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**TOWARDS SEXUALITY AMONG SEX THERAPISTS**

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*Abstract*

Throughout history, people's sexuality has been affected by values of the society, the state and the religion. With the advent of Christianity, people started relating to sexuality as a private and embarrassing field that they should keep hidden from the eye and even be ashamed of. This is the prevalent approach currently in traditional societies. However, in the western society today there is greater openness towards the issue of sex. Yet, the general perception is that sexuality is personal and private, usually with a taboo against talking about it. These attitudes are manifested by the way therapists cope in the encounter with their clients in the therapy room. This paper presents a survey of sex therapy according to Masters and Johnson's eclectic approach to sex therapy, the psychodynamic approach and the cognitive approach to sex therapy. Furthermore, the paper presents that criteria of the World and American Association of Sex Therapists Training.

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## 1. Introduction

Sexuality is an inseparable part of people's quality of life and of couples in society. Findings show that therapists have a sense of discomfort and low willingness to discuss sexuality with their clients. This has given rise to the need to explore the reason for it and the way of increasing sex therapists' sense of discomfort and willingness to discuss sex with their clients. Consequently, the training and supervision programs that focus on the field of sex should be examined and investigated.

The empirical literature presents studies of couple and family therapists, psychotherapists and medical therapists. However, there are no studies of sex therapists' level of willingness and readiness to discuss various sexual topics during the sex therapy sessions. Findings illustrate a direct relation between therapists' attitudes and knowledge and their level of comfort and willingness to talk about sexuality with the clients, while other studies have found just the opposite. This ambiguity indicates the need to conduct studies of the main factor or factors that will increase therapists' sense of comfort and willingness to discuss sexuality with their clients. Psychotherapists, couple and family therapists, sex therapists and medical teams that are responsible for their clients' quality of life, cope in the therapy room with sexual topics that the western society considers as a taboo as far as talking about them is concerned. Consequently, this paper aims to survey some of the empirical literature that deals with sex therapists' attitudes towards human sexuality. Moreover, it presents studies of therapists' sense of comfort to talk about the issue of sex with the purpose of improving their sense of comfort.

## 2. Literature Review

### Effect of society on sexuality

Foucault (2016) and Mottier (2008) argue that society affects people's sexuality. According to them, religion, state and society determine what is appropriate and inappropriate sexuality, what is allowed and what is prohibited, legislating laws against various sexual behaviors. For example, during a certain period, raping women was considered appropriate sexuality and even defined men's status. Conversely, in the 21st century western society, rape is considered as a criminal offense punishable by prison. Moreover, in the past, homosexuality was considered as a criminal offense. On the other hand, in the western world today, homosexuality is acknowledged and there is a struggle for the rights of people with this sexual orientation.

Kinsey, Pomeroy, and Martin (1948) was one of the first to investigate the sexual habits of American citizens. He found that the Americans perceived their sexuality as being heterosexual and that masturbation was unnatural. However, the findings of the survey that he had conducted, illustrated that sexuality that was not heterosexual was prevalent among Americans and so was masturbation. Kinsey et al. (1948) was greatly surprised to realize that these attitudes were adopted also by educated people and understood that when those who rule determine the 'facts', this has a crucial impact on public opinion. Hence, he recommended introducing sex education to adolescents and young people in the United States. Similarly, Masters, Johnson, and Kolodny (1987) in their breakthrough study, found that sexual dysfunction is affected and caused by social norms. For example: a man with a low sexual need is perceived as suffering from sexual dysfunction since the social norm advocates that men have an increased sexual need. On the other hand, the norm is that women have a low sexual need in relation to men. Consequently, a woman who initiates

sexual relationships can be perceived as a wanton woman. They also recommended sexual education as part of sex therapy (Masters et al., 1987).

One of the strong effects we have experienced until today with regard to sexuality, started with the advent of Christianity, which advocated a negative attitude towards sexuality. The initial perception was abstinence from sex, until people of the Church understood that this perception would obliterate the Christian believers. Then, having sexual intercourse was allowed with the purpose of procreation rather than for pleasure. As a result of this perception, sex was kept hidden, and people believed sexuality should be private and functional (Foucault, 2016; Mottier, 2008). These views have persevered until today in the conservative and traditional societies. In the secular society, sexuality is more open and more equalitarian but there are still traditional positions that affect the attitude towards sexuality. Moreover, in the secular society, the discourse about sexuality is not legitimate. This gives rise to values and perceptions that are affected by conservatism, making it difficult to discuss sexuality (Brian & Prat, 2004; Foucault, 2016; Mottier, 2008; Timm, 2009).

