Spring April 2013

Visual Sexuality: Integrating Art and Sex Therapies

Jillien Anne Kahn
Loyola Marymount University

VISUAL SEXUALITY: INTEGRATING ART AND SEX THERAPIES

by

Jillien Kahn

A research paper presented to the

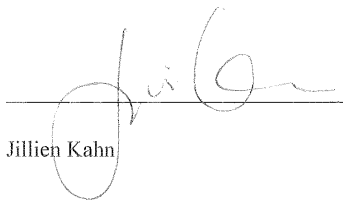
FACULTY OF THE DEPARTMENT OF
MARITAL AND FAMILY THERAPY
LOYOLA MARYMOUNT UNIVERSITY

In partial fulfillment of the
requirements for the degree
MASTER OF ARTS

May, 2013

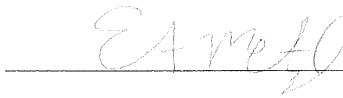
Signature Page

Author Signature:



Jillien Kahn

Research Mentor's Signature:



Einat Metzl, Ph,D., M.F.T., A.T.R.-B.C.

Abstract

The goal of this research was to understand the potential challenges and benefits of an integration between art and sex therapies. Three interviews were performed: two with certified art therapists, one with a certified sex therapist, in order to understand how each of these professionals has chosen to approach issues of sexuality and creative expression within his or her practice. The data from the interviews was critically compared within and between each interviewee, producing three overarching themes that provide a framework for understanding the potential benefits and challenges of this integration. These three themes are defined as: 1) The importance of theoretical training and scope of practice in unlocking sexuality; 2) Opening the door to sex and sexuality in clinical work using creative expression; and 3) Concerns and challenges for the clinician using artistic expression with sexuality. Through discussion of these themes, it was found that there is great potential for an integration of the two therapies, provided clinicians have access to appropriate training, as well as a deeper understanding of individual attitudes toward sexuality as provided by cultural experience.

Dedication

This project is dedicated to my parents, who worked hard to make sex and sexuality an open, shame free topic in our home. Educational videos, books and conversations were always available and no question was off limits. Thank you, Mom and Dad, for teaching me first that its ok to ask and explore, then, later, how to do so safely and maturely. I only hope I can do for others what you did for me.

Acknowledgements

I would like to thank my research mentor, Einat Metzl, PhD, LMFT, ATR-BC, for the tireless support and compassion that shaped this project, and an understanding of my capabilities that made it infinitely better. Your genuine interest and expertise brought the perfect combination of possibility and reality to give a solid foundation to this first research project.

I would also like to thank the three interviewees Nick Ryan, PsyD, ATR, Kate Loree, LMFT, ATR and JR for generously agreeing to take part in this research, for trusting me with their experiences, hopes, and frustrations, and for continuing to answer questions thoroughly and thoughtfully throughout the writing of this paper.

Table of Contents

Visual Sexuality: Integrating Art and Sex Therapies

This research explores the opportunity for integrating art therapy and sex therapy through the experiences of three therapists – one sex therapist and two art therapists – who have in common working with sexuality based populations, including sexual minorities, sexual identity concerns, and/or alternative sexuality lifestyles. Each clinician interviewed has provided the research with a unique and thought provoking point of view on treating sex and sexuality issues, both with and without the use of art. Each communicates a passion and dedication to helping clients find healthy satisfaction within his or her sexuality using different approaches. From the comparison of these approaches evolves an understanding of the benefits and challenges in utilizing art as a method of sexual understanding and change. This research begins with a literature review exploring the commonalities in research and methodological approaches between the two therapies, then explores and critically compares the interviews, culminating in a review of the possibilities presented by this integration.

Providing the foundation for this research is the understanding that art has been a conduit for the expression and communication of sexuality as far back as ancient China, India and Greece (Bhugara & de Silva, 1995). As Riley (2004) points out, our world develops visually first, with language giving name and communication to people and objects already existing within that world. Without diminishing the enormous value of words, this could suggest that our first and most natural emotional language is that of feelings and images – things that often transcend the power of verbalization.

In terms of sexuality, Goodwach (2005) purports that, "Biologically and metaphorically, sex is a core experience, and is part of the total person, not just the genitals" (p.161). Goodwach continues, suggesting that sexual urges and discovery begin in infancy and continue throughout the lifespan, but that throughout our lives anxieties caused by social and relational struggles can affect this development. The stress response activated by life events may limit the brain's ability for verbal communication, forcing our bodies to express emotions physically, often presenting as sexual dysfunction.

Sexuality, in both its nature and in our personal relationships with it, is a core, constantly evolving part of us (Ellis, 2007). For a clinician to truly understand the experience of a client, there must be a sense of comfort and competence in discussing sexuality, including a preparedness to discuss preference, desire, fantasies, and shame. Sexuality is, as Goodwach (2005) pointed out, something we develop throughout our entire lives: it is the culmination of a lifetime of experiences, internalizations and values. One foundational understanding of this paper is that a healthy sexuality is a primary necessity in achieving physical and emotional health - in becoming a whole, healthy person. While an individual's healthy sexuality may not match the cultural definition of healthy sexuality, it is absolutely imperative that the individual have a relationship of acceptance and deserved fulfillment with his or her sexuality. Without this, no relationship can satisfy and no basic need can be met.

Accordingly, it seems vastly important for clinicians to have a basic awareness of sexuality issues regardless of expertise. Based on previous research highlighted in

the literature review, as well as this paper's research findings, art lends itself naturally and seamlessly to sexual expression, providing a full range of discovery for clinician and client. For the art therapist, art can help to reach a level of comfort allowing access to hidden sexual constructs, providing the client with far deeper access into the core self. For the sex therapist, art can reach beyond the presentation of sexual dysfunction, providing deep understanding of the underlying roots of the dysfunction, giving the client the tools of self-awareness and lasting change.

Having had the good fortune of being born into a family that believes in a healthy, accepting and individualistic approach to sexuality, I have discovered throughout my life that most have not received sexual information with the same openness that I have. In fact, I have been dismayed to find that an enormous percentage of people have received very little useful information on this topic and as a result become very uncomfortable when discussing sex and sexuality. Looking outside of my immediate circle, I realized that this observation is supported in spades by the current sexual climate in our culture; by the battle for gay rights, the one-dimensional view of sexuality portrayed through media and the double standards that continue to haunt healthy sexual development, among many, many other factors.

Throughout this beginning of my professional maturation, I have discovered that this profession – both in terms of art therapy and therapy in general – is a microcosm of these larger cultural issues. Therapists – especially newly developing therapists – have too often lacked the opportunity to truly understand this complex,

vastly important piece of the human experience. My intention is to help start this conversation for the next generation of art therapists. We have been given a very fortunate tool, a tool that helps us to break silence without words, enabling us to understand complex thoughts before clients can verbalize them. What a great opportunity to break the silence, to open the doors and to use art as a way to help the client find words to express a part of him or herself that can so often be haunted by shame and judgment.

Background of the Study Topic

The integration of art therapy and sex therapy has very little history, which in itself necessitates research. As art therapy continues to solidify its legitimacy in the professional world, it is important to share its benefits and successes with professionals and clients throughout all therapeutic modalities. Current cultural shifts suggest that we are entering a new generation of sexual freedom, openness and acceptance, providing a new definition of sexual health. With this comes an unsurpassable opportunity for sex therapy and art therapy to help individuals explore their own contribution to this change – a necessary exploration for a culture that has, for much of our history, been taught to suppress just this type of openness. Perhaps due to these cultural changes, sex therapy is reportedly in a "figurative mid-life crisis" (Meana & Jones, 2010, p. 58). Having historically been through multiple changes, starting with psychoanalysis, moving to cognitive behavioral, then medicalization, it is now moving toward an integration of these modalities

(McCarthy & McDonald, 2009), an integration which mirrors the movement of sexuality into our holistic view of mental and physical health.

The long history of sex therapy is interwoven in the fabric of ancient cultures, which provide the foundation for current sexual morals and beliefs (Goodwach, 2005). This creates both an immense strength and enormous challenge. As sexual culture continues to change and mature, sex therapy is being forced to expand into a more open, integrated understanding of sexuality and sexual dysfunction. The struggle here, as with any change, is in letting go of ingrained beliefs to embrace this developing understanding of acceptable sexual practices.

Art therapy, on the other hand, is just beginning to gain attention and recognition, partly due to increased progress toward validation of efficacy in research (Slayton, D'Archer, & Kaplan, 2010). In one of the few articles on the integration of art therapy and sexuality, Ellis (2007) laments the lack of empirical research on the topic, lamentable largely because the two lend so naturally to one another. According to Fink and Levick (1973), clinical art therapy and its relationship to the subconscious allows sexual content to arise regardless of intention. Using art in a non-directive manner, the therapist will often discover reference to sexuality or sexual concerns that the client had no awareness of having added, otherwise known as latent content.

The strengths of art therapy can, potentially, offer a great deal of complementarity to the changes occurring in sex therapy (Ellis, 2007). The symbolic, visual nature of the therapy offers a depth to even short-term, behavioral based sex therapy techniques, increasing the possibility for lasting change (Rosal,

2001). Art helps the client express a complexity that the linearity of language cannot, providing an understanding for the therapist and the self that helps change the fabric of belief, rather than simply the behaviors. As sex therapy continues its growth to include cultural, relationship and individual factors, art can help achieve an understanding of what sexuality means to each individual client.

Literature Review

Art making has been a method of expression and communication for thousands of years (Farokhi, 2011), with sexuality having been a favored topic of artists throughout history (Bahrani, 1996; Cooper, 1986). Ancient civilizations, such as Greece, China and India, left legacies of manuals, poetry and art, expressing sexuality as essential, natural, erotic and spiritual (Goodwach, 2005). It is through the art of these civilizations that we understand historical attitudes toward sex, gender, sexuality, and sexual dysfunction, which in turn, educates us on our own attitudes toward these constructs. This relationship is inextricable, with the sexual art in some cultures, and lack thereof in others, giving us information about that culture's relationship with sexuality (Bahrani, 1996). This relationship can often be seen in modern understandings of these topics, having been communicated across many generations.

This paper will discuss these ideas in terms of communicating an individual's relationship to sexuality and sexual culture in psychotherapy. While the artistic expression of sexuality has remained culturally relevant from fine art (Cooper, 1986), to pop culture and media (Albury & Lumby, 2010), research and literature on the integration of art and sex therapies remains extremely limited (Ellis, 2007).

As sex therapy enters a period of change and growth, it is shifting from a limited, heterocentric, medicalized view, to a more broad, humanistic, individualized understanding (Leiblum, 2007; Meana & Jones, 2011). Meanwhile, art therapy is developing a popular understanding as a legitimate, quantifiable, universal modality, being applied in clinical settings to all populations (Farokhi, 2011; Slayton

et al., 2010). Here, the long-standing relationship between art and sexuality is explored in terms of how each is currently recognized in psychotherapy, as well as ways in which an integration of techniques may prove beneficial to both therapist and client.

A Short History of Sex Therapy

The earliest sex therapy techniques can be found within the legacies of the ancient world, with Ayurvedic medicine in Ancient India, acupuncture in Ancient China, and biological and spiritual understandings of sexual dysfunction in Greece and Rome (Berry, 2012; Bhugra & de Silva, 1995). While psychological causes were hinted at throughout history (Berry, 2012), it was not until the turn of the twentieth century that Freud and psychodynamic theory created major shifts in therapeutic approaches (Kelly 2004; Hyde & DeLamater, 2003). Just after Freud popularized the role of sex and sexuality in the human psyche, Ellis and Kinsey began to popularize the field of sexology, increasing the range of acceptable sexual behaviors through broadening the definition of sexuality to include women and homosexuality (as cited in Iasenza, 2010).

In the 1950s, behavioral approaches became the norm, beginning with sexually limiting techniques designed to discourage the existence and frequency of many sexual acts, such as masturbation and homosexuality (Goodwach, 2005). In the 1970s, these approaches shifted, with Masters and Johnson popularizing the first version of what we now know as sex therapy (Bhugra & de Silva, 1995). It was with the behavioral techniques of Masters and Johnson, then Kaplan, that couples were encouraged to work toward sexual equality, openness and enjoyment (Atwood

& Klucinec, 2007). This coincided with a sexual revolution in western culture, helping to pave the way for a complete overhaul of our sexual understanding (Goodwach, 2005).

The Modernization of Sex Therapy

According to the World Health Organization (WHO)(2002), sexual health is currently defined as:

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (p.5)

The American Association of Sexuality Educators, Counselors and Therapists (AASECT)(2004), describes current sex therapy practices with a similarly sex positive definition:

> Sex therapy is a subspecialty of psychotherapy, focusing on the specific concerns related to human sexuality. People of all ages, creeds, health status, ethnic backgrounds, whether partnered or single, may benefit from working with a psychotherapist who specializes in this area. ("What is Sex Therapy?". para.1)

AASECT continues by stating that while typical concerns can include "arousal, performance, or satisfaction…decreased or increased desire for intimacy

or…mismatched or discrepant desire or interest in sexual intimacy" (para.1), they also point out that sex therapy is not limited to sexual dysfunction, age bracket or lifestyle:

> At any age, performance or lovemaking skills can be of concern, just as can issues around orgasm and satisfaction. . . . Additionally concerns about sexual trauma in one's background, medical conditions that affect one's sexuality, sexual pain disorders, concerns about gender identity or sexual orientation, and issues around sexual compulsivity or addiction are frequent concerns that people discuss with a Certified Sex Therapist. ("What kinds of problems can benefit from Sex Therapy?" para.1-2)

In contrast, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR) (2000) presents four main categories of sexual dysfunction diagnoses: disorders of sexual desire, disorders of sexual arousal, orgasmic disorders and sexual pain disorders. Each disorder is further separated into sub-categories based largely on gender.

While the DSM-IV-TR definitions are currently under review in preparation for the DSM-V, Balon and Wise (2012) assert that there remain many perplexing and enduring problems regarding the ability to classify and diagnose sexual dysfunction, the first problem being the lack of "… a definition of norms and sociocultural norms in the distinction between normality and pathology" (p. 12). Meana and Jones (2011) agree, suggesting that the field of sex therapy is currently in "a figurative midlife crisis" (p. 58), even challenging the modern validity of the word "dysfunction". They attribute this midlife crisis to various factors, such as the

growing field of sexual medicine and the changing definition of cultural sexual values, a few of which include: a heightened importance of eroticism, lifespan concerns, and the acceptance of diversity in sexual preference. Levine (2003) explains, "When our personal evolution occurs along expected lines, others label us as mature or normal. When it does not, our unique developmental pathways are described as evidence of our immaturity or psychopathology" (p.xiii).

