AN EXPLORATION OF KNOWLEDGE AND PERCEPTIONS OF SEX THERAPY

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DISSERTATION APPROVAL

This dissertation submitted by Victoria Elf has been read and approved by three committee members of the American Academy of Clinical Sexologists. The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form, and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

This dissertation explores knowledge and perceptions of sex therapy by defining relevant concepts, and through analysis of published research and global literature on the reporting of sexual difficulties and the lack of help seeking behaviors. This paper also analyzes the results of a survey that was developed to assess the knowledge about, and attitudes towards, sex therapy. The results of this survey concur with the published literature on the rates of sexual difficulties and the lack of associated help seeking behaviors. That is, although a much larger proportion of the population reports suffering from sexual dysfunctions or disorders, only a smaller percentage of these individuals seek help for their sexual difficulties. The convenience sample that is studied in this paper provides valuable insight into the minds of a sexually active population. The majority of the sample is aware of the role of sex therapy and the benefit it could have on relationship functioning and well-being. The survey participants, for the most part, have accurate beliefs and perceptions about the nature of sex therapy. Findings of this survey depict that individual beliefs about oneself may be an influencing factor in a person's likelihood to seek sex therapy. This paper explains that although it is difficult to ascertain specific barriers to help seeking behaviors, the exploration of attitudes and perceptions about sex therapy provide a valuable framework to help understand what future steps must be taken to generate open dialogue about sexuality and sexual dysfunction with physicians, counselors, and psychologists. It also highlights the need for global education about the importance of sexual health and the resources available for sexual health care professionals and the public.

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Chapter 1: Introduction

In a recent survey by Trojan Condoms, Americans in 2012 were reporting lower rates of sexual satisfaction than they did in 2011; 67 percent claiming to be satisfied in 2012, and 76 percent in 2011 (New Trojan charged sex life survey, 2012). This same survey reports that nearly 81 percent of Americans are looking for ways to make their sex life more exciting (New Trojan charged sex life survey, 2012). Other research finds similar results indicating that sexual dissatisfaction exists internationally across cultures, genders, and generations (Moreira et al., 2005; Nicolosi et al., 2006; Laumann et al., 2009). This could indicate that we, as a society, are having less satisfactory sex than in generations past, or it could be a result of higher expectations. Regardless of the characteristics of these individuals or the reasons for their sexual discontent, the dissatisfied have one thing in common: They very rarely seek help for the sexual dysfunctions or relational issues that fuel their displeasure in the bedroom. The Global Study of Sexual Attitudes and Behaviors, which surveyed 27,500 people (both men and women 40-80 years old), found that almost half of the sexually active respondents reported sexual problems, but less than 19 percent attempted to seek help for these problems (Moreira et al 2005).

This paper defines key terminology, and includes detailed, published data on reporting of sexual difficulties and the lack of help seeking behaviors of men and women around the world. It explores the dissonance that exists, such that a high number of people report sexual difficulties, and a significantly lower number report seeking help for these sexual problems. This paper reports and discusses people's attitudes towards, and misconceptions about, sex therapy through a review of selected literature on the topic, and by analyzing the results of a survey conducted to assess knowledge and attitudes regarding sex therapy. This paper also explores the

issue of discussing sexuality during counseling sessions, as recent studies indicate that very few therapists inquire about the frequency or satisfaction of sex during treatment (Heitler, 2012).

Before exploring the knowledge and perceptions of sex therapy, and the lack of help seeking behaviors, it is important to be familiar with the possible types of sexual disorders. The primary characteristic of a sexual disorder, according to the DSM-IV, is "the impairment in normal sexual functioning." Impairment in normal sexual functioning is characterized by a disturbance in the sexual response cycle or pain during intercourse.

The sexual response cycle consists of four phases: Desire, arousal, orgasm, and resolution. (APA, 2000)

- Desire: This phase consists of sexual fantasies and the feelings of wanting to, or yearning to, have sex.
- Arousal: This phase, also known as excitement, consists of physiological changes in both males and females. Males in the arousal phase experience erection; females in the arousal stage experience moistness of the vagina and vulva, relaxation of the vagina muscles, and swelling of the clitoris.
- Orgasm: This phase represents the peak of the sexual response cycle, with release of the sexual tension through muscle contractions. Males experience this as ejaculation; females experience this as contractions of the muscles of the vagina and uterus, as well as feelings of pleasure in the clitoris.
- Resolution: This final stage consists of feelings of muscular relaxation and general well-being. In males, the penis, scrotum, and testicles return to normal state. Males also transition into a refractory period. In females, the vagina, clitoris, and uterus return to normal state.

Sexual dysfunctions can occur in any of the four stages, and can include pain during intercourse (IsHak, 2005). In order to be defined as a sexual disorder, an individual must report that the condition causes significant distress or interpersonal difficulty. DSM-IV defined sexual disorders are listed below and appear in Table 1.1 below (adapted from Ishak et al., 2005). Explanation of each disorder follows.

Table 1.1: Sexual Dysfunctions Listed in DSM-IV-TR

Sexual response cycle disorders
Desire disorders
Hypoactive sexual desire disorder
Sexual aversion disorder
Arousal disorders
Male erectile disorder
Female sexual arousal disorder
Orgasmic disorders
Premature ejaculation
Female orgasmic disorder
Male orgasmic disorder
It is important to specify:
Lifelong type or acquired type
Generalized type or situational type
Due to psychological factors or due to combined factors
Sexual pain disorders
Vaginismus
Dyspareunia

In the desire stage:

- Hypoactive Sexual Desire Disorder: An individual's lack of desire for sexual activity. This disorder is the most common sexual disorder among women, and is prevalent in about 15 percent of men and 33 percent of women (Laumann et al., 1999).
- Sexual Aversion Disorder: Persistent or recurring avoidance of sexual activity. This is a rare disorder, more common in women, and often reported by individuals suffering from anorexia nervosa (IsHak et al.2005)

In the arousal stage:

- Female Sexual Arousal Disorder: A woman's inability to maintain adequate lubrication and engorgement of the external genitalia in response to sexual excitement. This disorder is prevalent in approximately 20 percent of women (Marwick, 1999).
- Male Erectile Disorder: Also known as impotence, a man's recurring inability to achieve or maintain an erection. Prevalence is estimated to be between 10 percent and 52 percent, with higher percentages among older men (Laumann et al., 1999).

In the orgasm stage:

- Female Orgasmic Disorder: Persistent or recurrent delay in, or absence of, orgasm, for a woman, following normal excitement and sexual activity. Approximately 24 percent of women experience orgasmic difficulties at some point in the duration of their lives (Laumann, 1999).
- Premature Ejaculation: Persistent or recurrent ejaculation by a man, with minimal sexual stimulation before or shortly after penetration and before the man wishes it (IsHak, 2003). This is the most common sexual disorder in men, affecting approximately one third of males (Laumann et al., 1999).
- Male Orgasmic Disorder: Persistent or recurrent delay or absence of orgasm, for a man, following normal excitement and sexual activity. This is the least common sexual disorder in men, reported in approximately 8 percent of males (Laumann et al., 1999).

Pain during sex:

- Vaginismus: Persistent or recurrent involuntary spasms of the vaginal muscles that interfere with sexual intercourse by making penetration difficult or impossible (IsHak,

2003). Research reports that approximately 12 to 17 percent of females at sexual dysfunction clinics suffer from vaginismus (Spector and Carey, 1990).

- Dyspareunia: Recurrent or persistent genital pain, not caused by vaginismus, associated with sexual intercourse in either a male or female (IsHak, 2005). Dyspareunia can result in the prevention of intercourse among some sufferers (Basson, 2005).

There has been increased attention on sexual activity, sexual dysfunction, and pharmaceutical interventions for sexual difficulties in the recent decade (Luftey et al., 2009). The study of sexuality has grown tremendously, beginning with Kinsey's foundation work, transforming with Masters and Johnson's description of orgasm as the cornerstone of sexual activity (Luftey et al., 2009), and recently with pharmaceutical companies spending, and making, millions of dollars on medical interventions to aid with sexual dysfunction. The definition of "normal" sexual behavior and functioning is created and defined by such studies (Lutfey et al., 2009; Loe, 2004).

A number of research studies, which will be discussed in detail below, have defined and described the rates of sexual dysfunction both nationally and internationally. One such study, The Global Study of Sexual Attitudes and Behaviors (GSSAB), is a population survey of 27,500 men and women between the ages of 40 and 80, in 29 different countries conducted from 2001 to 2002 (Laumann et al., 2009). The data from the United States represents the responses of 1491 individuals; 742 males and 749 females (Laumann et al., 2009). Of these individuals, 50.1 percent of males and 57.8 percent of females reported sexual problems (Laumann et al., 2009). The most commonly reported sexual problems among males were erectile dysfunction (26.2 percent), erectile difficulties (22.5 percent), lack of sexual interest (18.1 percent), inability to reach orgasm (12.4 percent), and sex not pleasurable (11.2 percent). The most commonly

reported sexual problems among females were lack of sexual interest (33.2 percent), lubrication difficulties (21.5 percent), inability to reach orgasm (20.7 percent), sex not pleasurable (19.7 percent), and pain during sex (12.7 percent) (Laumann et al., 2009). Of those who reported one or more sexual problems, 45.2 percent of men and 43.9 percent of women did not seek any help or advice for their problem. 21.9 percent of men and 16.1 percent of women talked to a medical doctor about their sexual difficulties (Laumann et al., 2009). In this same study, results show that medical help was sought most frequently by individuals experiencing erectile or lubrication difficulties. Men were more likely to seek medical help if they reported being "very or somewhat dissatisfied with their own sexual functioning" or if they held the belief that "decreased sexual ability would significantly affect their own self-esteem." Women were more likely to seek medical help for sexual difficulty if they had been asked by a doctor during a routine visit (Laumann et al., 2009). Despite the high rates of reported dissatisfaction with one's own sexuality, there is a significant lack of help seeking behavior reported by study participants. This lack of help seeking behavior has been documented in a number of research studies, along with data on physicians' views of sexual dysfunction and their willingness (or unwillingness) to discuss sexuality during medical visits.

The importance of this research is two-fold. Not only is sexual dysfunction clearly correlated with cardiovascular problems, diabetes, high blood pressure, heart disease, as well as cigarette smoking, high alcohol consumption, and mental health issues such as anxiety and depression (Heiman, 2002); but sexual functioning is also associated with overall well-being and relationship functioning (Heiman, 2002; Mulhall et al., 2008, Laumann et al., 1999; Lutfey et al., 2009). A 2011 report from the National Marriage Project indicated that happily married couples

ranked sex as a top aspect of marital satisfaction, as well as communication, commitment, and generosity (Heitler, 2012).

The goal of this paper is to gain a clearer understanding of the individuals who report sexual difficulties and yet do not seek help for their sexual problems. This paper will take an in-depth look at the sexual dysfunction and lack of help-seeking behaviors in various populations reported in scientific literature. The paper will then report the findings of a survey on people's attitudes towards sex therapy, will describe the survey methodology and demographics, and will explore and discuss the data.

Chapter 2: Literature Review

A number of articles report extremely low rates of help-seeking behaviors for those who report sexual problems. The Global Study of Sexual Attitudes and Behaviors found that almost half of the sexually active respondents reported sexual problems, but less than 19 percent attempted to seek help for these problems (Moreira et al., 2005). These findings, as previously reported, involved 27,500 women and men, aged 40-80, in 29 different countries. The sample was based on random-digit dialing in Austria, Belgium, France, Germany, Italy, Spain, Sweden, the United Kingdom, Canada, the USA, Australia, New Zealand, Israel, and Brazil (Moreira et al., 2005). Door-to-door sampling was done in East and South-east Asian countries, and in Japan the questionnaire was sent by mail to a random sample (Moreira et al., 2005). The findings of this global study were reported in a number of research journals and texts. Findings from in-depth studies of each cultural subset of the Global Study of Sexual Attitudes and Behaviors are explored below.

