Routledge
Taylor & Francis Group

Sexual and Relationship Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/csmt20

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To cite this article: George W. Turner & William R. Stayton (2021): Are sex therapy and God, strange bedfellows? Case studies illuminating the intersection of client sexuality with spirituality, religion, faith or belief practices, Sexual and Relationship Therapy, DOI: 10.1080/14681994.2021.2007235

To link to this article: https://doi.org/10.1080/14681994.2021.2007235

SEXUAL AND RELATIONSHIP THERAPY
https://doi.org/10.1080/14681994.2021.2007235

Are sex therapy and God, strange bedfellows? Case studies illuminating the intersection of client sexuality with spirituality, religion, faith or belief practices

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ABSTRACT

Clients seeking sex therapy can bring into the clinical space a vibrant religious, spiritual and/or faith practice. Even those clients who do not consider themselves religious, often come to sex therapy with a prior relationship to a religion or with a higher power. While this relationship can be a source of strength, it may include a history of trauma, pain, and grief. This intersection of sexuality and faith can be a powerful clinical space; however, it is not without its challenges, specifically when shame, guilt and remorse are associated with the client's sexual experiences. Mental health professionals skilled in sex therapy are ideally positioned to support these clients; however, they are rarely trained in incorporating client religious issues. This paper seeks to expand professional discourse on supporting clients at the intersection of sexual and faith well-being. First, we discuss why mental health clinicians focused on sex therapy need to incorporate a faith informed practice lens. Next, three case studies are presented to highlight the intersection of psychosexualtherapy and a client's faith. The discussion section subsequently highlights preparation needed by mental health professionals and offers suggestions for better professional training in this specialty area. Finally, faith informed clinical interventions are presented.

LAY SUMMARY

People seeking a sex therapist bring their spirituality, religion, faith, or belief practices to therapy. Clinicians must acknowledge this aspect of a client's life and recognize that it can play a key role in their healing. Sex therapists rarely receive training in faith issues. This paper attempts to bridge that gap.

ARTICLE HISTORY
Received 12 July 2021
Accepted 8 November 2021

KEYWORDS
Qualitative research; sex therapy; faith -informed practice; clinician training; intimate/sexual relationships

Implications statement

- Relational and sexuality therapist roles need to be expanded to accommodate a religious/spiritual/faith informed framework.

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- Faith informed clinical work is a potential growth area and demonstrated competency in client religious/spiritual beliefs could reposition relational/sexual therapist roles within health care teams.
- Relational and sexuality psychotherapists practicing from a faith informed lens offer their clients a more nuanced and holistic approach to sexual wellness.

Some might consider sexuality and spirituality sworn adversaries, strange bedfellows or compatible compadres? We explore the question: does spirituality fit within sex therapy? A client's spirituality, religion, faith, or belief practices (SRFBP) can positively impact psychological health helping to counter depression, anxiety, substance abuse and suicide (Koenig et al., 2012). Therefore, it follows, that psychotherapists would want to tap into this powerful client strength. However, the integration of a client's SRFBP into the therapeutic relationship is often challenging and complicated and may be further exacerbated during sex therapy. Some might see these two client aspects, sexuality, and spirituality, as opposing forces or as a peculiar alliance, but we suggest that they are attuned companions that warrant clinical consideration. Ullery (2004) observed, "The complexity of human sexuality is compounded by the intricacy of human spirituality, yet they share common ground" (p.78). This speaks to why mental health professionals specializing in sex therapy should adopt a spiritually informed framework, one which examines the nuances, contradictions, and tensions inherent in society's relationship with sexuality and religion.

Clients seeking sex therapy can bring into the clinical space a vibrant SRFBP. Even those clients who do not consider themselves religious may come to sex therapy with a prior relationship to a religion or with a higher power. While this relationship can be a source of strength, it may include a history of trauma, pain, and grief. This crossroad of sexuality and spirituality can be a powerful clinical space, fertile ground for meaning-making and therapeutic change; however, it is not without its challenges, specifically when religiously based shame, guilt and remorse are associated with the client's sexual experiences. Psychotherapists skilled in sex therapy are ideally positioned to support these clients. However, they are rarely trained in adequately incorporating client religious issues, or the clinical implications of how sexuality and religion overlap, inform, enrich, and wound the other. Further, Frunza et al. (2019) suggest that "religion and spirituality may support the process of counseling by infusing both the client and the therapist with a set of values and principles that strengthen their relationship and improve the therapeutic process" (p. 60). Psychotherapists not prepared to address the intersection of client sexuality and SRFBP run the risk of missing this clinical opportunity of rapport building.

