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Development of an Instrument to Measure Therapists' Attitudes toward Client Sexuality

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Abstract

The Sex Therapists' Attitudes questionnaire (STAQ) was developed to examine the reactive attitudes of sexual therapists towards the sexuality of their clients, with the purpose of offering a comprehensive instrument that taps therapists' attitudes regarding their clinical practice and their perceptions and reactions to issues of sexuality expressed and communicated by their clients. The STAQ examines the therapist's personal attitudes on sexual topics such as normative sexuality, sexual identity, trauma or sexual abuse. STAQ contains items that describe a wide variety of sexual situations, from normative sexuality to violent and perverted sexuality encountered in the clinic. Therapists completing this questionnaire are then required to examine their attitudes toward their clients in the clinical situation and rate their degree of agreement with the feelings, emotions and attitudes presented in the STAQ items. The items in the STAQ describe situations where a client presents in the therapy session a sexual issue of concern such as infidelity, sexual dysfunction, sexual abuse, sexual intercourse, masturbation, sexual orientation, and a variety of sexual habits, both normative and deviant. The questionnaire, which was validated by both psychologists and sexual and family therapists in Israel, has very high reliability (= .95).

Keywords

Therapists' Attitudes, Sex Therapy, Sexuality, Comfort, Questionnaire, Instrument

1. Introduction

1.1. Background

In the clinic, psychotherapists encounter topics that can contradict their personal convictions and attitudes. This could make them shun the topics or avoid

raising sexual topics throughout the therapy (Harris & Hays, 2008; Derby et al., 2015; Timm, 2009). In order to understand, address and attempt to resolve these inhibitions that can potentially restrict the effectiveness of the therapeutic process, an instrument to effectively measure therapists' convictions and reactions to sexual issues that arise or are implied in the clinic is proposed.

There are a few questionnaires designed to tap therapists' attitudes toward client sexuality in the clinic. A study by Harris and Hays (2008) conducted on 175 marriage and family therapists (of whom 13 were also sexual therapists) assessed the relationship between marriage and family therapists' clinical training and education, their perceived sexual knowledge, their comfort with sexual material, and their willingness to talk about sexuality with their clients. Harris and Hayes (2008) developed the questionnaires needed for their study for the lack of existing instruments, among which is the sexual comfort scale (SCS). This 15-item instrument was an attempt to operationalize the concept of "sexuality comfort" suggested in Graham and Smith's (1984) qualitative study in which they interviewed sexuality educators. This questionnaire taps into the self-reported level of comfort with different aspects of sexuality, such as diseases, fertility, contraception, sexual abuse and sexual identity.

The SCS was also used in a study by Moor (2018), which attempted to determine whether sexual knowledge, training, supervision, clinical experience and personal sexual attitudes of therapists influence their comfort levels and willingness to engage in and discuss the topic of sexuality with a client. Results showed that graduate sexuality training, supervision experience, and clinical experience were positively associated with willingness to discuss sexual topics. However, none of the studies' variables predicted therapists' comfort level with sexuality.

An additional study that examined anticipated levels of discomfort among 340 occupational therapy students utilized Cohen et al.'s (1994) Comfort Scale (Jones et al., 2005). This scale measures how comfortable participants feel dealing with clients that have AIDS, are lesbian, exhibit some sexual behavior in the clinic, or have a physical exam that involves exposure of breasts or genitalia. Results showed that most participants did not feel comfortable "walking in on a client who is masturbating", "dealing with a client who makes an overt sexual remark" and "dealing with a client who makes a very sexual remark"; but they did feel comfortable with "Homosexual male", "14-year-old female seeking contraception", and "Handicapped individual who is inquiring about sexual options" (Jones et al., 2005). The 19-item Comfort Scale by Cohen et al. (1994), which was developed for the purpose of studying attitudes toward sexuality among medical students, was itself an expansion of a previous 10-item scale created by Fisher et al. (1988), also trying to tap willingness of medical students to treat clients with sexual concerns. It is interesting to note the limited scope of this 10-item scale, reflecting a more conservative environment that existed over 30 years ago compared to current times.

Another instrument developed by Trueblood, Hannon et al. (1999) and later validated by Hannon et al. (2010) examined the attitudes about personal sexual behavior and others' sexual behaviors (Trueblood sexual attitudes questionnaire [TSAQ]). The TSAQ contains 80 items of which 40 items reflect attitudes towards self sexuality and 40 items reflect attitudes toward others' sexuality. The scale is divided into five subscales: masturbation, heterosexual, homosexual, variations and commercial.