With regard to sexual medicine, Althof (2003) states that an impressive 90% of men with erectile dysfunction are finding success through drugs like Viagra, although most often family doctors who are quick to offer meds treat these men, at the cost of understanding potentially deeper issues. While it may be quicker and perhaps less embarrassing to ask the family doctor for medication, this process is robbing patients of the opportunity to improve intimacy and sexuality on every level (Berry, 2012). In addition, medical help for female sexual problems remains scarce, limited to dilators and surgical procedures to treat vaginismus (Goodwach, 2005; Laan & Both, 2011; Meana & Jones, 2011).

These limitations, combined with the previously mentioned broadening of sexual understanding, make it increasingly important to consider sexual dysfunction within a much wider framework. Shifting gender roles, diverse sexualities and a description of what healthy sexuality may actually look like contribute to this new framework (Kleinplatz et al., 2009; Meana & Jones, 2011). Nathan (2003) explains this further, suggesting that the diagnosis of sexual dysfunction is the marriage of many individual factors, such as the client's level of satisfaction, judgment and experience of the clinician, life context, and culture.

Current Techniques in Sex Therapy

Current research encourages a multifaceted approach to sex therapy, combining medical models with psychotherapeutic models for comprehensive, effective and lasting treatment (Althof, 2010; Jones et al., 2011; Leiblum, 2007; McCarthy & McDonald, 2009). According to Daines and Hallam-Jones (2007), this also includes combining psychodynamic approaches, which more comprehensively treat the complex nature of sexuality.

While historically sexual response models have focused on linear models thought appropriate regardless of gender (Leiblum, 2007), modern hypotheses take into consideration that desire can be built through intimate and emotional connection, as well as preferred touch (Iasenza, 2010) and differ according to gender (Leiblum, 2007). Furthermore, the challenges of sexuality do not begin and end with sexual dysfunction or differing sex drives; sexuality is far more complex, also including an individual's relationship with a sexuality that exists both within the individual and within a larger cultural framework (Jones et al., 2011).

Assessment. Assessment is an integral part of sex therapy, both as a starting point and as a continual tool throughout treatment (Hass-Cohen & Findley, 2009; Leiblum, 2007). Sex therapy assessments often involve taking a sexual history verbally and through standardized questionnaires (Kaplan & Krueger, 2010), in addition to medical assessments (Leiblum, 2007). According to DeRogatis (2008), in a review of ten standardized self-report questionnaires, validity has been found for large samples, with little research validating use with individual clients.

DeRogatis also points out that measures of sexual function are based primarily upon a group understanding of sexual dysfunction, an understanding that may ignore an individual's unique relationship with sexuality.

Factors to assess, which allow therapists to create unique treatments for the couple or individual, include: occasions in which orgasm is possible or impossible (Rosenbaum, 2007), length of time the problem has been present and/or distressing (Maurice, 2007), thoughts and feelings present during sex (Hatmann & Waldinger, 2007), masturbation history and feelings toward partner (Rosen, 2007), as well as assessing couple dynamics in terms of differences, similarities and communication styles when describing concerns (Heiman, 2007). Useful tools to achieve this understanding can be a sexual genogram (McGoldrick, Loonan, & Wohlsifer, 2007) or a sexual systems diagram (Jones et al., 2011), both of which will be discussed in following sections.

Arousal Techniques. Various arousal techniques exist and can be used as tools to help the individual become better acquainted with his or her own body (one-person techniques), as well as helping partners to communicate with one another to establish comfortable practices and techniques (two-person techniques) (Hyde & DeLamater, 2003).

Masturbation is an extremely common form of one-person sexual pleasure, with differing techniques for each gender (Kelly, 2004), involving stimulation of the erogenous zones, or extremely sensitive parts of the body such as mouth and genitals. This also often involves the use of sexual fantasy for both genders, and sex toys, such as vibrators or dildos, for women (Hyde & DeLamater, 2003).

Two-person, or partner, techniques are similar, with a partner performing the stimulation of the erogenous zones using hands, mouth, sex toys or his or her own genitals, or intercourse (Kelly, 2004). It has been found to be important in the treatment of some dysfunctions that partners take the focus off of intercourse, however, focusing instead on other types of satisfaction, thereby reducing performance anxiety (Rosen, 2007). Fantasy can also be used in partner sex, proving especially helpful in long-term, monogamous relationships (Hyde & DeLamater, 2003). One vitally important factor in partner sex is communication, both verbal and non-verbal, in order to understand one another's sexual needs, wants and challenges. Poor communication is often cited as a main factor in sexual dissatisfaction and dysfunction (Rosen, 2007).

Classical sex therapy theory provides a sexual response cycle, which acts as a foundation for current thought and practices, but the linearity of the cycle is becoming less relevant as the vast complexity of sexuality is discovered (Basson, 2007). Regardless, this cycle is important to understand, beginning with Masters and Johnson's four-phase model: excitement (first signs of arousal), plateau (stable state of arousal), orgasm (pleasurable release), and resolution (relaxation) (Sewell, 2005). The other important model to understand is Kaplan's three-phase model, which is an updated version of Masters and Johnson, with the addition of neurophysiological mechanisms. Phase one is the desire phase, phase two is the physiological response: increase in heart rate, breathing and build up of blood and tension in the pelvic area, phase three is orgasmic release (Kelly, 2004).

Cognitive-Behavioral Techniques. The cognitive-behavioral approach is popular in treating sexual dysfunction using a symptom based, outcome oriented approach. Sex therapy treatment, even integrated treatment, will often begin with this approach to alleviate symptoms before and during the use of more analytic approaches in integrated therapy (Daines & Hallam-Jones, 2007). By helping clients re-conceptualize and take action through psychoeducation and effective symptom-based solutions, they can become empowered, achieving a better understanding of, and relationship with, the body (Althof, 2010).

The primary assumption is that what a person thinks directly influences how he or she feels, leading to the conclusion that changing thoughts and perceptions will, in turn, alleviate symptoms (Kelly, 2004). Kelly (2004) discusses goals in the cognitive-behavioral approach, such as: giving oneself permission to value sexuality, making sex a priority, removing sexual blocks, minimizing performance pressure and using exercises to develop and practice healthy sexual function. Common exercises include both self (body exploration and masturbation) and partner arousal techniques (Hartmann & Waldinger, 2007), as discussed in the previous section.

Psycho-education, and interventions such as cognitive restructuring, communication training and sensate focus have achieved wide-spread, documented success (Althof, 2003; Hart & Schwartz, 2010; Rosen, 2007). Psycho-education can help clients understand how negative thinking is correlated to sexual difficulties (LoFrisco, 2011), while deepening the understanding of sexual anatomy and arousal (Hart & Schwartz, 2010); cognitive restructuring has to do with recognizing core

beliefs that may be affecting sexual function and working to change them using one, or any combination of, the techniques discussed in the following paragraphs (Hart & Schwartz, 2010).

Sensate focus assigns progressive levels of touching over a course of weeks, helping to build connection to self and/or partner(s), learn confidence, and focus on the connective experience, rather than the end goal of orgasm (Iasenza, 2010). Systematic desensitization, a similar technique, consists of touching the genital area with increasing levels of pressure, thereby increasing sensation tolerance (LoFrisco, 2011).

One challenge of cognitive behavioral theories is that while they have been recognized as effective during treatment, the long-term effectiveness has been questioned (LoFrisco, 2011; McCabe, 2001). LoFrisco (2011) suggests looking toward a greater integration of couples therapy within these techniques to understand more deeply the successes and failures. McCabe (2001) agrees that CBT alone may not be optimally effective in the long run, finding that only 50% of research subjects improved after ten weeks of treatment, suggesting that intensive long-term therapy may improve effectiveness for a wide range of disorders.

Systems Theory. Systems theorists look deeper than symptomology; in sex therapy this means believing that sexual symptoms are alarms signaling relational conflicts (Atwood & Klucinec, 2006) or are conflicts existing within the individual's sexual psyche (Jones et al., 2011). Understanding life contexts, such as religion, culture and social systems helps the client achieve self awareness and helps the

couple to understand one another, allowing each to become part of a new system of change (Wylie, Jackson, Hutchin, & Fitter, 2010).

According to this theory, multiple factors can be present. Sexual dysfunction can play a large part in maintaining homeostasis in a relationship; unresolved family issues may be at the root of sexual concerns; and environment may play a role in reinforcing the dysfunction (Jurich & Myers-Bowman, 1998). According to Heiman (2007), sexual communication has its own multilayered system such as symbolic interactions – words, ideas or gestures; affect-regulated interactions - speech affect, facial expressions and postures; and sensate exchanges - biological responses to sensation, such as motor reflexes and sensory patterns. These three systems are independent but interactive, each having its own message, but sending that message to its counterparts. See also Jones et al. (2011) for a comprehensive, but simple explanation of the systems specific to sex therapy.

Common theoretical practices such as externalization, family systems charts or diagrams (past and present) (Jones et al., 2011) and the sexual genogram (Betchen, 2001; McGoldrick et al., 2007;) help clarify where in the system problems may be occurring, as well as open communication and understanding between therapist/client and partners (Betchen, 2001). The Ideal Sexual Scenario (ISS) helps the client to imagine, connect with, and communicate desires, offering not only the current sexual profile, but perhaps underlying desires as well (Hartmann & Waldinger, 2007).

Attachment Theory. Attachment theory is a systems-based theory focusing on attachment. It "offers the couples therapist a comprehensive, normative, and

empirically validated theory of adult love that is also specific enough to address individual experiences and differences" (Zuccarini & Dino, 2010, p. 432). Attachment theorists believe that our early relationships form imprints that create expectations and assumptions about our romantic partners, what types of connections and behaviors we seek out and how we interpret them (Dewitte, 2012).

Individual attachment styles fall into three main categories: secure, anxious and avoidant (Dewitt, 2012). In terms of sexuality, Dewitt (2012) explains, secure attachment involves a balance of love and sexuality, sex is used for its pleasures alone with partners who comfortably enjoy a variety of activities and are attuned to partner needs. Anxiously attached partners have fused the ideas of sex and love. An intense need for the safety and security of a relationship causes these partners to use sex to attach quickly, creating anxiety laden, unfulfilling sexual encounters. Avoidant attached partners have created a disconnect between sex and love, causing it to become a less powerfully emotional experience, perhaps creating difficulty in reaching orgasm. These partners often use coercive tactics, are less attentive to partner needs and use sex as a form of control (Dewitte, 2012).

The therapeutic technique with this theory is to understand the context of relationship concerns and sexual dysfunctions. Through bonding exercises to increase trust and comfort, partners can communicate fears and concerns, creating an environment conducive to healing and security (Zuccarini & Dino, 2010).

Mindfulness. Mindfulness is an Eastern practice that has growing popularity in the Western world (Brotto & Heiman, 2007), involving a meditative awareness of the environment, a presence of mind that is aware of both the actions and

distractions occurring in a moment (Goldmeier, 2012). Through this presence of mind, according to Goldmeier (2012) self-insight, self-tolerance, compassion and understanding of suffering are achieved. The practice has been particularly popular for women with sexual dysfunction, helping them to be present in the moment, moving the focus away from a busy mind and placing it on bodily sensation (Althof, 2010; Brotto & Heiman, 2007). However, it has also been found advantageous in men with some dyfunctions (Goldmeier, 2012).

According to Grabovac, Lau and Willit (2011), there are three important factors to mindfulness: 1. Thoughts and sensations are transient; 2. Habitual, unaware reactions to transient thoughts and sensations cause suffering; 3. Thoughts, sensations and habitual reactions are separate from the self. In mindfulness training, clients are asked to practice awareness of bodily sensation, such as sitting in a chair, eyes closed, focusing on breath, then body, how the body feels touching the chair, and so on. This practice is slowly increased in focus and intensity, culminating in use during physical and/or sexual contact (Brotto & Heiman, 2007).

Many sexual dysfunctions may be correlated with emotional factors such as anxiety, inhibitions, self-criticism, and the resulting distraction from sensation, factors in which mindfulness has been found effective (Brotto & Heiman, 2007). In fact, mindfulness includes factors of arousal technique, sensate focus and psychoeducation, with Goldmeier (2012) encouraging the practice mindfulness techniques as a precursor to some of these interventions. While mindfulness

research in sex therapy has been limited, it is growing with positive results (Brotto & Hieman, 2007; Grabovac et al., 2011; Tan, 2008).

Art Therapy

According to the American Art Therapy Association (AATA)(2012):

> Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. Research in the field confirms that the creative process involved in artistic self-expression helps people to become more physically, mentally, and emotionally healthy and functional, resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, handle life adjustments, and achieve insight. ("Art Therapy", para.1)

Riley (1990), points out that prior to language, we know the world as a series of images, with language giving name to those images around age three when our brain begins to develop a firm grasp on the relationship between objects and their names. It would seem, Riley explains, that visualization is the first, and perhaps most natural, way of knowing our world. It is through images that our early personalities and first memories were formed, as well as where our first experiences and emotions are stored, an idea supported by neuropsychology (Hass-Cohen & Findlay, 2009; Lusebrink, 2004).

Vaccaro (1973) suggested regarding art therapy as a branch of psychoanalysis, based on its value as non-verbal communication, explaining that art is not simply art, but is communication through line, symbol and color, an

externalization of, "intrapsychic remnants, memory traces, or somatic excitation" (p. 82). Franklin (2000) points out that art has the benefit of being both objective and subjective; it is a cognitive, affective and kinesthetic way to engage in both our inner and outer world simultaneously. Wadeson (2010) agrees, discussing what she believes are art therapy's advantages: imagery, decreased defenses, objectification, permanence (art can be revisited and reviewed, both to see tangible progress, as well as to revisit ideas that memory may to distort), spatial matrix (where language is limited, art can communicate many ideas at once), creative and physical energy, and self-esteem enhancement.

While the efficacy of art therapy has been little researched due to difficulty quantifying outcomes, documented success is increasing through both qualitative and quantitative outcome studies (Slayton et al., 2010). One area of study lending validity is the neurological point of view. Lusebrink (2004) describes the neurological benefits of art therapy, stating that using visual techniques involves more, and different, areas of the brain than relying only on verbal techniques. This may provide access to more of the mind, allowing a wider range of understanding, as well as access to the basic building blocks of the mind.

Another valued aspect of art therapy is its universality – as its own therapeutic approach, art therapy can be applied to almost any psychological theory and any client demographic, including humanistic psychiatry (Farokhi, 2011). Art therapy has been applied to theories as widely ranging as psychoanalysis (Vaccaro, 1973), CBT (Rosal, 2001), systems theory (Huss & Cwikel, 2008; Riley, 1990) attachment (Hass-Cohen & Findlay, 2009), and mindfulness (Franklin, 2000).

While very little has been written on the integration of the two therapies (Ellis, 2007), the following literature comparison suggests a potentially fruitful integration of art and sex therapies, based upon the discovery that many of the most popular approaches in sex therapy can be matched to similar approaches art therapy. It may, in fact, be argued that this integration is already be occurring to a small, unofficial degree, further suggesting the need for in depth exploration.

