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Influence of a Group Supervision Program in Sex Therapy on Therapists' Self-Efficacy and Attitudes toward Sexuality

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Abstract

The present article investigated how psychotherapists' sense of self-efficacy and their attitudes toward their clients' sexuality change after a short-term supervision program. The study examined participants' expectations from the short-term supervision program and their attitudes after participation in the program. It was found that the intervention program influenced the therapists' self-efficacy and attitudes toward sex therapy. Religious and non-religious psychotherapists have different needs and emphasis is placed on the differences in the attitudes expressed by religious and non-religious therapists. Both groups of psychotherapists encounter issues considered to be taboo by society. However, they react differently to these issues. Supervision programs must therefore be adapted to the population of psychotherapists participating in the short-term supervision program. The present article suggests that the solution to psychotherapists' unwillingness to talk about sexuality is found in group sessions managed by supervisors. It is concluded that psychotherapists' interactions with group members and the supervisor provide them with opportunities to learn about their attitude toward their patients' sexuality as well as their own, and promotes their openness to this controversial subject in the process.

Keywords

Therapists' Attitudes, Sex Therapy, Sexuality, Comfort, Religious, Non-Religious, Religion, Self-Efficacy, Supervision Program

1. Introduction

Sexuality was among the most prominent subjects in psychotherapy at the dawn of psychoanalysis. The father of psychoanalysis, Sigmund Freud, placed sexuality

in the center of psychic development, the psychoanalytic theory, and clinical work. Freud viewed sexuality as omnipresent. Freud did not limit its influence to the period of Western culture when he made his discovery. He extended it to the overall experience of humanity whenever and wherever it took place. There were variations of sexuality in different epochs and parts of the world under discussion, but the supremacy of sexuality was never doubted. For Freud, sexuality was philosophically linked to the perpetuation and complexification of life. When analyzing the conceptions of sexuality through cultural differences, Freud observed that sexuality, with all its manifestations throughout the entire lifespan, is an extraordinary stimulus for thought, begetting all sorts of imaginative and mythical constructions. The potential of sexuality for transformation builds up, becoming a complex thought which is the most powerful incitement to psychic work. This kind of thought, to which Freud alluded at the end of the Wolf Man case, is based on intuition. However, it involves unconscious operations and deserves to be called primary. It is opposed to the one that is reachable only through language and secondary processes. No other psychic quality can play a similar role. Freud insisted that the place and influence of sexuality cannot be diminished and that a relationship between sex and life is primary to the human being (Green, 1995: p. 878).

However, by the last two decades of the 20th century, many psychotherapists had lost Freud's enthusiasm for sexuality. Andre Green reviewed the major psychoanalytic journals published in the 1980s and 1990s and found that psychotherapists clearly showed a lack of interest in sexuality. Sexuality in general had ceased to be a major concept, a theoretical function of heuristic value. It was no longer considered the main factor in child development. Nor do psychotherapists resort to sexuality in order to understand clinical psychopathology. Sexuality has long been stripped of the importance and function which Freud conferred on it in his work. In clinical work, psychotherapists do not discuss patients' symptoms through the lens of sexuality. They do not look for sexual undertones when discussing clinical symptoms. As Green observed, by the end of the twentieth century, sexuality was playing a lesser role in clinical descriptions and theoretical explanations (Green, 1995: p. 873).

Not only have psychotherapists begun to talk less about sexuality, they also began to feel increasingly uncomfortable when discussing sexual issues with their clients. Gone are the days when Freud (1920) spoke freely and wrote about people's sexual desires and traumas. Almost a hundred and twenty years after the publication of his small volume titled *Three Essays on the Theory of Sexuality*, more and more psychotherapists and social workers voice uneasiness when talking about sexual topics during therapeutic sessions. Extensive research has been conducted to analyze the reasons for this discomfort. The present paper contributes to this research, trying to answer the question of whether psychotherapists' personal attitudes toward sexuality affect their communication with a client who is eager to talk about sexual problems. In particular, the present research

investigated whether psychotherapists' religiosity and religious beliefs cause them to be reluctant to talk about their clients' sexuality. By focusing on religiosity more than on other reasons for psychotherapists' discomfort, the present study brings together the research on sexuality and the research on psychotherapists' religious and spiritual beliefs. Existing research on psychotherapists' religiosity usually aims to subvert the opinion that psychotherapist are overwhelmingly non-religious. This study goes further, and claims that psychotherapists' religious beliefs play a major role in their attitude toward patients' sexuality.

The present paper therefore focuses on two main topics—the psychotherapists' religiosity and their attitudes toward discussing sexual issues with their clients. After analyzing the findings of earlier researchers, it discusses a research conducted in Israel that studied a short-term group supervision program for psychotherapists. The research aimed to meet the need of psychotherapists who have completed their training but still feel that they lack self-efficacy to talk about sexuality in the clinic. This is due to the gap between the inner experience of discomfort and the expectations of the clients, who view the psychotherapists as experts able to help and assist them with the most painful and difficult issues. The solution to their anxiety offered by the present research is an intervention program that includes supervised group discussions of personal problems with clients' sexuality. The intervention program explored in the present study offers psychotherapists an opportunity to participate in group sessions, in which various sexual issues are discussed. The program allows the psychotherapists to clarify their own attitudes toward these issues, as well as to voice their negative feelings about them. By working according to the "here and now" approach, the psychotherapists are able to involve the group members and the supervisor, who helps the psychotherapists to find the reason for their negative attitude toward clients' sexuality.

As manager of a sex therapy center for more than a decade, supervisor, and psychotherapist, the author has often observed psychotherapists' inability and unwillingness to talk about sexual topics and that sex therapists feel anxious when clients try to describe an event of sexual harassment, homosexual intercourse, sexual intercourse or sadomasochistic relations. These problems often do not align well with the psychotherapists' personal attitudes toward sex. These are sexual issues that psychotherapists have not processed sufficiently well. When their clients try to discuss these topics, they often undermine psychotherapists' sense of self-efficacy toward sex therapy. Psychotherapists often feel unable to assist patients in the clinic (Timm, 2009). Consequently, psychotherapists often need help from a supervisor to respond to clients' problems professionally and efficiently.

2. Literature Review

2.1. Why Is It Difficult for Psychotherapists to Talk about Sex?

Extensive research has been conducted in an attempt to understand why psychotherapists shy away from talking about sex. In her famous article "'Do I Have

to Talk about Sex?' Encouraging Beginning Psychotherapists to Integrate Sexuality into Couples Therapy" (2009), Tina Timm listed reasons why psychotherapists should discuss sexuality with their clients. These reasons include the prevalence of sexual difficulties, the importance of sex in relationships, the association between sexual functioning and quality of life, and the health implications of sex. She compiled a list of reasons why psychotherapists feel reluctant to discuss sexual problems with their clients. The list included lack of training, psychotherapists' personal issues, and the division between sex therapy and couples therapy. Timm focused on the uncomfortable feelings of the psychotherapist. The solution to the latter problem is presented in the PLISSIT model. The model increases psychotherapists' comfort level with the topic of sexuality, provides fundamental questions to ask every couple, and gives examples of more detailed sexual history questions for use when relevant. Timm claimed that it is the psychotherapists' responsibility to decide whether to integrate sexuality into their work with clients, considering the lack of training in sexuality across mental health accreditation standards.