The purpose of this article is to examine and advocate for psychotherapists specializing in sex therapy to utilize a spiritually-informed lens with their clients. First, an argument is made that sex therapists are ideally situated to integrate and address a client's SRFBP while addressing their sexuality. Next, sexuality models that incorporate SRFBP are highlighted. Then, three case studies illuminating the intersection of sex therapy and a client's SRFBP are presented. Finally, training for sex therapists interested in integrating a SRFBP informed lens is discussed in addition to implications for practice.

Literature review

The rich connections between sexuality and spirituality often experienced by our clients justify clinical and scholarly examination; yet professional discourse can be elusive, caustic, and cautionary. For this paper, we use SRFBP noting that these are often distinct concepts for clients that may share commonalities but also have separate definitions. Spirituality can be seen as "a core dimension of humanity that seeks to discover meaning, purpose, and connectedness with self, others, and ultimately God" (MacKnee, 2002, p. 234). It is also recognized that clients typically engage in these as a way to be in relationship with something larger or more infinite than they are… a higher power, the Universe, or God. Thus, we approach SRFBP as providing meaning and purpose to a client's life, uniting them to the sacred or the origin (Puchalski et al., 2009). We encourage psychotherapists to engage with clients using their own language and aim to establish a working understanding of how these words provide meaning to their life. Researchers (Hernandez-Kane & Mahoney, 2018) have noted that "viewing marital sexuality through a sacred lens serves to sustain positive sexuality and marital satisfaction across the initial adjustment to being married" (p. 431). Thus, psychotherapists addressing relational and sexual issues could benefit from understanding a client's SRFBP. According to Turner (2021) sex therapists routinely collaborate with others involved in client well-being such as pelvic floor physical therapists and physicians. Adding pastoral counselors or clergy to a trusted partner network fits into best practices. Clergy that support healthy sexuality fit nicely within this practice approach of clinicians aligning with allied client well-being professionals. Further, Winterton et al. (2020) outlined core competencies for the Board of Examiners in Sex Therapy and Counselling of Ontario (BESTCO), which address spirituality stating:

> The therapist is able to gain an understanding of specific religious beliefs that may affect sexuality or sexual function including the role of sex, both partnered and solitary, in a person's religious or spiritual life (p. 146)

Lack of training

In an attempt to identify crucial elements for effective therapy relationships, Norcross and Wampold (2011) noted the patient dimension *religion/spirituality* as one of 4 patient characteristics impacting effective methods. However, research (Mitchell & Baker, 2000) has shown client perception considers seeking help from mental health professionals as conflicting with their religious beliefs and a last resort. And, while scholarship (Stayton, 2018; Turner & Stayton, 2014) has examined how religious leaders need to be trained in sexuality, the review of psychotherapy literature indicates limited professional training of sex therapists in SRFBP. This may speak to the taboo nature of religion within psychotherapy, a bias within the sex therapy profession, or simply an overlooked clinically relevant practice area. What is clear is that more explicit professional discourse is warranted.

Researchers have noted that mental health training programs for social workers, (Xu, 2016) marriage and family therapists (Williams-Reade et al., 2019), and

psychologists (Vieten et al., 2013) need to better prepare their students to address client spirituality through professional SRFBP competencies. Perhaps to fill this gap, there have been some special issues dedicated to spirituality and psychotherapy in mental health journals, such as the Journal of Clinical Psychology (Pargament & Saunders, 2007) and Mental Health, Religion & Culture (Joseph et al., 2006) and the now discontinued Journal of Sex Education and Therapy (Plaut, 2001). Additionally, the social work literature (Hodge, 2011; Oxhandler et al., 2018; Canda, et al., 2019; Crisp et al., 2020; Ranz, 2021) has examined client spirituality as have journals dedicated to psychotherapy (Woodhouse et al, 2020; Oxhandler & Pargament, 2018; Byram, 2015; Shumway et al., 2012; McVittie et al., 2007).

