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Sexual Integration Therapy:
A Sex-Positive Sexual Health Model Supporting Authentic Sexual Expression, While Addressing Sexual Compulsivity, Shame, Fear and Trauma

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ABSTRACT

Sexual Integration Therapy (SIT) is a client-centered sexual health model that focuses on the holistic integration of authentic sexuality and pleasure. SIT prioritizes working with clients to resolve the impact of sexual shame, fear, and past traumas that interfere with pleasurable sexual expression. While some clients may find pathology or addiction-based models helpful for their sexual concerns, SIT supports those who do not find solely cognitive-behavioral pathology, nor addiction treatment models effective. Through an examination of the evolution of psychology's problematic, subjective codifications of normal versus abnormal, paraphilic, or deviant sexuality, the authors demonstrate the potential risks of diagnostic pathologization. SIT moves beyond such problematic pathology-based diagnostic models and redefines normal sexuality as uniquely personal. The authors then detail how SIT builds upon recent sexual health models to shift the therapeutic paradigm and better address individualized desires, compulsive behaviors, or inhibitions, not supported by standardized therapeutic models.

Keywords: sex positive therapy; sexual authenticity; sexual health; mindfulness-based therapies; client-centered sex therapy

Lay Summary:

Sexual Integration Therapy (SIT) is a sexual health model prioritizing authentic sexuality by addressing sex-negative beliefs, compulsions, shame, fear, or past traumas hindering pleasurable expression. The authors examine historical and contemporary drawbacks in conventional treatments, highlighting SIT's use of mindfulness models to address desires or behaviors overlooked by standard therapies.

Introduction and Background

The range of human sexual expression and exploration has expanded considerably from the societal and psychological norms of the 1950s. This post-war period marked the beginning of the sexual liberation and sexual freedom movements. These early sex-positive movements were exemplified by: the publication of Playboy magazine; Alfred Kinsey's two books on male and female sexuality; the advance of gay and lesbian visibility and activism; the introduction of birth control pills: and other profound cultural shifts that carried on through the 1960s (Allyn, 2016; d'Emilio, 2012; Gerhard, 2000). The sexual liberation and freedom movements continued to expand over the decades into the current era. This most recent expansion reveals the exponential growth of: personal sexual explorations across a vast range of sexual expressions; broad acceptance of gay, lesbian and bisexual orientations (Browne & Bakshi, 2011; Davidson, 2001; Kilgore et al., 2005); the growth of interest in varieties of Kink-oriented sexuality (Coppens et al., 2020; De Neef et al., 2019; Hughes & Hammack, 2019; Sprott & Williams, 2019); the exponential growth of pornography viewing across a pantheon of genres (Parreiras, 2013; Price et al., 2016; Weinberg et al., 2010; Williams et al., 2020); exploration of polyamory and consensual non monogamy (Klesse, 2014; Tweedy, 2011; Vilkin & Sprott, 2021); the growth, normalization and prevalence of sexual pleasure products offered by the adult sex-toy industry (Dewitte & Reisman, 2021; Piha et al., 2018); renewed interest in ancient traditions of sacred sexuality such as Tantra (Hutchins, 2001; Twist, 2022; Urban, 2012); and a wave of growth in the professional fields of sex therapy (Kleinplatz, 2012), sex coaching (Perelman, 2018), sex/porn addiction therapy (Hall, 2011), and sex work (Sanders, 2006).

The swift growth in the volume of people exploring the evolving sexual landscape, across a multitude of new categories, has outpaced the psychological profession's capacity to study, understand, and agree on what are normal versus problematic sexual behaviors. Some theorists are beginning to note the shortfalls in outdated theoretical models applied to this emerging era of expanding sexual exploration. As such, the dangers of pathologizing complex sexual interests that are little studied nor understood at this stage are being highlighted. Markovic (2019) makes this point regarding diagnosing what is normal versus abnormal sexual behavior in the current era:

> Criteria for diagnosing 'excessive', 'hypersexual', 'obsessive' and 'compulsive' sexual behavior involve a level of judgment about what constitutes 'normal sexual behavior', 'normal levels of sexual desire', and how to distinguish those from pathological ones, thus entering a realm of subjectivity, normative comparisons, and potentially leading to pathologizing definitions. The question of who decides what is problematic and pathological, and what is a manifestation of a 'normal' range of diverse sexual expressions, remains a crucial challenge in this whole area, raising not only professional, theoretical, and practical, but also ethical and political concerns (Markovic, 2019, p.124).

The above statement by Markovic (2019) demonstrates the crux of the problem with subjective, top-down codes of normality. The authors argue that the institutional psychological codifications that led to the pathologization of numerous forms of non-normative sexuality, have been fundamentally flawed.

In response to the growing need to reframe healthy sexual behavior, this paper introduces a new theoretical and therapeutic sexual health model called Sexual Integration Therapy (SIT). The SIT model shifts emphasis away from previous

pathology-based models of sexual health to offer a more holistic approach for supporting clients with sexual issues. In this paper, the authors propose that it is time for the psychological professions to reconsider subjective diagnostic codifications of people's sexual behaviors as sexual pathology, move toward a sexual integration approach, and away from outdated and potentially harmful therapeutic methodologies.

An Emerging Sex-Positive Era Challenges Outdated Theories Pathologizing Sexual Behavior

What denotes "normal" versus "abnormal" sexuality is a question the psychological professions have tried to contend with and define since *Psychopathia Sexualis* was first published in 1877 (Krafft-Ebing & Chaddock, 1893). There were numerous revisions published over the span of several decades. Each edition further entrenched the idea of sexual pathologies, paraphilias and deviances, and this early medicalized, pathology model became prevalent within the psychological lexicon. The problems created by this subjective focus on diagnosing sexual pathology are highlighted by initial APA codifications that diagnosed homosexuality and consensual sadomasochism as pathological. Specifically, from 1952 through 1987, homosexuality was defined as a deviance situated with "sociopathic personality disturbance," then, "replaced with 'sexual orientation disturbance'," and later denoted as "ego dystonic homosexuality" before being removed entirely from the DSM (Surís et al., 2016, p.6). Further changes in the 2013 DSM-5 revision led to sadomasochism being reconsidered and removed as a paraphilia, when practiced by consenting adults.

These entrenched historical constructions of sexuality as pathology, stretching back over 100 years, set the stage for the contentious arrival of the concept, "sex addiction," a new terminology for so-called out of control sexual behavior, and an apparent 1970s/80s revisionist repackaging of 19th and early 20th century

conceptualizations of “perversion” (Reay et al., 2013, p.2). To complicate matters even more, in the eleventh revision of the International Classification of Diseases (ICD-11), compulsive sexual behavior disorder (CSB/CSBD) was introduced. The World Health Organization defined CSB as:

> Characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges, resulting in repetitive sexual behavior over an extended period (e.g., six months or more) that causes marked distress or impairment in personal, family, social, educational, occupational or other important areas of functioning (Kraus et al., 2018, p. 109).

This classification of CSB is another more recent popularization of sexual pathology that views sexuality through the reductive, binary lens of normal and non-normal sexual behavior. The historical trajectory of pathologizing non-normative sexual behaviors is important to prioritize, considering the potential for serious harm that may be caused when these behaviors are not better understood. As prime examples, the two major categories of sexuality previously noted, homosexuality and sadomasochism were initially pathologized as abnormal or deviant by the APA in all cases. This inaccurate diagnosis may have adversely affected millions of people. It took several decades before these errant codifications were eventually challenged, reconsidered, and reversed. The impact of pathologizing these significant populations has gone largely unrecognized and unacknowledged by the psychological institutions responsible, with the recent exception of The American Psychoanalytic Association (APsaA). Finally in 2019, the APsaA became the first US psychological association to take an accountable stance and apologized for “previously treating homosexuality as a mental illness, saying its past errors contributed to discrimination and trauma for LGBTQ people” (Trotta, 2019).

Since the 1980s, the popularized concept of sex/porn addiction has taken on a therapeutic paradigm that likens it to a disease that can be treated in similar ways to alcohol and opiates. The addiction discourse has "leant itself, almost seamlessly, to sexual matters; a strange, and momentary, combination of conservative Christian and radical feminist social purity" (Reay et al., 2013, p. 3). However, researchers are beginning to point out methodological complications that may arise when applying an addiction model to sexual behavior, suggesting that other motivating factors such as the proponents of religious, moral, ideological, or political beliefs are subjectively influencing the theory (Williams et al., 2020). Some scholars are pushing back against the addiction narrative arguing that it is a social construction inflamed by norms and values propagated via popularized media; it is not an actual medical condition. Furthermore, such a designation creates ways for individuals to circumvent personal responsibility for out of integrity behavior (Markovic, 2019). The addiction framework is thus embedded with social and religious by-products that frustrate accurately characterizing healthy sexuality in a way that moves away from pathologization and social or religious stigma. Scholars who recognize this have worked at unpacking the sex addiction framework and contend that such a framework becomes part of the problem rather than a solution. In such a view, shame and guilt are indelibly intertwined with sex, bound up by a long, stigmatizing history of demonizing sexual behavior that does not adhere to the narrow confines of so-called "normal." As a result, it then becomes easier to promulgate the notion of sex addiction (Reay et al., 2013).