In the modern period, people rebelled against religious conservatism and reference to sex was legitimized also as pleasure and not only for the purpose of procreation (Foucault, 2016; Mottier, 2008). The feminist movement joined this resistance with a years-long struggle for equal rights for women and men also in the field of sex, the right for free sex and free choice of sexual orientation (Richardson, 2018). The struggle for equality between the genders and the legitimization to talk about sexuality and discuss it, facilitate a considerable improvement in the willingness to conduct a discourse as well as grant sexual equality. However, sexual discrimination does exist and the sexual discourse is still not legitimate (Timm, 2009). The change is positive but the way is still long. Similarly, the MeToo movement has socially opened the sexual discourse but it is done more from the abusive aspect of sexuality (Dranzo, 2018; Regulska, 2018).

In light of the above, it is obvious that society should change the attitude towards sexuality. Following the recommendations of Kinsey et al. (1948) and Masters et al. (1987), the general population should be introduced to a psycho-educational supervision program about the social-sexual field, in order to eradicate the ignorance. Masters et al. (1987) saw the need for sex therapy that encompassed the psycho-educational supervision and developed sex therapy program that was comprehensive and innovative at that time.

The development of sex therapy and, in view of the conservatism and sensitivity prevalent in society with regard to this issue, turning to sex therapy and the therapy itself are still considered as a complex process. In order to comprehend the complexity of the sex therapy, the next chapter presents various approaches to sex therapy.

### **Sex Therapy**

Until the study of Masters et al. (1987), sex therapy was part psychiatry, and it usually lasted a very long time, yielding unclear results. The therapy focused on the perception that individuals have a difficulty or a problem (Lavi, 1991) and did not see the need for sex education. The model conceived by Masters and Johnson constitutes the perception of sex therapy until today. The model advocates that sexual dysfunction is acquired throughout life and, therefore, it can be improved by supervision and learning. Basically, the

model is multi-disciplinary, involving several therapists, such as: doctor, psychiatrist, social worker, nurse, as well as any professional who can assist and promote the client (Masters et al., 1987).

Masters and Johnson built a very unique model that has been preserved and adapted to the psychotherapy style. According to this model, the therapy lasts about 2 weeks with intensive daily sessions, aiming to reduce the level of anxiety and address recurrent mistakes. During this period, the couple is recommended to limit their familial, professional and social commitments so that they can focus on their relationship and on the therapy itself. Masters and Johnson's model relates to couple therapy, based on the understanding that even if one spouse does not experience a sexual dysfunction, he or she is affected by it. Hence, it is more appropriate to hear and understanding the problems from both spouses. The two therapists are involved in the process – a man and a woman – in order to avoid gender-oriented bias, allowing each client to identify with a therapist of his or her gender.

The model comprises several therapeutic principles that should be taken into consideration, for example:

Reference to and respect for the spouse's values and goals.

The perception that sex function is natural and, therefore, there is some kind of obstacle that should be eliminated. Once the obstacle has been eliminated, the spouse will return to a natural sex function.

Sometimes there is a need for sexual psycho-educational supervision in order to overcome perceptions and positions that undermine the natural sexuality.

The reduction of anxiety level is done by prevention of sexual intercourse and gradual exposure to touch and intimacy.

Avoiding the sense of "guilt" and reassessing with the couple what makes them feel comfortable and relaxed in the sexual relationship, assume responsibility for themselves and guide their spouse as to what is right and good for them in the sexual relationship.

Help couples to relate to sexuality as part of their life, not to attribute the sexual failure to their entire relationship, finding out the good and functioning part of their couple-ness in order to improve the relations between the spouses.

Sex therapy according to Masters et al. (1987) embodies the dynamic, cognitive and psycho-educational therapy. Over the years, with the development of psychotherapy, various approaches to sex therapy have been proposed, the basis being the sex therapy according to Masters et al. (1987).