Sex therapy and SRFBP

There is limited scholarship that explores the intersection of sex therapy and client spirituality, religion, faith, or belief practices. More specifically, our review of the literature only found one other work (Simpson & Ramberg, 1992) that provided in-depth case studies around the intersection of sex therapy and client SRFBP. More often, key tenets of world religions as they relate to sexual wellbeing were explored in the scholarship. Turner et al. (2004) present a theoretical approach that examines spirituality and sexuality providing a rich overview of the field of sex therapy in comparison to religious teachings. From an historical perspective, Ullery (2004) described both Christian and Eastern traditions regarding sexuality. Ullery highlighted that, "to date, [scholarship tends] to be making blanket references to psychotherapy and very little mention is made about specifically implementing spiritual sex therapy" (p. 80).

Sex therapists looking for clinical tools should consider reviewing Turns et al. (2013) who approach the topic specifically from a Christian sex therapist perspective. Two recent books tackle the intersection of religion and sexuality offering something for both clients and therapists. Stayton (2020) attempts, in his recent book *Sinless Sex: A Challenge to Religions*, "to impart useful science-based information about sexuality.…to correct misinformation about scriptures and religion that the majority of persons from the Abraham religions (Judaism, Christianity, and Islam) have been brought up to believe" (p. 5). Further, Stayton (2020) notes his desire was "to help people who experience a clash between their religion and their sexuality, and to counteract the false view many people have concerning the biblical view of human sexuality" (p. 5). Clinicians are often exposed to this same misinformation and ignorance about the various sexual belief systems thus are unable or severely limited in their ability to help clients negotiate the conflicts between their own sexuality and SRFBP. This is especially problematic around sexual guilt, shame, and fear. In *Advancing Sexual Health for the Christian Client: Data and Dogma* the Rev. Dr. Beverly Dale and Rachel Keller (2019) offer a sex-positive, body-positive approach using a common language with the client to build an effective therapeutic relationship. Further, they provide a toolkit for professionals working with clients with a Christian belief system and issues with sexual health.

Other than the above, there is a dearth of scholarship on sex therapy and SRFBP. Thus, it may be argued that sex therapists do not address this area adequately.

Why sexuality professionals need to use a spirituality-informed lens

It is good sex therapy practice to embrace the totality of our clients… their spiritual views, religious practices, and involvement in faith communities. Brémault-Phillips et al. (2015) have noted that practitioner attention to spirituality facilitated connection with patients and improved person-centered care. Despite this, even palliative care providers struggle to find ways to address spirituality in patient care (Sinclair & Chochinov, 2012) and the integration of spirituality within psychotherapy has been treated with suspicion (Gubi, 2002) and even hostility (Ellis, 1980).

Major mental health organizations advocate for clinicians to be aware of client religious practices and to be skilled at integrating this aspect of clients into psychotherapy. The National Association of Social Work (NASW) (2017) asserts,

> Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, *religion,* [emphasis added] immigration status, and mental or physical ability (Section 1.05 Cultural Awareness and Social Diversity).

Further, the American Psychiatric Association (Campbell et al., 2012) requires training in spiritual competencies during residency. Acknowledging the critical nature of client belief systems, the American Counseling Association (ACA) (2014) Code of Ethics under Standard A.4.b, tasks its members to "seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (p. 5). Other groups, such as the American Psychological Association (APA) (2017) Code of Ethics, address religion and religious issues within a diversity and inclusion statement, *Principle E: Respect for People's Rights and Dignity*, stating "psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, *religion*" [emphasis added] (p. 4). Continuing this theme of commitment to multicultural competence/cultural humility, the American Association of Marriage and Family Therapists (AAMFT, 2015) also have a non-discrimination statement where religion is mentioned within their code of ethics.

Religious models for clinicians

ISIS model

The merger of spirituality and sexuality in counseling is not new. Ogden (2001) provided a listing of some of the "characteristics of spiritual sex—oneness, heightened senses, transcendence, love and partnership, increased energy, and ecstasy" (p. 325). Ogden (2018) introduced the Integrating Sexuality and Spirituality (ISIS) Wheel paradigm based on her nation-wide survey which highlights that aspects of the sexual experience reside in the emotional and spiritual realm. However, discussions of spirituality are often viewed as the antithesis of scientific discussion and a discourse focused on the intersection of sexuality and spirituality is not without this sentiment. As Ogden (2018) points out, "sexuality and spirituality are seemingly

irreconcilable concepts in most of mainstream American culture. Perhaps they are especially irreconcilable in current sex research and therapy, where sexual norms are based on what can be counted and measured in random controlled trials and evidence-based treatments" (p. 8).

