# From Psychotherapy to Sex Therapy

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Much has been made, in the last two decades, of the American sexual revolution. Frequently cited components of this revolution include greater openness about sex in media and conversation, greater public acceptance of "taboo" activities such as premarital and extramarital intercourse, the legalization of abortion, and—in several states—the decriminalization of all sexual acts between consenting adults in private settings. These changes are primarily attitudinal; whether there has been a significant change in actual sexual behavior is less clear. Allowing for differences in sampling procedures and for a greater willingness of people to answer truthfully, recent surveys show remarkable few behavioral changes from the original Kinsey studies, the publication of which might be viewed as one catalyst for the sexual revolution.

The publication of Alfred Kinsey's books, with their emphasis on "total outlet" (number of orgasms), produced a new theme in American attitudes toward sexuality. Sex, once a devalued activity, gradually came to be viewed as a required ability. The public acceptance of Freudian theory also contributed much to this new emphasis on sexual adequacy and ability. Freudian theory (especially its popularized versions) stressed sexual maturation and functioning as the cornerstone of healthy personality. Kinsey's data added substance to this Freudian theoretical skeleton, in that anyone could now evaluate his or her own sexual functioning. Were you having as many orgasms as the average person of your sex and age? Did your "coital contacts" last as long as the national average?

### Sexual Functioning

This emphasis on sexual functioning had a number of long-range effects. "Marriage manuals"—a euphemism for sex technique training books—became best-sellers in the 1950s; and, with the passage of time, they became very direct in both title and approach (contrast, for example, Eichenlaub's *The Marriage Art* with Comfort's *The Joy of Sex*). While many people who were uninformed about sexual techniques undoubtedly were greatly helped by these books, many others turned to psychotherapy for aid with more serious sexual dysfunctions, such as lack of orgasm ("frigidity") in women and erectile failure ("impotence") or premature ejaculation in men.

In the 1940s and 1950s the psychotherapy establishment had relatively little to offer the person suffering from sexual dysfunction. American psychology and psychiatry were primarily Freudian psychoanalytic in orientation. In a seeming paradox, although one of Freud's greatest contributions was his emphasis on sexuality as a central element of personality, psychoanalysis proved to be an ineffective technique for treating sexual dysfunctions. Psychoanalytic treatment, focusing on uncovering repressed childhood experiences, resolving unconscious conflicts, resolution of the Oedipal complex, and development of a "transference" relationship with the analyst, is necessarily of great duration. For "frigidity" it was stated that "an appointment several times a week for a minimum of eight months" was required and that, therefore, "as a mass problem, the question of frigidity is not to be solved."

Even when a woman could afford treatment of this length, the results were generally poor. Following several years of analysis many, if not most, women remained inorgasmic. Results were not any better for men suffering from erectile problems or premature ejaculation.

In retrospect, it seems remarkably naive to have expected analytic treatment to have major effects on sexual functioning. For one thing, the psychoanalytic theory of sexual functioning was developed in the absence of any empirical knowledge of the physiology of human sexual response. The

Freudian belief in a transfer from clitoral to vaginal orgasm in the mature woman has not been substantiated by research on the physiology of female sexual arousal.

As another problem, psychoanalytic theory did not take into account the role of the sexual partner in contributing to sexual dysfunction. Consider, for example, an inorgasmic woman who is having sex with a man who is extremely abrupt and unskilled as a lover. Further assume, as is commonly the case, that the man and woman are both ignorant of the physiology of female sexual arousal. How could one possibly expect analytic therapy, with its focus on the past and on the woman's intrapsychic mechanisms, to have any effect in such a case?

In the late 1950s a quiet revolution began in American psychotherapy. In the place of historically oriented, long-term analytic treatment, a variety of new short-term approaches, based on learning theory and stressing direct behavioral retraining procedures in the "here and now," emerged. Therapists such as Joseph Wolpe, Donald Hastings, and Albert Ellis, in dealing with sexual problems, focused on various procedures such as reducing anxiety about sexual performance, changing negative attitudes toward sexuality, increasing communication between the couple, and education and training in sexual physiology and sexual techniques.

While this approach was remarkably successful (cure rates of 60–80 percent were reported), it was ignored by the mainstream of American psychology and psychiatry, as well as by the media. It was only with the landmark publication of Masters and Johnson's *Human Sexual Inadequacy* in 1970 that the general public became aware of the existence of a new and effective sex therapy.