More than 80 percent of men and 66 percent of women in the global sample reported that they had had sexual intercourse at least once in the 12 months leading up the interview. Among these sexually active participants, 43 percent of men and 49 percent of women reported experiencing at least one sexual problem. Of these individuals who reported sexual difficulties, only 18 percent of men and 18.8 percent of women made an attempt to seek medical help (Moreira et al., 2005).

Men and women from East Asia were the least likely to seek medical help, and men from South east Asia and women from Central/South America were the most likely to do so (Moreira et al., 2005). The most frequent action taken by study participants was to “talk to partner” (Moreira et al., 2005). Individuals from East Asia and the Middle East were the least likely to do

this, whereas individuals from South-east Asia and Southern Europe were the most likely to do so. The frequency of those who reported seeking psychological help from a psychiatrist, psychologist, or marriage counselor was low. From 2 to 12 percent of men, and 1 to 8 percent of women reported seeking psychological help. The least common action was talking "to a clergy person or religious advisor" (Moreira et al., 2005). The frequency of searching for information on the internet, in books or magazines, and talking to a mental health professional decreased with age among both males and females (Moreira et al., 2005).

Of the less than one-fifth of individuals who did report seeing a health professional for a sexual difficulty, men with erectile difficulties and women with lubrication problems were the most likely to do so. The results of this study suggest that individuals who have physiological sexual problems, that is, sexual difficulties that have biological components, consider the problems to be of the medical nature, not of the sexual nature, and are therefore more likely to seek medical help (Moreira et al., 2005). This coincides with the finding that the most common reason for not seeking professional help for sexual problems was cited as a belief that sexual problems are not in fact medical problems. This idea is repeated in numerous studies and seems to be an overriding theme throughout sexuality research.

Following this theme, studies show that a lack of sexual interest, among both women and men, was not significantly linked with the likelihood of seeing a doctor. Participants who believed that sex is an extremely important part of life were more likely to seek medical help for sexual difficulties, as were individuals who had been asked by a doctor about sexual difficulties in a routine visit (Moreira et al., 2005). Interestingly, one study indicates that although 40 percent of women did not seek help for sexual problems, 54 percent reported that they would like to do so (Berman et al., 2003). The main reasons for not seeking help, despite a desire to do so,

were anxiety and frustration about the treatment (Berman et al., 2003). One possible explanation for this could be that these women, who do not believe their sexual difficulties are medical problems, are unsure where to turn for answers and treatment. If sexual concerns are not treated as medical concerns, then it is plausible that seeking sex therapy would be a foreign concept for many.

One subset of data from the Global Study of Sexual Attitudes and Behaviors reported on the study population in Anglophone countries, including the United States, Canada, the United Kingdom, Australia, and New Zealand, during 2001 and 2002 (Nicolosi et al., 2006). Within this subset, the most commonly reported sexual dysfunctions were early ejaculation and erection difficulties among men, and lack of interest in sex and lubrication difficulties among women. Of the individuals who reported "periodic and frequent sexual problems" in the Anglophone sample, 74.1 percent of them did not consult with a health care professional.

Study respondents were asked why they did not consult a health care professional (Nicolosi et al., 2006). The answers were categorized in this particular study of the Anglophone sample in to four different categories including: 1) "lack of perception of problem(s)/not bothersome," 2) "thinks issue is not a medical problem," 3) "embarrassment," 4) "problem with access to or affordability of medical care" (Nicolosi et al., 2006). The first category, "lack of perception of problem(s), was reported by 72.1 percent, and was characterized by such statements as "I am comfortable the way I am," "waiting to see whether the problem goes away," "did not think it was very serious," "worried that a doctor might find something seriously wrong with me" (Nicolosi et al., 2006). The second category, "thinks issue is not a medical problem," was reported by 53.9 percent, and was characterized by statements such as "normal with aging," "do not think it is a medical problem," "physician cannot do much" (Nicolosi et al., 2006). The

third category, “embarrassment” was described by statements such as “not comfortable talking to a physician,” “physician is uneasy talking about sex,” “physician is the wrong gender,” “physician is of the wrong age,” “physician is a close friend.” This category was reported by 22.7 percent of individuals who reported sexual difficulty and reported not seeking medical care for it. The final category, “problem with access to or affordability of medical care” was reported by 12.2 percent and included such beliefs as “do not have a regular physician, or “physician is expensive” (Nicolosi et al., 2006). The authors of this analysis of a subset of data from the Global Study of Sexual Attitudes and Behaviors, write that “sex is an important part of life… humans also associate sex with love and affection, and so it retains its significance beyond the reproductive years and into older age… every effort should be made to enable the growing proportion of middle-aged and elderly men and women to continue to enjoy a satisfying sexual life” (Nicolosi et al., 2006). The results and discussion from this research indicates that although the majority of individuals who suffer from sexual difficulties do not seek help because they classify it as neither a problem, nor a specifically medical problem, the authors suggest the importance of a healthy, satisfying sex life, even if the study participants do not see the link between a specific sexual concern and overall health and functioning.

Another subset of the Global Study of Sexual Attitudes and Behaviors, mature adults in the United States, was described by E.O. Laumann and his associates. Results show similar findings as the above described subset, with early ejaculation and erectile difficulties as the most commonly reported male sexual problems; and lack of sexual interest and lubrication difficulties as the most commonly reported female sexual problems (Laumann et al., 2009). In this subset, approximately three-quarters of the sample who reported sexual problems did not seek help from a healthcare professional (Laumann et al., 2009). The majority of the sample reported speaking

with their partner about sexual difficulties, but going no further. Men aged 60 to 69 were more likely than their younger counterparts to seek medical care. Additionally, men who reported being "very or something dissatisfied with their own sexual functioning," those who held a belief that "decreased sexual ability would significantly affect their own self-esteem," and those who believed that "it is acceptable to use medical treatment for sexual problems" were more likely to seek help for their sexual difficulties. Similarly, women who had been asked by a doctor about sexual difficulties, and those who believed that a doctor should ask about sexual functioning in routine medical visits, were more likely to seek help for sexual difficulties (Laumann et al., 2009). It seems that the type of sexual dysfunction is less important than the associated feelings and thoughts, when it comes to determining whether an individual will seek help for sexual difficulties. This concept is further established in other, multicultural subset samples.

The Asian population, including individuals in China, Taiwan, South Korea, Japan, Thailand, Singapore, Malaysia, Indonesia, and the Philippines, were studied in a similar fashion. The most commonly reported sexual dysfunctions among men included early ejaculation, erective difficulties, and lack of interest in sex (Nicolosi et al., 2005). Among women, lack of interest in sexual, lubrication difficulties, inability to reach orgasm, and lack of pleasure in sex were the most highly reported complaints (Nicolosi et al., 2005). Of the respondents who reported sexual dysfunction, 45 percent did not seek any kind of help or advice for sexual difficulties, and approximately one-fifth sought out medical care (Nicolosi et al., 2005). It was most commonly reported, by both men and women in Asian countries, that the reason for not seeking help for their sexual dysfunction was the belief that their sexual problem was not a medical issue. Other reasons, which were highly reported, include embarrassment about the problem, and being able to access and/or afford medical care (Nicolosi et al., 2005). Cultural

differences played a role in these disparities. Embarrassment was reported as a reason for not consulting with a physician in over 96 percent of individuals in Malaysia, whereas it was reported in just under half of respondents in Hong Kong (Nicolosi et al., 2005). In this subset of data from the Global Study of Sexual Attitudes and Behaviors, it is apparent that socioeconomic and cultural factors play a major role in the sexual health behaviors of individuals in urban Asian areas.

Psychosocial factors undoubtedly played a role in the response patterns of a subset of survey participants from Brazil. In this sample, the most reported male sexual problem was early ejaculation for males and lubrication difficulties for females (Moreira et al., 2005). Interestingly, a diagnosis of depression was positively correlated to erectile difficulties and early ejaculation among men. The causal effect is unclear, however one could stipulate that the relationship is bidirectional: The lack of sexual function could be a factor in the feelings of depression as it is highly known that healthy sexual function is positively associated with general wellbeing, and yet the sexual difficulties may likewise be a symptom of the depression, which is highly reported in Brazil and Latin American countries due to unique social factors including unrest and violence in large cities (Moreira et al., 2005). Help seeking behavior was reported differently among men and women, with approximately half of women and three-quarters of men seeking no help for their sexual difficulties (Moreira et al., 2005). Women with high or medium rated household incomes were more likely to seek medical care for sexual difficulties than women with lower incomes, however income was not a significant factor in predicting men's reported help-seeking behavior (Moreira et al., 2005). Women were more likely to report seeking medical help if they held the belief that doctors should ask patients routinely about sexual health, whereas men were more likely to report seeking medical help for sexual

difficulties if they reported being somewhat or very dissatisfied with their sexual function (Moreira et al., 2005). The most common reason among both men and women for not seeking help for their sexual difficulties was that sexual problems were a normal part of aging. Over half of all survey participants in Brazil reported feeling uncomfortable or embarrassed discussing sexuality with their doctor and believing that doctors could not help for sexual dysfunction. Approximately one half of all respondents reported lack of access to medical care as a reason for not seeking help for sexual difficulties. Research in urban areas in Brazil report that only 37 percent have a regular doctor, and lower income was associated with worse health and physical well-being, as well as less frequent use of medical services (Mendoza-Sassi et al., 2003) including those for sexual dysfunction.

Although a number of research studies, as described above, discuss the significance of the thoughts and feelings associated with seeking care for sexual difficulties, it is also important to understand the types of sexual difficulties that research participants and clients report. Sexual difficulties may occur in any phase of the sexual response cycle, but erectile dysfunction is one of the most highly reported sexual concerns in the world, with prevalence rates ranging from 13 to 28 percent of men aged 40 to 80 years old (Mulhall et al., 2008). It is estimated that by the year 2025, approximately 300 million men will be affected by erectile dysfunction (Aytac, et al., 1995). Erectile dysfunction has a “well-documented impact on physical function” and can negatively impact the psychological well-being both of the man and his partner (Mulhall, et al. 2008; Guay, et al., 2003), and can be an indicator of vascular health, chronic disease, and cardiovascular disease (Mulhall et al., 2008). Utilizing partner support for erectile dysfunction, and the successful treatment of erectile dysfunction, has a positive impact on quality of life and emotional well-being for both males and their partners (Mulhall et al. 2008). The National

Institutes of Health recently recognized the negative impact of erectile dysfunction, labeling it as an important public health problem (Mulhall, et al., 2008).

Data from the Global Better Sex Survey show a huge majority of men (95 percent) and women (88 percent) reported that it is important for a man to be able to achieve and maintain an erection in order to have a good sexual experience (Mulhall et al., 2008). However, only 38 percent of men were satisfied with their erection, and fewer, 36 percent of women were satisfied with their partner's erection (Mulhall et al., 2008). Research shows that individuals who reported low satisfaction with erection were less likely to be satisfied with their sex life, overall love and romance, and their overall health (Mulhall et al., 2008). Approximately two thirds of the men suffering from erectile dysfunction reported that it made them hesitant to initiate sex in future encounters, and yet only 7 percent of men reported using prescription medication.

