

The Differences in Attitudes towards Sexuality between Religious and Secular Therapists as a Result of Participation in an Intervention Supervision Program

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Abstract

This paper presents the findings on qualitative research focusing on the differences in attitudes towards sexuality between religious and secular therapists. Psychotherapists that provide therapy which deals with the patients' sexuality must address an issue often considered taboo by society. Although psychotherapists may not have had training in providing therapy in topics relating to sexuality, when discourse focusing on sexuality arises during therapy in the clinic, the psychotherapists are required to maintain a professional approach, even while dealing with their personal attitudes to the topic. Furthermore, the psychotherapists' discomfort with issues relating to sexuality and their lack of knowledge of the topic may affect their sense of self-efficacy. Following the psychotherapists' participation in an Intervention Supervision program, the psychotherapists were asked to participate in semi-structured interviews as part of the post intervention stage of the study. The interviews were designed to examine the psychotherapists' personal attitudes towards sexuality and their sense of self-efficacy. Differences were found between religious and secular psychotherapists in their attitudes towards sexuality, in general, and more particularly towards the patients' sexuality. Even so, conservative attitudes and discomfort towards sexuality were apparent both in the religious and secular society, often driving the psychotherapists to avoid dealing with topics of sexuality in the clinic. The intervention program is designed to incorporate the main elements of supervision: transforming attitudes and skills in sex therapy through impartation of knowledge and acquisition of tools. The program's aim is to foster an enabling atmosphere for the various attitudes and to convene a discussion about diversity and conservatism. The supervisor's role is to be a role model for

talking about sexuality in a respectful and enabling manner.

Keywords

Psychotherapists, Sexuality, Self-Efficacy, Secular Participants, Religious Participants, Attitudes towards Sexuality

1. Introduction

Psychotherapists' low sense of self-efficacy during therapy discourse about sexuality in the clinic may be attributed to their level of discomfort in discussing sexuality with patients who expect to receive professional assistance in dealing with sensitive and difficult topics associated with sexuality. The psychotherapists may feel anxious about discussing sexual intercourse, and could deter discussions focusing on homosexual intercourse, sexual harassment, sadomasochism, and other topics of atypical sexuality, most especially when these issues do not align with their personal attitudes to sexuality (Timm, 2009).

An Intervention Supervision program designed for this study enabled the psychotherapists that participated in the study to participate in group sessions during which the therapists were able to conduct discussions about a variety of topics relating to sexuality. With the support of the intervention supervisor and the other group members, the psychotherapists clarified their personal attitudes about a variety of sexuality topics and used the discussions as a platform to present their negative attitudes. Following participation in the intervention program, changes to the psychotherapists' personal attitudes that could affect therapy discourse with the patient were examined. A comparison was carried out between the religious and secular psychotherapists' perceptions of sexuality and their sense of self-efficacy following the intervention program. Religion is an integral part of many societies, as it is in Israel. Placing a focus on religiosity was relevant to this study, since many psychotherapists in Israel are religious and practice professionally within the religious society and could be expected to have different attitudes to sexuality than those developed by the secular psychotherapists. The aim of the study was to investigate the effect of a short-term group supervision program for sociotherapists on their sense of self-efficacy and their attitudes toward their clients' sexuality.

2. Literature Review

2.1. The Intersection between Sexuality and Religion

Sexuality is related to the social behavior of couples and individuals, and the response to sexuality is likely to be influenced by social or religious values. For several decades, Masters and Johnson (1970) have been pioneers in many studies on human sexuality, problems with sexual dysfunction, and problems related to sexual performance. Their work included the design of sexual therapy programs

for the treatment of sexual incompatibility that were based beyond psychotherapy also on the influence of social attitudes on sexual function (Masters & Johnson, 1970).

Weber (1984) argued that individual and group behavior can be understood through the general perception of reality of a society. The general perception of reality is influenced by religion, which has power and influence on secular perceptions as well.

There is a taboo on sexuality embedded in Christian conservatism (Foucault, 2016; Mottier, 2008).

Mead and Crowley explain that a person gives meaning to the other's actions in the cultural and social context resulting from their interaction (Mead, 1934). Thus, the interaction among the group members makes it possible to examine his positions compared to the positions of the group members on the issue of sexuality. Exposure to diverse attitudes, which may be similar or contradictory to personal attitudes, will allow for an internal dialogue between the personal attitudes and the attitudes of others and a re-examination of the personal attitudes as a process that allows for change.

