Second Edition

What Every Mental Health Professional Needs to Know About Sex

Stephanie Buehler
WHAT EVERY MENTAL HEALTH PROFESSIONAL NEEDS TO KNOW ABOUT SEX
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SECOND EDITION

STEPHANIE BUEHLER, PsyD, CST-S
I dedicate this book to my husband
Mark—without your support this work would not be possible.
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Foreword

When I speak at colleges on the topic of sex, I often start by asking students in the audience “How many of your parents told you what a clitoris is when you were growing up?” In an audience of 300 students, perhaps five will raise their hands. When I ask, “How many of your parents explained to you what masturbation is or told you what orgasms are?” ten or fifteen hands will go up. These are students at some of the top colleges who were raised by some of the smartest parents on the planet during the 1990s—not the 1950s.

When parents are not comfortable giving their children words for some of the most powerful physical and emotional experiences they will have in life, a veil of secrecy is created around the subject of sex that children carry with them into adulthood. This is why there is such a great need for a book like What Every Mental Health Professional Needs to Know About Sex. It doesn't matter if the therapy we do is cognitively based, psychodynamic, interpersonal, or experiential, this book explores aspects of sex that are essential for therapists of all orientations to know.

Sex is an important part of most people’s lives, yet few mental health professionals receive any instruction about sex other than learning how to report suspected abuse. As a result, we aren’t always comfortable talking about sex and sexual pleasure with our patients. Although reading this book won’t turn us into Kinseys or Masters and Johnsons, it will help us to relax more and to listen better. And that, in itself, is an important accomplishment, regardless of how much or how little familiarity we have with sex education and sex research.

I have written a 1,200-page book on sex that is used in dozens of college and medical school sex-education classes. I have also read countless studies on sexual orientation, gender, pornography, paraphilias, sexual pain, low sex drive, high sex drive, casual sex, pedophilia, and the physiology and neurology of sexual response. Yet when I am with a patient or when a fellow mental health professional is consulting with me about a patient’s sexual issues, the most important thing I can do, besides being kind and caring, is to listen without making judgments. This is not always easy when you are raised in a culture with no shortage of shame-based messages about sex.

For example, consider our perceptions about women versus men when it comes to casual sex. Few of us would haul out our DSM-5s when a male informs us he has had 10 or 15 lifetime sexual partners. But if a woman has had 10 or 15 partners, or 20 or more, many of us would assume she was abused as a child, or
she’s bipolar or borderline, or she’s a “sex addict.” And what if she enjoys having threesomes, or she asks her partner to spank her or to act out rape fantasies? What if she wants sex way more than her partner does?

This book was written by a highly experienced and sensible mental health professional who encourages readers to listen and think rather than to automatically pathologize or apply assumptions about sexual behavior that are 50 years out of date. It reminds us that sexual behaviors that could reflect a psychological struggle for one person might reflect psychological health for another. One of our jobs is to evaluate which is which.

One of the biggest challenges we face in evaluating sexual behaviors is how multifaceted sex can be. Sexual feelings often begin as an erotic tension somewhere within our psyche or soma. They are then sifted through the labyrinth of our cognitive, cultural, and religious beliefs. When something is going wrong sexually, there are multiple layers where the problem can reside. I can't imagine trying to help a patient sort through sexual issues without knowing what Dr. Buehler explains in the pages that follow.

And finally, I want to caution you about the current state of sexual knowledge and sexual research: Our knowledge of human sexuality remains elementary. Researchers are still struggling to define what women’s sexual orientation is and how it develops over the life span. Several of the top researchers are questioning the validity of the state-of-the-art fMRI brain studies about sexual behavior that the media loves to sensationalize and therapists love to quote. And it’s difficult to know if studies about sex and relationships apply to anyone besides the students in college psychology courses who are getting extra credit for participating in them.

Fortunately, we have Dr. Stephanie Buehler’s very thoughtful, approachable, and well-written book to help us with this process.

Paul Joannides, PsyD
Author of *Guide to Getting It On!,* Eighth Edition
Preface

When I began the first edition of *What Every Mental Health Professional Needs to Know About Sex*, psychologists in California were required to have just 10 hours of instruction in human sexuality before sitting for the licensing exam—and nothing has changed since. Frankly, 10 hours just isn’t enough to learn anything of value. I know I certainly didn’t learn much of anything in those 10 hours, except that there were some mighty peculiar old sex therapy education films, and that many therapists in attendance with me were squeamish about sex. I wasn’t squeamish at all. I grew up in a liberal household in Los Angeles during the sexual revolution. Nothing offended me. But if I was going to hang out my shingle and treat sexual problems—after it was suggested by an endocrinologist with whom I worked—I was in sore need of education and training.

Like many psychotherapists—who tend to be an introverted bunch—my first stop was to do some background reading. I chose a book online and as soon as it arrived I sat down to read, highlighter in hand. It wasn’t long before I closed the book, my mind reeling. It wasn’t because there was anything wrong with the writing itself. All of the contributing authors appeared to know their topic well. However, I still had no sense of “This is how to do sex therapy.” I felt rudderless, adrift in a sea of technical language, with bits and pieces of various theories floating past like flotsam and jetsam.

Perhaps joining an appropriate organization might help me, I reasoned. I joined the American Association of Educators, Counselors, and Therapists and learned they had a certification process that included education and supervision. I chose Stephen Braveman, MFT, as my supervisor, and through his patient guidance and generous spirit (he sent me away with a duffle bag of materials on human sexuality), I began the 2-year trek to learn all I could to be an effective sex therapist.

