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## Clinical practice in Portuguese sexology

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### **Abstract**

Few studies explore the clinicians' knowledge, attitudes and practices regarding sexuality, despite their role in the sexual health socialization process. This study focuses on Portuguese sexologists engaged into clinical practice. It aims to characterize sexologists' sex education and training and their clinical practices, including diagnostic and therapeutic approaches. This research followed the methodology of a survey undertaken in France as a part of the Euro-Sexo study. From the 91 obtained questionnaires, 51 (56%) were active in clinical practice. Results indicate that the Portuguese clinical sexologist is significantly older, predominantly male, has had training in sexology, performs more scientific research and is more engaged on teaching activities when compared to non-clinical working sexologists. This paper describes main sexual problems presented by patients to Portuguese clinical sexologists and highlights differences in the professional groups and approaches towards treating these problems by medical doctors and non-medical professionals. Results reinforce the idea that there are intra-European differences in the educational background of sexologists and reveal important variations in Portuguese sexologists' education, training and clinical practice. The representations and practices of the

sexologists in Portugal, as in other European countries, are embedded in cultural scenarios and sexual cultures, with implications for the clinical practice.

**Keywords:** sexology; sexologists; cross-cultural studies; clinical practice; sexual problems

## **Introduction**

Sexology has been presented as a discipline that is still on the process of defining itself and that combines the inheritance of various scientific fields, namely the ones of the health, bio-medical and behavioural sciences. Sexology manifest function is dealing with sexuality, and in particular sexual function, while its latent function is similar to the one of religion and of medicine, that is establishing sex rules and borders, and defining right and wrong (Guasch 1993). In this sense, and as held by Béjin (1982), the scientific power of contemporary sexologists first relies on the agreement on a definition of “sexual health” as a new social norm and then holds to the fact they have been able to impose their definition of a cultural scenario and interpersonal scripts of the sexual acts, of the "legitimate means" to achieve this goal, and on the recognition of their competence in the definition, correction and prevention of sexual deviation (Gagnon 1990).

Nevertheless, the representations of sexuality attributed to sexologists, or which they themselves have, remain under-researched as though they could not have a lay or personal perception. Among the few existing studies, some French researchers (Giami 2010; Moulin 2007) have highlighted the difference between ‘the professional perspective’ and ‘the perspective of the professional’ indicating through these different expressions the fact that the collective, social professional perspective is not the same as the subjective, psychological dimension of the professional as a person regarding sexuality. Indeed, the professionals build their own representations, values and rules, according to their personal biography and subjectivity, and their professional experience to define the contours of a sexuality socially desirable or deviant. Also a recent study on the sexual attitudes, experiences, and functioning of an international group of sexuality professionals revealed that, as a group, sexuality professionals

tend to resemble the general population. Further, results of this investigation demonstrated that, for the most part, sexuality professionals are motivated to enter the field by their desire to contribute to the profession and to better the human condition (Luria, Byers, Voyer et al. 2013).

## *Sexology in Portugal*

In Portugal sexological clinical practice started in the sixties and especially in 1975 (the democracy was restored from a conservative fascist government in April 1974) with the creation of sexology units in public hospitals in Coimbra, Oporto and Lisbon (the largest cities). Sexual therapy was performed by some psychiatrists interested in the work of Masters & Johnson (Albuquerque 2010). The foundation of SPSC (*Sociedade Portuguesa de Sexologia Clínica* – Portuguese Clinical Sexology Association) happened officially in 1985, but research and training of specific psychiatrists, psychologists, and medical doctors had already emerged. In the nineties, the role of psychologists in sexology practice increased and, at the end of the decade, urologists and andrologists were also involved. Nevertheless earlier the (*Sociedade Portuguesa de Andrologia* – Portuguese Andrology Society) was founded on 1979 mainly by urologists and concerned exclusively with male sexual health and infertility issues (Moreira 2000). Professionals from both scientific societies collaborated but the sexology field and sexual therapy was more associated with the first. The medicalization of sexuality issues and the emergence of effective medical treatments changed this situation, raising the number of healthcare professionals in the sexology field. Nowadays sexology practice can be found in public services, mainly hospitals with multidisciplinary teams and in private offices. Some lists are available either in the “yellow pages” list of the Portuguese telephone directory or by searching for specific sexual therapy services (Alarcão, Machado and Giami 2016).