The first studies on attitudes and sex therapy were performed by Kinsey, who claimed that conservative society was dominant and perpetuated ignorance among the population. He concluded that youth in society should be exposed to sex education, so that they will learn the topic. This would decrease ignorance and reticence from dealing in this issue (Kinsey et al., 1948). Masters and Johnson performed research in the 1950s on the sexual issue and reached the conclusion that problems in sexual function stem from social influences based on gender stigmas. Change should therefore be made on the social level, and correct and adapted sex therapy should be given (Masters et al., 1987).

Derby et al. (2015) and Timm (2009), who do not interpret the conservatism but rather present it as a fact, suggested exposing therapists to the field of sex therapy to enable a change in attitudes. As indicated by the program participants, only open personal perceptions will enable therapists to change their conservative personal and professional attitudes toward sexuality in the clinic and cause them to feel more comfortable dealing in sexuality in the clinic. Therapists are apparently challenged by speaking about sexuality which is under a social taboo, and in their opinion this challenge should be changed by changing personal conservative perceptions to more open ones. This means that the interaction with members of the group regarding attitudes toward sexuality is characterized by flooding of the personal perceptions regarding sexuality as a way for changing conservative into more open perceptions.

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rapists are apparently challenged by speaking about sexuality which is under a social taboo, and in their opinion this challenge should be changed by changing personal conservative perceptions to more open ones. This means that the interaction with members of the group regarding attitudes toward sexuality is characterized by flooding of the personal perceptions regarding sexuality as a way for changing conservative into more open perceptions.

Religion has been associated with sexuality since it potentially influences attitudes and behaviors and several aspects of religiosity have been associated with sexual attitudes (Lefkowitz, Gillen, Shearer, & Boone, 2004). The conception of reality affects both individual and group behaviors in society. Religion may influence the conception of reality with the power to affect not only religious conceptions of reality, but also to influence secular conception of the reality within the same society (Foucault, 2016). Individual and group behaviors have altered the attitudes to sexuality over the years, and three models for sexuality have emerged. Religions embrace the moral/religious model as it relates to the status of sex as an integral part of Christian morality whereby it is regarded as the original sin (Mottier, 2008). The Christian religious conception of functional sexuality has been associated with producing children and has been considered a private act, little discussed in public. Oftentimes, this conception carries over into the secular society (Foucault, 2016). Another model for sexuality is the biological model which links sex with natural desires. Lastly, the social model of sexuality transfers responsibility for sexual neurosis onto society (Mottier, 2008). The therapist's perception of sexuality in the clinic will affect his or her self efficacy to talk about sexuality with the patient, so it is important to understand how the therapist's self efficacy to talk about sexuality can be improved.

2.2. Influencing Self-Efficacy

Bandura (1977, 1982, 1986) further argues that all behavioral and psychological change results from changing people's sense of their own competence. In his 1977 article on self-efficacy, Bandura writes that people process, weigh, and integrate various sources of information about their capabilities, and that this influences their choice behavior and effort expenditure. Based on Bandura's research, self-efficacy expectancy has the strongest influence on whether a person initiates a behavior and persists when faced with frustration. A self-efficacy expectancy is also regarded as the best predictor of behavioral initiation and persistence.

The psychotherapists' sense of self-efficacy is likely to impact the ability of the therapist to provide effective therapy to the patient. Self-efficacy relates to an individual's belief in their ability to effectively exercise control over the performance of their behaviors and the events that may affect their lives. In 1977, Albert Bandura published the self-efficacy theory which determined the four main sources that influence the individual's perceptions of their self-efficacy. These sources of influence are 1) mastery experiences, 2) vicarious experiences, 3) so-

cial persuasion, and 4) emotional or psychological arousal. Each one of these sources of influence does not have the same power, and thus each one has a different impact on self-efficacy expectancies. Mastery experiences exert the most influential influence on self-efficacy expectancies. Mastery experiences are associated with successes and failures. Success is expected to enhance the sense of efficacy, while failures could undermine the individual's self-efficacy (Maddux & Stanley, 1986).