Other researchers also asked why psychotherapists avoid talking about sex with their clients. They concluded that there are several reasons for psychotherapists' unwillingness to discuss sexual issues: they lack training, they fear offending their clients, they do not know what treatment is needed if clients present concerns and time constraints (Berman et al., 2003; Coleman et al., 2013; Harris & Hays, 2008; Kingsberg, 2006). Harris and Hays' (2008) review of the literature revealed that studies on how psychotherapists discuss sexual issues with their clients focused on physicians, occupational psychotherapists, sex educators, nurses, and mental health counselors. I will briefly summarize the reasons given by each of these professional groups for explaining why it is difficult for them to talk about sex with their clients.

2.2. Lack of Training

Driscoll et al. (1982) explored the attitudes, knowledge, and personal sexual practices of family physicians. The authors developed questionnaires that asked questions about the physicians' personal sexual practices, attitudes toward sexuality, and knowledge of sexual issues, measured by the Sexual Knowledge Attitude Test (SKAT). Driscoll et al. also asked questions about the physicians' medical practice: how many and what types of patients are seen. The researchers reported that although patients seek help with sexual issues from their family physicians, the medical education that physicians receive seems inadequate. Physicians are not equipped with the right knowledge to help their patients with sexual concerns. The researchers found that these physicians' sexual knowledge scores were similar to those of sophomore medical students. Their level of expertise was insufficient for sexual counseling.

McKelvey, Webb, Baldassar, Robinson, & Riley (1999) assessed the relationship between background and sociodemographic variables, attitudes toward the

controversial aspect of human sexuality, and sex knowledge among medical and nursing students using the Kinsey Institute/Roper Organization National Sex Knowledge Test. They concluded that medical and nursing students need two aptitudes to provide effective sex counseling: knowledge and an open-minded or positive attitude. Students with a negative attitude toward sex had lower scores in sex knowledge.

Quinn et al. (2013) explored mental health nurses' attitudes toward sexuality and asked whether sexual issues would be accepted as part of their care. This study presented a structured approach to help boost nurses' confidence to discuss sexual issues with their patients. Quinn et al. found that the majority of the nurses avoided discussing sexuality with patients, not considering it a priority, and that they tended to send patients to other health professionals when issues with their sexuality arose. Lack of access to information, lack of support from management, and the high cost of sex education were also highlighted by this study.

Haboubi & Lincoln (2003) investigated the views of physicians, nurses, psychotherapists, and occupational psychotherapists regarding discussion of sexual problems with their patients. They asked the participants to take the Kappa test, t-test, and one-way ANOVA. The participants' level of training was low (14% had significant training, whereas 86% had little or no training). The participants highlighted the lack of opportunities for training. The questionnaires Haboubi and Lincoln administered asked who should speak to the patients about sexual issues. The results showed that nurses (55%) and doctors (50%) were chosen most often, while occupational psychotherapists (14%) and psychotherapists (13%) were selected the least often. The reasons for not discussing sexuality with patients included lack of training (79%), lack of time (67%), and staff embarrassment (50%).

Ducharme & Gill (1990) attempted to determine why rehabilitation staff members could not address patients' sexual problems. The answers they received included anxiety about sexual topics, the myth of sex education increasing sexual inappropriateness, lack of empathy, denial, overprotection, or the belief that sex education is not relevant to the patient. The authors emphasized the rehabilitation staff members' lack of training in sex therapy.

One of the early studies on counselors' competence to address sexual issues with clients was conducted by McConnell (1976). This study was designed to investigate the claim that counselors need specific training in sex counseling to discuss sexual issues. Most of the research on training psychotherapists in sex counseling was performed on marriage and family therapy programs (Dermer & Bachenberg, 2015; Harris & Hays, 2008; Humphrey, 2000; Mutcher & Anderson, 2010; Timm, 2009; Zamboni & Zaid, 2017). This shows that research is limited and should be expanded. Other studies found that marriage and family psychotherapists (MFT) are provided with the broadest education in human sexuality.

Better training for MFT specialists is provided because of the requirements

needed for MFT students to obtain their master's degree and license. MFT education includes individual, group, couple, sex, family, and divorce therapy. As described by the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Psychotherapists (2018), marriage and family therapy involve an applied understanding of the dynamics of marital and family therapy systems, including individual psychodynamics, use of assessment instruments that evaluate marital and family functioning, designing and recommending a course of treatment, and use of psychotherapy and counseling. Expressing a common view, Harris & Hays (2008) indicated that most health professionals lack sufficient preparation to be considered competent to address sexual concerns. The authors believe that MFT's have an advantage over other licensed professionals due to their sex education and confidence in discussing clients' sexuality.

2.3. Discomfort with Talking about Clients' Sexuality

Other studies found that medical professionals and psychotherapists feel uncomfortable discussing sexual issues with their clients (Bloom et al., 2016; Harris & Hays, 2008; Timm, 2009; Weerakoon et al., 2008; Yallop & Fitzgerald, 1997). They showed that clients' need for counseling concerning sexual matters is not met in healthcare and counseling settings because professionals are not comfortable with situations involving sexuality (Bloom et al., 2016; Harris & Hays, 2008; Weerakoon et al., 2008; Yallop & Fitzgerald, 1997). Graham & Smith (1984: p. 439) defined sexual comfort as follows: "Sexual comfort is a broad, complex construct involving cognitive, affective, and behavioral responses to sexuality; as well as a developmental task influenced by the physiological, psychological, sociological, spiritual or religious, educational, and sexual aspects of one's being". These studies made it abundantly clear that although knowledge is an essential component for an effective sex educator, comfort with sexuality is also an important requirement.

Having established that psychotherapists experience discomfort when talking about clients' sexual issues, many researchers set out to analyze factors that can put psychotherapists at ease. Yallop & Fitzgerald (1997) designed a complex method relying on qualitative data and concluded that several factors contributed to psychotherapists' comfort with the issue of sexuality, including knowledge, experience, and attitude. A study conducted by Juergens et al. (2009) tested a model of factors predicted to influence the extent to which graduate students in rehabilitation counseling (RC) were willing to discuss sexuality with clients. They found that knowledge of and comfort with sexuality have a direct impact on willingness to discuss this topic, and that education in sexuality has an indirect impact on willingness to discuss sexuality through its direct effects on comfort with sexuality.

Harris & Hays (2008) focused on marriage and family psychotherapists. They assessed how their clinical training and education, perceived sexual know-

ledge, and comfort with sexual material influenced their willingness to discuss sexuality with their clients. The researchers complained that very little empirical data has been published to date on how psychotherapists can efficiently initiate sex-related discussions with clients. The study aimed to determine the extent to which formal sex education, perceived sex knowledge, and comfort with sexual topics influence family psychotherapists to hold discussions on sexuality with their clients. Harris and Hays found that sex education and supervision experience addressing sex issues are the best predictors of psychotherapists' comfort with talking about sexuality with their clients. The data suggested that as the participants' perception of their sexual knowledge increased, they felt more competent and confident to discuss sexual issues with their clients. The researchers indicated that the existing literature focused on physicians and sex educators. No analysis has been performed on psychotherapists' and mental health professionals' discomfort with talking about their clients' sexuality (Harris & Hays, 2008).

Harris and Hays examined psychotherapists' feelings of discomfort while talking about sexuality with their clients. Harris investigated how clinical training, knowledge of sexuality, and level of comfort toward sexuality affect psychotherapists' willingness to talk about sexuality with their clients. The research population in Harris' study (2008) consisted of clinical psychotherapists, where only 13 were sex psychotherapists. The findings showed that psychotherapists who acquired knowledge in the field of sexuality and were supervised in this field felt more comfortable when talking about their clients' sexuality. These findings support the hypothesis of the present study, that a supervision program about sexual issues will improve psychotherapist' attitudes toward their clients' sexuality.

