

THE USE OF SEXUALLY EXPLICIT MATERIAL IN SEX THERAPY

by

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Abstract

Using data from a sample of 99 sex therapists in the United States who participated in an online survey, the use of sexually explicit material (SEM) in sex therapy is explored. Findings suggest that prevalence rates for the use of sexually explicit educational material and erotica in sex therapy were very high, 92.6% and 81.1% respectively; while the use of pornography was much lower at 29.5%. Younger therapists, and therapists with less experience, were more likely than older therapists and therapists with more experience to use SEM in sex therapy. Overall, sex therapists were generally comfortable with sexually explicit educational material and erotica but less comfortable with pornography. Younger therapists and/or female therapists were most comfortable with the use of pornography in sex therapy. The primary theoretical rationale reported by sex therapists for using SEM was education. Several therapists indicated that they would not recommend the use of SEM in sex therapy with clients who expressed opposition or discomfort, clients who exhibit compulsive sexual behaviors, and with clients who have a history of sexual trauma.

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Chapter 1 - Introduction

Sexuality is an integral part of life that impacts individuals and relationships. It is a subject that, in recent decades, has gained prevalence in public discussion (Soble, 2009) and is often portrayed in the media (Menard & Kleinplatz, 2008). With the frequent emphasis of sexuality in the media, sexual expectations have become skewed (Brown, 2002), likely leading to more individuals' and couples' seeking outside resources to help resolve their sexual problems. Sexual problems are common (Heiman, 2002) and specialized treatments are now available. Clients, whose primary concern involves sexuality, may choose to seek services from a sex therapist-one who specializes in treating sexual problems.

With more people talking about sex and seeking treatment for sexual concerns, the demand for sex therapists has increased. In recent years, prominent television shows and magazines, such as the Oprah Winfrey Show and Cosmopolitan magazine, have frequently invited sex therapists to appear on their programs or in their magazines (Kleinplatz, 2009), introducing potential clients and future sex therapists to the profession. Sex therapists come from a variety of backgrounds, including psychology, counseling, clinical social work, and marriage and family therapy, providing many avenues to specialization in sex therapy. Perhaps, in part, due to the increased demand for sex therapists, media glamorization of sex therapy, and additional avenues into sex therapy, the number of sex therapists appears to be increasing, as evidenced by an increase in sex therapy certifications through the American Association of Sexuality Educators, Counselors, and Therapists (M. McGee, personal communication, April 1, 2011). Sex therapists utilize a variety of techniques and interventions. Woody (1992) suggested that the major interventions used by sex therapists are providing information/education, cognitive restructuring, and behavioral or experiential homework assignments. She suggested further that

one of the major homework assignments administered is the use of sexually explicit material (literature and films). Sexually explicit material (SEM) can be defined broadly as sexually explicit material created for the purpose of education, art, or stimulation. Among sex therapists, there are varying beliefs about what types of SEM (sexually explicit educational material, erotica, pornography) should or should not be used as therapeutic interventions.

One school of thought has suggested that the use of SEM, as a whole, in education and therapy enhances the clients' experience in addressing their concerns. For example, Striar and Bartlik (1999) suggested that "sex therapists have long appreciated the usefulness of erotic materials in helping patients achieve their desire for sexual fulfillment" and that clients "learn best when they are sexually aroused" (p.60). Additionally, visual materials may increase the awareness of sexual strategies for clients (Woody, 1992). Other sex therapists have been more reticent to use SEM, particularly pornography, due to the belief that problems and risks associated with pornography use outweigh the benefits. Maltz (2009) came to the conclusion, after many years of using pornography with clients, that because "porn conveyed harmful ideas about sex and could lead to hurtful and ultimately unrewarding sexual behaviors...therapeutically it [is] best to avoid pornography" (p.32). Others have also expressed concern for the potential harm it may have on clients (Court, 1984; Neidigh & Kinder, 1987).

There is growing evidence that sexually explicit materials, especially pornography have a negative impact on individuals and relationships (Carnes & Carnes, 2010). Concerns connecting pornography use to criminal behavior, such as providing stimuli for sexual perpetration (Oddone-Paolucci, Genuis, & Violato, 2000) and behavioral and sexual aggression (Allen, D'Alessio, & Brezgel, 1995; Malamuth, Addison, & Koss, 2000) have been presented. In addition, several studies have demonstrated the negative effects that pornography has on

relationships (Bergner & Bridges, 2002; Bridges, Bergner, & Hesson-McInnis, 2003; Oddone-Paolucci, et al., 2000; Schneider, 2003).

Part of the rising concern is that sexually explicit material seems to be increasingly available. Cooper (1998) suggested that the increase in pornography use has been due largely to what he called the *Triple-A Engine*: accessibility, affordability, and anonymity. These three factors essentially allow persons to access sexually explicit images from anywhere - at anytime - they have internet access (cell phones, iPods, laptops, etc.), with minimal monetary costs or threat of being discovered by others. These technological advances have led to increased access to all types of SEM as well as the increase in sexual addiction (i.e., addiction to pornography; Manning, 2006). With the increased availability of SEM, and the addictive nature of pornography (Kubey, 2009), advocating for the use of pornography in a therapeutic setting may inadvertently lead some clients to experience the negative effects of pornography.

Exactly how often sexually explicit materials are used in sex therapy is unknown. In fact, little is known about when it is most/least effective, what types of material are most/least effective, and the overall efficacy of SEM in the treatment of sexual problems. One obstacle in learning more about the efficacy of SEM in therapy has been the difficulty in defining different types of SEM. There are three primary types of SEM used in *sex therapy*, namely sexually explicit educational materials, erotica, and pornography. Sexually explicit educational material can be defined, with less controversy, as sexually explicit material created with the sole purpose of education. However, defining erotica and pornography has been much more difficult (Goldstein & Kant, 1973; Kronhausen & Kronhausen, 1967; Robinson et al., 1996). Notwithstanding the difficulty in defining SEM, Senn and Radtke (1990) proposed definitions for erotica and pornography. Erotica, they propose, refers to sexual material without violent,

dehumanizing, or sexist content (i.e., does not imply unequal power relationships, no implied acts of submission or violence). This material includes sexually explicit material which portrays persons present on their own accord, equal in power, and illustrating pleasurable sexual expression. Pornography is more complex and divided into two types: nonviolent (sexist and/or dehumanizing SEM without explicit violent content) and violent (sexist and dehumanizing SEM which demonstrate violence, or the aftermath of violence, or threat of violence). Although debatable, Senn and Desmarais (2004) later suggested that these definitions were accepted by most researchers.