Bandura (1982, 1997) proposed a model for enhancing self-efficacy. As reflected in the supervision program, this model consists of four parameters:

Observing behavioral models

The feeling of belonging to a group of peers;

Reduced sense of negative arousal in relation to the task.

Influencing someone verbally about the ability of a person to perform a task the following four processes were utilized to reinforce their sense of self-efficacy:

1) Developing skills required for performing the task and similar tasks.

2) Developing skills and competences in various areas simultaneously.

3) Controlling self-regulation mechanisms.

4) Behavioral-cognitive structuring of success in various activities.

The psychotherapist's self-efficacy in the clinic is necessary to allow him or her to feel comfortable with the patient, but when a psychotherapist feels uncomfortable talking about sexuality his or her self-efficacy will decrease, so it is important to understand what sexual therapy is.

2.3. Providing Sex Therapy

Attitudes to sex therapy may differ between the secular and religious society. Sex therapy is one of the specialized forms of psychotherapy, that may also encompass technical interventions aimed at treating sexual dysfunction. Traditional psychotherapeutic techniques for use in sex therapy have included providing support, confrontation of the sexual issues, interpretation of the situation, cognitive reframing of the problem, in addition to other behavioral interventions. These techniques may sometimes need to be backed up by consultations with medical specialists to ensure effective and comprehensive treatment (Althof, 2010). Most of the psychotherapists in this study had not specialized in sex therapy.

3. Research Method

While published literature has presented findings about psychotherapist's attitudes to sexuality, limited research has focused on exploring the attitudes of the psychotherapists to their patients' sexuality and the effect of personal attitudes on therapy discourse. In this study, the participants were psychotherapists with a two- or three-year education in therapy. In the study, the psychotherapists participated in a short-term group Intervention Supervision program for psychotherapists, aimed at improving the self-efficacy of the psychotherapists to discuss sexuality while providing therapy in the clinic.

This article focuses on the findings from my doctoral research. There were three stages, before during and after the intervention program. In this article there is a reference to the findings of the third stage the post intervention stage, which occurred once the therapists had completed the Intervention Supervision program. In the post intervention stage, the psychotherapists participated in semi-structured interviews that explored their attitudes towards sexuality and their feelings of self-efficacy when dealing with sex therapy. The group of respondents included 15 religious psychotherapists and 14 non-religious psychotherapists. Due to COVID-19 restrictions, the interviews were conducted via Zoom. A participant-focused methodology was the approach adopted for the study. The psychotherapists' responses to the interviews were analyzed using a qualitative approach that involved content analysis.

Analysis of the findings for the study included comparisons between two groups of participants according to their demographical characteristics. The demographics also enabled the differentiation between religious and secular participants and a comparison of their responses to interviews. The comparison examined differences in the psychotherapists' attitudes towards sexuality and their feelings of self-efficacy when dealing therapy discourse about sexuality.

Research instruments

- 1) An open-ended questionnaire.
- 2) A semi-structured interview.
- 3) Comparative analysis between groups.

Semi-structured interview

The purpose of the semi-structured interview is to find out the feelings and perceptions of the participants as therapists toward sex therapy, their clients' sexuality, and feedback about the intervention program during and after the intervention.

In order to reduce the tendency to please the researcher as much as possible, it was explained, at the beginning of the interview, that the purpose of the interview is to improve the intervention program, and that the authenticity of the participant's opinion and experiences is crucial.

Data Analysis: Content Analysis

The participant-focused methodology is the most suitable approach for the present study. The researcher is an expert in the field and comes from the field with years' long experience. She built and supervised the intervention program throughout the study in order to examine the change that the participants were undergoing. The participants' opinions, experience and feedback about the program were an important part of the research data. Based on this feedback

The qualitative data were collected from the open-ended questionnaire and the semi-structured interviews.

Validity, Reliability and Triangulation

This study examined the effects of self-efficacy and attitudes toward sexuality through an open-ended questionnaire and semi-structured interviews. Both tools were transferred to three Ph.D. and three M.A Specialists in sexual therapy.

This is a case study that uses action research and qualitative data analysis in order to examine a unique phenomenon. Researchers and participants who share unique qualities will make it difficult to replicate the research, although the research can be replicated with an expert researcher, scope and structure of the intervention, and under the authority of the current researcher.

