

1

Introduction

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What is Sex Therapy?

Sex therapists will tell you that one of the fundamental uncertainties that often drives clients into sex therapy is the worry: “Am I normal sexually?” I, in turn, often wonder: “Am I a normal sex therapist?” In my own work as a therapist treating sexual concerns, I sometimes use traditional sex therapy techniques such as sensate focus, but I also rely heavily on my broader training as a clinical psychologist and on my overarching feminist and constructivist psychotherapeutic theoretical orientation. Am I still doing sex therapy if I am not explicitly discussing the sexual response cycle, assigning sex-related behavioral homework, or helping my clients to discuss pharmaceutical treatment options with their doctors?

Thus, one of the most challenging aspects of editing this volume was determining what counts as sex therapy. As I set out to choose chapter authors and select the topics that would be addressed, I was forced to consider my own insufficiently-articulated viewpoints regarding questions such as, “Where does sex therapy stop and general psychotherapy begin?” and “What are the qualifications for a ‘sex therapist’?”

I am certainly not the first to raise these questions about the definition of sex therapy. Tiefer (2012) pointed out that—broadly speaking—across time, sex therapies have included ancient love potions, bloodletting, Masters and Johnson behavioral techniques, Viagra, and YouTube kissing advice videos, among others (p. 312). Yet, she acknowledged that, in contrast to this broad expanse of sex *therapies*, the term “sex therapy” has become nearly synonymous with a dysfunction-focused behavioral or pharmaceutical treatment approach.

Similarly, Levine (2009) reported that he now rejects his former identity as a “sex therapist” because, to him, sex therapy is too narrow and simplistic. He argued that sex therapy has become tantamount to treating DSM-defined sexual dysfunctions with an overly simplistic, behavioral-technique-focused approach. He contended that sexual problems are far too broad and complicated to be explained and treated using a single theory or treatment approach.

Binik and Meana (2009) agreed that the term sex therapy originally referred to the techniques championed by Masters and Johnson (1970)—psychoeducation about sexual functioning, behavioral homework, and so on—but they maintained that, over time, sex therapists began to use the same techniques and theoretical orientations that were used to treat other psychological problems. The authors argued that “sex therapy” is just therapy. Given (1) the lack of clear distinction between sex therapy, as it is typically practiced, and general psychotherapy; (2) the lack of a unifying theory of sex therapy; and (3) the lack of regulation regarding who may call themselves a “sex therapist,” Binik and Meana (2009) proposed that the treatment of sexual problems should be integrated into general psychotherapy practice rather than being treated as a separate subspecialty.

What Problems do Sex Therapists Treat?

Indeed, there is perhaps an even more basic question that must be answered before we can define sex therapy, and that is, “What is a sexual problem?” The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association, 2013) codifies the sexual difficulties that are officially acknowledged by the field of psychiatry. The DSM sexual dysfunction diagnoses are exclusively focused on sexual performance: desire, arousal, orgasm, and pain-free intercourse. This focus on genital performance in the DSM-5 and in earlier versions of the manual has been heavily critiqued for being heterosexist and phallogocentric; for promoting an anxiety-provoking, performance-oriented approach to sex; for ignoring cultural differences and gender-based power differences; and for sidelining essential facets of sexuality such as relationships, emotions, and pleasure (e.g., Apfelbaum, 2012; Kleinplatz, 2012; Tiefer, 2001).

Despite these cogent critiques, there is no denying that, for clients, it is often the symptoms of DSM sexual dysfunctions (e.g., lower levels of desire than they wish, erectile difficulties, orgasmic difficulties) that drive them into sex therapy. Of course, this raises a chicken-and-egg conundrum: Did these issues become the focus of the DSM diagnoses because they were the most troubling sexual issues for clients, or are clients most troubled by these sets of symptoms because they have been conceptualized and labeled as dysfunctional by the medical establishment and, in turn, by popular culture? In either case, clients do present with these difficulties, and as sex therapists, we frequently must address them in some manner. Depending on the sex therapist’s viewpoint, this might involve suggesting medications or behavioral exercises with the goal of relieving symptoms; it might involve helping the client to re-think the assumption that firm erections and timely orgasms are the only path to sexual pleasure and connection; it might involve addressing the underlying psychological and relational distress that is seen as leading to the sexual symptoms; or it might involve some combination of all three of these. Thus, although some sex therapists reject the performance-oriented, genital-focused nature of the DSM sexual dysfunction diagnoses, all sex therapists will be forced to confront these in the therapy office.