Integrating Art Therapy and Sex Therapy

In one of the few articles on the integration of art therapy and sex therapy, Ellis (2007) laments the lack of empirical research on the topic, lamentable largely because the two lend so naturally to one another. Perhaps, Ellis suggests, it is the clinicalization of sexuality that has contributed to the divide, with art lending more individualistic freedom to sexual expression, necessitating a more constructed, universal and scientific view in order to validate therapeutic interventions.

Similarly, sex therapy literature (Berry, 2012) suggests that the therapy has a historically non-integrative stance, meaning that it has developed, a trend that is only now beginning to shift, with increasing research on current psychoanalytic and integrative modalities arising, two modalities well represented in clinical art therapy practice (Robbins, 2001; Wadeson, 2001).

Clinical art therapy and its relationship to the subconscious allow sexual content to arise regardless of intention (Fink & Levick, 1973). According to Fink and Levick (1973), using art in a non-directive manner, the therapist will often discover reference to sexuality or sexual concerns that the client had no awareness of having added, otherwise known as latent content. Likewise, art therapy naturally

externalizes this latent content, allowing clients to tangibly interact with his or her own psychological constructs, providing the opportunity to physically change them, add to them, preserve or deconstruct them (Franklin, 2000).

In early vignettes of art therapy and sexuality, Fink and Levick (1973) find that the depth of experience is clear for both therapist and client, with the authors stating that art therapy is "unsurpassed" in "stimulating verbal and graphic information…and serving as a personalized opportunity for projective externalization" (p. 291).

As the techniques of sex therapy continue to develop based on modern understandings of relational and socio-psycho-sexual conflicts, it becomes more apparent that these conflicts often develop based on deeply rooted cultural understandings such as gender, sexuality norms, relationship values, and individual feelings about these understandings (Chilman, 1990).

Assessment. Art therapy assessments, like sex therapy assessments, are used to assess level of functioning, develop treatment goals and modalities, understand client strengths and challenges, and evaluate progress (Betts, 2006). While there are popular art assessments used by licensed psychologists, results are limited in reliability across research populations and presenting problems, and are valid only when administered by a psychologist (Anderson, 2001). Structured, qualitative art assessments are being developed and are helping to improve perceived validity of these assessments (Anderson, 2001; Kim, Kang & Kim, 2009;), but there remain many weaknesses in these standardized processes. The removal of the human element - which is the understanding that can occur in a less

structured emotional communication between clinician and client - is one major weakness in the less personal, highly structured nature of standardization (Mattson, 2010). This is a similar challenge to that reported in standardized sex therapy assessments by DeRogatis (2008).

The strength of art therapy assessments is in their consistent, interpersonal nature. Anderson reports the capability of the art assessment to illustrate a more honest reality, regardless of ability to quantify results. Kim, Ryu and Hwange (2006) point out that the symbolic nature of art includes not only an individual's psychological state, but also "cultural environments, such as values, languages, traditions, and behavioral patterns" (p. 61), giving the assessment the added benefit of communicating a very complex and individual set of factors, such as the relationship with sexuality.

Cognitive-Behavioral Art Therapy. Art therapy has been found to be complimentary to cognitive therapy, because "art is an inherently cognitive process" (Rosal, 2001, p. 217). Both modalities implement sensory techniques, such as touch, sight, smell, sound and situation, with the primary difference being that while behavioral techniques use breathing and visualization to create sensory experiences, art therapy uses actual sensory experiences (Sarid & Huss, 2010). Pifalo (2007) agrees, stating that the two therapies combine to create "a dynamic, synergistic pairing that is a powerful and efficient tool" (p. 170). Pifalo adds that behavioral therapy provides clear goals and structure to art therapy, allowing a short-term, goal oriented approach.

Unfortunately, literature discussing the integration of cognitive and art techniques in sex therapy is lacking, but many studies show efficacy of an integration of modalities for victims of sexual trauma (Sarid & Huss, 2010; Pifalo, 2007), including adult victims who experienced trauma in childhood (Waller, 1992). Techniques such as arousal of an emotional experience through drawing or creating a representation of the experience, then reframing by manipulating the creative expression, help in achieving control and power over the experience (Sarid & Huss, 2010), offering a method of cognitive restructuring.

Rosal (2001) created a list of art therapy research that outlines behavioral techniques used in art therapy, as well as common directives and media to achieve these goals: drawing events and/or situations, then adding the solutions in order to physically restructure the client's viewpoint, adding sense of power (problem-solving, cognitive mapping). Using soothing media, such as watercolor, to enhance relaxation (relaxation, mindfulness). Using images to begin exposure to stressful objects and situations, perhaps giving the client greater control by having them create this situation (systematic desensitization). Using images to induce emotional response, following with tools to help client regain control (externalization, stress inoculation). Draw mental imagery, giving both client and therapist the opportunity for depth of symbolic understanding (externalization, mental imagery, inner messages). Depict cycle of response (externalization). Draw inside and outside of self to express internal struggles (externalization). Depict feelings states, using outline of body to express where stress occurs and where desire occurs (psychoeducation, learning feeling states).

Systems Theory. Using art therapy to explore family systems both in current and past familial relationships, allows the client to create change through the safety of metaphor (Riley, 1990). Interventions and realizations occur organically through the art, illustrated in a case study shared by Riley (1990), in which a woman created an image of her struggles, accidentally depicting her grandmother and caretaker, rather than herself. Upon reflection, the client was able to understand ways in which her grandmother's values were affecting current relationships and was able to manipulate the image, creating a new image to gain symbolic control of the situation.

Genograms are one systems oriented intervention discussed both in art therapy and sex therapy literature, an intervention that lends itself quite naturally to the artistic process. Whether creating a family genogram or a sexual genogram, the client can choose symbols for each influencing person or factor, then depict relationships in a way that resonates. For the therapist, being part of this process, witness to the connections, the emotional reactions to each person and the artistic process can, in itself, be illuminating (Huss & Cwikel, 2008).

Huss and Cwikel (2008) found three common outcomes in the creative genogram process:

> (a) The art enabled the reconstruction of the emotional flooding and anxiety that the family history engendered, thus gaining of control of the emotions expressed through the art.

> (b) The art helped to make overt formerly hidden, non-acceptable stances on roles and standards through expressing them "silently" in a non-verbal fashion.
>
> (c) The art "solutions" helped to create more integrated and multifaceted expression of roles and inter-relationships, moving beyond rigid or binary categories. (p. 179)

In terms of the ideal sexual scenario intervention mentioned in the sex therapy section (Hartmann & Waldinger, 2007), while there is no literature illustrating the artistic use of this technique, it is not difficult to imagine how this fit could occur. Similar techniques have been used in art therapy, such as some of those discussed in the cognitive-behavioral art therapy section of this paper, drawing mental imagery of an ideal sexual scenario is one example, or changing a current scenario depiction to illustrate how it might improve.

Attachment. According to Hass-Cohen and Findaly (2009), "Art making in the presence of an attuned other…can evoke the security of relational attachment" (p. 182). Attachment based art therapy, with a loving and supportive partner or a trusted therapist can offer enormous opportunity for healing from childhood pain. Art therapy research expresses some common manifestations seen in children with insecure attachments that may carry into adulthood: safety – physical and emotional; helplessness and depression; shame and the need for perfection; and emotional hunger (Gonick & Gold, 1992). These factors can be discovered through the art - seen in various themes of danger, perfection, rejection and destruction of work, a focus on symbols of status, or rejection from parents or partners.

For adult partners, childhood attachment patterns often intermingle, creating similar challenges within the relationship (DeWitte, 2012; Hass-Cohen & Findlay, 2009). In a study on art therapy with adult partners, a method of assessment and intervention was found in a joint drawing task (Snir & Wiseman, 2010). It was found that attachment styles can be assessed in each partner's experience of the task, with negative, anxious experiences being reported by adults with insecure attachment. The varying dynamics of the attachment styles between partners can be discussed in later sessions, turning the assessment into an intervention.

While, again, research combining attachment with both art and sex therapies is lacking, one study suggests a strong connection between the modalities, finding a connection between pain, attachment and neuroscience. Hass-Cohen and Findlay (2009) found that attachment style may correlate strongly with pain threshold, perhaps suggesting a correlation with physical expression of pain and anxiety in general. The study discusses the emotional aspects of pain and their effect on pain tolerance, suggesting that factors contributing to insecure attachment may also contribute to a greater emotional reaction to physical pain. While this study is limited to back pain, the ideas may be applicable to any number of physical symptoms, including, but not limited to, sexual pain and dysfunction, as well as arousal techniques.

Attachment interventions can be found in various art therapy techniques, such as those mentioned previously in the behavioral approach: a representation of the self and the pain, drawing the problem, depicting internal and external

constructs, and depicting the self without pain can also be used as both interventions and assessments of progress (Hass-Cohen & Findaly, 2009).

Mindfulness. Mindfulness-based art therapy is an approach that incorporates the self-awareness and acceptance of mindfulness, with the tangibly meaningful aspects of art therapy (Monti et al., 2006). Franklin (2000) suggests that art is inherently a mindful activity, stating, "Few endeavours engage our contemplative impulses the way art does. As a mindfulness practice, art is replete with collaged layers of healing or restorative opportunity." (p. 19).

In a study by Monti et al (2006), it was found that after an eight-week intervention, female cancer patients experienced a marked decrease in distress and social functioning, as well as an increase in both mental and general health. Art interventions, such as drawing a picture of the self; mindful, sensation-based exploration of art materials; problem solving/self-care imagery; using emotion mindfulness to create art; stressful and pleasant event pictures; free art making; and drawing from a "healing place" were found useful, to teach both mindfulness techniques and to assess emotional states.

In terms of integrating these techniques with sex therapy, many mindfulness techniques have been interwoven throughout this section. Given the understanding that mindfulness is a meditation constructed to allow self-acceptance, understanding, compassion, and to be present in the moment (Goldmeier, 2012), as well as its usefulness with arousal techniques and physical touch interventions (Brotto & Heiman, 2007). It has been stated throughout the art therapy literature that the process of art therapy, which is the mindfulness in creative actions, the

connection of mind and body during creative activity and the reflection on artistic symbolism in therapy (Riley, 2004), all lead to the previously stated qualities. In this case, the art process itself may serve as mindfulness psychoeduation, further combining the qualities and benefits of multiple modalities.

Conclusion

This literature review discussed the modern, integrated view of sexuality and sex therapy, as well as four common sex therapy approaches according to that view. Art therapy was then discussed in terms of comparable theoretical approaches, with a literature comparison offering insight into how these techniques can be integrated, offering a depth and understanding to both therapies. The similarities and complementarity of the two therapies contextualize and support the need to explore possible integration as potentially beneficial to art therapists, sex therapists and their respective clients.

Methods

The following section is a more detailed look at the research methods used. After a list of definitions pertinent to understanding this research, the study design, data gathering and analyzation methods are discussed, providing an outline to understanding the approach and intention of the research.

Definition of Terms

Art therapy. Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. Research in the field confirms that the creative process involved in artistic self-expression helps people to become more physically, mentally, and emotionally healthy and functional, resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, handle life adjustments, and achieve insight. (American Art Therapy Association (AATA), 2012).

Sex therapy. Sex therapy is a subspecialty of psychotherapy, focusing on the specific concerns related to human sexuality. People of all ages, creeds, health status, ethnic backgrounds, whether partnered or single, may benefit from working with a psychotherapist who specializes in this area. At any age, performance or lovemaking skills can be of concern, just as can issues around orgasm and satisfaction. Additionally concerns about sexual trauma in one's background, medical conditions that affect one's sexuality, sexual pain disorders, concerns about gender identity or sexual orientation, and issues around sexual compulsivity or addiction are frequent concerns that people discuss with a Certified Sex Therapist.

(American Association of Sexuality Educators, Counselors and Therapists (AASECT), 2004)

Healthy sexuality. A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (World Health Organization (WHO), 2002, p.5)

Sexual dysfunction*.* Difficulties people have in achieving sexual arousal and in other stages of sexual response. (Kelly, 2004, p. 95) A sexual dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse. (DSM-IV-TR, 2000, p. 535)

Sexuality.

1. "The state or quality of being sexual*;*
2. "Preoccupation with or involvement in sexual matters*;*
3. "The possession of sexual potency*.*

(Collins English Dictionary, 2012)

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions,

> not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (World Health Organization (WHO), 2002, p.5)

Research Approach

This research used a qualitative approach by looking at the data from the viewpoint of the participants - looking for meaning in the lived experience of others (Creswell, 2009). Through the collection data from the chosen group of art and sex therapists, the researcher compared reported experiences, finding key elements commonly related to the culture of that experience. Techniques common to qualitative research that were used here include: collection of participant meaning, bringing personal values to the study and studying the context/setting of the participants (Creswell, 2009).

As Seidman (2006) pointed out, "I interview because I am interested in other people's stories." (p.7). Seidman stated further that the best way to understand a process is by understanding the experience of an individual involved in that process. Based on that understanding, qualitative interviewing was useful in this research by allowing the researcher to understand the experience of the participant as the participant understood it. This was further benefitted by the interview mimicking the experience of therapy – which was the interview topic - making the lived experience more accessible to the participants.

The semi-structured nature of the interview was chosen based upon this method's ability to be: "…particularly useful when exploring relatively unknown

material, when gathering in-depth information, and for learning about unique experiences…" (French, Reynolds & Swain, 2001, p. 129). Furthermore, semi structured interviews have been found to gather "rich and detailed data" from "relatively few research participants" (French, Reynolds & Swain, 2001, p. 127), a necessity for the small, exploratory nature of this research. The casual nature of this interview also lent itself well to the potentially awkward nature of the conversation, allowing researcher and participant free communication through which to explore thoughts and experiences.

Design of study.

1. Sampling

Purposive sampling was utilized with local clinicians who have worked largely with expressive therapy and/or sexuality, and were known to the researcher and research mentor.. Participants were chosen based upon professional licensure and experience as sex therapists and/or art therapists. There were no age or gender requirements.

Two participants (Nick Ryan and Kate Loree) were contacted first through email to explain the research intent and request participation, then emailed a second time, upon agreement, with further information, including the interview questions and the subject's bill of rights. Further contact was made as needed to appoint a meeting time and place for the interview. The third participant, JR, was found as a professional and personal acquaintance of another participant. JR was first contacted by chance in person, then further discussion and interview time and place were made through a telephone call. JR was then emailed the interview

questions and subject's bill of rights. The IRB application can be found in appendix A.

2. Gathering of Data

All interviews were audio recorded. Participants signed a written consent form regarding this recording and all confidentiality concerns at the onset of the interview. Interviews were semi-structured with open-ended questions regarding the participant's professional clinical experience treating sexuality concerns.

