Sex Therapy in Integrated Behavioral health

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Let's Welcome Compassion

We are here to learn, grow, and change.

We are trying our best.

Acknowledge your reactions.

Be curious.

Today I am sharing a perspective, not the only perspective on sex therapy in integrated behavioral health.

This webinar is designed to teach behavioral health providers to integrate discussions of sexual functioning and flourishing into brief, integrated behavioral health settings. The presentation will introduce the importance of attending to sexual well-being in behavioral health treatment and provide concrete strategies for providers to implement in their work with clients.

Learning Objectives

LO1: Describe the connection between sexual well-being and mental health.

LO2: Outline two approaches to integrating sex therapy into primary care and behavioral health settings.

LO3: Apply two interventions to support sexual well-being in integrated behavioral health settings.

About Gil (he/him)

- BORN, RAISED, AND CURRENTLY RESIDE ON UNCEDED ANCESTRAL HOMELAND OF THE OHLONE, RAMAYTUSH, AND MUWEKMA WHO ARE THE ORIGINAL INHABITANTS OF THE SAN FRANCISCO PENINSULA
- 33 YEARS OF AGE, CISGENDER, MALE, QUEER, ABLE-BODIED, FILIPINO
- LICENSED PROFESSIONAL CLINICAL COUNSELOR IN CALIFORNIA
- AASECT CERTIFIED SEX THERAPIST IN PRIVATE PRACTICE
- FULL-TIME TENURED PERSONAL COUNSELOR AT COLLEGE OF SAN MATEO

AASECT Certified Sex Therapists

AASECT Certified Sex Therapists are licensed mental health professionals trained to provide in-depth psychotherapy who have specialized in treating clients with sexual issues and concerns. Sex therapists work with sexual concerns and are prepared to provide comprehensive and intensive psychotherapy in complex cases.

AASECT staunchly believes that every individual has the inherent right to enjoy a life that prioritizes sexual health and freedom. This involves ethical, freely chosen, and individually governed expressions of one's sexuality that are free from undue risk of physical or psychological harm.

AASECT is uncompromising in its stance that sexual rights and freedoms are universal human rights that must be protected for all, irrespective of age, background, or life circumstances. AASECT opposes all psychological, social, cultural, legislative, and governmental forces that would restrict, curtail, or otherwise interfere with the fundamental values of sexual health and sexual freedom. We hold this true above all arguments that would justify harm on the basis of religion, citizenship, race, gender, social class, ability, or geopolitical borders.

HTTPS://WWW.AASECT.ORG/POSITION-STATEMENT-SEXUAL-RIGHTS-TIMES-WARFARE
HTTPS://WWW.AASECT.ORG/AASECT-CERTIFIED-SEX-THERAPIST-0

Sexual Well-Being

Sexual well-being refers to an individual's subjective assessment of a wide range of physical, cognitive, emotional and social aspects of relations with oneself and with others.

Two components that affect sexual wellbeing will be explored in this presentation:

1. the experience of sexual function (e.g., desire, arousal, orgasm, absence of pain; being able to experience sexual pleasure and satisfaction when desired). Sexual function is affected by psychological, sociocultural, and biological factors.

2. Sexual distress (e.g, negative emotions associated with one's sexual experience).

Lorimer, K., DeAmicis, L., Dalrymple, J., Frankis, J., Jackson, L., Lorgelly, P., McMillan, L., & Ross, J. (2019). A Rapid Review of Sexual Wellbeing Definitions and Measures: Should We Now Include Sexual Wellbeing Freedom? *The Journal of Sex Research*, *56*(7), 843–853. https://doi.org/10.1080/00224499.2019.1635565

Addressing Sexual Well-Being

Although reports on prevalence vary, it is estimated that both men and women commonly experience sexual dysfunction, with an estimated 10% to 52% of men and 35% to 63% of women experiencing a sexual problem over the course of a lifetime.