Several years after Harris and Hays' study, Træen & Schaller (2013) analyzed psychologists' attitudes toward addressing sexual topics during therapy and clinical work. The authors sought to find the relationship between the frequency of discussing various aspects of sexuality with clients and the psychotherapists' social background, training in sexology, and beliefs and attitudes toward handling sexual issues in therapy. One of every five participating psychotherapists reported that they often ask their patients about sexuality. However, 64% did not have any formal training in sexology. Psychologists with substantial clinical experience ($\chi^2 = 53.106$, 15 df, $p < .001$), and those over the age of 56 ($\chi^2 = 49.134$, 15 df, $p < .01$) reported asking clients about sexual satisfaction. The researchers concluded that their study is just a starting point and further research should include other health professionals, not only psychologists.

2.4. Religiosity

Another factor influencing psychoanalysts' attitudes toward discussing clients' sexuality is their religiosity. For the purposes of the present research, religiosity indicates the person's level of religiousness (Bilgrave & Deluty, 2002). It is true

that the distinction between religiosity and spirituality is not always clearly defined. However, this paper distinguishes between these two concepts. Religiosity focuses on beliefs and practices specific to organized religion. The majority of organized religions have some taboos on sexual activities. Psychotherapists' level of religiosity may therefore be correlated with their attitude toward sexual issues of the client that are not supported by the psychotherapist's religion.

Earlier research aimed to show that psychologists and psychotherapists are not as non-religious as has been thought. Indeed, it has always been believed that psychotherapist were less religious than the general public (Worthington, Kurusu, McCullough, & Sandage, 1996). Neeleman & Persaud (1995) argued that religion was of minimal importance in the life of most psychologists and psychiatrists. It is easy to find examples of ardent critiques of religion and defenders of atheistic values among the ranks of prominent psychotherapists (e.g., Freud, 1927/1961; Ellis, 1980). However, several studies were subsequently conducted to show that religion plays an important role in the lives of many psychotherapists.

A famous study by Bergin & Jensen (1990) on the religiosity of psychotherapists found that a majority (54%) of the mental health professionals surveyed could be classified in religious terms. They felt that religion, spirituality, or both were important in their lives. These professional psychotherapists showed levels of religious attendance and lifestyle commitment similar to the lay public's profile: 41% of the psychotherapists attended services regularly, compared with 40% of the lay public; 77% of the psychotherapists "try hard to live according to religious beliefs," compared with 84% of the general public. There was some difference in the religiosity of the mental health professionals according to their training: 50% of the marriage and family psychotherapists and 44% of the clinical social workers reported that they attended religious services regularly, but only 32% of psychiatrists and 33% of clinical psychologists reported that they did so. Bergin and Jensen's findings are in agreement with an earlier study by Regan, Malony, & Beit-Hallahmi (1980). Both studies concluded that there may be extensive covert religiosity among psychotherapists.

Smith & Orlinsky (2004) studied psychotherapists' religious backgrounds. The surveyed psychotherapists were from America and New Zealand. Smith and Orlinsky found that 94% of the surveyed psychotherapists were raised in a particular religious tradition, with the predominant group being Protestant (45%), followed by Roman Catholics (20%) and Jews (21%), although the representation of the latter group varied substantially by country. The data showed that 56% of the psychotherapists overall and 65% in the United States were affiliated with a specific religious denomination. The last figure, for a group consisting mostly of highly experienced psychologists primarily in independent practice, closely approximates the 68% membership in a church or synagogue for the United States population. The predominant religious background of this group is Christian. Even greater proportions of the Canadian and New Zealand psychotherapists

had a similar background, but were more often unaffiliated.

Walker, Gorsuch, & Tan (2004) investigated psychotherapist' integration of religion and spirituality into their psychotherapeutic practice. Of the 3813 participants, the majority identified themselves as Protestant (34.51%), Jewish (19.61%), or Catholic (13.89%). Of the studies included that examined psychotherapist' use of prayer in their psychotherapeutic practice, the majority (66.6%) reported using prayer in psychotherapy and 44% reported incorporating scripture in their psychotherapeutic practice.

Other researchers analyzed religiosity and psychoanalysis from a different angle. Walker, Gorsuch, & Tan (2004) examined research conducted by psychotherapists on the use of their religious experience. Coltart (1992: p. 244) wrote about psychoanalytical therapy among religious Christians. Spero (1996), Case (1997), and Sieve (1999) analyzed countertransference with religious participants. Marx & Spray (1972), Weisbord (1982), Houts & Graham (1986), and Giglio (1993) studied the effect of differences in religious perceptions between psychotherapists and clients. Erlanger (1988), Cohen (1994), Greenberg & Witztum (2001), Irvine (2003), and Novis Deutsch (2010) investigated how religious psychotherapists handle the conflict of values between the religious and professional worlds.

In studying the psychotherapist's religiosity, the present research goes further than the earlier researches on this subject. It joins the latter group of researchers because it goes beyond asserting that psychotherapists may be religious, and analyzes how a psychotherapist's religiosity can be reconciled with the professional world. That is, it investigated how psychotherapists' religiosity prevents them from discussing sexual issues with their clients. The findings of earlier research on a connection between religiosity and negative beliefs about people are useful here. Beavers (2006) found that higher levels of religiosity were related to increased levels of sexual prejudice. Ford & Hendrick (2003) emphasized the importance of understanding how psychotherapists' religiosity may influence their reactions to sexual issues voiced by clients. In both studies it was found that higher identification with the Christian faith may be related to stronger negative attitudes toward LGB individuals. Ford & Hendrick's (2003) study appears to be the only one to date to look specifically at how psychotherapists' religious values may influence their attitudes toward clients engaging in sexual activities.

Psychotherapists' religiosity also affects their self-efficacy. As explained in the next section, self-efficacy is developed through experience, feedback, self-evaluation, and the absence of anxiety.

2.5. Supervision

2.5.1. Types of Supervision

A brief description of existing types of supervision will be presented before exploring the benefits of the appreciative method in supervision. The researcher's preference for group supervision will also be explained. To date, there are three common types of supervision:

1) Individual supervision.
2) Triadic supervision.
3) Group supervision.

Individual supervision: As its name suggests, individual supervision presupposes social worker's one-on-one consultations with their supervisor. This is often the preferred type of supervision among social workers, since the supervisors gives their individual, undivided attention to the supervisee (Itzhaki & Hertzboyletti, 1998; Yedidiya, 2003). Individual sessions center entirely on the social worker's problems and needs. They grant some freedom to the supervisee. Since there are no other people vying for the supervisor's attention, the supervised person does not feel guilty about talking about himself or herself and about concentrating entirely on his or her problems (Borders et al., 2012). When social workers are supervised in larger groups, they need to give time and space to their colleagues to discuss their issues. During individual supervision, one can be in the spotlight and not worry about monopolizing the conversation. Individual sessions are easier for the supervisor as well, albeit for a different reason. When talking to the social worker face-to-face, the supervisor is able to give individualized feedback and rivet his or her undivided attention on his or her issues. Individual supervision also gives more space to the supervisee (Borders et al., 2012).

Triadic supervision: Triadic supervision includes three people. As a rule, one supervisor instructs two social workers during a shared session. The advantages of triadic over group supervision is clear: supervisees usually emphasize that they get more time to talk about their personal issues and receive more individual feedback from the supervisor compared to group sessions (Borders et al., 2012).