Another study, the Cross-National Survey on Male Health Issues, was conducted among 32,644 men aged 20 to 75 in the United States, France, Germany, Italy, Spain, and the United Kingdom (Shabsigh et al., 2004). The objectives of this study were to identify predictors of treatment seeking behavior among men with erectile dysfunction, and to identify the resistant behaviors among men with erectile dysfunction who did not seek treatment. Overall, 46 percent of men had sought treatment for erectile dysfunction, and 54 percent had not. Collected data showed that a desire to have sex, among men who had stopped trying due to erectile dysfunction, was positively associated with seeking treatment (Shabsigh et al., 2004). Those with intermittent erectile difficulties, and the youngest group of men (aged 20-30 years) were negatively associated with seeking treatment (Shabsigh et al., 2004). All males in the sample, regardless of nationality, reported not seeking treatment because they "believed ED was a normal part of aging, or because they felt their ED would resolve spontaneously" (Shabsigh et al., 2004).

There is an obvious disconnect, in which a high number of men report dissatisfaction with their erectile functioning, and yet a very low percentage of men report help seeking behavior. There is a proven association between a satisfying sex life and overall well-being and health, so understanding the barriers to treatment is of significant importance. A similar occurrence has been documented among women with sexual difficulties.

One such study is the Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking (PRESIDE) conducted in the United States in 2006 (Shifren et al., 2009). This study includes data on 31,581 female participants, aged 18 years or older. Of these participants, 44.2 percent reported sexual problems in the realms of desire, arousal, or orgasm (Shifren et al., 2009). Of these women self-reporting sexual difficulties, one in five women had discussed their sexual problem with a healthcare provider, which was labeled as formal help-seeking behavior; whereas two in five women discussed their sexual problem with someone other than a healthcare provider, which was labeled as informal help-seeking behavior (Shifren et al., 2009). A smaller group, 9.1 percent, had sought information from an anonymous source, such as television or internet; and 14.5 percent had never sought healthcare or information in regards to their sexual difficulties (Shifren et al., 2009). Women seeking formal or informal care were younger than women who sought anonymous help or none at all. Also women who were married or reported having a current partner were more likely to seek formal or informal help. Of women who reported difficulties with sexual desire, and who were distressed by such difficulties, the factors most commonly associated with not seeking formal health care were an absence of a partner, poor self-reported health, and being at least moderately embarrassed about discussing sexuality with a physician (Shifren et al., 2009).

When it comes to favoring informal help over professional help for sexual difficulties, there is no apparent shift from the past decade. Studies from the 1990s report that individuals are less likely to seek professional healthcare for sexual difficulties, and these findings are similarly reflected in later studies (Catania et al., 1990; Shifren et al., 2009). Additionally, research shows that doctors rarely ask patients about sexual health, even though most men and women would like them to do so (Laumann et al., 2009). In a sample of sexually active participants in Brazil, less than one-fifth of men and women had been asked about sexual health in a routine medical visit, and over three-quarters of them thought that a doctor should routinely ask about sexual function (Moreira et al., 2005), signifying a huge disparity between the expectations of patients and the reality of health care when it comes to sexual well-being.

Another study, done in Britain in 1994, found that 49 percent of men and 39 percent of women reported that they would like to receive professional help if they had sexual problems (Dunn et al., 1998). This same study reported that only 6 percent of men and 4 percent of women who actually wanted help had received any. Study respondents were given options of sources for professional help and asked who they would prefer to see for a sexual problem. The most common choice was a family physician, followed by a trained sex therapist and a family planning clinic; the least popular choices were trained marriage counselors and psychiatrists (Dunn et al., 1998).

In the Global Study of Sexual Attitudes and Behaviors, authors suggest that it is remarkable that approximately half of respondents, both male and female, were bothered enough by their sexual difficulties to discuss these issues with partners, friends, or family, and yet they did not seek medical help (Moreira et al., 2005). The findings of studies such as these indicate

the importance of identifying and overcoming barriers to discussing and seeking help for sexual dysfunctions for both individuals and physicians (Moreira et al., 2005).

Research on provider and patient discussions of sexual health during primary care visits has uncovered the perceptions of both physicians and patients. Physicians report that they do not proactively discuss sexual health with their patients due to a lack of time, not having effective treatment, being inadequately trained or not having enough experience, and being personally uncomfortable with the topic of sexuality (Shifren et al., 2009; Bachmann, 2006; Gott, et al., 2004; Humphery & Nazareth, 2001). Research shows that physicians may be underestimating the prevalence of sexual problems among their patients (Dunn et al., 1998). Possible explanations for this phenomena include physicians being reluctant to discuss sexual problems, physicians being unaware of available treatments and specialist services and therefore uncomfortable giving a referral (Dunn et al., 1998).

Patients report not discussing sexual health with their providers due to personal embarrassment, lack of time and privacy during provider visits, discomfort with their providers, and believing that sexual problems are normal and/or not serious or treatable (Shifren et al., 2009; Brock et al., 2006; Moreria, et al., 2005; Berman et al., 2003).

Data from the Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking study, described above, indicates that 78.2 percent of women who did seek formal health care for their sexual difficulties reported that they initiated the conversation about sexuality with their physician. This means that the majority of women who had sexual difficulties were not asked about their sexual health in primary care visits with physicians (Shifren et al., 2009).

Of the women who discussed sexual issues with a physician, younger women were more likely to initiate the discussion with the physician (Shifren et al., 2009). Sexual difficulties were most commonly discussed with gynecologists and primary care physicians. Of the women who did seek formal care, only 8 percent of them received "nondrug therapy" including marital therapy, sexual therapy, counseling, or behavioral therapy (Shifren et al., 2009).

The picture is clear: Individuals, regardless of nationality, age or type of sexual dysfunction, do not seek help for sexual dysfunction. So why is this important? There is a significant negative impact of sexual dysfunction and disorder on quality of life (Laumann et al., 1999; Ventegodt, S., 1998; Moreira, E. et al., 2005). Low satisfaction with one's sex life has been linked to dissatisfaction with love, romance, overall health (Mulhall et al., 2008), and quality of life (Laumann et al., 1999). A number of studies have shown a significant negative association between sexual problems and general emotional well-being (Lutfey et al., 2009) Bancroft et al., 2003; Basson, 2005); mental health (Laumann et al., 1999); and positive emotional feelings towards a partner during sexual activity (Bancroft et al., 2003). Research has also shown a positive correlation between sexual problems and childhood sexual abuse (Browning & Laumann, 1997), and a positive association between sexual problems and depression (Basson, 2005). Research shows the importance of physicians incorporating questions about sexual functioning into routine patient screenings, which would result in greater functioning for the patient and would also benefit the provider-patient relationship (Laumann, et al., 2009; Sadovsky, 2000). A number of researchers call for educational initiatives to increase awareness and knowledge about sexual health and well-being for the general population, as well as learning initiatives for physicians to address the barriers that many patients face when seeking help for sexual difficulties (Laumann et al., 2009).

It seems that medical physicians are not the only ones who do not routinely discuss sexual health with their patients. Therapists, counselors, and psychologists who do not self-identify as specializing in sex therapy, report hearing from their clients about sexual difficulties including issues relating to sexual desire, satisfaction, and dysfunction (Miller & Byers, 2012). However, it has been widely researched that clients will not discuss their specific sexual issues unless the psychologist or counselor initiates the conversation (Miller & Byers, 2012; Hegarty et al., 2007; Rubin, 2004). Over half of psychologists in one study reported rarely or never asking clients about their sexual health (Miller & Byers, 2012). Failure on the part of psychologists and physicians to address sexual concerns with clients has been labeled as problematic by the World Health Organization due to the important role that sexuality plays in health and well-being.

One recent study in Canada explored a model of how sex education and training impacts the confidence that psychologists, counselors, and therapists have in addressing sexual issues, and their willingness to address these issues with their clients (Miller & Byers, 2012). This particular study identified and surveyed 110 clinical and counseling psychologists who had a Ph.D., Psy.D., Ed.D., or M.A. degrees from universities in Canada or the United States, and who spent the majority of their professional time seeing adult clients. On average, survey respondents reported asking approximately 40 percent of their intake clients about sexual concerns, and treating 22 percent of their therapy clients for a sexual concern in the previous month (Miller & Byers, 2012). Older professionals, and those with more clinical experience, were somewhat more willing to treat clients with sexual concerns, as opposed to referring them. On average, the psychologists reported confidence in their ability and comfort exploring sexual concerns with clients, and yet they reported feeling only “somewhat confident” in their knowledge of sexual topics and ability to use sex therapy techniques and address sexual concerns with clients (Miller

& Byers, 2012). In one recent article in *Psychology Today*, it was reported that male marriage counselors "more often encouraged discussion" about sexual issues than did female marriage counselors (Heitler, 2012). It was also suggested that since there are more female than male marriage counselors – it is clear that most couples' therapists do not explore sexuality with their clients (Heitler, 2012).

Another study indicates that clinicians with more graduate level sex education and training were more likely to continue with sex education and training post-graduation, and these clinicians report higher rates of self-efficacious beliefs about their ability to treat clients with sexual concerns (Miller & Byers, 2012). These clinicians also report asking more sexual health related questions on intake assessments (Miller & Byers, 2012), which opens the door for discussion of sexual difficulties especially among those individuals who are more likely to discuss sexual concerns with clinicians who initiate the conversation. The authors of this study conclude that graduate training programs in counseling and psychology should incorporate more sexuality training and education, which would in turn promote continued post-graduate training, and would increase the willingness of clinicians to initiate conversations about sexual concerns, and to treat clients who have sexual problems (Miller & Byers, 2012).

Chapter 3: Survey Methodology

The purpose of this research is to explore individuals' beliefs about and attitudes towards sexuality and counseling in order to further understand why people are willing, or unwilling, to see a sex therapist. This survey also seeks to further uncover the previously researched lack of help seeking behaviors for sexual difficulties by collecting information on individuals' attitudes about, and barriers to, attending sex therapy.

The instrumentation used for this study was a survey questionnaire that was posted on SurveyMonkey.com from November 2012 until April 2013. The survey questionnaire was developed in English and consultation for its contents was provided by the dissertation committee.

The data for this study is based on a convenience sample of 107 survey respondents. Individuals were contacted via email and on social media websites and were asked to complete the survey online. Eligible respondents described themselves as 18 years or older, and were willing to provide information on their demographics and beliefs about counseling and sexuality. Respondents were informed that they would complete the survey anonymously and that any published results would be free of identifying information. The survey consent can be found in Appendix 1.

The survey questionnaire included 17 questions and collected demographic information on participants' age, race/ethnicity, gender, household income, religion, education, sexual orientation, and relationship status. The questionnaire also gathered data on participants' experiences and beliefs about sexual intercourse, pornography, sexual difficulties, and counseling, as well as participants' comfort level with body image and sexuality. The questionnaire asked detailed questions surrounding participants' beliefs about sex therapy, the

results of which will be described and explored in Chapters 4 and 5. The survey questionnaire can be found in Appendix 2.

The survey questionnaire took participants approximately 10 minutes to complete. Survey participants were thanked for their time, and were provided with the researcher's contact information if they had any questions.

Chapter 4: Research Findings and Discussion

The purpose of this survey questionnaire is to explore respondents' beliefs about, and attitudes towards, sexuality and counseling. This survey also seeks to further uncover possible explanations for the previously researched lack of help seeking behaviors by individuals reporting sexual difficulties. The survey, which was posted online, has two sections. The first part of the survey serves as a consent form with an introduction to the study and descriptions of the study inclusion criteria and consent. A copy of the survey consent can be found in Appendix 1. Following the consent page is section two, which has seventeen questions. Individuals provided information on their demographics; the results of which are described below, for questions one through nine. The remaining questions, ten through seventeen, are related to attitudes surrounding sexuality and counseling. Data for these questions is described as follows using graphics. Following the graphic depictions and explanation of data for each question, there is further discussion of key responses.