There is no question, however, that the DSM sexual dysfunctions do not capture the full range or complexity of the sexual concerns that propel our clients to seek therapy. Levine (2010) categorized sexual difficulties as *disorders* (those identified by the DSM), *problems* (frequent sources of suffering that are not captured by the DSM disorders), and *worries* (concerns about sexual issues that detract from sexual pleasure). In many cases, problems (e.g., anger and resentment about a partner’s infidelity, discomfort with or shame about sexual attractions) and worries (e.g., concerns about body image, fears that one is not sexually pleasing a partner) may actually be more distressing and have a more pervasive negative impact on sexual pleasure and enjoyment than relatively more straightforward disorders of physiological function. It is very often these problems and worries—rather than diagnosable disorders—that motivate clients to come to see a sex therapist.

What Techniques do Sex Therapists Use?

As noted by Kleinplatz (1996), Masters and Johnson’s behavioral techniques have become synonymous with sex therapy; as she put it, these techniques are “the Kleenex” of sex therapy (p. 190). This tendency to equate sex therapy with symptom-focused behavioral interventions—such as sensate focus and the squeeze technique—obscures the fact that there are actually many different brands of sex therapy. In reality, sex therapists, like all psychotherapists, employ a variety of therapeutic techniques and are guided by a variety of theoretical orientations when they work with clients to address sexual problems. Despite this fact, with a very few

notable exceptions (e.g., Hall, 2012; Hertlein, Weeks, & Gambescia, 2009), little is written about theoretical approaches to sex therapy.

Many sex therapists advocate for a biopsychosocial approach to sex therapy. This approach recognizes the importance of integrating medical, psychological, and relational components of treatment. Despite the importance of an integrated approach to treatment, however, the label “biopsychosocial” is uninformative in revealing the theoretical assumptions that guide the psychological and relational work that occurs in psychotherapy. Thus, a therapist working from a “biopsychosocial approach” might treat the psychosocial aspects of the problems using behavioral, cognitive, systemic, narrative, or emotion-focused interventions.

What Should Sex Therapy Be?

I agree with Tiefer (2012) that “sex therapy is politics” (p. 31). For that matter, all therapy is politics, but this is especially apparent in the case of sex therapy because issues of sexuality and sexual behavior are so highly politically contested. Thus, how “expert” professionals define “a sexual problem” and “sex therapy” speaks to their values—and helps to shape the values of the broader culture—around what is and is not sexually “healthy” or “normal” and which treatments are legitimate for addressing sexual concerns. Given that, in this volume, I wanted to represent a diversity of individual values and politics related to what counts as “a sexual problem” and as “sex therapy”.

However, to acknowledge my own values and politics, I also wanted to adopt an expansive definition of sex therapy as any therapy that values and promotes enjoyable sexuality as an integral part of overall physical and mental health. Levine (2009), in describing his rejection of the “sex therapist” label, said:

Sex therapy has no relevance to the management of gender identity disorders, sex perpetrators, paraphilics, the sexually compulsive, sexual victims, sexual risk taking, nonsexual relationship conflict, the anxieties of sexual beginners, and so on, unless, of course, by sex therapy we mean all things involving any aspect of sexuality brought to our clinical attention. (p. 1033)

I hope that the version of sex therapy advocated in this volume does, in fact, have relevance to all of those important sexual issues noted by Levine. Of course, given the breadth of my aspirational definition, no single volume could fully discuss all types of sexual problems, sex therapy clients, or sex therapy techniques; thus, I think of this volume as a mere sampling.

