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Let's Talk About Sex: The Relative and Practical Importance of Sex Therapy in Rehabilitation and Mental Health Counseling

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Abstract. Sex therapy offers unique insight into the mental, physical, and social well-being of people. Sex therapy, despite its controversy today, has been utilized as a therapeutic modality since ancient times throughout many cultures. In practice, sex therapy addresses and treats a multitude of social, psychological, and physiological issues preventing someone from attaining, developing, and maintaining a healthy sex life. Well established therapeutic and ethical guidelines exist to assist sex therapists in providing consistent and successful care for their clients several of which deserve evaluation and scrutiny. Damaging social and psychological implications of unhealthy sexual practices today constantly present professional and logistical challenges for Sex Therapists. This article proposes emphasis on comprehensive and applicable sex therapy practices and protocol alongside proactive sex education for rehabilitation and mental health professionals to implement in multiple therapeutic settings. Additional discussions are developed around life care planning strategies.

Keywords: sex, sexuality, sexology, therapeutic intervention, sex therapy, sex education, sex counseling

It is difficult to separate sexual behavior from the overall human condition. Sex is considered one of the three basic primary drives of human behavior, alongside food and water. From facilitating evolutionary processes in all living organisms, to dismantling entire societies over marital infidelity, sex has had an extremely rich and diverse history. Considering sexuality has been a focal individual and social issue across human existence, disregarding its influence on human behavior as taboo or irrelevant is simply irresponsible on behalf of the professional mental health community. Its importance to the human experience warrants incorporation into treatment planning.

As psychology and other mental health professions began its early steps to becoming an established and respected science, sexual behavior was largely overlooked (Berry, 2013). However, there were highly influential figures in the history of psychology who recognized the usefulness of incorporating sexuality into their theories and research. Unfortunately, much of their work was considered controversial or dismissed as inappropriate at times (Berry, 2013). Thankfully, several major contributions during the 19th and 20th centuries from psychologists and physicians like Sigmund Freud, Alfred Kinsey, William Masters, and Virginia Johnson opened the doors for the study of sexual behavior to be taken seriously. These leaps and others like them made possible the advent of sex therapy and the overall incorporation of sexuality into mental health and rehabilitative science and professions. Although discussing the topic of sex may still make many people uncomfortable due to social influences, its importance to psychological wellbeing has been thoroughly established and should not be ignored. As such, the present paper seeks to present a framework establishing the importance of open discussion and implementation of sexual therapeutic techniques throughout mental health and rehabilitation services.

History of Sex Therapy

The history of applying sex in psychologically therapeutic settings can be traced back to ancient times

(Bhugra, 1995). Ancient cultures incorporated sex into religious ceremonies designed to worship the miracle of humans' ability to create life and the mysticism of fertility (Bhugra, 1995). Different forms of sexual therapy in these ancient cultures was also believed to aid in treating some deviant behaviors (Berry, 2013). Ancient India, China, Greece, and Rome all viewed sex in different ways, but never ignored its importance to the human condition (Shea, 1992). Many Eastern cultures developed manuals, spells, aphrodisiacs, tantric yoga practices, and other forms of therapy to address psychological and physiological issues surrounding sex (Bhugra, 1995). Ancient Western societies viewed sexuality as highly influential on human behavior as seen in the powerful role sex played in the religious stories of their gods. Causes for sexual dysfunctions were largely thought to be physiological as well as metaphysical in nature (Berry, 2013). All societies have had changing cultural trends regarding the acceptance or rejection of certain sexual practices. Mainly, different sexual behaviors' endorsement or repression has reflected the religious attitudes of the society (Shea, 1992). What we have learned by studying these trends is that extreme repression of sexual behavior often results in social phenomena such as increases in gender inequality, sexual violence, and other unhealthy social practices (Shea, 1992).

Separating sex from religion became particularly salient during scientific advancements made in Western society during the 19th and 20th century. Largely dominated by physicians and psychiatrists, the 1800's and 1930's are considered by some to be the period of development for sexology becoming its own distinct scientific field. Sigmund Freud's unrestricted discussion of sex during this period, particularly the human sex drive termed "libido," brought the subject of human sexuality to the forefront of psychological discussion. Although his theory of Psychoanalysis and associated methods were and remain extremely controversial, his groundbreaking work opened doors for the study of sexual behavior and implementation of sex therapy.

