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**EDUCATION AND TREATMENT  
IN HUMAN SEXUALITY:  
THE TRAINING OF  
HEALTH PROFESSIONALS**

**Report of a WHO Meeting**

WORLD HEALTH ORGANIZATION

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# EDUCATION AND TREATMENT IN HUMAN SEXUALITY: THE TRAINING OF HEALTH PROFESSIONALS

Report of a WHO Meeting

## 1. INTRODUCTION

A Meeting on Education and Treatment in Human Sexuality was convened by WHO in Geneva from 6 to 12 February 1974 to discuss the training of health professionals in this field. Dr L. Bernard, Assistant Director-General, opened the meeting on behalf of the Director-General and he noted that a WHO Consultation in 1972<sup>a</sup> had called attention to the lack of opportunity for health practitioners to study human sexuality and to the shortage of teachers to plan and carry out educational programmes. The Consultation recommended that a survey should be undertaken of programmes, activities, and services in the area of human sexuality and that scientific meetings should be convened to explore the field thoroughly and to permit health practitioners who had established successful training programmes to share their experiences. The present meeting was prepared in response to these two proposals.

The participants<sup>b</sup> were invited to attend on the basis of their special knowledge and experience in teaching, research, or clinical practice in the field of human sexuality in various countries. Each member prepared one or more background papers for the meeting, either a survey of the teaching of human sexuality within a particular region, or a description of a therapeutic approach to the treatment of sexual problems. Their contributions are referred to by number in the text of the report and are listed in Annex 2.

The meeting was asked to make a critical review of, and to develop recommendations in, the following areas :

- the role of sexology in health programmes, particularly in family planning activities ;

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<sup>a</sup> MACE, D. R., BANNERMAN, R. H. O. & BURTON, J. *The teaching of human sexuality in schools for health professionals*, Geneva, World Health Organization, 1974 (Public Health Paper No. 57).

<sup>b</sup> The list of participants is given in Annex 1.

- the content and methodology of teaching in human sexuality to the health professions ;
- the identification of treatment and counselling models suitable to meet the priority needs in various sociocultural contexts and to be practised by general health workers ;
- the initiation, organization, and implementation of teaching and treatment programmes in human sexuality ;
- the international services for reference and coordination in the field of sexology.

In addition to plenary and small group discussions, certain sessions were used for the demonstration and evaluation of audiovisual instructional aids such as films, tapes, and slides that had been developed specially for education in human sexuality.

## **2. THE ROLE OF SEXUALITY IN HEALTH PROGRAMMES**

### **2.1 Definition of sexual health**

A growing body of knowledge indicates that problems in human sexuality are more pervasive and more important to the wellbeing and health of individuals in many cultures than has previously been recognized, and that there are important relationships between sexual ignorance and misconceptions and diverse problems of health and the quality of life. While recognizing that it is difficult to arrive at a universally acceptable definition of the totality of human sexuality, the following definition of sexual health is presented as a step in this direction :

Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love.

Fundamental to this concept are the right to sexual information and the right to pleasure.

According to Mace, Bannerman & Burton (op. cit.) the concept of sexual health includes three basic elements :

- (1) a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic,
- (2) freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship,
- (3) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.

Thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation or sexually transmitted diseases.

## **2.2 Basic service needs**

If preventive and curative health services are to meet sexual health needs, the following requirements would appear to be important, among others :

- basic information about biological and psychological aspects of sexual development, human reproduction, the variety of sexual behaviour, sexual dysfunction, and disease ;
- positive attitudes toward sexuality, and the possibility for objective discussion of sexual matters ;
- personnel who show understanding and objectivity towards the expression of sexual complaints, to inform and advise regarding sexuality and sexual problems ;
- training for health service personnel in this field ;
- sufficient knowledge and resources to deal with complex problems of sexuality.

## **2.3 Societal constraints**

The extent to which such conditions exist varies with each society, according to its traditional and cultural views on sexuality, its systems of education and health care, and its manpower resources. Each culture, each nation, and even each region has its own strengths and any effort to improve the local situation *vis-à-vis* problems related to human sexuality must be based upon those strengths and be accomplished by local personnel. In most parts of the world there is a need for survey and epidemiological data on social attitudes and practices related to sexuality, as well as a need to assess the related health problems, so that education and therapy programmes can be made responsive to local needs.

## **2.4 Levels of sexual health care—education, counselling, and therapy**

Education, counselling, and therapy may be regarded as inseparable parts of a total effort in sexual health care. First, the provision of sexual health *education* to the community, to the physician, and to other health workers has the highest priority because this can be done with the least

amount of training and will affect the greatest number of people. While sex education should be a basic part of preventive medicine, it has also been shown to be effective in assisting individuals and couples to overcome sex problems. Second, there is a need for *counselling* of individuals and couples with slightly more complicated problems; this can be carried out by the nurse/midwife, the general practitioner, the gynaecologist, and others. Third, there is a need for sex *therapy* in depth by specially trained professionals who see the people with the most complicated problems. Health and other community workers require more specialized training to undertake sex counselling and sex therapy.

### **2.5 Health workers involved**

Opportunities for the provision of sex information and counselling are particularly likely to arise in services for maternal and child health, family planning, mental health, community health, abortion and sterilization, and sexually transmitted diseases. Given the multiplicity of the problems affecting human sexual behaviour, it is necessary for most types of health personnel to be competent in providing sex education and counselling—nurses and auxiliary personnel as well as doctors. In addition, school and college teachers, youth workers, community development and farm extension workers, sanitarians and health inspectors, policemen and personnel of the armed services, and staff members of custodial and correctional institutions will from time to time have a comparable role to play. In some countries sexually troubled persons consult religious leaders more often than professional health personnel and this indicates that they also should receive training, especially in the area of counselling. The interest and involvement of such persons in counselling for sexual problems is borne out by reports of education/training programmes given to special community groups (11, 24, 27, 31, 33, 34).