Because sexual functioning is strongly linked both to mental health and overall well-being, it is highly likely that a psychotherapist will inevitably address sexual well-being at some point in the therapeutic process.

Despite the importance of addressing sexual well-being when working with clients, many therapists have not received formal training in treating sexual issues.

Given thaT sex is a taboo topic, individuals may be more reluctant to seek help from formal sources due to emotional discomfort and lack of knowledge. Instead, they may seek out informal or anonymous sources to support their sexual concerns.

Baker, B. D., Lea, E. J., & Lavakumar, M. (2020). The Impact of HIV on Sexual Functioning: Considerations for Clinicians. *Psychotherapy (Chicago, Ill.)*, *57*(1), 75–82. https://doi.org/10.1037/pst0000268

Sexual Concerns or Presenting Issues

"We're not having enough sex"

"I'm a sex addict" or "I'm out of control sexually"

"I climax too fast" or "I take a long time to climax"

"I can't get or keep erections"

"I feel guilty or ashamed a lot"

"I don't orgasm during sex"

"I think my spouse is cheating on me" (or already has)

"I watch too much porn" or "He watches too much porn"

"I spend too much time at strip clubs, massage parlors, or with escorts"

"I think about sex all the time" or "I'm less interested in sex than I used to be"

"We want more intimacy"

"I just can't connect with anyone"

"After being out of a relationship for 5 years, I'm scared to have sex again"

"Trying to have penetrative sex is painful for me" (or sexual partner)

"I need someone to talk to"

https://www.martyklein.com/therapy/

Intersecting Identities

It is important to pay close attention to intersecting identities, as each client will have a unique perspective of their sexual concerns and of sex overall.

All aspects of intersectional and cultural group identity, include age and generational status, disability status, race, ethnicity, gender/gender identity, affective/relational/sexual identity, religion and spirituality, social class, national origin and language, migration status, and veteran status, among others.

Dominant society limits what is a normal way for us to exist. This normal way of being–which we are all expected to strive toward, regardless of whether or not it is possible for us to achieve on an individual level–is defined by white supremacy culture, patriarchy, and capitalism. These same systems define what is function and dysfunction.

What is sex?
What is a reason people have sex?

