Part III
Ethics and Practice of Sex Therapy

20
Ethical Management of Sex Therapy Casework

Working with issues surrounding sexuality requires special attention to personal biases and stereotypes; management of transference and countertransference regarding sexual topics; and attaining competence in treating sexual problems. The intention of this chapter is not to provide a complete overview of ethics, but to explore a few select issues that can and do arise in the treatment of sexual problems. Of course, any time questions about ethics arise, it is always wise to consult with a colleague or supervisor, or to seek legal counsel.

MAINTAINING APPROPRIATE BOUNDARIES

The ethical and legal issue in sex therapy that most concerns therapists, supervisors, instructors, and insurance risk managers—as well as psychotherapy clients—is the inappropriate crossing of sexual boundaries. Virtually every ethics code, whether for psychologists, marriage and family therapists (MFTs), social workers, and counselors, explicitly states that sexual contact between client and therapist must never take place *during* psychotherapy. (*After* psychotherapy terminates is another matter and is discussed later in the chapter.) This is because there exists a natural power differential between therapist and client due to discrepancies in knowledge and authority. The client is dependent on the professional, who is expected to confer not only treatment, but also caring. Clients whose sexuality has been compromised in some way may be more susceptible to imagining special treatment or favor from a therapist who treats sexual concerns.

Sexual misconduct can consist of any type of inappropriate touch that is intended to create erotic or loving feelings within the relationship (Plaut, 2008). Like the patients of physicians, psychotherapy clients cannot be said to have given consent for such instances of touch. Perhaps the most insidious violation occurs when a therapist assures the client that having sex is an important part of treatment, exploiting both the caregiver and client roles for the therapist's own

gain. When sexual boundary violations occur, the consequences can be serious for both the perpetrator, who can lose his or her license, and the victim, who may suffer psychological consequences similar to those suffered from sexual abuse, that is, shame, low self-esteem, disruption of trust, and difficulty with current and future intimate relationships. Thus, when a therapist takes advantage of the power differential in order to meet sexual or relationship needs, it is looked upon with particular incredulity from ethics and licensing boards as well as colleagues.

The American Association of Sexuality Educators, Counselors, and Therapists (AASECT; 2014) has its own *Code of Ethics* that explicitly forbids sexual contact between AASECT members and their clients:

> The member practicing counseling or therapy shall not engage, attempt to engage or offer to engage a consumer in sexual behavior whether the consumer consents to such behavior or not. Sexual misconduct includes kissing, sexual intercourse and/or the touching by either the member or the consumer of the other's breasts or genitals. Members do not engage in such sexual misconduct with current consumers. Members do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of a current consumer. Sexual misconduct is also sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the member's activities or roles as a counselor or therapist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the member knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual misconduct can consist of a single intense or severe act, or of multiple persistent or pervasive acts. For purposes of determining the existence of sexual misconduct, the counseling or therapeutic relationship is deemed to continue in perpetuity. (Reprinted from American Association of Sexuality of Educators, Counselors and Therapists [AASECT])

While the AASECT Code advises that the counseling relationship is said to continue indefinitely, other codes differ. Most notably, the *APA Ethical Principles of Psychologists and Code of Conduct* explicitly states, "Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy." However, the APA later clarified that such intimacy should not take place "except in the most unusual circumstances." An example might be if an organizational psychologist were to act as a consultant to a company and then happened to meet and was attracted to someone who worked there. In other words, there is a relationship, but it is not a therapist–client relationship. In any case, the onus is on the psychologist to determine several factors that create such circumstance, including lack of exploitation; nature and intensity of the therapy; client's history; client's current mental status; and likelihood of adverse impact on the client. It is also wise to consult with a colleague or a specialist in ethics.

Similarly, the American Mental Health Counselors Association states that counselors "may not enter into an intimate relationship until five years post termination *or longer as specified by state regulations*" (italics added for emphasis). In point of fact, several states, including Texas and Minnesota, have state laws that supersede such codes and forbid sexual relationships with clients at any point in

time, even after the termination of the client–therapist relationship. Even when a relationship is carefully considered, intimate contact is never allowed.