Sexually explicit material has been a part of sex therapy for decades (Yaffe, 1982) and perceived by some sex therapists as “extremely helpful” in helping clients “enrich their sexual relationships” (Striar & Bartlik, 1999). Despite the long history of both sex therapy and SEM, together and individually, the research on the therapeutic use of SEM in sex therapy is limited. Not only is little known about its clinical efficacy, we know nothing of the long term effects (positive or negative) this material has on individuals, couples, and families. We do know that therapists who use SEM typically only utilize educational material and erotica (Kelley, Dawson, & Musialowski, 1989). However, we do not know what types of SEM are most/least effective, under what circumstances SEM is most/least effective, and how often SEM is being used in therapy. Although the current study is not directly testing the efficacy of SEM in sex therapy, this exploratory analysis will provide grounding for future best practice examinations.

The scope of the current study is to gain insight from sex therapists regarding how often SEM is used in sex therapy, which types of therapists are using it, when do therapists believe SEM is not useful, what components of each type of SEM are seen as most and least helpful, and

what theoretical rationale guides the use of SEM. The following are the operational definitions, derived from Senn and Radtke (1990) that will be used in this study:

- Sexually explicit material (SEM): visual material which depicts nude or partially nude person(s) who may or may not be participating in sexual behaviors.
- Sexually explicit education material: SEM with the sole purpose to educate (e.g., sensate focus tapes).
- Erotica: SEM with the intent to arouse, without violent, dehumanizing, or sexist content.
- Pornography: There are two types of pornography, namely nonviolent and violent.
 - Nonviolent: SEM with the intent to arouse, including sexist and/or dehumanizing SEM without explicit violent content.
 - Violent: SEM with the intent to arouse, including sexist and dehumanizing SEM which demonstrate violence, or the aftermath of violence, or threat of violence.

Chapter 2 - Literature Review

Sexually explicit material has been used as an intervention since the inception of sex therapy. Currently, there is not a consensus on what types of SEM should be used and in what situations they are most beneficial or harmful. In surveying the relevant literature, sources were targeted that explicitly involved the use of SEM. It must be noted, however, that SEM is often used in conjunction with other interventions and, therefore, may not be mentioned in studies as a guiding intervention. This review of the literature will contain brief histories of sex therapy and SEM. An overview of the argument for the use of SEM in sex therapy will then be presented, followed by concerns regarding the use of SEM in sex therapy. Finally, an overview of the studies which have specifically examined the use of SEM in sex therapy, literature specifying the theoretical rationale for using SEM, and previous studies similar to the current study will be provided.

Sex Therapy

Sex therapy has been in practice, in one form or other, for at least a century (Ellis, 1975). The research of Alfred Kinsey “helped pave the way” for the studies on sexual response by Masters and Johnson which ultimately produced their landmark text, *Human Sexual Response* (1966). Shortly thereafter, Masters and Johnson published *Human Sexual Inadequacy* (1970), which Kleinplatz (2009) suggested, “essentially created the field of sex therapy” (p.22). Although the word “created” is certainly too absolute, the arrival of William Masters and Virginia Johnson’s work on the scene of sexual research served as a catalyst to the profession as we know it today (Bullough, 1994). Masters and Johnson introduced major concepts to what would become sex therapy, namely sex as a biological function and that the relationship, rather than one symptomatic partner, should be the focus of treatment (Kleinplatz, 2009). In addition to

these concepts, Woody (1992) suggested other key elements of Masters and Johnson's work that remain integral to sex therapy, such as viewing the sexual dysfunction as the problem to treat, providing accurate information about sexuality, eliminating myths and sex-negative attitudes, and assigning clients behavioral/experiential homework assignments. Masters and Johnson's approach was filled with cognitive, behavioral, and experiential elements (Woody, 1992). These methods made sense, in that many clients simply needed to be educated and "learn to experience a positive, pleasurable, non-demand sensual/sexual relationship" (Woody, 1992; p.54).

Behavioral homework assignments have remained integral in this educational and experiential process (Woody, 1992).

Shortly after Masters and Johnson's initial impact on the field, Helen Singer Kaplan (1974) suggested using both psychotherapy and behavioral methods in treating couples with sexual dysfunction (Bullough, 1994). In this way therapists could explore deeper problems with clients when other brief sex therapy techniques failed to reduce sexual dysfunction (Ellis, 1975). The integration of sex and couples therapy became more prevalent (Kleinplatz, 2009) and persons, such as William Hartman and Marilyn Fithian, incorporated sex therapy techniques into their work as marriage and family counselors and taught seminars across the United States (Bullough, 1994). Sex therapy was making great strides as a profession but not without difficulty.

What is known as "the Viagra Moment" presented some difficulty in late 1990's (Kleinplatz, 2009). The emergence of pharmacological treatments, such as Viagra, Cialis, and Levitra, provided a "quick-fix" to sexual problems related to erectile dysfunction and encouraged many would-be sex therapy clients to opt for this less intrusive, quicker alternative. This proved to be an initial difficulty for the profession. Not only did pharmaceutical interventions provide

people with a quicker alternative to sex therapy, it also became easier to demonstrate clinical efficacy. In testing clinical efficacy, distributing a pill takes much less time than involving couples in therapy and also offers a clear treatment that can be administered in exactly the same way across a large sample, compared to therapy which may vary from couple to couple and therapist to therapist. Having an evidenced-based practice opens the door for managed care and thus reimbursement to clients. Unfortunately, as Kleinplatz (2009) suggests, “the most expedient treatment with the most clear-cut effectiveness in reducing symptoms of sexual dysfunctions may not be in the patient’s best interests in an area as complex as sexuality” (p.30). Fortunately, most clients desire more than “erections firm enough for penetration,” and hope for “a feeling of connection with their partners during sex and sex that is desired and worth wanting” (Kleinplatz, 2009, p.30). Many sex therapists have taken a multidimensional approach and integrate the use of pharmaceuticals with other therapeutic interventions (Kleinplatz, 2009).