Along the way, I received an entirely different education. First, colleagues and other professionals questioned my choice to become a sex therapist. Wouldn’t I be dealing with pedophiles and other pariahs? Second, some confused me with a sexual surrogate, a type of person who operates under the legal radar to teach people about their sexuality in a way that a professional license prohibited, for example, touching clients or having them examine bodies, both their own and that of the surrogate. Third, it struck me again and again how ludicrous it was, with all my education, that none of my college professors at the graduate level had ever really talked about sex. Why didn’t I know anything about the connection
between eating disorders and sexual problems? How come I had never heard of painful sex and what to do about it? Didn’t I need to know how to assess persons who had been sexually abused about their current ability to function normally in their adult relationships?

Additionally, I began to pay attention to what clients said when they found my services. If they were referred by another therapist, it was often because the therapists “didn’t do sex.” If they had been in therapy but were self-referred, it might be that they felt the therapist would be uncomfortable if they brought up the topic. Others were in therapy for years, but since the topic never came up, they never said anything. It was only when they realized that all the time and money they were spending had zero effect on their sexual pleasure that they searched for someone who would help them with the “real” problem.

I held two feelings about this. On the one hand, I was happy that I received appropriate referrals. On the other, I was upset that other therapists added to the clients’ shame about sex. By refusing or neglecting to ask about a client’s sex life, therapists reinforced the cultural message that “nice people don’t talk about sex.” But if people (nice or not) can’t talk about sex in the therapist’s office, where can they talk about it? Clearly something needed to change.

Back I went to thinking about my own evolution as a therapist. Information about treating sexual problems, I knew, was difficult reading. Few of the books take the therapist by the hand and lead him or her through the entire process of assessment and treatment from the moment of the intake call through termination. None of them deal with one of the most important issues of all: the sexuality of the therapist. Unless the therapist is comfortable with sex, there would be no discussion of the topic in the therapy office. That fact alerted me that if I were to write a book on how to do sex therapy, I needed to start there, with helping the reader to make sense of what sexuality is and how to understand one’s own development, experiences, thoughts, attitudes, and beliefs about sex.

In your hand or on your screen, you have the text I envisioned for every therapist to have as a graduate textbook or as a reference on his or her bookshelf. Whether you want to embrace sex therapy as a niche for your practice, or you want to be a therapist who “does” sex, my hope is that What Every Mental Health Professional Needs to Know About Sex will be a clear, pragmatic entrance into helping clients of all kinds resolve sexual concerns—a boat of sorts to help you navigate what can be a confusing area of human experience. I also hope that it will become a book you can turn to again and again when a client presents with a sexual concern to remind yourself that there exists an approach and information to calmly tackle common, and uncommon, sexual problems.

Human sexuality is perhaps one of the most complicated topics on the planet. Shrouded in secrecy, regulated by religion and law, and assigned meanings from original sin to the ultimate expression of sacred joy, sexuality can perplex even the wisest therapists. Yet, sexuality is often ignored in graduate programs in psychology, marriage and family therapy, and social work. As I offer online continuing education programs in sex therapy, I have corresponded with therapists in nearly every state and internationally, all of whom report that their training in sex therapy was inadequate.

What Every Mental Health Professional Needs to Know About Sex is a straightforward, plain language textbook designed to take the therapist who knows very
little or who might be uncomfortable about sex to a place of knowledge and competence. To accomplish this, Part I: The Courage to Treat Sexual Problems begins in Chapter 1 with a rationale regarding the reasons why all mental health professionals need to be able to address clients’ sexual concerns, especially the fact that our current social climate has raised clients’ expectations about pleasure. In Chapter 2, the reader will find a model of growth in becoming more comfortable with sexuality—both his or her own and the client’s. Psychosexual development and the physiology of sex are covered in Chapter 3, while Chapter 4 covers the recent history of the field of sexology and definitions of sexual health generated by various experts and organizations.

Part II: Assessing and Treating Sexual Concerns begins in Chapter 5 with an introduction to the sexological ecosystem, a framework for understanding a client’s past sexual history and current symptoms. The sexological ecosystemic framework, based on the work of Bronfenbrenner (1977), is an expansion of the biopsychosocial model as it includes interactions between and among systems, which is helpful since about half the clients presenting for treatment are couples. A thorough sexual assessment is included to use when it is determined that the presenting problem will require more intensive work. Annon’s PLISSIT model is also provided, as it guides the professional in deciding whether the presenting problem will benefit from information and suggestions, or if more intensive, long-term therapy will be required.

The next two chapters cover women’s, and then men’s, common sexual complaints as they pertain to the individual, including her or his biological makeup, development, relationship, and culture. Although omitted from the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013), Chapter 6 covers sexual aversion, a problem that occurs in both men and women. Chapter 7 includes delayed ejaculation, a problem once considered rare but is on the upswing, perhaps because expectations regarding sexual performance as men age also have increased. Both chapters include informational worksheets for the client’s—and therapist’s—benefit.

Addressing common sexual problems in couples explodes the myth that by fixing the couple’s relationship, their sex life will automatically improve. In fact, even couples that get along sometimes have sexual problems. As the therapist will learn in Chapter 8, whether the relationship is blissful or chaotic, most couples benefit from good sexual information; improved communication about sex; encouragement to explore the boundaries of sexual pleasure; and suggestions to help them. The most common problem is a discrepancy in sexual desire, which requires the therapist’s problem-solving skills to help the couple to stop blaming one another and learn how to derive solutions when the problem is sex.

