

SECOND EDITION

New Directions in

# Sex Therapy

INNOVATIONS  
AND ALTERNATIVES

Edited by  
**Peggy J. Kleinplatz**



**New Directions in**

**Sex  
Therapy**

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**Praise for the second edition of *New Directions in Sex Therapy***

“This is a groundbreaking book, innovative, and forward looking. It exposes some current myths about sexuality, sexual dysfunction, and the goals of sex therapy. It is humane, responsive to human needs, and creative.”

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North Carolina Wilmington; Past President, Society for Sex Therapy and Research; former  
editor, Journal of Sex Education and Therapy**

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# Acknowledgment

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The first edition of this book resulted from Alvin R. Mahrer, Ph.D. encouraging me to try to improve the field of sex therapy. He asked me about the writers I admired, had learned from, and respected. Could I bring these innovative thinkers and clinicians together, creating a forum for them to provide an alternative vision? With his guidance, the plan for *New Directions in Sex Therapy: Innovations and Alternatives* began to take shape. Twelve years later, I am still calling my mentor of a lifetime for advice, honest feedback, clarity and transfusions of courage. The brilliant illumination of his model philosophy of science, psychotherapy research and practice remain the guideposts for my work. He continues to tell me to say what I believe in candid, lucid, undisguised sentences. Al, I am working on it.

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# *Advancing Sex Therapy or Is That the Best You Can Do*

PEGGY J. KLEINPLATZ, Ph.D.

Ten years ago I began the first edition of this book by stating that I had a love-hate relationship with sex therapy. That was in the good old days. Increasingly, the field of sex therapy has become fragmented while the call for new treatments for sexual problems—albeit, not necessarily from patients—has grown. Ten years ago, I worried that popular myths about sexuality might have a deleterious effect on the development of the field. Increasingly, both the Internet and sexologists are disseminating the old/new “truths” that are accepted and entrenched so readily that they eclipse the possibility of analyzing and investigating their basis. Ten years ago, I noted that we behaved as though we had answers to some fundamental questions. Today, the questions themselves have been buried increasingly by a lay and professional discourse that presupposes that we have all the answers we need and the goal now is only to disseminate the existing, received wisdom and to find new treatments for well-understood conditions. Ten years ago I hoped that the field could benefit from new blood and new ways of thinking that might accompany fresh bodies. Ten years later, it is the future of sex therapy itself that is imperiled; it is disconcerting when even our leaders question if we have anything distinctive or, indeed, worthwhile to offer as clinicians.

I realize that this is a dreadful way to introduce a book, except that none of the problems enumerated here is insoluble. Each of these issues will be explored in this introductory chapter. I remain enthusiastic about our collective abilities to respond to these challenges, and it is for that reason that this new edition has been assembled. You are invited to join the contributors to this book as we take a critical look at the issues to be resolved and attempt to advance the work of sex therapy.

I am a Professor at the University of Ottawa and have been teaching Human Sexuality since 1983 as well as teaching Sex Therapy at the affiliated Saint-Paul University. I am certified as a sex therapist, educator, and supervisor and spend most of my time in the practice of sex therapy with individuals and couples (as well as the occasional group). On the side, I study and write about sexuality.

I like the people I meet in the field. The students are eager to learn more about sex, for personal and professional reasons. The clients are hoping to improve their sex lives. The educators, counselors, researchers, and therapists are generally open-minded, progressive, tolerant, and compassionate individuals who seek to broaden the acceptance of sexuality, in all of its manifold manifestations, in society. This has been a good profession, but it is at a crossroads and we must be honest, circumspect, and bold in choosing new directions.

This book takes a critical look at the field of sex therapy or clinical sexology and will try to improve it. The contributors to this book are individuals who would like to strengthen our field. These authors suggest that the cutting edge of sex therapy requires innovations in, alternatives to, and a redefinition of sex and sex therapy as we know it.

