Sexology as a challenge to the health care system: The Norwegian version.

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Introduction

Sexology as a profession developed in Europe at the end of the 19th century, with emphasis in Berlin, Prague and Copenhagen. The field was greatly impaired under the Nazi regime in Germany. On May 6th 1933, Magnus Hirschfeld's Institute for Sexology in Berlin was closed and the library was burnt (1). The sexological profession has gradually recovered, and today it represents a strong, versatile and vigorous milieu (2,3,4). Sexology includes different scientific disciplines. They include medical, non-medical and therapeutic practices based on medical, psychotherapeutic and pedagogical traditions (1).
Sexology is a field existing of knowledge and discourses that have been examined in many historical and sociological works (5,6,7,8). Until recently, however, no systematic surveys had been carried out in any country with the aim to describe and examine who the sexologists are. The only existing data have been the archives of the sexological organisations.

In 1998-1999 Alain Giami and Patrick de Colomby organised a national survey of French sexologists (9) based on persons who were members of professional sexological organisations and the yellow pages in France. The survey included socio-demographic characteristics of the sexologists, their therapeutic methods and how they were practicing sexology. After the French survey was accomplished, the questionnaire was translated and used for equivalent surveys in Denmark, Finland, Great Britain, Italy, Norway, and Sweden. Preliminary results have been presented at the meeting of the International Academy of Sex Research in Hamburg, 2002 (10), at the 16th World Congress of Sexology in Havana in 2003 (11) and at the 7th Congress of the European Federation of Sexology in Brighton in 2004 (12).

This paper will present data from the Norwegian survey witch was carried out in 2001 and 2002, at the same time as the first comprehensive educational program in Basic Sexology and Sexological Counselling started at the Agder University College.

The professional legitimacy of sexologists is an important topic. Unlike physicians, psychologists and other professions that have been defined through profession laws and government approvals, there is no official registration of who can call themselves sexologist, nor are sexologists included in the Norwegian Law for Health Professionals (13) that came into force in 2001. In order to assure the quality of practicing sexologists, the Nordic sexological associations, organised through the Nordic Association of Clinical Sexology

(NACS), with support from the Nordic Council of Ministers, have prepared Nordic guidelines for authorization of Specialists in Sexological Counselling (NACS) and Specialists in Clinical Sexology (NACS) (14). The first Nordic specialists in sexology were approved on May 3rd 2001. Educational programs that are supporting this authorization arrangement and that are built around the same curriculum exist in Denmark, Estonia, Finland, Norway and Sweden.

Sexology is a field in rapid progress, but is struggling with insecure financing and in getting permanent connection to Universities and governmental treatment facilities in many countries. Sexological researchers and clinicians have not always been taken seriously, and their motives have been under suspicion (7). A survey on persons that have distinguished themselves within different sexological relevant research in Norway shows that many projects are completed, but they are often not published, due to lack of grants for the actual writing and editing of the paper (15).

The Norwegian Society for Clinical Sexology (NSCS) was founded in 1982. The society has had a membership base of about 100 for most of the period, new members are arriving and old ones have withdrawn. During the last years, however, the number of members has increased and is now around 130. There are evident signs of professionals actively working with sexological problems. It is therefore important to look further into some questions:

- Do professional sexologists look at themselves as belonging to an independent sexological profession, or do they identify with their basic professions?
- What are these professions?
- What sort of education does the people who are calling themselves sexologists in Norway have?
- What sort of problems are they treating?
- What sort of treatment are they offering?
- Does sexologists act as a cooperative interdisciplinary group?
- What opinions do they have in relation to specific sexological problems?

Method

The Norwegian sample is selected by the same criteria as in the surveys of the other participating countries. Before the questionnaire was translated and the survey was put into effect, meetings were held between the people responsible for the survey in the different countries where the selection of method and the content of the questionnaire were examined. The questionnaire consists of eight different sections: 1. Initial professional training; 2. Training in sexology or in the field of sexuality; 3. Professional practice; 4. Clinical practice in sexology or in the field of sexuality; 5. Relationship with the clients; 6. Opinions about sexology and sexuality; 7. Other activities in the field of sexology; and 8. Sociodemografic information. The questionnaire consisted of 89 questions.
The Norwegian questionnaire was sent to the members of the Norwegian Society of Clinical Sexology; to members of the Resource- and Reference Group of Sexual Dysfunctions (consists primarily of urologists, but also of gynaecologists, physicians, psychologists and psychiatrists); and to students of the sexology program at the Agder University College.
The anonymous questionnaire and a separate nominative reply-letter were mailed to all the potential respondents. The reply-letter asked whether the person had replied or not, and the possible reasons for not replying. The reply-letter was to be returned in a separate envelope in order for the questionnaire to remain anonymous. One reminder was sent. In the Norwegian

survey SPSS-11 was used for the data analysis. Comparison of the data has only been done by concurrent presentations of the results. The data will be gathered in a mutual database in Paris.