In a recent study of 63 mental health practitioners and interns in supervision by LoFrisco (2013), a 29-item scale developed by LoFrisco (2013) was used to measure therapists' level of discomfort in dealing with sexuality in the clinic. The questionnaire was developed following interviews with eight therapists and counselors, in order to find out how they define sexual issues and what their level of comfort is in talking about sexual issues in the clinic.

The 29-item questionnaire included six demographic items, 18 items on current practice questions, and five items about the training experience. The 18-item current practice items focused on the level of difficulty, sense of discomfort and frequency in talking about sexual issues with clients, such as sexual dysfunction, sexual behavior, GLBT identity (gay, lesbian, bisexual and transexual), and sexual abuse. For each item, respondents had to choose the reason for discomfort (lack of formal or informal education, lack of experience, access to information, religious beliefs) and the level of discomfort (slight, moderate or substantial). The researchers constructed the questionnaire based on their clinical experience, their knowledge as sex therapists, results from other studies and research they co-participated in, in an unpublished study (LoFrisco, 2013).

In their study, Ford and Hendrick (2003) examined the relationship between therapists' own sexual values and their clients' sexual values and their sense of comfort with their clients' values using a 23-item questionnaire developed for the study. Items included value items such as: "Sex should be reserved for marriage only", "Homosexuality is a natural expression of sexuality in humans"; and comfort items: "I would be personally uncomfortable working with a client who engages in same-sex sexual practices", and "I would be personally uncomfortable working with a client who engages in group sex". Results showed that although therapists differed in their sexual values, they appeared comfortable working with any sexual issues brought to them by their clients. Results also showed that training in sexual issues is effective for clinical work (Ford & Hendrick, 2003).

In conclusion, the current relatively scarce literature shows that studies examined comfort levels or values of students and therapists relating to their client's sexual and sexuality issues. Most questionnaires tapped into therapist's values and opinions on the personal level and towards their clients. The subject matter of most of the above reported studies was from the realm of healthy sexuality, sexual dysfunction, sexual behaviors, homosexuality, and sexual abuse. Only Cohen et al. (1994) presented situations from the clinic, albeit from the experience of medical practitioners, not from psychotherapists. In conclusion, current questionnaires do not provide the scope needed to tap into the feelings

of comfort or discomfort of therapists towards their client's graphic descriptions of sexual problems or situations such infidelity, sexual trauma, sexual relationships, paraphilia, hypersexuality, and erotic transference. Moreover, no single questionnaire has a broad enough scope that taps into all these issues.

Therefore, the aim of the present study was to develop a new scale that taps into the subjective emotional experiences of comfort and discomfort encountered by therapists in the situations described above and named "Sex Therapist's Attitudes questionnaire" (STAQ).

1.2. The Development of the Sex Therapists' Attitudes Questionnaire (STAQ)

In order to examine the attitudes of therapists towards the sexuality of their clients in the clinic, a 33-item attitude questionnaire was constructed. A validation process was implemented for the questionnaire. Part of the process involved an academic professor from the field of psychology who helped to build questions that would reveal the respondents' positions, e.g., "how comfortable you would feel if a client described in the clinic…". The selection of sexual issues to be included in the questionnaire was composed of the professional experience of the author as a therapist and sexual counselor and as the manager of a sexual therapy center. Additional three experts from the field of sexology, a professor, and two doctors, all sexual therapists and certified counselors by the Israeli Sexual Therapy Association for over a decade, contributed from their experience to the questionnaire, too.

The experts suggested adding some topics in addition to the ones suggested by the author. After the consultation, the questionnaire had 33 questions describing situations in the clinic. The situations included diverse topics that may arise in the clinic, such as infidelity, sexual trauma, intercourse, sexual orientation, masturbation, Pedophilia, hypersexuality, erotic transference, sexual dysfunction and incest. The questions were structured in such a way that the interviewed therapist could imagine themself in the situation in which he was in the clinic and a sexual issue arose and found out the attitudes towards that situation and the level of comfort towards it, e.g., "How comfortable would you feel if a client describes in detail during the therapy session: anal sex/sex between a man and a woman/a woman who has been raped/violent sexual behavior towards women". As part of the process then the questionnaire has been completed by a certified sexual therapist and sexual counselor, of the American Association for Sexual Therapy (AASECT) with a master's degree. She has confirmed that the questionnaire is clear and understandable to complete.