3. Analysis of Data

Once data was collected, audiotaped interviews were transcribed and analyzed. Analyzation was preformed by organizing transcribed data by topic discussed, then comparing and contrasting topics within and between interviews. The amount of variance between topics discussed was part of the analysis, as the open-ended nature of the interview provided both high variance and many overlapping topics. A table was created highlighting each participant's answer to each question, as well as any emerging themes and then color-coded to link overlapping topics.

The table can be found on pages 46-47.

Results

Presentation of Data

In this section, the collected data will be presented and organized for analysis. The following data was collected in three individual interviews with three licensed therapists: two art therapists with sexuality experience and one sex therapist. Each therapist was interviewed in a 30-60 minute semi-structured in depth interview following the interview guide in appendix C. All interviewees were chosen based upon expertise in the fields of art therapy and/or sex therapy and were approached through a combination of snowballing and purposive sampling. Interviews were audio recorded, transcribed and then entered into a data table (p. 46-47) to link findings.

In the following section, participants will first be introduced by highlighting his or her qualifications, specializations and clinical interests as stated in the interview. Participants will be referred to as “interviewee” or “clinician” interchangeably throughout the research, as both of these roles and how they relate to the responses provided by the interviewees are important to this research. Following this explanation, a table will provide the organized and abbreviated data, followed by a more detailed narrative explanation of the comparisons within and between interviewees.

It is also important to note that each interviewee was provided the option to be associated with this research through the use of his or her professional name, or to provide an alias to in order to remain anonymous. Only one interviewee chose to remain anonymous, the following names were those chosen by the interviewee.

Nick Ryan is a Marital and Family Therapist, a board certified Art Therapist and a licensed Psychoanalyst (MFT-ATR, PsyD). “My interest, in particular, is working with trauma related issues, particularly with adults who experienced early neglect and child abuse, sexual abuse, and I also specialize in working with adolescents.” Regarding his therapeutic approach, he states, “My theoretical orientation is very much relational, in the sense that....we really talk about what is going on in the moment with us and how those feelings and experiences may have been felt or experienced earlier in life, so that way we tie back to their early experiences. And if someone is feeling anxious in a session or they are feeling disconnected, then we’ll pause and we’ll talk about that, and connect that to maybe a feeling or a physical sensation that they’re having.”

Kate Loree is a Marital and Family Therapist and a certified Art Therapist (MFT-ATR). “I work at (a) hospital full time and I have a private practice, specializing in minorities...in kink, poly, swing and sex workers, but I’m also affirmative for LGBTQ. Most of my clients are a combination of several things - these days people are more fluid, so they generally don’t present as ‘I’m kink’ or ‘I’m poly’…(my client is) somebody who is a hybrid of a lot of those different practices.” She also shares about her different approaches between settings, “Working at the hospital, if sex is brought up for the most part its under the subject of sexual molestation… inevitably you’re going to end up with some artwork that is linked to sexual trauma. In my private practice, usually the couples or individuals who come to me are talking to me about their relationships…even though these are people who are coming to me from these (kink, poly, etc) communities, the individuals just want

to know that I'm not going to judge them because they're a sex worker or what have you. A lot of times they don't really talk about (sex) very much. They just want to know that I'm not judging them for that. That I'm not going to get hung up on something that they're not hung up on."

JR is a Marital and Family Therapist (MFT) and a Doctor of Human Sexuality (DHS). He has a private practice and works within a well-respected sexual health facility in Los Angeles, as well as writing a sex column for an online publication and teaching human sexuality college courses. "My specializations are sex therapy, individual therapy with both men and women (and couples) with sexuality concerns as the main focus, such as early ejaculation, erectile concerns, painful sex, intimacy issues amongst couples, mismatched libidos, vaginismus. I also work with the LGBT community, polyamorous community and the kink community…There is always a connection between what we're working on and the sexual concerns that we're trying to improve upon. Some people don't realize that talking about your break up might help your erection. What I'm trying to do is have them express some of the frustration, some of the pain, some of the guilt and some of the difficulties they've been experiencing, but separate them from that at the same time…because a lot of people have fused their identity with their sexual concern."

The following table (p.42-43) is a description of the data obtained from the interviews.

Table 1

Comparison of Interviewee Responses to Interview Questions

Therapist	Clincial Interests	Sex in Clinical Work (Verbal)	Sex in Art	Theoretical Orientation
Nick Ryan	• Sexual Trauma • LG • Emotional Intimacy • Individuals & Couples	• Almost always comes up	• Never/rarely • Is not directive re sex	• Relational • Body/mind connection • Psychotherapeutic
Kate Loree	• Sexual Trauma • Kink/Poly/LGBTQ • Emotional Intimacy • Individuals & Couples	• Rarely	• Sometimes • Is not directive re sex	• Body/mind connection • Psychotherapeutic • Attachment
JR	• Kink/Poly/LGBTQ • Emotional Intimacy • Individuals & Couples • Sex Therapy • Educator • Columnist	• Always comes up, main focus	• Not an art therapist • Implements *some* art directives • Is directive re sex using some expressive techniques	• Body/mind connection • Psychotherapeutic • Attachment • Narrative • Cog. B

Table 1 (Cont.)

Therapist	Common Interventions	Common Clt Concerns	Common Thx Challenges	Common Clt Challenges
Nick Ryan	• Art w/99% clts • Dreams • Sand tray (tactile) • Breath	• Anxiety • Relationship • Loss	• Sexuality art directives feel like "too much of an agenda"	• Shame
Kate Loree	• Art w/5% clts • Visualizations	• Anxiety • Relationship • Sexual Minority issues • LT Mental Illness • Sexual Trauma	• Comfort/Security of PP • Feeling inexperienced in dealing with sexuality. • Directives can feel forced/invasive • PP clts may not want to do art • Countertransference – Safety alone in building at night, M submissives • Fear of reactions from other professionals, fear of shaming.	• Shame • Sexual Transference
JR	• Writing letters • Exposure Tx • Psychoeducation • Drawing/coloring body parts/body image work • Breath • Meditation(Visualizations?) • Masturbation exercises • Peaking exercises • Mirror genital exams	• Anxiety • Relationship/Intimacy • Sexual Dysfunction • Mismatched Libido	• Pacing • Countertransference/attractive clts may cause difference in tx quality.	• Shame • Transference • Resistance • Shame and anxiety vs bio-psychosocial

Each category presented multiple similarities and differences. These will be organized by interview question along with emergent themes. The miscellaneous category holds emergent themes that did not fit with any of the other categories.

Specializations/clinical interests.

All interviewees are LMFTs, two have an ATR and two have doctorates. All three work within sexual minority populations (gay and lesbian), with two interviewees also working within an awareness of kink, poly, sex work and other sexuality lifestyles. All three interviewees work with sexual trauma, as well as emotional intimacy for couples and individuals. Only one interviewee, the non-art therapist, formally specializes in sex therapy, treating sexual dysfunction and providing sexuality education.

Presentation of sexuality in clinical work.

Sexuality presents in clinical work for all interviewees at least some of the time. Two basic presentations were discussed: sexuality through verbalization and sexuality in artistic expression. Nick Ryan showed verbal expression "almost always", Kate Loree "sometimes", JR "always". While artistic expression in general occurs more often for Nick Ryan and Kate Loree, the expression of sexuality specifically through art occurs most often for JR and Kate Loree, particularly in reference to Kate's hospital practice. This finding is evidenced by the comparison of subjective accounts of techniques used, as well as JR's ability to illustrate a greater number of specific sexuality-based expressive directives. For Kate Loree sexuality comes out naturally based upon sexual trauma within the hospital population often relieving the need for specifically sexual directives, making the comparison

challenging. Perhaps a more accurate way to describe this finding is to state that JR gives more sexuality directives than the art therapists.

This data may be better understood with more context regarding the varied clinical settings in which they work, as well as the varied nature of each therapist's approach to sexuality and clinical art. Briefly, as these factors will be discussed more deeply in following sections, Nick Ryan approaches sexuality differently between his adolescent and adult clients, but never uses sexuality directives specifically. Kate Loree also approaches sexuality differently between two settings, using some sexuality/sexual trauma directives in the clinical setting, but has yet to discuss sexuality in depth in her private practice and uses art directives very rarely in this setting. JR uses expressive (not necessarily art) directives regarding sexuality as a regular part of his approach and while his clientele may sometimes include a history of sexual trauma, this trauma acts as a secondary focus as the cause of sexual dysfunction.

Training/Theoretical orientation.

Starting with techniques used in common, all interviewees reported using psychotherapeutic techniques, as well as what they each termed as "mindfulness" or "body/mind connection", which will be discussed further in the following section. Nick Ryan also works largely within a relational approach, as mentioned in his introduction. Similarly, both Kate Loree and JR use attachment theory as part of their theoretical orientation, although to varying degrees. Nick Ryan and Kate Loree have very similar training, both were trained as art therapists through a program focusing in Marital and Family Therapy with psychodynamic undertones, training

which encourages a less directive approach. It is important to note that neither has been trained to use art specifically for the purpose of expressing/understanding sexuality. In contrast, JR is trained in sex therapy, which focuses on the more directive approaches of cognitive behavioral and narrative techniques, in addition to some psychodynamic techniques.

Common Interventions.

All interviewees use expressive techniques with at least some clients, varying from visualizations, to dream work, to sexuality based directives or expressions. For Nick Ryan, art is often related to dreams, with the client creating art while Nick journals the dream narrative. Kate Loree often uses art in a similar way, with visualizations, providing the client with a starting point, then providing materials for the client to further explore his or her visualization. Kate describes these visualizations as, "an art product in their head. (The process is) a journey. I am creating the art expression through the visualization and they're painting it in … they'll take these things that come up from their subconscious, which are their resources, then, many times, put them in the art … the visualization allows them to access the best part of their subconscious and that part of their subconscious gives them gifts that they are able to grab and put in the art, allowing it to become richer and bigger."

JR often uses exposure therapy, such as directing a client to visit a sex shop, then asking the client to journal about what made him or her uncomfortable and how he or she was able to break through that discomfort. Other techniques used often by JR include psychoeducation, externalization, and various physical exercises, such as

masturbation and peaking techniques, in addition to his previously mentioned expressive techniques. "I think it is hard to utilize just one treatment modality, because, as clinicians, we have to be both detectives and magicians … finding out what works for clients and being able to be flexible and to cater to that."

In terms of sexuality art and/or expressive interventions specifically, Kate Loree uses some sexuality based art directives with her hospital clients, such as placing sexually suggestive images in the collage box to encourage discussion within her clinical groups. JR uses art expressions with some clients, such as coloring in parts of the body and mirror genital exams, which includes drawing genitals, as well as other expressive techniques, such as letter writing: "Some common techniques that I will use, lets say for example a person has anxiety, or erection difficulties, or vaginismus or painful sex, I'll have them write a letter to the body part that they're struggling with, or I'll have them write a letter to the anxiety they're experiencing. What I'm trying to do is have them express some of the frustration, some of the pain, some of the guilt, some of the shame, some of the difficulties, but at the same time separate them from that, because a lot of people have fused their identity with their sexual concern and have a difficult time seeing themselves as separate from what they're struggling with."

All of JR's interventions are sexuality based. Further, all three interviewees use visualization and mind/body connection in some form: both Nick Ryan and JR use breath work: according to Nick Ryan, "we talk about a feeling and at the same time monitor what is going on for them subjectively based on their breathing or how fast their heart is beating." JR shares, "it is very common in sex therapy to teach clients

breathing exercises."

In addition to these exercises, Nick Ryan also uses a sand tray and various other items throughout his office in order to help the client remain connected to his or her body. "Its all about tactile and sensory experiences and how to integrate the mind and the body, which is a perfect way to think about sexuality and intimacy, because that is, from my perspective, what sex is about: the mind and the body integrating together."

Common Presenting Concerns and Client Challenges.

All interviewees mentioned anxiety and relationship/intimacy issues as primary concerns for clients, both with regards to sexuality and life issues. Nick Ryan also mentioned loss as a common concern in his private practice. He did not mention common concerns in the clinic. Kate Loree added sexual minority issues for her private practice, as well as long term mental illness and sexual trauma for her clinical practice. JR mentioned sexual dysfunction and mismatched libido.

In terms of challenges specific to sexuality, all interviewees mentioned shame as a major challenge, often resulting in the client being unable to fully discuss sexual challenges and/or desires. According to JR, shame and anxiety are the cause of 70-90% of sexual dysfunction, as opposed to biological or physiological causes, which may be treated with medication alone. Sexual transference was another challenging factor mentioned by all interviewees, as JR states, "That (transference) comes up with sexuality. You are talking about sex on a weekly basis, sex is the forefront of your conversation and so you'll find that clients will develop feelings for you." Kate Loree shares recent examples of submissive males requesting treatment and asking

that she take the role of Dominant. She states that putting forth this request may in itself be extremely difficult for this population and, in combination with an appropriate response, may be part of the healing process. She has learned that "(you have to) say to them, when they have that transference with you, 'I'm glad that you feel connected with me. I can't be a Dominant for you, but I can help you work through your feelings, clarify your thoughts, and build coping skills in the session that you can generalize to the outside world thus allowing you to be better able to get your needs met.'"

Nick Ryan and JR also support the healing potential of sexual transference, with Nick Ryan sharing an example of a client responding with an extremely sexually aggressive statement. Nick shares feeling not frightened, but grateful, "It brought us to a different place in our treatment, where we were able to really get into the anger."

JR also added resistance - he was the only interviewee to mention this as a challenge, but is also the only clinician treating sexual dysfunction directly: "Ambivalence and resistance - even if (people) want to get better and have goals, there are self sabotages that people encounter, there are couples that have blaming perspectives and its hard for them to see their own contribution to the sexual dynamic."

Common Therapist Challenges.

Interestingly, Nick Ryan and Kate Loree both expressed difficulty providing art directives or expressions despite, particularly regarding sexuality due to feeling as if they are "forcing and agenda" or are being "too directive". Kate shares that she

prefers the term "art expressions" because, "art directives sounds too directive, it sounds almost authoritarian." These clinicians also stressed the importance of meeting a client "where they are at", highlighting another challenge of therapist agenda versus client agenda. Nick explains, "If I told you to create an art piece about sexuality, then its not really coming from you, its for me and I don't want to put a client in a position to where they're doing something to please me, or because I'm asking them to. (Then I would be) another person that they're trying to please, or that's asking them to do something that they don't want to do." Kate agrees, stating, "Most of my training is not to be directive, but to follow with the client where they are, in fact I use art directives a lot less often. Many times, I will say 'create whatever art you need to create that is either a reflection of what is going on for you emotionally, or what you need emotionally.'"

JR, on the other hand, relies heavily on specific directives. "I, often times, will ask clients in the first couple of sessions what their strengths are. That's something that I always file away for future interventions." He adds, "We have to be the ones who ask the tough questions. We have to be comfortable with that, because if we aren't, they may not come out and share with us."