Demographics:

The sample for this study is comprised of 107 survey participants including 72 females, 34 males, and 1 transgender. All of the participants are over the age of 21.

The breakdown of age groups in this study population include: 49.5% aged 21-29; 27.1% aged 30-39; 6.5% aged 40-49; 13.1% aged 50-59; and 3.7% aged 60 or older.

Figure 4.1: Age breakdown of study population

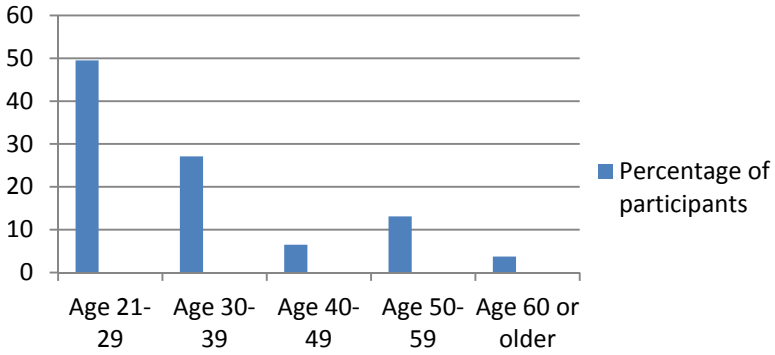
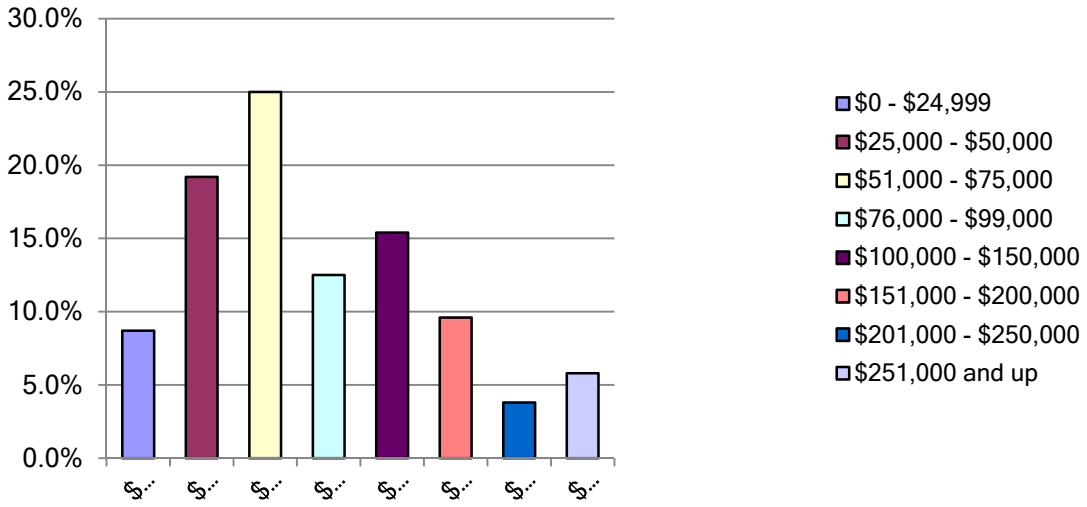


Figure 4.1 depicts the age breakdown of the study population.

Almost three quarters of the sample (73.8%) identified as White/Caucasian, (11.2%) identified as Black or African American, and (11.2%) identified as Hispanic or Hispanic American. Approximately 1% of the sample self-identified as American Indian or Alaskan Native, and 1% self-identified as Asian/Pacific Islander, with the remaining respondents describing themselves as multiple ethnicities.

Approximate average household income varied in range, with the one-quarter of respondents reporting earning $51,000 to $75,000, and the majority of participants reporting earning between $25,000 and $150,000. Detailed results are found in Figure 4.2

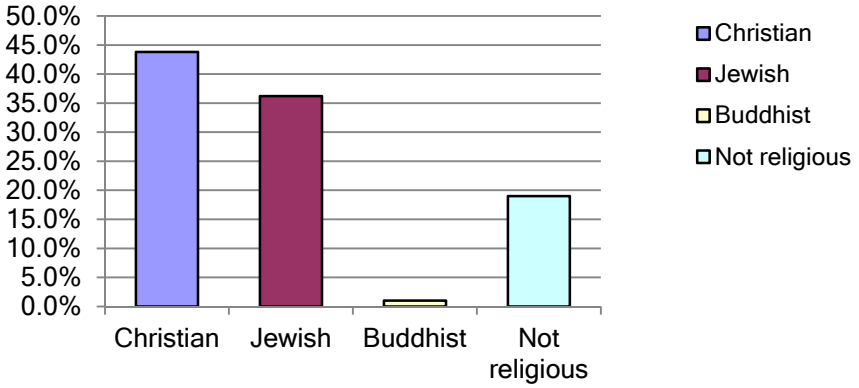
Figure 4.2: Household income of study population



The survey included two questions about religious beliefs. One question asked participants how religious they are. Over half of respondents (52.4%) indicated that they are "Somewhat religious," 41.9% indicated that they are "Not religious at all" and 5.7% indicated that they are "Very religious." The participants were also asked what religious group they consider themselves to be a part of. No participants described themselves as Muslim, Hindu, or

"a follower of some other religion." The breakdown of respondents who identified as Christian, Jewish, Buddhist, and "not religious" is found in Figure 4.3.

Figure 4.3: Religion of study population



Study participants were asked to select the highest level of education they had completed. 98% of the sample had graduated from high school, and approximately one-third of participants had graduated from college or university. Slightly over half had started or completed graduate school.

Participants were also asked about their sexual orientation and relationship status. The majority of the sample (93%) identified as heterosexual, and 6% identified as homosexual. One participant identified as bisexual. Just slightly over one-third of the sample (34%) is married, 26% in a relationship, 22% single and dating, 15% single and not dating, and 3% in a domestic partnership or civil union, at the time of data collection.

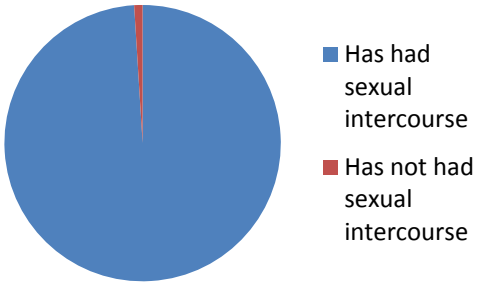
The remaining survey questions capture information on participants' attitudes towards sexuality and counseling.

Question 10: *Please answer the following questions by selecting Yes or No.*
a) Have you ever had sexual intercourse?
b) Have you ever experienced sexual difficulties?
c) Have you ever watched/looked at/read pornographic material?
d) Have you ever had an appointment with a sex therapist?
e) Have you ever had an appointment with any other type of counselor/therapist/psychologist?

Question 10a*: Have you ever had sexual intercourse?*

Of the 103 (of 107 total) participants who answered this question, all except for one individual reported having ever had sexual intercourse. This indicates that slightly over 99% of the sample has had sexual intercourse at some point in his or her life. Figure 4.4 depicts this data in graphical form.

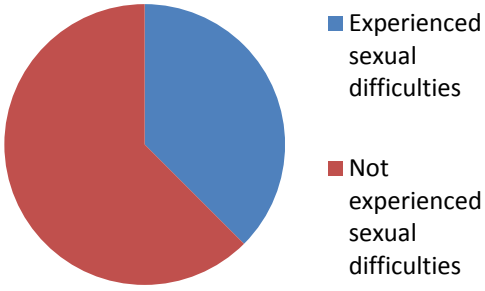
Figure 4.4: Sexual intercourse



Question 10b*: Have you ever experienced sexual difficulties?*

The majority of survey respondents indicated that they had not ever experienced sexual difficulties. 62% of respondents reported never having had sexual difficulties, while 38% of respondents reported having experienced sexual difficulties. This data is depicted in Figure 4.5. It is interesting to look at this information in concurrence with data from the Trojan Charged Sex Life Survey, which found that approximately two thirds of Americans were

Figure 4.5: Sexual difficulties

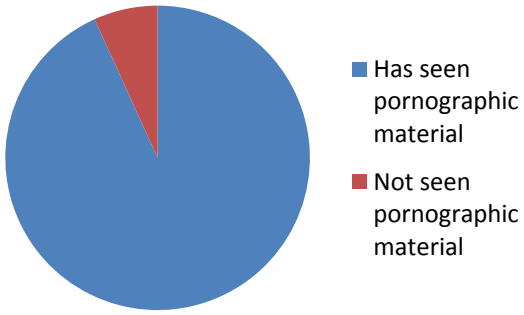


satisfied with their sex life (New Trojan charged sex life survey, 2012). The Good in Bed survey (Good in Bed, 2013), which collected data on 1418 men and 1923 women on the website goodinbed.com, reports that sexual satisfaction was mostly split in half, with 46% of the respondents expressing happiness with their sexual relationships, and 45% expressing unhappiness with their sexual relationships (Good in Bed, 2013). The goodinbed.com study also determined that women were significantly happier with the sexual quality of their relationship than were men. In the much smaller sample studied in this paper, the majority of men and women reported that they have never had sexual difficulties. 70% of women and 60% of men reported no sexual difficulties.

***Question 10c**: Have you ever watched/looked at/read pornographic material?*

Approximately 93% of survey respondents reported having watched, looked at, or read pornographic material. This data is shown in Figure 4.6.

Figure 4.6: View pornographic material



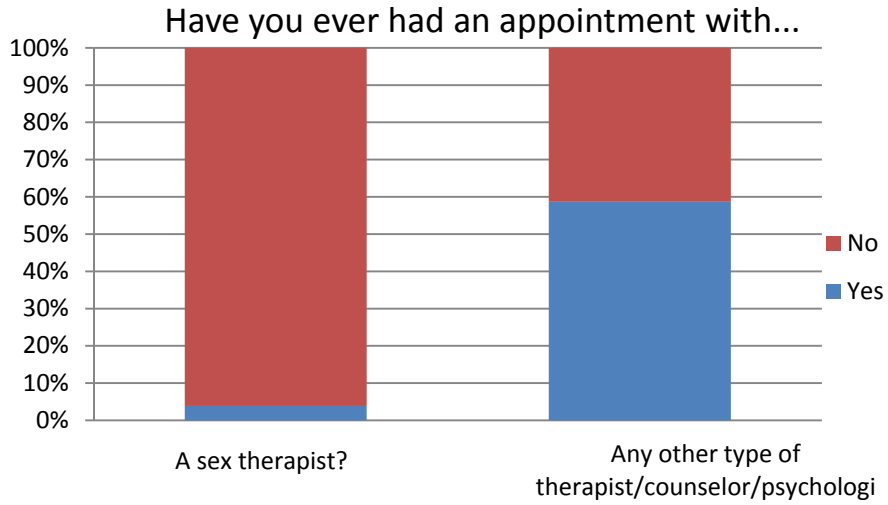
***Question 10d**: Have you ever had an appointment with a sex therapist?*

***Question 10e**: Have you ever had an appointment with any other type of counselor, therapist, or psychologist?*

Data from these two questions show that respondents were less likely to have seen a sex therapist than any other type of therapist, counselor, or psychologist. Over half of respondents (58.7%) report having had an appointment with a therapist, counselor, or psychologist, whereas only

3.8% of respondents report having had an appointment with a sex therapist. This data is depicted in a Figure 4.7 below.