The questionnaire is intended for all couple and family counselors, those who work with youth and adults, individuals, couples, family and group therapies in order to identify a sense of comfort or discomfort towards diverse sexual issues that may arise in the clinic.

The uniqueness of the questionnaire is:

The questionnaire is unique in the sense that it includes a range of issues that

the respondent is presented with some of which come from the world of sexuality, such as infidelity, sexual trauma, sexual orientation, masturbation, sexual paraphilia, hypersexuality, erotic transmission, sexual dysfunction, incest. No questionnaire that contains this combination of topics that was covered in the STAQ was found in the literature. In the ones found in the literature, the topics which are presented came from the world of healthy sexuality. Moreover, therapists are usually presented with just one or two topics, such as only sexual trauma or/and only sexual orientation, but not in the variety that appears in this questionnaire.

Another major difference between STAQ and previous questionnaires is that the STAQ examined the participant's attitude as a therapist in the clinic, in order to gauge the level of comfort or discomfort in being exposed to potentially embarrassing, uneasy or unacceptable sexual behaviors and situations. The items were structured in a way that the therapist was encouraged to think of the clinical setting and potentially remembered the emotions elicited by their past experiences or just imagine their would-be reaction to such situations. By describing the situation in the clinic therapists should connect the sexual issues of the client with the subject matter. Other questionnaires usually just tap into the general views and attitudes one has regarding sexuality.

The questionnaire specifically addresses the therapist in the clinic who can come from the world of psychotherapy but also from the world of medical care. It covers topics that arise in the world of medical care, such as sexual dysfunction, sexual orientation, masturbation; intercourse is covered as well as issues that are more relevant to the field of psychotherapy, such as sexual trauma, paraphilia, incest, hypersexuality and infidelity. The questionnaire was initially distributed to sexual therapists in Israel.

2. Methods

2.1. Participants and Procedure

A total of 98 family and sex therapists, of which 85 were women (86.7%), 12 were men (122%) and one identified their gender as "other" (1.0%), in the age range of 29 to 72 years ($M = 46.25$, $SD = 10.27$) participated in the study. 67 participants were married (68.4%), 11 cohabitated with a romantic partner (11.2%), eight were divorced (8.2 %), five were single (5.1%), four were living alone but were in a relationship with a romantic partner (4.1%), and two were widowed (2%). 83 of the participants had children (84.7%). Participants were reached through professional networks and forums and were provided with a link to the online questionnaire delivered by email.

2.2. Instruments

Personal Details Questionnaire

Demographic and professional background items relating to participants' professional training, their experience in therapy, training programs they have

attended, place of work, age and gender, family background and religion were administered. The questionnaire was designed by the researcher of the present study so that it is suitable for psychotherapists in Israel.

Sex Therapists' Attitudes Questionnaire (STAQ)

The STAQ, a self-report questionnaire, was used to assess individuals' attitudes towards sexuality in general and towards sexuality in the clinic in particular. The original questionnaire consisted of 33 items that describe different behaviors and situations regarding a client's sexuality and past and present sexual experiences (see Appendix 1). Following an initial exploratory factor analysis on a pilot study of 40 participants working as sex and family therapists (not shown), nine items were removed (items that were not loaded properly and were assessed to have descriptions of situations that do not pose an emotional challenge to the therapists, and do not contribute to overall variance), and a final 23-item questionnaire is presented that effectively taps sex therapists' attitudes. Participants were required to rank on a seven-point Likert type scale the degree of comfort the therapist feels when a client describes the situation depicted in the item in detail during a therapy session between 1—"I would feel very uncomfortable" to 7—"I would feel very comfortable". The STAQ consists of the following four scales: 1) Normative sexual behavior [e.g., "two men having anal sex with each other"; nine items], 2) Violent sexual behavior [e.g. "a violent sexual behavior towards a woman"; five items], 3) Dysfunctional sexual behavior [e.g. "suffering from premature ejaculation"; five items], and 4) Criminally abusive sexual behavior [e.g., "a woman being raped"; three items]. Each scale's score was calculated by averaging the scales' items. Additionally, a total score was calculated by averaging all 23 items.

2.3. Data Analysis

To study the factor structure of the STAQ, a Principal Axis Factoring (PAF) with oblimin rotation to allow for correlations among factors was performed. To study the reliability of the STAQ scales, Cronbach's alphas were calculated. Means and standard deviations of the STAQ scales were calculated. To study the inter-scale correlations, Pearson correlations were calculated.