However, becoming a sexologist in Portugal has not yet a clear defined pathway (Alarcão, Beato, Almeida et al. 2016). This situation is similar in other European countries (Giami and de Colomby 2006), while the Quebec case, where sexology is an autonomous discipline with an initial University education in the Faculty of social sciences and humanities leading to the acquisition of a diploma, is unique in the world (Dupras 2006). In Portugal training in sexology issues has been provided by SPSC and SPA, along with *Lusófona University* (a private university in Lisbon), and other institutions. SPSC provides a sexual therapist title since 1995, for those who have a medical degree or a clinical psychology background and have undertaken their two-year training program, which includes supervision sessions and research and clinical practice. Other institutions offer academic but not professional certification such as masters' degree (Kontula 2011). Nevertheless, the occupation is little institutionalized in terms of control and protection of the title and professional status of sexology, and the professionals are willing to forego the same, given that the title of psychologist, and even more so, the medical doctor title, transfers legitimacy enough, in Portugal as elsewhere (Giami 2012).

## **The current study**

This study is based on the assumption that sexology as a scientific discipline and of sexologists as a professional group must be investigated within a sociocultural, political, economic, and historical context (Giami 2012). In some cultures traditional healers or religious/spiritual leaders are the competing actors with sexologists and sex therapists in the process of re-shaping the concept of sexual health, proposing non-biomedical rationalities, challenging the

institutionalized dynamics of knowledge and power, and the existing models of care management and provision (Hall, and Graham 2013).

In this article, the term sexologist is used to describe sexuality professionals with different degrees and levels of training who work as physicians, psychologists, nurses, midwives, therapists, educators, and researchers, in settings that can range from universities to nongovernmental organizations (NGOs), health care, hospitals, government entities, and private practice, and who contribute directly or indirectly to the sexology perspective. We will focus on the subpopulation of sexologists who declared being engaged in clinical practice, but first compare clinical and non-clinical engaged sexologists' main characteristics. Our aim is to describe the type of training that Portuguese clinical sexologists have, to identify which sexual problems they are treating, and the treatments they are offering. In addition to that, we intend to investigate if clinical sexologists act as a cooperative interdisciplinary group, and understand their opinions regarding specific sexological problems. By studying the diversity among Portuguese sexologists, namely the gap between medical and non-medical approaches of sexual problems, we will expect to contribute to highlight the imbedded cultural conceptions of sexuality. Investigating which sexual problems are being treated, which treatments are being offered, and what are sexologists' opinions regarding specific sexological problems enables the understanding of dominant conceptions of sexuality and of the definitions of normal/functional and pathological/dysfunctional sexuality.

## **Method**

### ***Participants and procedure***

This research followed the methodology of the Euro-Sexo study, the large survey of sexologists carried out in France (Giami and de Colomby 2003) and duplicated in six other European countries (Denmark, Finland, United Kingdom, Italy, Norway and Sweden) (Giami and de Colomby 2006). The survey was performed from August 2012 to January 2013. To begin with, we identified professional sexology associations to which Portuguese sexologists could be members. Then, a total of 490 individuals working in the field as professionals with several backgrounds, and/or as students, were identified as sexologists, following the same criteria as in the surveys of the other participating countries. Copies of the questionnaire and a separate nominative reply coupon were mailed to all professional members of the SPSC and their former and current students of the sexual therapy training program, to the SPA, to the Family Planning Association (*APF – Associação para o Planeamento da Família*), and to sexologists identified in the “yellow pages” list of the Portuguese telephone directory. By using a separate nominative coupon, we ensured the questionnaire could remain anonymous. At least two reminders were sent to those who had not returned the nominative coupon. In addition to this, an electronic version of the questionnaire was also created and made available on the project’s website and in the Portuguese Clinical Sexology Association’s website. Plus, an invitation email was sent to the mailing list of the former and current students from the master in sexology from the *Lusófona University*.

After the first contact, 28 were excluded (21 were unreachable, 4 considered themselves not eligible for the study and 1 passed away), plus 4 participants explicitly refused to participate.

A request for permission to store and use data collected for this study was submitted to the National Commission for Data Protection, which accepted it. Participants expressed their



informed consent to participate by returning the questionnaire, and assurances of confidentiality were given. Participation was voluntary and no monetary compensation was given.

## *Measures and statistical analysis*

The original French version of the questionnaire (Giami and de Colomby 2003) was translated into Portuguese, compared to the previously translated Brazilian version by Centro Latino-Americano em Sexualidade e Direitos Humanos (Russo, Rohden, Faro, Nucci, & Giami, 2013), and adapted to Portuguese context (especially questions concerning academic training and the organization of the health system). The questionnaire was organized in the following 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) Relationships with the clients; 6) Opinions about sexology and sexuality; 7) Other activities in the field of sexology; and 8) Sociodemographic information. The majority of questions were closed and dichotomous, and results were reported in both proportions and total sample. To compare sexologists according to their professional category (medical doctors versus non-medical professionals) and gender, chi-square tests (or Fisher's exact test) were used for categorical variables, and the nonparametric Mann-Whitney test was used for continuous variables. All analyses were conducted using SPSS 21.0 for Windows and for all tests the level of statistical significance was set at 0.05.