In spite of “the Viagra moment” in sex therapy, the profession has seen an increase in clinicians. Professional organizations, such as The Society for Sex Therapy and Research (SSTAR), The Society for the Scientific Study of Sexuality (SSSS), and the American Association of Sexuality Educators, Counselors and Therapists (AASECT) continue to maintain membership and prominence. Leiblum (2007) suggested that, in some aspects, now is an opportune time to become a sex therapist. Leiblum proposed that the current expectation in sexuality has never been greater and that the majority of people expect to enjoy their sexuality and are often willing to seek treatment when things “go awry.”

Today, hundreds of sex therapists practice sex therapy and each is impacted in some way by the profession’s forerunners. Most therapists utilize, in some form, the interventions introduced by early sex therapists (e.g., Masters and Johnson). Although most interventions used

in sex therapy stem from the work of sex therapy pioneers, the interventions and treatment models used in sex therapy can vary from therapist to therapist. For example, sex therapists may disagree on the use of different types of SEM in therapy. Striar and Bartlik (1999) not only suggested using erotica with their own clients but reported that Helen Singer Kaplan would often recommend erotic videos to her patients, calling them “non-chemical aphrodisiacs.” However, in a recent psychotherapy magazine, Maltz (2009) stated her disagreement for the therapeutic use of similar videos, suggesting this material to be “capable of deeply harming the emotional, sexual, and relationship well-being of millions of men, women, and children” (p. 35). Although sex therapists, in general, have a similar goal (i.e., to help improve the lives of their clients), it is apparent there are different beliefs about the most effective way to obtain that goal.

Regardless of the differences clinicians may express in their use of sex therapy interventions, each sex therapist’s work should be guided by their respective ethical codes. For example, according to the AASECT Code of Ethics,

“The AASECT member shall accept that the consumer is in a unique position of vulnerability in respect to services related to sex education, counseling, therapy...and shall constantly be mindful of the responsibility for protection of the consumer’s welfare, rights and best interests...” (<http://aasect.org/codeofethics.asp>, retrieved on March 16, 2010).

Clients seek treatment expecting and hoping for the best care possible. Unfortunately, with limited empirical guidance, little can be said about a client’s “best interests.” This concept is a major reason for seeking out evidenced-based treatments, or best practice procedures. With little empirical guidance, clinicians, for the most part, are left to anecdotal evidence and their own judgment for clinical direction. Because therapists are often viewed by their clients as an

authoritative source, it is imperative that therapists adhere to their respective ethical codes and seek best practice interventions, including appropriate use of sexually explicit material.

Sexually Explicit Material

When one encounters the words “sexually explicit material,” the word pornography is likely to come to mind. This is in part because, historically, many used the term “pornography” for anything that was sexually explicit (Court, 1984). Currently, SEM is seen on a broader spectrum, including sexually explicit art, sexually explicit educational material, erotica, and pornography. Types of SEM vary in degrees of sexual explicitness and purpose. For instance, one marriage and family therapist, who had practiced sex therapy for over 40 years, suggested that one distinguishing factor between pornography and other sexually explicit material is in its primary purpose of use. Pornography’s primary purpose is to provide sexual stimulation and pleasure, whereas sexually explicit art and educational pieces are intended to entertain artistically and to educate (A.P. Jurich, personal communication, May 27, 2009). Others have suggested additional distinctions between pornography and erotica (Kuhn, Voges, Pope, & Bloxsome, 2007; Senn & Desmarais, 2004; Senn and Radtke, 1990; Zillmann, 1984). As mentioned previously, Senn and Radtke (1990) suggested that erotica lacks the violent, dehumanizing, or sexist content (typically directed towards women) often present in pornography. Kuhn and colleagues (2007) add that intimacy, or viewing the material with another person(s), is a defining characteristic of erotica, whereas pornography is viewed in isolation.

Sexually explicit material has been around for centuries (Wentland & Muise, 2010). Historically, SEM had been created primarily as a form of art, such as the Statue of David by Michelangelo and the Vitruvian Man by Leonardo da Vinci (Bucci & Buricchi, 2007). However, throughout time, SEM has adopted additional uses, such as to educate/instruct, entertain

sexually, and to elicit sexual arousal. Some uses of SEM have been more accepted than others. For example, in the current literature, there is little backlash against sexually explicit educational material, such as sensate focus films (Masters & Johnson, 1970). Pornography, however, has been much more controversial. In American society, pornography in print, whose primary use was/is to sexually arouse, was essentially unheard of in the “legitimate press” during the 1950’s (Brown & Bryant, 1989). Brown and Bryant suggested that, although pornographic films were available prior to 1965, they typically did not depict intercourse, except those films that were considered “underground” or “counter-culture.” From 1965 to 1975, sexual norms in America became less conservative, in both attitude and behavior (Robinson, Ziss, Ganza, Katz, & Robinson, 1991) and content in sexually explicit films became more graphic and also included more violence (Brown & Bryant, 1989). Following court decisions in the United States between 1958 and 1973, which “liberalized the availability of pornography in this country,” sexually explicit media content exploded in growth (Brown & Bryant, 1989). Surveys taken from the general public, between 1976 and 1985, supported the notion that standards of sexuality had changed and that SEM had become more acceptable (Winick & Evans, 1994). The majority of respondents in these surveys indicated they felt the right to obtain and view material containing every act of sex, including genital exposure. Roughly two decades later, Carroll and colleagues (2008) reported that nearly two thirds of emerging adult men and one half of emerging adult women reported the use of pornography, defined broadly as media used or intended to increase sexual arousal, as an “acceptable way to express one’s sexuality.” Also, nearly 9 out of 10 emerging adult males and nearly one third of emerging adult females used pornography at sometime.

Today, SEM is mainstream in American society and its production is burgeoning. For example, the worldwide pornography industry brings in nearly 100 billion dollars a year (Carroll, Padilla-Walker, Nelson, Olson, Barry, & Madsen, 2008; Ropelato, 2007), while the American porn industry alone has been estimated to bring in roughly \$10 billion annually (Hardy, 2008). The general public appears to be accepting of SEM (Carroll et al., 2008; Winick & Evans, 1994) and helping professionals have reported finding it useful in their work (Robinson, Manthei, Scheltema, Rich, & Koznar, 1999; Robinson, Scheltema, Koznar, & Manthei, 1996; Striar & Bartlik, 1999).