### **2.6 Family planning workers and programmes**

Family planning workers in particular find that people come to them with sexual problems that interfere with their capacity to plan their family as they wish or with their capacity to use methods of family planning successfully. The different methods of fertility control produce different types of sexual and psychological problems. It is necessary not only to give workers in this field an understanding of sexology, but also to train them to listen and understand their patients' complaints related to sexuality and to provide the appropriate services in response.

In the light of the current emphasis in many countries on family planning programmes, and considering that the changes in behaviour and attitude



demanding by family planning can affect sexual life, the Meeting felt it necessary to draw attention to the fact that family planning programmes most often overlook the sexual aspects of the health care they are providing, both in the provision of services and in the training of personnel. Early family planning efforts had a tendency to discourage any association with sexuality because of the emphasis on technique, i.e., the distribution and application of contraceptives. Most family planning personnel have not been prepared to appreciate and cope with either the sexual feelings and problems the couple may have that are related to the use of contraceptives or other methods of fertility regulation, or the question of separating sexual needs and sexual pleasure from the traditional reproductive function. Although sexual health is of concern to both sexes, in most of the existing health and family planning programmes the approach is directed mainly to women.

The fact remains that family planning information and information and counselling on sexuality are logical companions, and that family planning is a suitable context in which to introduce training and therapy programmes in human sexuality. Nevertheless, in certain situations, sexuality programmes could also be developed outside this context because of the connotations of birth control.

### 3. EDUCATION AND TRAINING IN HUMAN SEXUALITY

The need for education and training in human sexuality has become increasingly obvious as a public demand for sexual health care, and inadequacies in the present education and training of health professionals, have become evident (2, 4, 5, 20, 21). To meet the needs, family planning associations (2, 6, 12, 31), medical societies (12, 25, 26), and marriage counselling bureaux have organized special training programmes for their members, but these endeavours have often been isolated, constrained by limited resources, and have affected only small numbers of people. At the university level, independent and experimental programmes have been launched in response to requests from students (12, 24, 33), or as a result of initiative by interested faculty members (13, 24, 33).

Before reviewing the characteristics of educational programmes, it is important to consider the needs to which these programmes are directed: the development of appropriate attitudes, knowledge, and skills. The earlier WHO Consultation outlined these in some detail and the present Meeting regarded them as constituting a sound basis for the formation of appropriate training plans.

### **3.1 Attitudes**

In order to develop a better understanding of problems of human sexuality, it is necessary for health workers to develop healthy attitudes to sexuality, marriage, and contraception. An understanding by the worker of his/her own sexuality and a rational approach to his/her own sexual problems will help him/her to be better able to deal with the problems of others. It is also necessary for the worker to be aware of and to accept the wide range of variation in sexual behaviour so that he/she can transmit this assurance to those clients who seek help for what they consider to be abnormal behaviour in themselves or their partners (14).

The need for a change in attitudes—for acceptance of sexuality as a positive component of health, for oneself, and for others—is recognized as being particularly important. Health workers at all levels share the same beliefs, myths, and superstitions that exist in the society to which they belong, and they may themselves have unresolved sexual problems. Their training generally does little to dispel these attitudes, because of the current emphasis on curative rather than preventive services; for example, physicians are better prepared to cope with pain and disease than with the establishment of pleasure and sexual wellbeing. The attitudes of health workers can present an important obstacle to their effective functioning as educators and counsellors in the field of sexuality, and it is not surprising that they are often reluctant to become involved in this area. This reluctance may be manifested in an unconscious denial of the sexuality of their patients, or a mechanical and impersonal approach to the examination and prescription of contraceptive methods. To the extent that people with sexual problems look to health professionals for guidance and advice, punitive or negative attitudes, careless statements, and inappropriate methods regarding sexual matters may seriously damage the patient's sense of the value of his or her own personal sexual life. Negative attitudes may tend to be even more pronounced in certain societies in relation to sexuality among older people, the mentally retarded, the physically handicapped, prison inmates, and certain racial groups.

### **3.2 Knowledge**

In order to approach the topic with confidence, the health workers must themselves have accurate scientific knowledge regarding the facts of human reproduction and human sexuality; they must know what are the common sexual problems met and how to deal with them, and they must know when the solution of a problem is beyond their ability and requires referral to a specialist (14).

Existing training programmes have so far concentrated more on giving knowledge than on building up desirable attitudes in health personnel

toward sexuality and on developing their skills of communicating with people in this very personal area. A common tendency has also been to stress abnormal, deviant behaviour, and major pathological conditions; this can be seen in some medical school programmes where the only departments dealing with sexuality have been forensic medicine, psychiatry, and dermato-venereology. Other institutions have avoided the topic of sexuality by limiting instruction to reproductive biology and contraception. The results of recent research into the physiology of sexual response, gender identity, and sexual practices now make it possible to give more adequate information about normal sexual functioning and to achieve a greater understanding and acceptance of sexual behaviour in the context of positive health. An important development in this respect is the attempt to give sexuality a neutral and scientific language in order to circumvent the emotional overtones of culture-bound terminology.

### **3.3 Skills**

To enhance his or her ability to help those people who ask for help in the solving of problems related to sexuality, it is essential for the health worker to develop the necessary skills in the art of communication and of good listening. He/she must be able to use the appropriate terminology without embarrassment, must be able to deal with the problem faced by the individual, must be able to develop a good interpersonal relationship and establish rapport with him/her in a dispassionate way and yet with sympathy and with sensitivity (14).