In the triangulation methods, we compared measurements taken before, during, and after the intervention, and the two types of survey tools. We found that the same categories emerged in open-ended questions and semi-structured interviews.

4. Findings

In this article, the findings emerged from a comparison between religious and secular study participants regarding their attitudes and self-efficacy.

Findings from the content analysis led to the creation of categories. **Table 1** presents the categories relating to research question 1: How did the group interaction within the Intervention Supervision program affect the participants' self-efficacy? And **Table 2** relating to research question 2: How did the group interaction within the Intervention Supervision program affect the participants' attitudes towards sexuality?

Table 1. Findings relating to research question 1: How did the group interaction within the Intervention Supervision program affect the participants' self-efficacy?

Categories	Categories relating to self-efficacy	
	Acquiring knowledge about sex therapy	Self-efficacy as sociotherapist
Evidence	<i>The program gives a lot of new information. I think it answered what I expected, the requirements</i>	<i>It helped me a lot to open up. It helped me a lot to be able to relate to the subject...I also feel much less embarrassed, or not at all, when the topic comes up and I can also initiate questions on the topic,</i>

Table 1 presents the findings of this study. The findings are divided into two categories: Acquiring knowledge about sex therapy and the self-efficacy as sociotherapist. Those categories relating to self-efficacy.

Table 2. Findings relating to research question 2: How did the group interaction within the Intervention Supervision program affect the participants' attitudes towards sexuality?

Categories	Categories relating to attitudes towards sexuality				
	Interaction with group members	Interaction with the supervisor	Attitudes of sexuality	Attitudes of clients' sexuality	Attitudes of Sexual Therapy
Evidence	<i>"The group members and group dynamics, are what made the program..."</i>	<i>"And I talk a lot about 'modeling', you really made this language accessible through modelling."</i>	<i>"I think I was exposed to a field that is not talked about and that I do not talk about and it made me open..."</i>	<i>"... All the content that was related to mother violence... traumas, vulnerability, child violence, wow. It was hard for me."</i>	<i>"..Sexual assault within the family, okay? Not about us, a father who raped the girls, especially that the sisters knew, and the mother knew and no one..."</i>

Table 2 presents the findings related to research question 2. The findings are divided into five categories: Interaction with group members, Interaction with the supervisor, Attitudes of sexuality, Attitudes of clients' sexuality, Attitudes of Sexual Therapy. Those categories relating to attitudes towards sexuality.

Results of the content analysis of the semi-open interview data collected at the end of the training program raised the following categories:

1) According to both groups, sexuality is an issue with a social taboo. While secular therapists thought that it was necessary to change attitudes so that a more open dialogue could occur in a clinic, religious therapists expect that the program will be in line with their values and culture and that the focus will be on healthy sexuality.

The attitudes toward sexuality are one of embarrassment and shame, an issue that is not discussed and if it is, it is only in the context of education and healthy sexuality. There is a debate about the intercultural gap between religious and secular, which raises value questions. Religious participant SH-223 talks about her coping with sexual issues: *"I really considered it as very embarrassing, very uncomfortable issues, and I felt both the gap and the conflict of yes and no talk, Yes allowed or forbidden?"*

Participant *A-211* explains the impact of embarrassment from sexual issues that provoked opposition:

"It was still embarrassing, I told you about D. who provoked opposition but I also felt a lot of opposition." She is accustomed to such talk, with a message that a safe place in the group is needed.

Participants acknowledge the challenges of speaking about sexuality, and talk about the importance of starting from a personal clarifier. The next secular participant says Z-105 *"It's sexuality, it's ours, it's first of all ours. It's us. It's a topic like you've seen people shy away from. Will not help, not everyone you know, released. That when the principal is very asexual and also in the current relationship sex is out of the taboo and what do you need this subject for? And what is it interesting? And who asks it and who is like this and who is like that then it is not... No."* The change should start from our personal attitudes and perceptions about sexuality before we begin to address the issue in the treatment room. The following participant also noted the difficulty of talking about sexuality and the conversation in the training group gave her a place to deal with her sexuality as part of the process of giving legitimacy to talking about sexuality. The secular participant added L-453 *"But I'll say in general that it's dealing with my sexuality. It opened the door for me to dabble in my sexuality. First of all I was really interesting, I think I was exposed to a field that is not talked about and that I do not talk about and it very much made me open, open to talk about the subject... openness, um... as if a kind of legitimacy that everything is fine, that everything is fine."*

The participants also raise the intercultural gap, as shared by participant *SH-223*: *"I think this is very true and it is a very significant added value that you*

say the issue should be made accessible to the culture. Maybe there was something insensitive to culture enough and then it created and maybe it had an impact on the group. I had a very hard time, I did not feel I could speak freely or ask freely...