Assessing sexual value systems

Stayton (2020) offers a model that distinguishes between religious views based upon an "act-centered" sexual value system (SVS) and a "relationship-centered" sexual value system. An act-centered SVS judges specific "acts of sex" as holding moral or immoral value. For example, one's SVS may consider masturbation, homosexuality, pre-marital sex, extra-marital sex, or group sex as being immoral and sinful. At the other end of the SVS spectrum is a value system based on relationships. This SVS views human sexuality as intended for relationships. Relationships are what the Bible, creation, God, and life are all about. This SVS holds that there is nothing immoral or sinful about any of the acts of sex if the motives and consequences are clear and acceptable to all the participants. A problem is that, for most people, their choice between an acts-based or a relationship-centered belief system is dependent on the particular issue or comfort level with the "act." There is no consistent basis on making a decision other than the issue or comfort level. For example, the client may have accepted masturbation and oral sex as acceptable, but not homosexuality or anal sex. However, this decision was made exclusively on the issue or comfort level with the act.

Case studies

These hypothetical case studies are provided for illustrative purposes only and do not represent actual clients or actual client experiences. They are meant to provide an example of how an integrative spirituality informed approach can enhance sex therapy and offer a referral source to highlight the diverse interactions sex therapists engage in with allied health professionals. Additionally, case formats will include: a presentation of the client issue with client goals and how a biopsychosocial-*SexualSpiritual* approach was utilized in the rapport building, assessment, case conceptualization, and treatment planning clinical process.

Turner and Stayton (2018) discuss the many types of cases that are brought to clergy that need to be addressed. Cases to be discussed here include the following topics: 1. Madonna/Whore Syndrome, 2. Sexual Anatomy Ignorance, and 3. Internal Homophobia. These case studies are provided as an example of how mental health professionals, specifically those trained in sex therapy, can approach the intersection of a client's faith and their sexuality. As these case samples highlight, the sex therapist often needs to address multiple interconnected issues impacting a client's sexual concerns including other physical/medical issues, relational dynamics, cultural influence, as well as faith, spiritual and religious consideration.

Case 1: The Madonna/Whore Syndrome

Case formulation

Eduardo (45-years old) and Sofia (43-years old), a Latinx couple, have been married for twenty-five years and have three children. They consider themself Evangelical

Christians and after attending a church-based marriage program, followed by seeing a traditional couple's therapist for the past year, they have sought the help of a sex therapist. During the first session with their sex therapist Sofia forcefully states to the clinician "I want to see you alone first." The sex therapist honors the request. When alone Sofia tearfully exclaims, "I love my husband very much!" She pauses, and almost whispers, "…but I have no feeling down there." During a comprehensive sexual and religious history, Sofia shares that she grew up in a church as a young person and was a member of a purity group who pledged not to have sex until marriage. She was given very sex-negative messages filled with shame and guilt about any premarital sexual interaction. When asked about sex outside of marriage she firmly declares, "I didn't want to become dirty or go against God's plan for me." Sofia details how, as a youth, she would pray that God would help her to stay "pure" and not stray into becoming a "slut." Further discussion reveals Sofia currently feels embarrassed when she experiences sexual feelings. She did not marry until she was in her mid-20s. She thought that with marriage she would be free to enjoy her sexual feelings. Marriage did not free her to experience sexual feelings, in fact, physically she felt numb.

SRFBP & sex therapy integration

During the biopsychosocial-*SexualSpiritual* (Turner, 2020) assessment, the sex therapist explored differential diagnosis, such as investigating both individual and couple distress, anxiety, and grief issues. Due to her religious upbringing, Sofia was guarded, fearful and not accustomed to discussing sex with her husband; she viewed sexual desire as "dirty" and reserved for men. She desperately wanted to maintain her spiritual place as a "good girl." Unpacking these early messages and processing their meaning was a crucial clinical first step with Sofia. Sofia role played disclosing the interconnectedness of these religious messages to her sense of sexual pleasure. Eventually, the sex therapist was able to have Sofia invite her husband, Eduardo, into a session. As part of the ongoing assessment, it was noted that Eduardo was totally mystified with his wife's news; he experienced her as turned on, orgasmic much of time, and thought her body was consistently responsive to their love making. Ensuring that Eduardo was in attendance at all follow up appointments helped the couple see the importance and connection of their sexual and spiritual wellbeing and to frame the pursuit of both as a couple's agenda. Further, the sex therapist, using a spiritually-informed lens, engaged the couple in psychoeducation, helped them expand their sexual repertoire, normalized sexual conversations, and addressed co-morbidity issues.