In the years since 1970 there has been a virtual explosion of interest in sex therapy. The publicity sex therapy has received has been generally positive, stressing the effectiveness and rapidity of the treatment. This positive press has had the beneficial effect of encouraging people to go for therapy. However, the resultant high demand for sex therapy, coupled with a shortage of trained psychotherapists, has created a set of unique problems that might be termed "the professionalization of sex therapy."

## Sex Therapy: Procedures or Profession?

It is assumed that most people are now at least generally aware of the basic elements of sex therapy programs, as perhaps best described by Masters and Johnson. As noted above, sex therapy is a brief (often 10–15 sessions) therapy, with the emphasis on directly changing the clients' sexual attitudes and behaviors.

In an analysis of the theoretical basis for sex therapy procedures, it has been pointed out that there seem to be seven major underlying elements in the total therapy package for sexually dysfunctional couples:

- *Mutual responsibility*. Sex therapy considers any sexual dysfunction to be a mutual problem between the couple. Much therapy time is spent discussing the husband-wife interaction.
- *Information, education, and permission*. Couples are instructed in sexual physiology, sexual techniques, and are given "permission" by a respected authority (the therapist) to try out the new sexual techniques they learn.
- *Attitude change*. Much therapy time is spent in attempts to change negative attitudes toward sexuality. These attitudes are usually the result of societal or parental injunctions against sexuality, which are internalized during childhood and adolescence. Although the patient often has intellectually rejected these prohibitions, their emotional components are not so easily changed. Many of the attitude change techniques are adaptations of Ellis's Rational-Emotive psychotherapy.
- *Anxiety reduction*. Anxiety about sexual performance leads to goal orientation and the taking of a destructive, self-evaluative "spectator role" during sex. Various anxiety reduction procedures, including behavioral psychotherapy techniques such as systematic desensitization, are used to reduce performance anxiety.
- *Communication and feedback*. To increase the patients' ability to communicate and give each other feedback during sexual activity, a number of communication training procedures adapted from marital therapy programs are often included in sex therapy.
- *Intervention in destructive sex roles, life-styles, and family interaction*. Since sex exists in the context of an emotionally complex couple relationship, a variety of marriage therapy and family systems therapy procedures are used to restructure negative elements of the relationship which are interfering with sexual functioning.
- *Prescribing changes in sexual behavior*. Typically, in sex therapy the couple is initially forbidden to engage in actual intercourse. Instead, the couple is instructed in a series of "nondemanding" or "sensate focus" activities, consisting of body massage, hugging, and kissing. Gradually more sexual activities, such as breast and genital caressing, are included, eventually leading to intercourse. (As will be discussed later, with a few well-publicized exceptions the patients perform their sexual activities at home in private, without the therapists present or participating.) Throughout this behavioral retraining, the six elements listed above are concurrently being used to produce therapeutic change. Unfortunately, media coverage of sex therapy has emphasized only the element of changing the couple's actual sexual behavior and has led to the view that sex therapy consists *only* of the therapist prescribing body massages, genital caressing, and other sexual activities.

## What Is Sex Therapy?

Given this brief summary of the elements of sex therapy, the question arises as to what sex therapy is. Is it a complex,

multifaceted psychotherapy procedure to be used only by those with formal training (and a license) to practice psychotherapy? Is it, as many sex therapists argue, a form of educational activity not requiring psychotherapeutic skills on the part of the sex therapist? Is sex therapy merely a form of physical skill training, like golf or tennis lessons? This is not just an academic question, for the issue of what sex therapy is interacts with the most pressing issue facing the would-be consumer of sex therapy: what sort of training and skills does a sex therapist need to have to be effective?

There are at least two schools of thought on this issue of the qualifications needed to do sex therapy. On the one hand, the established mental health professionals tend to argue that sex therapy is a set of specialized procedures for use only by trained psychotherapists. On the other hand, a number of the new sex therapists argue that sex therapy is a separate new profession.

## Sex, once a devalued activity, has become a required ability

The point of view held by many, if not most, psychologists and psychiatrists is that sex therapy is a subspeciality of psychotherapy. It logically follows, then, that only those persons who are qualified by training and experience to do psychotherapy should be doing sex therapy. This viewpoint stresses that sexual dysfunction does not exist in a vacuum, but that it often is related to problems in the couple's emotional relationship, such as poor communication, hostility and competitiveness, or sex-role problems.