Moreover, the contextualization of "normal" sexual behavior has generally been considered only in the passive sense, if it has been considered at all. Some scholars go so far as to argue that any definition of normal sexuality will always be controversial, and that such definitions are not necessary for helping people reconcile sexual

preferences and desires. Exceptions are sexual behaviors that *can* be considered a disorder due to creating significant psychological impairment, or in the case of criminal acts that violate others (Joyal, 2015). The problem that has yet to be brought to the fore by academics and clinicians seems to be how "normal" sex is conceptualized. What remains, after all the behaviors defined and cataloged as abnormal, deviant or paraphilic, is this vague, undefined assumption of normal. Normal sexual expression has not yet been defined by exactly what it is, versus what it is not. More recent client-centered, sex-positive theoretical models are prioritizing how individuals should be the ones to determine if their sexual desires and behaviors are healthy or unhealthy forces in their lives. This is a significant shift away from previous top-down diagnostic models. These current theoretical models also put the focus on an individual's agency to determine what to do about any behaviors they deem unhealthy for them (Efrati & Gola, 2018). Client-centered models such as these, by definition, make standardizing any diagnostic or therapeutic model of sexual normalcy an outdated concept. As will be demonstrated below, contemporary scholars are reconsidering the relentless effort to pathologize non-normative sexual expression.

Coleman (2017) approaches the deconstruction of treatment for CSB in ways that align with other sex-positive modalities that prioritize sexual integration. Coleman argues that a sex-positive, integrated therapy model approaches the treatment of CSB in an interdisciplinary manner, utilizing a variety of perspectives and healing frameworks, ultimately understanding that normal sexuality is fluid, individual, and resides along a wide spectrum where, importantly, sexual behaviors such as "masturbation, sexual fantasies, and use of erotica are normalized and encouraged, and paraphilic interests are integrated rather than avoided" (Markovic, 2019, p. 127). Theorizing in these ways lays the foundation for developing new treatment models of sexual health that support

integration. A sexual integration model includes the reintegration of formerly pathologized sexual expressions such as fantasies, masturbation and “paraphilic interests” that may include practices such as BDSM (Bondage, Dominance, Sadism, Masochism).

Coleman et al. (2018) further argues for the imperative acknowledgment of the immense range of sexual behavior that can be identified as normal. It is suggested that the diagnosis of CSB misconstrues maladaptive behavior in a vacuum, that does not accurately account for the intricate, contextual intersectionality of social, emotional, cultural, physiological, and environmental influences. These factors, considered holistically in their complexity, suggest a sex-positive approach may be better suited to reconciling the vast range of sexual expression and the numerous external and internal factors that influence it (Coleman et al., 2018). This re-envisioning of sexuality and sexual behavior through a sex-positive lens prioritizes such intersections. Doing so adds the nuanced perspective necessary to understand and integrate behavior that can now be viewed as variably adaptive or maladaptive given specific contexts and layered influences.

The recent theoretical and clinical reversals by the APA regarding homosexuality and sadomasochism highlight the major consequences of misdiagnosing specific sexual behaviors as psychological disorders or paraphilias. This suggests that we need to pay careful attention to what have been categorical assumptions about normal sexuality. Taking into consideration the historical and sociocultural evolution of sexual expression and the variable ways it has been regarded points to the importance of treating each patient as an individual without labeling, out of context, behaviors as normal or non-normal. The authors are not alone in pointing out the need to develop a clearer understanding or altogether abandon notions of normal versus abnormal

sexuality. Regarding emerging sexual behavior disorders being considered (CSB, ICSB, sex/ porn addiction, etc), it has been recognized and demonstrated that diagnostic criteria and conceptualizations of sexual abnormality have varied over time and have been controversial as a result (Coleman et al., 2018). This points starkly to a continuing gap in theoretical and therapeutic understanding of this unprecedented era of sexual exploration across many new genres.

Furthermore, the authors believe these pathologizing approaches have created a new problem: people with non-normative sexual orientations feeling the necessity to hide or be secretive about their authentic sexual nature. To this point, there has been little to no recognition nor research of this phenomenon, regarding the psychological burdens of keeping such an integral aspect of one's humanity a secret. Returning to the qualifying factors or diagnostic criteria to assess sexual behaviors that Markovic points out above, the authors argue that such criteria are increasingly irrelevant for understanding the expanded range of sexuality that is being embraced today. While the newer constructions of sexual pathology are still fraught with problems similar to those viewed as historically inadequate (Bőthe et al., 2022; Gola et al., 2022; Griffin et al., 2021; Lew-Starowicz & Coleman, 2022), they do provide in-roads for a more sex-positive approach that "emphasizes developing greater affect regulation, increasing ability to self-regulate, resolving erotic conflict, building intimate connections, and creating sexually healthy lives in a sex-positive manner" (Coleman et al., 2018, p. 128). In recognition of this, the authors argue that the line separating normal from abnormal sexuality needs to be re-examined, redefined, expanded, or wholly set aside, where appropriate. In response to such shifting ideas about sexuality over time, other scholars are also beginning to recognize that "normative" sexuality needs to be reconceptualized

to better help those seeking out healthy sexual integration and the healing of sexual shame, fear, and trauma.

Sexual Integration Therapy: Moving Treatment Beyond Pathology

The concept of sexual integration (France, 2006; Helminiak, 1989; Horn, 2005; Wittstock, 2009) is the process of an individual welcoming their unique sexuality into their everyday lives in a way that is in integrity with their values, agreements, responsibilities, and relationships. Sexual Integration Therapy (SIT) originally developed out of the recognition of a need for alternative therapeutic support models for clients with sexual concerns who do not respond successfully to a solely cognitive/behavioral pathology model nor an addiction treatment model. Nevertheless, Sexual Integration Therapy is a sex-positive, client-centered approach to sexual health that may be better oriented toward contemporary sexual health concerns by: reconsidering outdated theories defining normative and non-normative sexual desire and behavior; prioritizing research and therapy models that best support a client's pursuit of being sexually authentic; recognizing and addressing how shame, fear, and past trauma interfere with confident healthy sexual expression; helping clients shift secretive, compulsive sexual behavior to authentic sexual expressions that are enacted from a foundation of integrity; and introducing a holistic sexual integration model to achieve these goals irrespective of the actual substance of the sexual acts being engaged.

The SIT model has drawn inspiration from a broad range of modalities including: cognitive behavioral therapy (Thoma & McKay, 2014; Wenzel & Hays, 2016), depth and analytical vis a vis Jung (Corbett, 2011, 2019; Santana, 2014), positive regard or person-centered therapy (Irwin & Pullen, 2022; Velasquez & Montiel, 2018; Vosper, et al., 2021), somatic psychotherapy (Calatrava et al., 2022; Weiss, 2009), and transpersonal psychology (Hartelius et al., 2007, 2013); as well as emerging practices of

meditation, mindfulness, embodiment, and the realm of non-cognitive imaginal processes. These holistic practices can aid in accessing meaningful insight from within the unconscious, not available through cognitive processes alone. The SIT model recognizes that exploring the depths of one's inherent and chosen expression of sexuality is complex psychological territory. Navigating this multifaceted terrain of sexuality requires an understanding of the nuances of consent, conscious intention, mindfulness, presence, embodiment, mutual negotiation, risk-awareness, and responsibility for being educated regarding specific sexual practices (Braun-Harvey & Vigorito, 2016; Markovic, 2019). In these ways, the SIT model emphasizes embracing one's erotic desires with full agency while reconciling and working to resolve any embedded fear, shame, trauma, or harsh sex-negative moral judgments opposing or interfering with one's embodied, conscious sexual expression.

There has been very little explicit effort by the APA or other psychological institutions to theoretically standardize "normal." A core principle of the SIT model, in contrast to previous models, redefines "normal" as personal to the individual. There is no standardized "normal" in SIT. The client determines their own norm and whether they need support for the fullest expression or regulation of their "normal" desires. The SIT model encourages clients to embrace their inherent human right, or birthright, to explore, express and negotiate for the fullest expression of their personal, authentic sexual nature. It provides the context for clinicians and clients to examine any sex-negative cultural, moral, familial, or religious codes the client has experienced, which may have led to a deep fear of being honest about their sexual desires. As an example, unpublished observational data from a recent survey (forthcoming) demonstrated that people's fear of revealing their true sexual nature to others or having it discovered, may be the result of being sexually shamed or traumatized growing up

within a sex-negative culture, family, or religion. In this forthcoming data set, 81% of respondents say there was a point where they began to feel conflict between their desires and the family, social, intellectual, or religious/moral environments they were raised in. Subsequently, 68% of those who felt conflict say it led to secretive sexual engagements and fear of discovery (unpublished observations). The authors feel such data provide an alternative lens for understanding how one's authentic sexuality may have been inhibited or diverted into secretive compulsivity or other unhealthy behaviors.