The major criticisms and challenges facing the field of sex therapy provide the focus of [Part I](#) of this book, as well as suggesting a need for new alternatives and innovations to advance our work, which a

## ***Current Trends Reify and Dress Up Old Assumptions as the Latest Science***

The cultural and intellectual backdrop for our clinical practice is always relevant, whether by facilitating or impeding our efforts. At this time, curiously, it is having paradoxical effects, both making it more likely that individuals/couples will be seeking professional help for their sexual problems and hampering our efforts to actually help them. Everywhere there is talk of sex. In a world where the news cycle—and public attention spans—keep diminishing and becoming shorter, sexual factoids float about that everybody knows. Their veracity or lack thereof is beside the point and gets lost before they can be scrutinized.

What this means is that we have a newly evolving problem: Twenty or thirty years ago, professionals were clearer on which myths were “theirs”, that is, the myths of the uninformed and misinformed lay public versus “our” reality arising from scientific endeavors. Part of our mandate was to distinguish between the falsehoods and the facts. It is far murkier now; we and they seem to hold a lot of shared beliefs that have melded into a huge, amorphous morass.

Here is a sampling of the latest “truths”: Sexual functioning is a normal, natural bodily function. What is natural is good. Sexual satisfaction results from effective genital stimulation. Sexual satisfaction is equated with orgasm. A woman’s attractiveness is determined by her waist-to-hip ratio. Size matters. There are fundamental differences between men’s and women’s sexuality. Men are more naturally sexual than women. Sex should occur within a particular range of frequency (rarely articulated but imagined nonetheless). There is a correct amount of desire. Desire is caused by testosterone. Intimacy is caused by oxytocin. If desire is low, testosterone levels should be checked. Lack of desire is necessarily problematic. Lots and lots of sexual desire is suspect at best. Sexual addiction is a disease. Women’s sexuality is far more complicated than male sexuality. Men are after one thing...and are hard-wired that way. Women need to be wooed to respond to men’s sexual overtures. Sexuality is essentially driven by the need to reproduce. Sexual desire is designed to be hot and heavy for about two years—a process determined by evolution—after which the bonding chemical takes over. Homophobia is a thing of the past. Orgasms should be properly timed: Men should not reach orgasm too soon; women cannot reach orgasm soon enough. Birth control is synonymous with hormonal contraceptives, primarily oral contraceptive pills. Ask your doctor.

Adhering to conventional ideas of sex and feeding into normative performance standards creates a myriad of problems (Irvine, 2005; Reiss, 1990). To the extent that we behave as if these unproven assumptions are facts, we are poorly situated to understand sexual difficulties and to help people deal with them.

## ***Sociocultural Changes and Their Impact in the New Millennium***

The role of the Internet and the Web in defining, narrowing, and expanding sexual options, norms, and ideals has had a huge impact on our society and our clinical practices in recent years. On the one hand, the Web in general and social media in particular have enabled sexual minority members of every conceivable variety to feel they are not alone. The Web has allowed individuals who once felt freakish

and alone to connect with like-minded souls and to have a sense of belonging. That alone has an important and therapeutic value.

On the other hand, it has created several clinical and intellectual challenges that confront us daily: The same technology that has provided breadth and diversity at the margins has narrowed and flattened norms, creating the perception of homogeneity at the center. Images of mainstream sexuality as depicted in Internet pornography have increasingly set the standards for the new “normal”. Prevailing images of “sex” are now *more* focused on performance than in the 1970s (see Zilbergeld [1978], who warned of the dangers of the performance orientation even then); correspondingly, there is less focus on pleasure, desire, feeling turned on during sex, communication, or intimacy than ever (Kleinplatz, 2011).

In mainstream porn, heterosexual intercourse is portrayed as the normal route to instant female satisfaction; sex is effortless and easy; men are always completely erect; sex is unrelated to intimacy—fact, sex is separate from everything else; anal intercourse is eagerly welcomed by all men and women; all women love “facials”; sex is never interrupted unless it is by a third party who suddenly materializes for a threesome; girl-on-girl action is always desired and desirable; male orgasm is inevitably accompanied by women’s loud moans and groans. Along the way, Internet porn has created new aesthetics, including the now standard Brazilian wax jobs; cosmetic staining for one’s labia minora, color-coded by race, so that every woman’s lips can look “fresh”, “youthful”, and pink (i.e., rosier for white women, paler for black women); anal bleaching and the impression that the labia minora should never extend past the labia majora.