Furthermore, even in those cases in which the sexual dysfunction is not related to relationship problems, the couple's emotional relationship is often damaged by the sexual problem and the feelings of guilt, inadequacy, and frustration that usually accompany sexual dysfunction. Therefore, it is stressed that training in psychotherapy (especially marital or family systems therapy) is required to deal with these problems. Finally, this viewpoint notes that sex therapy itself is a stressful procedure, and that psychotherapeutic expertise is required to deal with the patient's emotional reactions to the sex therapy process.

While the logic of this argument is certainly compelling, the new sex therapists point out that it is not based on any empirical research data. No one has conducted a study of effectiveness of sex therapy procedures when used by trained psychotherapists as opposed to lay persons trained only in sex therapy procedures. Outside the sex area, comparisons of effectiveness of therapy for emotional problems have generally *not* provided strong evidence that professional psychotherapists do better than nonprofessional psychotherapists (for example, ministers, family doctors, and so on).

Certainly those sex therapists who are not psychotherapists claim results every bit as good as those obtained by psychologists and psychiatrists. Indeed, even a written educational program without *any* contact with a "sex therapist" has been shown to be remarkably effective for premature ejaculation. In this vein, a number of "self-help" books for sexual dysfunction have recently appeared on the market. While formal research on their effectiveness is lacking, the authors all have numerous clinical examples to support the likely effectiveness of this "therapy without a therapist."

### Patients and Therapists

Even while acknowledging the truth of these counterarguments, it might be pointed out that those people who seek out a sex therapist may be more severely dysfunctional (or in a more troubled relationship) than those people who attend an educational program or choose only to read a self-help book. It may well be that the professional psychotherapists are correct in their assertion that their patients need their psychotherapy skills. It may also be true, however, that not all couples suffering from a sexual dysfunction need the services of a psychotherapist. For couples who have a loving and strong emotional relationship, but who are simply unskilled and naive sexually, education rather than therapy may be the treatment of choice.

The question may ultimately be reduced, then, to one of the nature of the patients seeking sex therapy. Most clinics that specialize in sexual dysfunction report that there has been a change in the characteristics of their patient applicants over the last few years. Some years ago most couples seeking therapy were basically very naive about sex; an education and training approach was usually quite successful. Recently fewer and fewer such cases appear. The current greater cultural acceptance of sexuality, and the widespread availability of good information about sexual physiology and technique, have apparently resulted in a lower incidence of sexual dysfunction caused by naiveté and ignorance. Current cases more commonly involve deep-seated negative attitudes about sexuality, relationship problems, or other factors not responsive to a sex therapy program that only includes education and behavioral retraining exercises.

If the "easy" cases are becoming less common, it becomes a matter of some concern that individuals with no psychotherapy training —such as most health educators, experimental psychologists, sociologists, and clergy—can represent themselves as sex therapists. This total lack of control over who can be a sex therapist is indeed the current state of affairs. There are absolutely no legal restraints to prevent anyone from hanging up a shingle proclaiming his or her status as a sex therapist. Anyone familiar with the national scene in sex therapy can cite any number of sex therapists who, before they became sex therapists, were not involved in any sort of therapy or human health services activity. While state licensing laws and professional societies prevent quacks from representing themselves as physicians, psychologists, psychiatrists, and—in some states—marriage counselors, the sex therapy field legally is wide open for anyone who wants to open the "Jones County Center for Sex Therapy."

Courtesy of Institute for Sex Research

Dr. Alfred Kinsey and colleagues. Photo by Dellenback

While some of the new sex therapists are obviously unqualified and seem to be attracted to the field because there is money to be made and no controls to keep them out, a perhaps more serious problem concerns those well-intentioned people who believe themselves to be competent but who may not be. This may be a more serious problem because such people usually have some sort of credentials to establish their credibility to the reasonably suspicious and sophisticated consumer, who will not patronize the outright quacks.

Many of these marginally competent sex therapists are qualified mental health professionals, but have very little or no training in the specialized techniques of sex therapy. Again, if sex therapy is considered a subspecialty of psychotherapy, seeing your local psychiatrist or psychologist for sexual dysfunction may be analogous to seeing a general practitioner for a medical condition that really requires specialized treatment.

It seems that the ideal situation would be for all mental health professionals to acquire, as part of their training, at least some passing familiarity with sex therapy techniques. Again, ideally, intensive training would be available for those who wish to specialize in the area, as would continuing education for practicing professionals. Unfortunately, however, the actual situation is about as far from this ideal as it is possible to be. While most medical schools now have a general, broad content course in human sexuality as an elective part of the curriculum, opportunities for training and supervised experience in sex therapy are almost nonexistent. Similarly, most clinical psychology and psychiatry residency programs simply do not provide such training. Those institutions that do have such opportunities for their students generally do so out of fortuitous circumstances rather than by design—someone on the faculty happens to have a research interest in sex therapy.