A sex-negative society has been defined as an historical and sociocultural atmosphere that "has considered any sexual behavior outside of heterosexual procreative behavior as pathological, deviant, or bizarre and must be controlled" (Coleman et al, 2018, p. 134). Scholars have shown that the effects of living in a sex-negative society renders people unequipped for developing the adaptive skills they need, to have healthy relationships with themselves, their sexuality, and with others. The ability to appropriately self-regulate is weakened within the complex interplay of the aforementioned intersectional, and often sex-negative or dysfunctional personal circumstances such as social, religious, and family norms (Coleman et al., 2018). The psychological conflicts imposed through such sex-negative social constructs may show up as unconscious resistance to uninhibited authentic sexual expression. This internalized inhibition can diminish, if not prohibit altogether, the client's intention to learn about, explore, and experience the depths of consensual ecstatic erotic pleasure, intimacy, and connection that their fully expressed sexuality offers.

The Sexual Integration Therapy model guides clients to assess, explore, and define the frequency, depths, and range of their authentic sexuality; claim their birthright as a sexual being with full rights to negotiate for what they desire with

partners and better avoid erotic mismatches in their long-term relationships; resolve sex-negative beliefs, shames, fears, or past traumas tangled up with or interfering with their honest sexual expression and pleasure; address unhealthy or out of integrity behaviors such as compulsive, secretive use of sex or porn; gain an understanding of why they are operating their sexuality in covert, secretive ways; examine the impact of being out of integrity with themselves and loved-ones in how they express their sexuality; consider any other behaviors or beliefs that interfere with the honest expression of their sexuality; and overall, operate their sexuality in an informed, consensual, and negotiated way.

There is a growing body of work that provides theoretical support for holistic, sex-positive therapeutic models such as SIT, that move beyond the pathologizing models of the past. A foundation is being laid for shifting from the solely cognitive/ behavioral model toward a holistic approach of integration, thus reprioritizing this type of approach as fundamental rather than alternative. Like the SIT model, therapies rooted in mindfulness techniques may help people understand that urges and compulsive cravings are momentary and changeable over time; and by reconciling their desires, people may gain greater agency and control over them, thereby gaining the skills to integrate once maladaptive behaviors in such a way that those behaviors are no longer a force of disruption in one's life (Blycker & Potenza, 2018). A mindfulness-based model of sexual health privileges empowerment strategies that aim to enhance sexual pleasure and help resolve past trauma or sexual shame. Some practices that assist with this include the cultivation of skills for self-reflection that engender greater forms of awareness and understanding. These fundamental skills help one garner access to inner information that may provide clarity and instill confidence in making decisions that prioritize health and well-being. In doing so, these mindfulness skills help to put into

place a new internal matrix for parsing through and organizing the influential factors that impact sexual health (Blycker & Potenza, 2018). Mindfulness practices such as these can assist in the overall reframing and treatment of CSB for example, allowing clients to achieve states of well-being that had not been accessible before (Efrati & Gola, 2018). Building upon such empathy-based, client-centered approaches, the SIT model utilizes mindfulness, embodiment, presence, and other techniques similar to those mentioned above in support of a client developing individual agency and empowerment.

Charting a sex-positive course for the current era

In the last forty years a number of sexual theories have evolved to conceptualize and clarify what has been termed “Compulsive Sexual Behaviors" (also referred to as CSB, CSBD, or ICSB), often used interchangeably with sex/porn addiction in popular culture (Borgogna et al., 2022; Derbyshire & Grant, 2015; Griffin et al., 2021; Williams et al., 2020). While these behaviors are problematic and disruptive for many, the SIT model considers that these so-called compulsive sexual behaviors themselves may not be the problem, but the symptom. It has been noted that prior therapeutic models of sexual psychology have looked to address the abnormal, deviant, pathological aspects of someone’s problematic sexual behaviors, or attempt to deal with physiological arousal issues, pain, or sexual dysfunction (Bancroft et al., 2009; Briken, 2020; Janssen & Bancroft, 2007; Rettenberger et al., 2016). However, they do not address the concepts of an innate human right to pleasure via freely expressed sexuality (Coleman et al., 2021) - nor the sexual birthright to live a sexually authentic life (Braun-Harvey, 2016; Harbin, 2011; Kernis & Goldman, 2006).

From the SIT perspective, the core psychological problem for a client may not be the compulsive use of porn, nor the genres of porn, nor the particular sexual

behaviors they are pursuing. These compulsive behaviors, for certain clients, can be better understood as a symptom of a deeper psychological issue: the pervasive fear they have of revealing their authentic sexual desires to others, and the consequent psychological stress of the concealment that follows. Without adequate psychological support that encourages one to be honest about their sexual truth, such secrecy compels diligent maintenance of a cover-up that often becomes unsustainable and problematic. On the one hand, conceptualizing compulsive sexual behaviors as the core problem someone may be experiencing obscures the unacknowledged issue of the pervasive, overwhelming fear many people have of being honest about what they desire sexually. For example, preliminary analysis of a forthcoming survey data set, has shown that of those who have experienced such conflicts, 66% felt shame about their fantasies, 68% feared discovery, and 54% repressed their sexual desire (unpublished observations). On the other hand, putting the focus entirely on diagnosing these behaviors as pathologies such as the CSB or sex/porn addiction models have done, entirely overlooks the astounding range and variety of human sexual desires and interests emerging, evidenced by the vast range of porn genres available (Fesnak, 2016; Parreiras, 2013; Price et al., 2016; Weinberg et al., 2010; Williams et al., 2020). The expansive emergence of sexual expression in this era is a seriously understudied phenomenon that is worthy of further research to understand.

To this point, scholars are beginning to focus on areas of research that consider the legitimacy of sex as leisure. Williams, Thomas, and Prior (2020) take aim at so-called sex/porn addiction, arguing that acting on a high sex drive and/or frequent viewing of porn, for many, is simply a form of leisure rather than pathology or addiction. This possibility is excluded or overlooked by theorists and clinicians that advocate the sex/porn addiction or pathology model (Williams et al., 2020). The ways in

which these authors establish sex as leisure is a good example of the ways in which sex-positive sexual integration approaches provide alternatives to those that pathologize alternative sexual expressions. These sex-positive approaches set a foundation for understanding that CSB models and sex/porn addiction theories linking frequent sexual behavior or porn viewing as problematic or addicting, are not adequate propositions. Their oversimplification of high sex drives or frequent porn viewing is the basis for an increased, pervasive popularization of the sex/porn addiction model, which relies on the widespread sex-negative messaging recognizable in modern society and within the scientific and medical realms. Therefore, contemporary sexuality scholars must ask:

> Why do people make the jump from conceptualizing a specific individual as having a problematic relationship with frequent sexual behavior or pornography viewing, to conceptualizing sex or pornography as something that causes addiction? One answer is… a significant history of the medicalization of sexuality (Williams et al., 2020, p. 4).

Consequently, the authors argue that conceptualizing sexuality in ways that lacks a critical view of historically subjective criteria, raises questions about the clarity and accuracy of theoretical or clinical assumptions about a person's frequent sexual behavior or porn viewing, reductively framing these behaviors as having a pathology or addiction. Maintaining labels such as these reifies the contentious historical path that medicalizes and thus compartmentalizes so-called aberrant sexuality into pathologies (Antons et al., 2022; Williams et al., 2020). In contrast, emerging sex-positive approaches prioritize the importance of supporting the client to consciously explore and integrate any imaginal, symbolic sexual fantasies they wish, as an intrinsic part of an empowered sexuality (McClintock, 2004; Quintanilla, 2022; Santana, 2014).

These emerging sex-positive integration models suggest that certain people diagnosed with compulsive sexual behavior disorders, hypersexual disorder, or pathologized as sex/porn addicts are being misdiagnosed. The importance of moving on from entrenched and inherently sex-negative pathologizing of a varied array of sexual expressions is noted by other contemporary theorists. Although some improvements can be noted, it is still crucial to understand that:

> Our sociocultural climate has considered any sexual behavior outside of any heterosexual procreative behavior as pathological, deviant, or bizarre and must be controlled… receiving these sex-negative messages leads to a variety of sexual problems… [and] neglect the primary sexual health principles of pleasure (Coleman et al., 2018, p. 134).

Sexual Integration Therapy follows this logic further, claiming that being sexually authentic is a birthright. Clients are encouraged to embrace their deepest sexual desires and express them in their relationships in honest, healthy ways.

Accordingly, the SIT model posits that sex, desire, and fantasy, regardless of the features of these acts, can be a healthy embodiment of pleasure – pleasure as an end in itself. This principle of pleasure is founded on the general principles of mutual negotiation, education, and consent between adult partners engaging sexually. When clients are unable to embody these authentic aspects of their sexuality in an honest way, they may find themselves entrenched in secretive, compulsive, problematic behaviors. Rather than stigmatizing the client with a clinical, pathologizing label, the SIT model identifies this avoidance of being honest with partners about their sexual desires with the concept of sexual inauthenticity. Sexual inauthenticity, in this regard, can be defined as an extreme and often lifelong effort to conceal inherent aspects of one's sexuality and an extreme, pervasive fear of revealing, or having one's authentic sexuality discovered,

shamed, judged, or punished by others (Braun-Harvey, 2016; Gillath et al., 2010). Some people with sexual inauthenticity issues may exhibit a broad spectrum of covert behaviors such as: elaborate, secretive, unhealthy actions they may take to cover-up the pursuit of their authentic sexual desires; a stifling fear of speaking honestly about what they desire with partners; experiencing persistent, harsh internalized sex-negative shaming or moral judgments that conflict with what one desires sexually; compulsive pursuit of their sexual pleasure in secret; taking irresponsible financial, health, and other risks to access sexual pleasure, that not only increase risk of harm to themselves, but others they may be responsible for or in relationship with; repeated cycles of shame, guilt, fear, or depression after a secretive exploration.