Skills appropriate to this area differ only very slightly from those that should be developed during the training of any doctor, nurse, or educator. It can nevertheless be pointed out that the general orientation toward specific tasks and techniques in the usual training of health workers is less appropriate for personnel dealing with sexual problems, where the ability to listen and to give support is of greater consequence in the initial stages. As a result of increased specialization and involvement in this field, there are a number of counselling techniques with which the worker ought to be familiar. As yet there appear to be only limited opportunities for exclusive specialization in sexology and sex therapy, and thus the approach to such specialization has been through psychiatry, psychosomatic gynaecology, or endocrinology.

### **3.4 Categories of health personnel to be educated and trained**

Although material presented to the Meeting largely concerned training in medical schools, discussions brought out the need for training to be provided at all levels.

### *Basic health and community development workers*

There is a great need for specific and improved training programmes for basic health workers, especially to help those working in family planning to recognize and deal effectively with the more personal aspects of sexuality as they relate to family planning needs.

Basic health education and counselling is undertaken not only by basic health workers, but also by home economists, community development workers, sanitary engineers, farm extension workers, communicable disease workers, rural health promoters, and nursing auxiliaries. Training for these personnel is at present centred on specific areas of work, but if their effectiveness as educators and counsellors is to be increased, they should have an integrated view of the various factors that interact to affect the development, health, and welfare of the individual and family. This would involve the recognition that health has a sexual aspect and that people are susceptible to sexual problems and sexual illness.

It would therefore be beneficial if community workers could learn to discuss sexual matters easily with people and could identify simple problems related to sexual health. The main objectives for their education on the subject are similar to those for other health professionals :

- development of a more comfortable and positive attitude towards sexuality, in onself and towards others ;
- greater knowledge, so as to avoid the perpetuation of erroneous beliefs, taboos, and myths in this field ;
- skills in handling patients presenting sexual problems and in communicating information on sexuality to the community.

Attention should be given to helping the individuals under training to understand their own sexuality and to come to terms with the sexual problems they may be facing. The health worker needs to be convinced that sexuality is useful and healthy.

At this level of training and health care, certain needs are apparent :

- the development of guidelines for training programmes and manuals ;
- appropriate teaching materials—audiovisual and written ;
- the availability of simple informational materials for distribution to the community ;
- special attention to the use of a simple and clear vocabulary (24) ;
- the “education” of community leaders and national administrative personnel so that they understand the importance of sexual health care and ensure administrative support to the health worker ;
- information and education to men as well as women ;
- services to which a patient may be referred.

Assurance of continuing moral and material support will be essential if the health worker is to be able to introduce the subject with some degree of confidence and comfort.

#### *Social workers, teachers, and marriage counsellors*

These personnel come into close contact with individuals in different communities and environments and might be asked for help with sexual problems. Available reports (2, 4, 5, 6, 11, 12, 16) indicate that only limited training and education in human sexuality is available to them at a few selected professional schools or in extracurricular courses organized by some medical schools. In some cases, seminars dealing with sexuality are provided through in-service training.

#### *Undergraduate medical students*

The meeting agreed that education in human sexuality should be introduced at the earliest possible stage of training programmes for health science professionals, and should be continued at all subsequent stages. Ideally, basic concepts presented at an early stage should coordinate with the family-life education given in the elementary and secondary schools (11). In fact, the majority of reports indicate that relatively little material is presented to undergraduates in the preclinical years; treatment of sexual subjects is reserved for the clinical years within each special discipline, such as psychiatry, psychology, urology, pediatrics, obstetrics, and gynaecology.

Among the practical considerations that have prevented the introduction of human sexuality into medical training programmes (20)<sup>a</sup> a major one is the already crowded curriculum. Lack of opportunity for student involvement in planning the medical courses and the fact that most courses are compulsory rather than elective has also made it difficult to introduce a new course.

#### *Postgraduates*

As mentioned earlier, a number of programmes in the form of seminars, courses, medical society meetings, and Balint groups (19, 31)<sup>b</sup> cater for specially interested groups of professionals who are providing sex education or sex counselling. These are mainly directed to the front-line physicians, e.g.,

<sup>a</sup> See also MACE, BANNERMAN, & BURTON, op. cit., p. 31-32.

<sup>b</sup> See: BALINT, M. Training general practitioners in psychotherapy, *Br. med. J.*, 1: 115-20 (1954); BALINT, E. & BALINT, M. Dynamics of training in groups for psychotherapy, *Br. J. med. Psychol.*, 28: 135-43 (1955); BALINT, M. The doctor, his patient and the illness, revised ed., London, Pitman Medical Publishing Company, 1964.

gynaecologists, paediatricians, urologists, general practitioners, clinical psychologists, and psychiatrists. The programmes are offered by both academic institutions and private agencies, such as the family planning and marriage counselling associations. The small group sessions are generally adapted to the specialty in question, but they range from general orientation to specialized training over a longer term (18, 31) to develop specialists in sexology in the absence of formal academic programmes.

Training for specialization in sex therapy is only available to a very limited extent, since this is dependent on the availability of experienced teachers and clinicians and on the existence of service centres where sufficient clinical experience may be acquired. Training is largely based on the accumulation of sufficient clinical experience and is conducted generally on an individual basis (18, 26, 35, 36).

### 3.5 Approaches and methods for education and training

Most of the programmes in human sexuality at medical schools are intended primarily for medical students, but to a limited extent they also reach physicians doing postgraduate work and other health professionals. From the reports presented to the Meeting, it seems clear that there is a wide variety of approaches to instruction in human sexuality in medical and other health science schools. Human sexuality may be taught as a required or an elective component of education, in a discrete course or integrated into a number of other courses. What is important is that the course organizers develop programmes that are appropriate, in both curriculum content and educational method, to sociocultural factors, the needs of students, and the health needs of the local population.