Even if training programs in psychiatry and psychology come to include sex therapy training in the future, the question remains as to how the current practitioners of psychotherapy can learn the specialized skills of sex therapy. When new treatment procedures are developed, the issue of continuing education for the already licensed professionals becomes a major issue.

It is again the case that such continuing education is simply not widely available. What is available are lectures and "workshops," usually consisting of a few evening or weekend lectures. It is certainly debatable that therapeutic skills can be learned by passively reading and listening to lectures. Like all complex and inexact arts, therapy skills are best learned by supervised practical experience under a master practitioner.

What is especially disturbing about the continuing education scene is that, once again, the high demand for sex therapy means there is money to be made here. Consequently, a number of people and institutions now offer high-priced brief "training" in sex therapy. The graduates of such courses can then represent themselves as trained sex therapists, and charge their clients high fees for their "expertise." As one concrete example, one sex therapy group offers a one-day workshop in a number of cities each year. The admission requirements for this workhop are minimal. After

sitting in a large room with perhaps one hundred others for a total of eight hours, the graduate receives an impressive diploma (complete with blue ribbon and gold seal) certifying status as a trained sex therapist. There is no examination to see if the trainee was awake and learning anything (or even physically present) during the course; if you pay your $85 fee in advance, you can merely show up Sunday afternoon to pick up your diploma.

## Laws are more often effective in protecting the status of the professions than in insuring competence for the consumer seeking therapy

There are some legitimate continuing education programs. Masters and Johnson periodically run training programs, as does the Human Sexuality Program of the University of California Medical School. To take the California program as an example, their trainees are required to have a formal training background in marital or family therapy, to complete seventy-five hours of relevant course work, and are personally interviewed before entering the training program. The program itself consists of training for two days per week for six months, including case work under intensive supervision. At the end of the course, the trainee receives a letter stating that he or she has satisfactorily completed the course. No diploma or certification as a sex therapist is given.

Apparently there is at least some legislative awareness of this lack of training in human sexuality in most professional schools and continuing education programs. Two laws recently passed in California (Assembly Bill 4178 and 4179, signed into law by the Governor in 1976) will require, as of January 1, 1978, evidence of training in human sexuality as a condition for licensure (or renewal of licensure) as a physician, psychologist, social worker, or marriage, family, and child counselor. If other states follow this model, professional schools and associations will be forced by law to do what they should have been doing in any case as part of their responsibility to the public.

The major problem in the professionalization of sex therapy is that the high demand for sex therapy has drawn many minimally qualified and untrained persons into the field. Reflecting both this high demand and the freedom of these new sex therapists from the ethical and legal controls of the established psychotherapy professions, at least two major problems have also arisen. These problems revolve around fees and the issue of sex between patient and therapist.

### Payment for Treatment

It is remarkable to consider that in the United States the average cost range for fifteen hours of outpatient psychotherapy with a private practice psychologist or psychiatrist is between $300 and $750. Yet the average cost range for fifteen hours (the usual duration) of sex therapy from one of the many new sex therapy centers is between $2,500 and $4,000. While there is an obvious reason for higher fees when two therapists see a given couple—a male-female cotherapy team is common sex therapy practice—the five to ten times higher fee level cannot be justified on any rational grounds.

Sex therapists, as discussed above, often have *less* formal training and experience than psychotherapists. The sex therapy consumer is *not* paying for longer training or expensive equipment, which are the usual reasons for higher fees of specialty practitioners. Regarding the necessity for higher fees to pay two therapists, there is at least some clinical evidence that a single therapist can be as effective as cotherapy teams. If further research supports this conclusion, the preference of sex therapists to work in dual sex teams may be just a luxury, the cost of which is unreasonable to expect the patients to underwrite.

As we move slowly toward a system of national health insurance in the United States, the issue of licensing mental health care practitioners becomes more crucial. The question of who will be eligible for reimbursement under a national health insurance system is currently the subject of vigorous lobbying efforts in Washington. Each of the health professions (not just the various psychotherapeutic professions) argues that it must be included—for the national welfare, of course, and not out of any self-interest. Before national health insurance for mental health problems (such as sexual dysfunction) can become a reality, someone is going to have to make some hard decisions about who can actually do psychotherapy.