For a number of different reasons, advancements in technology-especially the advent of the internet, has significantly increased the proliferation of SEM (Cooper, 1998; Hardy, 2008). The general public now has access to essentially whatever type of SEM they desire, at an affordable cost, with a high degree of anonymity (Cooper, 1998). This is, in part, why sexually explicit material has become such a prominent feature of popular culture in the United States (Hardy, 2008). It is not only used by the general public but clinicians use it as well. Each type of SEM (sexually explicit educational, erotica, pornography) has been used in sex therapy and inviting clients to experience erotic literature and films is a general treatment procedure in sex therapy (Woody, 1992). Sexually explicit material has often been employed to provide a structured sexual experience, by way of vicarious learning, as part of the treatment for various types of sexual dysfunction (Kelley, Dawson, & Musialowski, 1989).

As mentioned, little resistance has been given to the use of sexually explicit educational material (e.g. sensate focus films). However, when it comes to erotica and pornography, there is little consensus on what is therapeutically appropriate. Given the prevalence of SEM in our society, it is no wonder some view it as a highly effective intervention (Striar & Bartlik, 1999).

Yet, all clinicians and clinical researchers are not accepting of this position and consider ineffective what other therapists view as very effective (Maltz, 2009). So where do these arguments stem from? Because there has been so little research conducted on the effectiveness of SEM in sex therapy, most of these arguments stem from anecdotal evidence and research outside a clinical setting.

Positive Views of Therapeutic Use of Sexually Explicit Material

The use of SEM in sex therapy began with desensitization programs for reducing anxiety in sexual dysfunctions (Wolpe, 1958-as cited by Yaffe, 1982) and has since been used in both assessment and intervention. Effective assessment and intervention has helped clinicians appropriately diagnose and treat sexual dysfunction. Yaffe (1982) suggested that using SEM as part of the assessment process has enhanced clinicians' abilities to gain accurate information from the client and identify specific areas of concern. As interventions, sexually explicit materials have had the ability to transmit information much more quickly, and often more accurately, than verbal explanations (Bjorksten, 1976). With the pressure to provide quick, efficient treatment, providing or suggesting a visual depiction of anatomy or sexual act has appeared logical.

Wilson (1978) summarized findings on SEM's ability to prevent sexual problems, prior to 1978, and suggested that 1) a substantial proportion of both men and women reported acquiring sexual information from pornography; 2) men who develop patterns of sexually deviant behavior have suffered a relative deficiency of experience with pornography in adolescence; 3) adults demonstrated lessened sexual inhibitions with their regular sexual partners after viewing pornography; 4) people, who view pornographic movies, exhibit an increased

inclination to discuss sex with others shortly following such experiences. Wilson concluded that using SEM as an intervention can help prevent sexual problems.

Around this same time, other authors promoted similar arguments (Bjorksten, 1976; Gillan, 1978; Yaffe, 1982). Bjorksten (1976) suggested that, aside from persons with psychosis, severe depression, or a strong moral indignation for the public display of SEM, sexually graphic materials are safe and useful in clinical work with clients. Specifically, Bjorksten mentioned using SEM to treat anxiety about sexual behaviors, an inability to discuss sexual matters using specific terms, anxiety about having sexual fantasies, paucity of sexual fantasies, excessively restrictive conservative attitudes about one's own sexual behavior, ignorance about sex, unrealistic expectations of sexual performance, sexual identity confusion, general sexual enrichment with couples, and couples with communication difficulties. Gillan (1978) added that erotica enhances sexual pleasure, performance, and function.

Given the fact that most of what has been written from this perspective is over two decades old, it is apparent that more research is needed in the realm of therapeutic uses of SEM. However, more recent literature is available, regarding the *attitudes* towards SEM. Studies have suggested positive views of SEM among the public, specifically among emerging adults (Carroll et al., 2008; Hald & Malamuth, 2008) as well as some mental health and health professionals (Robinson, et al., 1996; Robinson et al., 1999)

Sexually explicit material has become more accepted in our society. Utilizing visual images to demonstrate concepts, positions, or anatomy will no doubt provide a more rapid learning experience for clients. In addition to "learning efficiency," SEM provides a means for sexual arousal that may be otherwise difficult to obtain. Given the liberalization of sexual values, visual learning efficiency, and its ability to sexually arouse, it seems for many professionals, the

use of SEM in sex therapy appears logical. Although previously we did not know how many therapists used SEM with their clients, or the long-term effects of its use, the early researchers from this perspective were adamant about SEM's therapeutic efficacy and put forward a strong argument for the clinical use of SEM.

While the argument for the use of SEM in sex therapy posits many good points, it must be noted that much of what has been written from this perspective took place prior to the proliferation of SEM via the Internet. One of the proponents for the use of SEM in sex therapy, Maurice Yaffe (1982), suggested that although SEM has a definite place in sex therapy, it may not be therapeutically justified to use SEM with clients simply because it is available. The difficulty of choosing an alternative, more time-consuming route to educate clients, especially because SEM is widely available, is understandable. However, the abundance of SEM on the Internet poses an additional concern to the use of SEM in therapy.

Concerns about the Therapeutic Use of Sexually Explicit Material

While little research has examined the use of SEM in therapy, much has been published demonstrating the negative impact SEM has on persons outside clinical settings (for reviews see Brown, 2003; Cline, 1994; Manning, 2006). Most of this non-clinical literature refers primarily to non-educational material described as “pornography.” However, what this literature calls “pornography” would likely be classified as erotica according to the definitions proposed by Senn and Radtke (1990; Allen et al., 1995; Carroll et al, 2008; Oddone et al., 2000; Zillmann & Bryant, 1986, 1988). For instance, Zillmann and Bryant (1986, 1988) utilized common sexually explicit material which “employed a narrative format” and displayed sexual acts containing no sexual violence or bondage and discipline. Others give no indication of the content of the material but classify it as “pornography” (Bergner & Bridges, 2002; Bridges et al, 2003;

Simmons, Lehman, & Collier-Tenison, 2008). Given the lack of clarity in defining pornography in some studies and an interchange of definitions in others, it may be that what is considered erotica in some literature (i.e., clinical sex therapy) is considered pornography (i.e., non-clinical samples) in other literature. Notwithstanding the ambiguity of these definitions, this review on the negative effects of SEM on individuals and couples will use the definitions set forth by the respective researchers.