Section I: Treating Specific Sexual Problems

As noted, sex therapists will inevitably treat sexual problems that correspond to the DSM-5 sexual dysfunctions. Not surprisingly, for many individuals, sexual desire (Althof & Needle, Chapter 3; Both, Weijmar Schultz, & Laan, Chapter 2), erections (Nobre, Chapter 4), orgasms (Carpenter, Williams, & Worly, Chapter 5; Rowland & Cooper, Chapter 6), and pain-free intercourse (Meana, Fertel, & Maykut, Chapter 7) contribute to pleasure, enjoyment, and satisfaction, and in turn, difficulty with these aspects of functioning detracts from sexual enjoyment. Thus, treatment of these diagnoses is addressed in Section 1 of this handbook. However, sex therapists also treat other issues that interfere with sexual pleasure, enjoyment, and satisfaction, such as difficulties in controlling unwanted (Grubbs *et al.*, Chapter 8) or illegal sexual behaviors (Berg, Munns, & Miner, Chapter 9), and lack of sexual passion (Mintz, Sanchez, & Heatherly, Chapter 10). Thus, these non-diagnostic problems are also addressed

in Section 1 of this volume. Further, throughout all sections of this volume, the rich case material unmistakably illustrates that the entirety of clients' sexual problems and concerns are not cleanly captured by the dysfunctions listed in the DSM-5.

Section II: Theoretical Approaches to Sex Therapy

Despite my contention that sex therapy is not synonymous with Masters and Johnson behavioral techniques, many (maybe most) sex therapists use at least some of the classic sex therapy techniques, and these are described by Avery-Clark and Weiner in Chapter 11; however, the authors also note that traditional sex therapy techniques, such as sensate focus exercises, have often been misrepresented and oversimplified. Their chapter reveals that even "simple" behavioral exercises involve thoughtful attention to complex psychological and relational factors.

Additionally, as noted above, sex therapists increasingly describe their approach as "biopsychosocial" to acknowledge the importance of biological, psychological, and relational contributions to sexual problems. However, in Chapter 12, McCarthy and Wald describe why they have abandoned the biopsychosocial approach in favor of a *psychobiosocial* approach—foregrounding the psychosocial and backgrounding the biological.

There is no doubt that cognitive and behavioral techniques are extremely popular approaches to treating sexual concerns, and this is evident throughout all the chapters in this volume. This is unsurprising, as cognitive-behavioral therapies currently represent the most popular psychotherapeutic treatment approaches for most mental health problems (Gaudio, 2008). However, the remaining chapters in Section 2 describe how some sex therapists' theoretical approaches to sex therapy extend well beyond cognitive-behavioral therapy to integrate techniques from systemic (Hertlein & Nelson, Chapter 13), existential-experiential (Kleinplatz, Chapter 14), narrative (Findlay, Chapter 15), and emotionally-focused (Johnson, Chapter 16) therapeutic traditions.

Bancroft (2009) identified theoretical diversity as one of the strengths of sex therapy, and I agree. Mood disorders have been shown to be effectively treated using a variety of different theoretical approaches, including cognitive-behavioral therapy, mindfulness-based cognitive therapy, brief dynamic therapy, and emotion-focused therapy (Hollon & Ponniah, 2010). Why shouldn't we similarly expect that sexual problems would likely be responsive to a variety of different treatment approaches?

Section III: Sex Therapy with Specific Populations

Over time, sex therapy has been criticized for being limited in terms of its target population—typically young, able-bodied, white, middle-class heterosexuals (e.g., McCormick, 1994). Recent publications (e.g., Hall & Graham, 2013), though, have attempted to expand culturally-competent sex therapy practice, and as demonstrated in Section 3 of this volume, sex therapists are providing sensitive and affirmative therapy for extraordinarily diverse client populations.

In this section, the chapter authors highlight considerations in treating sexual problems in sexual (Cohen & Savin-Williams, Chapter 17) and gender (Spencer, Iantaffi, & Bockting, Chapter 18) minorities; clients ranging in age from children (Lamb & Plocha, Chapter 19) to aging adults (Hillman, Chapter 20); clients who face barriers to sexual wellness in the form of intellectual (Hough *et al.*, Chapter 21), psychological (Buehler, Chapter 22), physical health (Zhou & Bober, Chapter 23), and trauma-related (Hall, Chapter 24) challenges; and clients

with diverse sexual ethics, including those with conservative religious values (Turner, Chapter 25) and those who embrace creative and kinky sex (Nichols & Fedor, Chapter 26).