JR also mentioned the need to carefully monitor pacing in treatment, meaning sensitivity regarding moving at the client's pace, as well as monitoring sexual countertransference which may result in more lax, less challenging and therefore lower quality treatment. "You will find that you may develop feelings for clients, so it is important for clinicians to address countertransference issues outside of the room through peer consultation. Be mindful of the feelings that might develop, or

the manner in which the attraction might change or alter treatment, whether that means being less challenging or more accommodating, there are things that you may not be paying attention to that we all have to be very mindful of."

Final Thoughts from Interviewee.

Both Nick Ryan and Kate Loree added the importance of transparency when treating sexuality issues, although had slightly different meanings for each. Nick Ryan discussed openness regarding his own sexual orientation, as well as discussing issues of gender, particularly in the case that the client is of the opposite gender. "I acknowledge gender and many of my patients know that I'm gay, so I like to explore what its like working with someone who has a different sexual orientation. Being up front, I think, has really increased the trust and the intimacy in our relationships." Kate Loree referred to increasing comfort with the topic by announcing the intention to discuss sexuality and working through these feelings as the client requires. "I think its important to be open when talking about sexuality, but to find ways to make it less intimidating. Many of the patients and clients that I have worked with have so much sexual shame that that the prospect of talking about it openly is initially extremely scary for them."

JR did not have particular final thoughts, although he did agree with Nick Ryan and Kate Loree regarding transparency, which he feels is particularly important when dealing with transference and resistance. As quoted in the preceding sections, JR believes that bringing either of these challenges into the room, when used appropriately, may help the client gain confidence and understanding in his or her vulnerability.

The data presented in this section was an elaboration of the data presented in Table 1, allowing a comparison within and between interviewees to understand the major differences in each approach, as well as the motivation behind the approaches. This discussion provided insight into three overarching themes, which seem to be undertones in the challenges of each clinician interviewed. The following section will elaborate further, presenting these themes with a discussion of their importance to research question.

Analysis of data: Explication of overarching themes

Each of the three interviewees shared clinical experiences working with sexuality and/or art and expressive therapies, providing insight into the possibilities and challenges of an integration of these two modalities. The data was first organized in terms of interview questions, with the answers being compared and contrasted within and between interviewees allowing for themes to emerge. In the following section, these three themes will be discussed in terms of how they contribute to the approach of each clinician, specifically with regard to how they may present challenges and/or possibilities in the integration of these two modalities.

The three emergent themes are: 1) The importance of theoretical training and scope of practice in unlocking sexuality; 2) Opening the door to sex and sexuality in clinical work using creative expression; and 3) Concerns and challenges for the clinician using artistic expression with sexuality.

The importance of theoretical training and scope of practice in unlocking sexuality. Two of the interviewees, Nick Ryan and Kate Loree, are graduates of the same art therapy program, lending to many similarities in their approaches, such as having a psychodynamic orientation peppered with goal oriented techniques like CBT. Interestingly, while both clinicians believe strongly in the value of the creative process, as well as the power of sexuality, both also share a hesitation to incorporate directive art approaches with sexuality, with the exception of treating sexual trauma. This hesitation may be due to the nature of psychodynamic training, as well as insufficient sexuality training, which is common

in MFT programs, particularly in comparison with JR's sexuality based training. This is also reflected in the rarity of a sexuality/sex therapy specialization within art therapy (Ellis, 2007). While this research did not focus on personal motivations for the inclusion of sexuality in the work of these therapists, one might speculate that unique personal and/or professional experiences may lead to greater interest and inclusion of sexuality issues in clinical work, an interesting thought for future research.

It is also interesting to note that Nick Ryan is more likely to intentionally bring sexuality into clinical conversation, perhaps due to his psychoanalytic training, which directly names the essential relationship between sexuality and the psyche. This could also be an outcome of his identification as a gay man who has had to define and withstand societal responses to his sexual identity for, presumably, much of his life. Despite this difference, it is important to note that both clinicians are trained to work within the construct of relationships and emotional intimacy rather than with sexuality directly, and are trained in a less directive approach overall.

Both of these clinicians discuss the importance of "meeting a client where they are at", rather than using a more directive approach. This is seen in Nick Ryan's previously mentioned relational approach, which means taking "what is going on in the moment with us (clinician and client) and how those feelings and experiences may have been felt or experienced earlier in life, that way we tie back to (the client's) early experiences."

Kate offers a similar account with the use of art, "Most of my training is not to be directive, but to meet the client where they are. In fact, I use art directives a lot less often. There have been many times where I have just said 'create art that is either a reflection of what is going on for you emotionally, or what you need emotionally.' I do that more and more, because then you perfectly attune (to the client). If I do a session with an individual, I'll verbally process with them for a while and then when I get to the heart of their processing, I'll say to them 'I think this might be a really good opportunity for an art directive. Does this attune for you?' I'll give them a suggestion and then invite feedback. Often their reply will enhance the attunement further. Through this dialog, we come up with the best art expression together."

JR, having received training in both Marital and Family Therapy and Sex Therapy, is trained to treat both relational challenges and sexual challenges, but with a primary focus on sex/sexuality, rather than emotional intimacy, the opposite of Nick Ryan and Kate Loree's focus. JR shares that his assessments often begin with a more traditional style of therapy, building rapport and relationships, gaining an understanding of the presenting problem(s), then move on to more behavioral sex therapy techniques. Due to the short-term, solution-based nature of the therapy with the client intending to fix a very specific, physical presentation of a problem, JR's treatment style tends to be much more directive than the other two therapists. He has found that his clients often feel most satisfied with therapy when given homework between sessions, in addition to in session directives, which is a far more prescriptive form of therapy than performed by the other two interviewees.

"Some common techniques that I'll use, lets say for example a person has anxiety, or erection difficulties, vaginismus or painful sex. I'll have them write a letter to the body part that they are struggling with or I'll have them write a letter to the anxiety they're experiencing. It's really more of a narratively focused intervention, because typically with narrative therapy we'll separate the client from their depression or anxiety. For sex therapy we can do the same thing, so I've had clients write letters to their penis, letters to their erection, letters to their anxiety and what I'm trying to do is have them express some of the frustration, some of the pain, some of the guilt, some of the shame, some of the difficulties, but at the same time separate them from that." JR goes on to express many more directives, such as exposure therapy, book recommendations, psychoeducation, often giving these interventions as homework to be discussed in the following week's session.

Comparing these three accounts, the differences in theoretical training seem to explain many of the challenges regarding the discussion sexuality issues. While Kate Loree and Nick Ryan are comfortable with sexuality and open to bringing it into their practices, psychodynamic training keeps them from leading the conversation in that direction. This presents a challenge with the nature of our cultural approach to sexuality being one of shame and secrecy. While these clinicians may open the door to sexual conversations in various ways, it is perhaps the more directive, arguably forceful nature of JR's approach that provides the appropriate climate for sexual conversation. Perhaps this data is suggesting that, in many cases, clients may need to be strongly encouraged to discuss sexuality in order to provide the safety and containment necessary for the conversation to occur.

On the other hand, this may suggest that clients have a limited desire to discuss sexuality unless they enter treatment for that purpose specifically. The shame and discomfort of discussing such a deeply private function in combination with admitting to dysfunction may be too much to bear. JR reports that many of his clients discontinue treatment as soon as they see progress, often terminating before permanent change or complete recovery can occur. This supports that idea that clients simply may not be comfortable discussing sexuality. Perhaps this is one of the ways that art therapy can benefit sex therapists. Through the natural tendency of creativity to transcend defenses and illuminate hidden constructs, perhaps a conversation can unfold through discussion of the art, rather than of sexuality directly. This is one of the benefits of externalization, by created a symbol of self and/or sexuality, for example, the client can have difficult conversations through metaphor, removing the self from the equation and creating a space for increased openness.

One benefit of such starkly different approaches is that it seems possible that a middle ground can be reached, that a directive yet open approach can be achieved through a combination of gentle encouragement and attunement. Perhaps by creating a framework in which a client can discuss sexuality without fear, or by helping the client explore his or her fears regarding the discussion of sexuality, we can move toward releasing the shame stopping this discussion from occurring organically.

Another variable is clinical setting and years of relevant experience. Kate Loree is a good example of this; while her interest lies in alternative sexualities, such

as kink, poly, swing and sex workers, she just beginning her private practice treating this population, which introduces the special challenge of building a solid clientele on top of the scope issues of being untrained to treat sexuality issues specifically. She does express openness to this shifting as she becomes more experienced in her private practice both in terms of dependable clientele and the development of this skill set. For the time being however, she is focusing on assisting this population with relational challenges and other life concerns, aided by an understanding of how alternative sexuality lifestyles can affect these issues.

Despite these seemingly enormous differences, the three interviewees have many overlapping techniques and interventions, including: mindfulness/meditation, visualization, mind/body connection, breath and art/creativity techniques. While the approach varies between clinicians – goal oriented vs psychodynamically oriented - the core intentions are actually very similar. Each of these techniques treat anxiety, allow clients to connect mind and body, provide self-soothing techniques, and help educate the clinician regarding the client's specific challenges. The greatest difference seems to lie in the presenting concern; while Nick Ryan or Kate Loree may implement breathing techniques when discussing stressful life events, or may provide art materials to illustrate a dream or visualization, JR may implement breathing techniques to reduce anxiety that may be stopping a client from achieving an erection or an orgasm, or he may provide an art directive to help a client learn his or her erogenous zones, or to assess how body image may be affecting sex drive.

Opening the door to sex and sexuality in clinical work using creative expression. Despite the differences in the presentation of sexuality, all three clinicians stated that they are aware of the overwhelming importance of sexuality in providing a sense of holistic well being and are interested in focusing on sex and sexuality as an aspect of his or her practice. Nick Ryan and JR both introduce sexuality into the therapeutic relationship from the beginning, although each does this to meet a different set of goals. For Nick Ryan, the approach depends on the population. With adolescent clients, he begins with questions pertaining to the client's sexual orientation and relationship history, which often lead into sexual activity, safe sex practices, etc., opening a door which the client can then choose to walk through. While the therapeutic relationship may not revolve around sexuality issues, the adolescent is made aware of the Nick's ability to discuss and understand these issues.

With his private practice clients, Nick may begin this conversation with an exploration of what it means to receive treatment from a male therapist, and may include conversations about his sexual orientation, based on his belief in the importance of transparency. "One of the questions I always ask is, and I ask this early on, is what is it like working with a male therapist? So I acknowledge gender and with many of my patients, they know that I'm gay, so I like to explore what its like working with someone who has a different sexual orientation. Being up front in those cases has, I think, really increased the trust and the intimacy in our relationships."

Nick has found that the latter factor, his sexual orientation, may have some effect on relationships with clients whether or not discussed directly, having noticed a small trend of women coming to identify as bi-sexual in treatment; women who had never previously questioned their heterosexuality. He believes this may be due to his own sexual orientation providing the space to open a door that had never before felt safe enough to visit, thereby allowing the client to truly explore new and hidden parts of themselves, a thought provoking piece to understanding how client and clinician can intermingle during psychoanalysis.

In contrast, JR's expertise brings him clients looking specifically for help with sexuality related challenges. In his sessions, the therapeutic relationship is built upon an understanding of how the client's sexuality is affecting his or her life and vice versa, starting with both sexual and family histories in order to understand how upbringing and sex education (or lack thereof) may affect the client's perceptions of sexuality. Rather than including a sexuality element to therapy, as Kate Loree and Nick Ryan discuss, JR's practice elevates the importance of sexuality and sexual functioning to the primary concern.

For Kate Loree, like Nick Ryan, the presentation of sexuality occurs differently according to therapeutic setting. In the hospital setting, discussions regarding sexuality are encouraged by putting sexually provocative images in the collage box and bringing trauma narratives into group work. In private practice, however, Kate finds it much more challenging. This is especially interesting considering Kate's focus on decidedly sexuality-based populations in private practice, a population very similar to that of JR. In this setting, Kate focuses on

countercultural lifestyle choices and how these choices may affect quality of life and relationships rather than focusing on how this affects sexuality specifically. "Because I'm not a sex therapist, I'm always dealing with relationships. I'm never trying to get straight to that aspect (sexuality) … usually couples or individuals who come to me are talking to me about their relationships. Even though these are people who are coming to me from these (kink, poly, etc) communities, the individuals just want to know that I'm not going to judge them because they're a sex worker or what have you. A lot of times they don't really talk about (sex) very much. They just want to know that I'm not judging them for that, that I'm not going to get hung up on something that they're not hung up on."

In terms of the presentation of sexuality in artistic expression, there are some surprising similarities and differences between the three clinicians. As discussed in previous sections, the two art therapists have refrained from providing sexuality-based directives for various reasons, particularly due to receiving training focused on a non-directive approach. Both clinicians express openness to sexuality presenting in the art, but with differing outcomes: Kate sees sexuality coming up "often" in the art, both in the hospital and with the occasional client bringing art into private practice sessions, while Nick Ryan expresses surprise that sexuality "rarely" is seen in the art of his clients. This is an interesting dynamic to consider, especially considering the many similarities in their approaches. Perhaps this has to do with Kate's more specifically sexual population, a population struggling to make sense of needs outside of the accepted norm. In her private practice, this could also be due to her clients bringing in art from outside of sessions, while Nick's clients are creating

art in session. Perhaps looking more deeply at this could help explain why clients seem to be uncomfortable bringing up sex with therapists who do not specialize in sexuality, even if the clinician has made his or her own comfort with the topic clear.

Interestingly, a comparison of JR's clinical work shows that he often uses creative expression to aid in sexual change and discovery, arguably an amount comparable to that of the art therapists. While this includes many activities outside of art specifically, it nonetheless shows the possibility of using creative means to achieve sexuality based understanding and change. The most striking difference lies in the nature of sex therapy training and its much more directive approach; JR has found that his clients express less satisfaction with treatment when given fewer prescriptive tasks, a marked difference from the needs of both Kate Loree and Nick Ryan's clients. This difference alone could explain the ability for JR to provide more artistic directives to his clients - clients come to him for a different form of therapy altogether.

To compare the presentation of sexuality in Kate Loree and JR's work, Kate is most likely to see sexuality in the art of clients who have been victims of sexual trauma. By providing her clients with a more open "art expression", Kate states: "Inevitably these things come up in the art", particularly when discussing the trauma narrative." She recognizes common images representing sexual abuse, particularly of closed in, blocked off images, such as dark X's over mouths, depictions of being boxed in, or alone in a dark room. "It becomes a double bind for them…that struggle of 'The box keeps me safe, but the box is killing me.'" Through therapy and healing, Kate shares that the images and the client's body language

slowly become more expansive "literally connecting them to their resources" with the art changing to more organic images and brighter colors, such as aqua and yellows. This is a great example, because it illustrates what is arguably one of the greatest benefits of using art in therapy: providing a tangible record of positive change. This is also an excellent example of how art therapy and sex therapy can each be used to inform the other. Kate's training as an art therapist, coupled with her understanding of sexuality and sexual trauma, allow her to intuitively understand and respond to sexual presentation and metaphor in the art. Through her personal comfort with sexuality and her experience working within these populations, Kate does not necessarily have to give sexual directives (with some populations) to recognize sexual themes in the creative process. Rather, experience has given her access to these themes, providing a deeper understanding of the client.