Group supervision: Group supervision includes more than three supervisees and the supervisor. The experiment conducted for the present study was designed for group supervision and included 12 - 15 social workers. The earlier research emphasized the advantages of group supervision over individual supervision. Supervisees' sense of self-value is protected better in a group than in one-on-one sessions. Group sessions allow for multiple perspectives (Goldberg, 2016; Wadley & Siegal, 2018): social workers receive feedback not only from their supervisor or one peer, as in triadic supervision, but from many peers simultaneously, each of whom can have a unique, individual take on the situation under discussion. Supervisors usually note the beneficiary effect of multiple perspectives, because they encourage more comprehensive learning from the supervision model and diverse opinions (Dimino & Risler, 2012; Yalom, 2006; Yerushalmi & Kron, 2000). In cases where social workers have different theoretical training, a group discussion gains more depth and enhances their case conceptualization (Borders et al., 2012). Group sessions become deeper when they promote exposure to different counseling styles. Instead of discussing a few clients and their problems, as social workers do during individual and triadic sessions, in group supervision they learn about ten or even fifty clients with their different problems and expand their counseling experience. There are other advantages to

group supervision. Yalom (2006) noted that it is easier for supervisors to reduce anxiety supervisees might experience during consultations in group sessions than in face-to-face meetings. Successful group supervision depends on the supervisor's ability to set achievable goals, create a productive atmosphere during meetings, regulate the group's progress and self-exposure, and bring sessions to conclusion in an adapted procedural manner (Yalom, 2006).

Although earlier researchers claimed that group supervision has clear advantages over individual and triadic sessions, it is not without disadvantages (Yalom, 2006; Yerushalmi & Kron, 2000). Disadvantages of group supervision include factors such as problematic group dynamics, group size, and limited information about clients whom social workers discuss during sessions. These disadvantages result in limited helpful feedback from the supervisor (Borders et al., 2012). When the supervisor needs to express his or her opinion about so many people's work, feedback becomes sketchier and less personal. The focus often shifts from the supervisee to the client, which makes the supervisor's feedback less helpful to the social worker in need of professional advice. The main complaint voiced by social workers attending group supervision sessions is that the supervisor's feedback in group sessions is shallower than in individual and triadic meetings. There are many people expressing their opinions in group sessions, and some supervisees feel intimidated and outshined by more talkative peers. When a discussion feels intimidating, some people in the group prefer not to divulge much and mostly listen to others. Time is also an issue. During one-on-one and triadic meetings time is divided between one or two supervisees, which leaves to them plenty of space for self-expression. In group sessions, many people need to speak and they have only a few minutes in which to present their case and talk about their problems. Supervisees' presentations during group sessions therefore inevitably become cursory and uninformative. Social workers' knowledge of each others' problems and clients therefore tends to be superficial. Supervisors usually experience problems with coordinating supervisees' responses during group sessions. They say that either the people refuse to give each other feedback, or several people dominate discourse, forcing others to shut down. When social workers are mismatched and have different proficiency levels, navigating through sessions becomes all the more challenging for the supervisor.

2.5.2. Supervision Program for Psychotherapists

The program explored in the present study was designed for psychotherapists. It aims to legitimize the right of clients and therapists to receive help and support regarding their difficulties that can be explained by means of social constructionism. Peoples' standards of functioning are shaped by the values and social expectations of the society in which they live. According to this approach, when a therapist deals with a problem or difficulty, e.g. clients' sexual dysfunction, or when a therapist seeks supervision following difficulties in sex therapy, the perception is that both have a problem. They feel conflicted about the values their

society dictates (Berger & Luckmann, 1991). Enhancement of this approach will be facilitated through the perception, according to which clients' sexual difficulties are caused by the norms of the social environment in which they find themselves. This assumption may reduce anxieties and calm the clients' concerns regarding sexual difficulties they raise in the clinic.

The intervention program aimed to provide therapists with information and skills, giving them time to undergo personal and interpersonal processes. The objective was to enhance their sense of self-efficacy as psychotherapists and improve their attitudes toward their clients' sexuality. Most supervision programs are designed for one to four participants and last a year or more. In the present study, the supervision program was short-term, designed for 10 to 15 participants and was conducted in five sessions of four hours each. This supervision program is unique. There is no similar training supervision program for psychotherapists in Israel.

2.6. Self-Efficacy

Existing literature has shown that psychotherapists' comfort in discussing sexual issues with clients increases when they acquire more knowledge, education, skills, and experience (Harris & Hays, 2008; Juergens et al., 2009; Yallop & Fitzgerald, 1997). These studies concluded that an increase in knowledge through training may improve counselor-in-training's self-efficacy to engage in discussions with clients about sexual issues (Diambra et al., 2016). The most widely used instrument for assessing counselors' self-efficacy is the Counseling Self Estimate Inventory (COSE, Larson et al., 1992). Kozina et al. (2010) examined changes in counselors' self-efficacy beliefs during training of first-year psychology students using the COSE. MANOVA revealed an overall significant difference between the 5 factors [$F(5, 15) = 4.66$, $p < .01$]. A follow-up univariate analysis showed a significant increase in micro-skills [$F(1, 19) = 8.59$, $p < .01$, $\eta^2 = .31$]. These results support previous research (Larson et al., 1992) that training is associated with an increase in one's counseling self-efficacy and suggest that increased counselor self-efficacy can occur after a short period of training.

The same year, Mutcher & Anderson (2010) created and tested the Psychotherapist Personal Agency during MFT training model. The goal of this study was to examine the relationship between personal agency and a psychotherapist's behavior. Bandura's (1986) Social Cognitive Theory was also used in the study. Three hypotheses were tested. MFT students from the United States and Canada were recruited and 125 completed sufficient data for inclusion. The COSE was one of the instruments used to measure the psychotherapists' self-reported efficacy. A latent variable model was created for the analysis. A variance inflation factor (VIF) analysis was performed to address concerns of multicollinearity. Mutcher & Anderson (2010) concluded that this study supported existing research on psychotherapists' development. They found that less fusion in one's family of origin was significantly correlated with psychotherapists' self-

efficacy and reported ability to establish a working alliance with clients. The researchers concluded that one's development as a psychotherapist is holistic and requires attention to multiple facets of a trainee's life, including the supervision relationship and relationships outside the training environment.

Miller & Byers (2012) took up the challenge and focused on mental health professionals. They studied how sex education and training affect psychotherapists' sexual intervention self-efficacy. Miller and Byers analyzed their willingness to address sexual issues with clients. Measures used included sexual intervention education and training questionnaire (Miller & Byers, 2008), post-internship sexual intervention educational training questionnaire (created for the study), verbal permission questionnaire, sexual conservatism scale, sexual communication comfort scale, sexual intervention self-efficacy questionnaire (Miller & Byers, 2008), and willingness to treat sexual issues questionnaire (Miller & Byers, 2008). ANOVA, mean, and Tukey's HSD test were used to analyze the data.

Miller & Byers (2012) found that clinicians with more sex education acquired in college and with more training engage in more continuous sex education and training post-internship. They found that graduate-level and post-internship training result in higher self-efficacy beliefs. The results of this study support sex education, training, and sexual intervention self-efficacy as key factors in the extent to which psychologists address sexual issues with their clients.