Figure 4.7: Therapy appointments



Considering almost four out of ten survey participants report having experienced sexual difficulties at some point, it is interesting that such a small number of them, less than four out of one hundred, have had an appointment with a sex therapist.

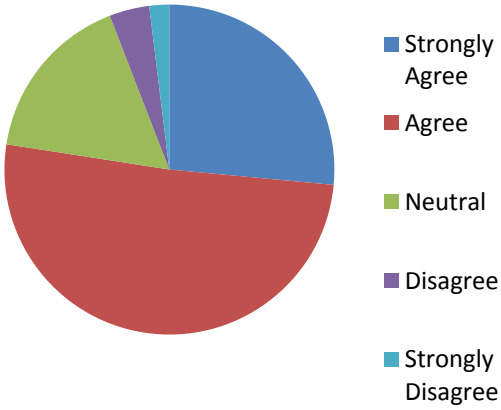
The following question consisted of two statements and asked survey respondents to describe how they feel about these statements by selecting one of the following choices: Strongly Agree, Agree, Neutral, Disagree, or Strongly Disagree.

Question 11: *Please select the response that best describes how you feel about the following statements.*
a) I am comfortable with my body image and sexuality
b) I believe sex is an important part of a relationship

***Question 11a**: I am comfortable with my body image and sexuality*

Slightly over half (26.5%) of respondents agree with the statement "I am comfortable with my body image and sexuality," whereas 26.5% strongly agree, and 16.6% are neutral. 3.9% and 1.9% of respondents reported disagreeing and strongly disagreeing, respectively, with the statement. This data is depicted in Figure 4.8.

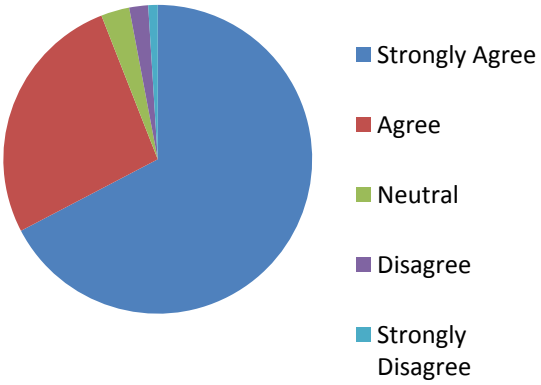
Figure 4.8: Comfort with body image and sexuality



***Question 11b**: I believe sex is an important part of a relationship*

Over ninety percent of respondents report that they strongly agree (67.3%) or agree (26.7%) with the statement "I believe sex is an important part of a relationship." 2.9% are neutral, 1.9% disagree, and less than one percent strongly disagree with the statement. This data is depicted in Figure 4.9.

Figure 4.9: Sex is an important part of a relationship



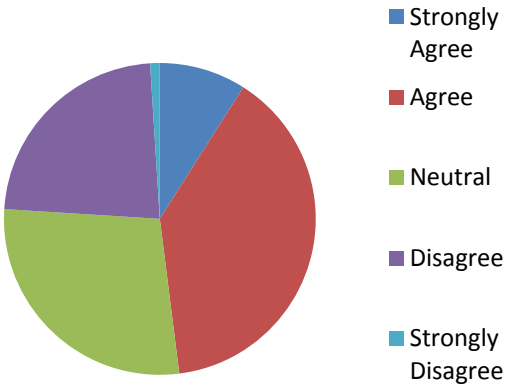
The next question consisted of 8 statements and asked survey respondents to describe how they feel about these statements by selecting one of the following choices: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree.

Question 12: *Please select the response that best describes how you feel about the following statements.*
a) I would see a sex therapist if I had questions about sex, or to improve my sexual and/or romantic relationship(s)
b) I would be embarrassed to talk to a sex therapist
c) I think sex therapy is too expensive
d) I believe that most people who go to sex therapy cannot help themselves
e) I believe that most people who go to sex therapy are promiscuous or perverted
f) I am much too private of a person to see a sex therapist
g) I would feel comfortable discussing my sexuality with a sex therapist
h) Sex therapists are required to keep client information private and confidential

Question 12a*: I would see a sex therapist if I had questions about sex, or to improve my sexual and/or romantic relationship(s)*

Almost half (48%) of survey respondents indicated that they strongly agree or agree with this statement, and over one-quarter (28%) of respondents felt neutrally about it. This data is depicted in Figure 4.10.

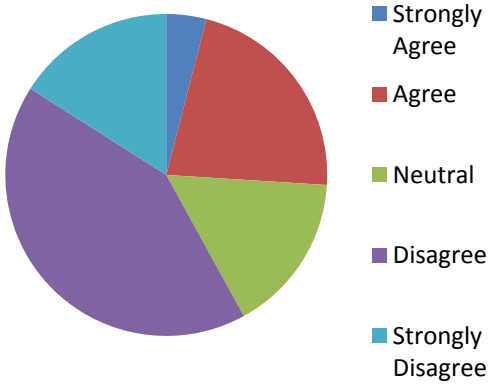
Figure 4.10: Would see a sex therapist for questions or to improve relationships



Question 12b*: I would be embarrassed to talk to a sex therapist*

Over half of respondents either strongly disagree (16%) or disagree (42%) with this statement, demonstrating that embarrassment is not a factor that

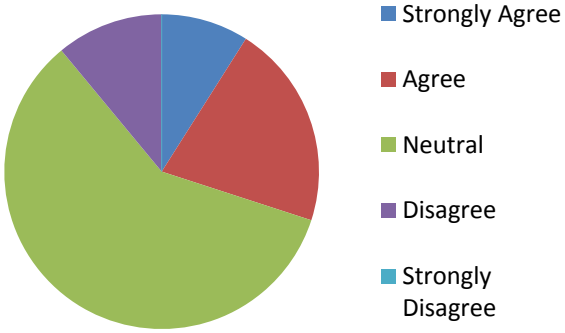
Figure 4.11: Embarrassed to talk to a sex therapist



affects most individuals in this sample. This data is depicted in Figure 4.11. The Global Study of Sexual Attitudes and Behaviors found that embarrassment was reported as one reason for not consulting with a physician about sexual dysfunction. It has been surmised that cultural ideologies play a role in whether embarrassment causes a lack of help seeking behaviors. Some cultural populations, for example individuals living in Malaysia, are more likely to report embarrassment as a reason for not consulting with a physician about sexual disorders than are individuals in other cultures (Nicolosi et al., 2005). In the smaller convenience sample reported in this paper, the only cultural group that had no participants reporting that they would be embarrassed to speak to a sex therapist was Hispanic/Hispanic Americans. This may be related to increased health-seeking behaviors among Hispanics and Latinos as a function of cultural norms. It is interesting to note that cultural influences may be apparent in this sample, but a number of other issues such as the small and non-representative sample size, mean it is not possible to draw definite conclusions.

***Question 12c**: I think sex therapy is too expensive*

Figure 4.12: Sex therapy is too expensive

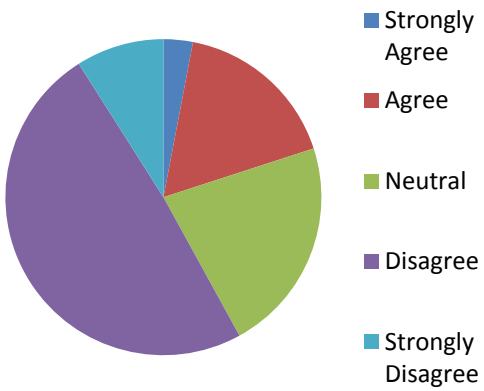


The majority of respondents had no feeling either way in regards to financial cost of sex therapy, with 59% responding with neutral to this question. Almost one-third of the sample either strongly agreed (9%) or agreed (21%) that sex therapy is too expensive, and 11% disagreed with the statement. This data is depicted in Figure 4.12. In the Global Study of Sexual Attitudes and Behaviors, a much smaller percentage of respondents in the

Anglophone sample reported that affordability of medical care was the reason for not seeking help for sexual dysfunction than were other reasons including lack of perception of a problem, thinking the problem is not medical, and being embarrassed about the problem (Nicolosi et al., 2006).

***Question 12d**: I believe that most people who go to sex therapy cannot help themselves*

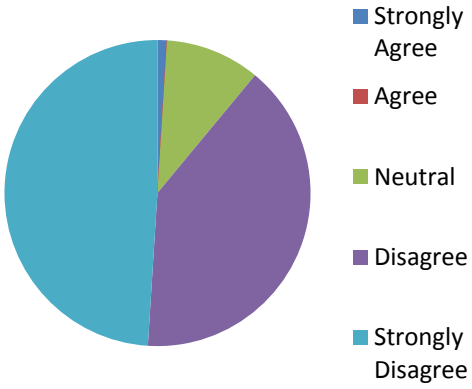
Figure 4.13: People who go to sex therapy cannot help themselves



Over half of participants disagree (49% disagree and 9% strongly disagree) with the statement "I believe that most people who go to sex therapy cannot help themselves." 22% feel neutrally about this statement, and one-fifth either agree (17%) or strongly agree (3%). This indicates that most survey participants believe that sex therapy can be helpful for individuals who are capable of helping themselves. This data is depicted in Figure 4.13.

***Question 12e**: I believe that most people who go to sex therapy are promiscuous or perverted*

Figure 4.14: People who go to sex therapy are promiscuous or perverted

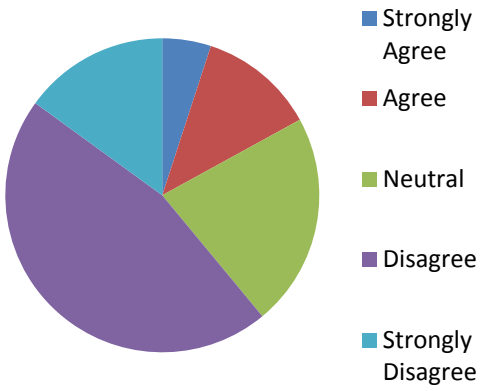


The majority of study respondents either disagree (40%) or strongly disagree (49%) with this statement, indicating that the majority of participants feel that sex therapy is not only for the promiscuous or perverted. 10% of respondents were neutral on this question; and only one individual strongly

agreed with this statement. This data is depicted in Figure 4.14.

***Question 12f**: I am much too private of a person to see a sex therapist*

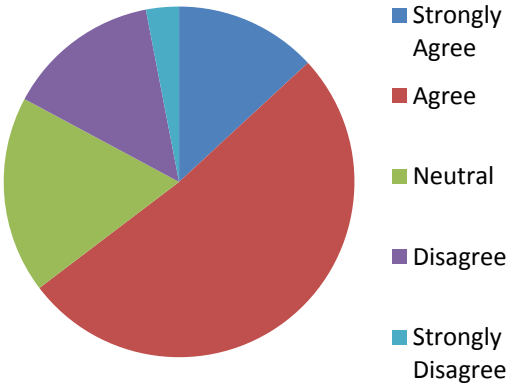
Figure 4.15: Too private to see a sex therapist



Over half of survey respondents disagreed with this statement, with 46% disagreeing and 15% strongly disagreeing. Less than one-fifth of respondents agreed or strongly agreed with the statement. It is clear that, for this population sample, being a private person is not correlated with not seeing a sex therapist. This data is depicted in Figure 4.15.

