ISSUE #1: THE QUESTION IS THE ANSWER.

- The range of interventions defined as sex therapies can be broad or narrow. Framing the question as ‘What are sexual therapies?’ suggests a range within which drug and other medical treatments have a limited place.

ISSUE #2: NON-MEDICAL INTERVENTIONS HAVE ZERO ADVERSE SIDE EFFECTS AND PROVIDE EDUCATION AND SKILLS — LIFELONG BENEFITS.

ISSUE #3: ALTERNATIVE TREATMENTS CAN BE PSYCHOLOGICAL, EDUCATIONAL, PSYCHOPHYSICAL, OR SPIRITUAL (AND GO BY MANY DIFFERENT NAMES).

- Psychological Approaches
  - Couples counseling, Sex Therapy, Relationship-focused therapies
  - Cognitive-behavioral interventions for individuals or couples (including mindfulness training, sexual skills trainings, body image work, and communication skills training).

- Psychophysical Approaches
  - Use of vaginal dilators
  - Pelvic floor muscle training
  - Physical bodywork practices

- Humanistic Sex Therapy and Spiritual Approaches (including groupwork, workshops, sex coaching, pastoral counseling, tantra and yoga)

- Community-based Approaches
  - Comprehensive sexuality education (including STI, HIV/AIDS)
  - Healthy relationship education (including sexual diversity, sexual consent)

- Self-directed Approaches
  - Books about sexuality, relationships, the body
  - Educational use of erotica
  - On-line sex education, e.g. http://mybeautifulsexlife.com/

ISSUE #4: WHAT ABOUT PREVENTION?

- Sex Education in the U.S. is Inadequate or Nonexistent.
  - Only 13 states require that sex education be medically accurate. Of the 22 states and DC that require sex education, 11 stress an abstinence model that favors shame over pleasure. This requirement produces inhibitions and conflicts that may lead to sexual dysfunction.
  - Women and girls are uninformed about female genital anatomy and diversity, contributing to shame and sexual dysfunction.
• **Research on the Prevention of Sexual Dysfunction is Limited.**
  o Preventing sexual dysfunction requires “sexuality education that actively affirms sexual pleasure” and understanding “good enough sexuality.”
  o Clinicians know that failures of communication, intimacy and sexual knowledge produce and maintain sexual dysfunctions, but who is researching the prevention of sexual problems and dysfunctions?

• **Direct-To-Consumer Advertising Offers (Mis)information that Exacerbates Sexual Distress.**
  o In DTC ads, real and expected life conditions and experiences (e.g., lubrication changes post-menopause, reduced sexual drive following childbirth) are turned into problems requiring expert intervention.
  o DTC ads promise lifelong youthful sexual function through use of pharmaceuticals. This “fountain of youth” approach creates personal and relational distress and anxiety.

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i Partial list