Chapter 9 includes material I have not yet seen in any other book for therapists on the topic of treating sexual complaints: helping parents address their concerns about their children’s sexual development and answering their children’s questions about sex. The chapter also provides a framework as to when to refer to a specialist for evaluation of atypical sexual behavior or development. The entirety of Chapter 10 is devoted to understanding the needs of LGBTQ clients who may, ironically, have suffered because of their parents’ lack of information about sexual orientation. A new model for understanding the sexuality of a “questioning” client is also included.

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Good mental health is essential to good sexual health, while mental illness can contribute to sexual dysfunction. In turn, feelings of guilt, shame, and sexual inadequacy can sometimes lead to mental health problems. In 2010, I wrote a groundbreaking book entitled *Sex, Love, and Mental Illness: A Couple’s Guide to Staying Connected* in which I addressed the effects of depression, anxiety, substance abuse, eating disorders, ADHD, and other disorders on the individual’s ability to function sexually and in a relationship. Chapter 11 is a broad summary of this review of the literature, while Chapter 12 provides an in-depth guide to understanding and treating sexual problems in adults related to sexual abuse experienced as a child or teen. An additional section on military sexual trauma has been added to this edition.

Chapters 13 through 17 are related in that they each cover an aspect of sexuality that is intimately tied to biology. Chapter 13 covers the effects of pelvic and genital pain on sexuality in women (Genito-Pelvic Pain/Penetration Disorder) and men. These conditions affect large numbers of people that sometimes have difficulty finding appropriate treatment, which adds to their suffering. In Chapter 14, therapists will learn what happens when recreation meets procreation, or how sexuality is affected by infertility. Sexuality can also be affected by all kinds of medical conditions, from diabetes to spinal lesions and paralysis, which is the topic of Chapter 15. Chapter 16 is entirely new, and its focus is on sexually transmitted infections (STIs). Finally, the effects of aging on sexuality and relationships, including in nursing homes, are the topics of Chapter 17.

Rounding up Part II, Chapters 18 and 19 explore what happens when people traverse conventional or expected boundaries. Chapter 18 covers legal, consensual alternative sexual practices. Whether a person has a sexual interest in spanking or shoes, he or she may need all kinds of care and support from kink-aware therapists, from absolution from his or her shame, to helping someone accept and perhaps participate in his or her partner’s erotic life—even if the person doesn’t fully understand it.

Chapter 19 is on out-of-control sexual behavior, primarily on the Internet. Though sexual images have seemingly been in existence since ancient cultures constructed phallic and other fertility-related symbols, there has been an explosion in sexual imagery of all kinds. The enormous availability and variety of pornography has both helped (people can indulge in fantasy material in private, such as looking at people having sex while wearing latex or furs) and hurt in that viewing pornography may drain sexual energy away from a primary relationship.

*Part III: Ethics and Practice of Sex Therapy* contains Chapter 20, which covers ethical challenges of working with people who have sexual concerns, including boundaries regarding touch; managing romantic or sexual transference and countertransference; handling secrets in conjoint therapy; and special topics such as treating people whose sexuality differs from one’s own and the effects of the field of sexual medicine on sex therapy. Finally, Chapter 21 ends the book with a look forward toward the future of sex therapy and the integration of sex therapy into one’s practice.

As with any book, there were some challenges presented. One challenge was the unwieldy term *mental health professional* used in the book’s title. Rather than shortening the term to *MHP*, which seemed impersonal, I most frequently use the
term therapist to refer to the variety of people working in the helping profession. Both mental health professional and therapist refer to psychiatrists, psychologists, psychiatric nurses, social workers, marriage and family therapists, and professional counselors, including those medical providers who discuss sexual problems with their patients.

Another challenge has been, as a cisgender (i.e., not transgender), heterosexual, White, monogamous, middle-aged female-identified person, to ensure that I have been inclusive of sexual minorities—gay, lesbian, bisexual, or other, and male, female, transgender, or other. I, and my family of origin, have always been an ally of diverse populations, whether religious, cultural, or sexual. If I have misspoken, demonstrated a blind spot, or excluded or misrepresented any group, it was unintended. In the spirit of learning, please use these instances as opportunities for productive discussion.

A related challenge was the use of gendered pronouns. As much as possible, I have used the word partner rather than man, woman, husband, wife, and so forth. Although gay, lesbian, bisexual, transgender, and queer (those individuals who do not identify strictly as male or female, or who question their orientation) roles and relationships are not strictly analogous to traditional heterosexual experiences, I have drawn from my clinical observation in classifying some components of all erotic relationships as being universal. Sexual desire, arousal, and orgasm are not exclusive to any group of people, and when two people hold one another as special and dear, it is nearly always called love.

A fourth challenge is culture as it relates to sexuality. In some areas, as with infertility, there exists a decent body of literature about the effect of culture on sexual beliefs or behaviors. In others, such as paraphilias, almost nothing has been written, although it can be assumed that an individual from a conservative family and culture may have different feelings about having a fetish than one from a more open and permissive culture. Fortunately, there exists online a tremendous resource, The Continuum Complete International Encyclopedia of Sexuality (Francoeur & Noonan, 2004), which any therapist can access to learn about the sexual practices of over 50 cultures.