The message promulgated is that when women are aroused, they, too, become lust-driven animals willing to do anything, just as men are. Actually, this notion is hardly new. It was the same message conveyed in Victorian pornography 130 years ago. The idea that men and women are ineluctably different is hardly new. The essentialism that predominated during the Victorian era is back—or perhaps it never left. To the extent that the cultural Zeitgeist enforces the idea that men and women are fundamentally opposite sexes—then as now—our sexual fantasies are bound to the notion that underneath the posturing and pretenses, we are really all alike.

The prevalence, penetration, and saturation of these impressions into the consciousness of the public has been facilitated or exacerbated by the ready and ubiquitous access to porn. The private nature of the viewing experience makes it harder to question, let alone unpack the sex script portrayed in porn, while at the same time leaving the viewer with the sense of instant expertise that can be conferred upon him/her by virtue of watching material usually hidden from public view and scrutiny.

### ***The Public Discourse Is Everywhere Juxtaposed Alongside Institutionalized Ignorance, Private Shame, and Their Fallout for Our Field***

The messages cleverly packaged in pornographic imagery would be of little consequence in a culture where we could talk openly with one another about sex. If there were some way of countering the omnipresent messages, we could indulge in them for what they are—tantalizing fiction—no more and no less. However, in a culture that actually aims for institutionalized ignorance, the consequences of having a limitless supply of drivel with scarce access to comprehensive sex education means that sex therapists are left to contend with the casualties of abstinence-only sex education. The United States currently has the highest rate of unwanted pregnancies in the Western world. Even that pales in comparison to the

skyrocketing rates of sexually transmitted infections. Those data are relatively easy to measure. The impact on private, sexual intimacy is much harder to delineate. It seems as if everywhere, we are surrounded by public attention to sex. It is in private, particularly in heterosexual relationships, that couples are unable to share with each other how they really feel, what they really want, and how each feels special, contrary to stereotypes. This leaves many people feeling alone, alienated, and defective. People everywhere are sure that they are having less sex than their neighbors, fewer orgasms, more performance difficulties, and that only their problems are unique.

The Internet has also brought with it all manner of perceived new dangers, real or imagined, that threaten conventional society with yet another form of sexual licentiousness. "Sexting" is everywhere and should it include adolescents, reactions to it have created a new category of sex offenders, listed on criminal registries for the rest of their lives. Although there is no consensus among professionals about "sexual addiction", the term has rapidly taken hold as has the new scourge of "Internet porn addiction". Celebrities from politicians to athletes to actors have been at the center of sex scandals, which have led to public shaming; acts of contrition; apologies to their families, constituents, and fans; and confession of the evils of pornography and temptation, with further repentance by way of sex addiction rehabilitation programs.

### ***Public Consensus and Professional Controversy: Men, Women, and Desire "Disorders"***

Although the public believes we have consensus, considerable controversy surrounds clinical conceptions of high and low sexual desire. Outside the celebrity spotlight, real people are drawn or dragged into our offices in the mistaken belief that we have already established diagnosis and treatment protocols for "sex addicts". We are now confronted by individuals and spouses who want us to treat the patient/addict and restore normal sexuality when the complaint itself and the vision of the "fixed" patient are themselves illuminating and somewhat disturbing. Just as our society is conflicted about appropriate sexual behavior, the field remains divided along ideological as much as by clinical differences regarding what sorts of sexuality should be normalized and which should be pathologized.

Kafka (2010) has proposed adding Hypersexuality Disorder to the *DSM-5*, which would, theoretically, apply to both sexes. However, Kafka acknowledges that in practice, much less is known about hypersexuality in women than in men and that the prevalence of hypersexuality would seem to be low in women, too, so the diagnosis would apply primarily to men. This proposal has been criticized from all sides: from those who conceptualize the problem as addiction to those who question if the problem is *sexual* to those who question if there is a ***problem at all***.