Results

The Norwegian sample

139 questionnaires were sent out: 107 to members of the Norwegian Society of Clinical sexology, 20 to members of the Resource- and Reference Group of Sexual Dysfunctions and 31 to the students of the sexology program at University College of Agder. After having been reminded once, 104 (75%) persons responded, 11 of them claimed that they didn´t have a sexological practice and for that reason could not participate in the survey. 93 questionnaires (67%) were object for further analysis.

Socio-demographic distribution

Table 1: Educational background

Educational level	Frequency
3 years in college/university	10
3 years in college/university with supplementary training	22
Higher university degree	25
Medical speciality	28
Ph.D	7
Other	1
Total	93

Professional education

Table 2: Distribution of respondents by gender and profession

	Men	Women	Total
Total physicians	**23**	**6**	**29**
GP's	5	1	6
Psychiatrists	2	0	2
Gynaecologists	1	5	6
Urologists	10	0	10
Other	3	0	3
Not specialists	2	0	2
Total non-physicians	**24**	**40**	**64**
Psychologists	15	11	26
Nurses	2	5	7
Midwifes	0	2	2

Family therapists	1	2	3
Social workers	1	3	4
Teachers	0	1	1
Social educators	1	4	5
Physiotherapists	0	4	4
Other	4	8	12
Total	**47**	**46**	**93**

Physicians and psychologists represent the largest group of professionals, 31,2% of the respondents were physicians and 28% were psychologists. Because the sample also consists of members of the Resource- and Reference Group of Sexual Dysfunctions that originated from a group that attended a congress for treatment of erectile dysfunction, it is not unreasonable that urologists represent a big part of the sample in the survey. It is also an international tendency that urologists are taking greater part in the field of sexology after the emergence of the PDE-5 inhibitors. The Resource- and Reference Group of Sexual Dysfunctions has also recruited some gynaecologists who are represented in this sample. If different methods for selection had been used, we would probably find that more gynaecologists are treating sexological problems.
In the French survey, physicians counted for 63 % of the respondents, 32% were GP's, 12% were psychiatrists, 9% were gynaecologists, 2% were urologists and 8% other medical specialists. The French survey, however, was carried out at a time when the PDE-5 inhibitors didn't have the marked position it has now. Psychologists only counted for 7% in the French sample. The French survey differs from the other surveys by the large proportion of physicians. This reflects a particular situation in France, where there is developed a particular sexological education and approval for physicians. The Norwegian sample is equivalent to the samples from the other European countries with regards to the distribution of professions.
The distribution of gender in the Norwegian sample is satisfying if one considers the value of both female and male therapists working with sexological problems, 50,5% of the respondents were men and 49,5 % were women.

Training in sexology

Table 3: Sexological training

	Physicians	Non-Physicians	Men	Women	Total
At least one Sexological training	13	30	18	25	43

43% of the respondents stated that they had attended at least one educational program where the title distinctly referred to sexology or sexuality. This is the lowest educational level in the countries studied. It is not surprising, however, considering that there existed no sexological education in Norway when the survey was done, except from incidental seminars or seminars abroad. Because of this it is interesting that so many of the respondents claim that they actually have sexological training.

Personal experience with Psychotherapy and Supervision

8% of the respondents reported that they had undergone personal psychoanalysis, 39% had undergone psychotherapy. 71% had undergone individual supervision, and 49% had undergone group supervision.
What other approaches had the respondents received specific training in?
The ten most frequent alternatives reported was: Psychotherapy: 24%, Cognitive- Behavioural therapy: 22%, Couple therapy: 16%, Research: 12%, Relaxation; 12%, Systemic therapy: 12%, Group therapy: 11%, Computer technology: 11%, Hypnosis: 10%, and Gestalt therapy: 10%.

Sexological practice

93,2% of the respondents reported that they are in some sort of clinical practice. 81,4% reported that they were giving lectures and supervision. 47,6% were doing research. 53,3% were active in work directed towards the general public, for instance sex education. 60,7% reported that they also were devoted to other sexological activities in their professional practice.