## **Results**

Of a total of 91 answers to our survey (20% participation rate), 51 sexologists (56.0%) referred doing clinical practice. Portuguese clinical sexologists included in this article are significantly

older (in average 10 years) than those who are not doing clinical practice. Medical doctors are a majority (n= 29, 56.9%) among the sexologists with clinical practice, most of them being male (n= 20, 87.0%), while the sexologists without clinical practice are mostly non-medical professionals (n= 34, 85.0%) and female (n= 30, 51.7%). (**Table 1**). A significantly higher number of the clinical practitioners have had sexology or human sexuality training (n= 42, 82.4%) and had performed research within this scientific area (n=38, 74.5%). A significantly larger percentage (n=30, 58.8%) is currently teaching and training as a complement of their clinical activity, when compared to the Portuguese sexologists who are not engaged into clinical practice. The sociological composition of the sexologist as a professional group in Portugal was described elsewhere (Alarcão, Almeida, Ribeiro et al. 2016).

Among the participant Portuguese clinical sexologists who have a medical degree, most are urologists (n=14, 27.5%), followed by Psychiatrists n=5 (9.8%) and Endocrinologists (n=4, 7.8%). Other non-medical professions (n=22, 43.1%), mostly psychologists (n=21, 41.1%) show a larger percentage of women (n=19, 67.9%) (**Table 2**).

### ***Professional training and dedication***

When asked about the main sources of education in sexology, all the sexologists mentioned conferences as a source, followed by formal diplomas (n=35, 68.6%) and courses (n=16, 31.4%). Non-medical professionals report having more training in psycho-therapeutic, complementary and human sexuality approaches when compared to medical doctors (**Table 3**).

While no medical doctors reported dedicating all their professional time to sexology and reported mostly working on sexology for only 10-25% of their time (41.4%), the majority of other professionals (31.8%) did so (**Table 4**).

## *The clinical practice of sexology*

### *What sort of sexual problems are they treating?*

When considering male sexual problems, erectile dysfunction (n=26, 92.3% for medical doctors and n=19, 86.4% for non-medical professionals) appears the most common problem encountered in practice. Emotional and relational problems in males are more diagnosed by non-medical professionals (72.7% versus 21.4%), while other sexual problems are more evenly distributed. (**Table 5**). The most diagnosed problem in female patients is loss/absence of desire (n=31, 66.0%), being the most diagnosed problem by medical doctors (n=15, 57.7%), while emotional and relational problems are the most diagnosed problem by non-medical professionals (n=16, 85.7%). All female sexual problems are more diagnosed by non-medical professionals (**Table 5**).

### *What sort of exams are they performing?*

Testing the help of oral medication for erectile dysfunction was the most common performed test by medical doctors (n=15, 51.7%), followed by laboratory investigations (n=12, 41.4%), general clinical examination and psychological assessment (n=11, 37.9%). However, non-medical professionals indicate general clinical examination (n=12, 54.5%) and specialized clinical examination (n=11, 50.0%) as the top requested exams (**Table 6**).

## *What sort of treatment are they offering?*

Overall, psychotherapy, such as cognitive behavioural therapy and counselling (n=46, 90.2%), and human sexuality techniques, such as couple therapy, classic sex therapy (Masters & Johnson type) and new sex therapy (Helen Kaplan) (n=43, 84.3%) are the most used by Portuguese sexologists. Medical sexuality techniques in general (n=25, 89.7%), especially oral medication for erectile dysfunction (n=25, 86.2%) and intracavernous injection (n=22, 75.9%), are the most used therapeutic techniques by medical doctors. Psychotherapy is also widely used by medical doctors (n=25, 86.2%), with an emphasis in cognitive behavioural therapy (n=13, 44.8%). Human sexuality techniques are used by all non-medical professionals (n=22, 100%), while 72.4% (n=21) of medical doctors referred to have use them in their practice. Complementary therapies, such as relaxation techniques are also widely used by non-medical professionals (n=16, 72.7%), whereas medical doctors (n=6, 20.7%) rely less on them (**Table 7**).