***Question 12g**: I would feel comfortable discussing my sexuality with a sex therapist*

Figure 4.16: Comfortable discussing sexuality with a sex therapist

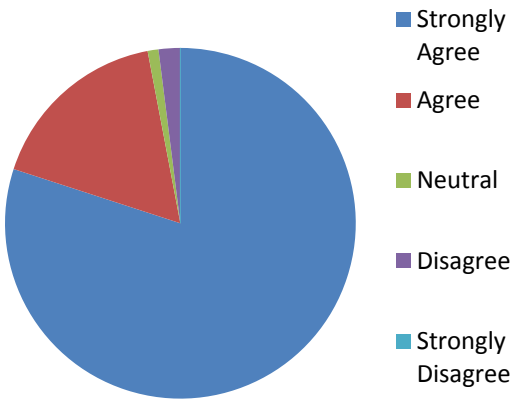


Approximately two-thirds of survey respondents report feeling comfortable discussing sexuality with a sex therapist, as 51% reported agreeing with the statement, and 13% strongly agreeing. 14% disagreed and 3% strongly disagreed. This data is shown in Figure 4.16. It is apparent that, within this sample, being comfortable discussing sexuality with a sex therapist is not correlated with attending sex therapy, as a much higher percentage of individuals report being comfortable discussing sexuality with a sex therapist than do report having seen a sex therapist (less than four percent).

***Question 12h**: Sex therapists are required to keep client information private and confidential*

97% of survey respondents agree with this statement. 80% of participants strongly agreed that sex therapists must keep client information private and confidential, and 17% agreed. 2 individuals disagreed with the statement, none strongly disagreed, and 1 individual was neutral. This data is depicted in Figure 4.17. This is good news for the field of sex therapy. Although this sample is not representative of the general population, it points in the right direction of individuals trusting that sex therapy is a legitimate form of therapy that is governed by the same rules and ethical standards as general mental health counseling and marriage and family therapy.

Figure 4.17: Sex therapists keep client information private and confidential

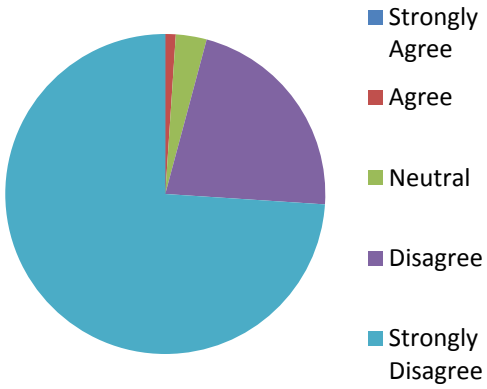


The following questions consisted of 8 statements related to sexual difficulties and sex therapy and asked survey respondents to describe how they feel about these statements by selecting one of the following choices: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree.

***Question 13:** Please select the response that best describes how you feel about the following statements.*
a) If I had sexual difficulties, I would speak with my pastor/preacher/rabbi/other religious figure
b) Sex therapy could be helpful for a person experiencing sexual difficulties such as low desire or difficulty reaching orgasm
c) I would go to sex therapy if it were covered by insurance
d) Sex therapy could help a person learn about sexuality and improve his/her sex life
e) Sex therapy is a legal form of prostitution
f) Sex therapists are perverts who want to know about people's sex lives
g) Sex therapy could help a person improve his/her relationship with a romantic partner
h) Sex therapy is only necessary for sex offenders

Question 13a: *If I had sexual difficulties, I would speak with my pastor/preacher/rabbi/other religious figure*

Figure 4.18: Speak with religious figure about sexual difficulties



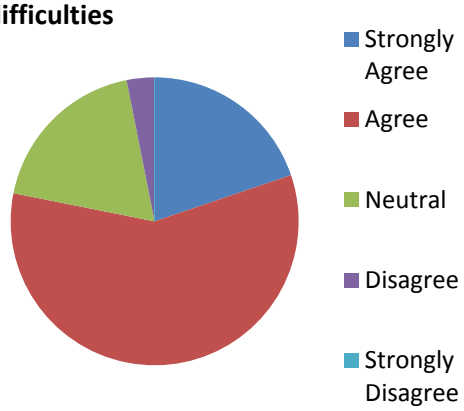
None of the participants strongly agreed with this statement, and only one individual (approximately 1% of the sample) agreed. Almost three-quarters (74%) of the sample strongly disagreed with this statement, and an additional 22% disagreed. This indicates that 96% of the sample would not speak with a religious figure about sexual difficulties. This data is depicted in Figure 4.18. It is interesting to compare this data with information gained from the previous question on religious beliefs. In that question, the majority of survey participants (approximately 52%) reported being "somewhat religious," and approximately 6% reported being "very religious." Despite the fact that over half of the participants reported being either somewhat or very religious, only four percent of this sample would speak to a religious figure about their sexual difficulties. This data is neither shocking nor confusing, however it further points to the fact that many people consider sexuality to be a taboo subject, one that is not discussed with physicians (Shifren et al., 2009; Brock et al., 2006; Moreria, et al., 2005; Berman et al., 2003), counselors (Miller & Byers, 2012), or religious figures.

Question 13b: *Sex therapy could be helpful for a person experiencing sexual difficulties such as low desire or difficulty reaching orgasm*

Three-quarters of the sample either agree (56%) or strongly agree (19%), indicating that the majority of the population believe that sex therapy can be helpful for individuals experiencing

sexual difficulties. Almost one-fifth (18%) feel neutrally, and about 3% disagree. This data is depicted in Figure 4.19. Considering that although approximately 38% of the sample had experienced sexual difficulties, and less than 4% of the sample sought sex therapy, it could be assumed that the sample was not aware that sex therapy could be helpful for sexual difficulties. This data disproves that hypothesis, showing that knowledge of the benefits of sex therapy seems to have no relation to actually seeking sex therapy for sexual difficulties.

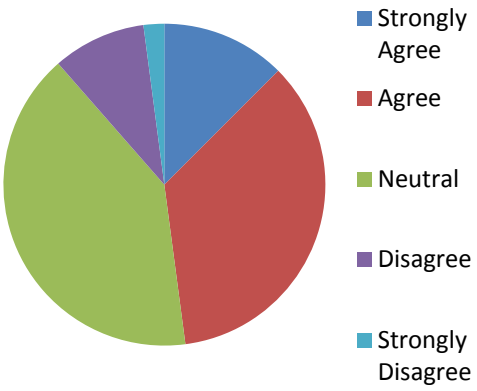
Figure 4.19: Sex therapy helpful for sexual difficulties



***Question 13c**: I would go to sex therapy if it were covered by insurance*

Almost half of the responses to this question were either strongly agree (13%) or agree (35%), indicating that some respondents would go to sex therapy if it were covered by insurance. A large percentage (41%) felt neutrally. This data is depicted in Figure 4.20.

Figure 4.20: Go to sex therapy if it were covered by insurance

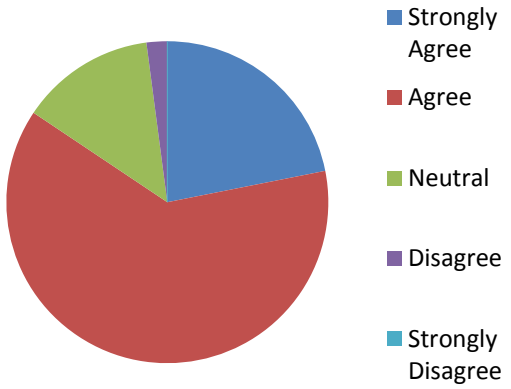


***Question 13d**: Sex therapy could help a person learn about sexuality and improve his/her sex life*

The majority of the sample agreed (63%) or strongly agreed (22%) with the statement, indicating that approximately 85% of the sample believe that sex therapy is helpful to learn about sex therapy and improve one's sex life. 14% responded neutrally, and 2% disagreed. No one in the sample strongly disagreed with this statement. This data is shown in Figure 4.21. It is clear that

the sample, for the most part, has a good perception of the benefits of sex therapy. This is similar in nature to data from question 13b, which indicates that the sample also sees the benefits of sex therapy for people who have sexual difficulties such as low desire or difficulty reaching orgasm. The Trojan study (New Trojan charged sex survey, 2012) reports that nearly 81% of Americans are looking for ways to make their sex life more exciting, so it is interesting to see, again, that although people want to make their sex life more exciting, and recognize that sex therapy can help reach this goal, individuals are still seeking sex therapy at low rates.

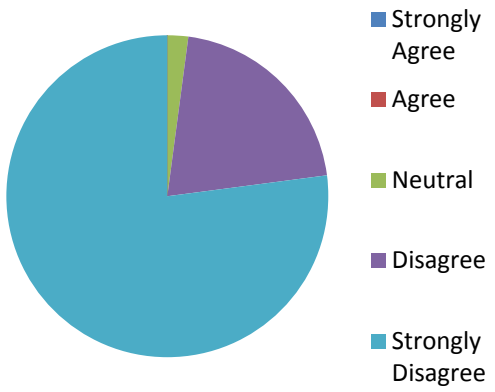
Figure 4.21: Sex therapy is helpful to learn about sexuality and improve sex life



***Question 13e**: Sex therapy is a legal form of prostitution*

Almost the entire sample disagrees (21%) or strongly disagrees (77%) with this statement. Two individuals reported feeling neutrally, and no one in the sample agreed, as depicted in Figure 4.22. This is great news for the field of sex therapy, which can sometimes be inextricably tied to sexual surrogacy, which is sometimes confused with prostitution (Kerner, 2012). Dr. Ian Kerner describes sexual surrogacy as "polarizing in clinical and medical circles" and the legality of which is "fuzzy" at best (Kerner, 2012).

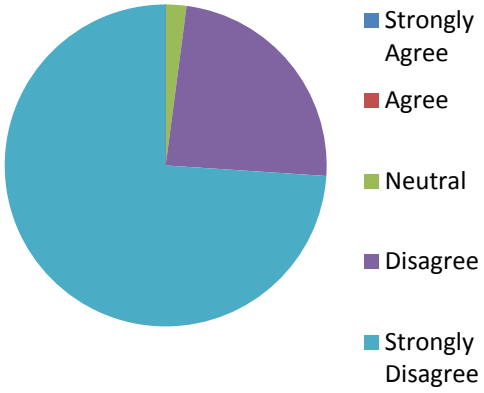
Figure 4.22: Sex therapy is legal prostitution



***Question 13f**: Sex therapists are perverts who want to know about people's sex lives*

98% of the sample either strongly disagreed (74%) or disagreed (24%) with this statement, indicating that almost the entire sample would not describe sex therapists as perverts. As indicated in Figure 4.23, no one in the sample strongly agreed or agreed with this statement, which provides another nod to the population's overall opinion of sex therapy as a legitimate, and useful, form of therapy.

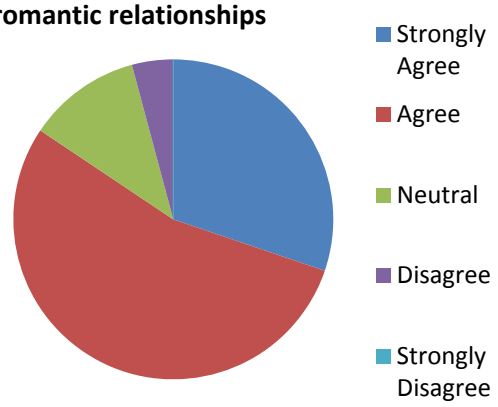
Figure 4.23: Sex therapists are perverts



***Question 13g**: Sex therapy could help a person improve his/her relationship with a romantic partner*

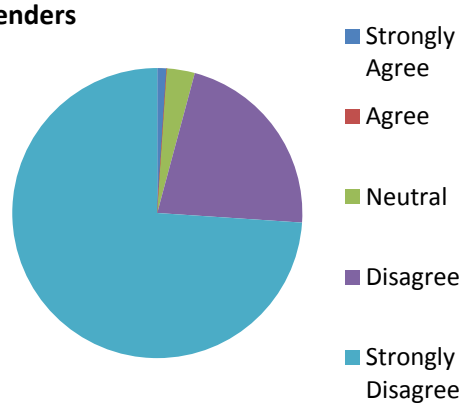
Over half (54%) of individuals reported that they agree that sex therapy could be helpful in improving a romantic relationship, and almost one-third (30%) strongly agree with the statement, which indicates that the majority (84%) of the population believe sex therapy could help a person improve his or her relationship with a romantic partner. 11% felt neutrally about this statement, and 4% disagreed. This data is depicted in Figure 4.24, and is in line with previously reported data from this sample, which indicates that the majority of the population do recognize the multiple benefits of sex therapy.