For most of the respondents sexological activity represented a small part of their clinical work:

Table 4: Sexological clients and total clients per week

Clients per week	Sexological clients	Total clients
<5	66,1	11,3
5-10	21,0	17,7
11-20	4,8	24,2
21-50	6,5	25,8
51-70	1,6	8,1
>70		12,9

Table 5: Proportion of sexological activity by gender and profession

	Physicians	Non-Physicians	Men	Women	Total
<10%	17	23	21	19	40
10-25%	9	22	13	18	31
25-50%	1	3	3	1	4
50-75%	0	4	3	1	4
75-100%	1	4	3	2	5
Unknown	1	6	4	2	6

71% report that sexological activity counts for less than 25% of their clinical work. Gender differences are minor. Only 3% report that they work with sexology full time, all of these are women and none are physicians.

Table 6: Duration of sexological consultations by profession and gender:

Duration of consultation	Physicians	Non-Physicians	Men	Women	Total
<15 min					
15-30 min	10	1	9	2	11
30-45 min	6	6	7	5	12
45-60 min	6	21	17	10	27
>60 min		11	2	9	11
Unknown	7	25	12	20	32

Non-physicians spent more time on sexological consultations and had more often consultations for longer than one hour than physicians. It seems that women have a tendency to have longer consultations than the male respondents in this survey.

Table 7: Number of consultations by profession and gender:

Number of consult-ations	Physicians	Non-Physicians	Men	Women	Total
1	2	0	2	0	2
2-4	12	6	13	5	18
5-10	6	16	10	12	22
11-20	2	10	6	6	12
>20		6	3	3	6
Unknown	7	26	13	20	33

The most frequent number of consultations is between 2 and 20. Non-physicians and women have more consultations than physicians and men.

Professional identity

26% of the respondents consider themselves sexological counsellors. 10% consider themselves sex therapists. 8% consider themselves sexologists. 4% considered themselves both sexologists and sex therapists. 23% of the respondents wouldn't use any sexological title. 28% considered themselves as "Other", and 2% of the respondents did not answer the question.
Less than half of the respondents identified themselves as belonging to a sexological profession. Contrary to this, 70% of the respondents in the French survey considered themselves primarily as a sexologist or sex therapist.

Presented problems

What sort of problems does the clients present? The respondents were asked the following question: "For which sexual problems do your male/female clients seek help?"

The 10 most frequent reasons for seeking consultations, reported by male and female clients seeking sexological treatment:

Table 8: Presented sexological problems

Problem	Male clients Often or very often	Female clients Often or very often
Absence of orgasm	13,7	42,9
Problems with sexual desire	23,2	60,7
Genital pains during sexual act		30,2
Premature ejaculation	27,3	
Erectile dysfunction	47,3	
Lack of sexual satisfaction	27,8	38,2
Problems with turn-on patterns	28,3	9,1
Emotional problems in the relationship	35,2	63,2
Victim of abuse or violence	18,1	42,9
Other	33,3	25,0

Who are the Sexologists' clientele?

Who are seeking sexological treatment? While the majority of clients seeking sexological treatment in the French survey were men, the distribution of clients was far more even in the Norwegian survey. The respondents report that 33% of the people seeking treatment are men without a partner, 28% are women without a partner and 39% are couples.
We also asked which age groups were treated. 3,6% of the respondents reported that they often or very often treated children; 23,3% reported that they often or very often treated adolescents; 17% reported that they often or very often treated adults, and 23,5% reported that they often or very often treated elderly people.

What about the sexual orientation of the sexologists' clientele? 73,7% of the respondents reported that they often or very often treated heterosexual men and women, 15,8% reported that they often or very often treated homosexual men, 7% homosexual women, 8,6% bisexual men, 7,3% bisexual women, and 8,9% reported that they often or very often treated transsexuals/transgenderists.
Only 2% reported that they often or very often treated clients with HIV/AIDS. 17% reported that they often or very often treated persons with physical disabilities. 13% reported that they often or very often treated persons with mental retardation, while 25% reported that they often or very often treated patients with chronic diseases.