Mentimeter poll

https://www.menti.com/aleovx52pea7

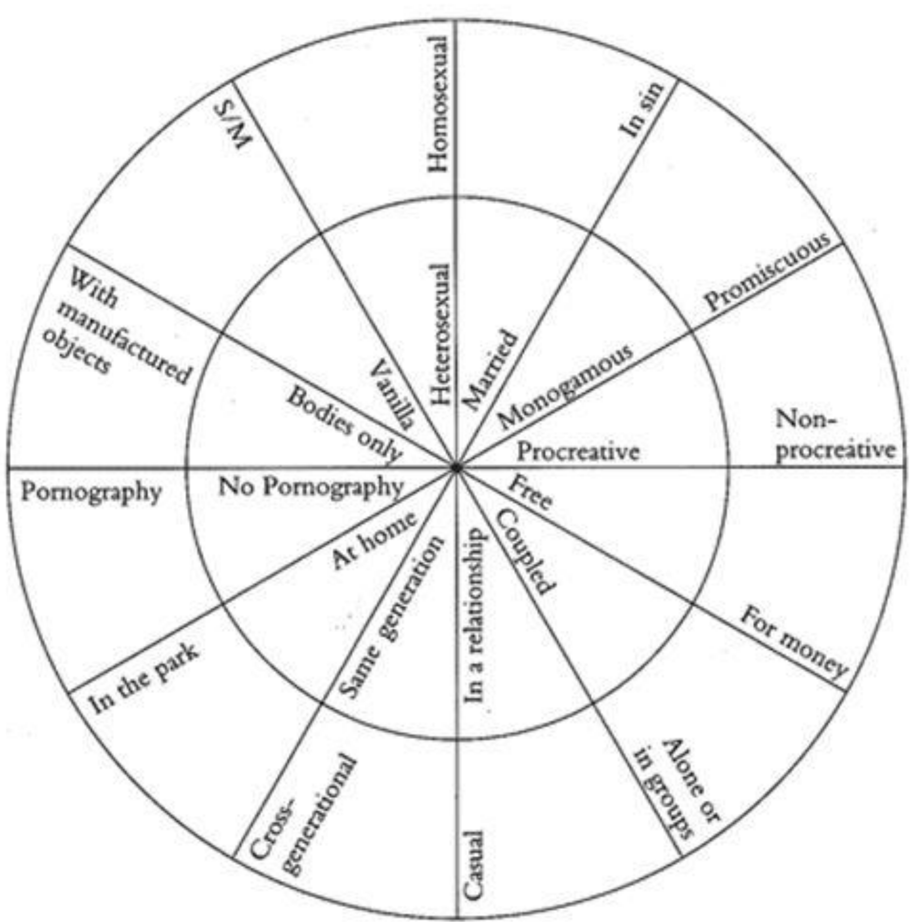
Code: 2418 6899

Let's Talk About Sex

- What is sex? What makes an act, a desire or a relationship sexual is a matter of social definition. These meanings are contextual and variable. What is sexual to one person in one context may not be to someone else or somewhere else.
- The heteronormative idea that women and men are "made for each other" is sustained through the commonsense definition of vaginal penetration by the penis as "the sex act." This may also show up in various sexual and relationship orientations.
- Why do people have sex? Sexual behaviors are not only sex acts but also about the meanings they carry, the desires motivating them and the social interaction through which they are accomplished.
- Sex in itself is neither good nor bad, neither uniquely pleasurable nor uniquely dangerous, neither intrinsically oppressive nor liberating; it become so through the particular social conditions under which our sexual lives are lived.
- Sex in society has contradictions: e.g. Sex is taught to be natural but becomes something you work at or "get fixed."

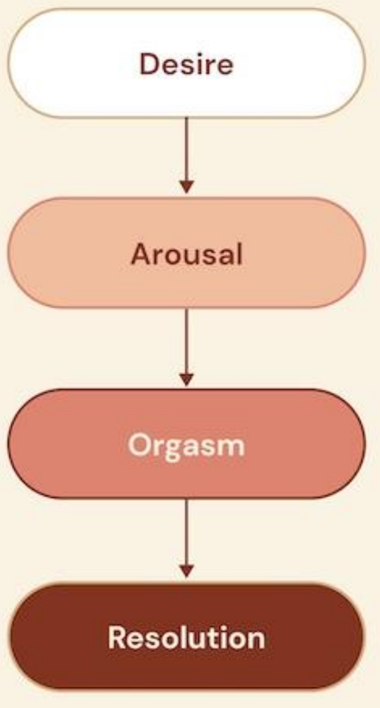
JACKSON, RAY, L., & SCOTT, S. (2010). THEORIZING SEXUALITY. MCGRAW-HILL.

The ‘charmed circle’



Source: Gayle Rubin (1984) Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality

The Old Sexual Response Model



1. **Desire**
   The motivation to have sex or mental arousal, sexual tension starts to build in this phase and some physical changes may be noticeable.

2. **Arousal**
   The excitement phase, in which physical changes can intensify and sexual tension builds.

3. **Orgasm**
   A sudden, forceful release of sexual tension accompanied by involuntary muscle contractions and other changes.

4. **Resolution**
   The process by which your body returns to normal functioning.

Origin.

https://www.theoriginway.com/blog/female-sexual-response-cycle

Debunking Sexual Myths (2015)

What influences
The Dual Control System
by Emily Nagoski

CONTEXT: whether a sensation is perceived as pleasurable or uncomfortable depends of how we perceive context.
E.g.: You might love being kissed but if you mother is looking you might not enjoy it at all!

