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ORIGINAL ARTICLE

Working interactively using a systemic sex therapy model for common sexual problems within a modern health service setting[☆]

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Summary Sexual and Relationship Couples Psychotherapy is a specialist form of psychotherapy and counselling within which different theoretical perspectives may be employed by clinical staff. These include psychodynamic, family-of-origin, cognitive behavioural and systemic therapies. Systemic therapy has developed from a family systems background for the management of couples with relationship difficulties and in certain instances for couples with both relationship and sexual difficulties. The history and development of systemic therapy is described followed by a more specific review and outline of systemic therapy in the management of sexual problems. We go on to describe the specific training experience of a member of staff in systemic therapy to build upon the existing clinical framework employed within the service. Inherent for systemic therapy, there is a need for a team of observers, which in our clinic incorporates both staff and our postgraduate trainees. The experience of the member of staff learning specific skills in systemic sex therapy and live supervision of the team of her work during development of her skill set is explored and discussed. Issues around clinical outcomes and clinical governance are further described as our service is provided within a national health system service where these are considered mandatory.

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Introduction

The specialist practice of relationship and sex therapy are both recognised forms of psychotherapy, and are often practiced in tandem. In the UK, the profession of sex therapy is supported by the British Association for Sexual and Relationship Therapy. Full training allows for accreditation in the specialty and recognition by the United Kingdom Council for Psychotherapy (UKCP).

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When clinicians are planning to undertake new treatment or therapy interventions, it is prudent for this to be considered both operationally by the clinic management team, or if appropriate, the hospital clinical governance committee or equivalent. Strategically, business planning before introducing or implementing changes to clinical services is important. Where NICE guidance is available, there is recognised and formal guidance as a reference (Freedman and Swanson, 2006). Once services are made available, clinical governance ensures that systems are in place to monitor safety and quality of clinical practice; that clinical practice is regularly reviewed and improved as a result and that clinical care meets certain agreed standards.

Clinical governance is a system through which clinics and organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (Scally and Donaldson, 1998). Considerations should include whether the procedure has been used elsewhere and how will the procedure improve patient care. It is usual to have expected outcomes of the intervention or procedure and to clarify if this is replacing or additive to current practice. Of increasing importance is reference to the practitioner's professional body for a definition as to whether the proposed intervention is within the practitioner's scope of practice. Additionally, will practitioners have to adjust their practice and are there initial and/or ongoing training requirements for the proposed procedure?

Usually, there will be some evidence of training by the clinician about to undertake the work and some demonstrable evidence of their competency to perform the type of therapy work.

For some procedures there may be stringent review of proposals. This will involve performing an assessment of the safety and efficacy of the proposed new intervention (including in peer reviewed journals), review of the evidence of benefits to patients and staff and assessment of the methods (and measures) for monitoring outcomes as well as auditing the interventions.

Where the introduction is less formal, there is benefit by the clinician (or clinical team) informing colleagues, both within and beyond the department of the new intervention and the clinical indications for undertaking the procedure, and for consideration of referral to that clinician for the specialist intervention. As above, the details of the training and acquisition of competencies required by the therapist are outlined and agreed with managerial team members identifying the evidence of the training that is being undertaken or that has been completed as well as any resource needs.

Suitable business planning requirements should take place as most psychotherapeutic treatment opportunities have high fixed staff costs. In addition there should be adequate identification of potential adverse effects and risks. The development of patient information sheets and a clear description of the consent process should be formalised.

Within the UK, sexology is practiced across a number of professions (Wylie et al., 2004) and psychotherapy is recognised as an effective treatment (Hiller, 2006, SRT, 21, 3, 385–389). Supervision is an essential part of the process, which is of benefit to both patients and staff. The concept of live supervision is well established for both couples and

sex therapy (Crowe and Ridley, 1990) and family therapy (see below). However, very little has been written about systemic sex therapy (Hertlein and Weeks, 2009).

We present the development of systemic therapy into the training schedule for our postgraduate students on a Master's training course. This has occurred alongside an established sex therapy training course, which already offered basic training in psychotherapy and sex therapy using an integrated model of sex therapy (MIST – Daines and Hallam-Jones, 2007) and where certain clinicians were practicing systemic sex therapy (Wylie and Hallam-Jones, 2009).

Systemic therapy

“No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends' or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.”