## *Do sexologists act as a cooperative interdisciplinary group?*

Almost all of the participant Portuguese clinical sexologists refer patients to other specialists (n=49, 96.1%). Most of the non-medical professionals refer their patients to either urologists or gynaecologists (n=20, 90.9% for both), while none refers them to psychologists and psychotherapists. The opposite happens with medical doctors, who refer mostly to psychiatrists (n=18, 62.1%) and psychologists (n=17, 58.6%). Women refer considerable more patients to gynaecologists (n=22, 78.6%) and urologists (n=23, 82.1%) than men (n=10, 43.5% and n=9, 39.1%), respectively (**Table 8**).

*What opinions do they have in relation to specific sexological problems?*

Though a majority of the study participants agree that male problems are both organic and psychological, medical doctors significantly believe more in an organic cause (n=9, 31.0%, p value <0.05), while non-medical professionals believe that sexual problems are more solely psychological (n=9, 40.9%, versus n=4, 13.8% in medical doctors). The majority of the participants agree that female problems are mainly psychological (n=31, 60.8%) (**Table 9**).

## **Discussion**

Since 1998, the Euro-Sexo study group has been characterizing sexologists, particularly in European countries, and reporting interesting differences in the way professionals define and practice sexology (Giami & de Colomby, 2003; Wylie et al., 2004). However Portugal, as well as Spain, was not included initially (Giami & de Colomby, 2006). Our study was the first of its kind in Portugal, as to date no systematic survey had been conducted to characterize sexologists as a professional group and describe the clinical sexologists' practices, including diagnostic and therapeutic approaches.

The diversity of professions in the general sexology practice is interesting. For example, in Finland (Kontula & Valkama, 2006) and the United Kingdom (Wylie et al., 2004), nursing professions are prevailing, which is different from Portugal (Alarcão, Almeida, Ribeiro et al. 2016), Italy, (Simonelli et al., 2006) or Norway (Almaas & Giami, 2006), where nurses are also less frequently represented. It is also interesting to note that midwives are a large and important group within sexology in Sweden (Fugl-Meyer & Giami, 2006), but nonexistent in Portugal. GPs are prominent in France (Giami & de Colomby, 2003) and Denmark (Kristensen & Giami, 2006)

and much less represented elsewhere, including Portugal. In Portugal, urologists are the most dominant medical group, and psychiatrists appear in very small numbers despite the sexological history in which psychiatrists played an important role in the emergence of sexology. Considering the sexology foundation where their role was fundamental we can suggest that they retired ever since and were not replaced by other colleagues from the same field, but probably by other medical specialties, like urology, following the medicalization trend in general sexology (Alarcão, Almeida, Ribeiro et al. 2016).

The field of sexology in Portugal is not reducible to clinical practice, despite being primarily a clinical activity, as the French sexology (Giami et al. 2009). Of the 91 participating Portuguese sexologists, 51 (56%) were working in clinical sexology, and 29 (57%) of them were physicians, while the large majority of Swedish sexologists (91%) were active in clinical sexology yet a minority of these were physicians (24%) (Fugl-Meyer and Giami 2006), the same as the Norwegian scenario (Almaas and Giami 2006).

Most of the participant sexologists dedicate around 10-25% of their professional time to sexology, which is concordant with other studies (Wylie et al. 2004; Giami and de Colomby 2003; Kontula and Valkama 2006; Fugl-Meyer and Giami 2006). This indicates that across Europe, sexology is mainly considered as a part-time occupation. Interestingly, none of the medical doctors reported to work full-time as a sexologist in Portugal, which differs from the above mentioned countries where a small percentage reports working full time (Fugl-Meyer and Giami 2006; Giami and de Colomby 2003; Simonelli et al. 2006).

The majority of sexologists had specific instruction in sexology, in post-graduate and other training, which reveals specialization within a broader profession in sexology. Continuous

training is frequently done in congresses, especially for medical doctors. In Denmark, courses and conferences also represented the main source of education for medical doctors (Kristensen and Giami 2006). However, in Italy the majority of sexologists (88.9%) refer that they have no formal diploma in sexology, which is largely opposite to the results we have obtained in Portugal, where a majority has a diploma. Non-medical professionals have more training in all the groups of therapeutic techniques which can be related to their need of using them in their practice, as opposed to medical doctors.

Considering diagnostic processes, in the United Kingdom, erectile dysfunction was also mentioned as the most common sexual problem in men, as well as loss/absence of desire for women (Wylie et al. 2004). Interestingly, in the United Kingdom, medical doctors (sexologists) are diagnosing more sexual problems in males than non-medical sexologists, but when it comes to female problems it follows the exact same trend as in Portugal: female sexual problems are more diagnosed by non-medical sexologists.

