sexuality is not strong, relationship conflicts may be. Psychologically, they need time to recover. Most importantly—not to be underestimated—is the energy needed to begin and maintain abstinence. The psychic energy required is considerable, and sometimes there is just simply not enough energy left for sex.

Alcoholism and sexual dysfunctions have a detrimental effect on family life and because family support is so important to recovery, sexual recovery is essential. Sex should be viewed as one more aspect of communication which may need attention. Open discussion of sexuality and of sexual functioning, as part of the treatment program, goes hand in hand with recovering one's self-esteem, and putting perspective on fears regarding performance and the acceptability of himself/herself as a man or as a woman.

Because we support the theory that the very nature of alcoholism requires a total recovery of the patient as a whole person, one of modalities we offer is sex therapy in our continuing therapy program. The timing for the use of this treatment is of great importance in the recovery process. We offer sex therapy 3 to 6 months after the patient has left the month-long treatment program. The reason for this is that in the first few months of recovery the patient already has a multitude of physical, mental, and emotional changes and adjustments to deal with. There is also the chance that in the first few months of recovery the basic sexual dysfunction will have begun to heal itself. Sobriety is the primary goal in the early stages of recovery. However, if sexual dysfunction is still a major concern for the patient or his partner by the end of 3 to 6 months, sex therapy is appropriate. Sex therapy has as its primary objective the relief of the sexual symptom. It is brief, lasting anywhere from 3 to 6 months. It involves the integrated use of systematically structured tasks with conjoint therapeutic sessions.

The basic prescription for sex therapy is:

1) Assess the sexual dysfunction.

2) Rule out physical, significant psychiatric, or drug-related causes.
3) Induce attitudinal changes.

4) Reduce performance anxiety.

5) Increase communication and effectiveness of sexual technique.

6) Change destructive lifestyles and sex roles.

7) Assign sexual tasks, sensate focus, and pleasuring exercises.

8) Conjoin therapy and brief directive counseling aimed at symptom removal.

The application, of course, should only begin after a detailed sexual dysfunction history has been taken that includes description of dysfunction, onset and course of dysfunction, patient's concept of cause and maintenance of problem, past treatment and outcome, current expectations, and goals of treatment. Obviously, this therapy should not be considered until the patient actually requests help in this area; for some patients this will be much further along than 3 months into the recovery process.

Recovering alcoholics with sexual dysfunctions obviously need more than the "how to" manuals can provide. Sex therapy can offer an excellent opportunity to begin building self-esteem, an initial step in rebuilding one's lifestyle that had been grossly damaged by alcohol. It can serve as a unifying force for a couple that has not had the experience of working together as a loving team for quite some time. Most importantly, it can reinforce sobriety and improve a patient's chance of recovery by supporting the benefits of a chemical-free lifestyle, resulting in a healthy human sexual response. As treatment professionals dealing with the family illness of alcoholism, we must acknowledge that sexuality is a fundamental dimension of human existence. Our sexuality is our identity. It is connected to the man--and woman's--desire for personal fulfilment and to his/her consequent need to establish satisfactory relationships with others. A satisfactory sex life is just one more aspect that will add balance and harmony to the family as they all recover from their lifestyle dysfunction known as alcoholism.
BIBLIOGRAPHY