SENSITIVITY , we all have brakes and accelerators but each of us has different sensitivities. People with high brakes might find difficult to get in the mood while the ones with high accelerators may be more easily and intensely aroused.

ACCELERATORS activated by things like: feeling wanted, connected, porn, erotica, being touch right, novelty and surprise, sexy consent, previous positive sexual experiences.

BREAKS hit by things like: stress, body image, shame, anxiety, previous negative sexual experiences, lack of trust, sexual ignorance, lack of consent, sexual conflict, medication, physical and emotional pain.

@IntimacyCoachMiriam

Gender Norms and Sexual Expression

Gender norms reinforce traditional heteronormative sexual scripts that depict people socialized as men as sexual initiators and people socialized as women as sexual gatekeepers.

These scripted roles dictate that men initiate sexual activity and women respond to men's advances which, may create a sexual double standard, permitting more sexual freedom for men while restricting women's sexual expression, which could influence consent communication.

The traditional heteronormative view of successful sexual functioning (e.g. sexual response cycle) as penetrative sex that leads to orgasm can regulate and set limits on the sexual expression of individuals and define gender roles and relations.

Attempts to avoid hurting men's feelings (i.e., caretaking egos) and of what women "should" do with respect to having sex with men who "put in the work." Societal sexual scripts give the message that people socialized as men are responsible for giving their partner an intercourse-based orgasm. Research on women's reasons for faking orgasm (i.e., to protect their partner's egos) supports this notion.

Queer relations may reassert or challenge heteronormative gender roles–i.e., the myth that masculine sex partners must penetrate feminine sex partners because penetration and masculinity are conflated with dominance and control while femininity and being penetrated are associated with being passive and submissive.

Warshowsky, H., Mahar, E. A., & Mintz, L. B. (2023). Cliteracy for him: effectiveness of bibliotherapy for heterosexual men's sexual functioning. *Sexual and Relationship Therapy*, *38*(1), 52–73. https://doi.org/10.1080/14681994.2020.1739638

Low Sexual Desire

Desire (e.g. innate drive for sex) is often situated as low because of its relative status to a partner's level of desire.

This is not a gender-neutral process. When a woman experiences lower desire than a man partner, her desire is often labeled low.

In the case of a man reporting lower desire than a woman partner, the woman's desire is labeled too high (e.g., they are labeled in negative ways), rather than the man's desire being labeled too low.

This highlights the gendered subjectivity inherent to conceptualizations of low desire, where low desire is most often seen as residing not just in bodies, but in women's bodies relative to men's desires.