Individuals

A major concern of using SEM is the potential that a user could become addicted. Because of the aforementioned *Triple A Engine* (Cooper, 1998), the Internet has the ability to exacerbate exposure to SEM and potentially lead users to become addicted to Internet SEM. It has been proposed that, in some cases, persons may become addicted only hours after exposure (Young, 2008). Easy access to SEM, via the Internet, has led to a number of concerns, such as individuals' viewing SEM excessively, and becoming habituated to material. When this takes place, financial strain, public and/or private embarrassment, and relationship conflict may be the result (Manning, 2006; Schneider, 2003). Even prior to the SEM explosion on the Internet, Zillmann and Bryant (1986) discovered that this habituation to SEM led individuals to seek more, graphic content to satisfy their desires.

Other studies have reported the impact on individuals of exposure to SEM to be associated with sexual deviance (Davis & Braucht, 1973; Marshall, 1988; Oddone-Paolucci, et al., 2000; Propper, 1970; Walker, 1970) and violence towards women, including acceptance of the rape myth or the belief that victims bear partial or primary responsibility for the rape (Allen, D'Alessio, & Brezgel, 1995; Allen, Emmers, Gebhardt, & Giery, 1995; Malamuth, 1981; Malamuth, Addison, & Koss, 2000; Malamuth & Check, 1985; Simmons et al., 2008). Persons

exposed to pornography have also reported feeling less satisfaction with their current sexual partner's physical appearance, affection, sexual behavior, and sexual inquisitiveness due to comparisons with the unrealistic comparisons to pornography (Zillmann & Bryant, 1988). There is little doubt that pornography can have a negative impact on individuals.

Couples

It has been well documented that the use of pornography has been more common among men than it has women (Carroll et al., 2008; Schneider, 2000). Because of that, most of the research demonstrating the impact of pornography on romantic and spousal-type relationships has focused on male users (Bergner & Bridges, 2002; Bridges, Bergner, & Hesson-McInnis, 2003; Schneider, 2003). Bergner and Bridges (2002) specifically mentioned the impact pornography consumption had on a male consumer's partner: feeling worthless because if they were "good enough" their partner would have never viewed pornography; feeling sexually undesirable because they could not "measure up" to the erotic models; and feeling weak and stupid, because anyone who would put up with this behavior must be "weak and stupid." These same women felt that their partners' use of pornography demonstrated that they were inadequate husbands/fathers, liars who could not be trusted, and selfish individuals "invested exclusively" in their own desires because they satisfied their sexual desires without the approval or participation of their non-using partners. Consumers have also reported experiencing negative effects. Zillmann and Bryant (1988) reported that men exposed to pornography felt a diminished importance of sexual faithfulness, as well as elevating the importance of sex without emotional involvement, due to the examples they witnessed in pornography. Furthermore, Kenrick, Gutierrez, and Goldberg (1989) studied the impact of erotica on men's perceptions of their partner. Participants were exposed to erotica of the opposite sex and then given questionnaires,

including items related to the attractiveness of their partner and the love they had for their partner. Men who were exposed to erotica found their partners to be less attractive and reported less love for their partners than those who were not exposed to the erotica. From these findings, it may be concluded that pornography can negatively impact couples in a variety of different ways.

The findings of Amelang and Pielke (1992) suggested that these negative effects, at least for men, may hinge on the visual component of SEM. Amelang and Pielke investigated the liking and loving responses towards their partners of men and women exposed to non-visual erotic material (e.g. texts describing the courting and mating of heterosexual couples). The results showed no significant difference between those exposed to non-visual erotica and those who were not exposed to erotica. These results suggested that the types of SEM (visual or non-visual) to which persons were exposed may factor into the type of effect it has on individuals and couples.

In addition to individuals and couples, negative effects have also been reported for children. Schneider (2003) found that when a parent involved themselves with SEM excessively, their children often suffered. Some of the negative effects on children included decreased parental time and attention, witnessing parental conflicts, and exposure to sexually explicit material. From this literature, it is evident that SEM has the potential to adversely affect individuals, couples, and children.

Empirical Support for Using Sexually Explicit Material in Sex Therapy

A handful of studies have examined the efficacy of utilizing sexually explicit materials in clinical settings. Within this research, the primary focus has been on educational audiovisual material, rather than erotica or pornography. Although not all the studies reported positive

findings (Wincze, 1971), most reported results that suggested some degree of efficacy in specific circumstances.

Most studied the couple's use of audiovisual materials with other interventions. For example, Cole and colleagues (1980) used sexually explicit lectures, slides and films, along with a variety of other interventions, in treating couples with a variety of different sexual dysfunctions. Researchers followed up with participants two months after treatment and found that the majority of participants found the treatment pertinent, acceptable, and ultimately helpful. Specifically, roughly 90% of the participants reported the sexually explicit lectures, slides and films to be enjoyable and useful. In fact, one participant noted the explicit material as being a great "teaching device" and "sexual stimulant."

In one of the only studies to test exclusively the efficacy of sexually explicit educational materials, Jankovich and Miller (1978) examined the effectiveness of an audiovisual sex education program for adult women with primary orgasmic dysfunction. In their first week of therapy, a slide show consisting of 100 slides in video format, a 15-minute film illustrating the male and female sexual response cycle brought on by manual genital stimulation by a partner, and an 18-minute film of heterosexual intercourse was shown to 17 women with primary orgasmic dysfunction. Before they returned for their second session one week later, 7 of the 17 women reported obtaining orgasm, illustrating clinical significance.

Researchers have also found positive effects of sexually explicit audiovisual material in treating frigidity (Caird & Wince, 1974). Caird and Wincze utilized systematic desensitization in a case study they performed on a woman who suffered from frigidity. After the treatment was completed, the participant reported no anxiety during intercourse, as well as obtaining orgasm on multiple occasions. Others reported that sexual anxiety was reduced by showing SEM to female

clients while they utilized relaxation techniques (Nemetz, Craig, & Gunther, 1978) as well as when SEM was used to educate clients (Kilmann, Mills, Bella, Caid, Davidson, Drose, & Wanlass, 1983).