2) The interaction with the supervisor opens up a cross-cultural space that can conflict with the values and language of the participants, as well as move between their resistance to cooperation. The religious participants dealt with intercultural conflict and differences in values, while the secular participants viewed the interactions as a means of modeling. Religion participant *A-211*, who participated in a homogeneous group of religious therapists, very clearly explains the intercultural gap between the supervisor as secular and the group participants who are religious: *“Suddenly someone meets us and does not know the baggage we bring and guides it in a very different way that very much eliminates what we are, what we come with, not culturally sensitive to it, there is no dialogue between the worlds... Today I experienced it so this is what I believe: a religious person who seems to be rooted in the values of religion, this issue should be learned from a religious person. I do not usually say this, it takes a lot of cultural sensitivity... so I think that a supervisor who brings this to our public should take this field first and study this subject within the public. What are the religious positions that educate the public around these charged issues, what is considered allowed and what is forbidden, what exists and what is not. What is happening in this religious public, what are the concepts... if it is about masturbation, if it is about homosexuality, modesty, thoughts, all sorts of things. It is important to come with a knowledge base, you have the knowledge base on sexuality and we have a knowledge base (on religiosity).”* She explains that the supervisor must come with prior knowledge of the culture, values, conflicts they face and, in her experience, there was a failure in the guidance, so much that she says: *“If I had to recommend someone like me to take such a course, I would only recommend with a lecturer who matches her worldview.”*

It is important that the supervisor with the same cultural values as the members of the group.

The following secular participant presents her perception of the supervisor as a role model I-342 *“And I talk a lot about ‘modeling’, so I think you brought a lot of accessibility to this language through modeling... and meeting you like that opened up possibilities for dialogue about it.”* In which the subject of sexuality is discussed. It can be said that the interaction with the supervisor in the intervention program is perceived as a cross-cultural space that can create a gap between the participants and the supervisor in values, content and language that may create resistance among the group participants. The interaction with the supervisor is also perceived as a source of expertise that includes knowledge, group setting management, diverse activation alongside the ability to calm and control, the ability to contain, listen and accept.

3) Perceptions about the interaction with group members. The data show that

interaction with group members in the intervention program is perceived by secular participants as a source of diverse human encounters that can be a place for learning, enables or blocks through a safe, pleasant, respectful encounter and by religious participants as an intercultural encounter that can be enriching or inhibiting.

Therefore, the next secular participant V-342 shares: *“On a personal level I also very much admired the girls who shared their personal problems, their sexuality and how they connect and so on. I feel that the girls in the group also enriched me, with the knowledge and examples they brought, and their references. The girls, as I said before, were diverse and so I learned something from each of them. I think this is how dynamism and group development were created.”* She emphasizes the positive meaning and contributions of the diversity of group members. The next participant supports the idea that diversity among group members has contributed to. The secular Participant *M-560*, who participated in a secular and religious mixed group, finds that heterogeneity enriches: *“An excellent sense of openness, honesty that we are all from the different sectors from the places each comes from. We all speak the same language, talking completely about what we are talking about. It is true that there are things that are different for each one, but it is still things that concern everyone and so this particular meeting in my opinion was very intriguing and interesting.”*

This is how participant SH-223 as a religious person in a homogeneous group of religious, explains the avoidance of group members to talk about sexual issues: *“Maybe I say in retrospect, maybe for the group it would have thawed and allowed the group to be there more comfortably... as if silence or refraining from speaking in my eyes is like missing out. I experienced a lot of fear of talking about it, anxiety that it might undermine values, that it should not even be given a place, a verbal conceptualization of things. Because maybe it will meet their personal experience, I do not know.. I will not go to a group of seculars on the other side because it is really far from my life, it is a completely different world but I feel missed”.* She presents the interaction with group members which is a homogeneous group, all religious, as needed to preserve them and their values, in order not to offend them on the one hand, and on the other hand the loss that the conflict between the professional opportunity to be exposed and talk about sexual content and the conservative values that guide not to talk about this content. The interaction within the group in the intervention program is perceived as a place where there is a conflict between the religious values that are conservative and the professional commitment as socio therapists to engage in sexual issues, group interaction can emphasize diversity and be an enabling or blocking place. The feeling of comfort and discomfort in a homogeneous versus heterogeneous group also increases.