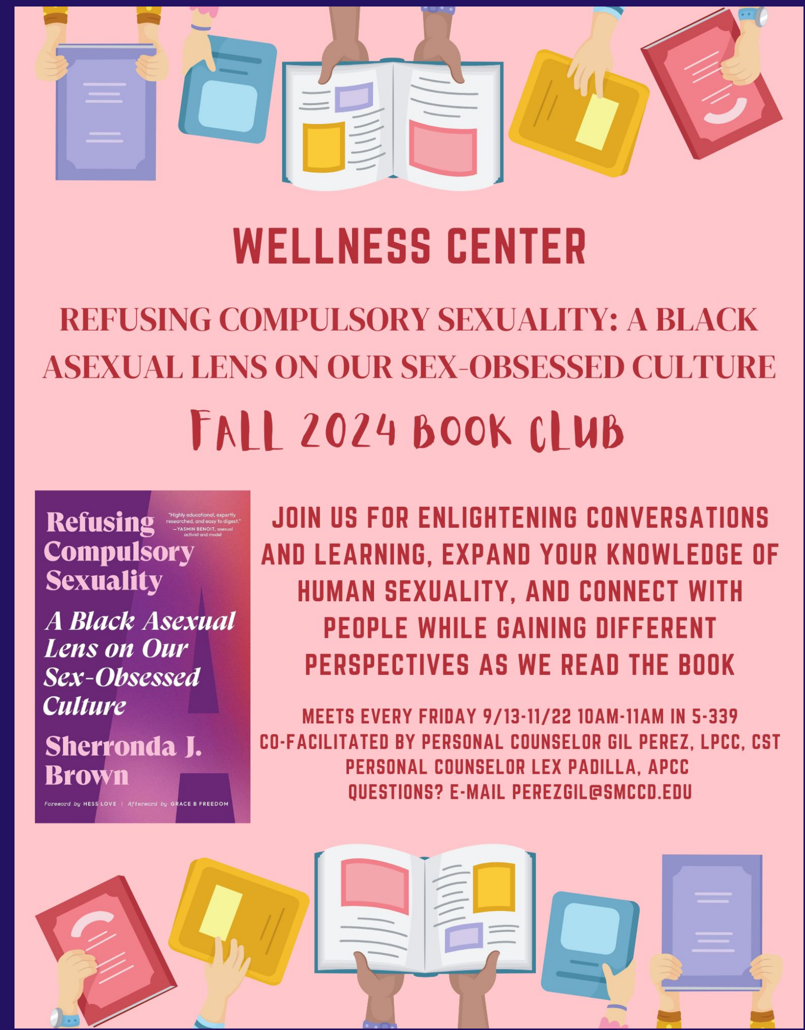
Low desire is typically seen as a problem residing in peoples'—usually women's—bodies in part because sexual desire is seen as a natural and human universal.

But, is low desire really the problem? Desire can ebb and flow. There are also things that decrease desire (e.g. pressure/expectation/a sense of obligation or "duty"; anxiety or depression; stress)

Asexual individuals have also helped society understand that little to no sexual desire for other individuals is a part of human diversity.

van Anders, S. M., Herbenick, D., Brotto, L. A., Harris, E. A., & Chadwick, S. B. (2022). The Heteronormativity Theory of Low Sexual Desire in Women Partnered with Men. *Archives of Sexual Behavior*, *51*(1), 391–415. https://doi.org/10.1007/s10508-021-02100-x

Wellness Center Book Club



"An asexual framework grounded in Blackness engages multiple realities simultaneously. It posits that a world of limited thinking must end in order for the full breadth of the universe of all possibilities to fully thrive, with fewer resistances for us impossibles, mythicals, enigmas, and the 'more than, less than, and other than' humans" (p. 179.)

Bibliotherapy, the use of written materials to treat psychological or sexual concerns, is a type of intervention to increase knowledge of sexual functioning, debunking dysfunctional sexual beliefs, decoupling sexual prowess and self-esteem, and increasing sexual communication skills.

Brown, S. J., & Shen, Y. A. (2022). Refusing compulsory sexuality: A black asexual lens on our sex-obsessed culture. Unabridged. New York, North Atlantic Books.

Aging and Sexual Functioning

As people age, they experience changes in their sexual functioning due to biological, physiological and hormonal mechanisms that influence them differently. Also consider chronic health issues, acquired disabilities, and side effects of various treatments..

The present study examined the perceptions of older men and women ages 60+ regarding their sexual functioning.

Almost all interviewees acknowledged experiencing some changes in sexual functioning with age. With very few exceptions, these changes were portrayed as negative. Some (particularly women) experienced the changes in their partners, rather than in themselves.

The most common sexual change identified by both men and women was male erectile dysfunction, followed by a lack of desire and premature ejaculation. These demonstrate the importance that older adults place on sexual intercourse and especially on men's ability to engage in penetrative sex.

Men appeared to be more likely to identify sexual challenges in themselves than in their partners. Women too were more likely to attribute changes in sexual functioning to their male partners.