TRANSFERENCE AND COUNTERTRANSFERENCE OF ATTRACTION

Transference and countertransference between therapist and client are generally thought to be a constant, even normative experience during the course of therapy (S. Fisher, 2004). Self-disclosure of such feelings can be therapeutic, as when the therapist expresses genuine feelings of sadness when a client is grieving, or when a client tells the therapist of his or her gladness for a therapist's help. However, a therapist's self-disclosure in regard to the development of feelings of romantic and sexual attraction is a whole other topic. On one hand, being open about attraction normalizes that such feelings do develop and can be managed without acting on them. Being open may also allow the client to discuss whether he or she has sensed any countertransference from the therapist. On the other hand, such disclosure can be a sign of an inappropriate boundary crossing. For example, in an analogue study of therapist ratings of mock scenarios in which therapists either disclosed or kept silent about their sexual feelings, disclosing therapists were seen as less expert and their therapeutic intervention as less effective than those who did not disclose (S. Fisher, 2004; Goodyear & Shumate, 1996).

Aside from issues of professionalism and therapeutic effectiveness, H. E. Fisher (2004) reminds therapists that harm to the client can take place even when actual sexual touch has not occurred—harm that can be foreseen and prevented, which makes disclosure of attraction unethical. If the sexual disclosure is unwanted, it may also be perceived as sexual harassment (H. E. Fisher, 2004; Plaut, 2008). Unless sexual self-disclosure is part of informed consent (and what therapist would risk stating in his or her policies that the therapist may disclose feelings of sexual attraction), the client cannot be prepared for such an experience.

Clients, of course, can develop a romantic transference to the therapist. Clients may confuse the open, intimate, and vulnerable nature of the relationship with the therapist as being romantic or as filling emotional needs that may be unmet in other relationships. They may instigate boundary crossings such as requesting to meet for coffee rather than in the office, making frequent contact between sessions, or openly flirting. Therapists have an ethical obligation to maintain appropriate boundaries and act with professional decorum, yet must not be emotionally distant or punitive if the relationship is to be preserved. If a therapist is struggling, then he or she may need to seek supervision or pursue his or her own psychotherapy.

What if the client is overtly sexual rather than simply flirtatious or romantic? When romantic disclosures from the client occur, the therapist may want to explore the reason for the transference and assist the client in determining how to get needs met appropriately. If the therapist feels threatened by the client's sexual behavior in any way, then it is appropriate to make referrals so that the client can obtain appropriate care with a different provider. When possible, a release of information can help facilitate understanding and treatment with the next therapist. If the sexual behavior is harmless or simply unwelcome, then it may be possible to reflect with the client about the incident to understand the meaning of the behavior, what triggered it, and how they might discuss or manage such behaviors in the future.

STEP INTO MY OFFICE . . .

Kenneth came to my office weekly for depression after having had an embarrassing first try at sex with an older, more experienced woman. Kenneth was still a virgin and had never had a girlfriend. One day, after bitterly complaining about his desire to experience sex before he died, he looked at me with a grin and patted the sofa beside him. "Dr. Buehler, we could close the blinds and lock the door. We could go for it right here, right now!"

Knowing he wasn't serious about his invitation, I chuckled. "Good try! But listen, if you can say that to me, then you can say it to someone who is closer to you in age and not your therapist!" Kenneth laughed, and then we continued to explore how he could develop his social and dating skills.

There are a variety of solutions when sexual feelings arise in therapy, but the responsibility is on the therapist to manage them, whether they emanate from the therapist or the client. If they emanate from the client, the therapist can help the client understand why they have sexualized a helping relationship and risked putting that potential help into jeopardy. The therapist can also explore what it means to have sexual feelings that cannot be acted on.

If sexual feelings originate with the therapist, then the therapist has several choices. The therapist can silently reflect on their meaning, seek supervision or consultation with a trusted colleague, or enter personal therapy. At such times, the therapist may need to especially ensure good boundaries, such as not permitting appointments after hours when the office space might be more private, or not meeting anywhere outside the office. The therapist may also need to consider whether his or her objectivity has been compromised and if a referral to another therapist is best for the client's well-being.

OBJECTIVITY AROUND ISSUES OF SEXUALITY

In order to do no harm to the client, therapists who treat sexual issues must be aware of their own biases and refrain from imposing their values on the client. Because sexuality develops in such variable ways, it is sometimes difficult to determine what cultural norms, or even generational attitudes, might prevail in any situation. In addition, stereotypes can dash a newly formed therapeutic alliance and must be guarded against. This section will explore three exemplary areas where objectivity is critical: (a) treatment of lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients; (b) treatment of clients who engage in alternative sexual practices; and (c) the use of medical interventions in the treatment of sexual concerns.