Where human sexuality is being taught, its place in the curriculum and in the institution varies. It is common to find that in certain specialties—gynaecology, psychiatry, urology, venereology, and physiology—a few hours may be devoted to sexological subjects. Sexology is usually not coordinated among these disciplines and the extent and quality of coverage depends on each instructor's motivation and interest. Emphasis is frequently on deviancy and pathology rather than on normal sexual development and behaviour. In the more advanced programmes, sometimes a special programme or entire institution has been set up within a university for research and teaching in sexology,<sup>a</sup> and occasionally also for sex therapy.

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<sup>a</sup> Some examples are: The Institute of Family and Sexological Sciences, University of Louvain, Belgium; The Department of Sexology, University of Quebec at Montreal, Canada; The Sexological Institute, Charles University, Prague, Czechoslovakia; The Department of Sexology, University of Frankfurt, Federal Republic of Germany; The

(footnote continued on next page)

Some interdisciplinary programmes have been prepared by groups of university staff (13) or by specialists (24). Of the programmes reported, some can best be considered as "national" programmes in terms of the organization and extent of their activity, and others have a distinctly regional character or are related only to a particular medical school.

Amidst this variety of approaches and programmes two needs are distinguishable: an introduction to basic concepts to be given in the pre-clinical years, and the sexological aspects of each discipline to be presented in greater depth and in a coordinated way in the clinical years. Present programmes are attempting to remedy the lack of both, but they are essentially interim measures or trials until such time as sexology is covered in a systematic and adequate manner in the education and training of health professionals and comes to be regarded as a component of health services.

As for the general courses on human sexuality, course formats vary from concentrated courses, held every day for a week or more, or weekend courses, to programmes that extend for a few hours a week for longer periods of time. The latter approach is used particularly for the higher level education programmes and for training in sex therapy. The courses are usually elective, particularly those leading to specialization, but in some cases are obligatory.

In the more developed programmes there is a considerable amount of methodological experimentation and innovation; multidisciplinary faculty teams are a common feature. Among the methods being tried are: panel discussions, male-female teaching teams, videotape case presentations, guest speakers from the community, and survey questionnaires for assessment of sexual attitudes and knowledge. The primary objective of many programmes is to help students achieve an effective and more positive and broad-minded attitude toward problems in human sexuality. A number of teaching methods have been selected because they oblige students to confront their own attitudes, values, and feelings regarding sexuality. Examples of these are the use of frank sexual films followed by small group discussions; interviews with homosexuals; role playing; and other methods requiring the active involvement of the learner (13, 34). In most countries there is a dearth of appropriate training materials in the form of films, slides, videotapes, manuals, and even textbooks or other written material for the teaching of human sexuality, all of which must be suitable for the local sociocultural context. There is also an obvious shortage of interested

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teachers who can devote the necessary time to acquiring sufficient knowledge and skill in dealing with human sexuality to organize and lead educational programmes in this area.

With educational programmes at various stages of development, and still largely experimental, and with the general shortage of teachers and educational materials, it would be premature to recommend any particular approach. Nevertheless, there was consensus on the following points:

- an interdisciplinary approach is necessary to cover the field of sexuality adequately as it relates to psychology, psychiatry, gynaecology, urology, paediatrics, nursing, social work, and health education;
- improving the attitudes of students is a basic goal;
- there is a need to train teachers who can train others, creating a multiplier effect;
- evaluation should be undertaken to determine the impact of educational programmes on clinical and health service practice.

In the long run, it was felt that, depending on local conditions, human sexuality should be encouraged to develop as an autonomous discipline in the education and training of health professionals and become a recognized component of general health services, particularly family health.

#### 4. SERVICES FOR SEXUAL HEALTH CARE

##### 4.1 Objectives and priorities

The goal of the educational programmes described above is to enable health workers to provide appropriate services for sexual health care, whether preventive as in sex education, or curative as in therapy.

Earlier in this report, it was stressed that education, counselling, and therapy are inseparable parts of sexual health care, and that education of the community has the first priority in being able to affect positively the greatest number of people. There is a great and universal need to bring about positive change in the existing attitudes towards human sexuality among the general public, as well as among health and other personnel who are responsible for sex education and sex counselling. In many countries and in many subcultures the existence of sexual taboos and myths and the resulting guilt or secrecy imposed by society on sexual matters are important obstacles to sex education. So also in certain societies is the cult of *machismo*, or male dominance and victimization of women; this makes it difficult to introduce the idea of sexual enjoyment for both partners that



would appear essential for the achievement of healthy sexual relationships. Feelings of sexual guilt sometimes result from the influences of extraneous cultures that may bring about radical changes in patterns of behaviour. Another major barrier to sex education is the attitude that sex is sinful unless it is meant for procreation—a common teaching and one that can create feelings of guilt in the use of contraceptive methods.

While the prevention of sexual problems and maladjustments through appropriate sex education takes priority, the Meeting agreed that the next most important area of concern should be the development of counselling and therapy programmes directed to the care of the most common kinds of problems and disorders and designed to reach the largest number of people in need, with the limited manpower and financial resources available. As already emphasized, this would involve the training of health workers at all levels to give sex information, to carry out elementary sex counselling, and to refer more complex cases to specialized staff or institutions.

#### 4.2 Sexual health problems

The following list of the most common sexual problem areas was considered by the Meeting, and may be useful for planning the content of educational and service programmes :

(a) Problems related to infection : not only sexually transmitted diseases but such problems as vaginitis and cystitis, which may cause a variety of sexual difficulties.

(b) Problems related to the life-cycle : those sexual problems that occur in conjunction with pregnancy, childbirth, and the postpartum period, those associated with the menstrual cycle, etc.

(c) Problems related to a changing technology : e.g., use of condoms, hormonal contraception, or IUDs, when breakthrough bleeding may be a problem.

(d) Problems that are related to sociocultural factors, including legal and economic factors.

The main sexual problems have also been categorized by age group<sup>a</sup> as follows :

*Infants and young children* : educators' and parents' reactions to infantile sexuality and masturbation ; children's questions ; privacy problems for intimacy between parents.