Equally contentious are notions on the other end of the spectrum about low desire. It has been proposed (Brotto, 2010) that, in women, low arousal and low desire be combined in one category: Sexual Interest/Arousal Disorder or Sexual Arousability Disorder in women. (The existing *DSM* nosology, which distinguishes between erectile dysfunction and low desire, would remain unchanged for men.) The rationale for collapsing the categories in women includes the beliefs that women cannot distinguish between their own arousal and desire and that women's sexual desire may be more fundamentally responsive than men's (Brotto, 2010). Men's sexual desire is hypothesized to be spontaneous and initiatory, while women's sexual desire is said to be more receptive (Basson, 2001, 2002).

2010). Although this model has been endorsed by only one-third of women (Sand & Fisher, 2007), it has become popular among clinicians (e.g., Weiner-Davis, 2003).

It has become “politically correct” to focus on the fundamental differences between men and women (Bancroft, 2009) on both ends of the political spectrum. No profit is generated from the discourse on how men and women are alike (Kleinplatz, 2011). Although the similarities between male and female sexuality are greater than the differences, and some areas have even converged in recent years (e.g., reports of intercourse incidence, extramarital sex, sexual permissiveness), ideas about these behaviors (e.g., the double standard) have actually diverged over time (Peterson & Hyde, 2010). Similarities between men and women are no longer highlighted in this and other contexts (Peterson & Hyde, 2010). It may be time for a more balanced reconsideration of gender and desire (Meana, 2010).

### ***What Do We Know, and When Did We Know It?***

The field acts as if we had answers to questions that have seldom been asked, and so the assumptions built into the practice of sex therapy are never articulated and remain difficult to identify, challenge, dislodge, etc. These questions include: What is sexuality? What makes an experience “sexual”? What is the role of the body in sexual experience? Why do some things seem powerfully erotic to some people and abhorrent to others, and irrelevant to still others, leaving them cold? To what extent are fantasies, desires, or preferences subject to change? Are all people capable of some kind of sexual feeling? What is “normal” sexuality? What is the relationship between “normal” and “abnormal” sexuality, and what can we learn about one from the other? What kinds of sex do we want to promote? How are we to conceptualize sexual problems? What is the context in which certain things come to be defined and come into existence as sexual problems? What should our goals be in dealing with sexual problems? These questions seem to be so laughably simple as to be almost absurd, but we have yet to tackle them. This seems ironic given that it is practitioners, unlike theoreticians, who most need answers to these questions or at least to have working hypotheses. It is clinicians who require a set of provisional principles in order to engage in therapy.

### ***The Adverse Impact of Professional Trends: What Is “Sex Therapy” at the Moment?***

Four interrelated trends have converged to isolate sex therapy from the broader worlds of psychotherapy in particular and health care in general. The first of these is the current conceptualization of sexuality itself and the resulting/corresponding limitations around our clinical parameters. The second is the simultaneous narrowing of the field and splintering of our professional bodies. The third is the reduction in training at the same time that patients are being told to “ask their doctors” for help with sexual problems. The fourth is the estrangement of sex therapy from developments in psychotherapy research over the last 20 years, which have left our treatment models impoverished and our clinicians relegated to using paradigms that are not necessarily applicable to human sexual difficulties. Together, these trends have thwarted the advancement of sex therapy as follows.

### ***Sex Therapy Has Devolved Into Treatment of Symptoms of Sexual Dysfunctions***

Social and technological changes have led to increased public attention to sexuality, thereby concealing and accentuating personal discomfort with one's own sexuality. Consequently, more people seek clinical services. But whose services they will actually receive is quite another matter.

In 2001, I wrote of the coming of age of sex therapy as a profession. The situation has changed quite dramatically in the interim. Although individuals and couples are still seeking more fulfilling sex lives, the emphasis is increasingly limited to treatment of symptoms of sexual dysfunctions and disorders. These are not necessarily the same thing, but the distinction between promoting sexual gratification versus merely ameliorating sexual symptoms may be lost on both the public and the new frontline providers of services. The more groundbreaking project of sex therapy itself has been eclipsed as we have settled for fixing performance problems rather than optimizing sexual potential (Kleinplatz, 1999, 1996, 2006, 2010; Ogden, 2007; Schnarch, 1991, 1997; Shaw, 1997).