HOMOPHOBIA AND THE TREATMENT OF THE LGBTQ POPULATION

While attitudes toward the LGBTQ population have shifted over the past 20 years, there still exist cultural misunderstandings and dislike or even hatred of people who engage in homosexual sex. Ahmad and Bhugra (2010) especially note that while media portrayals, law and politics, and medicine have moved to better

serve the rights of LGBTQ people, new assumptions have replaced old—but they are still assumptions. In particular, they state that the general population may hold beliefs such as, "Homosexuals are all knowledgeable and open about sex," or "Homosexuals are hedonistic and are not weighed down by responsibilities."

Generally, people (including therapists) who are politically conservative and belong to a more fundamental religious organization with an authoritarian leader are more likely to have negative attitudes toward lesbian and gay people and less likely to support human rights, while those who are politically liberal and who belong to more open-minded religious organizations tend to have more positive attitudes and to take a position of support for the LGBTQ population (Green, Murphy, & Blumer, 2010).

The case of *Bruff v. North Mississippi Health Services* (2001) demonstrates what can occur when one's conservative religious beliefs collide with laws regarding the rights of LGBTQ people and the tenets of mental health training and services. In brief, Bruff worked as a psychotherapist in an employee assistant program (EAP) and treated a woman who identified as a lesbian. When the client stated that she wanted to work on relationship issues, Bruff told the client that because of her religious beliefs she would only work with the client on other issues. Through a series of lawsuits, the U.S. Court of Appeals for the Fifth Circuit found that Bruff's stance created a discriminatory environment and could harm a client seeking the help that was wanted or needed.

Since *Bruff v. North Mississippi Health Services, Inc.*, another case with similar impact was decided. In *Ward v. Wilbanks*, Julea Ward, a practicum student enrolled at Eastern Michigan University (EMU), refused to see a gay client on the basis that her religion did not condone homosexual behavior and therefore sought to have the case transferred to another practicum student. The counseling program told Ms. Ward that this was not permitted and offered her remedial training. Ward refused and, after due process, was dismissed from the program. An organization then filed a lawsuit on Ward's behalf, charging that the counseling program violated Ward's right to free speech and exercise of religion, among other issues.

The American Counseling Association (ACA) then became involved in the case, both to support the EMU program in following the ACA Code of Ethics that prohibits discrimination, and to address the enforceability of its code. In July 2010, Judge George Steeh ruled in favor of EMU and ACA, and against Ward. Kaplan (2014) states this case demonstrates that a counselor cannot discriminate against a homosexual client on the basis of his or her values. A counselor may only refer a client to another therapist because of a question of competence, not because of differences in values. The case also made it clear that a client becomes a client at the moment the person requests assistance. Therefore, a counselor cannot make a referral to another therapist midtreatment when the therapist discovers a difference in values.

Using Bowen's theory to analyze dynamics in the *Bruff* case, Priest and Wickel (2011) make the observation that when values differ, therapists may become anxious, causing them to fuse with the group with which they most identify and to assume those values are correct. The result is that therapists may triangulate their values into therapy. Priest and Wickel conclude that therapists must be able to differentiate themselves from such groups and focus on listening to the value of the client without judgment; the therapist's role is not to teach his or her values, but to understand the client's experience. They also advocate that faculty and

supervisors involved in training MFTs in particular engage in "Biblical tolerance" by familiarizing themselves with readings focused on acceptance; emphasizing acceptance and empathy for those who are different; emphasizing secular laws that protect gay rights; and familiarizing trainees with the LGBTQ population by giving them reading assignments on LGBTQ issues, addressing diversity, and working with diverse clientele in all coursework.

Therapists as well as trainees would also do well to heed what Israel, Gorcheva, Walther, Sulzner, and Cohen (2008) labeled as "helpful" and "unhelpful" attitudes and behaviors in the treatment of LGBTQ clients. Helpful interventions included development of gay-affirming attitudes; understanding homophobia, both within themselves and the client; not focusing on the client's orientation unless the client expresses concern; and being aware of community resources for additional support. Unhelpful interventions included seeing homosexuality as a disorder; attributing all the client's concerns to his or her orientation; lack of knowledge about the process of coming out; and expressing demeaning beliefs about homosexuality.