While JR does not discuss common themes in client expression, perhaps due to his lack of training in recognition of symbols and metaphors, he does share common directives he may give that have the potential for expressing deeper meaning. For example, using art to better understand a client's relationship to his or her body and mirror genital exams, during which the client may artistically depict the mirror image. Body image work is often used in art therapy in a similar way as that described by JR, coloring in areas of the body or drawing one's perception of his or her body shape, providing an insight through factors such as the level of anxiety while performing the activity, the areas focused on first and colors used. In addition to these two art directives, JR uses expressive/creative approaches, such as writing

a letter to one's anxiety or sexual dysfunction. All three clinicians use other techniques that may arguably be considered creative or expressive, such as mind/body connection and visualizations. For example, while Nick Ryan may use the sand tray to encourage mindfulness through tactile experiences in combination emotional recognition, JR may assign masturbation or partner exercises that include mindfulness techniques to reduce anxiety and allow the client to become more in touch with his or her sexual response. As shown in table 1, many similar techniques are shared, suggesting an easy transition from a non-sexual to sexual approach.

Concerns and challenges for the clinician using artistic expression with sexuality. A final important piece to understanding this research is an awareness of the common challenges in treating sexuality concerns for both clients and clinicians. All three interviewees shared comparable challenges, citing sexual shame and fear of judgment as the primary boundary to open discussion about sexuality. This is an important challenge, as it may explain a great deal of the hesitation on the part of both clinician and client in bringing sexuality into clinical and creative work. While the interviews did not include information regarding the personal experience of each interviewee within his or her generation's sexual climate, it is nonetheless important to note that each individual – clinician and client - operates based upon this experience. An understanding of sexuality provided by family, religion, sexual orientation, lifestyle and each individual's placement within (or outside of) his or her generational cohort (along with an infinite number of other things) provides an inescapable framework through which sexuality is seen, experience and expressed. This framework very likely presents numerous challenges when approaching

sexuality, with shame and sexual repression being a theme throughout our culture's history. One suggestion for future research is to isolate these factors, allowing an assessment of their influence on treatment from both sides of the couch.

Next, Kate Loree and JR added sexual transference, with the combination of therapeutic work and sexual openness creating especially fertile ground for sexual transference. Nick Ryan did not name this specifically, but did share case examples with transference as a primary factor, suggesting that this element is important and challenging to all three clinicians. As a side note, it could be argued that shame is it's own form of transference, with the client projecting his or her own insecurities onto the clinician. All three clinicians assert the importance of speaking directly to transference so that it can be used therapeutically. Finally, JR mentioned resistance as a factor, as well as the necessity of meeting resistance openly and transparently. This may factor be unique to JR's treatment due to the primarily sexual nature of his treatment, or perhaps may be one of the challenges of a more directive approach.

In terms of challenges for the clinician, pacing was stated as a major factor by both Kate Loree and JR, with Kate mentioning this as one challenging factor in deepening her private practice; wanting to both challenge clients and ensure their comfort, Kate prefers the risks of going slowly to those of pushing too hard. Kate's sense of caution seems to be born from a combination of factors, starting with a desire to attune to and provide for the client's current emotional temperature, thereby allowing her to provide the client with exactly the service they want and need. This, in combination with anxiety regarding the start of her private practice certainly encourages caution. It might also be argued that this is a feminine trait,

although Nick Ryan seems to also be more cautious when providing art directives, suggesting that this may have more to do with training and the value of a non-directive approach than gender norms.

For JR, the directive, goal oriented nature of sex therapy creates this challenge. Going too quickly may compromise the safety and honesty of the therapeutic space, while going to slowly may leave clients feeling unsatisfied or hopeless. JR stresses the importance of checking in with clients to ascertain comfort levels and ensure appropriate pacing for each individual. He also mentions countertransference as a challenge, stating that sexually open conversation with attractive clients can result in a differing quality of care. He stresses that it is important for clinicians to attend to any sexual countertransference with supervisors or other clinicians in order to treat these clients as any other.

Another important consideration, which ties in with previously mentioned scope challenges, is the career stage of the clinician. This challenge was highlighted by Kate Loree, whose private practice is in its infancy, requiring a careful nurturance. While her hospital population is unable to simply leave treatment, many of her private practice clients have expressed discomfort with art, a discomfort Kate is not yet ready to challenge. Kate expresses recognition of the positive potential of bringing sexuality into the room to better understand a couple's relationship or an individual's relationship with sexuality, but is leaving this for a time when the challenge feels more appropriate.

The three themes discussed here: 1) The importance of theoretical training and scope of practice in unlocking sexuality; 2) Opening the door to sex and

sexuality in clinical work using creative expression; and 3) Concerns and challenges for the clinician using artistic expression with sexuality, provide one way of understanding the findings of this research. Three interviews provided insight into the experience of three clinicians using some combination of creativity and sexuality in clinical work. The themes illuminate both the potential and the challenges inherent in this integration; due in large part to a cultural approach of shame and repression regarding sexuality, the topic can be extremely uncomfortable for both client and clinician. While clinicians may be comfortable with and even compelled toward sexuality personally, the data shows that it can remain challenging to bring this into clinical work.

One benefit of this integration could be the assistance of art in softening this discomfort, by providing a non-verbal buffer. Clinicians may have the opportunity to learn to recognize sexual themes in art, as well as to provide the client with a means of communication while removing the pressure of verbalizing such an intimate experience. This may also provide a framework through which to explore the client's (or clinician's) resistance to discussing sexuality, allowing a deeper understanding of the effect of culture on the experience of the individual.

Through these interviews, the interviewees were given the opportunity to explore his or her own approach to bringing sexuality into clinical conversation, to share challenges and successes, and through comparison helped illuminate the potential of an integration of techniques as a deepening of treatment for both modalities. The following section will provide a deeper discussion of the findings and their meanings.

Discussion of Findings and Meanings

The premise of this research falls on two essential ideas, as pointed out in the introduction. First, "Biologically and metaphorically, sex is a core experience, and is part of the total person, not just the genitals." (Goodwach, 2005, p. 161), meaning that sexuality is an inextricable piece of our core selves, providing important insight into our experiences and how those experiences intertwine to construct who we are. Second, our world develops visually first, with language giving name and communication to people and objects already existing within that world, suggesting that our first and most natural emotional language is that of feelings and images – things that often transcend the power of verbalization (Riley, 2004). Based upon these understandings, it follows that an integration of art and sex therapies could lend itself naturally and easily to a deeper understanding of the core self.

Unfortunately, the cultural framework around sexuality creates shame and unease when approaching the topic, often giving it a sense of being both readily accessible and completely unreachable. The result is a barrier in exploration, often coming from both clinician and client, with the barrier being built from family, religion, early sexual experiences, peer experiences, and the sexual climate of our times, among many, many other factors. This research suggests that through a careful education and removal of some of these cultural constructs, we can approach sexuality with an increased understanding and openness, but this currently seems most often approached in the prescribed fashion of goal-oriented, behavioral approaches, which may risk losing the opportunity for depth of reflection. When left to the openness of more traditionally psychotherapeutic approaches, sexuality often

remains unapproached, or approached with a limiting sense of caution, even when the clinician purposefully opens the door.

This research used the experiences of three clinicians who use some combination of art or expression and sexuality in their clinical work. Each clinician was interviewed individually to gain an understanding of his or her personal approach in order to compare and contrast within and between interviews allowing a better understanding of the challenges and successes of the three unique approaches. Two interviewees have training in art therapy in addition to pyschydynamically-based training in Marital and Family Therapy. One of the art therapists has also recieved additional training as a psychoanalyst. The third therapist has training in Martial and Family Therapy and Sex Therapy. Each of the shared experiences provided a unique approach, understanding and level of comfort with both art therapy and sex therapy.

Based on the experience of each interviewee, it is immediately apparent that sexuality is a vital piece for all clients, not only based on the specialties and sub-specialties of these particular clinicians, but also simply based on human nature. This is an important consideration, one that seemingly gets lost in a culture of shame and privacy, creating a predicament that necessitates us, as clinicians, to create a space within which the client can comfortably discuss this challenging, private and vulnerable piece of him or herself. In order to do this, we must face our own challenges, a journey which, for most other aspects of therapy and clinical training, is part of our graduate education. With this particular topic, however, education and personal development is often touched too briefly, removing the

opportunity to increase comfort and confidence when approaching the topic clinically, succeeding only in perpetuating this culture of silence and shame.

Through this research, while the aim was to understand the challenges associated with the integration of art and sex therapies, it was found that it is important to first understand why this integration has thus far been discussed only minimally. Both art therapists have a personal comfort and compulsion toward issues of sexuality, but neither feels comfortable insisting that clients explore this topic, with the exception of treating sexual trauma. JR, the sex therapist, lies at the opposite end of the spectrum, making sexuality the topic of almost every clinical conversation, although doing so in a way that seems much more goal oriented and less open to pure self-discovery. The intent becomes to understand how both ends of the spectrum can move toward the middle, realizing the opportunity inherent in the art for the deeper understanding that can contribute to lasting change, as well as what clients may require - such as gentle insistence from the clinician - in order to create a space safe enough to remove the feeling of exposure when discussing sexuality.

Three themes emerged in the research, helping to define the specific challenges that came up for each clinician, as well as the possibilities, and providing insight into the existing barriers that have thus far kept the two therapies separate: 1) The importance of theoretical training and scope of practice in unlocking sexuality; 2) Opening the door to sex and sexuality in clinical work using creative expression; 3) Concerns and challenges for the clinician using artistic expression with sexuality. Each theme presents its own set of challenges, and clues regarding

the solution to those challenges, based upon a comparison between and within interviewees.

The first theme, *the importance of theoretical training and scope of practice in unlocking sexuality,* seems to be interwoven throughout the other challenges. It is in the training and approach of the therapist that confidence and comfort are instilled. For the art therapists, this limitation exists in the combination of a relatively unstructured, non-directive approach and a lack of sexuality training leaving both clinicians unwilling to push a topic that most clients will not discuss without encouragement. For the sex therapist, the limitation lies in a lack of training regarding recognizing and understanding metaphor and symbolism present in the art, losing an opportunity to gain deeper, meta-verbal understanding of the underlying challenges for the client. For all three clinicians, the limited access provided through minimal training and life experience has provided a basic understanding of the one another's approaches. From the positivity communicated by each therapist based upon these basic understandings, one can imagine the possibilities existing within this integration.

The second theme, *opening the door to sex and sexuality in clinical work using creative expression,* rests on the previous challenge. In order for the door to open, the clinician must first have taken this journey and must be prepared to lead the client through. It is important to remember, however, that some clients simply do not want to walk through this door. For the art therapist, the question becomes: how important is it that clients be encouraged to explore this aspect of themselves? If the question is one of sexual trauma, this undeniably becomes a vital piece. To

compare to a non-sexual understanding of the client, if the issue were one of attachment, each of these three therapists might assess and reflect back to early attachment experiences, providing an understanding the client's current state through that lens. If sexuality is a core piece of our experience, as Goodwach (2007) suggests, it can be argued that this is equally as vital as attachment. How, then, can art be used to assist in opening this door? An excellent example of this is Kate Loree's work with victims of sexual trauma. Her reports of the client's artistic progression mirroring the personal healing process show that art can lead to understanding without requiring verbalization, a potentially safer way for many clients to begin the conversation. Kate did not need her client to talk about the pain, she could see it in the dark, closed off images that were created. Through these images, she was able to experience the emotions with the client, providing a safe space to begin the conversation.

For sex therapists, the question lies in how art can augment existing approaches. While JR used creative processes to help clients understand sexual struggles and reach treatment goals, these techniques barely reach the surface of art therapy's potential. If he were trained to look more deeply into the art, using the client's symbolic keys to understand and discuss the challenges on a deeper level, clients could then be approached from a more thorough understanding of the presentation of the dysfunction. The art can also simultaneously provide an understanding of the client's feelings about both the dysfunction and sexuality in general. Perhaps if these internal battles could be recognized and challenged, clients would be more able to see treatment through to completion.

The third and final theme deals with *concerns and challenges for the clinician using artistic expression with sexuality,* which can help in understanding the challenges inherent in treating sexuality issues for all clinicians. While these challenges can be generalized to all forms of therapy and certainly to all three interviewees, it is important to ask if art will help or hinder when approaching these challenges when combined with sexuality. According to Fink and Levick (1973) sexual content is irrepressibly expressed through art making, making art uniquely suited to assist in sexual self-expression and discovery. While more research is needed to answer this question, all three clinicians interviewed express a respect for the potential of integration. In addition, Wadeson's (2010) list of art therapy's benefits, which include decreased defenses (resistance), a tangible record of change (for clients to see progress) and self-esteem enhancement, suggests a real possibility for art assisting in this process.

A final important challenge to discuss is that of client preference for treatment modality. Each clinician discussed "meeting a client where they are at" which in part means providing the client with the type of therapy that is most congruent with his or her natural inclinations. Not all clients will have an appreciation for art therapy and not all clients will feel ready to discuss sexuality. Combining the intimacy of sexuality with the depth of art may also feel too vulnerable for some. Based on these findings however, it seems important that clinicians feel prepared to at least initiate and/or invite a dialogue about sex and sexuality, as well as assess the usefulness of expressive techniques and their ability to enhance the effectiveness of the work. It is important to note that these

conversations should be approached with encouragement rather than force to avoid a rupture to the therapeutic space.

This research poses many new questions. While it would require additional training to bring sex therapy into the scope of art therapists and vice versa, these findings suggest that a deeper understanding of one another's treatment modality could be beneficial for clients and therapists alike and may not be exceptionally time consuming if approached through short certificate trainings, as one possible example. It is not the intention of this research to suggest that either modality change its foundational methodologies or approaches, but rather to point out the importance of a more integrative understanding of sexuality for all therapists, as well as to point out the usefulness of art for many diverse forms of therapy.

Due in part to the preliminary and limited nature of this research, there are many potential challenges to the validity of this data. Participants were invited to participate in this study based on snowball and purposive sampling. The resulting participant number was very small, with professional training and affiliations that may not be shared by other sexuality and/or art therapy clinicians. This may produce results skewed toward sexual openness and/or an appreciation of art therapy that was greater than the norm.

Conclusion

This study set out to explore the possibility of an integration between art and sex therapies through in depth interviews with three clinicians: two certified art therapists and one certified sex therapist. Overall, findings illuminated important challenges and benefits and supported the literature review regarding the possibilities of a meaningful integration.