Almost from the moment that Viagra™ was released in the U.S. market in March 1998, the advertising slogan, "Ask your doctor," helped to open discussion in physicians' offices about sexuality. That is unquestionably a laudable development. My objection here is to the implication that sexual problems are to be understood primarily as technical difficulties, subject to treatment and cure devoid of the psychological, relational, and social contexts in which they come to be perceived as problematic. More fundamentally, even the difference between carefully assessing and/or dealing with the underlying problems versus treating only the presenting sexual symptom has been obscured. In fact, to the extent that we confound sexual symptoms with the underlying problems they mask, clinicians may be inclined to target the wrong problem, which can make matters worse instead of better. To go yet a step further, if we ignore the underlying purpose—not the cause—of the symptom, we will fail to appreciate how the symptom is generated by these same contexts (Kleinplatz, 1998, 2004, 2006, 2007). Patients referred for treatment of dyspareunia are further hurt when lubricants are prescribed instead of careful attention to the hurried sexual stimulation that turns them off. When the man with the soft penis is enabled to attain erections sufficient for penetration despite his lack of attraction to a partner who belittles him, his subjective experience has been denied and designated irrelevant. The possibility that any man whose sexual functions well would and should be *unable* to get an erection is often barely considered (Kleinplatz, 2004). When the woman who is so reluctant to become pregnant in this marriage that her vaginismus introitus quietly objects to the intrusion of a penis is treated by Botox™ for vaginismus, her concerns about her family's future have been circumvented and silenced anew.

Is it any wonder that in recent years, as mechanical problems that obstruct intercourse have been treated "successfully", there have been increasing reports of far more complex problems such as low desire (Leiblum, 2010), delayed ejaculation (Hartmann & Waldinger, 2007; Perelman, 2010; Perelman, McMahon, & Barada, 2004; Perelman & Rowland, 2008; Waldinger, 2010), and of young men faking orgasm (Muelenhard & Shippee, 2010)?

### ***Narrowing of the Field: The (Further) Rise of Biological Reductionism***

In 2001, I expressed concern over the consequences of "success" in the field of sex therapy leading to our being isolated from the larger field of psychotherapy. A variety of forces have contributed to the further

intellectual deprivation of the field of sex therapy as our rightful allies in related therapy disciplines continue to grow. In 1994, Schover and Leiblum warned presciently of the medicalization of sex therapy. By the time the “Viagra™ moment” had left its mark upon our society and our field, their prediction had more than been realized, although perhaps not in the ways many would have predicted. In 1998, just before the release of sildenafil citrate, the first of the phosphodiesterase type-5 inhibitors [PDE-5], our physician colleagues warned us that our business would soon be reduced dramatically, with men seeking out urologists (and later family physicians) instead of sex therapists. On the contrary, our business doubled; it was precisely the fact that men—and their partners—could no longer avoid seeing the complexity of men’s sexual functioning in interpersonal context that led to the flourishing of our practices and, not so coincidentally, a spate of articles on “the role of the mental health professional in dealing with patient non-compliance” (e.g., Althof, 2002; Wise, 1999). Nonetheless, one major impact of the new emphasis on organic factors in the treatment of sexual dysfunctions was the reconceptualization of sexual problems—and sexuality itself—in terms of biological reductionism (Loe, 2004).

### ***Increasing Estrangement From Psychotherapy and Its Research Data***

We increasingly gave lip service to “biopsychosocial” (in that order) models of sexual dysfunction as well as touted the value of interdisciplinary teams. In reality, what truly had begun as an interdisciplinary field became increasingly cut off from its admixture of roots. We increasingly colluded to profit from a model that advocated randomized clinical trials (RCTs), “best practices”, and empirically validated treatment (EVTs) as if these notions and the intellectual baggage cached cleverly inside of them were theoretically neutral. Research models that may be ideal for pharmaceutical investigation, i.e., the “gold standard” double-blind RCT, may neither be relevant nor appropriate for measuring complex outcomes in psychotherapy practice. Heiman (2002) notes, “endpoints are more restricted and unidimensional in pharmacology clinical trials than in psychosexual studies” (p. 74). The realization that multifactorial, multidetermined problems require commensurately complex clinical strategies—not simple treatment algorithms—and therefore demand more sensitive research paradigms was well established in the world of psychotherapy outcome research more than 10 years ago. Even though the field of psychotherapy has spent the last decade going beyond the crude EVT and HMO fights of the 1990s (c.f., Bohart, 2000; Duncan, Miller, Wampold, & Hubble, 2009; Goldfried & Burum, 2007; Greenberg, 2008; Mahrer, 2000; 2010; Norcross, Beutler, & Levant, 2005; Wampold, 2005, 2007), sex therapy has been blinded to the broader field’s progress.