Psychologists such as Alfred Kinsey and Henry Havelock Ellis brought the study and discussion of human sexuality even further by conducting in depth research in the area during the first half of the 20th century (Goodwach, 2005). In his two books that would become known as The Kinsey Reports—*Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953)—Kinsey assessed a wide variety of topics related to human sexuality. Particularly innovative as well as controversial was Kinsey's study of sexual orientation. Although many scientific criticisms concern his methodology and statistical analysis, social outrage about the publications mainly surrounded the open discussion of topics previously considered taboo. The Kinsey Reports are widely considered as an important precursor to the sexual revolution of the 1960's and 70's.

From there, William Masters and Virginia Johnson continued to break down barriers and progress sex therapy in many ways. By specifically addressing sexual dysfunctions and physiological aspects of sexual activity, scientific knowledge of human sexuality expanded greatly. They also introduced sexual surrogacy, work with couples, and the implementation of cognitive behavioral therapeutic techniques.

Medical breakthroughs and intensified focus on the biomedical model during the last three decades of the 20th century brought about the "medicalization" of sex therapy in dealing with sexual dysfunction (Tiefer, 1996). "Medicalization" refers to the usage of pharmaceutical and/or other medical interventions in the treatment of a diagnoses. The advent of pharmaceutical drugs like Viagra and different hormone therapies as well as advanced surgical procedures on genitalia pushed sex therapy even further into the biomedical model during this time (Tiefer, 1996).

Today, sex therapy experts and other mental health professionals trained in sexology advocate for a more biopsychosocial model when approaching the treatment of sexual dysfunction and the study human sexuality (Berry, 2013). As the scientific study of sex evolved in the 19th and 20th centuries, sex therapy emerged as its own branch of therapeutic specialization made up of a community of professionals focused on helping individuals struggling with sexually related problems.

Sex Therapy as a Profession

The components required for an occupation to be considered professional, especially in the realm of psychology (Greenwood, 1957), are all met by Certified Sex Therapists (CST). First, theories laden with social, psychological, anatomic, and physiological foundations provide the basis for sex therapy. Second, knowledge base in how to treat an extremely complex set of issues with regard to sexual behaviors is required of sex therapists; their educational attainment, training, and competency must reflect this. Thirdly, there are numerous subspecialties within sex therapy such as physiologically concentrated therapy that addresses issues like erectile dysfunction or socially concentrated problems that may include pedophilia, voyeurism, etc. Fourthly, sex therapists have publicly and legally recognized authority to practice as professionals and must answer to a specific board in order to be licensed and certified. For instance, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) has an established code of ethics and strict guidelines for certifying their members. As stated, sex therapists must be adequately knowledgeable in a wide range of areas to be effective in

their practice. For this reason, educational requirements for certification to be a CST are extensive (AASECT, n.d.); a list of AASECT core knowledge areas can be found in Table 1.

Lastly, sex therapists belong to an exclusive community with a deeply professional culture. Publications, conferences, sponsored talks, workshops, and sex education courses represent some of the professional outlets CST's and other sexology practitioners utilize to get their knowledge and work out into the public realm. Several scholarly journals like *Sex Roles* and *The Journal of Sex Research* focus on publishing important psychological and physiological research specifically related to sexual behavior (see Table 2). After becoming a CST, one is expected to utilize the empirically supported therapeutic techniques that have been established to ensure the consistent and professional practice of sex therapy.