As for the therapeutic intervention process, as erectile dysfunction is among the most prevalent sexual dysfunctions in Portugal (Quinta Gomes and Nobre 2013), and has become a major sexual health issue (Giami 2007) it is not surprising that medical doctors prescribe a large percentage of diagnosis tests that are directly or indirectly linked to this particular sexual problem. Interestingly, general clinical examination was more mentioned by non-medical professionals, as well as specialized medical examination. We would have expected these results; as for medical doctors a comprehensive physical examination is considered a first step towards a diagnosis in most of the medical conditions. The wide use of the test of help with oral medication by non-medical professionals is also a surprising result, as in Portugal this medication can only

be prescribed by medical doctors according to our regulations. These findings can be explained by the fact that all the non-medical sexologists have referred their patients to other professionals (mainly urologists and gynaecologists) at a given time, and that medical doctors had prescribed the medication. However, we suggest that further studies are conducted to understand the reasons why non-medical professionals refer the use of this drug.

Overall, psychotherapy and human sexuality techniques are the most used techniques in Portugal, which is concordant with some studies in other countries (Giami and de Colomby 2003). Psychotherapy is widely used in both France and Portugal, as well as in Norway (Almaas and Giami 2006). Portugal has a much higher use of pharmacologic therapies among medical doctors when compared to Norway, which suggests that in Portugal sexology is highly medicalized. However, in Norway the survey was carried out in 2001 and 2002, and the authors claim to believe that the prescription of oral medication in the treatment of erectile dysfunction has increased since that time. In the French survey this form of treatment was not incorporated, but still a total of 33.3% of the respondents reported that they prescribed intra-cavernous injections.

Referral to other specialists differ by background profession, while non-medical sexologists referred their patients to medical doctors, medical doctors choose to refer mainly for psychologists. This is most probably due to the fact that professionals refer their patients for a complementary evaluation, diagnosis or treatment that is beyond their scope or capacity. Our results are similar to other studies (Simonelli et al. 2006).

Portuguese sexologists' opinions about etiologies of sexual problems also differ by background profession. Interestingly, other studies have also found that sexologists refuse to see



female problems caused by a solely organic cause, and the majority are concordant that male problems have a mixed etiology, despite some believe that they can be solely or prevalently organic (Simonelli et al. 2006). In the Portuguese context, these results relate to the therapeutic approaches used in clinical practice: sexual problems in women are less medicalized when compared to men. In the United Kingdom, however, both medical doctors and non-medical professionals tend to agree that both male and female problems have mainly a mixed etiology (Wylie 2006). Despite scientific evidence pointing towards a mixed etiology, we believe that this question is still worth being discussed, as our results of sexologists' beliefs related to the etiologies of male and female sexual problems clearly show.

There is evidence of the traditional, mainstream cultural sexual script highly gendered in the most advanced research of the field of sexology. According to Giami (2007), one of the major dimensions of this discussion opposed the so-called "simplicity" of male sexual function to the "complexity" of female sexual function. In fact while male sexuality tends to be approached from the predominantly biomedical perspective, centered on the physiology of erection and drug prescription, female sexuality is considered to be conditioned by relationship problems, when psychological intervention is more adequate (Rohden and Russo 2011; Tiefer 2006). Clinicians along with their patients must be aware that they are active participants in the social construction of sexual health (Giugliano 2004).

### **Study limitations**

Our study has limitations in the low response rate and in the total number of participants obtained. Our response rate (20%) was similar to Italy (Simonelli et al. 2006), and contrasting with the 80% of response rate accomplished by the Swedish study (Fugl-Meyer and Giami 2006)

and of the other countries of the European investigation in sexologists as a professional group (Giambi and de Colomby 2006). To the best of our knowledge, there are no published studies on the response rates by healthcare professionals in Portugal and only scarce academic tradition to investigate the healthcare professionals as a target group.

The instrument used in Euro-Sexo research was developed before the presence of pharmaceutical companies in the sexuality field. In the future, it might be interesting to develop a new questionnaire that integrates new and relevant issues in the sexology field while maintaining some questions from the present instrument for further comparisons. An evaluation of the sex education and training that sexologists receive and their sexual intervention self-efficacy would provide important additional information (Miller and Byers 2009).

A qualitative research on how Portuguese sexologists have been defining and legitimizing their own expertise, and how they integrate their professional role into the vast multidisciplinary field of sexual health illustrated the potential of sexology as a transdiscipline (Alarcão, Beato, Almeida et al. 2016). Further research should be conducted to clarify the clinical sexologists' practices and attitudes, and the beliefs concerning what influence their practice. Qualitative methodologies can be an asset in exploring the clinical practice in Portuguese sexology and the involvement of certain professions and their interpretations.