Interventions

Normalize sexual conversations. The sex therapist was able to facilitate bringing Eduardo into the treatment as a vital part of the sexual healing, while working with Sofia's religious messaging that "good girls don't discuss sex." Modeling healthy use of sexual vocabulary and genuine curiosity about each client's sexual history helped the couple integrate this aspect into their communication. This was followed up with homework for the couple to create an "Erotic Zone Map" that depicted the sexually arousing parts of their bodies. The sex therapist used a white board to draw an outline

of a person instructing the couple to circle areas that are enjoyable labelling them a "3". Next, they were asked to place a "2" next to body parts that were essential for their enjoyment or that helped lead to orgasm. Finally, the couple was told to place a "1" on the body parts that were mandatory to reach an orgasm or the pinnacle of pleasure. A follow up discussion or homework could be to detail the type of touch needed for the body parts circled. Instructing the couple to complete the Erotic Zone person individually and not discuss it prior to their next joint session provided a safety net for couples not accustomed to sexual talk with their partner. Processing the homework in a joint session normalized discussing their sexual life. This also laid the foundation for the sex therapist to invite Eduardo to give voice to his feelings. Eduardo for the first time was able to discuss feeling betrayed and sexually incompetent. The goal is to bring sexual communication back into the relationship.

Psychoeducation. The sex therapist had the couple read: *PURE: Inside the Evangelical Movement that Shamed a Generation of Young Women and How I Broke Free* (Klein, 2018). The sex therapist then explained the concept of the Madonna/Whore Syndrome to the couple. The Madonna was the Virgin Mary. She was to be loved, adored, even worshipped, but not sexually desired. The Whore was the wild, seductive, sexually excited, desired, and responsive woman but not marriageable. This messaging, a common model taught if not explicitly it is often implicitly woven into many religious institutions, can result for some parishioners to develop genital anaesthesia (Stayton, 2020).

Group therapy/expanding sexual information and skills. It was suggested that the couple participate in a Sexual Attitude Reassessment (SAR) (Stayton, 1998) program where they viewed explicit movies of real couples in real relationships. A fundamental piece of this group experience is the collective processing and discussion with fellow participants. Following s SAR, clients can become more sexually responsive feeling the fullness of sexual pleasure. A sex therapists may need to help clients explore finding a church that is more progressive in their sexual attitudes.

The sex therapist would want to rule out other clinical issues that might interfere with pleasure and orgasm such as menopause or sexual side effects of Selective Serotonin Reuptake Inhibitor (SSRI) antidepression medication which can include anorgasmia (difficulty reaching orgasm) and lowered desire. The sex therapist can normalize that the majority of women need direct clitoral stimulation to reach an orgasm, meaning that while vaginal penetration can be an enjoyable activity it may need to be augmented in order to facilitate an orgasm. Further, the addition of a vibrator may be recommended. However, some clients may be resistant to a vibrator on religious grounds or see it as a juvenile or a less "normal" means than penetration.

Case 2: Sexual anatomy ignorance

Case formulation

Janet and Sol, a couple in their early 20's, have been married one year. Their pastor referred them to see their physician. They are trying to get pregnant and initially

sought pastoral guidance. Janet reported that sex is painful thus the physician began treating her for vaginismus. Recognizing that the treatment was not helpful, the physician then referred the couple to see a sex therapist. The couple is understandably upset after seeking two trusted sources for help and not finding a solution. They are anxious about seeing a sex therapist. Moreover, given that neither a spiritual or medical solution was found they are feeling hopeless and fearful that the problem may be more complicated than originally thought.

A very important part of sex therapy is getting an accurate, thorough sexual history. While talking about their sexuality can be challenging for most clients, for some religiously fundamentalist clients this task can be even more onerous. During the intake session, Janet tearfully shares, "It just hurts down there." Sol follows up, "Every time we try to make love, I end up making her cry. I feel terrible. I don't want my wife to be in pain!" As part of the assessment process, the sex therapist shared pictures of the female sexual anatomy to the couple and asked them to show on the pictures, how they made love. The sex therapist prompted Janet to note when and where she developed pain. Rather quickly the problem was discovered. The couple thought that intercourse occurred through the female urethra, because they reasoned that a man, urinates, impregnates, and has sexual pleasure with one body part, his penis, then this must be similar for the woman. The couple disclosed that they had been trying to insert the husband's penis in the wife's urinary opening. The couple was convinced that the vagina was only for delivering the baby.