Even if the issue of which practitioners should be eligible for national health insurance payment can be resolved, it is still very doubtful that sex therapy would be covered. Currently most private health insurance does pay for psychotherapy by psychologists and psychiatrists. However, payment for psychotherapy (even by these practitioners) for marital or sexual problems usually is specifically excluded. Some psychologists and psychiatrists routinely give their sexually dysfunctional patients fraudulent diagnoses on insurance forms so that the patient's insurance will pay for the cost of therapy. The ethics of this practice may be questionable, but it is unreasonable that treatment of anxiety and depression caused by job problems is covered by insurance, while treatment of anxiety and depression caused by marital or sexual problems is not. Perhaps this represents a last vestige of our society's Victorian heritage, or alternatively, the insurance companies may simply fear that with the divorce rate approaching 40 percent nationally, such coverage would break the bank. However, given the social cost of broken marriages (welfare aid to dependent children, tying up the court system with divorce cases, and so on), inclusion of sexual and marital psychotherapy under national health insurance might be a bargain at almost any price.

## Sex between Therapist and Patient: Trick or Treatment?

The procedures of sex therapy as described by Masters and Johnson have a firm theoretical basis in learning theory and behavioral psychotherapy, and are also empirically based in that they have been shown to work when properly used. In contrast to this mainstream approach, there is now a growing trend for sex therapy to include some form of quasi-sexual or directly sexual contact between therapist and patient, or between patient and "sexual surrogate"—a paraprofessional who serves as a sexual partner for those individuals who do not enter therapy in the context of an established sexual relationship. Such procedures are as yet rare outside of California, which most psychotherapists consider to be the "weirdness" capital of the profession. Yet, if it is true that California is the cultural bellwether for the rest of the country, such procedures may become more widespread and common.

One variety of quasi-sexual therapist-patient contact is the "sexological exam." In this procedure each of the nude patients is sexually stimulated by the opposite sex therapist. This stimulation usually includes breast and genital manipulation. The purpose of the exam is described as being to check for sexual response and demonstrate it to the patient. Of course, anyone with any reasonable degree of sophistication might note that whether sexual response is elicited by a stranger in an examining room does not necessarily tell anything about how the patient responds to his or her spouse in a private setting. In any case, the possibilities for abuse of this sexological exam by therapists are obvious.

Another variety of quasi-sexual contact between patient and therapist involves nudity and massage. The assumption here is that nudity per se is somehow therapeutic. This nude therapy is usually done in groups, and sometimes includes procedures such as having the patients float across a warm swimming pool thinking "I give myself completely" or having the patients buy fruits and nuts because they are reminiscent of early sexual symbols. While it would seem requisite for therapists who use such procedures to provide some data on their effectiveness, they have not done so. What one sees instead are sweeping, unsubstantiated statements that the procedures are beneficial.

The most direct form of sexual contact between therapist and patient is, of course, for the therapist—or a surrogate partner provided by the therapist—to actually go through the therapy program with the patient. Masters and Johnson started this approach, using carefully screened and trained surrogates under close supervision in cases where a man lacked a sexual partner. They discontinued this approach partly because of legal problems and partly because they noticed a selective tendency for their surrogates to become emotionally involved with wealthy patients.

Today there is an International Professional Surrogates Association which makes surrogates available to therapists who would like to use them. While the use of surrogates has been described as "thinly veiled prostitution," the use of a surrogate is at least a seemingly logical approach (although not the only approach, as the surrogate advocates claim) for the dysfunctional patient who does not have a sexual partner. Again, there is an obvious problem: while the advocates of surrogate therapy claim high success, data on whether the patient's new-found ability to function generalizes from the surrogate to a real-life sexual partner are almost totally nonexistent. In the absence of such data, the practice of providing surrogates to married men with wives who are unwilling to enter therapy with their husbands is at best questionable, even ignoring the other problematic issues involved in such cases. Perhaps more disturbing, there is a current trend for these surrogates to move toward becoming independent therapists, and to operate without any professional consultation or supervision.

In all procedures involving nudity, touching, and sexual activity between patient and therapist, even the most charitable observer must question the therapist's motives for using such procedures. Is there a theoretical rationale or actual data to support the utility of such risky procedures? Is the enjoyment and gratification of the therapist, rather than patient welfare, a major factor in the decision to use such procedures? While less relevant in cases where the therapist provides a surrogate for the patient, in cases of direct patient-therapist sexual contact the issue of exploitation of the patient is an enormous one, yet one that is simply denied by the advocates of this approach. Because of the obvious risks of exploitation of patients, sex between patient and therapist is considered to be unethical by all of the professional psychotherapy disciplines.