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Table 1. Distribution of sexologists according to clinical practice

	<b>Clinical practice, n (%)</b> <b>51 (56.0)</b>	<b>Without clinical practice, n (%)</b> <b>40 (44.0)</b>	<b>P value</b>
<b>Age, mean (n=89)</b>	47.43	37.21	<b>&lt;0.001<sup>i</sup></b>
<b>Gender</b>			
Men	23 (69.7)	10 (30.3)	<b>0.038<sup>ii</sup></b>
Women	28 (48.3)	30 (51.7)	
<b>Professional group</b>			
Non-medical professionals	22 (43.1)	34 (85.0)	<b>&lt;0.001<sup>ii</sup></b>
Medical doctors	29 (56.9)	6 (15.0)	
<b>Sexology or human sexuality training</b>			
Yes	42 (82.4)	26 (65.0)	<b>0.050<sup>ii</sup></b>
No	9 (17.6)	14 (35.0)	
<b>Research in sexology (any time)</b>			
Yes	38 (74.5)	15 (37.5)	<b>&lt;0.001<sup>ii</sup></b>
No	13 (25.5)	25 (62.5)	
<b>Ongoing sexology teaching/training practice</b>			
Yes	30 (58.8)	13 (32.5)	<b>0.011<sup>ii</sup></b>
No	21 (41.2)	27 (67.5)	
<b>Ongoing sex education/information practice (n=90)</b>			
Yes	23 (46.0)	23 (57.5)	0.192 <sup>ii</sup>
No	27 (54.0)	17 (42.5)	
<b>Proportion of professional activity dedicated to sexology</b>			

< 25%	26 (51.0)	19 (47.5)	0.453 <sup>ii</sup>
<= 25%	25 (49.0)	21 (52.5)	

<sup>i</sup>Mann-Whitney Test; <sup>ii</sup>Fisher's exact test



**Table 2. Distribution of clinical sexologists according to gender and background profession**

<b>Background Profession</b>	<b>Gender</b>		<b>Total n (%)</b>
	<b>Men</b>	<b>Women</b>	
<b>Medical doctors</b>	<b>20 (87.0)</b>	<b>9 (32.1)</b>	<b>29 (56.9)</b>
Urologists	13 (56.5)	1 (3.6)	14 (27.5)
Gynaecologists	0 (0.0)	3 (10.7)	3 (5.9)
Psychiatrists	2 (8.7)	3 (10.7)	5 (9.8)
Endocrinologists	4 (17.4)	0 (0.0)	4 (7.8)
Others	1 (4.3)	2 (7.1)	3 (5.9)
<b>Non-medical professionals</b>	<b>3 (13.0)</b>	<b>19 (67.9)</b>	<b>22 (43.1)</b>
Psychologist	2 (8.7)	19 (67.9)	21 (41.1)
Nurse	1 (4.3)	0 (0.0)	1 (2.0)
<b>Total</b>	<b>23 (45.1)</b>	<b>28 (54.9)</b>	<b>51 (100)</b>

**Table. 3 Dimensions of training in sexology according to background profession and gender**

	Education in sexology			Training in therapeutic techniques		
	Diploma	Courses	Conferences	Psycho-therapeutic Approaches	Complementary approaches	Human sexuality approaches
Medical doctors	15 (51.7)	6 (20.7)	29 (56.9)	12 (41.4)	4 (13.8)	13 (44.8)
Non-medical professionals	20 (90.9)	10 (45.5)	22 (43.1)	19 (86.4)	10 (45.5)	16 (72.7)
Men	11 (47.8)	5 (21.7)	23 (45.1)	10 (43.5)	3 (13.0)	10 (43.5)
Women	24 (85.7)	11 (39.3)	28 (54.9)	21 (75.0)	11 (39.3)	19 (67.9)
<b>Total</b>	<b>35 (68.6)</b>	<b>16 (31.4)</b>	<b>51 (100)</b>	<b>31 (60.8)</b>	<b>14 (27.5)</b>	<b>29 (56.9)</b>