Lastly, because I wanted to make the text easy to use for instructors, I have created an Instructor’s Manual, as well as a PowerPoint presentation for each chapter. These materials are available to qualified instructors and may be requested by e-mail (textbook@springerpub.com). Reproducible worksheets, available to students and practitioners, can be downloaded from the Springer website (springerpub.com/buehler).

REFERENCES

When I decided to become certified in sex therapy, my supervisor, Stephen Braveman, early on stated, “In our culture, no one escapes having some form of sexual damage.” Unfortunately, this statement also describes the influence of culture on mental health professionals across the life span. Consider how other systems, such as family, school, or peers, influenced your own sexual development. Perhaps you experienced being sexually harassed on the schoolyard or the workplace. You may be the one in four women or one in six men who were molested as children and who did not feel supported enough by parents or school to tell. You may have engaged in sex when you didn’t want to—or even coerced someone into having sex with you—which changed your cognitive framework and your approach to sex, even in safe relationships. Or perhaps you were educated as a therapist in a setting influenced by the larger culture, where sexuality was a marginalized topic of study.

With any luck, you grew up to be a sexually functioning adult capable of emotional and physical intimacy with a partner of your choosing, but there is a strong likelihood that you have had struggles with your sexuality, as do surprisingly large numbers of men and women in the population at large (Laumann, Paik, & Rosen, 1999). It is in regard to our sexuality that we are perhaps most like our clients, kept in the dark about its nature and discouraged from opening the door to understanding. Insight and knowledge into sexuality requires that therapists pay attention to their own development, but our training reflects the reluctance of our culture as a whole to “go there.” For most therapists, learning how to address sexual topics requires specialized training that may be difficult to access, requiring travel and other expense.

What happens to our clients if we, ourselves, don’t have or make the opportunity to understand our own sexuality? Can we call ourselves competent if we don’t assess or treat the entire spectrum of human experience, including those that are baffling or taboo? As self-appointed healers of mental health,
I believe we must take responsibility to heal the whole person, including the sexual part of the self. Otherwise, we may inadvertently sustain or contribute to a client’s struggle with sexuality. Mental health and medical professions have yet to fully recognize that sexual problems can contribute to depression, anxiety, trauma, eating disorders, substance abuse, pain disorders, and so on; conversely, such problems can affect a person’s sexuality, yet remain unaddressed in the therapist’s office. Yet if we don’t “do sex” as part of our practice, we may miss out on an essential part of what is troubling our clients.

Consider Len, a client in his mid-60s who was so guilt ridden after his first attempt at intercourse that he struggled with erectile dysfunction for all the years that followed. Len became depressed after a divorce and sought relief through therapy, medications, and, at times, alcohol. In all his years of counseling, no one had asked him about his sex life—until he mentioned a urology appointment. Concerned he might be ill, the therapist asked more about the appointment. The question prompted Len to cry as he told her about his impotence. Fortunately, the therapist soon realized this was a long-standing, complex issue for Len and a referral was made for my help. After months of treatment with Len and his partner, he was, at last, able to resolve his sexual concerns.

But how different might Len’s life have been if someone had earlier inquired, “How’s your sex life?” Len’s treatment was influenced by a culture in which nonspecialized therapists lack training or comfort discussing sexual topics. He also needed a therapist who could use a systemic approach to understand why his struggle was so long-standing and intense, which had to do with his development in an extremely restrictive family, church, and community environment. The restrictive environment caused Len undue shame about his sexual needs, which in turn caused him to lose his erection in his first sexual encounter. Later in life, changes in Len’s biological system made attaining any kind of erection almost impossible, adding further frustration. Only when Len’s frustration was more painful than his secret could he break out of his shell and reach out for help.

Clients come to us to help them solve all kinds of problems, which may include sexual concerns. The Laumann survey (Laumann et al., 1999) of male and female sexual problems—the largest of its kind—reported that about 60% of women and 30% of men have had some type of sexual dysfunction. With numbers like these, it is safe to assume that a good portion of your current clients have a sexual problem. If you do not ask, however, you may never hear about these issues. But clients sometimes do tell me, as an identified sex therapist, some of the reasons why they left a former therapist who didn’t talk about sex:

- One woman found the courage to seek help for the fact that she was still a virgin 7 years after her wedding night due to vaginismus (spasm of the vagina that prevents penetration), but she could not bring herself to tell the therapist about her problem. Since the therapist never asked about sex, the client got the message loud and clear: Sex is not spoken here.
- A couple trying to get past an affair that nearly destroyed their marriage couldn’t bring themselves to tell their “uptight” therapist that they had enjoyed swinging early in their relationship. The couple’s history added to their confusion about boundaries and rules in the marriage, but their weeks
in therapy were useless because they feared the therapist would judge them if they disclosed their early history.

• Sam and Cynthia sought a therapist’s help for Cynthia, who believed she had a low sex drive as a result of being molested as a child. Because the couple had difficulty talking about sex, the therapist changed the topic from sex to finances because, explained Sam, “the therapist thought if we made more money, we’d be happier.” Two years later, Cynthia still had a low sex drive; fortunately, the couple sought appropriate help.

No one, least of all our clients, wanted to be judged as defective, naive, or perverse. People want reassurance that they are essentially normal or that they can become more what they think normal is for them. When therapists don’t talk about sex, they may convey a belief that the client is weird for wondering about his or her own sexuality.