3. Research Method

The rationale of the supervision program is a new conceptual model for the integration of group supervision processes of sex therapy (Wadley & Siegel, 2018). The supervision program aimed to improve psychotherapists' attitudes toward the sexuality of their clients, and their self-efficacy as psychotherapists, by giving them a toolbox based on learning by observing, modeling, practicing, and integrating a range of sex therapy practices within reflective group processes. It was based on three elements: core knowledge, learning skills and reflective processes. The program was designed for psychotherapists and included 10 three-hour sessions.

The program is based on a program presented by Harvey-Brown in a recently-published book titled *The Art of Sex Therapy Supervision* (Wadley & Siegel, 2018). The major difference between the program proposed by Harvey-Brown and the program explored in the present study is the duration of the intervention. Harvey-Brown studied supervision groups that lasted one or two years. In the present study, the program was short-term and lasted five months. It is structured and didactic, dictating topics to be discussed in every session, in order to prevent avoidance of topics with which therapists refrain from coping.

Published literature has presented findings on psychotherapists' attitudes toward sexuality. However, only limited research has focused on the attitudes of psychotherapists toward their patients' sexuality and the effect of personal attitudes on therapy discourse. In this study, the participants were psychotherapists

with two or three years of therapy education. The psychotherapists participated in a short-term Group Supervision Intervention Program aimed at improving psychotherapists' self-efficacy to discuss sexuality while providing therapy in the clinic.

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

Analysis of the findings included comparisons between two groups of participants, religious and non-religious, and a comparison of their responses to interviews. The comparison examined differences in the psychotherapists' attitudes toward sexuality and their sense of self-efficacy when dealing in therapy discourse about sexuality.

3.1. Research Instruments

Three instruments were designed in order to conduct the present research:

1) An open-ended questionnaire;

2) A semi-structured interview;

3) Comparative analysis between groups.

The open-ended questions were designed to investigate the participants' feelings and perceptions about sex therapy, their clients' sexuality, and expectations from the intervention program before attending the program. The participants filled out the open-ended questionnaire through an email link.

A semi-structured interview aiming to analyze the participants' attitudes toward sex therapy, their clients' sexuality, and feedback about the intervention program during and after the intervention consisted of fixed but open-ended questions so that the participants could answer freely and openly. The interview was administered by three Ph.D. experts in the field of sex therapy (two from Israel and one from the United States). A frontal interview was conducted at a convenient location chosen by the participant, and the interview at the end was conducted via Zoom. Before the interview, the participants were informed that it would be recorded, translated by a professional, and parts of the interview would be used for research. Only after the participant agreed did the interview begin.

Group comparisons between two of more research groups were performed on one or more dependent variables. Comparison between the groups was based on

the participants' demographic characteristics, in particular their religiosity. A comparison was made between the two groups regarding their sense of self-efficacy as sex therapists and their attitudes toward sex therapy.

3.2. Data Analysis

It was decided that the participant-focused methodology would be the most suitable approach for the present study. The participants' opinions, experience, and feedback on the program comprise an important part of the research data. The supervision program was upgraded based on this feedback.

Qualitative data were collected from the open-ended questionnaire and the semi-structured interviews and a comparison between the religious and the non-religious group. Data analysis included testing the validity, reliability, and triangulation of the qualitative research. Validity was assessed using open-ended questions, semi-structured interviews and a comparison between the religious and non-religious groups. Validity was also measured as the validity of a structure in which there is an examination of the degree of correspondence between the distinguishing concepts chosen in the construction of the research tool and the concepts used in data collection. This study examined the effects of self-efficacy and attitudes toward sexuality through an open-ended questionnaire and semi-structured interviews and a comparison between groups.

The study was unique from several aspects. Its reliability was difficult to assess, considering that a reliability of a study is tested by asking whether it can be repeated in other contexts. The present study, based on qualitative research, examined a unique phenomenon. An exact repetition of the research is not possible due to the researcher's individuality and personal characteristics and the unique interaction with the participants. The reliability of the research could not be assessed in the sense of its replicability.

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

3.3. Sex Therapy Group Supervision Intervention Program

The program was 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.

Rationale: The program was based on a new conceptual model for the integration of psychotherapy and group supervision. The model integrates client sexuality and reflective group processes within psychotherapy supervision (Wadley & Siegel, 2018).

Design: The program was designed as a short-term group supervision for psychotherapists and was evaluated in 10 sessions of 3 hours each.

Added-value: The supervision program can be adapted to a variety of therapy domains, and can be part of therapists' education process.

Aims: The aims of the intervention program are to improve psychotherapists' attitudes toward the sexuality of their clients by giving them knowledge, skills and processing based on learning by observing, modeling, practicing, and integrating a range of sex therapy practices within reflective group processes (Heinrich, 2010; Kadushin & Harkness, 2014; Winnicott, 2009, 2018; Yerushalmi & Kron, 2000; Yerushalmi, 2008); to improve participants' self-efficacy as sex therapists by interacting with the supervisor and team members and learning from the supervisor as a role model for dealing with sexual issues in the clinic (Bandura, 1982; Kadushin & Harkness, 2014; Yalom, 2006; Yerushalmi & Kron, 2000; Yerushalmi, 2008) and by understanding that although they are not sex therapists, they can deal with sexual issues (Bandura, 1982, 1997; Erikson, 1968; Locks & Latham, 1990; Mor et al., 2016).

The intervention program consisted of 10 sessions, held every other week, and lasted about five months. Due to the COVID-19 pandemic, about half of the meetings were held in person and about half online. Changing to an online intervention program changed the nature of the sessions and affected the groups in different ways. Six groups met in five different locations. The participants were divided into four heterogeneous groups composed of therapists who were not familiar with each other and went to the location chosen by the researcher. In two homogeneous groups, the therapy center manager brought the group supervision program, so the supervisor came to them, and group participation was forced on them. Five of the sessions were held face-to-face, and the rest were online. Ultimately, all groups participated in a frontal meeting under COVID-19 conditions, which meant being outside, keeping their distance and wearing masks. At this meeting, certificates were handed out and feedback was given.

4. Findings

The aim of this study was to examine how participation in a sex therapy supervision program affects therapists' attitudes and self-efficacy. Results of the content analysis of the semi-structured interviews collected at the end of the supervision program and comparison between three stages of the research (before, during and post intervention) yielded the following categories, as shown in Table 1 and Table 2.

Table 1 presents the two categories that were found with reference to self-efficacy: acquiring knowledge about sex therapy and self-efficacy as psychotherapist.

Table 2 presents the five categories that were found with reference to attitudes toward sexuality: attitudes toward sex therapy, interaction with the supervisor,

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

Categories relating to self-efficacy	
Categories	**Evidence**
Acquiring knowledge about sex therapy	"*The program gives a lot of new information. I think it answered what I expected, the requirements.*"
Self-efficacy as psychotherapist	"*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.*"

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

Categories relating to attitudes toward sexuality	
Categories	**Evidence**
Attitudes toward sex therapy	"*…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…*"
Interaction with the supervisor	"*And I talk a lot about 'modeling', you really made this language accessible through modelling.*"
Attitudes toward sexuality	"*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…*"
Interaction with group members	"*The group members and group dynamics, are what made the program…*"
Attitudes toward clients' sexuality	"*…All the content that was related to mother violence…traumas, vulnerability, child violence, wow. It was hard for me.*"

attitudes toward sexuality, interaction with group members and attitudes toward clients' sexuality.