In reviewing these and other studies, Neidigh and Kinder (1987) warned against coming to the conclusion that using audiovisual materials in sex therapy is effective and that the inappropriate use of SEM may lead to increased sexual anxiety. They noted that nearly all of the studies (except for Jankovich and Miller, 1983) used additional interventions in conjunction with audiovisual materials, making it difficult to attribute the success of therapy exclusively to audiovisual materials. Jankovich and Miller (1978) were able to isolate their treatment to an audiovisual sex education program and, thus, to see the efficacy of using exclusively sexually explicit educational material. However, Jankovich and Miller's study had other methodological flaws that often plague clinical research, such as no control group and small/specific sample size. These methodological shortcomings were common in the studies reviewed and make it difficult to draw strong conclusions from their findings. Also, these studies examined the use of SEM, while clients were present in sex therapy. However, homework assignments are often used in sex therapy, including the suggestion to experience erotic literature and films at home (Woody, 1992). This suggestion may appear benign, but left unregulated, has the potential to lead to excessive use and addiction.

There is a substantial amount of research which purports that SEM, specifically pornography, has a negative impact on those who view it and their partners (for reviews see Brown, 2003; Cline, 1994; Manning, 2006). Addiction to SEM has become more prevalent and many therapists have clients who are involved in sexual addiction (Carnes & Carnes, 2010). Yet other professionals are strong advocates for the use of SEM as interventions in sex therapy

because of their ability to arouse passion (Striar and Bartlik, 1999), educate (Bjorksten, 1976) and assess and treat sexual deviations and/or dysfunctions (Kelley, Dawson, & Musialowski, 1989). The discrepancies and gaps in the literature make it very difficult to make informed judgments about the ethical use of SEM in sex therapy.

Theoretical Rationale for Using Sexually Explicit Material in Sex Therapy

In beginning their review of sexually explicit audiovisual material used in sex therapy, Neidigh and Kinder (1987) state: “A variety of theoretical rationales and practical considerations have led to the widespread use of sexually explicit audiovisual materials in the treatment of sexual dysfunctions” (p. 64). The majority of the referenced theories were educational in nature, such as observational learning, vicarious learning, and learning theory. Desensitization was also mentioned as a primary rationale for using audiovisual material. However, Neidigh and Kinder concluded that although there is a sufficient theoretical base for the use of sexually explicit audiovisual materials in sex therapy, limited empirical evidence exists to substantiate the efficacy of SEM as a part these theoretical rationales. Considering this report was published over 20 years ago, the current study sought to examine if these theoretical rationales were still used to guide the therapeutic use of SEM as well as to discover additional reasoning for using SEM in sex therapy.

Similar Research Studies

The research of Robinson and colleagues (1996, 1999) is similar in nature to the current study. Robinson and colleagues gathered data from mental health and health professionals in the United States and Czech/Slovak republics between 1992 and 1993. Their first article (1996) examined attitudes of professionals towards sexually explicit material. Results suggested that,

aside from bizarre/paraphiliac and violent sexually explicit materials, professionals in general held favorable views towards sexually explicit educational material, soft-core material, and hard-core material. These researchers also replicated prior findings that higher religiosity was related to less favorable views towards SEM (Lottes, Weinberg, & Weller, 1993). In addition, they found that, after controlling for religiosity, gender was not significantly related to attitudes towards SEM. Perhaps due to the participants' additional training, these findings were contrary to previous studies which cited men in the general population as having more favorable views towards SEM than women (Cowan & Dunn, 1994; Leiblum et al., 1993). In a second article published from this study, Robinson and colleagues (1999) examined the therapeutic use of SEM and found that professionals were 2.6 times as likely to mention specific instances when use of SEM was beneficial than instances when it was not useful. After examining instances in which participants mentioned SEM not being helpful, Robinson concluded that SEM should be used judiciously and suggested that professionals should be particularly careful in using SEM with clients with a history of sexual abuse and clients with strong religious beliefs/values.

The current study seeks to build upon the research of Robinson and colleagues by addressing additional deficits in the literature, such as how many sex therapists use SEM and with what percentage of their clients it is used. The current study specifically examined the use of SEM among sex therapists rather than all mental health and health professionals. This exploratory study also assessed what sex therapists perceive to be the most and least helpful components of SEM and the common theoretical rationales for use of SEM. The overall goal of the current study is to provide descriptive data to help define the use of SEM in the field of sex therapy. Doing so may provide grounding for future research in the efficacy of SEM in sex therapy. To accomplish this goal, the following research questions were examined:

1. What are the prevalence rates of using SEM among certified sex therapists?
2. Are there characteristics, such as gender, age, geographical location, religious affiliation, religiosity, years of sex therapy practice, and professional identity that factor in to use of SEM or feelings towards the use of SEM?
3. What is most and least helpful about the use of each type of SEM?
4. In what instances do sex therapists *not* recommend using SEM?
5. What are the most common theoretical rationales that guide the work of sex therapists in using SEM?

Chapter 3 - Research Method

Sample

Participants were 99 clinicians from the United States who were members of the American Association of Sex Counselors, Educators, and Therapists (AASECT) and indicated practicing sex therapy. Participants were contacted via email, which was attained through ASSECT's public website, and asked to complete a 64-item online survey. Because this was an electronic survey only sex therapists that provided an email address were invited to participate in the survey. Four reminder emails were sent to participants at one week, six weeks, eight weeks, and ten weeks after the initial invitation, encouraging them to participate in the survey. The survey was administered using Axio Survey, through Kansas State University's online service (K-State Online). Axio Survey is a secure web-based survey creation program which enables researchers to create and administer a wide variety of surveys. In all, 471 therapists were contacted and 99 responded to the invitation to participate in the study, for a response rate of 21%. Of the 99 therapists who began the survey, 77 filled it out completely. All data submitted in the survey were analyzed, regardless of when participants elected to terminate the survey. Each participant was provided with an informed consent prior to completing the survey. Participants were informed of his or her right to withdraw from the study at any time.