This extract from Meditation XVII by John Donne epitomises the fundamental concept of systems theory. The notion that an individual is not causative of the “symptom”; rather it is the interplay between members of the system which is the problem. This is the main discrepancy from previous analytical schools of thought.

The idea of systems theory and its subsequent branching into a modern breed of therapy has been developed and adapted by countless men and women throughout history, from philosophers and anthropologists, to psychologists and therapists. We aim first therefore to perambulate through the history and works of systemic thinking and show how this has influenced the therapies in practice today.

It is somewhat difficult to trace back the ancestry of systems thinking to a single person or specific piece of literature; however Alexander Bogdanovic's work on technology in the 1920s introduced a way of looking at science and nature from a systems point of view (Biggart et al., 1998). His early work was translated into German and is believed to have influenced von Bertalanffy in his works into systems thinking.

Von Bertalanffy (1968) distinguished the difference between open and closed systems in his 1968 book, General Systems Theory. A family is an example of an open system as there is constant interaction with the outside environment. Change in the environment may cause the natural equilibrium to be affected; it is then social interaction between members of the system, which is necessary to return the system to a state of equilibrium (Barker, 2007).

Despite this work, there was still a great tendency in to put blame on the family or family members for their problems. It was not until the 1950s that when Nathan Ackerman began to develop the idea that external factors and social context were big determinants of emotional problems (Hayes, 1991). Ackerman (1966) went on to write how it was important to treat the family as an organic whole. Bateson (1978) began to study how communication was a key element in therapy. This school of therapy caused the devel-

opment of the Mental Research Institute (MRI) established by Don Jackson in 1959 (Hayes, 1991).

Over the next two decades the three main schools of systemic therapies were born. The structural school of therapy is widely credited to Salvador Minuchin. By introducing the ideas of sub-systems, hierarchies and boundaries, Minuchin (1974) described the family's structural organisation. The goal of therapy is to restructure the family in order to relieve the problematic symptom.

The second school of systemic therapy to be spawned was the strategic school, of which there are two separate variants. The first, developed at the MRI, has its foundations in the study of communication patterns (Hayes, 1991). The second was founded by Haley and Madanes as a blend of structural and strategic therapy. Strategic schools have the belief that normality is a myth and that the key to a family's efficiency is the successful adjustment to everyday difficulties and change (Nichols, 1984), and that problems arise when members unsuccessfully adapt to a change in circumstances at critical points in the family's life. Haley (1978) also makes the assumption that the problematic system has altered hierarchical organisation, which cascade down in the pattern of interaction (Haley, 1978). The aims of strategic therapy are to search for a repetitive sequence of interaction, which is causing the problem, identify the embedded symptom and focus on correcting the processes around it (Hayes, 1991). Haley and Madanes aim for this to in turn disrupt its structure (Hayes, 1991).

The pioneers of systemic therapy include the Milan quartet of Palazzoli et al. (1980), Hoffman (1982), Penn (1982), and Tomm (1984) (Hayes, 1991). The early protagonists of this theory, the Milan group, devised a triad of principles upon which systemic therapy is based. The first point is that of circularity or circular causality, which describes everyone's behaviour, moods and actions are seen as a circuit of interactions contained within a system, yet affected by external environmental and social factors (Hoffman, 1982). Therefore, one person's behaviour does not propagate another's, it merely influences, which in turn influences another (Sanders, 1985). Piercy and Sprenkle (1986) described this pattern of interaction within a system as often repetitive and predictive. This continual circling is what can cause problems within the system to become deep seated and amplified.

The Milan group also introduced the idea of hypothesising. This notion gives the therapist the chance to conceptualise problems within the system and determine how members of the family are affected by the problem. Throughout therapy sessions, hypotheses can be supported or rejected. The third area of systemic therapy is that of neutrality, which is vital to the approach to interviewing family members (Palazzoli et al., 1980). Tomm (1984) described neutrality in systemic therapy as having four components. These were to remain neutral to family members and not to take sides. Also, it is important to maintain an impartial view of the family's beliefs, culture, religion and values; and thirdly, to remain neutral regarding the symptom. It is also essential for the therapist to stay neutral and not impose pressure for the family to change.