THE ETHICS OF TREATING CLIENTS PRACTICING ALTERNATIVE SEX

One factor that prevents therapists from engaging in treatment of sexual problems is fears about working with people who identify as kinky. Although there is not much research on the topic of the ethics of treating this population, there are a variety of professionals who are recognized for their expertise, for example, Kolmes, Stock, and Moser (2006), in Moser and Kleinplatz (2006) and others. Working with such clients can push therapists to recognize their own limitations and boundaries. If a therapist is to do no harm, then he or she must not treat someone from the kink community if the therapist does not have appropriate training and supervision. In such cases, referrals may need to be made in a way that does not shame the client, such as transparently disclosing one's limitations, similarly to what one might do if faced with a client who has an eating disorder or other problem that the therapist does not normally treat. A therapist might state something such as the following: "I hope you don't find offense in this, but I don't think I am knowledgeable enough to give you the best help. May I refer you to someone who has better knowledge and training?"

Sufficient training to treat people who practice alt sex does not mean knowing someone who practices bondage, watching kinky porn in one's off hours, or having read *50 Shades of Grey*. It means reading professional literature, taking coursework, and finding an appropriate supervisor with whom to discuss such cases. Kolmes et al. (2006) describe "helpful" and "unhelpful" strategies for working with BDSM clients in particular. (The acronym BDSM commonly stands for *bondage, dominance, and sadomasochism*, while those who are more knowledgeable may state that BDSM stands for *bondage and discipline, domination and submission, and sadism and masochism*.) Helpful behaviors include being open to reading and learning about BDSM, asking more experienced therapists questions about BDSM, working with the client to overcome internalized stigma of practicing kinky sex, and ensuring the client is practicing "safer, sane, and consensual" BDSM. It is also critical to focus on the behavior and not the objects or details, or as one colleague stated to me, "Poop or shoes, the therapy is the same." Unhelpful strategies include not understanding that BDSM practice requires consent, not

maintaining one's own boundaries (e.g., disclosing one's own kinky practices to the client), abandoning clients who engage in such behavior, assuming (and rooting around for evidence of) past abuse, shaming or judging the client, and "expressing a prurient interest" in the client's sexual practices.

SEXUAL MEDICINE: BLESSING OR CURSE?

Before the dawn of Viagra®, sexual problems were considered to be largely psychological in nature, treated with behavioral or psychodynamic therapy, or both. The creation of phosphodiesterase type 5 (PDE5) inhibitors generated a flood of direct-to-consumer ads and record sales of prescription medication. Next came the supposition that if older men could now easily have an erection by taking a pill, older women might benefit from medication to generate sexual desire in order to keep up. Thus began research for Intrinsa, a low-dose testosterone patch for women. This spurred scholar Tiefer (2001) to create a proclamation called the "New View," in which low sexual desire is viewed as being simply a normal variation among people and the pharmaceutical industry is described as "disease mongering."

The testosterone patch for women never passed the Food and Drug Administration's (FDA) restrictions in the United States, but an oral medication for low desire for women, Addyi® (flibanserin) was approved in October 2015. Prior to its approval, a similar argument was made that the drug company was profit-driven, creating a medical response to a nonmedical problem. Addyi was problematic for another reason: It can cause severely low blood pressure and, though very rare, fainting if taken with any alcohol. When prescribed Addyi, a woman must be counseled and make a solemn promise not to drink while on the medication. Beyond that, some feared that Addyi could be employed as a date rape drug because of this interaction with alcohol.

Another concern regarding the medicalization of sexual problems is the currently accepted belief that being sexually active equates with good health (Segal, 2012). Segal especially discusses that cancer survivors are often portrayed as needing to embrace their sexuality even though they are perhaps at their least attractive and energetic. Likewise, Tiefer (2012) points out that a plethora of books by celebrities and self-proclaimed experts depathologize sex, but also make the case that in order for a person to be considered normal, he or she must engage in sexual activity. This creates high expectations leading to sexual discontent, perhaps provoking people to seek various therapies, both medical and nonmedical, which may be unnecessary.

Conversely, in an editorial on the need for biological treatments for sexual problems, Kingsberg and Goldstein (2007) assert that "[n]eedless to say, it is wrong to make a woman feel diseased or defective just because she doesn't feel a certain way, but it is just as wrong to discount a woman's distress when she presents with hypoactive sexual desire and wants to be treated." A similar argument (Bedor, 2016) exists regarding Osphena® (ospemifene), a nonhormonal oral medication for treating vaginal dryness and painful intercourse associated with menopause. Bedor asserts that this may be a "pharmaceuticalization" of a culturally derived symptom, as women in cultures outside the United States don't complain as frequently of vaginal atrophy during menopause. But what of the American woman in menopause who wants to but cannot engage in penetrative sexual activity because it hurts? Is she to be told that the best course is to accept

her naturally aging body and cease to have intercourse because women in other countries seem to cope differently or better?