**Table 4. Professional work devoted to sexology by background profession and gender\***

	<b>Medical doctors</b>	<b>Non-Medical professionals</b>	<b>Men</b>	<b>Women</b>	<b>Total n (%)</b>
<b>&lt;10%</b>	8 (27.6)	1 (4.5)	6 (26.1)	3 (10.7)	9 (17.6)
<b>10-25%</b>	12 (41.4)	5 (22.7)	8 (34.8)	9 (32.1)	17 (33.3)
<b>25-50%</b>	6 (20.7)	3 (13.6)	6 (26.1)	3 (10.7)	9 (17.6)
<b>50-75%</b>	2 (6.9)	5 (22.7)	2 (8.7)	5 (17.9)	7 (13.7)
<b>100%</b>	0 (0.0)	7 (31.8)	0 (0.0)	7 (25.0)	7 (13.7)

*\*Considering all your professional work, what percentage of your time you dedicate to the field of sexology or human sexuality (including clinical practice, teaching, sex education and research)?*

**Table 5. Most common problems reported by sexologists' background profession and gender**

	<b>Medical doctors</b>	<b>Non-Medical professionals</b>	<b>Men</b>	<b>Women</b>	<b>Total n (%)</b>
<b>Male problems (n=50)</b>					
Erectile Dysfunction	26 (92.9)	19 (86.4)	23 (100.0)	22 (81.5)	45 (90.0)
Premature ejaculation	21 (75.0)	18 (81.8)	19 (82.6)	20 (74.0)	39 (78.0)
Sexual dissatisfaction	12 (42.9)	13 (68.1)	11 (47.8)	14 (51.8)	25 (50.0)
Loss/absence desire	14 (50.0)	9 (40.9)	14 (60.9)	9 (33.3)	23 (46.0)
Emotional and relational	6 (21.4)	16 (72.7)	7 (30.4)	15 (55.5)	22 (44.0)
<b>Female problems (n=47)</b>					
Loss/absence desire	15 (57.7)	16 (76.2)	12 (60.0)	19 (70.3)	31 (66.0)
Emotional and relational	8 (27.7)	18 (85.7)	5 (25.0)	21 (77.7)	26 (55.4)
Arousal difficulties	11 (42.3)	14 (66.7)	7 (35.0)	18 (66.7)	25 (53.2)
Sexual dissatisfaction	7 (26.9)	16 (76.2)	5 (25.0)	18 (66.6)	23 (49.0)
Difficult/absence orgasm	8 (30.7)	14 (66.6)	8 (40.0)	14 (51.8)	22 (46.8)

**Table 6. Most common performed exams by sexologists' background profession and gender**

	<b>Medical doctors</b>	<b>Non-Medical professionals</b>	<b>Men</b>	<b>Women</b>	<b>Total n (%)</b>
<b>Psychological assessment</b>	11 (37.9)	6 (27.3)	9 (39.1)	8 (28.6)	17 (33.1)
<b>Assessment of sexual history</b>	8 (27.6)	5 (22.7)	6 (26.1)	7 (25.0)	13 (25.5)
<b>General clinical examination</b>	11 (37.9)	12 (54.5)	9 (39.1)	14 (50.0)	23 (45.1)
<b>Specialized clinical examination</b>	9 (31.0)	11 (50.0)	9 (39.1)	11 (39.3)	20 (39.2)
<b>Laboratory Investigations (Doppler, ultrasound, Hormonal etc.)</b>	12 (41.4)	5 (22.7)	12 (52.2)	5 (17.9)	17 (33.1)
<b>Testing by intracavernous injection</b>	9 (31.0)	1 (4.5)	8 (34.8)	2 (7.1)	10 (19.6)
<b>Testing the help of oral medication for Erectile Dysfunction</b>	15 (51.7)	9 (40.9)	12 (52.2)	12 (42.9)	24 (47.1)
<b>Penile plethysmograph/RigiScan</b>	2 (6.9)	2 (9.1)	2 (8.7)	2 (7.1)	4 (7.8)
<b>Psychometric tests</b>	0 (0.0)	4 (18.2)	1 (4.3)	3 (10.7)	4 (7.8)
<b>Other investigations</b>	1 (3.4)	3 (13.6)	1 (4.3)	3 (10.7)	4 (7.8)

Table 7. Therapeutic techniques used by sexologists' background profession and gender