4) Perceptions about self-efficacy. The data show that self-efficacy will increase when there is an increase in the feeling of security, overcoming embarrassment through peer learning, knowledge acquisition and modeling that allows

the sexual issue to be made accessible in the treatment room.

The religious participant L-216 concluded that diverse learning allows effective learning. She further mentioned additional personal processes that are involved in the learning process: *“The program made me process and reflect upon the things that bother me or that I am comfortable with, in this type of therapy. Ultimately, I have to decide on what to act upon. I remember for example something I experienced, I cannot name it, or did not understand that it is something that can be used as a therapeutic technique. It was the first task that was hard on everyone: you told us to imagine clients or people having sexual relationships. I shared that it happens to me when a client talks about his sexual issues. I always thought it was my wild imagination, some issue with me, I never imagined this could be used as a therapeutic tool! I was so relieved to have learned it. I really had a moment of enlightenment.”* The next participant reinforces the change she experienced in her ability and says E-330 that *“It really helped me open up. It really helped me to be able to relate to the subject... to learn from other women, other views, it's like in my awareness. Definitely yes. I also feel much less embarrassed, or not at all, when the topic comes up and I can also initiate questions on the topic, addressing the topic, even if the patient did not choose to bring it up themselves. It's like yes... added as something constant in the process of saying my assessment, my intake the added value is that in 'refining' the issue.”*

The following participant details the change in her abilities in the face of her coping with sexuality in the treatment room and thus notes L-453 *“I think if I had met them today, then I would have had something more inclusive, more understanding, more open, more listening. I was able to connect. I was not scared or anything like that. I did manage to connect to things.”* It is clear that what leads to the change in abilities, she says, is the ability not to panic about the issue. Participants in the intervention program perceive their self-efficacy as shifting from low self-efficacy resulting from a perception of reluctance toward the sexual issue in the clinic to high self-efficacy resulting from a sense of change due to their participation in the supervision group.

5. Discussion

Sexuality is perceived by both groups as a discourse with a social taboo. There were no differences between the two groups. This in turn poses a challenge for therapists to change the conservative perceptions and attitudes about sexuality, one has to engage with open personal perceptions. There are conservative societies in Israel, and there is a taboo on dealing with sexuality in general, as well as in the clinic. Therapists feel that this is a challenging topic for them. This can be seen in therapist training programs, which generally do not contain any reference to the field of sexuality. If there is reference to sexuality, the therapist will participate in one general course that is not sufficient for changing attitudes. There is thus a need for open discourse to not only for changing therapists' pro-

professional attitudes toward sexuality in the clinic, but also for creating a change in their personal attitudes and perceptions toward sexuality. Participation in a supervision program that deals entirely in sexual issues enables dealing openly in sexual issues and clarifying and changing conservative attitudes toward this issue.

This finding can be explained by sociological theories related to religion and sexuality, which explain that the social taboo on the sexual discourse, which challenges religious and secular therapists to cope with the issue of sexuality, stems from the influence of religious conservatism on the entire society. [Weber \(1984\)](#) explained that in order to understand individual and group behavior, we must understand the general perception of reality of that society, and religion is part of the general perception of reality and has power and influence over secular perceptions. The conservative perception according to which there is a taboo on the sexual issue thus originates in Christian conservatism ([Foucault, 2016](#); [Mottier, 2008](#)).

The first studies on attitudes and sex therapy were performed by Kinsey, who claimed that conservative society was dominant and perpetuated ignorance among the population. He concluded that youth in society should be exposed to sex education, so that they will learn the topic. This would decrease ignorance and reticence from dealing in this issue ([Kinsey et al., 1948](#)). Masters and Johnson performed research in the 1950s on the sexual issue and reached the conclusion that problems in sexual function stem from social influences based on gender stigmas. Change should therefore be made on the social level, and correct and adapted sex therapy should be given ([Masters et al., 1987](#)). Kinsey and Masters contend that differences in attitudes between secular and religious therapists can be explained by the religious conservatism imposed on religious and secular societies.