SRFBP & sex therapy integration

While many religious institutions have pre-marital instructions for couples, they seldom offer instruction on sexual anatomy (Turner & Stayton, 2014). It is not uncommon for couples seeking sex therapy to have little sexual knowledge, but especially those from a fundamental church background (Simpson & Ramberg, 1992). In order to gain an accurate clinical picture, it is essential to make sure that an assessment explores a client's early religious affiliations and the moral tone in their household or culture. Many women and men, for example, have little understanding of the clitoris (Stiritz, 2008). Further, female masturbation or anal stimulation can be foreign concepts to couples steeped in a traditional missionary, penetrative sexual narrative that is often reinforced through religious teachings (Joannides, 2017). Even fundamental pregnancy or sexually transmitted infection (STI) prevention methods such as condom use can be skewed by clients exposed to the abstinence-only until marriage (AOUM) movement (Santelli et al., 2017). Sexually illiterate or misinformed clients are also affected by clergy anxious about broaching the subject of sexual and erotic anatomy and response.

Interventions

Psychoeducation. Once aware of the problem, the sex therapist used genital graphics to review basic anatomy, detailing both male and female anatomy. Then the sex therapist explained the process of sexual arousal, intercourse, and pregnancy. An additional tool might be offering instructional videos. Ensuring that this couple develop a healthy understanding of sexual pleasure, and the skills to facilitate that

aspect into their relationship, might become a goal of therapy. In that event learning about sensate focus might be a useful homework assignment that can be facilitated with a video such as *A Couples Guide to Sexual Pleasure: Heterosexual Couples* (Stayton, 2006).

Sexual genogram. A therapeutic tool such as a sexual genogram (Hof & Berman, 1986) helps clients expand their sexual script. This may be especially useful for clients who have a religiously restricted view of sexual activity as solely for reproduction. Being able to introduce other functions of sexual activity such as playfulness and pleasure may help a couple expand their understanding of their sexual connection.

Case 3: Internal homophobia

Case formulation

Robert is a 55-year old African American who adamantly responds "I'm not religious" during the intake session with the sex therapist. He is seeking help with erectile difficulties and is recently single. Despite identifying as a "bottom," Robert feels pressured to have an erection so he can also top partners, stating "Grinder can be brutal, plus tops get more action." Robert expresses remorse that "I've just never been a real man;" he has clinical depression and sees a psychiatrist for medication management of his symptoms.

SRFBP & sex therapy integration

After the clinician completes a religious history, Robert discloses that he was brought up by his grandmother and regularly attended church. Robert dismissively shares that he "grew up in the Baptist church" routinely attending summer tent revivals. Sharing his clinical assessment with Robert, the sex therapist highlights that a significant amount of Robert's developmental years were spent participating in an organized religion. The sex therapist points to these early messages from the church around masculinity or a cultural narrative prioritizing strong Black men, and asks Robert, "Could these messages follow you into the bedroom? Or might they be interfering with your Grinder hook-ups?"

Interventions

Clergy consult on religious shame. Despite Robert adamantly stating that he no longer attends church nor practices any faith, the sex therapist remains vigilant inquiring further if any of that residual teaching may still be impacting Robert's sexual identity, practices, and beliefs. During case conceptualization, sex therapists can differentiate clinical issues and allocate them to appropriate professionals. In this case, the sex therapist makes a recommendation that Robert visit a pastor who can discuss religious doctrine from a sex positive, inclusive and supportive framework.

Confronting toxic masculinity. Robert was able to identify his struggle with meeting a social/religious ideal of masculinity, specifically as it related to the

African American community. The sex therapist worked on decentering "tops" as more masculine and reframing a narrative for Robert where he could own both masculine and feminine aspects of how he identified in a holistic space of pride. The sex therapist outlined the gay community's own misogynistic (Hale & Ojeda, 2018) and internalized homophobic (Thepsourinthone et al., 2020) struggles that perpetuate hetero-normative ideals.

Psychoeducation. The clinician introduced a pleasure model of sexuality (Vernacchio, 2012), that normalized a flaccid penis during sex play for the client. The sex therapist challenged Robert's idea that he had to label himself a "top" or "bottom" giving him permission to enter sex play with the goal to maximize pleasure. This new model provided Robert with affirmation and a sense of sexual agency.

Addressing co-morbidity issues

The sex therapist referred the client to his physician to test for diabetes, since erectile dysfunction can be an early sign. Further, Robert was asked to discuss the sexual side effects of his anti-depressant with his psychiatrist as well as possible different management strategies for his depression.