Measures

Although Robinson et al. (1996) developed a measure to assess the attitudes towards SEM of mental health professionals, no measures are currently available which assess the use of SEM in sex therapy. Therefore a survey was developed which included questions that directly addressed the research questions. Because of the exploratory nature of this study, several

questions that were asked in the survey were not included in the analysis for this study. For purposes of this study, four quantitative sections have been included: demographic information, prevalence of SEM in sex therapy, feelings towards SEM, and beliefs about the most and least helpful aspects of SEM. Participants were also asked two open-ended questions regarding any instances in which they would not recommend using SEM in sex therapy and their theoretical rationale for using SEM in sex therapy. For a complete list of survey questions see Appendix A.

Demographic Questions

Basic demographic information was gathered, including gender, age, marital status, religious affiliation (Catholic, Christian, Jewish, Other, None), and geographical location (Northeast, Southeast, Mideast, Midwest, Intermountain West, Pacific Coast). To gain a greater sense of what characteristics distinguish those therapists who are more likely to use SEM with their clients from those who do not, participants were also asked regarding their professional identity (Marriage and Family Therapist, Psychologist, Sex Therapist, Other), years of practice, clientele (individuals or couples), religiosity (1=Not at all religious, 5=Extremely religious), and exposure to SEM in their core graduate program (Never, 1-2 classes, 4-5 classes, Majority of classes).

Prevalence and use of SEM

No empirical study has examined how prevalent the use of SEM is in sex therapy. Questions were asked to identify how many sex therapists utilize the different types of SEM, and if used, how often SEM is used in their clinical practice. In order to determine if SEM was used more frequently in assessment, diagnosis, education, early intervention or late intervention,

therapists were asked, “At what point in the process of therapy do you choose to use SEM in sex therapy?”

Feelings towards SEM

Sexually explicit material has been found to illicit strong responses from sex therapists (Maltz, 2009). From the review of literature, it is apparent there has been a wide range of feelings regarding the clinical use of SEM. Previously, only one study has examined the attitudes of health professionals (e.g., sexologists, sex therapists, marriage and family therapists, psychiatrists, sex educators, physicians, nurses, etc.) about the use of SEM in treatment and education (Robinson, et al., 1996; Robinson et al., 1999) and no studies have been conducted to examine therapist’s perceptions of clients reactions toward SEM in sex therapy. The questions in this survey (e.g., “how would you describe your feelings towards the use of erotica in sex therapy?” and “In general, what is your client’s initial reaction to erotica?”) sought to add to our current understanding regarding sex therapists’ feelings about SEM, as well as how sex therapists perceive their clients to react to SEM in sex therapy.

Most and least helpful aspects of SEM

There are those who believe certain types of SEM are not appropriate for clinical settings (Court, 1984; Maltz, 2009) and others who do (Striar & Bartlik, 1999). However, little is known regarding what exactly is believed to be most and least helpful about the use of SEM in sex therapy. Therefore, each participant was asked to identify which aspects of sexually explicit educational material, erotica, and porn are most (i.e., efficiency of communication of sexual material, power of visual stimuli, facilitating a sense of ease with his/her own sexuality, desensitize against sexual anxiety, erotic arousal, novelty) and least (i.e., culturally distasteful,

potential for addiction, dehumanizing own sexuality, exacerbating body image concerns, facilitate unrealistic expectations, detaching spiritual and physical dimensions of sexuality) helpful.

Data Analysis

Quantitative data was analyzed using the software program PASW Statistics 17. Basic descriptive statistical procedures were used to describe the sample and identify the prevalence and use of SEM in sex therapy, feelings towards SEM in sex therapy, and which aspects of SEM are believed to be most and least helpful in sex therapy. Chi square tests of significance were utilized to examine any relationship between demographic variables and the use of SEM in sex therapy and feelings towards the use of SEM in sex therapy.

In order to analyze the qualitative data, two coders, who had been trained previously in open coding, independently read through the responses to the questions: “Are there any instances in which you would not recommend using SEM? If so, what are they?” and “What is your primary theoretical rationale for using SEM?” While carefully reading the responses, coders used inductive or “open” coding to identify themes for each question (Bernard, 2000; Strauss & Corbin, 1990). Upon completing this individually, the two coders worked together to reconcile any differences on the identified themes. The coders then went through each response and classified the response into the appropriate category. When differences arose between coders, responses were discussed until they were mutually agreed upon. Because some answers included several ideas, where appropriate, responses were coded into multiple categories.

Chapter 4 - Results

Quantitative Results

Participants were invited to complete both a quantitative and qualitative section of the study. Table 1 presents the descriptive statistics. Female participants represented approximately two-thirds of the sample (67.7%). Most of the participants were married (73.7%) and aged 60 and over (51.5%). The sample was represented by participants from all over the country: Northeast (26.3%), Southeast (20.2%), Pacific Coast (16.2), Mideast (14.1%), Midwest (12.1), and Intermountain West (11.1%). Participants were relatively diverse in regards to religious affiliation, with 29.3% identifying as Christian, 12.1% as Catholic, 18.2% as Jewish, and 15.2% as other religious preferences (e.g., Buddhist, Unitarian, Religious Science). Roughly a quarter of the sample (25.3%) indicated “None” as their religious preference. Overall the sample indicated low levels of religiosity (“not at all religious,” 33.3%; “not very religious,” 24.2%; “somewhat religious,” 34.3%), with very few reporting high levels of religiosity (“very religious,” 5.1%; “extremely religious,” 3.0%). No professional identity was dominant, with 30.3% claiming psychologist, 29.3% sex therapist, 20.2% marriage and family therapist, and 20.2% as other various professional identities (e.g., counselor, social worker). The majority of participants had practiced sex therapy for over 20 years (21-30 years, 27.3%; more than 30 years, 28.3%) and reported seeing both individuals and couples in sex therapy (62.3%).

When asked about their exposure to SEM in their core graduate training program, over half of the participants reported no exposure to SEM (55.2%), while roughly 10% indicated they had only discussed SEM in their core graduate training. Nearly one-third of sex therapists reported viewing and discussing SEM in their core graduate program (30.2%) and 4% suggested they had conducted therapy using SEM while in their graduate program. Notwithstanding limited

exposure to SEM during their graduate training, overall, therapists reported feeling comfortable using sexually explicit educational material (83.2%) and erotica (73.7%) in sex therapy (see Table 2). Therapists were much less comfortable with the use of pornography in sex therapy (26.3%). Also, age and gender were related significantly with feelings towards the use of pornography in sex therapy, with younger therapists (50's and younger; $\chi^2 (4) = 12.32, p < .05$) and female therapists ($\chi^2 (2) = 6.55, p < .05$) reporting greater comfort. Results for therapists' feelings towards the use of pornography in sex therapy are presented in Table 3.