Therapeutic techniques

From the problems presented we understand that sexological treatment includes many different types of problems that demand different therapeutic techniques. From this survey we see that the respondents are using a wide spectre of treatment-methods. The ten most frequently used methods are: Couples therapy: 32%; Cognitive-behavioural therapy: 30%; Psychotherapy: 28%, Supportive therapy: 29%; Relaxation: 24%; Classical sex-therapy ad modus Masters & Johnson: 24%; Systemic treatment: 18%; Oral medication for erectile dysfunction: 16%; Intra-cavernous injections: 14%; Intra-urethral medication: 12%. Psychotherapeutic methods are very common in treatment of sexological problems, but it was surprising that only 24% of the respondents used the classical sex-therapy ad modus Masters and Johnson (16). Therefore we wanted to see what characterised this small group of respondents. It was 7% of the physicians and 17% of the non-physicians, 15% of the men and 9% of the women in the sample who used Masters and Johnson's treatment-methods. Compared to the French survey the Norwegian respondents reported far less use of psychotherapeutic techniques. Even French physicians report that they use more psychotherapy (69,9%), couple therapy (59,6%) and sex- therapy (47,3%) than the overall of the Norwegian sexologists.
This survey was carried out in 2001 and 2002. There is reason to believe that the use of oral medication in the treatment of erectile dysfunction has increased after this. In the French survey this form of treatment was not incorporated, but still a total of 33,3% of the respondents reported that they used intra-cavernous injections. It is interesting to note that in the Norwegian sample only one female physician reported to use oral medication for erectile dysfunction, and no female physicians used intra-cavernous or intra-urethral injections.

Discussion

Sexology is a profession that is starting to become well established in many countries in Europe. We can see this by the number of people organised in sexological organizations. Countries like France, Great Britain, Spain, Belgium, Denmark, Holland and Finland have offered sexological education for many years (2). In Norway such an education has been offered since 2001, when Agder University College started an educational program in Basic Sexology and Sexological Counselling.
This survey showed that the majority of people working with sexology are physicians or psychologists, but many other professions are also involved. It is reason to believe that this part will increase as a result of the sexological education. Fewer than 50% of the respondents in this survey identified themselves as sexologists or sexological counsellors. It was however, a relatively high number, considering that there was no sexological authorization or no regulation of sexology as a profession at the time of the survey. It was also relatively relatively few of the respondents that had a sexological education. The treatment of sexological problems was largely based on non-sexological methods, preferably psychotherapeutic. A Norwegian survey from 1997 showed that 11% of the respondents had experienced sexual problems that they needed professional help to solve. 6% reported that they had received professional help to solve their problems and 47% were satisfied with the help they were given. 64% of the persons that experienced problems reported that their problems were totally or partially solved (17). There is reason to believe that sexual problems need professional treatment. There are other effective treatment methods, but many patients are treated with non-adequate methods. The Dutch Sexologist Woet Gianotten has suggested that further development of Sexology as a profession should be organized according to the different problem-areas that sexologists are working with today. This is in order to develop the specialized qualifications needed in the different areas (18):

- *Sexual dysfunctions* can be treated by sex-therapy and/or medical or surgical treatment.
- *Gender belonging* problems are treated through conversational therapy. Transsexuals are often treated with hormones and surgery. In addition they may need of help from a speech therapist, social worker and a hairdresser.
- Conversational therapy is helpful when it comes to problems with *sexual orientation;* what gender one is attracted to. With this group one also has to be aware of the extensive risk for suicide and drug-related problems.
- There are many different *sexual turn-on patterns*; some of these may become so problematic that treatment is necessary. There are a number of stories of reckless treatment of unwanted sexuality, for example by aversion therapy where the client were given electroshock associated with unwanted sexuality. This have little or no effect. There are also examples of long and useless psychotherapeutic treatments of sexual expressions; witch first and foremost is a problem for an intolerant society.
- *Medical sexology*. Many clients are experiencing sexual problems in relation to somatic diseases. In this field it is necessary to have adequate competence in sexual physiology and anatomy to prevent the sexual functioning from suffering as a result of the disease and/or the treatment. In those cases where sexual ability will suffer, it is important to inform and prepare the client of the change in sexual functioning. It is also important to offer sexual aids when necessary.
- People with *mental retardation* represent an important challenge because they usually have a normal sexual development, but have a mental developmental level witch is not always capable to manage the sexual needs that they have. With this group psychological and pedagogical methods are of great importance.
- Persons with *physical disabilities* represent other challenges, especially considering development and instructions to use of sexual aids. With this group it is also necessary to accommodate having a sexual-life at the institutions, in their homes and connected to leisure activities.
- *Forensic sexology*. Treatment of persons who have committed sexual assaults needs therapeutic environments where it is possible to work in groups with more than one therapist. This is a group of heavy clients, many of them in denial and with dissociation. The people working with this group have developed specialised therapeutic techniques and special environments for this work.