Section IV: Future Directions in Sex Therapy

Although some argue that sex therapy has remained stuck in the 1960s and 1970s with Masters and Johnson, in reality the psychotherapeutic treatment of sexual problems has moved forward in all kinds of ways. In some cases, this forward movement is guided by creative clinical experimentation, but in many cases, it is advanced by outstanding basic and clinical research findings. The final section of this book, Section 4, summarizes the empirical literature on four topics that represent highly promising future directions in the field of sex therapy.

In Chapter 27, Barker provides an overview of the theory and research on mindfulness interventions for sexual problems. Mindfulness is arguably not at all new to sex therapy. Indeed, as described by Avery-Clark and Weiner (Chapter 11), it is the cornerstone of sensate focus, one of the most traditional and widely-used sex therapy techniques. However, mindfulness as an explicitly articulated approach to treating a wide variety of sexual problems (not to mention other mental health problems, e.g., Baer, 2003) has recently received very encouraging empirical support, and thus the entire field of sex therapy is taking notice. Indeed, many authors throughout this volume mention mindfulness as a promising adjunct to other sex therapy interventions. In light of the strong empirical support for mindfulness interventions, these types of interventions seem likely to become an essential component of sex therapy going forward.

Given the controversial but undeniable movement toward a medicalized approach to conceptualizing and addressing sexual concerns (which is discussed—and sometimes bemoaned—throughout the chapters in this volume), sex therapists, regardless of their personal views on the issue of pharmacological treatments for sexual problems, will inevitably work with patients who are also using medication to treat their symptoms. Thus, Conaglen and Conaglen (Chapter 28) offer a framework for effectively incorporating partners into individualized medical treatments for sexual dysfunction. Their chapter provides guidance on how sex therapists might continue to incorporate the psychosocial aspects of sex therapy even in the face of an increasingly biomedical orientation towards the treatment of sexual concerns.

Finally, because traditional, face-to-face psychotherapy is expensive, time-consuming, and sometimes hard to access for individuals outside of urban areas, there is increased interest in the broader field of psychotherapy in promoting minimal contact therapies, such as technology-assisted and bibliotherapy interventions (e.g., Newman, Szkodny, Llera, & Przeworski, 2011). Because sex therapy is often focused on single, circumscribed sexual difficulties and because some individuals are very uncomfortable discussing sexual issues in a face-to-face context, some sex therapy clients may be particularly good candidates for these minimal-contact therapeutic interventions. The final chapters in this section describe the promising empirical research findings on biblio-sex therapy (van Lankveld, Chapter 29) and internet-based sex therapy (Connaughton & McCabe, Chapter 30) as treatments for a variety of different sexual concerns. Selective use of these types of minimal contact interventions may allow the field of sex therapy to expand by ensuring that sex therapy remains accessible and affordable to a wide range of client populations.

What are the Values of Sex Therapy?

Certainly the chapters in this volume illustrate the very real conflicts and divides within the field of sex therapy. For example, some authors celebrate new biomedical advances in the treatment of sexual problems (e.g., Conaglen & Conaglen). Other authors lament the

medicalization of sexual problems (e.g., Kleinplatz; McCarthy & Wald)—that is, the framing of complex sociocultural, psychological, and relational problems as simple medical conditions that can be treated with a pill. Some authors praise the continued influence and effectiveness of Masters and Johnson’s traditional behavioral sex therapy techniques, including sensate focus and squeeze techniques (e.g., Avery-Clark & Weiner; Rowland & Cooper), while others argue that such approaches are too mechanistic, reductionist, and heavily focused on symptoms rather than promoting optimally enjoyable and pleasurable sex (e.g., Barker; Kleinplatz; Turner). Some authors argue that close, long-term, committed intimate relationships provide the context for the most passionate sex (e.g., Johnson); other authors problematize this position, suggesting that the security and closeness provided by long-term relationships can often result in an overfamiliarity that can contribute to loss of sexual passion (e.g., Mintz *et al.*).