Therapeutic Goals of Sex Therapy

Sex therapy in practice is a form of psychotherapy with the ultimate goal being to help the client(s) overcome psychological and/or physiological barriers preventing them from having a healthy, active sex life. It is often implemented specifically to treat sexual dysfunctions when a physiological cause is not obvious or as a complement to medical treatment. Sexual dysfunction can apply to any number of psychological or physiological problems. Psychological problems that are sexual in nature can manifest as unwanted sexual fetishes, sexual addiction, or a lack of sexual confidence. Physiological problems are usually seen as erectile dysfunction, low libido, or painful sex. Many other issues can potentially be caused by a combination of psychological and physiological issues such as premature ejaculation or absence of/diminished sexual desire. Helping victims overcome damage caused by sexual assault is also considered a form of sex therapy. Lastly, everyday factors such as stress and relationship problems can greatly impact a per-

Table 1
AASECT Core Knowledge Areas

A. Ethics and ethical behavior.

B. Developmental sexuality from a bio-psycho-social perspective across the life course.

C. Socio-cultural, familial factors (e.g., ethnicity, culture, religion, spirituality, socioeconomic status, family values,) in relation to sexual values and behaviors.

D. Issues related to Sexual Orientation and/or Gender Identity: heterosexuality; issues and themes impacting lesbian, gay, bisexual, pansexual, asexual people; gender identity and expression.

E. Intimacy skills (e.g., social, emotional, sexual), intimate relationships, interpersonal relationships and family dynamics.

F. Diversities in sexual expression and lifestyles, including, but not limited to polyamory, swinging, BDSM, tantra.

G. Sexual and reproductive anatomy/physiology.

H. Health/medical factors that may influence sexuality including, but not limited to illness, disability, drugs, mental health, conception, pregnancy, childbirth, pregnancy termination, contraception, fertility, HIV/AIDS, sexually transmitted infection, other infections, sexual trauma, injury, and safer sex practices.

I. Range of sexual functioning and behavior, from optimal to problematic, including but not limited to common issues such as: desire discrepancy, lack of desire, difficulty achieving or maintaining arousal, sexual pain and penetration problems, difficulty with orgasm.

J. Sexual exploitation, including sexual abuse, sexual harassment, and sexual assault.

K. Cyber sexuality and social media.

L. Substance use/abuse and sexuality.

M. Pleasure enhancement skills.

N. Learning theory and its application.

O. Professional communication and personal reflection skills.

P. History of the discipline of sex research, theory, education, counseling, and therapy.

Q. Principles of sexuality research and research methods.

Table 2
Publication Samples

Sex Roles	Burn, S. M. (2009). A situational model of sexual assault prevention through bystander intervention. *Sex Roles, 60*(11-12), 779–792. doi:10.1007/s11199-008-9581-5
	Franiuk, R., Seefelt, J. L., & Vandello, J. A. (2008). Prevalence of rape myths in headlines and their effects on attitudes toward rape. *Sex Roles, 58*(11-12), 790–801. doi:10.1007/s11199-007-9372-4
	Ryan, K. M. (2011). The relationship between rape myths and sexual scripts: The social construction of rape. *Sex Roles, 65*(11-12), 774–782. doi:10.1007/s11199-011-0033-2
Journal of Sex Research	Albright, J. M. (2008). Sex in America online: An exploration of sex, marital status, and sexual identity in internet sex seeking and its impacts. *Journal of Sex Research, 45*(2), 175–186. doi:10.1080/00224490801987481
	Morgan, E. M. (2011). Associations between young adults' use of sexually explicit materials and their sexual preferences, behaviors, and satisfaction. *Journal of Sex Research, 48*(6), 520–530. doi:10.1080/00224499.2010.543960
	Wright, P. J. (2013). U.S. males and pornography, 1973-2010: Consumption, predictors, correlates. *Journal of Sex Research, 50*(1), 60–71. doi:10.1080/00224499.2011.628132
Journal of Sexual Medicine	Bronner, G., & Ben-Zion, I. Z. (2014). Unusual masturbatory practice as an etiological factor in the diagnosis and treatment of sexual dysfunction in young men. *Journal of Sexual Medicine, 11*(7), 1798–1806. doi:10.1111/jsm.12501

son's sex life; so, sex therapists must also be able to address these concerns when helping client(s). As sex is often considered a taboo topic, especially in Western cultures, when dealing with sexually related issues such as these, professionalism on behalf of sex therapists is of the upmost importance.

An overall transformative approach is taken when developing a treatment program in sex therapy. Sex therapy aims to understand the psychological, biological, pharmacological, relational, and contextual aspects of sexual problems. Because the underlying causes of sexual problems are so variable in nature, extensive medical and psychological evaluations are needed before a treatment plan can be assessed.