Through the analysis of the three interviews several categories emerged and three overarching themes were discussed: 1) The importance of theoretical training and scope of practice in unlocking sexuality; 2) Opening the door to sex and sexuality in clinical work using creative expression; and 3) Concerns and challenges for the clinician using artistic expression with sexuality. Each theme provided insight into a clinician's unique challenges and possibilities presented by this integration. Theoretical training and scope provide a foundation for comfort and confidence in clinical approach. For art therapists, the common lack of sexuality training in MFT and art therapy programs, in combination with a non-directive approach, contributes to clinician discomfort providing art directives designed to explore sex/sexuality. For sex therapists, creative expression is often used, but with limitations due to a lack of training on the potential symbolic and metaphorical meanings present in the product of the expression. By using art and creativity to open the door to sex and sexuality, clinicians may be providing a non-verbal method to express a core construct that our cultural language may not provide words for.

The concerns and challenges inherent in discussing sexuality may be, at least in part, alleviated through the use of art, based upon art's unique ability to decrease

defenses and communicate constructs that even the client may not have an awareness of. This benefit may be challenged, however, by the client's resistance to the art itself, resulting in increased difficulty bringing the topic into clinical work.

This research has many limitations, including a small sample size and a reliance on participants known to have an appreciation both for the importance of sexuality and the benefits of art therapy. It also, however, provides a foundation for future research and one potential clinical application of integrative approaches.

References

Albury, K & Lumby, C. (2010). Introduction: Children, young people, sexuality and the media. *Media International Australia, 135,* 56-60.

Althof, S.E. (2003). Therapeutic weaving: The integration of treatment techniques. In S.B. Levine (Ed.), *Handbook of clinical sexuality for mental health professionals* (pp. 359-376). New York, NY: Brunner-Routledge.

Althof, S.E. (2010). What's new in sex therapy? *Journal of Sexual Medicine, 7*, 5-13.

American Association of Sexuality Educators, Counselors and Therapists (AASECT). (2004). Frequently asked questions: About sex therapy. Retrieved from http://www.aasect.org/faqs.asp#What_is_ST

American Psychiatric Association. (2000). *Diagnostic and statistical manual* (4th ed., text rev.). Washington DC: American Psychiatric Association.

Anderson, F.E. (2001). Needed: A major collaborative effort. *Art Therapy: Journal of the American Art Therapy Association, 18*(2), 74-78.

Balon, R. & Wise, T. (2011). Update on Diagnoses of Sexual Dysfunctions:

Controversies surrounding the proposed revisions of existing diagnostic entities and proposed new diagnoses. In R. Balon (ed), *Sexual Dysfunction: Beyond the brain-body connection* (1-15). Switzerland: Karger.

Bahroni, Z. (1996). "The Hellenization of Ishtar: Nudity, fetishism, and the production of cultural differentiation in ancient art". *Oxford Art Journal, 19*(2) pp.3-16.

Basson, R. (2007). Sexual Desire/Arousal Disorders in Women. In S.R. Leiblum (4th ed), *Principles and Practice of Sex Therapy* (25-53). New York: The Guilford Press.

Berry, M.D. (2012). The History and Evolution of Sex Therapy and Its Relationship to Psychoanalysis. *International Journal of Applied Psychoanalytic Studies,* doi:10.1002/aps.1315.

Betts, D.J. (2006). Art Therapy Assessments and Rating Instruments: Do they measure up? *The Arts in Psychotherapy, 37*(4), 328-334.

Bhugra, D. & de Silva, P. (1995). Sexual Dysfunction and Sex Therapy: An historical

perspective. *International Review of Psychiatry, 7*(2), 159-167.

Brotto, L.A. & Heiman, J.R. (2007). Mindfulness in Sex Therapy: Applications for women with sexual difficulties following gynecological cancer. *Sexual and Relationship Therapy, 22*(1), 3-11.

Chilman, C.S (1992). Promoting Healthy Adolescent Sexuality. *Family Relations, 39*(2) 123-131.

Cooper, E. (1994). *The Sexual Perspective:Homosexuality and art in the last 100 years in the west* (2nd ed). London: Routledge.

Daines, B. & Hallam-Jones, R. (2007). Multifacted Intervention Sex Therapy (MIT). *Sexual and Relationship Therapy, 22*(3), 339-350.

DeRogatis, L.R. (2008). Assessment of Sexual Function/Dysfunction Via Patient Reported Outcomes. *International Journal of Impotence Research, 20,* 35-44.

Dewitte, Marieke. (2012). Different Perspectives on the Sex-Attachment Link: Towards an Emotion-Motivational Account. *Journal of Sex Research, 49*(2-3), 105-124.

Ellis, M.L. (2007). Images of Sexualities: Language and embodiment in art therapy.

International Journal of Art Therapy, 12(2), 60-68.

Farokhi, M. (2011). "Art Therapy in Humanistic Psychiatry". *Procedia – Social and Behavioral Sciences, 30* pp.2088-2092.

Fink, P.J. & Levick, M.F. (1973). Sexual Problems Revealed Through Art Therapy. *Art Psychotherapy, 1*, 277-291.

Foucault, M. (1978). The History of Sexuality. New York: Random House.

Franklin, M. (2000). Art Practice/Psychotherapy Practice/Contemplative Practice: Sitting on the dove's tail. *Guidance and Counseling, 15*(3), 8-23.

French, S., Reynolds, F. & Swain, J. (2001). *Practical Research: A guide for therapists* (2nd ed.) Oxford: Butterworth-Heinemann.

Goldmeier, D. (2012). Mindfulness: A sexual medicine physician's personal and professional journey. *Sexual and Relationship Therapy,* 1-7.

Goodwach, R. (2005). Sex Therapy: Historical evolution, current practice. Part 1. *Australian and New Zealand Journal of Family Therapy, 26*(3),155-164.

Grabovac, A.D., Lau, M.A. & Willett, B.R. (2011). Mechanisms of Mindfulness: A

Buddhist psychological model. *Mindfulness 2*(3), 154-166.

Hart, T.A. & Schwartz, D.R. (2010). Cognitive-Behavioral Erectile Dysfunction Treatment for Gay Men. *Cognitive and Behavioral Practice, 17*, 66-76.

Hartmann, U. & Waldinger, M.D. (2007). Treatment of Delayed Ejaculation. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(241-276). New York: The Guilford Press.

Hass-Cohen, N. & Findlay, J.C. (2009). Pain, Attachment and Meaning Making: Report on an art therapy relational neuroscience assessment protocol. *The Arts in Psychotherapy, 36*,175-184.

Heiman, J.R. (2007). Orgasmic Disorders in Women. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(84-123). New York: The Guilford Press.

Huss, E. & Cwikel, J. (2008). Its Hard to Be the Child of a Fish and a Butterfly Creative Genograms: Bridging objective and subjective experiences". *The Arts in Psychotherapy, 35*, 171-180.

Hyde, J.S. & DeLamater, J.D. (2003). *Understanding Human Sexuality* (8h ed.). New York: McGraw Hill.

Iasenza, S. (2010). What is Queer About Sex?: Expanding sexual frames in theory and practice. *Family Process, 49*(3), 291-308.

Jones, .E., Meneses da Silva, A.M. & Soloski, K.L. (2011). Sexological Systems Theory: An ecological model and assessment approach for sex therapy. *Sexual and Relationship Therapy, 26*(2), 127-144.

Jurich, J.A. & Myers-Bowman, K.S. (1998). Systems Theory and Its Application to Research on Human Sexuality. *The Journal of Sex Research, 35*(1), 72-87.

Kim, S., Kang, H.S. & Kim, Y.H. (2009). A Computer System for Art Therapy Assessment of Elements in Structured Mandala. *The Arts in Psychotherapy, 36*(1), 19-28.

Kleinplatz, P.J., Menard, A.D., Paquet, M., Paradis, N., Campbell, M., Zuccarino, D. & Mehak, L. (2009). The Components of Optimal Sexuality: A portrait of "great-sex. *The Canadian Journal of Human Sexuality, 18*(1-2), 1-13.

Laan, E. & Both, S. (2011). Sexual Desire and Arousal Disorder in Women. In R. Balon (ed), *Sexual Dysfunction: Beyond the brain-body connection* (16-34). Switzerland: Karger.

Leiblum, S.R. (2007). Sex Therapy Today. In S.R. Leiblum (4th ed), *Principles and*

Practice of Sex Therapy (3-22). New York: The Guilford Press.

Levine, S.B. (2003). Preface. In S.B. Levine (ed), *Handbook of Clinical Sexuality for Mental Health Professionals* (xiii-xv). New York: Brunner-Routledge.

Lusebrink, V. (2004). Art Therapy and the Brain: An attempt to understand the underlying processes of art expression in therapy. *Art Therapy Journal of American Art Therapy Association, 21* (3), 125-135.

Meana, M. & Jones, S. (2011). Developments and Trends in Sex Therapy. In R. Balon (ed), *Sexual Dysfunction: Beyond the brain-body connection* (57-71). Switzerland: Karger.

Mattson, D.C. (2010). Issues in Computerized Art Therapy Assessment. *The Arts in Psychotherapy, 37*(4), 328-334.

Maurice, W.L. (2007). Sexual Desire Disorders in Men. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(181-211). New York: The Guilford Press.

McCabe, M.P. (2001). Evaluation of a Cognitive Behavior Therapy Program for People with Sexual Dysfunction. *Journal of Sex and Marital Therapy, 27*, 259-271.

McGoldrick, M., Loonan, R., Wohlsifer, D. (2007). Sexuality and Culture. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(416-441). New York: The Guilford Press.

Pifalo, T. (2007). Jogging the Cogs: Trauma-focused art therapy and cognitive behavioral therapy with sexually abused children. *Art Therapy: Journal of the American Art Therapy Association, 24*(4), 170-175.

Riley, S. (1990). A Strategic Family Systems Approach to Art Therapy with Individuals. *American Journal of Art Therapy, 28*(3), 71-79.

Robbins, A. (2001). Object Relations Art Therapy. In J.A. Rubin (Ed) *Approaches to Art Therapy Theory and Technique* (54-65). New York: Brunner-Routledge.

Rosal, M. (2001). Cognitive-Behavioral Art Therapy. In J.A. Rubin (Ed) *Approaches to Art Therapy Application and Technique* (210-225). New York: Brunner-Routledge.

Rosen, R.C. (2007). Erectile Dysfunction. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(277-310). New York: The Guilford Press.

Rosenbaum, T.Y. (2007). Physical Therapy Management and Treatment of Sexual Pain Disorders. In S.R. Leiblum (Ed) *Principles and Practice of Sex Therapy* (4th ed.)(157-177). New York: The Guilford Press.

Sarid, O. & Huss, E. (2010). Trauma and Acute Stress Disorder: A comparison between cognitive behavioral intervention and art therapy. *The Arts in Psychotherapy, 37*(1), 8-12.

Sewell, K.W. (2005). "The Experience Cycle and the Sexual Response Cycle: Conceptualization and application to sexual dysfunctions". *Journal of Constructivist Psychology, 18*, 3-13.

Sexuality. (n.d.). *Collins English Dictionary - Complete & Unabridged 10th Edition*. Retrieved December 03, 2012, from Dictionary.com website:http://dictionary.reference.com/browse/sexuality

Slayton, S.C., D'Archer, J. & Kaplan, F. (2010). Outcome Studies on the Efficacy of Art Therapy: A review of findings. *Art Therapy: Journal of The American Art Therapy Association, 27*(3), 108-118.

Snir, S. & Wiseman, H. (2010). Attachment in Romantic Couples and Perceptions of a Joint Drawing Session. *The Family Journal, 18*(2), 116-126.

Tan, E. (2008). Mindfulness in Sexual Identity Therapy: A case study. *Journal of Psychology and Christianity, 27*(3), 274-278.

Vaccaro, M.V. (1973). Specific aspects of psychology in art therapy. *Art Psychotherapy, 1*(2), 81-89.

Wadeson, H. (2001). An Eclectic Approach to Art Therapy. In J.A. Rubin (Ed) *Approaches to Art Therapy Theory and Technique* (306-317). New York: Brunner-Routledge.

Wadeson, H. (2010). *Art Psychotherapy*. New Jersey: John Wiley & Sons.

Waller, C.S. (1992). Art Therapy with Adult Female Incest Survivors. *Art Therapy, 9*(3), 135-138.

World Health Organization. (2002). Defining Sexual Health: Report of a technical consultation on sexual health 28-31 January 2002, Geneva. Retrieved from http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

Wylie, K.R., Jackson, C., Hutchin, B.A. & Fitter, J. (2010). "Working Interactively Using a Systemic Sex Therapy Model For Common Sexual Problems Within a Modern Health Service Setting". *Sexologies, 19,* 196-201

Received_____

LOYOLA MARYMOUNT UNIVERSITY

Human Subjects Research

APPLICATION TO THE LMU INSTITUTIONAL REVIEW BOARD (IRB)

Principal Investigator (P.I.): Jillien Kahn

Title of Project: Visual Sexuality: Integrating Art Therapy and Sex Therapy

P.I. Type: (check one) ☐ Faculty ☒ Graduate ☐ Undergraduate ☐ Other

Department: Marital and Family Therapy

Campus Address: 1 LMU Drive, Los Angeles, CA 90045

Telephone: (818) 338-4562 E-mail: jillienk@gmail.com

Faculty Sponsor (if applicable): Einat Metzl

Submission: ☒ New ☐ Renewal ☐ Addendum ☐ Staff ☐ Other Previous IRB No.

For evaluation of your project, indicate involvement of any of the following:

- ☒ Audio recording of subjects
- ☐ Charges incurred by subjects
- ☐ Deception
- ☐ Elderly Subject (over 65)
- ☐ Establishment of a cell line
- ☐ Experimental devices
- ☐ Experimental drugs
- ☐ Fetal tissue
- ☐ Mentally disabled subjects
- ☐ Minor subjects (younger than 18)
- ☐ Non-English speaking subjects
- ☒ Non-patient volunteers
- ☐ Patients as subjects
- ☐ Placebos
- ☐ Psychology Subject Pool
- ☐ Questionnaires
- ☐ Sensitive Topics
- ☒ Subjects studied off campus
- ☐ Subjects to be paid
- ☐ Surgical pathology tissue
- ☐ Approved drugs for “Non-FDA” approved conditions
- ☐ Charges incurred by third party carriers
- ☐ Data banks, data archives, and/or medical records
- ☐ Filming, photographing, and/or video recording of subjects
- ☐ Pregnant women, human fetuses, and neonates
- ☐ Prisoners, parolees, or incarcerated subjects
- ☐ Subjects in Armed Services (Active Duty)

The principal investigator assures the Committee that all procedures performed under the project will be conducted by individuals legally and responsibly entitled to do so and that any deviation from the project (e.g., change in principal investigatorship, subject recruitment procedures, drug dosage, research methodology, etc.) will be submitted to the review committee for approval **prior** to its implementation.

What do you plan to do with the results? Please provide a brief summary statement below:

Complete requirements for Masters degree, will be posted in a scholarly way on the internet.