The fact that therapists don’t talk about sex may be through no fault of their own. If you are reading this textbook because you are enrolled in a full graduate course in sex therapy, you are in the minority. There are programs that offer zero hours of education in sex therapy, or at minimum one credit—10 to 12 hours—of education. In a survey of 110 Canadian and American psychologists, Miller and Byers (2010) identified that psychologists lacked the ability to directly address clients’ sexual concerns (“Skills Self-Efficacy”) and to relate accurate information about sex (“Information Self-Efficacy”). In another survey of 188 Canadian psychologists, 60% did not seem to have the training or comfort level to do so (Reissing & Giulio, 2010). Physicians and nurses who ostensibly know the most about sexual anatomy and hormones fare no better, for example, when faced with oncology patients whom they know to have sexual issues, but do not have the knowledge nor comfort level to help them (Ussher et al., 2013).

Of course, that means that some therapists do ask about sex. In another survey, about half of therapists reported that they “always” ask about sex (Miller & Byers, 2009). But people in general (including therapists) over-report their comfort level when it comes to sexuality, as they want to appear normal or current. What about the other half of therapists? There is an adage that we are always communicating, even if we say nothing. Therapists’ silence about sex in the therapy room sends many messages, but perhaps the loudest is please don’t talk about sex!

**WHY THE SILENCE ABOUT SEXUALITY?**

Almost everyone is raised in an atmosphere of secrecy when it comes to emotional and psychological aspects of sex. The reasons are complex. Depending on one’s religious perspective, a person’s very conception can be shrouded with mystery. As we grow, we covertly observe romantic and sexual behaviors between adults of which we are told little. We experience our own biological urges, such as a desire to masturbate, but are given neither tacit nor explicit permission to ask questions. When we do ask, we may not get an answer—or we may get a lecture on why some sexual topic is naughty or dirty, something good girls and boys avoid. Although many of today’s parents talk openly with their children about sex, there are still households where sex is a forbidden topic. People still bar their children from attending formal sex education classes in school,
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and people from other countries, for example, Saudi Arabia, may not have been offered any sex education opportunities at all.

Our physical and psychological sexual development takes place on entirely different planes, and interactions between systems reflect this. Secondary sexual characteristics signal to adults around us that we must be protected from such risks as unwanted pregnancy or disease. Meanwhile, we are left to privately grapple with sexual dreams and fantasies, curiosity, and desire. Reflecting what is still often a Puritanical culture, we aren’t given information about giving and receiving sexual pleasure. The complexities of a sexual relationship are explained away with myths like, “All men are interested in is sex,” or “Once you get married, your sex life will disappear.”

We certainly aren’t told how to manage feelings of sexual inadequacy, so if a problem comes up like difficulty having an orgasm or getting an erection, we may keep it under wraps for decades. As a society, we also may act as if sexual problems appear suddenly in adulthood. However, as I have learned from my clients, teens (who on average in the United States begin having intercourse at 15) have sexual problems that plague them, sometimes leading to depression, eating disorders, alcoholism, and other mental illness. As therapists know all too well, secrecy and silence are associated with feelings of shame and guilt that can contribute to overall poor mental health. Nowhere, perhaps, is this truer than when it affects our sexual development.

It doesn’t help that sex does have a murky side. Subjects like sexual abuse, assault, and rape tend to be hushed by the victim and, if they learn about it, family members or friends. If the media gets hold of such a story, it is sensationalized, which may cause victims to further retreat away from possible unwanted attention. Meanwhile, media attention on cases such as Jerry Sandusky, the Penn State football coach convicted of molesting children, do little to address underlying problems such as the need to educate children at an early age about appropriate physical boundaries, the right to say no to unwanted touch, and permission to tell if someone harms them. Our culture also has done a poor job of acknowledging that pedophiles and people with other difficult sex and social problems do exist and frequently deserve compassionate treatment (Cantor, 2012).

For teens and young adults, date rape is distressingly common on college campuses; many young women have shared with me that the reputed response of campus security was so lukewarm that they made a decision not to report. Yet, its effects can linger well into adulthood. Today’s young adults are also the first to grow up in the digital age. Many have spent so much time viewing Internet pornography that they neglected to develop the social and sexual skills to have a real partner. How might things be different if they were raised in a culture that acknowledged sexual needs, made it easy to attain contraception, and talked openly about what it means to be in a healthy sexual relationship?

Therapists are not immune to such sexual negativity. Pope and Feldman-Summers (1992) report that about two thirds of female and one third of male therapists responding to a survey regarding sexual abuse among therapists had experienced molestation, the majority of incidents associated with a close relative. It isn’t difficult to surmise that one reason therapists may avoid the topic of sex is that they have been victims of sexual abuse or exposed to other types of negative sexual experiences, from mild harassment to outright assault. Although
therapists may be drawn to the field to help other victims become survivors, they may be disappointed with how little attention their graduate training gives to the sexual late effects of abuse.

The negative effects of such experiences may intensify what Saakvitne and Pearlman (1996) called vicarious traumatization. Vicarious traumatization is defined as “the therapist’s inner experience as a result of his or her empathic engagement with and responsibility for a traumatized client.” Listening to sexual material can be difficult for therapists if they have their own sexual struggles. Like our clients, we may have trouble setting appropriate sexual boundaries, struggle with questions about the morality of sexual practices (anything from casual “hook-ups” to looking at—or even engaging in the making of—hardcore pornography), be dealing with our own sexual inhibitions, be worrying about a partner’s sexual function after cancer or other illness, or simply have basic concerns about our own physical appearance and sexual attractiveness. Discussing such matters may create such distress for the therapist that they are simply avoided.