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<sup>a</sup> Adapted from VAN EMDE BOAS, C. *Le médecin de famille et la petite sexologie, Bruxelles Médical*, 49 (11) : 693-706 (1969).

*Latency period* : sexual curiosity, sexual games.

*Puberty and adolescence* : masturbation ; sexual experimentation with partners ; feelings of loneliness, physical and emotional inadequacy.

*Unmarried adults* : sexual needs ; difficulties in finding a partner ; feelings of loneliness and inferiority ; love affairs without a future ; unwanted pregnancy and wishful exposure to unwanted pregnancy.

*Couples* : sexual problems dependent on duration of marriage : (i) problems of initial adaptation ; (ii) alienation, divorce ; (iii) temptations and extramarital relationships, infidelity, jealousy ; (iv) problems of middle and old age, quantitative differences.

*Divorcees, widows, and widowers* : problems largely similar to those of unmarried adults.

In addition to the problems grouped above there are some that are specific to men or women and are less related to age, such as sexually transmitted disease.

While most of the therapy programmes reviewed by the meeting are concerned with the more specific psychotherapeutic approaches to sexual (erotic and copulatory) dysfunctions, it is recognized that the care of sexual problems encompasses a much broader field, including the gynaecological and psychosomatic aspects, therapy for endocrine dysfunction, and the use of drugs for infectious and other medical conditions relevant to sexual health. The consideration of genetic and endocrine factors is important in relation to both therapeutic intervention and training of health personnel, and special attention should be given to a better understanding of childhood sexuality.<sup>a</sup>

### 4.3 Sex therapy

To illustrate the various approaches to therapy of common sexual dysfunctions, background papers were presented to the meeting covering behavioural therapy (3), psychoanalysis and hypnosis (1), couple therapy of the type described by Masters and Johnson (28), other forms of short-term therapy based on psychotherapy (17), and various methods of group therapy for dysfunctional couples and individuals (35) often with a distinctly educational emphasis.

An extract from the background paper by Kaplan concerning the basic principles behind recent methodologies in sex therapy (17) is presented as

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<sup>a</sup> The roles of genetic and endocrine factors and the problems of gender identity in children are discussed more fully in the following book : MONEY, J. EHRHARDT, ANKE A. Man and woman, boy and girl. Baltimore and London, Johns Hopkins University Press, 1972.

Annex 3 to this report. The range of therapeutic approaches is so wide that a separate meeting would be required to evaluate them. Some of the main features and advantages of the different methods are highlighted below.

(a) *Somatic therapy* :

- even though few sexual dysfunctions are of organic origin, it is essential to begin with a physical and, if appropriate, an endocrinological examination ;
- physical, pharmacological, and/or surgical therapies have been established for coital and erotic disabilities secondary to another dysfunction, as in hormonal deficiency during development ; geriatric hormonal insufficiency ; hermaphroditism, vaginal atresia, and other birth defects of the sex organs ; traumatic injury or disease of the sex organs ; genital tract infection ; depression and other psychiatric disorders ; accidental and iatrogenic toxic effects ; and disability secondary to metabolic, auto-immune, and other systemic diseases ;
- in general, in cases of sexual dysfunction such as dyspareunia and impotence, there is a tendency towards excessive use of hormonal therapy, which should be used only in well-defined instances.

(b) *Behavioural therapy*—the modern approach is characterized by :

- careful and precise definition of the ultimate goal of treatment ;
- insistence on the changing of attitudes rather than immediate change of behaviour, since it is possible for certain combinations of attitudes to block the whole process of sexual functioning ;
- flexible and rational orientation to meet the needs of the individual patient.

(c) *Psychoanalysis* can be useful with regard to :

- determination of the significance of symptoms in the context of the total personality ;
- the quality of sexual functioning ;
- the importance of fantasy and imagination in sexuality.

(d) *Hypnosis*, although its nature is not fully understood, can be useful in the process of desensitization and in inducing relaxation, for example :

- hypnotic visualization of the sexual act ;
- sensory utilization of hypnosis to induce positive sensations such as a feeling of heat at the base of the abdomen to induce easier achievement of sexual pleasure.

(e) *Couple therapy* based on the Masters and Johnson model has suggested the following advantages :

- focus on the couple and on the pathological aspects of their relationship ;
- therapy practised by the couple during an intensive and continuous period of two weeks ;
- insistence on the expression of feelings—the goal of sexual therapy is not only the relief of symptoms but enhancement of the sexual experience through richer fantasy and sensitivity and a more positive attitude toward sexuality.

(f) *Group psychotherapy* offers some advantages in permitting an exchange of experiences and the establishment of an improved environment where sexual attitudes can be reformed.

(g) *Other short therapies*. Other approaches using very different and original methods have been suggested. These include, on the one hand, psychotherapy with a psychodynamic orientation emphasizing the verbalization of emotions, and on the other hand a number of methods aimed at increasing "body awareness" (sensory relaxation, massage, vibrators, etc.).

Despite the varied trends in therapy, consensus was obtained on a number of points :

(1) Therapists are increasingly viewing human sexuality in terms of relationships ; it is couples that are being treated, not individuals. Both partners participate in the therapeutic tasks and improved interpersonal communication becomes an important goal.

(2) Therapeutic procedures are still under development and combinations and variations of methods are being tried. Experience is being gained on the following aspects : the types of therapist and the number required, the length and format of treatment, the types of sexual task and their programming, the utility of audiovisual media, self-help materials, and diagnostic questionnaires for more expeditious handling of large numbers of cases. These experiments are being undertaken with limited financial and manpower resources, and comparative research would probably help evaluate more efficiently the effectiveness of the various approaches to therapy. There are no universally applicable solutions ; the choice of method should be made to respond to the specific problem, to the cultural background of the patient, and to the training and skill of the therapist.