These disagreements among authors about the nature of and solution to sexual problems are unsurprising, especially given the diversity in region, culture, and profession among the authors in this volume, and those in the field of sex therapy more broadly. Indeed, the authors in this volume represent seven different countries and include psychologists, social workers, endocrinologists, and gynecologists. Some authors are primarily researchers, and others are primarily clinicians. Given the extraordinary diversity of the authors, differing perspectives seem inevitable. Indeed, these conflicts within the field are not new, and some authors have suggested that the intensity of these differences of opinion has led to a damaging splintering of the field of sex therapy (e.g., Kleinplatz, 2012).

However, it is important to note that the disagreements reflected in this volume are generally a matter of degree rather than kind. For example, although some authors are clearly more open than others to integrating biomedical treatments into their sex therapy practice, no author in this volume advocates pharmaceutical interventions implemented in isolation from psychosocial assessment and intervention.

Further, by focusing on disagreements within the relatively small field of sex therapy, it is easy to overlook the many shared values espoused, to at least some degree, by every author in this volume. These values include the essential role of sex and sexuality in overall psychological health; the importance of providing clients with thorough and accurate information about sexuality and sexual functioning; the potentially damaging effects of repressive and shaming messages about sex from families, religion, and the broader culture; the multifaceted nature of sexual problems and sexual pleasure; and the relevance of sexual pleasure and enjoyment as a psychotherapeutic goal. In a cultural context in which middle-school teachers can be fired for saying the word “vagina” (Bethencourt, 2016) and state Houses of Representatives are attempting to pass measures to allow for legal discrimination on the basis of sexual orientation (Suntrup, 2016), these are clearly values with which not every therapist, doctor, or member of the general public would agree, so the fact that these values are consistently endorsed across every chapter of this volume is truly meaningful. To me, these values are the foundational components of sex therapy, and they are what unite our field even in the face of substantial disagreements about more specific conceptual and clinical questions. Thus, I ultimately agree with Pukall’s (2009) simple conclusion that “what ... makes ‘sex therapy’ special is that it deals with sex” (p. 1039).

Conclusions

Just as I don’t believe that there is one narrow version of “normal” sexuality, I hope that this volume illustrates that there is no one way to be a “normal” sex therapist. There are multiple ways to be an effective sex therapist. This is important, in part, because the numbers of sex therapists are rapidly dwindling (Bancroft, 2009; Kleinplatz, 2012). The field of sex therapy

badly needs to attract clinical, counseling, and social work graduate students who are in the process of choosing their career path, as well as established mental health professionals who are looking to expand their practice in new directions. If these students and mental health professionals believe that sex therapy involves merely referring men with erectile dysfunction for Viagra prescriptions, telling women with vaginal dryness where to purchase lubricants, or training men with premature ejaculation in the squeeze technique, then sex therapy may only attract a small group of individuals who enjoy short-term, structured, and highly focused treatment approaches. These types of interventions may be an important part of sex therapy for some clinicians, but they do not reflect the range of challenging and multifaceted sexual problems that are encountered or the diverse and complicated interventions that are employed in sex therapy. Indeed, reducing sex therapy to exclusively behavioral or pharmaceutical interventions would be equivalent to reducing treatments for depression to mere behavioral activation; behavioral activation is important and often useful, but most therapists treating depression do far more than assigning behavioral homework, and some therapists may never assign behavioral homework as a treatment for depression.

When mental health professionals select to specialize in sex therapy, they need not and should not set aside their broader theoretical understanding of psychological problems, their advanced training in psychotherapy techniques, or their carefully honed therapeutic communications skills (e.g., empathy, authenticity). Those conceptualizations and skills—when combined with a genuine valuing of healthy sexuality as part of overall wellness—are essential for good sex therapy.

Therefore, I hope that this volume will provide some interesting new ideas and techniques for those who already identify professionally as sex therapists. I also hope that it will function as a starting place for students and psychotherapists who do not—or do not yet—identify as sex therapists, but who value sexual health and wellness as an essential part of general mental health and wellness and who thus hope to work better with sexual concerns as part of their general psychotherapy practice.

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