Additionally, people may experience compound factors that cause them to pursue their sexual desires secretly. They may be in a prohibitive relationship with a partner who objects to or condemns their particular sexual interests. They may have been raised in or still be immersed in a religious or sociopolitical, cultural system that considers what they desire a grave infraction of the system's moral codes, condemning them to hell or ostracization. They may have a social or professional position they feel would be threatened if their sexual desires were to become known. All these conditions may be exacerbated by deeply seated sexual shame, fear, or past traumas that make it feel unsafe to be sexually honest. And, ultimately, they may have been disconnected from and disempowered from their right to be sexually authentic. Sexual Integration Therapy works to reconnect the client to their own sexual agency to advocate and negotiate for their personal sexuality in their life and relationships. At the same time, SIT supports the client to address the internalized, disempowered complexes within their internal psychology that have led to behaving inauthentically.

The sex-positive SIT model encourages the client to claim their right to be who they are sexually, to explore once taboo sexual expressions immersively if they choose, and to negotiate for that right in their relationships. These are foundational principles of SIT. Furthermore, in treating a partnered client with concerns about secretive, compulsive sexual behaviors, the SIT model considers the attendant deception and cover-up - the sneaking, hiding, lying, being out of integrity, perpetual fear of discovery and the elaborate attempts to hide the behavior from their partners - as the more significant and core problem for many people. Through this lens, the fear of discovery is brought into view as a notable component that drives the deception. The client's examination of where this fear is grounded is a standard practice of the SIT model. Recently collected, forthcoming survey data found that 37% of all respondents say fear of discovery is among the biggest obstacles or conflicts that interfere with authentic and honest expression of their deepest sexual desires, and 29% of all respondents cite shame around their sexual desires (unpublished observations). Observations such as these begin to demonstrate the factors that may contribute significantly to the perpetuation of sexual secrecy in their life and relationships. In cases where people have been pursuing their sexual desires in secret, the SIT model in practice emphasizes the right of each person to negotiate for their authentic sexual desires in their relationship, while also examining the origins of their fear and the consequences of hiding their authentic sexual nature to those closest to them.

The SIT Structure for Therapeutic Application

To support these aims, the Sexual Integration Therapy model provides a sex-positive framework and methodologies that support clients to:

- Embrace and explore the ecstatic depths of pleasure their inherent sexuality offers.

- Address internalized shames, fears, harsh sex-negative judgments, or past traumas that interfere with or inhibit the honest, confident expression of their sexual desires.
- Claim their birthright to be fully expressed sexual beings in their life and relationships.
- Operate their sexuality in ways that are healthy, informed, consensual and negotiated.
- Shift compulsive, secretive, unhealthy sexual behaviors, often labeled CSB, hypersexual disorder or sex/porn addiction, into authentic, honest, confident sexual expression.
- Integrate their authentic sexuality into their everyday life in a way that is in integrity with their values, responsibilities, agreements, and relationships.

Scholars such as Braun-Harvey and Vigorito (2016) and Markovic (2019) emphasize "the importance of the practice of assessing sexual behaviors not being based on fear, pathologization, and moral judgements, but being led by the sexual rights of consenting adult sexual partners" (2019, p. 123). These scholars deconstruct previous ways of regarding sexual behavior by shifting the sex-negative focus for assessment of behavior, to one that exalts an individual's sexual agency and autonomy. This shift mirrors the aims of the SIT model. Taking inventory of the client's sexual integration objectives sets a foundation for the reflective self-assessment required for the integration work to unfold.

For clients engaged with SIT, restoring sexual agency is the process of untangling embedded, unconscious fear, shame, trauma, internalized sex-negative judgments, and compulsive or out of integrity sexual behaviors, from one's authentic sexual expression. Until resolved, these unconscious sex-negative emotions and beliefs

can arise on-cue at the same moment someone is becoming aroused sexually. This tangled up expression can leave people feeling shut-down, clumsy, or disconnected physically, emotionally, and spiritually, rather than feeling their sexual excitement and pleasure. This disconnected state effectively blocks people from the depth, power, and exhilaration that is natural to their authentic sexuality. Kernis and Goldman (2005) affirm that authenticity is crucial for the development and maintenance of self-awareness, and to gain the skills to parse personally relevant information that lends to such development. These skills are essential to being in integrity and in alignment with one's values and needs. They enable healthy interpersonal relating from a place of mutual honesty and trust. The SIT model supports a client to develop a path to become sexually empowered and authentic. This path often opens potentials for powerful healing of past sexual traumas, fears, harsh internalized sex-negative judgments, and shame.

Five key assessment criteria for sexual integration

The following five key self-assessment categories help the client identify where they feel they stand currently on their individualized path to sexual integration. From these assessments they can begin to consider what steps to take in any area they feel they are falling short of their own expectations. Their assessments of these "Five Keys" provide the information they need to create an individualized roadmap to sexual empowerment. They may also discover additional keys that are important to them personally.

Exploring and defining an individual's sexual authenticity

As was introduced briefly above, scholars have taken steps to acknowledge the importance of, and systematically define authenticity. They highlight the significance of centering the "true" or "core self," and further break it down into its central components: "awareness, unbiased processing, behavior, and relational orientation"

(Kernis & Goldman, 2005, p. 32). This conceptualization of authenticity naturally lends itself to an understanding that touches all aspects of life, including sexuality. Scholars further articulate that when one behaves in accordance with their true, authentic self, they are able to attain greater levels of confidence, or self-esteem, which translates into overall satisfaction with life. Such authentic living creates a sense of fulfillment around needs and desires (Fogle et al., 2007).

With these considerations of authenticity in mind, the SIT model regards each person as possessing an innate, authentic sexuality, as distinct as their fingerprint and as inherent as their eye color. Their authentic sexuality defines how strong and frequent the natural rhythm of their desire is currently and over time, the erotic type(s) they are attracted to, and the core themes, fantasies, and activities their sexual desire is aroused by, across the full spectrum of sexual possibilities. It is each person's basic human right, or birthright, to both express and consensually explore their authentic sexuality to the fullest extent. In fact, the prioritizing of authenticity in research and clinical settings is on the rise, where it is increasingly understood as the foundation upon which well-being is built. Conversely, it is being observed that the absence of authenticity precedes an increase in dysfunctional behavior (Wood et al., 2008). In these ways, SIT's emphasis on sexual authenticity encourages the client to both fully explore and express their true desires, and also to be aware that past inauthentic behaviors that are not in alignment with the authentic self will ultimately negatively impact well-being and potentially harm relationships (Kernis & Goldman, 2005). This emphasis on sexual authenticity is not a stagnant process, but one that is returned to over time to allow the fullest expressions of sexual authenticity natural to the client.

Developing the skills of sexual honesty

The assessment of one's sexual honesty provides a measure of how disconnected or distant one may be from being fully integrated sexually. For many people, choosing to live their authentic sexuality in an honest, transparent way can be a challenge, when previously they have been keeping their sexuality a well-guarded secret. The SIT model affirms and builds upon what has been previously posited regarding authenticity, namely that the first step toward being fully authentic can be broken down as such: learning to identify any mismatches between awareness, or desires, and experience and behavior. This is a process of becoming *radically honest* with oneself and then committing to live according to those values and beliefs that one confirms is true for themselves. This is the foundation of living in integrity (Wood et al., 2008). In other words, being able to cultivate and integrate honesty is imperative for developing and maintaining authenticity.

Once a client has begun to understand and embrace their authentic sexual nature, and be honest with themselves about their desires, the next step is to consider how they can share their desires with their intimate partner(s) in a forthright manner. This stage supports identifying any embedded, unconscious conflicts that have kept their innate desires hidden due to shame, fear, past traumas, or harsh internal moral judgments. This step also intends to put the client in touch with their human right to negotiate for what they want sexually in their relationships, and what areas they may want to place boundaries around. The SIT model emphasizes the client's right to privacy as well, to choose with whom they do or do not share their deepest sexual truths. Developing the skills of sexual honesty can support creating a safe environment to discuss, encourage and support their current partners to be honest as well, or to discover and avoid erotic mismatches in their future relationships.

Using embodiment practices to achieve sexual empowerment

To date, the theorization of empowerment across disciplines is vast and dependent upon the context in which it is raised. Generally, empowerment has been characterized as: mastery, participation, forwarding the social good, goal achievement (Cattaneo & Chapman, 2010); and according to Zimmerman (1995) empowerment is psychological, comprised of "intrapersonal, interactional, and behavioral components" (1995, p. 587). As it will be shown, these criteria are fundamental to guiding someone down the path of integration within the SIT model. Similar to the vast array of ways in which empowerment is theorized, embodiment too has been theorized in myriad ways. However, a general theme among such conceptualizations is that the body has a significant influence on psychological processes. In fact, the psychological, physiological, and sensory processes overlap and interact to influence cognition, movement through space, and social interactions (Glenberg, 2010). Even more specifically, embodiment is the idea that "thoughts, feelings, and behaviors are grounded in sensory experiences and bodily states" (Meier et al., 2012, p. 706). Being embodied is about creating meaning between the self and the world around us. It is subjective, corporeal, and bound by personal perceptions that encompass how we relate to ourselves and others. Meaning-making strategies are necessarily embodied practices, or body techniques (Maus, 1979) that "entail bodily activity, patterned movements, or postures" (Crossley, 2004, p. 33).