(3) Experiences in therapy are continually providing greater insight into the causes of sexual dysfunction, and they highlight the value of sex education.

(4) Most therapies now place less emphasis on the medically-oriented model that is commonly applied to the diagnosis and cure of sexual dysfunction.

Programmes for counselling and therapy occur in a wide variety of institutional settings. These range from sexology centres that are extensive in scope and have a significant investment in basic research, to smaller institutions that deal only with sex counselling or sex therapy; from comprehensive and varied programmes undertaken in institutions where relatively large numbers of people are seen and where a wide variety of approaches to sex counselling, sex therapy, and family therapy are applied, to relatively small programmes where small numbers of couples and individuals are seen. Similarly, there is variation in the degree of training received by therapists conducting counselling or therapy programmes. In the training of sex therapists (35), preceptor models seem to be commonly used and group discussions of case material extending over a considerable period of time (19, 31) are also in frequent use.

## 5. REGIONAL RESOURCE CENTRES FOR SEXOLOGY

The limited resources for education and treatment in human sexuality will continue to be a major impediment to progress in this field for some time to come. The creation of regional or national coordinating bodies to perform the following functions (8, 12) would be most valuable :

- take the leadership and initiative in developing sexological training programmes, curricula for medical schools, etc. ;
- coordinate training, research, and service activities to avoid duplication and to promote the best utilization of resources ;
- serve as a central reference centre, with both library and publication services ;
- create a consortium of specialists through which specialist care for complex sexual problems could be provided ;
- support surveys of sexual practices, epidemiological research into the sexual health needs of the population, and services available to meet these needs ;
- coordinate clinical research ;
- facilitate coordination and communication internationally with other institutions working in the same field ;

- develop locally appropriate educational materials: films, manuals, guidelines, etc. ;
- promote programmes for the prevention of sexual ill health particularly through sex education programmes aimed at the population at large ;
- convene meetings to promote exchange of experiences.

The Meeting recommends that a number of these functions could be usefully supported by WHO at the international level. Four main areas of assistance are envisaged.

(1) *Assistance to training activities*

Including :

- development of a prototype curriculum for training in human sexuality, or at least guidelines for curriculum development for members of the health team, especially workers dealing with maternal and child health and family planning, and basic health workers ;
- development of other prototype educational materials such as manuals and guidelines, a basic textbook on sexology, a glossary of basic sexual terms and audiovisual aids ;
- support for national training programmes through fellowships for programme leaders, advisory services by consultants, exchanges of staff, listing of qualified teachers.

(2) *Preparation of reference materials*

Including :

- a compendium of articles on sexology ;
- a bibliography of sexology, with reprints available on request (29) ;
- reports of meetings and conferences on sexology ;
- a directory of institutions and agencies providing services or engaged in training or research in human sexuality (9) ;
- collection of data on sexual practices, attitudes, and beliefs in different cultural areas, and on existing research projects in this area.

(3) *Convening meetings and conferences*

To consider such topics as :

- human sexuality as a part of total health ;
- definition of terms in sexology ;
- comparative evaluation of new sex therapies ;

- communication and the use of various media in sex education for health professionals ;
- methodology for surveys and epidemiological studies in sexual practices, sexual problems, and the availability of service and training facilities in different countries ;
- establishment of standards for textbooks and educational materials for use in training and sex therapy programmes ;
- the use of audiovisual aids in sex education, counselling, and therapy ;
- identification of the needs of populations that may be at risk with regard to the development of sexual problems, e.g., migrant workers, the elderly, children 0-5 years of age, the handicapped, minority groups, pregnant women ;
- sex education as a means towards the prevention of alcohol and drug abuse, sexual crimes, child abuse, divorce, and mental disorders ;
- review of methods and techniques of programme evaluation.

(4) *Support to research*

Including :

- survey studies of sexual practices and problems in different countries ;
- surveys of available services for sexual health care in different countries ;
- follow-up studies of WHO fellows trained in sexology.

## 6. CONCLUSIONS

The Meeting reached a consensus on the following main points :

### **The role of human sexuality in health programmes**

1. While recognizing that it is not possible at present to define the totality of human sexuality in a form that would be acceptable to all countries, the following definition of sexual health is proposed as a step in this direction :

Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love.

Every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation.

2. There is a need to change the existing attitudes toward human sexuality among the general public, as well as among health and other personnel who are responsible for sex education and sex counselling.

3. Any effort to improve the local situation as regards problems related to human sexuality must be adapted to suit the local culture and conditions and must be accomplished by indigenous health and other personnel.

4. In most parts of the world there is a need for survey and epidemiological data on social attitudes and practices related to sexuality. There is also a need to assess the related health problems in order to plan teaching and therapy programmes. Information of both types should be used in formulating programmes of education and training in human sexuality.

5. Family planning programmes should pay adequate attention to sexual behaviour and to sexual problems and needs. While family planning usually provides a suitable context in which to introduce training and services for sexual health, in certain situations where family planning is regarded as being exclusively concerned with birth control, sexuality programmes could also be developed outside this setting.

#### **Education and training in human sexuality**

6. While in many countries work of a pioneering nature has been done in the field of human sexuality, this has been the result of enthusiasm and self-teaching rather than training. There is a need for organized training of most categories of health and other personnel involved with sex education and sex counselling, including not only medical and auxiliary personnel who are in closest contact with persons presenting sexual health problems, i.e., gynaecologists, psychiatrists, paediatricians, general practitioners, nurses and nurse/midwives, basic health workers, and rural health promoters—but also a number of other community workers who undertake education and counselling, such as social workers, marriage counsellors, teachers, community and youth workers, clergy, and rehabilitation counsellors.

7. The development of positive attitudes towards sexuality as an integral component of total health should be a primary goal of education and training activities.