[Derby et al. \(2015\)](#) and [Timm \(2009\)](#), who do not interpret the conservatism but rather present it as a fact, suggested exposing therapists to the field of sex therapy to enable a change in attitudes. As indicated by the program participants, only open personal perceptions will enable therapists to change their conservative personal and professional attitudes toward sexuality in the clinic and cause them to feel more comfortable dealing in sexuality in the clinic. Therapists are apparently challenged by speaking about sexuality which is under a social taboo, and in their opinion this challenge should be changed by changing personal conservative perceptions to more open ones. This means that the interaction with members of the group regarding attitudes toward sexuality is characterized by flooding of the personal perceptions regarding sexuality as a way for changing conservative into more open perceptions.

Another factor that contributes to the differences in attitudes between their religious and secular therapists is the supervisor's involvement, which can open up an intercultural dialogue that can conflict with the values and language of the participants, as well as move between their opposition and cooperation. The re-

religious participants dealt with intercultural conflict and differences in values, while the secular participants saw interactions as a means of modeling

Therapists who voluntarily participated in a supervision group in the field of sexuality come with the need to address these issues in therapy. Their participation in a program in which the supervisor exhibits knowledge and confidence in speaking about sexual topics comprises a role model, such that the participants learn how to speak and deal in the sexual issue. The interaction with the supervisor shows how to react and cope with the sexual issue such that it will be easier to talk about. This exposure will change therapists' attitudes into more positive and enabling.

This finding is consistent with Bandura's (1982) learning theory, which explains that self-efficacy will increase if the participants in the group will view the supervisor as a role model. If participants feel that they identify with the supervisor, they are in the same profession, both are therapists, there is appreciation of the supervisor who has reached achievements that participants would like for them self and has knowledge and expertise in the field which can be learned from her. As indicated by the research participants who viewed the supervisor as an expert with the ability to handle sexual issues which are socially taboo, the good coping of the supervisor with sexual topics enabled a reduction in the embarrassment of the participating therapists and comprised a role model (Bandura & Houston, 1961). Therapists apparently perceived their interaction with the supervisor, who was perceived as a role model in coping with the social taboo toward sexuality, as decreasing their negative attitudes toward sex therapy. This means that the interaction between members of the group and the supervisor as a role model regarding attitudes toward sexuality is characterized by better coping with the social taboo on sexuality and decreases negative attitudes, if such exist.

Different perspectives regarding group interactions can explain the different attitudes between religious therapists and secular therapists. This finding can be explained in that the participation of therapists in the supervision program offers interactions with additional therapists that enables comparing between personal attitudes toward sexuality in the clinic and the attitudes of members of the group regarding their own sexuality. The interaction with members of the group and the discourse on sexual topics forces the therapists to clarify and ask themselves about their attitudes as therapists toward sexuality in the clinic. The personal clarification enables therapists to clarify their own personal attitudes toward sexuality. People who perceive themselves as liberal toward sexuality can discover that they are more conservative than they thought, and vice versa, people who perceive themselves as conservative can discover that they are much more liberal, such that a gap is created between the personal perception toward sexuality that can be liberal or conservative, and attitudes toward sexuality in the clinic that can be opposite to the personal perception.

This finding is consistent with supervision approaches that explain that par-

ticipation in a supervision program is perceived as a safer place than a face-to-face encounter. In addition to exposure of the therapist to different perspectives and feedbacks from members of the group, it enables exposure to a larger number of cases with which the therapists in the group coped (Derby et al., 2015; Timm, 2009), and will enable the therapist to clarify his or her personal and professional attitudes toward sexuality.

The finding is also consistent with the symbolic interaction theory, through which Mead and Cooley explain that in an interaction with the other, the person tries to afford meaning to the other's actions in the social and cultural context in which they are found (Mead, 1934). Thus, the interaction with members of the group enables testing the personal attitudes of the therapist on the issue of sexuality compared to the attitudes of other therapists in the group. Exposure to diverse attitudes, that can be similar or contrary to the personal attitudes, will enable internal dialogue between the personal attitudes and the attitudes of the others and re-examination of the personal attitudes as a process that enables change.