Table 3 presents the findings of this study. The integrative findings between the three stages: pre, during and post intervention program related to the attitude towards sexuality, five findings were found: 1) Interaction with group members provides opportunities to learn about the socio-therapist's attitude towards sexuality as well as their own. 2) To deal with the socio-therapist's attitudes towards the client's sexuality the participants testified that they would avoid dealing with problems that have deviation or violence. 3) sexuality is a taboo topic in society, which in turn poses a challenge for socio-therapists. To change the conservative attitudes about sexuality, one has to engage with an open mind. 4) Sex therapy is perceived as an area of discomfort and a sense of low self-efficacy that causes avoidance of exposure to content that is perceived as threatening. Participation in the intervention program allows for a change of attitudes and an increase in the sense of comfort in sex therapy. 5) The interaction with the supervisor as a role model is capable of guiding and addressing socially taboo issues in the clinic and reducing the socio-therapist's attitudes and embarrassment. The

Table 3. Findings relating to the research questions: Integrative findings between the different stages related to attitudes toward sexuality.

Findings	Evidence
Interaction with group members provides opportunities to learn about the sex therapist's attitude toward sexuality as well as their own.	"*I m not so happy with the group, I m quite disappointed. I feel they are not serious enough or take it seriously, maybe it originates from personal embarrassment.*" "*…over time, yes, something was released over time, because I think it has to do with the group, if everyone was uncomfortable at first then later people opened up like that, that's how it seems to me.*"
To deal with the sex therapist's attitudes toward the client's sexuality, the participants indicated that they would avoid dealing with problems that include deviation or violence.	"*…sexual abuse within the family, okay? Not on us, a father who rapes the girls…shocking and very difficult. These, these are the difficult contents for me: pedophilia, incest…*" "*I am unable to work on anything related to pedophiles in the pedophile section. Not something I am, not something I accept, not something I will deal with, as it goes against my faith…*"
Sexuality is a taboo topic in society, which in turn poses a challenge for sex therapists. To change the conservative attitudes about sexuality, one has to engage with an open mind.	"*…It's a subject as you saw that people shy away from. It won't help, you know, not everyone is free. When the manager is very non-sexual and even in the current relationship, sex is outside (the discourse) (there is) a taboo…so what is the need for this topic, why is it interesting, and who is asking it? Therefore, it isn't…*"
Sex therapy is perceived as an area of discomfort and a sense of low self-efficacy that causes avoidance of exposure to content perceived as threatening. Participation in the intervention program allows for a change in attitudes and an increase in the sense of comfort in sex therapy.	"*I think I'll freeze, I don't know what I'll do, I can't deal with this issue. This is my red line this thing. What do I do with it?*"
The interaction with the supervisor as a role model enables guiding and addressing socially taboo issues in the clinic and reducing the sex therapist's attitudes and reluctance to address the topic.	"*And I talk a lot about 'modeling', so for me, so you really brought the accessibility of this language to the modeling of this way, and meeting with you in this way opened up possibilities for discourse.*" "*Thanks to your very enabling atmosphere, I had a good time. As well as being relaxed, very open, very accepting, and very non-judgmental, you were very honest about yourself, what shrinks your stomach, what is less, what arouses you…so the expectation is not that, okay, now the pedophile will come and I can work with him.*"

interaction with the supervisor as a role model is capable of guiding and addressing socially taboo issues in the clinic and reducing the socio-therapist's attitudes and embarrassment.

Table 4 presents the findings of this study. Integrative findings emerging from the comparison between secular and religious participants related to self-efficacy. Religious beliefs see knowledge of sex therapy as conflicting with cultural values associated with modesty and a lack of knowledge of sex issues, which may result in an unwanted change experience. Religious beliefs see knowledge of sex therapy as conflicting with cultural values associated with modesty and a lack of knowledge of sex issues, which may result in an unwanted change experience. For religious the Information about sex therapy should be accessible and culturally

Table 4. Integrative findings emerging from the comparison between secular and religious participants with reference to self-efficacy.

Religious Therapists	Non-religious Therapists
Religious therapists view knowledge of sex therapy as conflicting with cultural values associated with modesty and a lack of knowledge of sex issues, which may result in an unwanted change experience.	**Non-religious therapists view knowledge about sex therapy as able to assist changing personal attitudes toward sexuality.**
Evidence: "*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?*"	**Evidence**: "*…but it was interesting, the material was clear, clear, structured…and I decided it could expand my education and contribute to me. So, I joined. I love to learn, love to enrich myself. That it is okay to talk, that it is okay to have things and that I will know a little more how to be attentive to them without panicking, without shutting down…so that's something that opened up in me.*"
For religious therapists, the information about sex therapy should be accessible and culturally sensitive.	**Non-religious therapists view knowledge as a means to raise a sense of comfort and self-efficacy among sex therapists.**
Evidence: "*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 and then it created and maybe had an impact on the group. I had a very hard time, I did not feel I could speak freely or ask freely…*"	**Evidence**: "*…it gives me confidence that I have more knowledge…*" "*…at the level of knowledge I received the knowledge, at the level of accessibility I also received the accessibility to the subject. I got a big gift…*"
Both the religious and the non-religious groups perceived the opportunity for discourse in the sex therapy Supervision Intervention Program as a factor that increases their sense of self-efficacy as sex therapists.	
Evidence: "*…It gives me confidence that I have more knowledge, that I have approached this topic, that I have some body of knowledge, this booklet, that I can look at to get tools and that I know where to refer.*" "*… If in the past I would have said 'not appropriate at the intake meeting…' then it contributed to me. Although I was very, very embarrassed and very hesitant and insecure, but it…it gave a lot.*" "*I gained a lot on a personal level as well…and it really opened my mind and I think I won't be so scared today if there are things in the therapy room, I won't be scared, it's more friendly for me…I was very, very comfortable, my eyes were opened a little to the world, to things I don't know, don't know… Something opened a little to me.*"	

sensitive. secularists saw knowledge as a means to raise a sense of comfort and self-efficacy among socio-therapists. Both religious and secular groups perceive the opportunity for discourse in the sexuality supervision group program as a factor that increases their sense of self-efficacy as socio-therapists.

Table 5 presents the findings of this study. Integrative findings emerging from the comparison between secular and religious participants related to attitudes towards sexuality. Both religious and secular groups perceive interaction with group members as a source of safe and enabling encounters. The religious saw the encounter as an intercultural encounter. The secularists saw it as an interpersonal encounter. The religious dealt with intercultural conflict and differences in values. The secular viewed the interactions as a means of modeling. In both groups, the supervisor was perceived as a source of knowledge, acceptance, and the ability to create an atmosphere that would lead to a change in perceptions and attitudes.

Table 5. Integrative findings emerging from the comparison between religious and non-religious participants with reference to attitudes toward sexuality.