Discussion

Overall, this paper adds to the discourse surrounding the importance of client spiritual, religious, faith, belief practices (SRFBP) specifically as it applies to sex therapy. While we are all born sexual, we are not born good lovers (Stayton, 2020). Nor are we prone to embrace and walk in harmony through the intersection of our sexuality and spirituality. Enter sex therapists, and perhaps more importantly, enter the issue: *Is the profession of sex therapy prepared to aide clients' sexual wellbeing, while supporting, acknowledging, and celebrating the intersection with their spirituality?* Sex therapy clients may identify as religious, spiritual, or following a faith practice that aligns them with a higher power or God. Psychotherapists, specifically sex therapists, practicing from a spiritually-informed lens prioritize becoming familiar with client spiritual, religious, faith, belief practices (SRFBP). This approach is further supported by Ullery (2004) who stated, "the fundamental connection between spirituality and sexuality, their shared pursuit toward wholeness, creates a natural springboard for examining this realm" (p.81). We have advocated for a model of sex therapy that integrates a spiritually informed lens aligning with a customizing approach of psychotherapy commitment to create "the optimal match in psychotherapy" (Norcross & Wampold, 2011, p. 128).

Our paper expands upon similar earlier work by Simpson and Ramberg (1992), updated to be less heteronormative and highlighting three distinct clinical areas: case conceptualization, SRFBP integration, and interventions. Further, this paper encourages sex therapists to approach clients more holistically by considering models of sex therapy that embrace client religiosity. This paper is in alignment with sexuality scholars such as Stayton (2020) who advocates that all persons are spiritual and sexual beings. He proposes that whenever a person asks about the meaning of

their sexuality, that this is always a spiritual issue. Further, Stayton argues that religion has too often separated spirituality and sexuality. We would add that science of sex therapy should not fall into the trap of forcing an artificial bifurcation between God and sexual pleasure but rather welcome the natural integration of these two client aspects.

Each of the three case samples emphasizes different clinical considerations and highlights how a spiritually informed lens can facilitate a successful approach to integrating sex therapy with a client's SRFBP. In particular, we have illustrated dynamic cases that walk a sex therapist through the critical steps of case conceptualization to clinical interventions. Most importantly reviewing the case studies paves the way for sex therapists to incorporate a spiritually informed practice lens into sex therapy. We recognize the potential struggle for clinicians who may be struggling with their own spiritual relationship and who may operate from foundational training that isolated client's SRFBP from therapy, relegating it to clergy (Turner et al., 2004). A sex therapist's willingness to explore, welcome and celebrate a client's SRFBP requires a clinical humility that acknowledges a force larger than the profession of sex therapy (Aponte, 1996).

This article examined three case studies which highlighted the intersection of client SRFBP and sexuality. Cases illuminated how sex therapy clients bring their SRFBP into the clinical space. This integration of religion, faith, and spirituality with sex therapy is important because for "sex therapy to have relevance in a society that considers spirituality to be important, a holistic approach is called for wherein individuals are understood in relation to their belief system and behavior" (Turner, et al., p.419, 2004).

Limitations

The cases presented are not actual clinical cases which are often more complex, thus this curated sample has limited applicability. We were unable to provide additional clinically diverse cases and suggest future work include other samples. Future research should examine how sexuality and religion are discussed in counseling programs and students' level of comfort integrating both topics into their clinical identity. Specifically, programs like social work that feed many students into the private practice of sex therapy should be included. Further research should consider examining the positionality of sex therapists in regard to the religious messaging they were exposed to and how that might impact their clinical framework.

Implications for practice

Preparation & training

Critical self-reflection is a common therapist tool for improvement; it is a "process that requires introspective work on issues in [their] own life, that has an impact on the process of therapy in both positive and negative ways" (Timm & Blow, 1999, p. 333). As a first step, mental health professionals must examine their own religious history and relationship with a higher power and/or a faith of practice. Is there a

religious foundation within one's history? Are there spiritual wounds hindering clinical insight? Is there an experience of guidance from and connection to the Universe? A clinicians first responsibility is learning to appreciate, understand, and navigate their own religious landscape. More specifically, a sex therapist must critically reflect on the space where their own sexuality and faith intersect and inform their practice, as this is potentially a volatile space for a therapist.

Next, as Turner (2020) has noted, being open to client sexuality or, being "*askable* provides you tools to more holistically see your clients" (p. 309). Expanding upon this notion, clinicians should be viewed as available, open, or 'askable' regarding spirituality issues as well by their clients. Yet, how will clients identify this SRFBP approachability in their sex therapist?