### **2.1. The psychoanalytical sex therapy**

In the psychoanalytical sex therapy, according to Freud (2012), therapists start with the assumption that erotic urges and sexual fantasies of incest in early childhood, are protected by one's consciousness. Thus, these urges and fantasies are manifested by various symptoms that inhibit and disrupt the normative development. Consequently, therapists should check what underpins the symptoms, gradually expose them and their motives, for the purpose of reaching the childhood sexual fantasies that evoke the neurotic symptoms of adult life (Brian & Prat, 2004; Freud, 2012). Sex therapy according to the modern psychoanalytic approach, relates to problems that develop in early childhood and they have to be explored and investigated during the therapy (Brian & Prat, 2004).

## **2.2. Sex therapy according to the cognitive approach**

The behavioral-cognitive sex therapy is short-term. It includes tasks to be performed at home and they are examined and checked during the therapy. The therapy engages in the identification of sex function schemes and the inculcation of information and skills. This approach advocates an examination of schemes that organize the information about the various topics of sexuality, e.g. sexual behavior, gender, implications of sexuality (Marom, Gilboa-Sslechtman, Mor, & Meijers, 2011). These schemes are built of experiences, skills and knowledge and when they are built in a negative manner, they might result in avoidance of sexual situations (Marom et al., 2011; Sbrocco & Barlow, 1996). The therapy includes analysis of the situation and identification of the scheme that prevents each of the spouses from engaging in sex. These schemes affect the emotion, thinking and sex function. Derby, Peleg-Sagy, and Guy (2015) argue that the improvement will not be spontaneous and natural since it is not customary to talk about the schemes that harm the sex function. Hence, if there is no intervention, no improvement will be generated.

The sex therapy is complex and diversified, embodying attitudes that are affected by one's home and environment, past experiences, knowledge, communication with the spouse, sexual identity and so on. It is therefore logical that, nowadays, the eclectic approach is prevalent. It integrates various approaches to sex therapy, such as: the psychodynamic approach side-by-side with the behavioral-cognitive approach. These two approaches combine sex supervision and education, each approach complementing the other (Brian & Prat, 2004). The sex therapy consists of treating the emotional and communicational parts and of the inculcation of knowledge and skills. Ever since the time of Masters and Johnson, the need for teaching sex therapy has been created and, at present, there are worldwide organizations that engage in it. The next sub-chapter presents the criteria of sex therapists training (Brian & Prat, 2004).

Following the review of the various approaches to sex therapy and the components thereof, it seems that the modern approach is based on Masters et al. (1987) approach, integrates the different approaches and sets the sex therapists training as a challenge. The next chapter presents the elements of sex therapists training according to the world and American organizations.

### **Sex Therapists Training**

According to the World Association for Sexual Health (2019), the American Association of Sexuality Educators, Counselors and Therapists (AASECT, 2018) the sex therapists training program includes:

**Inculcation of knowledge – female and male anatomy, sexual dysfunction, sexuality in the cycle of life, sexual trauma, sexual identity and multicultural sexuality.**

### **Skills – sex psychotherapy**

#### **Sex attitude reassessment (SAR).**

In parallel to these programs, there are short-term 1-year long programs or programs as part of a B.A. in sex therapy. The programs that comply with the requirements of national or worldwide sex therapy associations, are significant and comprehensive, offering wide-ranging knowledge, experience and reassessment of therapists' attitudes towards their clients' sexuality. Sex therapy training focus on sexual dysfunction, including exposure to additional topics, e.g. sexual trauma, sexual orientation, sexual aberrations, etc. The complexity of sex therapy is that, in spite of the focus on sexual dysfunction, therapists

encounter in the therapy room sexual problems that each has usually its own specialization: education for healthy sexuality, treatment of sexual dysfunction, treatment of sexual traumas, treatment of sex offenders, sex therapy of sexual identity (Marom et al., 2011). Sex therapists complete their training that has focused on sexual dysfunction. However, if one of the clients shares a sexual trauma he or she has experienced, and the therapist has no background and training in this field, the therapist might feel discomfort in the therapy room and a low sense of self-efficacy as therapist in general and sex therapist in particular (Marom et al., 2011).

The empirical literature illustrates that therapists encounter difficulties in their sense of comfort when they have to discuss sexuality with their clients in the therapy room. The next sub-chapter presents studies that have explored therapists' sense of comfort to discuss sexual topics with their patients in the therapy room.