Religious Therapists	Non-religious Therapists
Both the religious and the non-religious groups perceived the interaction with group members as a source of safe and enabling encounters.	
"*Moreover, I really admired the girls who shared their places, aspects of sexuality, and how they connected and all. The girls in the group also enriched me with their knowledge, examples, and references. The girls, as I said before, were diverse, so I learned something from each of them. This is how a group's dynamics and development are created.*"	
The religious therapists viewed the encounter as an intercultural encounter.	**The non-religious therapists viewed it as an interpersonal encounter.**
"*No-one lashed out from his inner world of values that contradicts what the teammate just said. There was listening, there was mutual completion. The team was very high quality. People tried to, you know, respect each other's opinion. The fact that we were not all in the same field, in the same profession, also contributed a lot and helped a lot… About how religious people look at sex and sexuality. How do non-religious people see sex and sexuality? So this diversity was very important, religious-non-religious.*"	
"*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 does 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).*"	"*…Later on, I think the most important thing I got was the ability to talk about sex and sexuality more openly. First of all with myself, between myself, and also with other people and with patients. which, I must say, was quite new to me.*"
The religious therapists dealt with intercultural conflict and differences in values.	**The non-religious therapists viewed the interactions as a means of modeling.**
"*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…*"	"*I had a really good time with the very enabling atmosphere you created. And I think also in the kind of…something very relaxed, very open, very accepting, very non-judgmental. And with the fact that you were very honest about yourself, what shrinks your stomach, what is less, what it arouses…like…the expectation is not that, okay, now the paedophile will come and I'll have fun working with him.*"
In both groups, the supervisor was perceived as a source of knowledge and acceptance, with the ability to create an atmosphere that would lead to a change in perceptions and attitudes.	
"*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.*"	

Table 6 presents the findings of this study. Integrative findings emerging from the comparison between secular and religious participants related to attitudes

Table 6. Integrative findings emerging from the comparison between religious and non-religious participants with reference to attitudes toward sexuality.

Religious Therapists	Non-religious Therapists
Sexuality is perceived by both groups as a discourse with a social taboo.	
"*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*?"	
Religious therapists expect that the program will be in line with their values and culture and that the focus will be on healthy sexuality.	**Non-religious therapists express the need to change attitudes to allow for more open dialogue in the clinic.**
"*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 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…*"	"*…I think the most important thing I got was the ability to talk about sex and sexuality more openly.*" "*This is someone who thus showed depression and very great difficulties in a relationship and I was not ashamed to go down already at the intake meeting.*"
Religious therapists discussed the conflict between their religious-cultural values that limit the discourse on sexuality and their role as sex therapists to clients in need.	**Non-religious therapists are caught in a conflict between their desire to protect themselves from threatening content and their role as sex therapists.**
"*My part was very lacking, the reference to the religious public. It is true that the structure of the human body is the same structure but I think the attitudes and values in which everyone grows up, even the physical environment. I do not have to tell you, it is very, very significant, it cannot be disconnected. When you come to study a particular field then also the population for which it is intended, it must be about the way, the theoretical knowledge you knew. But regarding the religious place it was very lacking, maybe one meeting to bring some kind of Torah figure that would bring her unique position. Even asking questions, what to do in cases, even what the law is. On the part of halakha (the collective body of Jewish religious laws), what is allowed, what are the boundaries of halakha in these areas.*"	"*I think I'm having a hard time and I wrote it down for you in all the questionnaires, something you know I cannot work with and I will not work with, it's all related. In pedophilia, in the section on pedophiles. Not something I am, something I have a hard time accepting and not something I will take care of. Both because I am not qualified, and also because it goes against my believing self. Nor do I want an issue where children are harmed.*"
Sex therapy was perceived by both groups as a variety of challenging sex issues, and participating in the program enabled them to bridge the gaps and gain personal clarity and choice.	
"*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 it 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.*"	

towards sexuality. Sexuality is perceived by both groups as a discourse with a social taboo. Religious expect that the program will be in line with their values and culture and that the focus will be on healthy sexuality. Secularists who the need to change attitudes to allow for more open dialogue in a clinic. Religious participants discuss the conflict between their religious-cultural values that limit the discourse on sexuality and their role as socio-therapists to client in need. Secularists are caught in a conflict between their desire to protect themselves from threatening content and their role as socio-therapists. Sex therapy is perceived by both groups as a variety of challenging sex issues, and participating in the program enabled them to bridge the gaps, as well as gain personal clarity and

choice.

5. Discussion

Dealing with sexuality poses a challenge for therapists because they must engage with open personal perceptions in order to change conservative beliefs about sexuality. There are conservative societies in Israel, and there is a taboo on dealing with sexuality in general, as well as in the clinic. Therapists find this topic challenging. The lack of reference to sexuality in therapist training programs is evidence of this. When sexuality is mentioned, the therapist will attend a general course that does not change attitudes. The need for open dialogue extends not only to changing therapists' professional attitudes toward sexuality, but also to changing their personal attitudes and perceptions of 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.

As a social taboo, sexuality is regarded by both groups as a subject that is not talked about. Religion and sociological sexuality theories can explain this finding, which suggests that the social taboo on sexual discourse stems from the influence of religious conservatism on the entire society, which challenges religious and non-religious therapists to deal with sexuality (Weber, 1984). According to Weber (1984), we must understand the general perception of reality in a culture in order to understand individual and group behavior, and religion plays an important role in influencing secular perceptions. According to Foucault (2016) and Mottier (2008), Christian conservatism is the origin for the conservative perception that sexual issues are taboo.

According to Kinsey et al. (1948), conservative society promotes ignorance. According to them, young people should be exposed to sex education in order to learn about the topic. This will reduce ignorance and reluctance to address this issue. In the 1950s, Masters and Johnson claimed that issues related to sexual function are caused by social stigmas associated with gender. It is therefore imperative to make changes on the social level, and provide appropriate sex therapy adapted to the individual's needs. According to Kinsey and Masters, religious conservatism imposed on religious and non-religious societies explains differences in attitudes between religious and non-religious therapists. Rather than interpret conservatism, Derby et al. (2015) and Timm (2009) proposed exposing therapists to sex therapy so that attitudes may change. Therapists are more comfortable dealing with sexuality in the clinic if they have open personal perceptions, as indicated by the participants. In their opinion, this challenge should be resolved by changing personal conservative perceptions of sexuality to more liberal perceptions, as sexuality is under a social taboo. The interaction with group members regarding sexuality is therefore characterized by flooding of the individual's perceptions and a way to change conservative attitudes into more liberal ones.

The findings revealed a difference in attitude between religious and non-religious therapists regarding the supervisor's involvement, which can open up an intercultural dialogue that may conflict with the participants' values and language, as well as move between opposition and cooperation between the participants. Religious participants dealt with intercultural conflict and differences in values, whereas non-religious participants saw interactions as modeling. In therapy, therapists who voluntarily participate in a sex therapy supervision group will need to address these issues. Through participation in a program where the supervisor demonstrates knowledge and confidence in discussing sexual topics, the participants learn how to speak and deal with these issues. The interaction with the supervisor facilitates talking about sexual issues in a way that will be easier to deal with in the future. Experiencing this will change therapists' attitudes into more positive and enabling ones.

Regarding change in self-efficacy as psychotherapists, according to Bandura's (1982) learning theory, self-efficacy increases when the supervisor is viewed as a role model by the group members. The participants can identify with the supervisor: they are in the same profession, they are all therapists, and they appreciate the supervisor for reaching achievements that participants would like for themselves and has knowledge and expertise in the field from which they can benefit. According to the participants, the supervisor's good coping with sexual topics allowed participating therapists, who viewed her as an expert role model who could handle taboo sexual topics, to reduce their embarrassment (Bandura & Houston, 1961). As a result of their interaction with the supervisor, who was viewed as a role model in coping with social taboos, the therapists were able to mitigate their negative attitudes toward sex therapy. The interaction between members of the group and the supervisor about attitudes toward sexuality thus resulted in better coping with social taboos and decreased negative attitudes.