In the Sexual Integration Therapy model, a sexually empowered person is viewed as one who has the capacity to fully express their sexuality in the moment, and is unencumbered by internal psychological, emotional, or physical resistance, in that moment. To feel empowered in one's authentic sexuality, it is helpful for the client to learn how to use embodiment practices such as mindfulness, presence, breath, movement, and imaginal versus cognitive techniques to slow down internally and

become grounded in the self through the act of being present, in the moment, and self-reflective. In doing so, the aim is to be able to fully connect with and experience one's authentic sexuality, without the distraction of the innumerable internal disturbances trying to influence the moment.

To this end, the SIT model expands on Blycker and Potenza's (2018) Mindful Model of Sexual Health (MMSH). The MMSH advances the argument that mindfulness can become a conduit to access meaningful information from within internal states of one's mind and body. Such information can shed light on inter- and intrapersonal experiences, as well as increase emotional and sexual intelligence, which feeds back into the cultivation of self-awareness and empathy (Blycker & Potenza, 2018). Via such conscious embodiment practices, individuals may be better able to shift the overpowering, unconscious embodiments of shame, fear, trauma, and internal sex-negative moral judgments. These internal conflicts, embedded since childhood for many, relentlessly interfere with their fullest authentic sexual expression, physically, emotionally, and psychologically. By cultivating such practices of presence, physical embodiment, and mindfulness, the client can learn to feel empowered to fully express their own authentic desires in the moment. These embodiment practices can allow clients to begin to explore and enjoy their authentic sexual expressions in present time, without having to wait until they complete the deeper work of resolving deep-seated internal sexual conflicts.

Integrating the sexual shadow

The concept of the "shadow" has a long history grounded in Jungian and related theories that have been interpreted over time among an expansive range of disciplines. The psychological core of this concept, however, centers on the shadow being a part of the self that we wish to mask or hide; as well as being considered an intermediary

between the conscious ego and the deeper, unconscious self (Bolea, 2016). The shadow has been characterized as "the inferior personality," the part of the persona that wants to stay hidden, that is dense, fearsome, and lurks in the background (2016, p. 85). While the shadow may be comprised of those qualities people would rather hide from view, other theories believe that acknowledging and integrating those qualities into one's being is a fertile source of growth that advances the journey toward wholeness (Patton, 2006). Therefore, the integration of the shadow can be fruitful for the creation and evolution of the self (Bolea, 2016). This is particularly useful for understanding the importance of the process of integration for the sexual shadow and its creative potential.

In the SIT model, the sexual shadow represents all the past secretive sexual behaviors the client practiced, or those that were not in integrity with themselves or others. Some examples of these sexual shadows for people that exhibit secretive, risky, compulsive, unhealthy, dishonest, violating sexual behaviors, are indicated in forthcoming survey data as: 64% created a secret email/mailing address, 54% lied to a partner, 51% created a separate secret persona, and 32% lied to co-workers (unpublished observations). These past ingrained patterns of operating their sexuality and covering it up are important to be brought to conscious awareness. These shadow components may have held power over the client's behaviors, often for decades. Bringing these shadow aspects to conscious awareness reduces the capacity of these parts of the unconscious to override the client's conscious intention to operate their sexuality with integrity. For instance, clients whose sexual interests lie outside the so-called "norm," including taboo fantasies and behaviors such as BDSM and polyamory, can be guided to embrace rather than shun these aspects of their sexual desires. They can learn to integrate these non-normative but authentic aspects of their sexuality in ways that are honest, in integrity (i.e. with transparent communication and

abiding by consensual ethics), and fully embodied (Coleman et al., 2018). This is an example of how SIT might frame the sexual shadow and work to integrate it.

Reconciling sexual paradox

All too often, clients may experience difficulty embracing their sexual truth due to embedded sex-negative beliefs and judgments about sexual pleasure outside procreation, derived from religious, social, and cultural conditionings. These internal conflicts can be perceived as intractable paradoxes, leading to tension between a person's perceived reality and their desires. Individuals experience sexual paradox when their personal innate desires are judged or condemned by their culture, religion, family or partners, as hedonistic sin, morally corrupt, or disgusting, uncivilized behavior. The formation of sexual paradox comes from the deeply embedded sexual mores stemming from family, sociocultural and/or religious upbringings, that goes against what the client innately desires. Additionally, the experience of past sexual traumas and abuse could create an unconscious association and resistance to sexual pleasure that can interfere with or shut down one's sexual pleasure in the present.

Learning to understand and embrace the concept of sexual paradox, allows the client to accept that they can have desires that are frequent, unconventional, "perverse," or taboo, without detracting anything from their ability and desire to be loving, tender, intelligent, successful, honorable, civic-minded, spiritual beings, considerate of their partner(s) and others. Research has shown that people who are able to conceive of paradoxes in generative ways can experience a cathartic and creative effect in their lives. Paradoxical frames, or "mental templates that encourage individuals to recognize and embrace contradictions" (Leung et al., 2018, pp. 443), create the conceptual space for people to re-evaluate their relationship to internal contradictions in ways that can be productive rather than confounding. The SIT model helps clients learn to accept that

being authentic sexually, when expressed with integrity, in no way diminishes, nor contradicts being a good parent, partner, worker, citizen, or spiritual, soulful being. Being fully expressed sexually and being an ethical, loving human, is no longer an either/or proposition, it is both/and. The task here is for the client to learn how to hold their sexual desires and their most noble aspirations for the world in an aware and conscious balance, that is in integrity with their agreements and responsibilities to their communities, professions, partners, and themselves.

The practitioners' own sexual integration process, a training imperative

The SIT model aspires to follow the "above all, do not harm" adage when it comes to client care. A critical component of this aspiration is supporting therapists to resolve their own sexual confusions and woundings and claim their birthright as an authentic sexual being. Research has shown that it is important for practitioners to understand and have a positive association with their relationship to sexuality (Stayton, 1998; Dermer & Bachenberg, 2015). A therapist's personal experience growing up in a generally repressive, sex-negative culture or family may have produced deeply embedded psychological fears, shame, and trauma around their sexuality, as well as embedded sex-negative beliefs and biases (Prause & Williams, 2020). The authors argue that if a therapist has not addressed their own sexual biases, the risk of projecting their sex-negative beliefs onto clients rises significantly. The lack of such training may significantly impact the interventions that clients receive (Washington, 2023). This can lead to therapists providing ineffective support for their clients, if not causing further psychological harm (Burnes, Singh & Witherspoon, 2017; Hipp & Carlson, 2019; Timm, 2009).

The current field of sexology, or sex therapy, lacks a unified theory, as well as practices or outcomes, and little is known about training and qualifications (Binik &

Meana, 2009; Berry & Barker, 2015; Miller & Byers, 2012; Prause & Williams, 2020; Timm, 2009). In a recently published study, Zeglin et al (2024) have identified and reaffirmed that there is a significant absence of standards for sexuality training for therapists. It remains unclear whether "sex therapists" are competent to ethically provide such services (Zeglin et al, 2024). For instance, the Zeglin et al (2024) study found that only "25% of sex therapists across the country are certified and 32% have zero graduate training in sex therapy" (Zeglin et al, 2024:4). Additionally, from the undergraduate to postgraduate level, and through the supervisory phase, a licensed therapist's own sexual mental health has not been considered important to address before being sanctioned to treat clients for complex sexual concerns. The studies that have investigated this issue have shown that sexuality training is important and helpful for therapists working with clients with sexual concerns (Burnes, Singh & Witherspoon, 2017; Ford & Hendrick, 2003; Harris & Hays, 2008; Merritt, 2011; Miller & Byers, 2008, 2012; Moore, 2018).

Moreover, the isolation of sex therapy as distinct from general mental health care, allows practitioners that are not comfortable treating sexual concerns to outsource this work. This advances the notion that sexual health should be treated apart from the whole person rather than sexuality being integral to overall wellbeing. Outsourcing also allows practitioners to avoid their own discomfort for treating sexual concerns and perpetuates the challenge of codifying sexual health training. Such a focus on specialization, not only frustrates the move toward a unifying sex-positive therapeutic framework but also serves to "perpetuate societal discomfort with sexuality" (Binik & Meana, 2009:1016). Binik & Meana (2009) appropriately point out that a therapist's comfort level around treating sexual concerns is important, as sexuality is an integral

aspect of life, and all mental health professionals need to be equipped to deal with sex as it is the “very activity that perpetuates human life” (1023).