Certified Sex Therapists are expected to follow Jack Annon's PLISSIT model which outlines a structure system of levels when conducting sex therapy and formulating treatment plans. The PLISSIT model, separated as P-LI-SS-IT, represents four levels for sex therapists to address (AASECT, n.d.). First, level "P" of the model represents Permission mandating that the therapist create an open and comfortable environment for the client(s) to feel permissible in sharing sexual concerns. The therapist should accomplish this by introducing basic information about sexuality being an important human behavior and validating its legitimacy as a psychological and/or health issue. Second, level "LI" represents Limited Information where the therapist addresses the client(s) specific sexual concerns correcting any myths or misinformation that may surround them. The third level of the model "SS"—Specific Suggestions—instructs the therapist to compile and evaluate a sexual history of the client(s) and then: 1) define issues and concerns, 2) determine how these issues have evolved over the client(s)'s history, 3) guide understanding of and offer a number of resolutions pertaining to main issues, and 4) help the client develop healthy and correct perceptions about the causes for issues while formulating attainable and appropriate plans for resolution. Certified Sexual Counselors under AASECT's guidelines are expected to be trained in these first three levels of the PLISSIT model, while Certified Sex Therapists must be trained in all four. The fourth level of the model—"IT"—represents Intensive Therapy where a CST must design and provide extensive therapeutic intervention for client(s)'s whose sexual issues share comorbidity with other complex issues such as mood or personality disorders, substance abuse problems, physical disabilities, and/or intrapersonal or interpersonal conflicts (AASECT, n.d.). Duration of sex ther-

apy depends on the causes of the problem and so varies accordingly. For instance, if a male presents with erectile dysfunction caused by physiological deficiencies in blood flow, simple pharmaceutical intervention with drugs like Viagra can be implemented relatively quickly. However, if a female client presents with sexual dysfunction caused by an extensive history of sexual abuse, therapy could take several months to years to correct a multitude of problems. Overall, the strict guidelines for conducting sex therapy are designed not only to ensure sexual dysfunction is handled professionally, but also to debunk social myths that mock sex therapy as being irrelevant or even humorous.

Social Implications of Myth Acceptance Surrounding Sexuality

Social, religious, and educational systems are hesitant to embrace sex therapy research findings although much of their data has been shown to significantly improve psychological wellbeing of individuals as well as preventing sexist attitudes in groups that may lead to sexual violence. For instance, myths surrounding female sexuality such as believing women do not desire sex result in women experiencing significantly less satisfying sex lives (McCabe et al., 2010). Considering a satisfying sex life has been shown to improve self-esteem and decrease stress (Tiefer, 1996), many women are at a disadvantage when myths such as this are widely accepted and perpetuated in the media. In addition, females who express sexual desire openly are often equated with being immoral and suffer stigmatization (McCabe et al., 2010). Similarly, damaging myths surrounding male sexuality can also negatively impact men's self-esteem. For example, social expectations that men are constantly wanting sex and the pressure to sexually perform can severely effect men's self-worth after experiencing erectile dysfunction (Tiefer, 1996). Correcting socially-perpetuated myths such as these in individuals are relatively easily addressed with simple sex education and therapy.

However, the most dangerous myths surrounding sexuality that sex therapists must address are those that perpetuate rape culture and contribute to sexual violence. For a definition of "rape culture" and other terms, see Table 3. Most importantly, those myths that place women in subservient sexual roles to men propagate rape myth acceptance, increase men's propensity to rape (Herman, 1988), and present specific problems for sex therapists. For example, when a woman engages in flirtatious behavior with a man, expresses sexual interests, but then refuses the man's advances, the likelihood of her being raped significantly increases. This social reality stems from the pervasive sexual myth that women owe sex to men and that men are entitled to sex after a woman shows interest or "teases" him.