3. Results

3.1. Principal Axis Factoring

A PAF, with promax rotation, was performed (**Table 1**). Four factors were extracted (based on eigenvalue > 1 and Scree criterion). The four-factor solution is responsible for the common variance constituting 69.2% of the total variance; while four principal components would account for 75.1% of the total variance. Almost all communalities of the variables ranged between .45 and .93, with a low communality of .22 ("having pedophilic attractions"), and medium communality of .36 ("using the services of sex workers"). The four-factors revealed a diverse dimensionality based on different types of sexual behavior (normative, violent,

Table 1. Exploratory Factor analysis loadings (pattern matrix) for the Sex Therapists Attitudes Questionnaire (STAQ).

	Factor:	1	2	3	4
	Normative sexual behavior				
Q04	A woman masturbating	1.02			
Q02	Intercourse between a woman and a man	1.00			
Q05	A man masturbating	.96			
Q07	Oral sex	.95			
Q01	Two men having anal sex with each other	.94			
Q03	Two women having sex which each other	.94			
Q06	Anal sex	.89			
Q22	Suffering from erectile dysfunctions	.75			
Q23	Suffering from premature ejaculation	.67			
Q20	A transgender identity	.65			
	Violent sexual behavior				
Q12	A man being raped		1.03		
Q11	A woman being raped		.90		
Q13	A violent sexual behavior towards a woman		.79		
Q14	A violent sexual behavior towards a man		.78		
Q18	An incestuous relationship that they experienced during childhood		.63		
	Abusive sexual behavior				
Q16	Exploiting and abusive behavior			.69	
Q10	BDSM activities			.64	
Q09	Using the services of sex workers			.58	
Q15	having pedophilic attractions			.55	
Q08	Being unfaithful to their partner	.43		.49	
Q19	Posting sexually related photos and video clips online			.40	
	Patient-Therapist sexual attraction				
Q20	As a therapist, you feel an erotic attraction towards a patient/client				.71
Q21	An erotic attraction towards you, the therapist				.66

abusive, and patient-therapist sexual attraction). Each item held its highest factor loading on the scale to which it theoretically belonged. All loadings on each item's primary factor exceeded .40. Only one item loaded on another factor with loading of .43. No other items loaded higher than .32 on secondary factors.

The correlation coefficients between the factors "Abusive sexual behavior"

and "Normative sexual behavior" ($r_{(96)}$ = .53) and "Violent sexual behavior" ($r_{(96)}$ = .58) and between the factors "Normative sexual behavior" and "Violent sexual behavior" ($r_{(96)}$ = .35) and "Patient-therapist sexual attraction" ($r_{(96)}$ = .34) showed that the factors were interrelated to some degree.

3.2. Correlations between Subscales

Pearson correlations between the subscales of the STAQ were calculated (Table 2). They ranged from $r_{(96)}$ = .13 (Abusive sexual behavior and Patient therapist sexual attraction) to $r_{(96)}$ = .61 (Normative sexual behavior and Abusive sexual behavior). This indicates small to moderate correlations between the subscales.

3.3. Reliabilities of the Scales

The reliability of the "Normative sexual behavior" dimension was very high (10-items; α = .97), as were for the "Violent sexual behavior" (5-items; α = .91). The reliability of the "Abusive sexual behavior" was good (6-items; α = .82), and satisfactory for the "Patient-therapist sexual attraction" (two items; α = .68). Total reliability of the 23-item questionnaire is very high (α = .95).

3.4. Comparing Scales by Types of Treatment Administered by Therapists

The 98 therapists were categorized according to whether they treat individuals, couples, families, and groups (each therapist can treat one or several types of treatment). Most therapists (n = 93) reported they treat individuals; therefore, they were not compared with the few (n = 5) that do not treat individual patients. All other treatment types were compared between those who reported administering couples therapy (n = 51), and those who didn't (n = 47); those who reported administering family therapy (n = 39) and those who don't (n = 59); and between those who reported administering group therapy (n = 45) and those who didn't (n = 53). No significant differences were found between the groups of each treatment type in each of the STAQ scales and the STAQ total score.

4. Discussion

In the present study, a new questionnaire (the STAQ) was developed. This

Table 2. Pearson intercorrelations between STAQ scales.