Another reason for many therapists’ silence about sex is the fear of becoming isolated or being ostracized by colleagues. Not only do therapists fear being judged by clients for expressing interest in their sex life, but also by other therapists who find dealing with sexual problems too uncomfortable or distasteful. For example, I recently lucked upon an opportunity to share space in a pretty office with a psychanalyst. My deposit was promptly returned because, on reflection, the analyst decided that my sex therapy practice was not a good fit for her office, presumably since she and her clients might happen upon my (drooling?) clients in the waiting room. Working with sexual problems can also feel unsafe in certain communities because of the social and political climate. Where I live in Southern California, condoms and lubricants are sold over the counter at the drugstore, but there are still parts of the country where such items are difficult to procure. Designating oneself as a sex therapist in such areas can mean opening oneself up to ridicule or harassment.

Therapists may also be quiet about sex due to strict training in laws and ethics concerning sexual contact with clients, a topic covered in detail in Chapter 19. Therapists are rightly warned that because there is an inherent power differential in relationship with the client—who is dependent on us for emotional support—the potential for doing serious emotional damage by acting out sexual urges comes with enormous risk. Little is said, however, about reconciling the need to manage one’s sexual attraction or arousal while discussing sex in a therapeutic manner with the client. In any case, stern warnings about curbing one’s sexual feelings may send the message that it’s best not to deal with sex in the treatment room.

A final reason for therapist reticence about sex concerns diversity. While learning to tolerate cultural differences has been a priority in training programs, tolerance of a wide range of gender, orientation, and sexual behaviors has not. In my area of California, for example, human sexuality credits for marriage and family therapists have been cut to the minimum requirement in several schools. If therapists are to properly address client sexuality, then they must not only have appropriate training, but they also must become sexually sensitive—a tall order for those raised in an American society that lags in tolerance behind many developed countries, including neighboring Canada.
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On the other hand, perhaps none of these concerns about being silent about sex applies to you! You might be someone who relishes the idea of talking to clients about sex. Or maybe you are a graduate student who wants to write a dissertation on a sexually related topic, or to work at an agency that isn’t afraid that you will query their clients about their sex lives. If so, be fearless. Give your dissertation or agency chair a copy of the studies cited about the need for therapists who can work with clients regarding sex. Show them this book. Offer to get outside consultation or supervision from a practicing and/or certified sex therapist. Find professors and others in your community who will support you. Just be persistent and even pesky, because your community needs someone like you.

Otherwise, consider that you are about to become at least one step ahead of your clients as you learn more about sexuality. You won’t be a therapist who “doesn’t ‘do’ sex.” You will be able to help clients overcome their deepest fears so that they can enjoy one of life’s pleasures without undue shame or guilt. Increasing a client’s capacity to love and be loved often has a ripple effect in the client’s life, giving him or her the optimism, confidence, and freedom to tackle other developmental milestones such as finding a healthy relationship or even making a much-feared job change. Our sexuality is such a core part of who we are, and as therapists we are fortunate to be in a position to help our clients achieve health in this critical area of human existence.
1. Sexuality and the Mental Health Profession

**TAKE-AWAY POINTS**

1. Sexual health is part of good mental health and should not be considered as a “frill” or marginalized.

2. Although sexual problems are common, the majority of therapists are unprepared to address them. According to Miller and Byers (2009), the two main reasons therapists don’t treat sexual problems are the lack of “Skill Self-Efficacy” and “Information Self-Efficacy.”

3. Sexual problems can be the cause as well as the result of mental illness.

4. Therapists also may not talk about sex for the same reasons clients do not, for example, shame and embarrassment regarding the topic. Therapists may also have faced sexual trauma or experienced vicarious traumatization. They are also sometimes told to avoid addressing sexual issues due to the fear that they may violate their ethics.

5. Therapists can become more comfortable with sexuality by seeking sex-positive instructors, reading more about sexuality, and seeking appropriate supervision with clients.
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ACTIVITIES

1. Whether you have refrained from talking about sex with your clients or do so on a regular basis, it can be fruitful to examine your own attitudes about human sexuality. In a “sexological journal,” write about influences you have experienced in your sexual development.

2. What steps have you taken or will you take to increase your comfort in talking with clients about sex? List them in your journal.

3. Locate a colleague with whom you can consult or from whom you can receive formal supervision of cases that present with sexual issues. Keep notes on your consultations in your journal.
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RESOURCES

The Kinsey Institute website has produced a page of resources for professionals interested in the field of sexology entitled Kinsey Confidential. Kinsey Confidential can be found at http://kinseyconfidential.org/resources/sex-research-sex-therapy.

REFERENCES

Making the Shift: Comfort With Sexuality

One of the things I treasure most about the mental health profession is its optimism and emphasis on growth and change. When it comes to sexuality, we have the ability to adopt new beliefs, modify our role with clients, and change the rules about talking about sex in the therapy room. Knowledge is an imperative in helping clients make those changes, and can be acquired by following a four-stage model (Harris & Hays, 2008):

Stage 1: Self-examination
Stage 2: Awareness of the problem from the client’s point of view
Stage 3: Increased freedom and comfort in discussing sexual topics
Stage 4: Awareness of a new level of comfort with clients’ sexual issues

Stage 1: Self-examination

The first step requires the therapist to examine his or her sexological worldview (Sitron & Dyson, 2012). Sexological worldview is defined as “the result of the socialization process that is comprised of values, beliefs, opinions, attitudes, and concepts specific to sexuality, including any and all sexual behavior and identities.” These values, beliefs, and so forth, come from many sources, including one’s family, school, religion, peers, and media, as well as through sexual relationships and experiences. In order to be nonjudgmental, empathic, and effective in helping clients with sexual problems, the therapist must set aside biases and deal with the client’s matter at hand, though they may differ in sexological worldview.