As the debate regarding the medicalization of sexual problems continues, the ethical, helpful position of the therapist is to listen to the client's complaint, explore what has been tried to date, and to help the client understand the meaning of using medication to achieve his or her goal. Confronting the client with one's own philosophy regarding "disease-mongering" or withholding knowledge regarding sexual medicine is likely unhelpful. If medications have proven to be disappointing, then the aim may not be to tell the client to stop his or her use, but to explore why the medications did not work. Nondrug interventions can be added to a medication regimen, or may be efficient without medication. Also helpful is to identify whether the client holds realistic expectations about sexuality given his or her age, circumstances, or health status, and to help the client come to terms with those goals that cannot be achieved. Finally, decisions about the appropriateness of medical treatment are best made in conjunction with a physician, and not by the therapist who has no medical training.

MANAGING SECRETS IN CONJOINT THERAPY

The final ethical issue for exploration is coming to terms with the divulgence of secrets in marital therapy. Since much of sex therapy is conducted with couples, therapists need to ensure that they are prepared to handle certain disclosures in order to prevent harm, that is, as when one partner is involved in another relationship without consent of the other. The legal and ethical need to maintain confidentiality sometimes collides with the need to keep communication open in couples therapy (Butler, Rodriguez, Roper, & Feinauer, 2010; Kuo, 2009). Butler et al. (2010) make the case that power and control shift when the therapist holds secrets for one partner. It may also prevent the betrayed partner from making an "empowered decision." Additionally, the therapist needs to consider the effect if he or she chooses to keep secret a disclosed affair, for example, and then it is later learned by the other partner that the therapist knew about the affair all along.

On the other hand, learning about an affair has been known to create posttraumatic stress disorder (PTSD)-like symptoms for the betrayed partner (Lustermann, 2005). Pittman (1989) and Abrahms-Spring (1996) in Butler et al. (2010) maintain that disclosing an affair may lead to divorce, which is by many therapists considered to be an antithetical goal of couples therapy and which may cause more harm than good.

What is the ethical approach to maintaining confidentiality? Kuo (2009) observes that therapists differ in their approaches to holding secrets and identifies four basic models: (a) no secrets held; (b) secrets held unless there is an explicit release of information; (c) secrets held with identified exceptions, for example, extramarital affairs, contagious diseases, and terminal illness; and (d) secrets held at the therapist's discretion. Each model has its drawbacks. For example, if the therapist will not hold any secrets, one or both clients may feel inhibited from sharing material that is essential to healing. If the therapist takes it upon him- or herself to determine which secrets to disclose, then the balance of power may shift to the therapist and make therapy less effective. Finally, if the therapist determines that a secret needs to be shared, who has the responsibility

to share the information, and what might its effect be, depending on the party who is chosen to disclose?

Therapists sometimes choose to conduct what Butler et al. (2010) term *facilitated disclosure*, helping the client who disclosed the secret to the therapist to talk about it with his or her partner in the next conjoint session. Therapists may also choose to give the client who disclosed time to stop the behavior in question. Alternatively, the therapist can tell the individual who disclosed that if he or she doesn't share the information, the therapist will disclose and refer the couple out. Finally, the therapist may not share the information but make the referral nonetheless because he or she believes the therapy has been compromised and rendered ineffective.

STEP INTO MY OFFICE . . .

One of my initial sex therapy cases turned sour quickly because I had not developed a policy regarding disclosure of secrets. I met with a conservative Egyptian couple that had not consummated their marriage because he had erectile dysfunction (ED). I determined to split the second session to get more history and met with the male partner first. He immediately disclosed that he was gay but that I could not, under any circumstances, tell his wife.

I realized that I had created an ethical conundrum for myself and took a minute to reflect. Since I could no longer be objective, nor truthful to the wife, I told the client that unless he disclosed, I could not continue couples therapy. He declined. I called his wife back into the treatment office and stated, "I have some critical reasons that I will not be able to treat your case. I am going to give you three referrals to other therapists who may—or may not—be able to help." After that, I developed a "no secrets" policy that I modify under some circumstances, for example, if someone has a sexual behavior his or her partner knows about but doesn't want to hear details about, or if a partner once engaged in sexual behavior that has no bearing on the present relationship.