Various Sexuality Attitudes Reassessment (SAR) programs formulated since the 1970s have been a singular, non-standardized, optional sexuality training tool for therapists and mental health practitioners to engage with (Kristina & Lindroth, 2022; Sitron & Dyson, 2009; Stayton, 1998). SARs have been a useful tool for therapists to challenge their own sexual biases and gain a deeper understanding of the diverse range of client sexual interests and concerns, but they are less commonly used today (Binik & Meana, 2009). Surprisingly, the APA Commission on Accreditation does not currently require any sort of sexual health or sexuality training for a graduate program to achieve accreditation (APA, 2006; Burnes, Singh & Witherspoon, 2017). The implication of this lack of standardized training is that psychology curricula are not prioritizing sexuality, which potentially affects a significant aspect of a client’s life. Consequently, the authors contend that while a SAR can be a valuable tool at the cognitive level, it does not address the deep sexual shame, fear or trauma that may have occurred in the therapist's own developmental stages. Any deep-seated, sex-negative psychological woundings, beliefs or judgments the therapist has, if left unresolved, can become activated when trying to support clients who have particular sexual preferences or experiences that agitate this unconscious unresolved material within the therapist’s psyche. The resultant behavior from the therapist may range from discomfort, or avoidant side-stepping of the client’s sexual concern, to outright condemnation and shaming of the client for being who they are sexually (Berry & Barker, 2015; Burnes, Singh & Witherspoon, 2017; Hanzlik & Gaubatz, 2012; Hipp & Carlson, 2019; Prause & Williams, 2020).

The authors maintain that the therapist's own sexual integration is a key element of a sex-positive approach to supporting clients with complex sexual desires and

associated psychological conflicts. As the authors have demonstrated above, *sex-positive* frameworks for implementing mindfulness-based approaches to sexual health have been lacking. This is where the SIT model aims to intervene and move mindfulness-based therapeutic practices forward to create concrete and standardizable methodologies for treating the whole person. To best serve their clients, it will be a requirement that SIT practitioners undergo their own sexual integration process utilizing the SIT assessment and integration protocols. To accomplish this objective, various coursework, one-on-one training, an experiential group workshop, and an accreditation process to help practitioners become competent in the SIT method, are in development.

Further considerations for individualized therapeutic application

Sexual Integration Therapy begins with supporting the client to define what is true about their sexuality in all regards. The SIT model then supports them to understand and resolve what interferes with or resists the honest expression of their sexuality. The client, with the therapist's support, can learn to develop their personal methodology to integrate their sexuality into their everyday life. The therapist also works to support the client to reconcile the internalized psychological conflicts, traumas, and sex-negative beliefs that obstruct the fully empowered, embodied experience of their sexuality. To the greatest extent, the pathways and sequence of treatment is mapped through the client's own intentions and insights.

The full scope of the SIT model's theoretical and therapeutic concepts, processes and practices used to support clients, and training modalities for practitioners, extend beyond the scope of this paper. In sum, Sexual Integration Therapy draws from clinical CBT, depth, analytical, positive, somatic, and transpersonal theories of psychology, and other practices to provide meaningful support to clients with sexual concerns to positively impact a holistic approach to general wellbeing. The SIT model follows a

client-centered approach that does not recommend specific, ordered steps that are applied uniformly to each client during the treatment process. The specific psychological work and the path forward after the SIT assessment process above is defined by the client. The therapist, equipped with experiential SIT training, supports the client with suggestions about tools and practices they may use such as mindfulness practices, embodiment techniques, and others, when needed.

Each client will be a special case; one client may be better served by a completely different set of practices than a previous client. It is important to keep the focus on the client's own agency and inspiration throughout the therapy process. The SIT model encourages the client to personalize any process they might utilize in a way that is meaningful to them, or to insightfully discover their own processes. There is no diagnosis nor prescription involved, other than the client's own assessment and prescription. The SIT model thus operates on the premise that no one knows better about what the issues are, their origins, and the best remedies, than the client themselves, further affirming the fundamental rather than alternative nature of this therapeutic modality. Even if a client starts out in total confusion, ultimately the answer to what challenges the client, and what might be done, is to be found within their own being.

Conclusion

For centuries, in Western culture in particular, people with sexual desires outside the narrowest range of procreative sexuality have been pathologized and treated as abnormal, deviant, or perverse by the psychological professions, or as a sinner by religious doctrines. The authors believe that many individuals who have been pathologized, condemned or terrorized for sexual desires that fall outside the cultural or religious "norms," suffer from a deep separation of their sexual psyche from the rest of

their psyche. For too many, their sexuality exists and operates in a secretive, hidden part of their being. For these individuals, their sexuality is disconnected and suppressed from their overall public persona. How can their birthright as a sexual being be welcomed into their everyday life under these conditions? How can people achieve a balanced state of mental health and overall well-being when such an integral aspect to the human experience is hidden, feared, and repressed?

To date, there have been few good answers. There has been little acknowledgment nor examination by the psychology profession of these complex issues clients experience regarding their intense fear of being honest about their authentic sexuality. Furthermore, current clinical psychological theory and practice often isolates sexuality from the rest of the person, treating it as distinct rather than integrated into an overall approach to wellbeing. Many clients have expressed the need and desire to bring their sexuality back from the secretive, disconnected ways it has been operating. They desire to resolve the intense psychological stress, turmoil, and fear this disconnection creates, which distances them from experiencing well-being. Many want relief from the fear, shame, and past trauma that has further separated them from their authentic sexual pleasure and intimacy.

The Sexual Integration Therapy model can help to bridge this gap with its sex-positive, client-centered, non-pathologizing approach to sexual health. It encourages clients to embrace their inherent human right, or birthright, to explore, express and negotiate for the fullest expression of their personal, authentic sexual nature, while resolving internalized psychological conflicts that resist its fullest expression. The SIT therapeutic model consists of a broad palette of techniques, practices, and guidance from a cross-section of other therapeutic modalities to help clients on their path to integrating their authentic sexuality into their everyday life. The authors believe the SIT

model can help people move from states of disempowered sexuality, driven by secretive, compulsive, irresponsible, fearful, exploitive sexual behaviors on the one hand, or a shut-down, disconnected, disinterested libido, stifled by shame, fear, or past trauma, on the other. It is the mission of the Sexual Integration Therapy model to become positioned as a therapeutic modality that is not relegated to the margins, but standardized to create new ways to support people to reintegrate their sexuality into their whole being in a way that optimizes sexual and mental health.

Possible limitations and future research

Sexual Integration Therapy, as a new therapeutic sexual health model, currently lacks any formal evidence-based research into its efficacy for clients. While SIT training for therapists has been approved for Continuing Education (CE) credits for licensed therapists from two accredited institutions, there is currently no accredited education and training program for therapists to learn the practice of Sexual Integration Therapy. It is our long-term goal to address each of these limitations, including: the development of practitioner SIT training course work, one-on-one training, experiential group workshops, and an accreditation process to help practitioners become competent in the SIT method; the publication of case-study materials and client evaluation data; publication of data and analysis of a 1200 participant, IRB-approved survey related to SIT; as well as several papers related to specific SIT concepts, supported by the survey data. Presently, the data set for this survey is complete, and analysis is in progress, with publication of results anticipated in 2024.

Further future research related to the Sexual Integration Therapy model, based on the forthcoming publication of the “Personal Erotic Myth” (PEM) survey referenced above will include: an in-depth exploration of the PEM concept that is characterized as an inherent and distinct psychological erotic structure for a certain percentage of people,

that contains the fantasy imagery, story-lines, mythic archetypal personas, actions, props, dialogue, and more that drives them to orgasm or other deep erotic states. The PEM becomes activated during fantasizing, masturbation, or engagement with a partner. Correspondingly, “Fetishsexuality” as sexual orientation is the topic of a forthcoming publication. It will make the case that a certain percentage of people engaged in Kink and/or BDSM, should be recognized as having an inherent sexual orientation we term “Fetishsexuality,” which circumscribes all the legal, political, and social rights of any other sexual orientation. And, a final forthcoming publication pursues the conceptualization of, and investigation into, “Sexual Authenticity Disorder” (SAD): an extreme and often life-long effort to conceal aspects of one’s inherent sexuality, characterized by pervasive secrecy, sexual dishonesty, intense fear of revealing your sexuality or having your innate sexuality discovered, shamed, judged, or punished by others.

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REFERENCES

Allyn, D. (2016). *Make love, not war: The sexual revolution: An unfettered history*. Routledge.

American Psychological Association. (2006). Guidelines and Principles for Accreditation of Programs in Professional Psychology (G&P). Retrieved from http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf

Antons, S., Engel, J., Briken, P., Krüger, T. H., Brand, M., & Stark, R. (2022). Treatments and interventions for compulsive sexual behavior disorder with a focus on problematic pornography use: A preregistered systematic review. *Journal of Behavioral Addictions*, 11(3), 643-666.

Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The dual control model: Current status and future directions. *Journal of Sex Research*, 46(2-3), 121-142.

Berry, M., & Barker, M. J. (2015). Sex therapy. In The Palgrave handbook of the psychology of sexuality and gender (pp. 353-372). London: Palgrave Macmillan UK.

Binik, Y. M., & Meana, M. (2009). The future of sex therapy: Specialization or marginalization?. Archives of Sexual Behavior, 38, 1016-1027.