8. An interdisciplinary approach—working in the first instance through psychology, psychiatry, gynaecology, urology, paediatrics, nursing, social work, and health education—is necessary to cover the field of sexuality adequately.

9. There is a need to prepare and exchange up-to-date audiovisual and other teaching materials, including films, slides, textbooks, and manuals.



for use in sex education programmes for health professionals and for the general public. Such teaching aids should be based on and relevant to the culture of a particular country or region.

10. Depending on local conditions, human sexuality should be encouraged to develop as an autonomous discipline in the education and training of health professionals and to become a recognized component of general health services, particularly family health.

#### **Services for sexual health care**

11. Education, counselling, and therapy must be regarded as inseparable parts of a total effort to achieve optimal sexual health.

12. The provision of appropriate sex education for the general public should receive the highest priority of all the approaches to sexual health care, because of its importance in terms of prevention and its potential for affecting the largest number of people.

13. The second most important field of work for the future is the development of counselling and therapy programmes dealing with the most common kinds of sexual problems and disorders and designed to reach the largest number of people as inexpensively as possible.

14. In the treatment of sexual problems, as with other health problems, there can be no universally applicable approach and the choice of method should be made in relation to the specific problem, the cultural background of the patient, and the training and skill of the therapist.

15. Sexual therapy should be provided as part of the general health services and should thus be covered by the same schemes of health care payment.

#### **Regional resource centres**

16. Country or regional resource centres should be established to provide consultation and assistance in programmes of training, production of educational materials, research, and therapy related to sexuality.

19. Standard terminology to be used in education and therapy in human sexuality should be developed, and standards should be set with regard to training, therapy, textbooks, and audiovisual materials.

20. Increased communication between experts in the field of human sexuality is needed and could be promoted through the organization of an international institute, through meetings and publications, and through visiting teams.

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LIST OF BACKGROUND PAPERS <sup>a</sup>

1. Abraham, G. Psychological treatment of sexual dysfunctions : from psychoanalysis to hypnosis
2. Bancroft, J. The training of health professionals in human sexuality : the situation in the United Kingdom
3. Bancroft, J. Behaviour therapy for sexual disorders : a brief review
4. Bidgood, F. E. & Burleson, D. L. Sex education in the nursing curriculum in the USA
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13. Hertoft, P. Teaching sexology at the University of Copenhagen
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15. Israel, Sarah. Training needs in the teaching of human sexuality
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17. Kaplan, Helen S. Overview of sex therapy
18. Kaplan, Helen S. The sex therapy training programme at the Cornell-New York Hospital Center
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21. Meyenburg, B. & Sigusch, V. Sex education for health professionals and sexual treatment in the Federal Republic of Germany

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<sup>a</sup> A limited number of copies of these papers is available to persons officially or professionally interested on request to Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

22. Money, J. Phyletic and idiosyncratic determinants of gender identity<sup>a</sup>
23. Money, J. Identification and complementation in the differentiation of gender identity<sup>a</sup>
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25. Pasini, W. & Abraham, G. Sex education for health professionals in Latin America
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27. Rivera, R. P. Education and treatment in human sexuality: some indicators in Asian countries
28. Sarrel, P. M. & Sarrel, Lorna J. The dual therapy approach to the treatment of sexual dysfunction
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30. Trenc, P. Teaching of sexology and treatment facilities: current situation in Yugoslavia for medical professionals
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33. Vandervoort, H. E. The human sexuality programme at the School of Medicine, University of California
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35. Vandervoort, H. E. The sex advisory and counselling unit at the School of Medicine, University of California
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<sup>a</sup> Papers no. 22 and 23 were published under the same titles in the *Danish Medical Bulletin*, 19:259-264, 265-268 (1972). They were reproduced for the Meeting by kind permission of the Editor of the *Danish Medical Bulletin*.

<sup>b</sup> Paper no. 32 was published under the title "Le médecin de famille et la petite sexologie" in *Bruxelles Médical*, 49 (11): 693-706 (1969). It was translated and reproduced for the Meeting by kind permission of the Editor of *Bruxelles Médical*.

WHAT IS SEX THERAPY? <sup>a</sup>

The new approach to the treatment of sexual dysfunctions differs from other forms of therapy in two respects : first, its goals are limited essentially to the relief of the patient's sexual symptoms. Second, it represents a departure from traditional techniques in that it employs a combination of prescribed sexual experiences and psychotherapy to achieve its primary objective.

**Limited goals**

Sexual therapists differ somewhat in the way they define their therapeutic goals. All workers in this field focus on fostering better sexual functioning, but some espouse broader objectives. Thus they also include improvements in the couple's mode of communication and in their relationship in general, as well as resolution of the intrapsychic conflicts which underlie their sexual problems, among the final goals of treatment. However, the overriding objective of the new treatment of sexual disorders is to cure the patient's sexual symptoms. All therapeutic interventions, sexual tasks, psychotherapy, couple therapy, etc., are ultimately in the service of this goal.

It is this admittedly limited objective that distinguishes the new sex therapy from other forms of treatment, such as psychoanalysis and marital therapy. Although the patient's problem may appear to be limited to his inability to function adequately in the sexual sphere, psychoanalysts tend to regard the presence of a sexual dysfunction as a manifestation of psychological illness. Proponents of this position contend that all sexual disorders, regardless of their nature and severity, are expressions of unresolved intrapsychic conflicts and/or destructive interpersonal interactions. The patient's conflicts and his interpersonal difficulties exert their noxious influence on other aspects of his behaviour as well. The aim of treatment, therefore, necessarily extends beyond alleviation of the patient's sexual problem ; rather, its main objective is the resolution of the patient's deeper intrapsychic and interpersonal problems, and the concomitant reconstruction of his neurotic personality.