“Progress” in sex therapy seems increasingly to be predicated on being oblivious to the factors that research has proven lead to patient improvement in psychotherapy. In other words, the increasing isolation of the field of sex therapy (Kleinplatz, 2003) has led us to narrow our vision of available or even possible research/treatment options to those advocated by the natural and biological sciences, whether or not these models are ideally suited to a field claiming the need for comprehensive treatment modes. Astonishingly, we ignore the salient literature (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Bohart, Elliott, Greenberg, & Watson, 2002; Castonguay, Beutler, 2005; Duncan, Miller, Wampold, & Hubble, 2009; Goldfried & Burum, 2007; Greenberg, 2000; Norcross, 2002; Norcross, Beutler, & Levant, 2005; Wampold, 2001, 2005, 2007) that shifts the focus to empirically validated principles of practice. This body of outcome data demonstrates that the factors that

lead to change in psychotherapy comprise, for example, the therapist-patient relationship more than any other variable, including treatment technique, and account for the majority of the variance in outcome.

### ***Splintering of the Profession and Professional Bodies: The Fragmentation of Sex Therapy***

The demise of our field as an interdisciplinary meeting ground for clinicians of diverse backgrounds reflected in the current composition of our major professional organizations. The number of clinicians who identify primarily or are trained as sex therapists has dropped dramatically, at least as indicated by the records of the American Association of Sexuality Educators, Counselors and Therapists (AASECT). The number of AASECT-Certified sex therapists has dropped from 928 in 1987 to 442 at present, a drop of 52% over the last 25 years. Of the current certified sex therapists and counselors combined, fewer than 5% (15) are physicians. Similarly, the interdisciplinary Society for the Scientific Study of Sexuality (SSS) lost 42% of its membership over the last 20 years, which has fallen from 1,198 in 1992 to 700 as of 2011. Only the Society for Sex Therapy and Research (SSTAR), the smallest of our “major” organizations, has remained relatively constant by design, at 263 in 1993 and 271 at present. A new organization was established in 1999, originally known as the Female Sexual Function Forum and since 2001 as the International Society for the Study of Women’s Sexual Health (ISSWSH). As of 2011, ISSWSH membership had swelled to 909 members, with 52% physicians (of whom 108 are urologists and 112 gynecologists) rather than clinicians trained/identifying as sex therapists. (It had followed the establishment in 1982 of the International Society for Impotence Research.) The latter is currently known as the International Society for Sexual Medicine and now boasts 1,982 members. Approximately 75% of its members are urologists.

It seems a shame that we are losing the critical mass of colleagues with a similar or at least a complementary base of training in sex therapy and the opportunity to meet on a regular basis and cross-fertilize. We may never have had the kind of multidisciplinary brain-trust required for our profession to develop and thrive, each benefiting from the knowledge base and perspective of the other’s home discipline; however, whatever collective, intellectual meeting ground we shared has surely been eroded by the splintering of our field into separate specialty domains. Many conferences are now marketed toward and attended by physicians rather than clinicians who identify as sex therapists. Similarly, conferences populated primarily by social scientists are impoverished by the absence of our medical and biologically oriented colleagues. It is to our mutual detriment when we fail to incorporate the insights and advances of our fellow professionals who deal with sexual issues and concerns (Kleinplatz, 2003).

As a result of this professional fragmentation, one cannot count on seeing a clinician who has received a fundamental core of training in the biological, psychological, interpersonal, and social aspects of human sexuality (Kleinplatz, 2003).

### ***Lack of Training in Sex Therapy and in Sexual Health Care***

There is an alarming deficit of training opportunities for clinicians in sexology/sex therapy, and it is exceedingly rare to find them offered in an interdisciplinary fashion. Training in human sexuality and



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