Given that there are few trained professional sex therapists around, that many nonprofessionals are calling themselves sex therapists, that many questionable activities are practiced under the guise of sex therapy, and that many professionals are doing sex therapy with little or no specific sex therapy training, what is to be done? This question really has two components: what can be done legally or professionally to protect the consumer (a long-term social policy question) and what a couple seeking sex therapy can do to make sure that it finds a competent practitioner (an immediate personal question).

## Consumer Protection

The sorry state of affairs in regard to sex therapy is only slightly worse than that found in the mental health field in general. Licensing and certification laws for psychiatrists, psychologists, and social workers (the three major psychotherapeutic professions) have been under recent attack by consumer groups. Basically, the current licensure laws can be faulted on at least two major counts.

The laws are more often effective in protecting the status of the professions than in insuring competence for the consumer seeking therapy. Most state licensure laws restrict *only the use of the title* of psychiatrist, psychologist, or social worker to those who have met certain qualifications. The actual

*practice* of psychotherapy is unregulated. As is true of the title "sex therapist," anyone can advertise and practice as a "psychotherapist" or "counselor."

Even within the three legally regulated professions, the requirements do not begin to insure competence. It is neither unethical nor illegal for any licensed physician to practice as a psychiatrist; no special training or competence is required. The vast majority of psychiatrists do complete a psychiatric residency training program, but the quality control the American Medical Association exercises has been severely criticized. Similarly, certification as a psychologist in most states is not limited to those trained as *clinical* psychologists—experimental psychologists whose entire training has been limited to laboratory work are eligible. Social work licensure is also not restricted to clinically trained social workers.

However, even completion of a *clinical* training program is no guarantee of competence. Both the American Psychological Association and the National Association of Social Workers have recently been criticized for failure to adequately evaluate and control quality of clinical training programs. This failure is critical since bad psychotherapy is not merely ineffective; some psychotherapists have been shown to consistently make their patients *worse*. Bad psychotherapy produces a "deterioration effect"; it is worse than no therapy at all.

All three major mental health professions do have additional, more rigorous *voluntary* examination and certification (by the American Board of Psychiatry and Neurology, the American Board of Professional Psychology, and the Academy of Certified Social Workers). However, this certification is completely voluntary; and since the average consumer-patient is unlikely to be aware of the existence of such boards, lack of certification really has little or no negative effect on private practitioners. Nationally, for example, only 33 percent of psychiatrists are board certified.

It would seem, then, that the issue of insuring competence of sex therapists cannot be separated from the larger issue of insuring competence of all mental health professionals. While a discussion of the complexities involved in such a general reform of training and licensure is beyond the scope of this paper, some specific recommendations can be made in regard to sex therapy.

Both to control the sex therapy explosion and for general consumer protection, uniform laws need to be passed regulating who can engage in the *practice* of psychotherapy or provision of mental health services. Licensure which simply restricts the use of the three major professional titles is not enough. The proliferation of nonprofessional sex therapists who are legally exempt from current laws is a good example of this inadequacy. The issues involved in such a "license-to-practice" law are extremely complex; such laws have to define what "psychotherapy" and "mental health services" *are*. Does a clergyman doing pastoral counseling need to be licensed? What about marriage counseling, vocational rehabilitation, encounter groups, sensitivity training, EST, and a whole host of other procedures that might or might not be considered "mental health services"?

A feasible solution might be a law which restricted to licensees the practice of "psychotherapy, personal counseling, marriage counseling, hypnosis, sexual therapy, or related procedures aimed primarily at the amelioration of psychological distress through direct personal intervention by a practitioner." Rather than trying to write a law which covered all possibilities, individual borderline cases could be handled by a licensure board, which would include a variety of professional disciplines, legal experts, and consumer representatives. Consumer representatives would be necessary both to insure that the professional societies upgrade their quality controls on training programs, and to insure that qualified persons were not arbitrarily excluded from licensure simply because they lacked a "union card" in one of the major mental health fields.

Licensure would be based on evaluation of actual psychotherapeutic competence, not just on professional degree status (although formal clinical training would be a necessary prerequisite for evaluation). Furthermore, such competence-based licensure would be reevaluated at periodic intervals to insure that effective continuing education to keep the practitioner abreast of new developments in the field was indeed taking place. Such mandatory evaluation of competence and enforcement of such laws would obviously be very expensive, but worthwhile given the current almost total lack of protection for the consumer seeking psychotherapy. Under some such competence-based "license-to-practice psychotherapy" system, the issue of incompetent sex therapists being able to practice would not arise.