Ayalon, L., Gewirtz-Meydan, A., Levkovich, I., & Karkabi, K. (2021). Older men and women reflect on changes in sexual functioning in later life. *Sexual and Relationship Therapy*, *36*(4), 347–367. https://doi.org/10.1080/14681994.2019.1633576

Improving Sexual Functioning

Behavioral health care professionals should assist older adults in identifying more diverse views of sexual functioning as they age beyond a heteronormative perception. This could potentially result in greater satisfaction and lower distress concerning sexual functioning.

A small portion of men and women reported an improvement in their sexual functioning over time:

- When men discussed improvements in their sexual functioning, this was done through the use of a broader definition of sexual functioning, which incorporated intimacy and attention to one's partner.
- When women discussed improvements in their sexual functioning, they primarily referred to becoming more familiar with their own likes and dislikes over time.

Instead of viewing sexual functioning in old age as being on the decline or absent, it can be viewed as different. Whereas the majority equates sex with penetrative sex, some older adults consider other forms of intimacy, such as cuddling, kissing or holding hands as meaningful forms of sexual expression.

Ayalon, L., Gewirtz-Meydan, A., Levkovich, I., & Karkabi, K. (2021). Older men and women reflect on changes in sexual functioning in later life. *Sexual and Relationship Therapy*, *36*(4), 347–367. https://doi.org/10.1080/14681994.2019.1633576

HIV and Sexual Functioning

The presence of HIV itself may not impact sexual functioning.

Societal stigma and the psychological impact (e.g. fear of rejection, fear of transmitting HIV to sexual partners) of the diagnosis of HIV may impact sexual functioning including diminished sexual interest and desire after diagnosis, less spontaneous sex, or less pleasurable sex.

Using condoms during sex significantly reduces risk of transmission. However, this knowledge may not fully dispel the fear that a person can still transmit HIV to others. Many clients are unaware of recent research that concludes consistently taking antiretroviral medication and achieving viral suppression results in nearly zero risk for transmitting HIV to sexual partners.

The development of preexposure prophylaxis (PrEP) also provides additional protection against transmission of HIV for serodiscordant couples—in which one partner is HIV- positive and the other is HIV-negative.

Clients, who may only know of basic harm reduction strategies, would benefit from psychoeducation about advances in prevention. This information might also motivate individuals to increase or maintain medication adherence to reduce risk of transmitting HIV.

Baker, B. D., Lea, E. J., & Lavakumar, M. (2020). The Impact of HIV on Sexual Functioning: Considerations for Clinicians. *Psychotherapy (Chicago, Ill.)*, *57*(1), 75–82. https://doi.org/10.1037/pst0000268

Self-Reflection

Develop positive provider beliefs (i.e., that sexual concerns are important to discuss clinically) and decrease providers' emotional discomfort in having discussions about sexual concerns.

1. What assumptions shaped your understanding about sex and sexual functioning/dysfunctioning when working with clients of diverse backgrounds?
2. What are normative expectations for sexual performance? Do you assume that a body part needs to be used in a certain way?
3. How comfortable (or not) are you to talk about sex? How does your comfort level affect the therapeutic process? Any stigma associated with the topic of sex?
4. How does sex get brought up in therapy? How do you invite the topic of sex into therapy? Is there a right/wrong time to bring up sex?
5. What questions do you have about sex therapy? What do you want to learn more about?

Deconstruct Assumptions About Sex and Sexual Functioning

- Deconstruction decenters dominant ideas by asking questions about the assumptions embedded within them.
- Decentering dominance is important because, when certain ideas are centered by giving positions of dominance, privilege, or normativity, other ideas get pushed to the margins.
- When we deconstruct a word or an idea, we unpack the meanings in. it. This reveals things that are not true across all times, places, and cultures. They are not the only truth.
- Ask questions about things we don't usually investigate because we assume them to be true and natural.
- Through deconstruction, we expose the centrality of one idea, which then allows us to subvert it and make room for previously marginalized ideas and entirely new ones.

Tilsen, Julie (2021). Queering Your Therapy Practice: Queer Theory, Narrative Therapy, and Imagining New Identities . Taylor and Francis.