### **3.1. Therapists' sense of comfort to discuss sexual topics in the therapy room**

The studies of therapists' sense of comfort in the therapy room, engaged in couple and family therapists, psychotherapists and medical therapists (Bancroft, 2006; Caupit, 2010; Nasserzadeh, 2009; Marom et al., 2011; Moore, 2018; Pukall, 2009; Sbrocco & Barlow, 1996; Timm, 2009). However, there are no studies of these therapists' sense of comfort to discuss sexuality in the therapy room. This sub-chapter reviews the sense of comfort of couple therapists, psychotherapists and medical therapists, but not of sex therapists, to discuss sexuality. It is likely to assume that this topic has not been sufficiently explored as far as sex therapists are concerned. The first reason is that the field of sex therapy is relatively new (Yoav, 1991). The second reason is the mistaken assumption that therapists, trained as sex therapists, will not find it difficult to discuss the topic of sexuality.

Sexuality is an important and inseparable part of people's life and the life of couples. Hence, it is important that therapists display a sense of comfort to discuss the clients' sexuality and if it does not happen, then the therapy is undermined (Bancroft, 2006; Caupit, 2010; Kazukauskas & Lam, 2010; Moore, 2018; Moser, 2009; Pukall, 2009; Timm 2009). Contradictory findings were obtained from studies that examined therapists' sense of comfort and willingness to discuss sexuality with their clients, searched for the relation between knowledge about the topic of sex and the clients' attitudes towards sexuality.

Haag (2008), Green, Murphy, and Blumer (2010), Juergens (2006). Kazukauskas and Lam (2010) and Weerakoon, Sitharthan, and Skowronski (2008) found a direct relation between therapists' knowledge and attitudes and their sense of comfort and willingness to discuss sexuality with their clients. Conversely, Decker (2010), Harris and Hays (2008) and Pebdani (2013) found no relation between therapists' knowledge of sexuality and sense of comfort to discuss sexuality with their clients.

Jones, Weerakoon, and Pynor (2005) examined medical students' level of comfort to discuss sexuality. They showed that with reference to various topics and situations, the students pointed out a sense of discomfort to discuss the concerned topic. The important fact of the study was that the participants claimed they had not received sufficient training in the topic of sex.

Timm (2009) and Humphries (2013) specifies the difficulty of couple and family therapists to talk about sexuality in the therapy room. She explains it by mistaken beliefs, such as: talking about the sexual topic in the therapy room is sensitive, it has a taboo on the part of society and it might embarrass or offend the clients. Another apprehension is that clients might be offended and avoid coming back to continue to

therapy. Moreover, therapists might even feel that, as therapists, they lack sufficient knowledge on this topic. The obvious conclusion is that training in the topic of sexuality will improve therapists' sense of comfort and willingness to discuss the clients' sexuality in the therapy room (Humphries, 2013; Timm, 2009). Similarly, Harris and Hays (2008) as well as Johnson and Federman (2014) found that training and supervision that focused on clients' sexuality in the therapy room, enhanced the latter's self-confidence and self-efficacy to talk about sexuality.

Cohen, Byrne, Hay, and Schmuck (1994) investigated a medical staff and organized a 2-day intensive workshop about the topic of people's sexuality. The researchers found that even a 2-day training had considerably improved the medical staff's attitudes towards sexuality. The participants indicated a greater sense of comfort to discuss sexuality and said that they had acquired knowledge about sex. They attributed it to the group sense of belonging and the legitimization they received in the group.

### 3. Research Method

A deep review of the literature.

### 4. Conclusion

The studies reviewed in this paper investigated couple and family therapists, psychotherapists and medical therapists who are working directly with clients. Clients' sexuality is part of their life quality. These therapists also experience discomfort and lack of willingness to discuss sexuality with their clients. Consequently, it is necessary to find a way to enhance the therapists' sense of comfort to do so. The obvious conclusion is an examination and investigation of the training and supervision programs that focus on the field of sex. The lack of studies of sex therapists' attitudes and sense of comfort to talk about sexuality with their clients, calls for studies of sex therapists. Due to the contradictory results that explain therapists' sense of discomfort and willingness to discuss sexuality with their clients, it is recommended conducting studies of the main factor or factors that will enhance therapists' sense of comfort and willingness to talk about sexuality with their clients.

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