During the 1990s, the post-modern approach to therapy materialized as a digression of the Milan school of systemic therapy. Anderson (1997) writes that the removal of the

"expert" tag from the therapist helps to promote change in the family system. The therapist becomes a member of the system as an equal to its other members. Anderson goes on to explain that it is the client who brings the expertise about the relationship to sessions and the therapist is only an expert in the process of therapy. This second order change underlines the concept that the therapist cannot understand everything about each different family, especially between families of cultures different to their own (Barker 2007).

Systemic sex therapy

Throughout the 20th century, sexual dysfunctions and problems were pretty much unspoken of until the contrivance of sex therapy (Kleinplatz, 2009). During the late 1940s, into the early 1950s, Alfred Kinsey began to categorize a spectrum of normal sexual behaviour. This popular yet wholly controversial work paved the way for a new era into the investigation of sexual function and dysfunction. Masters and Johnson (1966, 1970) first devised the Human Sexual Response Cycle (HSRC) before publishing their work on human sexual inadequacy. In this pioneering work, they described how the relationship should be the focus of treatment (Masters and Johnson, 1970), laying down the groundwork for the entire field of sex therapy. From this point, the rapid growth of sex therapy ensued, however, widespread acceptance of methods without consideration of underlying theories meant that current assumptions were not explored (Kleinplatz, 2001, 2003; Wiederman, 1998). Masters and Johnson's HSRC began to receive criticism because of its rigid structure leading to Helen Kaplan (1974, 1977) introducing the element of desire to the model. The increase in integrative methods of therapy was, however, side-tracked by the release of effective, oral pharmacological treatments for erectile dysfunction onto the market in 1998 (Goldstein, 1998).

A systems framework for sex therapy and intersystems theory was developed by Weeks (1977, 1994) and a post-modern approach was described by LoPicollo (1987) (Hertlein and Weeks, 2009). There are distinct differences between systemic sex therapy and more traditional, sexology therapies. Systemic therapists aim to contextualize sexual dysfunctions in terms of the religious, cultural and other social situations of the couple as opposed to earlier in depth analyses of an individual's own physiological, psychological and medical make up (Markovic, 2007). There is also a more indirect approach to therapy and the use of circular, not linear questioning in systemic sex therapy; as well as the notion that the client is the expert, not the therapist as in previous schools of therapy (Markovic, 2007).

Learning a new skill set as an established sex therapy and being involved as part of the clinical and training team during the process. A personal reflection by a mature student.

The following is the description of a personal experience of one of the authors working into the service.

"I became a member of the observing team for the clinic's weekly systemic session during my training here at the Porterbrook Clinic. Once I completed my training I moved from being a member of the observing team to being one of the co-therapists in the therapy room. This move was not ideal in that I replaced one of the primary therapists

who had been working with the couple for a considerable time. Her absence was due to sickness. However, it was my opportunity to work systemically with a co-therapist.

Subsequently, I secured a full time position at the clinic as a sex and relationship therapist, which meant I became a member of the clinical team as well as the training team. This in turn meant that I had the opportunity to work systemically with one of the first year trainees as my co-therapist on a regular fortnightly basis. With regard to the other systemic slot I was back in the observing team. It was at this point that I began to feel I needed a more in depth knowledge of Systemic Therapy. My concern was that I was working the way I would normally work but doing so under the label of Systemic Therapy. So although I felt confident with regard to my skills in the field of sex and relationship therapy I did not feel that I had a solid enough grounding in Systemic Therapy.

Thereafter, I expressed my concerns about a lack of systemic knowledge at supervision and one of my colleagues who has a wealth of experience said "Well you just must get yourself on a course for Systemic Therapy". It was this statement that prompted me to approach my line manager. Coincidentally, not long after that she received a flyer for a course that was being run in close proximity to the clinic. I made enquires and obtained the details I needed to fill out the necessary application for study leave and founding. The application subsequently received approval.

I started the 15-week course that is run over three semesters on a fortnightly basis and found myself, from Day one, being totally impressed by how the course manages to teach systemic therapy by delivering the course material using systemic techniques and approaches. That is, by example, which has led me to believe that systemic is not so much a way of doing but rather it is a way of being. Moreover, the course has generated a feeling of empowerment, coupled with a sense of being in an environment that allows you to feel safe and encourages you to develop.

Having emphasised the positive it needs to be said that there have been times since starting the course when I have felt quite different. It has been hard to come from that safe, encouraging, empowering environment with so many new and exciting ideas to the busy clinical/teaching setting where sometimes I feel there is no space to manoeuvre. This is very interesting because in the systemic course we are learning that we need to create space. We are learning it because we are feeling the space and how it allows you to think differently.