Perhaps the most majorly influential social myth that influences members of a society to blame victims of sexual assault and deny them the proper justice and care they deserve is when rape is attributed to uncontrollable sexual desire. All too often rape is excused by a person's uncontrollable sexual desire towards another (Herman, 1988). Rape of another human being is never about sexual desire, instead it stems from the need to exert power, humiliation, and entitlement over a person's existence. Victim blaming occurs when a society accepts this myth and puts the victim at fault for luring the perpetrator in with sexually provocative behaviors (Herman, 1988).

Similarly, the systematic and widespread objectification of women in a society transforms her body into a commodity that can and should be possessed by a man (Fredrickson & Roberts, 2006). When a woman internalizes these messages and experience self-objectification, attaining a healthy sex life becomes a serious challenge because they are taught to place their desires second to the man's sexual satisfaction (Calegaro & Thompson, 2009). Considering most young men today first learn about their sexuality by watching pornography and majority of pornographic materials reflect these myths, serious problems often arise in their sexual behaviors (Brod, 1988). The lack of accurate sex education and extreme accessibility to porn through technology has become as major problem for sex therapists to confront. As such, a major component of sex therapy is addressing myths such as these and correcting maladaptive sexual attitudes and behaviors that result from them.

Discussion

Sex therapy occupies a unique branch of mental health professions operated by a highly professional community whose goal is to improve the human condition by addressing sexuality and its implications in society. Although sex therapists, counselors, and educators already significantly contribute to the mental health and rehabilitation community, they should not be the only professionals equipped to address human sexuality issues. The entire mental health and rehabilitation community should not underestimate the importance of incorporating sex into their research and therapeutic settings. Sexual drive, behaviors, and social implications make up a significant part of the human condition; so, when mental health and rehabilitation professionals evaluate a client looking to improve their livelihood, their sex life and attitudes towards sex should not be ignored. All practitioners in these fields should take professional responsibility for addressing the needs of their clients and society at large when human sexuality is threatened, overlooked, or misunderstood. Better educating mental health and rehabilitation professionals on basic tenants of human sexuality and methods for handling

Table 3
Important Terms for the Practice of Sex Therapy

Sexuality	An ability to get pleasure from sexual activity; all aspects of sexual behavior
Biological sex	The property or quality by which organisms are classified as female or male on the basis of their reproductive organs and functions
Gender	The condition of identifying as male or female or neuter; implies cultural, social, behavioral and psychological aspects
Sexual orientation	A person's enduring attraction to one sex or the other: usually categorized but not limited to: 1. heterosexuality (opposite sex) 2. homosexuality (same sex) 3. bisexuality (both males and females) 4. asexuality (no sexual attraction to any sex) 5. pansexuality (any sex or gender identity)
Sexual activity	The manner in which humans physically experience and express their sexuality
Intercourse	One's penetration vaginally, anally, and/or orally of another person; usually penetration of a penis, but may include other body parts or foreign objects
Masturbation	The process of manipulating one's own genital organs, whether a penis or clitoris for the purposes of self-stimulating without a partner
Libido	An individual's overall sexual drive or desire for sexual activity
Sexual dysfunction	A heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure
Sexual fetish	Any object or nongenital part of the body that causes a habitual erotic response or fixation
Sexual confidence	One's comfort with communicating, developing, and experiencing healthy sexual desires
Intimacy	The level of commitment and positive affective, cognitive and physical closeness one experiences with a partner in a reciprocal (although not necessarily symmetrical) relationship; can also describe sexual activity with another person
Pornography	The visual and/or auditory depiction of erotic behavior intended to cause sexual excitement
Cyber sexuality	Any expression or experience of sexuality over the Internet
Sex-typing	Behaviors that results from socialization about what activities and expressions a male or female should do; also known as gender-typing
Sexual assault	Any involuntary sexual act in which a person is coerced or physically forced to engage in against their will; any non-consensual sexual touching of a person
Rape culture	A theoretical concept or qualitative theory in which rape is pervasive and normalized due to societal attitudes about gender and sexuality
Pedophilia	A psychiatric disorder in which an adult or older adolescent experiences a primary or exclusive sexual attraction to prepubescent children

sexual issues would improve these profession and increase client care.

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Endnote

This article is a summation of the literature presented in conjunction with the professional experiences of the second author.