As a whole, therapists tend to be more liberal than their clients, but there are areas where this isn’t true. Since premarital sex has become more prevalent in our society, many young sexually active adults are likely to have had multiple partners. Ford and Hendrick (2003) report that both male and female therapists...
tend to view clients who have had multiple sexual encounters as having more pathology than monogamous clients, reflecting a more conservative sexological worldview on the part of therapists. In such instances, therapist and client must together explore the meaning of sex with multiple partners. The therapist may discover that the client believes that sexual experimentation is a requirement in order to find a suitable partner, or that they were exposed to one or both parents in the wake of divorce who had active sex lives with subsequent partners. In any case, the therapists would be mistaken in undervaluing present mores and overvaluing his or her personal opinion.

There are additional issues that may create a conundrum for a therapist trained in traditional, psychodynamic, or systemic theories. Therapists are less likely to condone lifestyles such as swinging (married or committed couples switching sexual partners) or polyamorous relationships (couples who simultaneously have sexual and romantic partnerships with other adults, with everyone's mutual knowledge and consent). While such “consensual nonmonogamy” (Barker & Langridge, 2010) is rare (about 1%–3% of the population), therapists cannot automatically assume that participants possess underlying pathology, such as viewing one partner as so depressed or fragile that he or she gives in to the wishes of the other. Therapists may be interested to know that couples with these arrangements will sometimes seek help from a sex therapist even when the problem isn’t sexual, because they fear judgment by “vanilla” therapists. By developing an attitude of acceptance and flexibility, most therapists will find they can establish rapport and conduct an earnest assessment of the presenting couple’s issues without condemning personal choices.

Another unfortunate bias that some therapists hold is toward variations in sexual orientation. While having improved in recent years, one study of social work students found that 11% of those surveyed had homophobic attitudes toward gays and lesbians (Ahmad & Bhugra, 2010). Although conversion or reparative therapy has been banned in several states, including California, Oregon, and New Jersey, there is still a contingent of psychotherapists who may practice under the guise of treating “sex addiction.”

There is also confusion about the wide range of orientation, as well as its fluid nature, a phenomenon referred to as gender fluidity. A woman may change orientation more than once over the course of her life (Diamond, 2009), while a man may have sex with men but not identify as gay (Nichols, 2006). In the lesbian, gay, bisexual, transgender, or queer (LGBTQ) community there is a faction of people who identify as Q, which is understood as meaning that one is “questioning” one’s orientation or gender, or is “queer” and does not identify with an orientation or gender. Understanding and affirming that an individual can have a bisexual physical orientation but a heterosexual romantic orientation can reduce a client’s confusion and shame while he or she explores a definition of sexuality. For details, refer to Chapter 10 in this text.

Unlike their mature clients, therapists may hold the view that sex is for the young. They may be ignorant that people continue to have vital sex lives into age 60, 70, and beyond if they are in good health and have a partner available. (I recall that while teaching a course on human sexuality, the mere mention of people in their 70s still having intercourse elicited “Ew!” from a young student at the back of the room.) Stereotypes of “dirty old men” and “cougars” (older women who “prey” on younger men, as Mrs. Robinson seduced Benjamin in
The Graduate) add to the prejudice. Additionally, the misunderstanding that “sex” means “intercourse” precludes therapists and clients from imagining an intimate physical connection between partners even when intercourse is no longer possible, thus maintaining a damaging stereotype.

Additional sexual stereotypes also persist. Wiederman (2001) reports specifically on the dangers of sexual myths, such as the belief that men “always” have more interest in sex than women, or that men and women reach a “sexual peak” at different times. People can be harmed by such myths, since the expectation is that they will experience frustration if they remain in a long-term relationship. In his article, Wiederman demonstrates that this myth has persisted despite faulty empirical data. Therapists need to be aware of myths about gender differences as well as other phenomena so that they can educate clients and create an understanding of the diversity within human sexual experience.

**STAGE 2: SEX FROM THE CLIENT’S POINT OF VIEW**

The way in which clients present sexual problems may differ from the presentation of other common problems such as grief over the loss of a loved one or a behavioral problem in a child. Although not all clients feel embarrassed by their sexual behavior, many are fearful of being judged. Clients may not use the same language as the therapist to describe sexual problems or activities. Just the word sex may mean many things, from penetrative penis–vagina intercourse to any sort of sexual contact. While the therapist can model the use of appropriate language (“You used the word ‘va-jay-jay,’ I say vagina”), acceptance of the client’s language, whether describing symptoms or sexual acts, is equally important; correct anatomical language is covered in Chapter 3.

Clients also may have limited knowledge about the complexities of sexuality. Like therapists, their sexual education may be based on what they learned in school or from peers. They also have expectations about sexual performance from the media that may be all out of proportion to what most people experience in their day-to-day relationship, such as believing that all women reach orgasm from intercourse or that acquiescing to anal sex is a woman’s ultimate expression of love for her man. Much of the therapist’s task is to disassemble myths and impart appropriate knowledge to help the client realistically overcome challenges.