Figure 4.24: Sex therapy helps to improve romantic relationships



***Question 13h**: Sex therapy is only necessary for sex offenders*

Figure 4.25: Sex therapy is only necessary for sex offenders

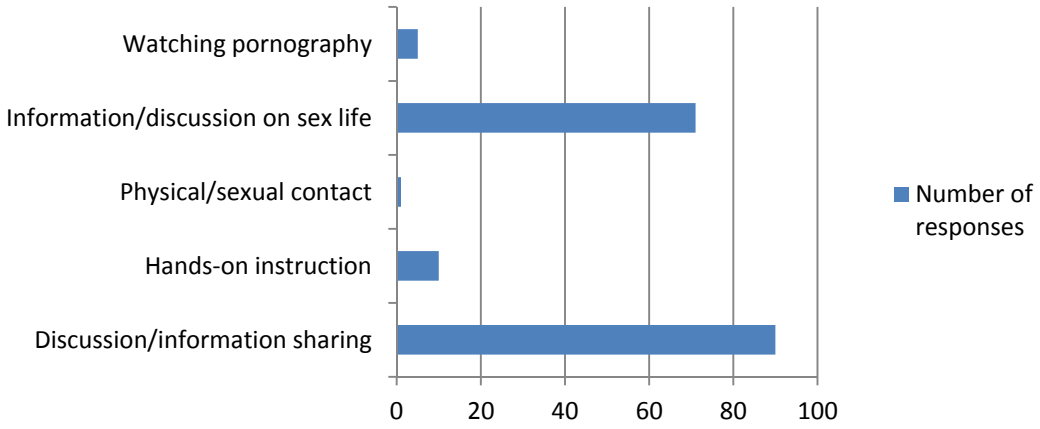


Almost three-quarters of the sample (74%) strongly disagree that sex therapy is only necessary for sex offenders, and 22% disagree. One individual agreed with the statement, and 3 were neutral. This data, depicted in Figure 4.25, is complimentary to data from previous questions which indicate that survey respondents have a good understanding of the benefits of sex therapy, and that sex therapy can be beneficial for all types of individuals, not solely sex offenders.

***Question 14:** What do you believe occurs during sex therapy?*

Respondents were asked to check as many responses and they would like, and most did select multiple answers. The response choices and how often they were selected are depicted below in Figure 4.26.

Figure 4.26: What occurs during sex therapy



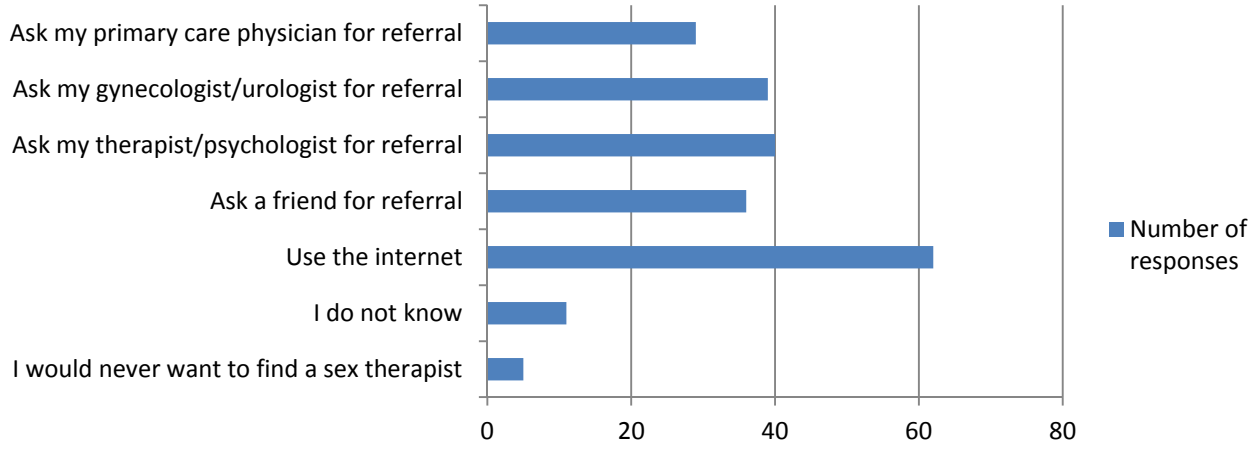
The majority of participants believed that sex therapy includes discussion and information sharing regarding intimacy, sex, and sexual dysfunction, as well as information and

discussion surrounding tips to improve one's sex life. Approximately 10% of participants believe that sex therapy includes hands-on instruction from the therapist, and 5% of participants believe that therapists and clients watch pornography during sessions. One individual believed there was physical/sexual contact between sex therapists and clients.

Respondents were given the option of describing other things that they believe occur during sex therapy. The responses included: "Counseling through problems," "Mental health issues that act as barriers to intimacy," "Books, homework with partner," and, interestingly, one respondent said "Lots of under the radar flirting and innuendo, by the nature of the position."

Question 15: *If you had a sexual problem, and wanted to find a sex therapist, which of the following actions would you take?*

Figure 4.27: How to find a sex therapist



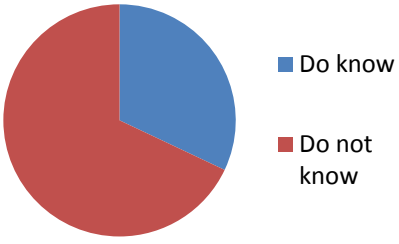
Participants were asked to select all approaches they would take to find a sex therapist. The results of this question are shown above in Figure 4.27. The most popular choice was to use the internet to find a sex therapist, with over two-thirds of participants (65%) reporting this. The next most common was to ask a therapist/psychologist for a referral (42%), ask a gynecologist or

urologist for a referral (41%), ask a friend for a referral (38%), and ask a primary care physician for a referral (31%). It is important to note here, as reported in the literature, that individuals report feeling more comfortable discussing sexual health with, and asking for a referral from, a physician if the physician brings up the topic first. In this sample, approximately 12% did not know where they would go to find a sex therapist, and approximately 5% said they would never want to see a sex therapist. This data provides interesting and valuable information for sex therapists, who can use this to develop and update their marketing strategies and referral networks, and for physicians to highlight the importance of having a strong referral network of sexual health professionals.

Question 16: *Do you know what sexual surrogacy is?*

As depicted in Figure 4.28, almost one-third of the sample (32%) indicated that they do know what sexual surrogacy is. The remaining 68% did not know. Of the individuals who reported knowing what sexual surrogacy is, all answered the following question correctly. **Question 17** asked "*What is sexual surrogacy*?" All of the respondents selected the correct response: "An individual who engages in intimate physical relations with a client to help him/her with sexual or intimacy problems."

Figure 4.28: Knowledge of sexual surrogacy



Chapter 5: Conclusion

The data gathered and analyzed in this sample concur with the abundance of literature on the subject of rates of sexual difficulties and associated help seeking behaviors. The Global Study of Sexual Attitudes and Behaviors, found that almost half of the sexually active respondents reported sexual problems, but less than 19 percent attempted to seek help for these problems (Moreira et al., 2005). The data collected in this survey demonstrate that 38 percent of the sample had experienced sexual difficulties; almost half of the sample indicates that they would see a sex therapist about their sexuality or to improve sexual or romantic relationships, and yet less than 4 percent of the sample had ever had an appointment with a sex therapist.

Although this sample is not a representative sample of the population, over 99 percent of the sample has had sexual intercourse and 94 percent believe that sex is an important part of a relationship. The individuals who participated in this survey could reasonably be considered potential future clients of therapists. The data in this study is in no way demonstrative of attitudes or beliefs of the general population of the world, yet it does provide valuable insight into the minds of individuals who are sexually active, and who, for the most part, find sex to be an important part of a relationship. Future research could recreate this survey for use in a sample that is statistically representative among gender, race, ethnicity, sexual orientation, and other demographics that may provide greater awareness into the personal differences in attitudes towards sexuality and barriers to sex therapy. Due to the highly researched impact that positive sexual functioning has on an individual's overall health and wellbeing, and the lack of help seeking behaviors for sexual dysfunction, it is important to address any and all concerns about sex therapy and barriers to sex therapy that are uncovered in surveys such as this one.

After reviewing the literature, which is explored in Chapter 2, I was hopeful that the survey would uncover some beliefs and attitudes about sex therapy that may help to explain why

there are high rates of sexual difficulty and dysfunction reporting, and much lower rates of help seeking behaviors, including seeking help from couples or sex therapists.

One hypothesis for why there are low rates of help seeking behaviors for sexual difficulties is that individuals have extremely negative and skewed versions of what sex therapy is and what sex therapists do. In this sample, it is apparent that this is not at all the case. 98 percent of the survey respondents do not believe that sex therapy is legalized prostitution; 98 percent of the survey respondents do not believe that sex therapists are perverts; and 96 percent do not believe that sex therapy is only necessary for sex offenders. Almost all (97 percent) believe that sex therapists are required to keep client information private and confidential. Based on the data from this sample, it seems unlikely that individuals do not seek sex therapy due to misperceptions about sex therapy, although it is concerning that even a small percentage of individuals hold negative or false beliefs about sex therapists. Further research must be done to attempt to uncover the sources of incorrect information, and to determine what can be done to provide appropriate education on what sex therapy is.

Another similar hypothesis for why individuals do not seek sex therapy is that people do not realize the benefits of sex therapy. In order to ascertain the truth of this theory, the survey asked a number of questions on whether or not sex therapy could be helpful in certain situations. The overall inference from this sample is that most people do understand the benefits of sex therapy: 85 percent believing sex therapy could be helpful to learn about sexuality and to improve one's sex life; 89 percent believing it could help improve relationships with romantic partners; and 75 percent believing that sex therapy could be helpful for individuals experiencing sexual difficulties. It is great news for sex therapists that the majority of this population understands the value of sex therapy, but it is also concerning that these numbers are not at 100

percent. This data suggests that there are still a number of individuals who do not know, or believe in, the benefits that sex therapy can provide to those who seek it.

Interestingly, almost everyone in the sample believes that sex therapy includes discussion and information sharing regarding intimacy, sexuality and sexual dysfunction, as well as information and tips on how to improve one's sex life. A small, but alarming, number of individuals believe that sex therapy includes hands on instruction or watching pornography in session. Although this is a small sample size that is not generalizable, it does stress the importance of education to develop a more global understanding of how sex therapy can be beneficial.

Another hypothesis for why individuals would not seek sex therapy for help with their sexuality or sexual difficulties could be beliefs about one's own self, such as embarrassment or sense of privacy. The questions that sought to determine whether personal beliefs could be a factor provided mixed data. Over half (58 percent) of survey respondents reported that they would not be embarrassed to speak to a sex therapist. Just over three-fifths (61 percent) of the sample indicated that they do not consider themselves to be too private to go to a sex therapist; and almost two-thirds (64 percent) reported that they would feel comfortable discussing their sexuality with a sex therapist. This information demonstrates that there is some possibility that beliefs about oneself play a role in people's lack of help seeking behaviors for sexual issues.