TAKE-AWAY POINTS

1. Therapy *never* includes sex, and it is the therapist's responsibility to ensure that sexually inappropriate touch and/or innuendo does not occur.
2. Natural transference and countertransference develop in most all therapeutic relationships. At times, it can be helpful to process a client's romantic or sexual feelings toward the therapist. But if the client's feelings become a threat to the therapist, the therapist can refer the client to a new therapist. If the therapist's feelings become romantic or sexual toward the client, then the therapist must take care to do no harm and possibly seek therapy or supervision.
3. Therapists may not discriminate or make referrals on the basis of religion—only on the basis of expertise or lack thereof.
4. Sexual medicine is controversial, but ultimately it is not the therapist's task to influence a client regarding the use of medication to improve sexual function.
5. Therapists differ in their policies about keeping secrets in couples therapy, from not keeping any secrets to using clinical judgment to make decisions about what secrets must be shared, for example, when one partner discloses a contagious disease. One ethical consideration is that when the therapist and one partner have knowledge that the other partner does not, the unknowing partner cannot make an "empowered decision" about the relationship.

ACTIVITIES

1. Reflect on times in your practice when you may have been sexually attracted to a client. Are you satisfied with how you handled the situation? What changes might you make to how you approach your countertransference? Have you identified a trusted colleague, supervisor, or therapist with whom you can process your feelings?
2. Reflect in the same way on times a client expressed or you sensed a client's attraction to you.
3. What kinds of biases do you hold regarding working with people who are LGBTQ, working with those who practice alt sex, or regarding sexual medicine? How might you work through these biases?
4. If you have not done so already, develop a policy regarding secrets in couples therapy.

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21

Sex Therapy: Now and in the Future

Sex therapy is often distinguished from other types of psychotherapy as being specialized strictly in the treatment of sexual issues. This is unfortunate, because sex therapy covers the broad spectrum of human problems and experiences. Our sexuality can touch almost any aspect of life, with minor or profound effects. Our self-esteem, our relationships with others, our perception of life as being joyful or dismal, can all depend on our sexuality. Thus, it is erroneous to think of sex therapy as being limited. The therapist who does sex therapy needs to be a good diagnostician, excel at quickly developing rapport, and have adequate training in treating couples as well as individuals.

Therapists who include treatment of sexual problems must also be adept at several different theoretical approaches. When Masters and Johnson conceived of sex therapy, it was mainly a behavioral approach to treating distinct sexual problems. Later, Kaplan added a psychodynamic perspective. Weeks (1987) furthered treatment possibilities by combining sex therapy with family systems theory, encouraging therapists to examine underlying relationship dynamics to expose contributing factors. Most recently, with the advent of medications such as PDE5 inhibitors, sex therapists must understand the biology of sexual dysfunction in order to stay abreast of pharmaceutical and other therapeutic treatments. In short, sex therapy is a broad, evolving field, changing not only in theoretical outlook, but also with the evolution of society and its mores.

As it currently stands, for most clinicians the path to becoming a sex therapist is long and complicated; each therapist comes into the field by following a unique path. Though a handful of schools have degree programs specialized in sexuality that lead to a master's or doctorate degree and licensure (e.g., Widener University), nearly all those who want to be a sex therapist will need to avail themselves of a more general degree. The choice of whether that degree is in marriage and family therapy, professional counseling, social work, or psychology is an individual one, as is whether one wants to practice at the master's level or go the distance of getting a doctorate.

My own path may inform some readers. I earned a Master of Arts in Psychology and then applied to earn a Doctorate in Psychology (PsyD) with an emphasis on family therapy. Within that emphasis, I chose to concentrate on medical family therapy. At that time, I had no thought of specializing in sex therapy, but I ensured that I trained and was employed in settings where I would work not only with children, but with adult couples. I am glad that I did; although I was certain I wanted to work with children, once I was in private practice I changed my mind for the simple fact that I wanted to save all of my "kid energy" for home, with my own child.

My specialization in medical family therapy led me to work with an endocrinologist, and together we formed a wellness center that included a physical therapist, dietitian, and acupuncturist. Endocrinologists are physicians who specialize in diseases and conditions affected by hormones, which naturally include those concerning sexual health. It was the endocrinologist who suggested that I learn about sex therapy, because while people frequently came to her complaining of low libido, it was rarely because of hormone imbalance.