NOTE: Applications and any additional material requested by the IRB will not be processed unless **signed personally** by the principal investigator.

Date	Signature of Principal Investigator (Required)	Name (printed)
Date	Signature of Faculty Sponsor (Required)	Name (printed)
Date	Signature of Department Chair or Dean (Required)	Name (printed)

For ORSP Dept. Use Only

Date	IRB Approval (Signature)	Name (printed)
	IRB Approval Number	

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

1. Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jillien Kahn** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 09/02/2012

Certification Number: 976735

LOYOLA MARYMOUNT UNIVERSITY

IRB Application Questionnaire

1. RESEARCH BACKGROUND

Please describe the purpose of your research. Provide relevant background information and briefly state your research question(s). You may provide relevant citations as necessary. (300 Word Max.)

Art has been a conduit for the expression and communication of sexuality as far back as ancient China, India and Greece (Bhugara & de Silva, 1995). Riley (2004) points out that our world develops visually first, with language giving name and communication to people and objects already existing within that world. Without diminishing the enormous value of words, this could suggest that our first and most natural emotional language is that of feelings and images – things that often transcend the power of verbalization.

Similarly, according to Goodwach (2005), "Biologically and metaphorically, sex is a core experience, and is part of the total person, not just the genitals." Goodwich continues, stating that sexual urges and discovery begin in infancy and continue throughout the lifespan. She asserts that at times throughout our lives the occasionally overwhelming nature of social and relational struggles can cause an infantile regression, limiting the ability for verbal communication. When our emotions restrict that form of communication, our bodies will often use physical means to express frustration – otherwise known as sexual dysfunction.

It is the goal of this research to understand if, and how, art therapy can provide the opportunity for clients to express these emotions and experiences visually, tactily and otherwise Meta-verbally. This process invites the therapist to literally take part in the experience of his or her client - first through images, then in helping the client to find the words.

2. SUBJECT RECRUITMENT

How will subjects be selected? What is the sex and age range of the subjects? Approximately how many subjects will be studied?

How will subjects be contacted? Who will make initial contact with subjects? Specifically, what will subjects be told in initial contact?

If subjects will be screened, describe criteria and procedures.

This study will use a semi-structured interview (see interview guide Appendix C) to gain insight and understanding into the experiences of three licensed therapists who work with sexuality issues with and without the use of art.

Purposive sampling will be utilized with local clinicians known to the researcher and researcher's mentor. Participants will be chosen based upon professional licensure and experience as sex therapists and/or art therapists. There are no age or gender requirements.

Initial contact will be made by the researcher twice; first by telephone, then email. The phone call will serve as an introduction, brief explanation of the research, as well as to obtain verbal consent. The email will follow with a more the comprehensive explanation of the research, the planned structure of the interview, topics to be discussed, and consent forms.

3. PROCEDURES

Summarize fully all procedures to be conducted with human subjects.

Then intent of this research is to explore the possibilities of clinical art therapy techniques to describe, explore, promote acceptance and implement change for clients with sexual challenges. This study will compare the experiences of three therapists describing their clinical experience in gaining access to client sexualities with and without the use of art.

Participants will be contacted first by telephone for a brief introduction and to obtain verbal consent to participate. Participants will then be provided with a more detailed description of the research, as well as written consent forms via email. Interview date, time and location will be set up through telephone or email.

All interviews will be audio recorded. Participants will sign written consent forms regarding this recording and all confidentiality concerns at the onset of the interview. Interviews will be semi-structured with open-ended questions regarding the participants' professional clinical experience treating sexuality concerns.

4. RISKS / BENEFITS

What are the potential benefits to subjects and/or to others?

What are the reasonably foreseeable risks to the subjects? (Risks may include discomfort, embarrassment, nervousness, invasion of privacy, etc.) If there are potential risks to subjects, how will they be minimized in advance? How will problems be handled if they occur?

The main potential benefit of this study is obtaining a greater understanding of the benefits and limitations regarding the integration of art therapy and sex therapy. This includes the benefit of deepening this awareness for the participants, as well as the potential enrichment of therapeutic practice for the participants and researcher, both personally and professionally.

Potential risks are minimal, but include possible discomfort of discussing any challenging experiences treating client sexualities. In an effort to avoid this potential risk, the researcher will ensure interview questions are as open ended as possible, allowing participants to avoid uncomfortable or emotional experiences.

5. CONFIDENTIALITY

Will subjects be identifiable by name or other means? If subjects will be identifiable, explain the procedures that will be used for collecting, processing, and storing data. Who will have access to data? What will be done with the data when the study is completed? If you are collecting visual images of your subjects please justify this.

Due to the participants of this research being clinical professionals in the mental health field, the choice will be provided to maintain his or her professional name within this research. In the case that the participant chooses to remain professionally associated with the research, the researcher will work with the clinician to ensure that his or her client's confidentiality is maintained.

Should the participant choose to remain confidential, identifying information will remain known only to the researcher. The researcher will keep confidentiality of the interviewee to the extent permitted by law, and attempt to disguise identifying information as much as possible without damaging the meaningfulness of their subjective point of view.

This researcher will also discuss possible implications of publication via verbal communication and written consent form, and will answer questions regarding specific concerns about shared information when those arise. All interviews will be recorded through audio-recordings, transcribed, and all collected data will be kept in a secure, unnamed file on a locked computer within possession of the researcher only. The researcher will keep a copy of recordings with coded information for up to 2 years for use of possible publication of study results per consent forms. After a period of two years, the recordings and images will be discarded.

6. INFORMED CONSENT

Attach an informed consent form or a written request for waiver of an informed consent form. Include waiver of written consent if appropriate. If your research is being conducted in another language, please include copies of the translated "Informed Consent" or "Waiver of Written Consent" forms.

See appendix B

7. STUDENT RESEARCH

When a student acts as principal investigator, a faculty sponsor signature is required on the application form.

Faculty Sponsor: Einat S. Metzl, Ph.D., LMFT, ATR-BC

8. RENEWAL APPLICATIONS

When the submission is a Renewal Application, include a summary of the research activities during the previous granting period specifically addressing: number of subjects studied and any adverse reactions encountered, benefits which have been derived, any difficulty in obtaining subjects or in obtaining informed consent, and approximate number of subjects required to complete the study.

N/A

9. PAYMENTS

If subjects are to be paid in cash, services, or benefits, include the specific amount, degree, and basis of remuneration.

N/A

10. PSYCHOLOGY SUBJECT POOL

When students from the Psychology Subject Pool (PSP) are to be involved as subjects, permission must be obtained from the PSP prior to running subjects.

Forms are available from the Psychology Office in 4700 University Hall. It is not necessary to inform the IRB of approval from the PSP, however the PSP requires IRB approval prior to permission for using the pool being granted.

N/A

11. QUALIFICATIONS AND TRAINING

Describe the qualifications of, or method of training and supervision afforded student experimenters. This includes past experience, type and frequency of student/sponsor interactions during the experiment, and Human Subjects Protections Training.

The student has completed graduate course MFTH-691 Research Methodology, and is being supervised by a research mentor, Einat S. Metzl, Ph.D., LMFT, ATR-BC as part of follow up research methodology course MFTH-696.

12. RANDOMIZATION

Describe criteria for assigning subjects to sub-groups such as "control" and "experimental."

N/A

13. USE OF DECEPTION

If the project involves deception, describe the debriefing procedures that will be used.

Include, verbatim, the following statement in the consent form: "Some of the information with which I will be provided may be ambiguous or inaccurate. The investigator will, however, inform me of any inaccuracies following my participation in this study."

N/A

14. QUESTIONNAIRES AND SURVEYS

Include copies of questionnaires or survey instruments with the application (draft form is acceptable).

If not yet developed, please so indicate and provide the Committee with an outline of the general topics that will be covered. Also, when the questionnaire or interview schedule has been compiled, it must be submitted to the Committee for separate review and approval. These instruments must be submitted for approval prior to their use.

Consider your population. If they are foreign speakers, please include copies in the foreign language.

N/A – See interview guide in appendix C

15. PHYSICIAN INTERACTIONS

To ensure that all patients receive coordinated care, the principal investigator is obligated to inform the primary physician (when not the principal investigator) of all studies on his/her patients.

N/A

16. SUBJECT SAFETY

Describe provisions, if appropriate, to monitor the research data collected, to ensure continued safety to subjects.

N/A – Participants in this study are professionals in the mental health field discussing client vignettes, therefore safety regarding data will not be an issue.

17. REDUNDANCY

To minimize risks to subjects, whenever appropriate, use procedures already being performed on the subjects for diagnostic or treatment purposes. Describe provisions.

N/A

18. COUNSELING

In projects dealing with sensitive topics (e.g., depression, abortion, intimate relationships, etc.) appropriate follow-up counseling services must be made available to which subjects might be referred.

The IRB should be notified of these services and how they will be made available to subjects.

N/A – While sexuality can be a very sensitive topic, this research will discuss therapist accounts regarding working with client sexualities in a clinical setting; therefore will avoid first person sensitivities of this topic.

19. SAFEGUARDING IDENTITY

When a research project involves the study of behaviors that are considered criminal or socially deviant (i.e., alcohol or drug use) special care should be taken to protect the identities of participating subjects.

In certain instances, principal investigators may apply for "Confidentiality Certificates" from the Department of Health and Human Services or for "Grants of Confidentiality" from the Department of Justice.

N/A – all participants are interviewed regarding their professional engagement and no illegal or ethical concern is expected.

20. ADVERTISEMENTS

If advertisements for subjects are to be used, attach a copy and identify the medium of display.
N/A

21. FOREIGN RESEARCH

When research takes place in a foreign culture, the investigator must consider the ethical principles of that culture in addition to the principles listed above.

N/A

22. EXEMPTION CATEGORIES (45 CFR 46.101(b) 1-6)

If you believe your study falls into any of the Exemption Categories listed below, please explain which category(ies) you believe it falls into and why.

1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), if information taken from these sources is recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

3) Research involving survey or interview procedures, except where all of the following conditions exist: (i) responses are recorded in such a manner that the human subjects can be identified, directly or through identifiers linked to the subjects, (ii) the subject's responses, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability, or be damaging to the subject's financial standing, employability, or reputation, and (iii) the research deals with sensitive aspects of the subject's own behavior, such as illegal conduct, drug use, sexual behavior, or use of alcohol.

   All research involving survey or interview procedures is exempt, without exception, when the respondents are elected or appointed public officials, or candidates for public office.

4) Research involving the observation (including observation by participants) of public behavior, except where all of the following conditions exist: (i) observations are recorded in such a manner that the human subjects can be identified, directly or through the identifiers linked to the subjects, (ii) the observations recorded about the individual, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability, or be damaging to the subject's financial standing, employability, or reputation, and (iii) the research deals with sensitive aspects of the subject's own behavior such as illegal conduct, drug use, sexual behavior, or use of alcohol.

5) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

6) Unless specifically required by statute (and except to the extent specified in paragraph (1)), research and demonstration projects which are conducted by or subject to the approval of the Department of Health and Human Services, and which are designed to study, evaluate, or otherwise examine: (i) programs under the Social Security Act or other public benefit or service programs, (ii) procedures for obtaining benefits or services under those programs, (iii) possible changes in or alternatives to those programs or procedures, or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

LOYOLA MARYMOUNT UNIVERSITY

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.

2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.

4. I will be given an explanation of any benefits to be expected from the study, if applicable.

5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.

6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.

7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.

8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.

9. I will be given a copy of the signed and dated written consent form.

10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

LOYOLA MARYMOUNT UNIVERSITY

Informed Consent Form

Note: This form is only a template and is invalid without information particular to a proposed research study. It is the responsibility of the Principle Investigator (PI) to complete all blanks prior to submission.

Date of Preparation November 08, 2012

Loyola Marymount University

1) I hereby authorize Jillien Kahn, Marital and Family/Art Therapy trainee to include me in the following research study: Visual Sexuality: Integrating art therapy and sex therapy.

2) I have been asked to participate on a research project which is designed to explore the benefits and limitations of integrating art therapy and sex therapy techniques as a way to gain a deeper understanding of individual sexualities developed within a complex sexual culture. This interview will last for approximately 1.5 hours.

3) It has been explained to me that the reason for my inclusion in this project is that I am licensed sex therapist or art therapist experienced in working with sexuality issues.

4) I understand that if I am a subject, I will participate in a one time interview discussing my successes and challenges working as a clinician treating sexuality issues, with or without the use of art.

The investigator will collect my material. Data collected for this study will be kept confidential to the extent allowed by law and digitally stored in a computer only the researcher or research mentor has access to. Data will be discarded two years after the study is completed. The results of the research study will be used for the investigator's final research and may be published. In case of publication my name will not be used, and my identifying information will be concealed/protected.

These procedures have been explained to me by Jillien Kahn, MFT-ATR trainee.

5) I understand that I will be audiotaped in the process of these research procedures. It has been explained to me that these tapes will be used for teaching and/or research purposes only and that my identity will not be disclosed, unless I choose to, and provide written consent, to remain professionally attached to this research. I have been assured that the tapes will be destroyed after their use in this research project is completed. I understand that I have the right to review the tapes made as part of the study to determine whether they should be edited or erased in whole or in part.

6) I understand that the study described above may involve the following risks and/or discomforts: discussing challenging or unpleasant experiences treating client

sexualities.

7) I also understand that the possible benefits of the study include obtaining a greater understanding of the benefits and limitations regarding the integration of art therapy and sex therapy. This includes the benefit of deepening this awareness for the participants, as well as the potential enrichment of therapeutic practice for the participants and researcher, both personally and professionally.

8) I understand that Jillien Kahn who can be reached at (360) 689-4031 and Dr. Einat Metzl who can be reached at (310) 338-4561, will answer any questions I may have at any time concerning details of the procedures performed as part of this study.

9) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.

10) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to my professional status or abilities.

11) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.

12) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.

13) I understand that I have the right to refuse to answer any question that I may not wish to answer.

14) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 (310) 258-5465, david.hardy@lmu.edu.

15) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Subject's Signature _____Date _____

Witness _____Date _____

Interview Questions

1. Describe your practice and theoretical orientation.

2. Share a vignette of the sexuality concern most commonly presented by your clients.

3. Share a vignette describing your most memorable case.

4. Share a vignette describing your most challenging case, if different.

5. Share a vignette of the techniques you have used to treat resistant or challenging clients.

6. Share the vignette of a client who experienced shame and how you helped this client build comfort and confidence both within and outside of your sessions.

7. Are there any significant gender differences in your clients? For example, what is the gender ratio? What are common challenges between the genders? Is there a difference in how or if each gender communicates concerns with his or her partner?

8. If you use art therapy in your practice, share a vignette of how this specifically has contributed successfully and another of how this may have contributed extra challenges. What are your feelings regarding the integration of art therapy and sex therapy?

9. Are there any other parts of your practice we have not discussed, but that seem important to this research