Today we have an educational program in Norway that attends to the three lowest levels of the PLISSIT-model (19):
P: Permission to be sexual
LI: Limited Information. Be able to give limited information about sexuality
SS: Specific Suggestions. Give suggestions to actions that can solve the problem.
At the top level, IT: Intensive Therapy, The Norwegian Association for Clinical Sexology is preparing an additional educational program.
Today there are approved 14 Specialists in Clinical Sexology (NACS) and 42 Specialists in Sexological Counselling (NACS) by the Nordic Assosiation for Clinical Sexology. The last group is mainly qualified through the education at the Agder University College. The first group has qualified through congresses, seminars, practice and supervision, equivalent to a 2-year full-time education.
Efforts are being made to develop a common program for a Master Degree in sexology and to systematize clinical education to qualify more specialists in clinical sexology. Compared to the other countries included in this European study, Norway is at the bottom level regarding

sexological education. In light of the prevalence of sexological problems, it is necessary to take responsibility and make sure that clinicians have the necessary competence. This includes both the professional competence in relation to sexological problems, and the attitudinal competence to meet the clients in a professional manner with this, for many, sensitive issue. We also lack a public approval of sexology as a science and public approval of the competence Norwegian sexologists represents through social security rights and operating subsidy grants. This client group is equal to the group of depressed patients (17), and are probably to a certain degree overlapping with this group, in addition to other client groups. The treatment offered needs to be developed in a number of areas, especially within established institutions where sexologists should be integrated in many different health professions. Practice has shown that sexological work demands a special interest and competence which one cannot expect every health professional to have. The easiest way is probably to offer education to those health professionals who wish to work with sexological problems, in addition to establishment of sexological competence centres, preferably within each of the five health regions in Norway. These centres should give both guidance to health-personnel generally and offer counselling and treatment to clients with sexological problems. Still there are many challenges in the development of sexology as a profession in Norway!

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Summary

Background. Sexology is a new profession that has evolved over the last century. New educational programs in sexology are developed throughout the world, and the field is in rapid progress. Sexological practice has mainly been organised through national and international associations. At the same time, sexology has been in a weak position in relation to official funding, and to tradtional educational and clinical institutions. There has been no systematic studies aiming at studying sexologists in any country. The only existing data has been located in the files of the sexological organisations.
In 1999, Alain Giami and Patrick de Colomby organised a national study of French sexologists. During 2001 and 2002 studies based on the same inventory were carried out in Denmark, Finland, Great Britain, Iitaly, Norway and Sweden. The results have been presented at the International Academy of Sex Research in Hamburg, 2002, at the 16th World Congress in Sexology in Havana in 2003 and at the 7th Congress of the European Federation of Sexology in Brighton in 2004. In this paper, the results from the Norwegian study is presented.

Results. Medical doctors and psychologist represent the largests group of professionals working with sexological problems in Norway, with one third each. The last third consists of different health and educational professionals. 43% reports that they have undergone training programs in sexology. This is the lowest educational level in all the countries studied. 71% have had individual supervision, 49% have had group supervision in sexology. 93,2% are in clinical practice, but for most this is a minor part of their clinical work. 71% report that sexological activity represents less than 25% of their clinical work. Gender differences are minor. 3% work with sexology full time, all of these are women, and none are medical doctors.
Not surprisingly, problems with orgasm (42,9) and sexual desire (60,7%) are among the most frequent problems reported among female clients, while erectile dysfunctions (47,3%) are among the most freqent problems among male clients. Emotional problems in the couple relationship is the most frequent problem reported, 35,% among male and 63,% among female clients. The respondents also report problems after sexual violence or abuse, 18,1% among male and 42,9% among female clients. 30% report genital pain among their female clients.

Medical doctors represent an important part of the therapeutic field, while sexology is less than a minor part of medical education, both pre- and post-graduate.
The most important treatment methods that are reported in this study are psychotherapeutic. There is however, reason to believe that PDE-5 inhibitors represent an increasing content of the kinds of treatment. With better treatment methods for ED, more men will seek therapy, and this will in its turn convey need for more couples therapy and treatment of female sexual problems.
New education programs in sexology are constantly being established. Sexological problems needing professional treatment are reported in as many as 10% of a representative group of the Norwegian population (17). It is reason to believe that many of these problems overlap with other health problems, like depression and muscular-sceletar pain. It is a challenge to health authorities to acknowledge and support the sexological competence that has been developed and contribute to the development of relevant treatment in the future.