Another hypothesis for why people would not seek sex therapy is based on individuals' perceptions of the types of people who do seek sex therapy. In order to determine whether this could be a possibility, the survey asked for respondents' level of agreement with statements about people who seek sex therapy. The data here shows that less than one percent of respondents think that people who go to sex therapy are promiscuous or perverted. The data also

illustrates that one-fifth of respondents believe that people who go to sex therapy cannot help themselves. This could indicate that people believe that they are capable of helping themselves with their sexual difficulties, or that sex therapy is not required to resolve sexual difficulties.

A final hypothesis, one that I was very curious to explore, is that the cost of sex therapy is considered to be too high by many people. The results of this survey are somewhat difficult to understand, in that rather high numbers of survey respondents report feeling neutrally when it comes to matters of costs. 59 percent were neutral about the cost of sex therapy – neither agreeing nor disagreeing that sex therapy is too expensive. Similarly, 41 percent said they would go to sex therapy if it were covered by insurance.

Many couples therapists will tell you that relationship issues oftentimes rear their ugly heads in the bedroom. Sex issues not addressed in couples counseling or by physicians can result in dissatisfaction with one's relationship or overall well-being (Miller & Byers, 2012; Mulhall et al., 2008; Laumann et al., 1999). Research shows that, for the most part, people do not like to bring up sexual issues with their counselors, much preferring the counselors be the ones to first broach the subject (Miller & Byers, 2012; Hegarty et al., 2007; Rubin, 2004). Interestingly, studies also show that counselors rarely bring up the subject of sexuality in sessions (Heitler, 2012), with over half of psychologists in one study reporting that they rarely or never initiate conversation about sexual health with their clients (Miller & Byers, 2012).

People report being bothered enough by their sexual difficulties that they discuss the issues with partners, friends and family, and yet they are reluctant to discuss this with health care providers (Moreira et al., 2005). Data from the survey described in this paper indicate that the majority (96 percent) of individuals would not speak with a religious figure about sexual difficulties. So it seems that people, generally, do not speak to their health care providers,

counselors, or religious leaders about their sexuality, regardless of how important it seems to them and how much it is affecting their quality of life.

It is interesting to explore the idea that individual's religious beliefs and values play a role in their decision of whether to seek help for sexual dysfunction. The majority, 96 percent, of survey respondents said they would not speak with a religious figure about their sexual difficulties. This is especially interesting considering approximately four-fifths of the sample did describe themselves as a follower of some religion (primarily Christianity or Judaism). Although these individuals align themselves with certain religious sects or traditions, they are highly unlikely to seek counseling from a religious figure if having sexual difficulties. It is possible this is so because of the conservative morality of many religions, which oftentimes suggest that sexual desires and behaviors are immoral or sinful. It could be that many individuals associate religious figures and institutions with this sinful view of sexuality, and so do not want to be frowned upon by religious authorities for engaging in, or having questions about, an immoral act. Although only 6 percent of the survey respondents described themselves as "very religious," while the majority reported being "somewhat religious" (52 percent) or "not religious at all" (42 percent) it is conceivable that individuals were influenced by conservative, even Puritanical, views in their childhood. It is commonly known that religious experiences in early life influence individuals' sexuality throughout life. In American culture, sex is still considered to be a taboo topic, even though it is widely used in marketing and in the media. It is possible that the Puritan views of American ancestors have traversed into current generations, which could help us understand why individuals do not seek sex therapy. Despite their current, liberal, less religious viewpoints – some individuals may, perhaps even unbeknownst to them, be engulfed in the deeply Puritan views of their ancestors when it comes to sex and sexuality.

It appears that although it was difficult to ascertain specific barriers to care in this study, the exploration of individuals' attitudes about sex therapy provide a framework for understanding what steps must be taken in the future to pave the way for open dialogue about sexuality and sexual dysfunction. It is clear that further research must be done to develop and explore educational tools, for individuals and for physicians, therapists, psychologists, and religious counselors. To increase the awareness of health care professionals, it could be helpful to develop and implement evidence-based training programs on how to incorporate sexual health into routine screenings or assessments. A greater global understanding of the importance of sexual health and the vast availability of resources for sexual health care could result in increased sexual satisfaction, healthier relationships, and improved physical, mental, and psychological wellbeing.

The World Health Organization defines sexual health as: "A state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (World Health Organization, 2013). Sex therapy is defined by the American Board of Sexology as: "The application of professional and ethical skills to deal with the problems of sexual function of people. It assumes recognition of the concept that sexuality is of legitimate concern to professionals and that it is the right of individuals to expect expert knowledge when seeking remedies with sexual concerns" (American Board of Sexology, 2013).

The resources for sexual health exist, and each person has the right to explore his or her sexuality in a safe environment and to be made aware of the possibility of good sexual functioning. Sex therapy has proven to be effective in treating sexual dysfunction, and

improving relationships and overall health and wellbeing. The challenge is to incorporate sexology, sex education, and sex therapy into mainstream culture and healthcare, to remove the stigma of sex therapy, to eradicate barriers to seeking sex therapy, and to embrace the benefits of good sexual health.

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Sex Therapy

Greetings,

My name is Victoria Elf. I have a Master's Degree in Marriage and Family Therapy and am currently pursuing a Ph.D. in Clinical Sexology at the American Academy of Clinical Sexologists. The data collected in this survey will be used in my doctoral research dissertation.

The topic of this survey is people's attitudes towards sex therapy. In order to take this survey, you must be:
•18 years or older
•Willing to provide information regarding your demographics (age, gender, etc.) and your beliefs about counseling and sexuality.

This survey is anonymous. You will not be asked to reveal your name or contact information. The results of this study will be kept confidential and only used for the purpose of completing the requirements for my doctoral dissertation. Any published results will be free of identifying information.

Thank you for taking the time to complete this survey. If you have any questions, please contact me at VictoriaClaire3@gmail.com.

Sincerely,
Victoria Elf, M.S.Ed.

Sex Therapy

1. How old are you?

- ◯ 18-20
- ◯ 21-29
- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60 or older

2. Which race/ethnicity best describes you? (Please choose only one.)

- ◯ American Indian or Alaskan Native
- ◯ Asian / Pacific Islander
- ◯ Black or African American
- ◯ Hispanic or Hispanic American
- ◯ White / Caucasian
- ◯ Multiple ethnicity / Other (please specify)

3. What is your gender?

- ◯ Female
- ◯ Male
- ◯ Transgender

4. What is your approximate average household income?

- ◯ $0 - $24,999
- ◯ $25,000 - $50,000
- ◯ $51,000 - $75,000
- ◯ $76,000 - $99,000
- ◯ $100,000 - $150,000
- ◯ $151,000 - $200,000
- ◯ $201,000 - $250,000
- ◯ $251,000 and up

5. Do you consider yourself Christian, Jewish, Buddhist, Muslim, Hindu, a follower of some other religion, or not religious?

- ◯ Christian
- ◯ Jewish
- ◯ Buddhist
- ◯ Muslim
- ◯ Hindu
- ◯ A follower of some other religion
- ◯ Not religious

6. How religious are you?

- ◯ Very religious
- ◯ Somewhat religious
- ◯ Not religious at all

Sex Therapy

7. What is the highest level of education you have completed?

- ◯ Did not attend school
- ◯ 1st grade through 5th grade
- ◯ 6th grade through 8th grade
- ◯ 9th grade through 11th grade
- ◯ Graduated from high school
- ◯ Some college/university
- ◯ Graduated from college/university
- ◯ Some graduate school
- ◯ Completed graduate school

8. What is your sexual orientation?

- ◯ Heterosexual
- ◯ Homosexual
- ◯ Bisexual
- ◯ Asexual
- ◯ Other (please specify)

9. What is your current relationship status?

- ◯ Single and not dating
- ◯ Single and dating
- ◯ In a relationship
- ◯ Married
- ◯ In a Domestic Partnership/Civil Union

Sex Therapy

10. Please answer the following questions by selecting Yes or No.

	Yes	No
Have you ever had sexual intercourse?	☐	☐
Have you ever experienced sexual difficulties?	☐	☐
Have you ever watched/looked at/read pornographic material?	☐	☐
Have you ever had an appointment with a sex therapist?	☐	☐
Have you ever had an appointment with any other type of counselor/therapist/psychologist?	☐	☐

Sex Therapy

11. Please select the response that best describes how you feel about the following statements.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am comfortable with my body image and sexuality	◯	◯	◯	◯	◯
I believe sex is an important part of a relationship	◯	◯	◯	◯	◯

Sex Therapy

12. Please select the response that best describes how you feel about the following statements.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I would see a sex therapist if I had questions about sex, or to improve my sexual and/or romantic relationship(s)	◯	◯	◯	◯	◯
I would be embarrassed to talk to a sex therapist	◯	◯	◯	◯	◯
I think sex therapy is too expensive	◯	◯	◯	◯	◯
I believe that most people who go to sex therapy cannot help themselves	◯	◯	◯	◯	◯
I believe that most people who go to sex therapy are promiscuous or perverted	◯	◯	◯	◯	◯
I am much too private of a person to see a sex therapist	◯	◯	◯	◯	◯
I would feel comfortable discussing my sexuality with a sex therapist	◯	◯	◯	◯	◯
Sex therapists are required to keep client information private and confidential	◯	◯	◯	◯	◯

Sex Therapy

13. Please select the response that best describes how you feel about the following statements.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
If I had sexual difficulties, I would speak with my pastor/preacher/rabbi/other religious figure	◯	◯	◯	◯	◯
Sex therapy could be helpful for a person experiencing sexual difficulties such as low desire or difficulty reaching orgasm	◯	◯	◯	◯	◯
I would go to sex therapy if it were covered by insurance	◯	◯	◯	◯	◯
Sex therapy could help a person learn about sexuality and improve his/her sex life	◯	◯	◯	◯	◯
Sex therapy is a legal form of prostitution	◯	◯	◯	◯	◯
Sex therapists are perverts who want to know about people's sex lives	◯	◯	◯	◯	◯
Sex therapy could help a person improve his/her relationship with a romantic partner	◯	◯	◯	◯	◯
Sex therapy is only necessary for sex offenders	◯	◯	◯	◯	◯

Sex Therapy

14. What do you believe occurs during sex therapy? (Please check all that apply)

- [ ] Discussion and information sharing regarding intimacy, sex, and sexual dysfunction
- [ ] Hands-on instruction from the therapist
- [ ] Physical and/or sexual contact with therapist
- [ ] Information and discussion on tips to improve sex life
- [ ] Watching pornography
- [ ] Other

Other (please specify)

15. If you had a sexual problem, and wanted to find a sex therapist, which of the following actions would you take? (Please check all that apply)

- [ ] Ask my primary care physician for a referral
- [ ] Ask my gynecologist/urologist for a referral
- [ ] Ask my therapist/psychologist for a referral
- [ ] Ask a friend for a referral
- [ ] Use the internet
- [ ] I do not know
- [ ] I would never want to find a sex therapist
- [ ] Other

Other (please specify)

Sex Therapy

16. Do you know what sexual surrogacy is?

- ◯ Yes
- ◯ No

Sex Therapy

17. What is a sexual surrogate?

- ◯ An individual who engages in intimate physical activities with a client solely for financial gain
- ◯ An individual who engages in intimate physical relations with a client to help him/her with sexual or intimacy problems
- ◯ An individual who engages in intimate physical relations with a client for the purpose of personal pleasure
- ◯ An individual who participates in a legal form of prostitution
- ◯ I do not know

Sex Therapy

Thank you for participating in this research study!