Counseling and Enhancing Patient-Provider Communication

1. Ask about sexual history/concerns during intake and assessment. Normalize the topic of sex with clients to model sexual communication. Let clients know they can talk about sex with you as they develop trust to openly discuss their sexual concerns. Hold space for any discomfort.

2. Incorporate a biopsychosocial framework to explore sexual concerns and improve sexual well-being (i.e., high sexual function and low sexual distress).

3. Create a culture of inquiry (i.e., curiosity around what feels natural, innate, the right way, universal truths, etc.)

4. Explore socially constructed meanings and sexual scripts that shape perception and expectations of sexual functioning and performance of sex.

5. Explore distress (e.g. fears, anxieties, worries) rather than only a medical issue to be remedied. Move away from a strict perception of sex as either existing in the form of penetrative sex or as being absent. Sex does does not have to start with spontaneous desire and end in achievement of orgasm. Are there parts of your client that feel unseen or invisible?

6. Support clients to adapt to change (e.g. acquired disability or health issues, aging) in sexual functioning and explore different forms of intimacy.

7. Encourage the use of sexual communication. Sexual communication refers to sexual partners' ability to discuss sexual concerns (e.g., sexual preferences or sexual problems) with each other to decrease unwanted sexual experiences and increase pleasant experiences and intimacy.

8. Offer resources related to sexual health and sexual communication.

9. Openly discuss the rationale for making a referral as well as offering clear expectations for a specialist visit. A multidisciplinary approach to treating sexual concerns may be an effective treatment strategy (e.g. combining therapies–medical, physical therapy, psychotherapy)

10. Contextual factors (e.g. partner in the room) should be addressed. Is the sexual concern an issue for the client or their partner?

Assessing for Medical Contributors (p. 18)

- When exploring possible medical or physiological issues, you will want to know whether a client has had this issue for as long as they can remember or if it started at a particular point in their life.
- If the latter, you will want to know what occurred during this point in life. Was it a stressor, major life change, or something physical or medically related? Certain operations and medications will cause sexual issues.
- You will want to know if they have this issue when they are masturbating or only with a sexual partner or partners.
- If the issue is only occurring when they have sex with others or with specific partners, then that is more likely to be a psychological issue.

Enhancing Pleasure for Gay Men

A Clinical Guide for Healing and Acceptance Through Better Sex

Israel Martinez, LCSW, CST, PhD

Using Inclusive Language

A recent report from the Association of American Medical Colleges identifies physician competencies and institutional and curricular standards to improve the clinical experiences and care of sexually minoritized patients.

Physicians can use inclusive, normalizing, and behaviorally focused questions such as "are you sexually active?", "When you are sexually active what parts of your body do you use?"

Such lines of questioning provide a validating message of normalcy that may increase trust and the likelihood that a patient would feel comfortable disclosing important details about their sexual behaviors as well as any sexual problems or concerns and implications about health risks.

Self-identified gay, lesbian, and bisexual patients who reported being "out" to their usual provider were more likely to have discussed sexual problems or concerns than those who were not "out."

The minority stress theory offers a framework by which to understand how unique, chronic, and socially based stressors impact sexual functioning.

Flynn, K. E., Whicker, D., Lin, L., Cusatis, R., Nyitray, A., & Weinfurt, K. P. (2019). Sexual Orientation and Patient-Provider Communication About Sexual Problems or Concerns Among US Adults. *Journal of General Internal Medicine : JGIM*, *34*(11), 2505–2511. https://doi.org/10.1007/s11606-019-05300-3