Blycker, G. R., & Potenza, M. N. (2018). A mindful model of sexual health: A review and implications of the model for the treatment of individuals with compulsive sexual behavior disorder. *Journal of Behavioral Addictions*, 7(4), 917-929.

Bolea, S. (2016). The persona and the shadow in analytic psychology and existentialist philosophy. *Philobiblon*, 21(1), 84.

Borgogna, N. C., Garos, S., Meyer, C. L., Trussell, M. R., & Kraus, S. W. (2022). A review of behavioral interventions for compulsive sexual behavior disorder. *Current Addiction Reports*, 9(3), 99-108.

Bőthe, B., Koós, M., & Demetrovics, Z. (2022). Contradicting classification, nomenclature, and diagnostic criteria of Compulsive Sexual Behavior Disorder (CSBD) and future directions: Commentary to the debate: "Behavioral addictions in the ICD-11". *Journal of Behavioral Addictions*, 11(2), 204-209.

Braun-Harvey, D. (2016). Sex Outside the Lines: Authentic Sexuality in a Sexually Dysfunctional Culture. *Journal of Sex & Marital Therapy*, 42(6), 566-567.

Braun-Harvey, D., & Vigorito, M. A. (2016). *Treating out of control sexual behavior. Rethinking sex addiction*. New York: Springer.

Briken, P. (2020). An integrated model to assess and treat compulsive sexual behaviour disorder. *Nature Reviews Urology*, 17(7), 391-406.

Browne, K., & Bakshi, L. (2011). We are here to party? Lesbian, gay, bisexual and trans leisurescapes beyond commercial gay scenes. *Leisure Studies*, 30(2), 179-196.

Burnes, T. R., Singh, A. A., & Witherspoon, R. G. (2017). Graduate counseling psychology training in sex and sexuality: An exploratory analysis. The Counseling Psychologist, 45(4), 504-527.

Calatrava, M., Martins, M. V., Schweer-Collins, M., Duch-Ceballos, C., & Rodríguez-González, M. (2022). Differentiation of self: A scoping review of Bowen Family Systems Theory's core construct. *Clinical Psychology Review*, 91, 102101.

Cattaneo, L. B., & Chapman, A. R. (2010). The process of empowerment: a model for use in research and practice. *American Psychologist*, 65(7), 646.

Coleman, E. (2017). PL-04 Impulsive/Compulsive Sexual Behavior–A Sex Positive and Integrated Model of Treatment. *The Journal of Sexual Medicine*, 14(5), e213.

Coleman, E., Dickenson, J.A., Girard, A., Rider, G.N., Candelario-Pérez, L.E., Becker-Warner, R., Kovic, A.G. and Munns, R. (2018). An integrative biopsychosocial

and sex positive model of understanding and treatment of impulsive/compulsive sexual behavior. *Sexual Addiction & Compulsivity*, 25(2-3), 125-152.

Coleman, E., Corona-Vargas, E., & Ford, J. V. (2021). Advancing sexual pleasure as a fundamental human right and essential for sexual health, overall health and well-being: An introduction to the special issue on sexual pleasure. *International Journal of Sexual Health*, 33(4), 473-477.

Coppens, V., Ten Brink, S., Huys, W., Fransen, E., & Morrens, M. (2020). A survey on BDSM-related activities: BDSM experience correlates with age of first exposure, interest profile, and role identity. *The Journal of Sex Research*, 57(1), 129-136.

Crossley, N. (2004). 1 Ritual, body technique, and intersubjectivity. Thinking through rituals: *Philosophical Perspectives*, 31.

Corbett, L. (2011). *The sacred cauldron: Psychotherapy as a spiritual practice*. Wilmette, IL: Chiron.

d'Emilio, J. (2012). *Sexual politics, sexual communities*. University of Chicago Press.

De Neef, N., Coppens, V., Huys, W., & Morrens, M. (2019). Bondage-discipline, dominance-submission and sadomasochism (BDSM) from an integrative biopsychosocial perspective: A systematic review. *Sexual Medicine*, 7(2), 129-144.

Derbyshire, K. L., & Grant, J. E. (2015). Compulsive sexual behavior: A review of the literature. *Journal of Behavioral Addictions*, 4(2), 37-43.

Dermer, S., & Bachenberg, M. (2015). The importance of training marital, couple, and family therapists in sexual health. Australian and New Zealand Journal of Family Therapy, 36(4), 492-503.

Dewitte, M., & Reisman, Y. (2021). Clinical use and implications of sexual devices and sexually explicit media. *Nature Reviews Urology*, 18(6), 359-377.

Efrati, Y., & Gola, M. (2018). Treating compulsive sexual behavior. *Current Sexual Health Reports*, 10, 57-64.

Fesnak, M. (2016). Organizing pornography, Organizing desire. *The iJournal: Student Journal of the University of Toronto's Faculty of Information*, 1(2).

Fogle, E., Hamilton, L. D., & Meston, C. (2007, March). Sexual Authenticity And Female Sexual Function. In SSTAR 2007: 32nd Annual Meeting (p. 40).

Ford, M. P., & Hendrick, S. S. (2003). Therapists' sexual values for self and clients: Implications for practice and training. Professional Psychology: Research and Practice, 34(1), 80.

France, S. J. (2006). Spirituality and the embodied self: An exploration of the relationships between spirituality, sense of self, embodiment, and subjective well-being. ProQuest.

Gerhard, J. (2000). Revisiting" the myth of the vaginal orgasm": The female orgasm in American sexual thought and second wave feminism. *Feminist Studies*, 26(2), 449-476.

Gillath, O., Sesko, A. K., Shaver, P. R., & Chun, D. S. (2010). Attachment, authenticity, and honesty: dispositional and experimentally induced security can reduce self-and other-deception. *Journal of Personality and Social Psychology*, 98(5), 841.

Glenberg, A. M. (2010). Embodiment as a unifying perspective for psychology. Wiley interdisciplinary reviews: *Cognitive Science*, 1(4), 586-596.

Gola, M., Lewczuk, K., Potenza, M. N., Kingston, D. A., Grubbs, J. B., Stark, R., & Reid, R. C. (2022). What should be included in the criteria for compulsive sexual behavior disorder?. *Journal of Behavioral Addictions*, 11(2), 160-165.

Griffin, K. R., Way, B. M., & Kraus, S. W. (2021). Controversies and clinical recommendations for the treatment of compulsive sexual behavior disorder. *Current Addiction Reports*, 8(4), 546-555.

Hall, P. (2011). A biopsychosocial view of sex addiction. *Sexual and Relationship Therapy*, 26(3), 217-228.

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. American Journal of Sexuality Education, 7(3), 219-236.

Harbin, A. (2011). Sexual authenticity. Dialogue: *Canadian Philosophical Review/Revue Canadienne de Philosophie*, 50(1), 77-93.

Hartelius, G., Caplan, M., & Rardin, M. A. (2007). Transpersonal psychology: Defining the past, divining the future. *The Humanistic Psychologist*, 35(2), 135-160.

Hartelius, G., Rothe, G., & Roy, P. J. (2013). *A brand from the burning: Defining transpersonal psychology*. The Wiley‐Blackwell Handbook of Transpersonal Psychology, 1-22.

Helminiak, D. A. (1989). Self-esteem, sexual self-acceptance, and spirituality. *Journal of Sex Education and Therapy*, 15(3), 200-210.

Hipp, C. J., & Carlson, R. G. (2019). Comfort in treating sexual problems: Current training and counselor self-efficacy. The Family Journal, 27(2), 105-114.

Hutchins, L. A. (2001). *Erotic rites: A cultural analysis of contemporary United States sacred sexuality traditions and trends*. The Union Institute.

Hughes, S. D., & Hammack, P. L. (2019). Affirmation, compartmentalization, and isolation: Narratives of identity sentiment among kinky people. *Psychology & Sexuality*, 10(2), 149-168.

Irwin, R., & Pullen, C. (2022). A person-centered approach to psychosexual therapy: theorizing practice. *Sexual and Relationship Therapy*, 37(1), 11-25.

Janssen, E., & Bancroft, J. (2007). The dual control model: The role of sexual inhibition and excitation in sexual arousal and behavior. *The Psychophysiology of Sex*, 15, 197-222.

Joyal, C. C. (2015). Defining “normophilic” and “paraphilic” sexual fantasies in a population-based sample: On the importance of considering subgroups. *Sexual Medicine*, 3(4), 321-330.

Kernis, M. H., & Goldman, B. M. (2005). From thought and experience to behavior and interpersonal relationships: A multicomponent conceptualization of authenticity. *On building, defending and regulating the self: A psychological perspective*, 31-52.

Kernis, M. H., & Goldman, B. M. (2006). A multicomponent conceptualization of authenticity: Theory and research. *Advances in Experimental Social Psychology*, 38, 283-357.

Kilgore, H., Sideman, L., Amin, K., Baca, L., & Bohanske, B. (2005). Psychologists' Attitudes and Therapeutic Approaches Toward Gay, Lesbian, and Bisexual Issues Continue To Improve: An Update. *Psychotherapy: Theory, Research, Practice, Training*, 42(3), 395.