I have so wanted to share my experiences on the course with the team but time is an issue. It is a bit like when you go on holiday and you take shots of all your favourite views and you come home and show them to people and they just do not seem to see what you see and it is hard to understand why. The problem is you have the context and they do not. Context is a key concept in systemic therapy and the example above helps to see why (Hedges, 2005).

Furthermore, now that I am learning about all the different strands of systemic therapy I am conscious that there is more than one way to do it and that what we are practising is more akin to strategic and what I am learning is more akin to post-Milan. So that has been helpful to know but difficult to reconcile. It is the functioning of the observing team, which has been the hardest aspect to feel good about. This is because as I learn more about reflective teams I can see how

the use a positive inquisitive questioning approach can generate the hope and the vision that can in turn empower the clients to see where change is needed and possible. Reflective teams give multiple views that are non-judgemental and space is created that allows room to think differently (Dallos and Draper, 2010).

Another concept that I have found inspiring is that of externalising the problem. I have started using the notion in my clinical practice and have found the results encouraging. I had not appreciated the fact that a lot of clients see the problem as being them. So that when you say to them how about we look at the problem for what it is (i.e. something that you are carrying around with you) and look at it from as many different angles as we can you can almost see a great weight lifting from them. Not only that you can see them realise that they are something other than the problem. Once they see that you have the opportunity to explore just who they are or who they could be.

The idea of being who you are or could be links in well with another interesting and exciting concept namely, that of narrative therapy (White, 2007). This is because it opens up the potential to encourage or support clients to start writing or developing a new narrative for themselves – one that suits their hopes and dreams. Moreover, they can begin to realise that for too long they have been readily accepting the narratives written for them by other people. What better way to help them realise they are in control and they can have the potential to change.

Having a philosophy background could easily explain why systemic therapy has such an appeal for me. Given that philosophy is about looking for questions rather than answers. Philosophy teaches that the answers are easy and it is the questions that are difficult. Look for the questions and you will have the answer available to you. Systemic seems to be saying the same thing.

It is also worth mentioning that the systemic course has encouraged us to reflect on how what we are learning may have an impact on our personal lives as well as our work. This aspect of reflective thinking is maybe more difficult to do but it certainly has proved to be very beneficial. I have become much more aware of others writing narratives for me that I am not comfortable with and I have started to focus on the narrative I want for myself.

Finally, I would like to say that my line manager and my clinical lead have been very understanding and supportive of the learning curve that I have been experiencing while at the same time trying to do the job I love and want to do to my full potential for as long as I can."

Supervising the team live with the various requirements and expectations; and measuring outcome of this intervention.

Deciding to offer a systemic experience for staff, trainees and patients in what is usually a fully integrated clinic approach to sexual and relationship therapy has not been without difficulty. Meeting the challenge has included deciding what being part of the live team means; the composition of the live team and what this means to the patients, staff and the trainees involved. Trainee psychotherapists have historically been involved in systemic family and couple's therapy teams working in other settings and training institutions (Boscolo and Cecchin, 1982; Aronson, 1990; Clarke and Rowan, 2009). Over the past few years it has also been

offered as a regular but limited part of the training experience in our clinic.

Some of the joy but also the complexity inherent in offering this specific way of working has been in the range of experience brought to the team by the staff and trainees included. Only one of our permanent staff members is systemically trained, and completed this training more than 10 years ago, specifically in working with couples. The two other members of staff comprising one of the therapists in the room and one supervising the team have, until recently, had no formal training in working systemically other than that included in the training offered in the clinic. Trainee Sexual and Relationship Psychotherapists on our training programme are recruited from diverse backgrounds, e.g., Psychiatry, General Medicine, Nursing, Psychology, Psychotherapy, Counselling and other non-clinical occupations. They each bring to the training course a wealth and variety of life experiences; some have had clinical experience, a few have not, and they present to be trained at various levels of maturity and understanding of systemic theory.

Supervising the training team requires the ability to keep in mind, and attempt to balance, each patients' experience and how they are progressing in the systemic therapy both as individuals and as a couple. This is alongside an awareness of the needs and experiences of the trainees, as a group and as individuals, and also the therapists in the room, with whom there are working relationships beyond that of collaborative therapists.