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<sup>a</sup> Excerpts from background paper No. 17 (with slight editorial changes). See also KAPLAN, H. S. *The new sex therapy*. Brunner/Mazel, New York, 1974.

The techniques of psychoanalytical treatment reflect this theoretical orientation. First, sexual problems are never treated in isolation from the patient's other problems. Second, the sexual symptoms are not treated directly, i.e., no attempt is made to modify the immediate causes of the patient's sexual dysfunction. Instead, the psychotherapist proceeds on the assumption that the intrapsychic and/or interpersonal causes of the patient's sexual dysfunction are invariably embedded in the developmental matrix of the past. Third, since, as noted above, the patient's sexual disorder is regarded as a manifestation of his deeper psychological problems, any symptomatic improvement that may occur in the course of treatment is considered a "by-product" of the resolution of his more basic personality problems and/or the modification of his pathological pattern of interpersonal relationships. Therefore, when the impotent man is again able to have intercourse, and when the inorgastic woman has an orgasm, treatment is not terminated. Therapy ends only when the psychotherapist feels that the basic oedipal conflicts and/or the marital power struggles that have presumably given rise to the patient's sexual problems have been resolved.

Dynamically oriented sex therapists do not dispute the fact that some sexual symptoms can be traced to intrapsychic conflicts and destructive interpersonal relationships, and can best be understood in terms of the patient's childhood experiences. However, the sex therapist is concerned first and foremost with the immediate causes of the patient's sexual problem and the specific defences he has erected against sexuality. In contrast to the forms of treatment described above, the remote determinants of the problem are dealt with in sex therapy only to the extent necessary to cure the sexual target symptoms, and prevent a recurrence of the disability. Psychodynamic and transactional factors are interpreted, and neurotic behaviour is modified by dynamically oriented sex therapists, but only if these are directly operative in impairing the patient's sexual functioning, or if they obstruct the progress of treatment. Therefore, sexual therapy is concluded when the patient's sexual functioning has been restored. This is not to say, of course, that treatment is terminated precipitately, as soon as the impotent patient manages to have intercourse on one or two occasions. Treatment is terminated, however, when in addition to alleviation of the sexual dysfunction, the factors immediately responsible for its onset have been identified and sufficiently resolved to warrant the assumption that sexual functioning is now reasonably permanent and stable.

#### **Sexual tasks combined with psychotherapy**

The use of sexual tasks constitutes the crucial technical difference between the new sex therapy and traditional forms of treatment. In other

forms of psychotherapy the events that occur in the therapist's office provide the setting for the therapeutic process. Thus, in traditional treatment based on the psychoanalytical model, the analyst does not intervene directly in the patient's life, except perhaps to admonish against self-destructively "acting out" conflicts and resistances. He generally refrains from making specific suggestions, and certainly never instructs the patient to engage in specific experiences outside the clinical setting. Such behavioural prescriptions would be interpreted as an attempt on the part of the therapist to "manipulate" the patient, which is considered by many authorities to be contraindicated to psychoanalytically-oriented psychotherapy. Instead, the psychoanalyst relies exclusively on the events that transpire during the therapeutic sessions—and particularly on the patient-analyst relationship—to achieve his results.

The marital therapist, who generally employs sessions in which husband and wife as well as the therapist participate to resolve marital discord, also considers the couple's experiences during these sessions to constitute the primary element involved in achieving cure.

Similarly, the various techniques employed by behaviour therapists with the object of extinguishing the fears and inhibitions that impair the patient's sexual response are also generally administered in the therapist's office under his direct guidance. Usually, behavioural therapists do not exploit the therapeutic potential of extra-office experiences.

This exclusive reliance on the office session is in sharp contrast to the approach of sex therapy. Sex therapists consider specific experiences, suggested by the therapist and conducted by the patient and his or her partner while they are alone together, to be the crucial feature of the therapeutic process; indeed, these prescribed tasks are regarded as essential agents in the production of change. The integrated use of these therapeutic experiences increases the effectiveness of psychotherapy enormously.

A variety of tasks have been developed by sex therapists. These have different goals and effects. For example, Masters and Johnson use a systematic sequence of tasks that begin with "sensate focus". This consists essentially of a period of coital and orgasmic abstinence for both partners. During this time they take turns in gently caressing each other, thereby substituting the goal of giving and receiving of pleasure in sexual contact, for the destructive one of feeling one must give a sexual "performance". Another technique used in sex therapy is the "stop-start" penile stimulation technique prescribed for the couple in cases of premature ejaculation. This method is specifically indicated to teach orgasmic control in this disorder. Other sex therapists use a variety of erotic films and literature, masturbation, vibrators, and various techniques of erotic stimulation as part of their treatment procedures. In general, it is the aim of the thera-



peutic erotic tasks to dispel performance anxiety, fear of rejection by the partner and guilt and shame. These factors seem to be highly prevalent deterrents to sexual abandonment, which is a prerequisite of adequate sexual functioning.

Some sex therapists rely exclusively on prescribed sexual experience to improve the couple's sexual abandonment. However, psychodynamically oriented sex therapists employ an integrated combination of sexual experiences and psychotherapy. This combination constitutes its main innovation and is probably largely responsible for its impressive success. Psychotherapeutic intervention, in itself, whether it is conducted on an individual basis or by joint treatment of husband and wife, alleviates sexual problems to some extent. It is also safe to assume that highly stimulating and concomitantly reassuring sexual experiences have enabled some persons to overcome their sexual difficulties. However, the judicious combination of prescribed sexual interactions that are systematically structured to relieve specific sexual difficulties, and psychotherapeutic sessions that are designed to modify the intrapsychic and transactional impediments of adequate sexual functioning, is the most effective and far-reaching approach to the treatment of sexual difficulties devised to date. As such, the new sex therapy may be considered to constitute a major advance in the science of behaviour.