This piqued my interest! Sex therapy perfectly combined my interest in medical conditions and family systems. But I was at a loss as to how to acquire the education and training I needed to practice ethically. Through an Internet search, I found the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) and attended my first conference in Portland, Oregon. I felt electrified by the atmosphere, the camaraderie, and the workshops, and a sense that I had found my "tribe." At some point I determined that I wanted to acquire certification and found a mentor, supervisor, and friend in Stephen Braveman, a marriage and family therapist in private practice, to help me. I have been on the path of sex therapy practice for almost a decade and have never had a moment of regret. Sexuality is infinitely interesting, and there is much work to be done.

PROBLEMS IN THE FIELD

Conducting sex therapy, however, also carries stigma. As discussed in Chapter 1, whenever sex is the topic of conversation, red flags may be raised. There are other less obvious reasons for concern, however. Sex therapists have been asked to or may seek to be in the limelight. Often they are sincere in their wish to educate the public, but even when well-intended, their media appearances may seem self-serving or gratuitous, making the profession appear lightweight or frivolous. Sex therapists also put a great deal of emphasis on the importance of sex, rather than correctly locating it as but one aspect of overall mental health and well-being. Through their own doing, or through the manipulation of the media, talking about sex becomes just another form of entertainment, part of the noise in the background rather than focusing on the message that "good enough sex" (Metz & McCarthy, 2010) is just that—good enough.

It is my belief that every therapist needs to be able to treat sexual problems, and that only the clients with the most complicated issues see a specialist. Sexuality should not be viewed as a frill, but as a legitimate aspect of mental, emotional, physical, and relationship health. Nor should sexuality be marginalized as a side issue to be dealt with at the end of therapy, as if a

dollop of healing is all that is needed for remedy. Therapists need to proudly embrace their ability, among all other professionals, to help people repair the places where they may be the most deeply and privately broken. Therapists alone have the skills, the time, and, hopefully, the compassion to treat sexual problems.

THE PRACTICE OF SEX THERAPY

One decision to make is whether doing sex therapy will be a major or minor part of your practice. It is truly up to you to decide how far you want to treat people's sexual concerns when they arise. The point of asking about sexual concerns is to identify any confounds that may inhibit the treatment of the presenting or identified problem. If clients endorse such concerns, then you can follow the Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT) model to provide information and suggestions; in the case of complex cases, refer out for intensive therapy.

If you wish to stay within the information and suggestions part of the PLISSIT framework, then you will need to have lists of resources for your clients. Such resources may include handouts from this book and others, as well as from the Internet; titles of self-help books; names of physicians who treat sexual problems of various types; and community resources, for example, a contact at the nearest lesbian, gay, bisexual, transgender, or queer (LGBTQ) center.

You will also want to acquaint yourself with nearby clinicians who identify as sex therapists. You may find that some only work with couples, some only with women, and some only with the LGBTQ population. Be sure to let them know your specialty, whether it is treating substance abuse, eating disorders, chronic illness, and so forth, so that you can cross-refer.

If you are intrigued enough to make sex therapy a bigger part of your practice, venturing into doing intensive therapy, then I am going to transparently state that reading this book is not enough to put out your shingle. Unless you are one of the very, very few individuals who are completely comfortable with the topic of sex, you are going to need support.

"Support" does not refer only to a consultant or supervisor. It also refers to emotional and collegial support. Many therapists who practice sex therapy report feeling marginalized, misunderstood, or isolated. Discomfort with sex is so great that sex therapy is stigmatized, especially in smaller, more conservative communities. That is why belonging to an organization that serves sex therapists can be a critical part of one's development. A list of such organizations appears at the end of this chapter.

Will you keep the fact that you do sex therapy something you share only with colleagues in order to get referrals, or will you market yourself to the public as such? Marketing to professionals has the advantage that stigmatization may be minimized and your colleagues in essence are prescreening some of your clients as being appropriate for sex therapy. A disadvantage is that your community may benefit from marketing your services. There are several states, such as Montana and Wyoming, where there are no AASECT-certified sex therapists. People who truly need services may not get the therapy they need or may travel long distances for help.

MARKETING YOURSELF AS A SEX THERAPIST

If you decide to take the steps to be able to conduct intensive therapy, and if you wish to market your services to the community, then you will need to market yourself. Some therapists are nearly as afraid of marketing as they are of sex! They may see marketing as cheapening their profession or as being counterproductive to one's aim of helping people. Marketing is not a bad word! Marketing allows people to identify you as someone who can give them the help they need.