Kleinplatz, P. J. (Ed.). (2012). *New directions in sex therapy: Innovations and alternatives*. Taylor & Francis.

Klesse, C. (2014). Polyamory: Intimate practice, identity or sexual orientation? *Sexualities*, 17(1-2), 81-99.

Krafft-Ebing, R., & Chaddock, C. G. (1893). *Psychopathia sexualis: With especial reference to contrary sexual instinct: A medico-legal study*. FA Davis.

Kraus, S. W., Krueger, R. B., Briken, P., First, M. B., Stein, D. J., Kaplan, M. S., Voon, V., Abdo, C. H. N., Grant, J. E., Atalla, E., & Reed, G. M. (2018). Compulsive sexual behaviour disorder in the ICD-11. *World psychiatry: Official Journal of the World Psychiatric Association* (WPA), 17(1), 109–110.

Kristina, A. J., & Lindroth, M. (2022). Exploring the role of sexual attitude reassessment and restructuring (SAR) in current sexology education: for whom, how and why?. Sex Education, 22(6), 723-740.

Leung, A. K. Y., Liou, S., Miron-Spektor, E., Koh, B., Chan, D., Eisenberg, R., & Schneider, I. (2018). Middle ground approach to paradox: Within-and between-culture examination of the creative benefits of paradoxical frames. *Journal of Personality and Social Psychology*, 114(3), 443.

Lew-Starowicz, M., & Coleman, E. (2022). Mental and sexual health perspectives of the International Classification of Diseases (ICD-11) Compulsive Sexual Behavior Disorder•: Commentary to the debate: “Behavioral addictions in the ICD-11”. *Journal of Behavioral Addictions*, 11(2), 226-229.

McClintock, W. J. (2004). *Herosexual: An archetype for sexual healing* (Doctoral dissertation, Pacifica Graduate Institute).

Markovic, D. (2019). " Sexual compulsivity"," sexual addictions", or hypersexuality"? An overview of contrasting perspectives. *Journal of Psychological Therapies*, 4(2), 120-130.

Meier, B. P., Schnall, S., Schwarz, N., & Bargh, J. A. (2012). Embodiment in social psychology. *Topics in Cognitive Science*, 4(4), 705-716.

Miller, S. A., & Byers, E. S. (2008). An exploratory examination of the sexual intervention self-efficacy of clinical psychology graduate students. Training and Education in Professional Psychology, 2(3), 137.

Miller, S. A., & Byers, E. S. (2012). Practicing psychologists' sexual intervention self-efficacy and willingness to treat sexual issues. Archives of Sexual Behavior, 41, 1041-1050.

Moore, B. J. (2018). Therapists' attitudes, knowledge, comfort, and willingness to discuss sexual topics with clients. Walden University.

Parreiras, C. (2013). Mainstream, Alternative and Amateur: Brief Notes on Categories of Classification of Online Pornography. In *Desire, Performance, and Classification: Critical Perspectives on the Erotic* (pp. 109-117). Brill.

Patton, J. F. (2006). Jungian spirituality: A developmental context for late-life growth. American Journal of Hospice and Palliative Medicine, 23(4), 304-308.

Perelman, M. A. (2018). Sex Coaching for non-Sexologist Physicians: how to Use the sexual tipping point model. *The Journal of Sexual Medicine*, 15(12), 1667-1672.

Piha, S., Hurmerinta, L., Sandberg, B., & Järvinen, E. (2018). From filthy to healthy and beyond: Finding the boundaries of taboo destruction in sex toy buying. *Journal of Marketing Management*, 34(13-14), 1078-1104.

Prause, N., & Williams, D. J. (2020). Groupthink in sex and pornography "addiction": Sex-negativity, theoretical impotence, and political manipulation. Groupthink in science: Greed, pathological altruism, ideology, competition, and culture, 185-200.

Price, J., Patterson, R., Regnerus, M., & Walley, J. (2016). How much more XXX is Generation X consuming? Evidence of changing attitudes and behaviors related to pornography since 1973. *The Journal of Sex Research*, 53(1), 12-20.

Quintanilla, D. (2022). *Treatment of Sexual Shame in Psychotherapy through Application of Myths and Archetypes* (Doctoral dissertation, Pacifica Graduate Institute).

Reay, B., Attwood, N., & Gooder, C. (2013). Inventing sex: The short history of sex addiction. *Sexuality & Culture*, 17, 1-19.

Rettenberger, M., Klein, V., & Briken, P. (2016). The relationship between hypersexual behavior, sexual excitation, sexual inhibition, and personality traits. *Archives of Sexual Behavior*, 45, 219-233.

Sanders, T. (2006). Sexing up the subject: Methodological nuances in researching the female sex industry. *Sexualities*, 9(4), 449-468.

Santana, E. S. (2014). *Jung and sex: Re-visioning the treatment of sexual issues in psychotherapy through an exploration and analysis of Jung's writings on sexual phenomena*. Pacifica Graduate Institute.

Sitron, J. A., & Dyson, D. A. (2009). Sexuality Attitudes Reassessment (SAR): Historical and new considerations for measuring its effectiveness. American Journal of Sexuality Education, 4(2), 158-177.

Sprott, R. A., & Williams, D. J. (2019). Is BDSM a sexual orientation or serious leisure?. *Current Sexual Health Reports*, 11(2), 75-79.

Stayton, W. R. (1998). A curriculum for training professionals in human sexuality using the sexual attitude restructuring (SAR) model. Journal of Sex Education and Therapy, 23(1), 26-32.

Surís, A., Holliday, R., & North, C. S. (2016). The evolution of the classification of psychiatric disorders. *Behavioral Sciences*, 6(1), 5.

Thoma, N. C., & McKay, D. (Eds.). (2014). *Working with emotion in cognitive-behavioral therapy: Techniques for clinical practice*. Guilford Publications.

Timm, T. M. (2009). “Do I really have to talk about sex?” Encouraging beginning therapists to integrate sexuality into couples therapy. Journal of Couple & Relationship Therapy, 8(1), 15-33.

Trotta, D. (2019, June 21). U.S. psychoanalysts apologise for labelling homosexuality an illness. *Reuters*. Retrieved from: https://www.reuters.com/article/us-usa-lgbt-stonewall-psychoanalysts/u-s-psychoanalysts-apologize-for-labeling-homosexuality-an-illness-idUSKCN1TM169/

Tweedy, A. (2011). Polyamory as a Sexual Orientation. *University of Cincinnati Law Review*, 79, 1461-1515. https://scholarship.law.uc.edu/uclr/vol79/iss4/5

Twist, M. L. (2022). Tantra with a Twist: application of an ancient spiritual practice for modern relational communication. *Sexual and Relationship Therapy*, *37*(3), 443-457.

Urban, H. B. (2012). *Tantra, American Style. Transformations and transfer of Tantra in Asia and beyond*, 457-495.

Velasquez, P. A. E., & Montiel, C. J. (2018). Reapproaching Rogers: A discursive examination of client-centered therapy. *Person-Centered & Experiential Psychotherapies*, 17(3), 253-269.

Vilkin, E., & Sprott, R. (2021). Consensual non-monogamy among kink-identified adults: Characteristics, relationship experiences, and unique motivations for polyamory and open relationships. *Archives of Sexual Behavior*, 50(4), 1521-1536.

Vosper, J., Irons, C., Mackenzie-White, K., Saunders, F., Lewis, R., & Gibson, S. (2021). Introducing compassion focused psychosexual therapy. *Sexual and Relationship Therapy*, 1-33.

Washington, K. (2023). "They Won't Work With Me," and Other Client Experiences When Attempting to Discuss Sexological Topics in Therapy (Doctoral dissertation, Adler University).

Weinberg, M. S., Williams, C. J., Kleiner, S., & Irizarry, Y. (2010). Pornography, normalization, and empowerment. *Archives of Sexual Behavior*, 39, 1389-1401.

Weiss, H. (2009). The use of mindfulness in psychodynamic and body oriented psychotherapy. *Body, Movement and Dance in Psychotherapy*, 4(1), 5-16.

Wenzel, A., Dobson, K. S., & Hays, P. A. (2016). *Cognitive behavioral therapy techniques and strategies*. American Psychological Association.

Williams, D. J., Thomas, J. N., & Prior, E. E. (2020). Are Sex and Pornography Addiction Valid Disorders? Adding a Leisure Science Perspective to the Sexological Critique. *Leisure Sciences*, 42(3-4), 306-321.

Wittstock, J. S. (2009). *Further validation of the Sexual-Spiritual Integration scale: Factor structure and relations to spirituality and psychological integration*. Loyola College in Maryland.

Wood, A. M., Linley, P. A., Maltby, J., Baliousis, M., & Joseph, S. (2008). The authentic personality: A theoretical and empirical conceptualization and the development of the Authenticity Scale. *Journal of Counseling Psychology*, 55(3), 385.

Zeglin, R. J., Goldberg, S., Stalnaker-Shofner, D. M., Walker, B. M., & Schubert, A. M. (2024). Sex therapy credentials: a descriptive analysis of the training of clinicians who do sex therapy. Sexual and Relationship Therapy, 39(1), 4-19.

Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology*, 23, 581-599.