The findings revealed differences in attitudes between religious and non-religious therapists due to different perspectives regarding group interactions. These findings can be explained by the fact that participating in the supervision program allows therapists to interact with other therapists. This enables them to compare their attitudes toward sexuality with those of their group members. Interaction with members of the group and discourse about sexual topics force therapists to clarify their attitudes toward sexuality as therapists. Therapists can clarify their own attitudes toward sexuality through the personal clarification process. People who perceive themselves as liberal toward sexuality can discover that they are more conservative than they thought, and vice versa. There is a gap between personal perceptions of sexuality, which can be liberal or conservative, and attitudes toward sexuality in the clinic, which may be contrary to those perceptions.

This finding is consistent with supervision approaches that explain that participation 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 therapists to clarify their personal and professional attitudes toward sexuality.

The finding supports 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). According to Timm (2009), therapists avoid discussing sexuality in the clinic because they fear that their lack of knowledge and professionalism will harm the patient. According to Timm (2009), interacting with members of the group and gaining exposure to different, more open attitudes, will clarify therapists' professional and personal attitudes toward sexuality. As therapists in the clinic, they appeared to perceive their interaction with the group members as a source for understanding the gap between their personal attitudes toward sexuality and their clinical attitudes. Interactions with members of the group regarding attitudes toward sexuality are characterized by pinpointing the difference between personal attitudes and attitudes as a therapist.

Regarding perceptions of self-efficacy, both the religious and the non-religious groups believed that self-efficacy would increase if the feeling of security increased, overcoming embarrassment through peer learning, knowledge acquisition, and modeling that allowed the sexual issue to become accessible in the therapy room. These findings are in line with Bandura's (1977, 1982, 1986) theory of learning and with supervision theories which explain that participating in supervision programs that impart knowledge and skills, where members of the group and the supervisor interact to facilitate discussion on sexual topics, enables participants from both religious and non-religious groups to experience diverse perceptions and opinions.

Derby et al. (2015) and Timm (2009) noted that therapists who do not feel that they are experts in sexuality have difficulty discussing sexuality in the clinic. Participant's sense of self-efficacy to speak about sexuality in the clinic increases as a result of discourse on this issue. The acquisition of knowledge in the field of sexuality and discourse on sexuality enabled the therapists to perceive that the social interaction in the supervision program contributed to their sense of self-efficacy as therapists. The social interaction during the supervision program and the acquisition of knowledge in sexuality enhanced their sense of efficacy as therapists through discourse on sexuality.

The present research supports these findings. Religious psychotherapists who participated in the present research viewed the knowledge of sex therapy as conflicting with their cultural values and religious beliefs associated with modesty. They feared that by talking about clients' sexual concerns they would acquire undesirable life experiences. During the sessions with the supervisor, religious psychotherapists thus voiced the opinion that sex therapy should be culturally sensitive. During supervision sessions, they often discussed the conflict between their religious and cultural values and their roles as psychotherapists obliging

them to attend to the needs of their clients, even when voicing their sexual concerns. In contradistinction, non-religious psychotherapists participating in the research viewed training in sex therapy as a means to feel more comfortable when discussing clients' sexual problems. Non-religious participants also considered knowledge of sexuality conducive to self-efficacy.

The present research clarifies that religious affiliation relates to attitudes toward sexuality and sexual behaviors. It suggests that religiosity influences self-efficacy for working with clients presenting issues related to sexuality and sexual activities. As data obtained by the present research amply demonstrate, higher levels of psychotherapists' religiosity impact their self-efficacy by decreasing the likelihood of engagement in experiences with clients who report participation in sexual activities that conflict with psychotherapists' religious beliefs. Psychotherapists' religious values that conflict with clients' sexual activities also increase the likelihood of psychotherapists experiencing anxiety about addressing clients' sexual behaviors. This anxiety hinders the development of the psychotherapist's self-efficacy. Participating in group discussions under the supervisor's supervision may alleviate this anxiety and improve self-efficacy. In the present research it was found that both religious and non-religious groups perceive the opportunity to participate in the supervision group program as a factor that increases their sense of self-efficacy as psychotherapists.

The present research found that participants who are religious experience greater difficulty in talking about sexuality with their clients. Because organized religion (Judaism) places constraints on what is considered to be acceptable and unacceptable sexual behaviors, psychotherapists participating in the present research were more cognizant of how their own religious beliefs may affect their work with clients. They proved to be more cautious when incorporating religious values into treatment with clients presenting issues related to sexuality and sexual activities. Overall, they felt more anxious than non-religious peers who participated in the present research when discussing sexuality with their clients. It is only by discussing their anxiety with the supervisor that religious psychotherapists could decrease their embarrassment, thereby emphasizing the importance of group supervision for psychotherapists' improved sense of self-efficacy.

6. Conclusion

According to the research question regarding self-efficacy, social interaction within the supervision program is perceived as developing knowledge and skills in the field of sexuality. Interaction in the supervision program and knowledge acquisition in the field of sexuality allow therapists to discuss sexuality and increase their sense of self-efficacy. The supervisor as a role model and interactions with peers facilitate discourse on sexuality and increase participants' sense of self-efficacy as therapists. Furthermore, the religious therapists perceived the supervision program as an intercultural encounter, and adapting the program to their religious values would enhance their sense of self-efficacy. As a result, the

social interaction within the supervision program and the acquisition of sexuality knowledge are characterized by diversity and require cultural adaptation on the part of the religious therapists, whereas non-religious therapists perceived it as an opportunity to improve their sense of self-efficacy and comfort.

The findings of the present research are in line with the findings of Miller & Byers (2012). However, the present study stresses the supervisor's presence during group discussions. It was found that the interaction with the supervisor as a role model helps psychotherapists address socially taboo issues in the clinic and reduces their embarrassment. The current research shows that the supervisor was perceived as a source of knowledge, acceptance, able to create an atmosphere that would lead to a change in perception of and attitude toward sexuality.

Recommendations

- A supervision program model should take the social values of the group members into account. The supervision program should be adapted to the participants by forming culturally homogeneous groups. The group should be allowed to discuss the gaps and differences within the group if it has heterogeneous social values, and each culture should have a place in it as an enriching and enabling discourse. This can be a parallel process that can be used in the clinic with clients whose cultural background differs from the therapist's.
- This study examined the therapist's contribution to changing attitudes and enhancing self-efficacy in the supervision group. Participation in a short-term supervision program focused on the contents of sex therapy allows therapists to clarify their gaps and conflicts, their personal values, and how they perceive their role as therapists who help their clients. A supervisor in a sex therapy supervision group must be aware of the gaps and conflicts in a client and provide room for group discussion, so that the therapists can bridge the gaps and make choices that will benefit the therapists and will increase their sense of self-efficacy as therapists. Another implication is that supervision programs must be constructed with reference to cultural differences between the participants and between the participants and the supervisor. Adaptations must be made so that the therapists feel congruence between their values and the content and discourse of the program. For example, if the group of therapists is religious, a religious supervisor should be preferred, and emphasis should be on healthy sexuality.
- The present study indicates that therapists avoid discussing their clients' sexuality in clinics. Sex therapy supervision groups and courses in the field of sex are therefore recommended for them. In addition, when the therapists clarified their attitudes, they discovered a mismatch between their professional and personal perceptions, as well as a need to avoid sexual issues in order to protect themselves and their values, as was evident in the present study. Rather than ignoring the topic, therapists should clarify their personal

and professional attitudes toward sexuality in the clinic and, if necessary, refer clients to specialists in this field.

- Despite completing their specializations in therapy, therapists report a low sense of self-efficacy and negative attitudes toward their clients' sexuality. It is recommended that therapists participate in sex therapy supervision groups as part of their training and certification.

Conflicts of Interest

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

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