Aside from the common ways therapists currently market, for example, with a website and through directory listings, there are a few other means to get the word out that you do sex therapy. One of the most critical is making referral connections with physicians. Not only do they need you, but also you need them so that you can appropriately refer your clients for medical evaluation. Were I to begin this type of marketing, I would follow these steps:

1. Identify various types of physicians who provide services your clients need, especially urologists and gynecologists.
2. Send out three to five letters at a time to physicians introducing yourself and your practice.
3. Follow up your letter with a phone call and, potentially, a visit. Ask to speak to the practice manager, who may either meet with you or facilitate a meeting with the physician.
4. When and if you do meet with the physician or someone else in the office, ask how you can help that individual with his or her clients who have sexual complaints.
5. After the meeting, follow up with a thank-you letter. Be sure to ask for some of the physician's cards, too.

It really isn't that difficult. Remember, you are not asking for referrals—you are offering a service to a busy physician.

A second way is through appearances in the media. It isn't as hard as you might imagine. Start by making a list of local or cable television and radio programs that invite live guests. Make a list also of journalists at the local paper who write about science and health. You can include college media as well. Let them know who you are and some topics you are able to cover. You may not hear anything right away, but it is perfectly acceptable to follow up when you have a quote on a relevant story. For example, it was recently the 10th anniversary of Viagra®; local media might have been interested in interviewing you on how this medication has changed the public's view of sexuality. One important ethical consideration: Reporters often contact therapists to obtain clients for them to write about. Don't; if the story is unflattering, it can create an irreparable rift in your relationship. Worse, it can result in a complaint to the licensing board.

CONTINUING EDUCATION

Sexuality is a fluid topic. New ideas and information are constantly being discovered. How we understand sexual development, behavior, and function both expands and deepens. Any mental health professional who works with

sexual concerns needs to stay current in the field. There are multiple conferences and journals to serve that purpose. They are listed in the "Resources" section as well. Ongoing consultation is also an important part of being able to competently treat clients' sexual concerns. Because sexual problems develop in private, they can be particularly difficult to understand or off-putting. Consultation can help the therapist maintain an appropriately nonjudgmental and compassionate stance.

IN CLOSING

For well over a decade, I have devoted my career to treating people with sexual concerns. I have never been bored. Sex can be sad, funny, perplexing, disturbing, endearing, loving, and enraging. Sex can bond two people like nothing else. It can be a form of entertainment and stress relief. Sex can become a journey of self-knowledge, an understanding of one's body and capacity for pleasure that can be achieved in no other way. It can be self-affirming, life-affirming, and life-giving. Sex is a beautiful thing.

By reading this book, I hope I have inspired you to become a therapist who "does sex." I hope that in 10 years' time, people will no longer be referred to me because their therapist refused to help them with a sexual problem. It has been my pleasure to fulfill part of my mission to help every therapist be comfortable with sexual concerns by writing this book. May you embark on a journey to your own sexual wellness, as well as the sexual wellness of your clients.

TAKE-AWAY POINTS

1. Coming full circle, therapists need to recognize that sexual problems are very common and should be prepared to help clients overcome them.
2. Complicated cases can be referred to specialists in sex therapy. Becoming a specialist in sex therapy will generally require additional education, training, and supervision.
3. It is beneficial to market to physicians and the public and let them know that there is help available for distressing sexual problems.
4. Congratulations on becoming a sex-positive therapist.

RESOURCES

SELECTION OF SEXOLOGICAL ORGANIZATIONS

American Association of Sexuality Educators, Counselors, and Therapists (AASECT): www.aasect.org
International Pelvic Pain Society: www.pelvicpain.org
International Society for the Study of Women's Sexual Health: www.isswsh.org
Society for Sex Therapy and Research (SSTAR): www.sstarnet.org
Society for the Scientific Study of Sexuality (SSSS): www.sexscience.org

SELECTION OF SEXOLOGICAL JOURNALS

Archives of Sexual Behavior: http://link.springer.com/journal/10508
Journal of Sex & Marital Therapy: http://www.tandfonline.com/toc/usmt20/current
The Journal of Sexual Medicine: http://www.jsm.jsexmed.org
Sexual and Relationship Therapy http://www.tandfonline.com/toc/csmt20/current
The Gay and Lesbian Review Worldwide http://www.glreview.org/about

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