Finally, reflect on how familiar you are with religion in general, but more specifically do you have a working knowledge of the major faiths practiced by the majority of your clients? Seeking the advice from a trusted network of clergy partners could augment a clinician's ability to navigate a basic conversation with clients around the tenants of their belief system? It might be argued that if you are not literate in your client's faith practices then they will not bring that aspect into the relationship with you. Clinicians may want to consider additional training in this area. To learn more see https://www.incarnationinstitute.org/about.

Bio psycho social sexual spiritual

While psychotherapists have traditionally utilized a biopsychosocial approach, and it has been advocated (Turner, 2020) for an expansion of this model to include sexuality to "center this vital aspect of client life, sexual well-being" (p.306). A more holistic model would embrace an explicit inclusion of both sexuality and spirituality to create a BioPsychoSocial-Sexual*Spiritual* [emphasis added] lens. Given the often-central position of sexuality and spirituality in most clients' lives, explicitly including both of these aspects into a clinical approach invokes arguably a more holistic, client-centered, best practice model. When a sex therapist is working with a couple it merits consideration to explore how SRFBP is situated in both clients' lives and if it is shared.

Brief assessment

A brief but effective assessment can include these three questions: (1) How was your religious upbringing helpful to your acceptance of your sexuality and your sexual body? (2) How was your religious institution helpful to you becoming a good lover? and (3) What aspects of your SRFBP do you find most helpful (or harmful) to your sexual wellbeing?

Partnering with clergy

It is important for clinicians to partner with clergy and other religious leaders. First, as noted by Turner and Stayton (2014), "clergy and religious leaders confront an

array of sexuality issues—reproductive technologies, teen and single parent births, marital crises and divorce, sexual abuse, infidelity, clergy sexual misconduct, and the crossing of professional boundaries, sexual orientation, gender identity and expression, sexual dysfunction, and a host of other concerns" (p. 485). Clearly, a sex therapist could be a valuable resource to clergy. However, often clients need affirmation for their actions from a respected religious leader. Thus, building relationships with clergy and lay pastoral leaders in the community is an essential tool for sex therapists. While it can be easy to dismiss all religions as anti-sex, sexuality professionals must remember that religions are not a monolith. Sex therapists should make it a goal to identify local priests, rabbis, imams and pastors who are open, accepting and sex positive. If the clinician cannot find local spiritual leaders to partner with, consider religious scholars who have written on the topic of spirituality and sexuality (Helminiak, 2000, Stayton, 2020; Spong, 1998). Sharing these books or other accessible resources such as Facebook pages (https://www.facebook.com/JohnShelbySpong) or podcasts (https://bettersexpodcast.com/rachel-keller-beverly-dale-sex-positivity-in-the-christian-faith/) can be a welcomed solace for religious clients struggling with some aspect of their faith and sexuality.

Conclusion

Given that spirituality has an intrinsic transcendental purpose, the implications for sex therapy is richer sexual awareness and achievement. This article proposes that sex therapists need to incorporate spiritual, religious, faith, belief practices (SRFBP) as part of culturally aware, holistic, client-centered sex therapy. Those that integrate a spiritually informed lens enhance the likelihood of successful client treatment. In pursuit of this ideal the article detailed three case studies that highlight the intersection of client spirituality and sexuality. Given how ingrained SRFBP are within the client experience we believe unequivocally that SRFBP does fit within sex therapy and a spiritually informed lens is warranted by sex therapists.

Acknowledgments

We are grateful for Dr. Landi Turner's review, edits, and thoughtful feedback.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Turner, G. W. (2021). Sex therapy: Advanced training specialty practice area for social workers (chapter 26). In S.J. Dodd (Ed.), The Routledge International Handbook of Social Work and Sexualities. New York, NY: Taylor & Francis. Turner, G. W. (2021). A vision of justice: Seeing the Sex-ABILITY of people with intellectual disabilities (chapter 20). In S.J. Dodd (Ed.), The Routledge International Handbook of Social Work and Sexualities. New York, NY: Taylor & Francis

Turner, G. W. and Pelts, M. (2021). Sexual well-being informed social work practice: Harnessing the power of reflection and a hallmark experiential sexuality education activity, British Journal of Social Work. I acknowledge the Traditional Owners and Custodians of the land I work on as the first people of this country and respect the elders past and present

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