	M	*SD*	Normative sexual behavior	Violent sexual behavior	Abusive sexual behavior
Normative sexual behavior	4.55	1.50			
Violent sexual behavior	2.46	1.28	.38**		
Abusive sexual behavior	3.15	1.04	.61**	.57**	
Patient therapist sexual attraction	2.45	1.00	.28**	.15	.13

** $p < .01$.

questionnaire consists of four scales and assesses sex therapists' reactive attitudes to expressions of sexuality communicated by their clients in the clinical setting. It is the first questionnaire that measures attitudes and emotional reactions to the content expressed by the client in the clinical setting. The results of the Factor Analysis exposed a four-scale dimensionality, tapping therapists' reactions to normal, violent, and abusive sexual behavior, as well as to signs of sexual attraction between therapists and clients. The alpha reliabilities of all scales were satisfactory to high. The correlations between the subscales were small to moderate. No differences were found in the STAQ scales and total score, between types of therapy practiced, i.e., therapists treating couples, were not different than those who didn't treat couples; therapists treating families were not different than those who didn't treat families; and finally, therapists treating groups were not different than those who didn't treat groups.

This study presented a new instrument that can benefit sex therapists confronting sensitive and personal issues in the clinical setting. Being a therapist naturally does not negate being human, and therefore susceptible to prejudice, discomfort in certain situations, having personal beliefs and opinions regarding what is acceptable or not in sexual inclinations and behaviors, the ability to help even clients who present situations that are far from normative and can cross the boundaries of morality and or legality. This tool can be used in clinical supervision settings for sex therapists and psychotherapists in general, and also in intervention programs designed to help improve reactive attitudes among psychotherapists in order for them to better accommodate their clients' needs.

Limitations

The present study had several limitations. First, the sample was relatively homogenous, consisting mainly of women therapists. The questionnaire was a self-report scale and in the context of the current study, it was not accompanied by depth interviews which could have shed more light on the way the participants perceived and interpreted the questionnaire and whether they encountered and to what degree each of the situations described in the items. Finally, less than 100 participants were sampled with a link to the online questionnaire sent via a mailing list. The setting for administering the STAQ was not ideal, with less control over the conditions and concentration participants had in completing the questionnaire that deals with such sensitive issues.

Future directions

Continued validation of the STAQ is warranted. For this reason, it is advised to retain for the following studies the full 33-item STAQ so that flexibility regarding the dimensionality and reliability of this tool continues to be assessed before locking the instrument with a pre-defined number of items and dimensions. Naturally, it is expected that professionals with many years of seniority who work with difficult populations are expected to be less sensitive to non-normative, violent and abusive sexual behaviors and would probably be more immune to sexual transference in the clinical context. To better demonstrate these hypothesized differences, future studies should sample groups of

therapists according to seniority, professional fields of practice, and other personality traits.

Conflicts of Interest

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

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Appendix 1: The Original STAQ (Items Removed Following the Small Pilot Study Are Marked with an Asterix)

How would you feel if a patient/client described the following situation, in detail, during a therapy session? [1—"I would feel very uncomfortable", 2—"I would feel uncomfortable", 3—"I would feel slightly uncomfortable", 4—"I would not feel particularly comfortable or uncomfortable", 5—"I would feel slightly comfortable", 6—"I would feel comfortable", 7—"I would feel very comfortable"].

1) Two men having anal sex with each other;

2) Intercourse between a woman and a man;

3) Two women having sex which other;

4) A woman masturbating;

5) A man masturbating;

6) Anal sex;

7) Oral sex;

8) A woman being raped;

9) A man being raped;

10) A violent sexual behavior towards a woman;

11) A violent sexual behavior towards a man;

12) A patient/client describes himself as having pedophilic attractions (being sexually attracted to pre-pubescent children);

13) A patient/client describes herself as having pedophilic attractions (being sexually attracted to pre-pubescent children)*;

14) Kinky sexual behaviors*;

15) Being unfaithful to their partner;

16) BDSM activities;

17) Exploiting and abusive behavior;

18) Using the services of sex workers;

19) An incestuous relationship that they experienced during childhood;

20) Sexually related photos and video clips that they are posting on social networks;

21) Using pornographic materials*;

22) Engaging in out-of-control sexual behaviors (OCSB)/compulsive sexual behaviors*;

23) Engaging only in random hookups*;

24) Objectifying their partner (no reference to what the partner feels, wants, prefers, agrees/disagrees) during intercourse*;

25) Posting their nude pictures on social networks*;

26) Homosexual or lesbian sexual relationships*;

27) A transgender identity;

28) An erotic attraction towards you, the therapist;

29) Suffering from premature ejaculation;

30) Suffering from erectile dysfunctions;

31) Having a diagnosis of vaginismus*;

32) Having intimacy issues with their partner*;
33) As a therapist, you feel an erotic attraction towards a patient/client.