The finding is consistent with approaches that refer to sex therapy as an encounter with the sexual topic which is socially taboo and deters therapists and causes them to have negative attitudes toward sex therapy (Derby et al., 2015). Timm (2009) explained that therapists fear that their lack of knowledge and professionalism in sex therapy will cause harm to the patient, and therefore avoid talking about sexuality in the clinic. The interaction with members of the group and exposure to different and more open attitudes will enable clarification of the professional and personal attitudes toward sexuality. The therapists apparently perceived their interaction with members of the group as a source for understanding that a gap exists between their personal attitudes toward sexuality and their attitudes as therapists in the clinic. This means that the interaction with members of the group regarding attitudes toward sexuality is characterized by pinpointing of the gap between personal attitudes toward sexuality and attitudes as a therapist in the clinic.

Perceptions about self-efficacy. Both religious and secular groups perceived that self-efficacy will increase when there is an increase in the feeling of security, overcoming embarrassment through peer learning, knowledge acquisition and modeling that allows the sexual issue to be made accessible in the treatment room.

This finding is consistent with Bandura's (1977, 1982, 1986) learning theory and with theories on supervision that explain that participation in supervision programs which impart knowledge and skills, and in which interactions that enable discourse on sexual topics take place between members of the group and with the supervisor, enables exposure to diverse perceptions and opinions, as indicated by participants from both groups, the religious and the secular. Derby et al. (2015) and Timm (2009) explained that therapists who do not feel that they are experts in the field of sexuality exhibit difficulty in speaking about sexuality

in the clinic. As indicated by the participants of the present study, discourse on the issue of sexuality increases their sense of efficacy to speak about sexuality in the clinic. Therapists apparently perceived the contribution of the social interaction in the supervision program in their coping with their sense of self-efficacy as therapists through the acquisition of knowledge in the field of sexuality and the discourse on sexuality. This means that the social interaction during the supervision program and acquisition of knowledge in the field of sexuality enables discourse on sexuality and thus increases their sense of efficacy as therapists.

6. Conclusion

During the interviews with most of the participants in the study, acknowledgement was made of the effect that the personal attitudes of the psychotherapists about sexuality had on the discourse with their patients during therapy. Despite the intercultural gap that exists between the secular psychotherapists and the religious psychotherapists, there was often much in common with their personal attitudes to addressing sexuality in the clinic. Participation in the Intervention Supervision program drove the psychotherapists to a realization about how their personal attitudes were affecting discourse about sexuality and provided guidance about dealing with sexuality in the clinic. The psychotherapists' attitudes about sexuality often led them to feelings of embarrassment and shame or to ignoring sexuality as a topic for discourse. In other instances, discourse about sexuality in the clinic was limited to discussions about normative sexuality. Despite their participation in the Intervention Supervision program, some participants still had reservations about addressing sexuality, more often when the situation involved atypical or abusive sexuality.

Within the religious society, gaps existed between the attitudes of the various religious psychotherapists, often depending on their levels of religiosity. These religious differences were expressed in the morals and values of the participants and resulted in differing levels of comfort with discourse about sexuality during therapy. Yet, it was shown that participants in both the religious group and the secular group showed an interest in altering their attitudes towards sexuality. The secular participants seemed to seek support in changing their attitudes, while the religious participants looked for ways to adapt their attitudes, in conformance with their religious morals and values.

Self-efficacy was shown to be influenced by the acquiring of knowledge about topics related to sexuality. The psychotherapists were more likely to overcome their embarrassment about sexuality, through education in and exposure to sexual issues and topics of sexuality. Yet, differences were found between the secular and religious participants relating to acquiring knowledge of different topics about sexuality. The secular participants more commonly perceived knowledge as a manner by which to increase their sense of comfort with discourse about sexuality. In comparison, amongst some religious participants, addressing sexuality was likely to conflict with religious and cultural values that promote modesty and foster inaccessibility to knowledge about sexual issues. Nevertheless,

most participants viewed the intervention program as an opportunity for discourse in topics related to sexuality, that was likely to boost the psychotherapists' sense of self-efficacy.

A supervising program that clearly focuses on attitudes toward sexuality, knowledge, tools, and sexual therapy skills changed their attitudes and improved their sense of self-efficacy when discussing sexuality in the treatment room. Thus, it is important for any psychotherapist training program to include sexual supervision programs.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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