### AASECT Certification

An alternative approach to insuring the competence of sex therapists is to similarly certify (or license) sex therapists directly, not as a subfield of psychotherapy practice. Indeed, there is at least one nationwide voluntary certification program, started by AASECT—the American Association of Sex Educators, Counselors, and Therapists—in 1974. AASECT was just AASEC for many years; it was primarily an organization of educators involved in teaching sex education. The "T" for "Therapist" was added only last year.

AASECT's standards for certification are probably too low to guarantee uniform competence, although many expert therapists are AASECT certified. A person can be certified by AASECT in one of two ways. As a "grandperson" (already established sex therapist) one must have an M.A. degree or its equivalency (not defined) plus one thousand hours of paid clinical experience as a sex therapist, or an M.A. degree plus an internship (not defined) with a certified sex therapist in a recognized agency. If the applicant cannot meet the "grandperson" requirements, certification is available by having a masters degree or its equivalent (not defined) in a clinical field. However, for nonclinicians workshop programs can satisfy the equivalency requirement. In

addition to the degree (or equivalency), certification requirements include one thousand paid hours of experience as a sex therapist, a written examination, a personal interview, and attendance in a two-day AASECT workshop on sexual attitudes and values. Obviously the AASECT focus is on sex therapy rather than on psychotherapy training. If one certifies, as sex therapists, persons who have a nonclinical masters degree plus "workshops," one is assuming that general psychotherapy training and experience are not necessary to be an effective sex therapist.

When AASECT established this program in 1974, there was a good deal of resistance from the professional community. Were the standards too low to insure competence? Was it appropriate for any one membership organization to coopt the field and arbitrarily announce "*we* will be *the* certification body for sex therapy"? (This issue, some years ago, led the Association for Advancement of Behavior Therapy to decide *not* to begin a certification program for behavior therapists.) In any case, was AASECT, basically an organization of health educators specializing in sex education, and an organization without any formal ties to mental health services or psychotherapy, the appropriate one to certify therapists? Was voluntary certification by an educational association with little public visibilty worthwhile? Given that AASECT certification is not backed up by any legal constraints on who can use the title "sex therapist" or who can practice sex therapy, is it at all meaningful?

On the other hand, were the professional psychotherapists opposing AASECT certification as part of an elitist attempt to keep sex therapy as part of their exclusive (and suddenly profitable) domain? Were the professional organizations themselves doing anything about the unqualified "sex therapists" who were suddenly getting lots of publicity, and with it, lots of unsuspecting patients?

The situation today has clarified only somewhat. A good deal of squabbling still goes on between psychiatry, gynecology, urology, clinical psychology, AASECT, and various marriage and family therapy organizations as to who properly "owns" sex therapy. The AASECT program has slowly gained acceptance. Several of the nationally prominent therapists who initially declined "grandperson" certification when it was offered by AASECT recently accepted it, including Masters and Johnson.

AASECT has recently started, in conjunction with a local college, a training program for sex therapists. While this is a laudable idea, there are obvious potential conflict of interest problems in the certification organization offering training (will a candidate who has paid AASECT the substantial tuition for this program ever be found unworthy of certification?). Because of these obvious problems, in all other health-related disciplines the license or certification is granted by an independent state-regulated board, not by the professional school or the professional association.

In recent telephone conversations with several AASECT board members, there seemed to be a general feeling that certification is only a marginally useful first step. Statutory regulation of practice was mentioned as the most desirable option, with two current board members feeling that the current voluntary certification was essentially meaningless. Others voiced concern about the low level of professional psychotherapy training required, but as one initially opposed but now certified therapist put it, "It's the only game in town." Whether the AASECT certification program has social utility in protecting the consumer, or at least in guiding the consumer to a competent sex therapist, remains to be seen.

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Individuals with no psychotherapy training can represent themselves as sex therapists. This total lack of control is the current state of affairs

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As a first step in providing some consumer protection, AASECT has recently proposed a code of ethics for sex therapists which would forbid nudity (except in same-sex groups), sexological exams, and all sexual contact between patient and therapist. Albert Ellis, the chairman of the Ethical Standards Committee, indicated in a recent conversation that there is some resistance to this proposed code, primarily from California-based sex therapists. It will be interesting to see if AASECT adopts this code, and, if so, whether it will be enforced by withdrawing certification from those therapists who use such procedures. Again pointing out the limited value of voluntary certification by a membership organization such as AASECT, some California therapists who disagree with the proposed AASECT code are talking about starting a national certification program of their own.