Patients come to clinic hoping for help with their problem, as they see it. They have had to talk to another professional about their problem in order to be referred to the clinic, and they are then expected, in order to engage in systemic work, to share their problems with not only one or two, but a team of therapists. The potential for difficulty here should not be underestimated for patients who may be presenting with sexual problems, for example erectile dysfunction, hypoactive desire disorder or sexual pain disorders. These may be as well as relationship difficulties, for example loss of intimacy, communication difficulties, or relationship conflict and has been offered as a reason not to continue with this type of therapy by a considerable number of our patients. They may ask to return to the internal waiting list for assessment or treatment of sexual or relationship difficulties, whereby the patient(s) can be reallocated to another therapist who can accommodate the patient request to work without being observed or recorded or state that they do not wish to work with trainees. Any recording of patient sessions involved full consent by all the patients involved, with the right to withdraw consent at any time. Strict procedure is in place to secure and erase the recordings in line with Department of Health and local Trust policy, and they are stored with the same confidentiality and security arrangements as the medical records. The fact that more couples decline or fail to continue in this way of working than accept the systemic approach is probably significant, and does little to help maintain team morale and expectation nor facilitate cumulative benefit for either patient or team from the therapy experience itself.

For those patients who do agree to systemic therapy, there are conditions attached, including being recorded, attending a specific slot – a 09:00 start (which can prove dif-

icult for working partners or parents) and allowing trainees to be involved in their care. They are made fully aware of the role of the team in engaging in the therapy, and this is usually arranged as observing via camera recording from another room. However, we have had patients asking to meet the team, which may create difficulty if the team changes on a weekly basis, depending on the trainee teaching commitments, and when the team may consist of only one person.

The feedback between the team and the therapists in the room must also be carefully considered – when is the best time for the observing team to ring through to offer their reflections on the session, under what circumstances should the session be interrupted, how do both patients and therapists accommodate the interruption and feedback, who should be the person ringing through, and are they fully and objectively representing the team? It has been problematic at times to endeavour to meet the training needs of the group whilst remaining fully engaged in the process and content in the therapy room. Even greater consideration needs to be given when there are training needs, discrepancies and/or deficits of the staff team members involved.

In terms of measuring the outcome of this intervention for our patients, this has also proved to be a complex issue. We are currently working on developing an outcome measure to use in our service generally. In the context of clinical governance and practice-based evidence, it is apparent that there is both a need for a way to demonstrate an evidence-based for sex and relationship therapy and to identify a tool by which to do so.

Current thinking in outcome measurement is highlighting the importance of the therapeutic alliance, patient self-reporting and the use of outcome informed care (Brown and Jones, 2005; Barkham et al., 2008). Having employed the use of patient satisfaction and specific sexual symptom questionnaires during the past 2 years, these have provided some useful information about how patients evaluate our service. However, neither of these measures has been used to demonstrate the effect of systemic interventions discreetly from other integrated therapy offered in the clinic. What is evident is that we do not yet have an adequate way to measure outcomes, in particular for couple or relationship issues. The work by Barkham et al. (2008), which set out to look at the specific effects of different models of psychotherapy, actually demonstrated that effects were greater from certain individual psychotherapists, regardless of therapeutic orientation. Therefore, it may be argued that a general outcome measure for sexual and relationship therapy, if it were to include measures of therapeutic alliance, patient self-reporting and the capacity for outcomes informed therapy, might also be valid and useful as a way to measure outcomes of systemic therapy in treating these difficulties and, perhaps more importantly, individual therapist effects. There has been a long tradition of theoretical alignment and jostling for position as best type of therapy to address clinical issues, with competition between theoretical orientations raging and often rejecting and/or resisting of integration of modalities (Roth and Fonagy, 2005). It appears that this might be less important than once thought, despite recent department of health endorsement for particular ways of working. Our energies might be best directed at allowing patients to say what

works for them and using this information to help therapists to offer better “tailor-made” therapy to their patients.

Perhaps the notion of patients as experts is the position of choice for this collective experience!

Conclusions

The team has continued to develop and expand the use of systemic therapy, a natural modality for use with couples with sexual problems and as a training opportunity for developing sex therapists. Services can accommodate and develop access to provision of good therapy particularly when the system of change involves the couple, the therapists and the therapy/training team.

Conflict of interest statement

None.

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