	Medical doctors	Non-Medical professionals	Men	Women	Total n (%)
<i>What therapeutic techniques do you use with your patients with sexual problems?</i>					
<b>Psychotherapy, such as:</b>	<b>25 (86.2)</b>	<b>21 (95.5)</b>	<b>20 (87.0)</b>	<b>26 (92.9)</b>	<b>46 (90.2)</b>
Cognitive behavioural therapy	13 (44.8)	17 (77.3)	8 (34.8)	22 (78.6)	30 (58.8)
Counselling	17 (58.6)	10 (45.5)	13 (56.5)	14 (50.0)	27 (52.9)
Psychotherapy	10 (34.5)	9 (40.9)	9 (39.1)	10 (35.7)	19 (37.3)
<b>Complementary therapies, such as:</b>	<b>6 (20.7)</b>	<b>16 (72.7)</b>	<b>6 (26.1)</b>	<b>16 (57.1)</b>	<b>22 (43.1)</b>
Relaxation techniques	5 (17.2)	14 (63.6)	6 (26.1)	13 (46.4)	19 (37.3)
<b>Human sexuality techniques, such as:</b>	<b>21 (72.4)</b>	<b>22 (100.0)</b>	<b>16 (69.6)</b>	<b>27 (96.4)</b>	<b>43 (84.3)</b>
Couple therapy	11 (37.9)	19 (86.4)	9 (39.1)	21 (75.0)	30 (58.8)

Classic sex therapy (Masters & Johnson type)	13 (44.8)	17 (77.3)	9 (39.1)	21 (75.0)	30 (58.8)
New sex therapy (Helen Kaplan)	11 (37.9)	15 (68.2)	6 (26.1)	20 (71.4)	26 (51.0)
<b>Medical sexuality techniques, such as:</b>	<b>26 (89.7)</b>	<b>7 (31.8)</b>	<b>19 (82.6)</b>	<b>14 (50.0)</b>	<b>33 (64.7)</b>
Oral medication for erectile dysfunction	25 (86.2)	7 (31.8)	19 (82.6)	13 (46.4)	32 (62.7)
Intracavernous injection	22 (75.9)	2 (9.1)	18 (78.3)	6 (21.4)	24 (47.1)
Surgery	15 (51.7)	1 (4.5)	14 (60.9)	2 (7.1)	16 (31.4)

**Table 8. Referral to other specialists by sexologists' background profession and gender**

	<b>Medical doctors</b>	<b>Non-Medical professionals</b>	<b>Men</b>	<b>Women</b>	<b>Total n (%)</b>
<i>During diagnosis or treatment, do you refer patients to other specialists?</i>					
<b>No</b>	2 (6.9)	0 (0.0)	0 (0.0)	2 (7.1)	2 (3.9)
<b>Yes, to:</b>	27 (93.1)	22 (100.0)	23 (100.0)	26 (92.9)	49 (96.1)
General practitioners	2 (6.9)	10 (45.5)	4 (28.6)	8 (17.4)	12 (23.5)
Urologist	12 (41.4)	20 (90.9)	9 (39.1)	23 (82.1)	32 (62.7)
Gynaecologist	12 (41.4)	20 (90.9)	10 (43.5)	22 (78.6)	32 (62.7)
Psychiatrist	18 (62.1)	15 (68.2)	16 (69.6)	17 (60.7)	33 (64.7)
Psychologist	17 (58.6)	0 (0.0)	13 (56.5)	4 (14.3)	17 (33.3)
Psychotherapist	8 (27.6)	0 (0.0)	5 (21.7)	3 (10.7)	8 (15.7)
Marital therapist	7 (24.1)	2 (9.1)	4 (17.4)	5 (17.9)	9 (17.6)
Other	5 (17.2)	3 (13.6)	5 (21.7)	3 (10.7)	8 (15.7)



**Table 9. Etiologies of sexual problems by sexologists' background profession and gender**

	<b>Medical doctors</b>	<b>Non-Medical professionals</b>	<b>Men</b>	<b>Women</b>	<b>Total n (%)</b>
<i>Do you consider that the etiology of male sexual problems is ...</i>					
Solely or prevalently organic	<b>9 (31.0)</b>	<b>0 (0.0)</b>	7 (30.4)	2 (7.1)	9 (17.6)
Both organic and psychological	<b>16 (55.2)</b>	<b>13 (59.1)</b>	12 (52.2)	17 (60.7)	29 (56.9)
Solely or prevalently psychological	<b>4 (13.8)</b>	<b>9 (40.9)</b>	4 (17.4)	9 (32.1)	13 (25.5)
<i>Do you consider that the etiology of female sexual problems is ...</i>					
Solely or prevalently organic	4 (13.8)	0 (0.0)	4 (17.4)	0 (0.0)	4 (7.8)
Both organic and psychological	10 (34.5)	6 (27.3)	7 (30.4)	9 (32.1)	16 (31.4)
Solely or prevalently psychological	15 (51.7)	16 (72.7)	12 (52.2)	19 (67.9)	31 (60.8)

Bold values indicate statistical significance at  $p < 0.05$ .