This review of the current state of affairs in the enterprise of sex therapy makes it clear that quality controls are sadly lacking. The existing laws, the professional psychotherapy disciplines, and the AASECT have not been effective in guaranteeing the competence of the practitioners of sex therapy. In the absence of such effective controls, the patient couple seeking sex therapy must be very wary in entering treatment.

**Choosing a Sex Therapist**

To turn to the personal issue of just how a couple seeking sex therapy can find a qualified practitioner, several brief guidelines can be mentioned. If you are considering sex therapy and seeking a practitioner, you should keep the following principles in mind.

Do not respond to paid advertising in any media. Such advertising is against the ethical codes of virtually all professional organizations. AASECT is on record as recommend-

ing that sex therapists "use traditional professional forums for announcing their practices."

On the other hand, media *news* coverage (not advertising) of university, medical school, or social agency sponsored sex therapy clinics is often an excellent way to locate qualified sex therapy centers. In general, institutional clinics, with their higher standards of in-service staff training and supervision, are more likely than private practice settings to exercise quality control on patient care. Additionally, fees are usually lower in such institutional settings than the going rates in private practice. In psychotherapy the best is not always the most expensive. Psychoanalysis, usually the most expensive form of psychotherapy, seems to be among the least effective for sexual dysfunction.

Fifteen hours of outpatient psychotherapy cost between $300 and $750. Yet the average cost range for fifteen hours of sex therapy is between $2,500 and $4,000

Be sure that your prospective therapist is licensed as a psychiatrist, psychologist, or social worker in your state. There are obviously other types of qualified therapists (and not all psychiatrists, psychologists, or social workers are even minimally competent), but this license provides you with certain legal protections that are worth having. (Employees of state agencies are often exempt from licensure, so this is less relevant if you are going to a university- or agency-based therapy program.)

Check on the qualifications of your therapist. Beyond state licensure, is the therapist board certified by his or her profession? Does the therapist have training and experience in marriage or relationship therapy, as well as in the specialized sex therapy techniques? A board-certified therapist who simply has read Masters and Johnson and has now decided to see sexual dysfunction cases is not the optimal choice.

A call to your local medical society or state psychological association for a referral is not likely to be helpful. Usually these organizations are required to simply give you the names of three of their members, sequentially taken from the membership roster without prejudice. Even in those cases where referral to particular practitioners is allowed, this referral is based on the members' *self-described* (not evaluated) area of competence and interest. A phone call to the nearest university department of psychiatry, clinical psychology programs, or school of social work may, however, help you locate a specialist in sex therapy. Within the reservations noted previously about the level of standards, the AASECT list of certified therapists may be helpful. If someone is both licensed and boarded as a psychologist, psychiatrist, or social worker *and* is AASECT certified, you can be reassured about his or her competence.

Take referrals from your family doctor, pastor, or other professionals with a grain of salt. Often such referrals are to a friend, classmate, or golfing partner, rather than being based on actual evaluation of the therapist's skills. Such referrals are a useful starting point, but still check out the therapist's qualifications in accordance with the above points.

### "Let the Buyer Beware"

Changing cultural attitudes about sex and the development of new psychotherapeutic techniques have combined to create high public demand for sex therapy. As a combined result of this demand, a lack of action by the professional psychotherapy disciplines, and the inadequate laws regulating psychotherapeutic practice, a major problem has arisen regarding the competence of those people who call themselves sex therapists. Currently there is virtually no legal or professional protection of the consumer seeking such therapy.

Again reflecting high demand, the fees charged for sex therapy are irrationally high when compared to other forms of outpatient psychotherapy. Finally, there is a small but growing trend for sex therapy to include a variety of both quasi-sexual and frankly sexual interactions between therapist and patient. These sexual interactions lack a theoretical basis, are of unproven utility, and may exploit or harm the patients. Therapists who engage in such interactions may be gratifying their own needs at the clients' expense, and the ethicality and legality of such procedures is dubious.

Taking these three issues in the professionalization of sex therapy together, it is apparent that long-term consumer protection reforms in the training and licensure of therapists are indicated. On a short-term basis, consumer education is indicated to enable prospective sex therapy patients to protect themselves. The current situation suggests that in seeking out sex therapy the appropriate strategy is indeed "let the buyer beware."□

*READINGS SUGGESTED BY THE AUTHOR:*


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