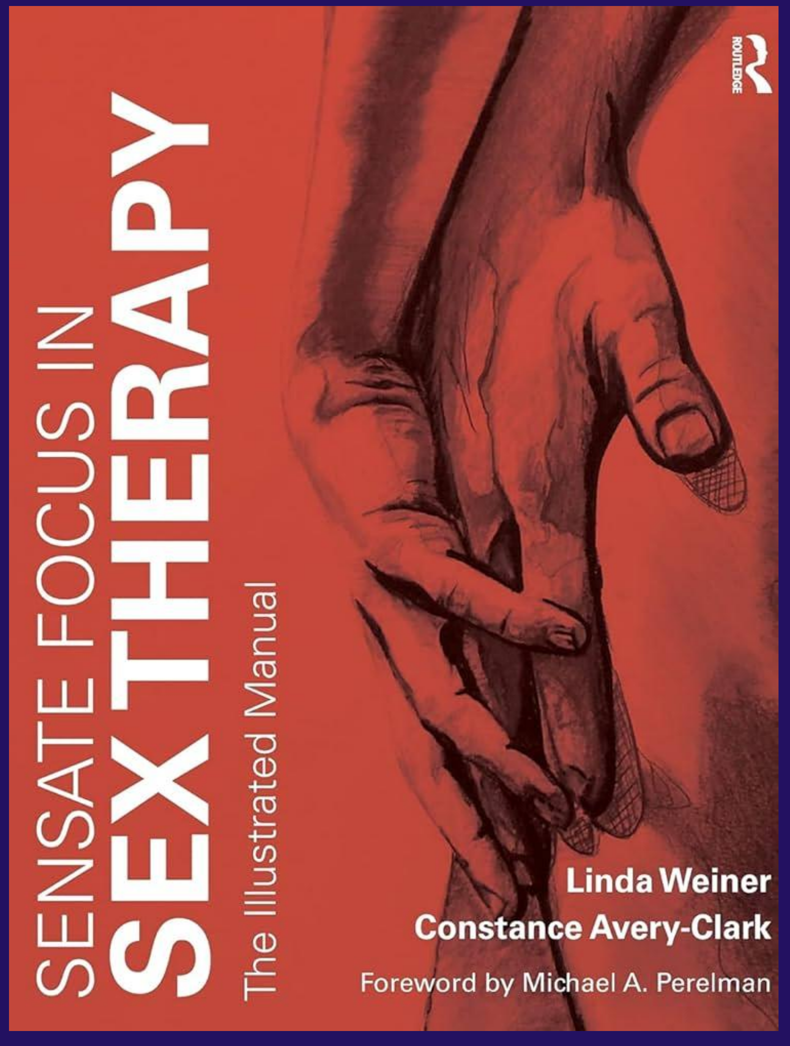
Sensate Focus

As therapists, we are learning how to work with the intimate relationship between the body and the mind.

Emotional states (some from the present, others carried from the past) follow us into the bedroom and play themselves out in our physiology. Day-to-day stress, deep trauma, attachment wounds, sociocultural factors, feelings of insecurity, “performance pressure,” and/or relational discord can all interfere with the unfolding of the arousal process and, in some cases, can lead to sexual discomfort, avoidance, or dysfunction.

Sensate Focus aids the clinician in identifying these barriers to intimacy and embodiment, and then engages them via touch exercises that are prescribed for the client to do at home.

Each exercise builds on the next bringing the client(s) into closer contact with themselves, their partner(s) (if present), sensation, learning, and possibility. The end result? Resolution of “sexual dysfunction;” greater ease in identifying and communicating sexual needs; a mindset of ongoing sexual curiosity, discovery, and expansion; and a more nuanced, intimate understanding of our sexual selves and relationships.



Starfish Reflection

Keep doing...

Starting doing...

Do more of...

Stop doing...

Do less of...

“To be truly visionary we have to root our imagination in our concrete reality while simultaneously imagining possibilities beyond that reality”
- Bell Hooks

Thank You!

Questions Regarding the Equity and Justice Focused Integrative Behavioral Health Training Project can be directed to:

ibhequity@sfsu.edu

To see a schedule of future events and archived webinars, visit:

ibhequity.sfsu.edu

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