**STAGE 3: FREEDOM AND COMFORT IN TALKING ABOUT SEX**

Sex is funny in that most partners think it’s something they do with each other without any discussion. It is difficult to imagine another human activity that is so shrouded in silence. Hence, one of the major causes of both therapist and client discomfort with sex is lack of communication. Clearly, if a goal of therapy is to improve communication about all topics, clients need to be more at ease in both talking to the therapist and to their partners.

One way to become more fluent in talking about sex is to become familiar with the chapters in this book on sexual health and history taking. These chapters will give you a road map on how to start a conversation about sex and where to guide it. To increase comfort, you can role-play with colleagues to practice
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asking questions or simply permit yourself to say words aloud that aren’t part of your everyday vocabulary. Supervision or consultation, discussed as follows, is also a place to speak comfortably about sex.

STAGE 4: A NEW LEVEL OF COMFORT WITH CLIENTS’ ISSUES

As you learn more about sex from all aspects, you will feel less inhibited and more confident in your ability to talk to clients about sex. Your clients will grow, too; in my practice, clients often express appreciation for having a safe place to learn to talk about sex and they are visibly more relaxed after several sessions. The only way to reach this stage is to talk about sex with your clients at every appropriate opportunity. The more you talk about sex, the more you will understand why it is such a critical topic if you want to promote true mental health in your clients.

SUPERVISION AND CONSULTATION

These are the other requirements for becoming competent in treating clients’ sexual concerns. Before addressing this need, it may help to clarify differences between “supervision” and “consultation,” which are sometimes used synonymously, though they are not necessarily the same. Supervision occurs prior to becoming licensed in most states, but is also the term used when one’s cases are supervised for certification in a type of therapy or technique, such as sex therapy or Eye Movement Desensitization Reprocessing (EMDR). In some settings, licensed clinicians may continue to work under the direction of a supervisor, who continues to hold ultimate responsibility for the care of patients or clients within the clinical setting, though this person often holds the title of “director.” Consultation generally occurs after getting licensed. Consultation may happen in diverse contexts and with a variety of appropriate consultants, including former instructors and supervisors, colleagues, and paid experts. Peer consultation groups, either lead by someone in a consulting position or leaderless, are also a possibility.

Whether seeking supervision or consultation, either is essential when first planning and treating clients with sexual complaints. For all the reasons that therapists avoid the topic of sex in the first place, countertransference—in the form of anxiety, embarrassment, or moral judgment—may cloud potential solutions. For example, consider what a newly minted therapist might think if presented with the following situation:

In the intake call, Julian, age 68, described having a difficult time with delayed ejaculation, and the therapist assumed he meant with his wife. Thus, the therapist felt shocked when Julian revealed that he was having sex with massage therapists in order to resolve the problem he was having with his wife. Knowing that such activity was illegal and, in her eyes, immoral, the therapist choked and muttered some thoughts about aging and sexuality, including the bias that sexual activity among elderly people is unseemly. Julian left the office without any help for the frustrating situation with his wife.
Cases such as this often occur in the context of problematic relationships, so it is helpful to have a seasoned and objective supervisor or consultant for guidance and to examine the source of negative countertransference. Supervisors and consultants can be found in various ways. One way is to inquire in one’s local professional organizations regarding experts in sexuality who might be available. There also are several organizations listed in Resources at the end of the chapter that provide support in various ways to therapists in their quest for understanding and treating sexual concerns, including certification, conferences, journals, and so forth.
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**TAKE-AWAY POINTS**

1. Becoming comfortable with sexuality—one’s own, and the client’s—is a process that occurs over time in four stages: (a) self-examination; (b) awareness of the problem from the client’s point of view; (c) increased freedom and comfort in discussing sexual topics; and (d) awareness of a new level of comfort with clients’ sexual issues.

2. Becoming comfortable with sexuality also entails an examination of one’s “sexological worldview.”

3. Obtaining supervision and consultation is an important part of becoming comfortable with sexuality, including talking about sex with clients.
ACTIVITIES

1. Nearly everyone carries stereotypes about sex. Some of these are relatively harmless or even amusing (the horny middle school student) while others are destructive (“all men want sex all the time”). Examine some stereotypes you have observed, considering at what systemic level they may have been generated or perpetuated. Examples include “religious women don’t enjoy sex” or “passion always dies in a long-term relationship.” Write your observations in your sexological journal.

2. What stereotypes about sex do you hold? As you think about your own sexual development, think about what messages you were given, implicitly or explicitly, about gender, orientation, reproduction, sexually transmitted disease, and sexual activity. Write in your journal.

3. The Online Slang Dictionary (www.onlineslangdictionary.com) lists 164 words for “sexual intercourse” including boff, boink, horizontal bop, go all the way, make the beast with two backs, shtupp (Yiddish), and knock it out. Either make a list or discuss some of the words you have read or used to describe other sexual acts, body parts, or people (e.g., virgins, gays, or the elderly). Are these words reflective of your own personal values about sex?

4. In what ways do you think your values and beliefs about sex might differ from those held in the population with which you work? How might you begin the work of being nonjudgmental about people’s sexuality? Would supervision help? Identify someone who can help you with issues of treatment and/or countertransference.

5. Read widely about sexuality. Visit some of the following sites. Write about your impressions.
   - International Society for the Study of Women’s Sexual Health: www.isswsh.org.
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RESOURCES


REFERENCES