Frequency distributions were utilized to discover the prevalence rates of using each type of SEM (see Table 4). Results indicated that sexually explicit educational material (92.6%) and erotica (81.1%) were used by the vast majority of participants, while pornography (29.5%) was used much less frequently. Chi square tests of significance revealed that only age and years of practice were related significantly to the use of SEM, with younger therapists (Erotica, $\chi^2 (2) = 6.12, p < .05$; Pornography, $\chi^2 (4) = 21.83, p < .001$) and therapists with fewer years of experience (Pornography, $\chi^2 (4) = 8.20, p < .05$) more likely to use SEM in sex therapy. Specifically, when compared to their peers in their 60's, therapists under 60 were more likely to use erotica. For pornography, each successive age group was less likely to use pornography, in that those therapists in their 40's and younger were more likely to use pornography than those in their 50's and 60's, while those in their 50's were more likely to use pornography than those in their 60's. Gender, marital status, geographical location, religious affiliation, religiosity, and professional identity appeared to have no significant impact on the use of SEM in sex therapy.

Although the vast majority of sex therapists reported using SEM with clients, only 22.5% of sex therapists indicated using sexually explicit educational material with over half of their clients. There was an even smaller portion of sex therapists who reported using erotica (17%)

and pornography (3.8%) with the majority of their clientele. It appears that if sex therapists elect to use SEM in therapy (some do not use it at all: Educational, 6.3%; Erotica, 20%; Pornography, 62.5%), many of them use it with less than 25% of their clients (Educational, 43%; Erotica, 37.5%; Pornography, 26.3%) while a smaller number of therapists use SEM with 25-50% of their clients (Educational, 27.5%; Erotica, 25%; Pornography, 7.5%).

In addition to prevalence of SEM use, participants were asked “At what point in the process in therapy do you choose to use SEM in sex therapy?” Originally, therapists were provided six options: assessment, diagnosis, education, early therapeutic intervention, later therapeutic intervention, and “I do not use (educational, erotica, pornography) in sex therapy.” Because very few therapists reported using SEM during the assessment and diagnosis process of therapy (assessment, 2; diagnosis, 3), analyses were only run for education and intervention (early and late intervention categories were merged for analytical purposes). Results indicated that sex therapists used sexually explicit educational material in both education and intervention (education only, 25.3%; intervention only, 38.9%; education and intervention, 28.4%). Erotica was used primarily for intervention (education only, 5.3%; intervention only, 60%; education and intervention, 15.8%), as was pornography (education only, 5.3%; intervention only, 20%; education and intervention, 4.2%). A chi square test of significance revealed no pertinent findings between demographic variables and when sex therapists choose to utilize SEM.

Insight was also provided into how sex therapists believe their clients feel about SEM in sex therapy. Sex therapists were asked, “In general, what is your client’s initial reaction to (educational, erotica, pornography)?” Per therapist report, clients were generally uncomfortable with pornography (Uncomfortable, 63.8%; Neutral, 22.5%; Comfortable, 13.8%) and slightly

more comfortable with erotica (Uncomfortable, 46.3%; Neutral, 25%; Comfortable, 28.8%) and educational material (Uncomfortable, 36.3%; Neutral, 22.5%; Comfortable, 41.3%).

Concluding the quantitative portion of the survey were responses indicating which components of SEM sex therapists felt were most and least helpful. Tables 5 and 6 represent these results. Efficiency of communication of sexual material (educational, 88.8%; erotica, 52.5%), power of visual stimuli (educational, 70%; erotica, 70%), facilitating a sense of ease with his/her own sexuality (educational, 81.3%; erotica, 71.3%) desensitize against sexual anxiety (educational, 73.8%; erotica, 56.3), and erotic arousal (educational, 61.3%; erotica, 77.5%) were noted by the majority of sex therapists as reasons why SEM was most helpful. Fewer therapists indicated components of pornography which were believed as most helpful. Components of pornography that were noted most frequently as being most helpful included: power of visual stimuli (43.8%), erotica arousal (45%), and novelty (32.5%). Roughly one-third of the participants (35%) indicated no components of pornography to be helpful.

Facilitating unrealistic expectations (educational, 57.5%; erotica, 67.5%; pornography, 82.5%), exacerbating body image concerns (educational, 60%; erotica, 63.8%; pornography, 73.8%), and being culturally distasteful (educational, 57.5%; erotica, 57.5%; pornography, 70.0%) were noted by the majority of sex therapists as reasons why SEM was least helpful. Sex therapists responded in similar ways to sexually explicit educational material and erotica, yet very differently to pornography. Specifically, pornography was associated much more frequently than educational material and erotica with being culturally distasteful, having a potential for addiction, dehumanizing sexuality, facilitating unrealistic expectations, and detaching spiritual and physical dimensions of sexuality.

Qualitative Results

In the qualitative portion of the survey, sex therapists were asked to provide their theoretical rationale for using SEM in sex therapy and indicate any instances in sex therapy in which they would not recommend using SEM.

Theoretical Rationale

Of the sex therapists who were invited to participate in the study, 51 completed this portion of the survey. Respondents were asked, “What is your primary theoretical rationale for using SEM?” Four main themes emerged from therapists’ responses to this question: Education, Desensitization, Stimulation, and Theory.

Education

Education was the largest theme, which was identified by 31 of the 51 respondents. Common responses included, “education,” “learning,” and “teaching.” Evident in the responses was the belief that clients often had a lack of knowledge about sexuality and that increased knowledge and/or understanding would benefit the client. The following excerpts demonstrate this belief: “Many people have little to no sexual education and they can benefit from accurate information. Most people have no idea of where to go to get this” and “Sexual anxiety is frequently based in a lack of knowledge. Healthy knowledge reduces fear and embarrassment.”

Given that many therapists believe a number of clients suffer from a lack of knowledge, it makes sense that some therapists appeared to take on the “teacher” role as it pertained to using SEM. One therapist highlighted using SEM in this capacity, “If and only if I feel it is the most effective way of teaching in a particular circumstance.” Another therapist mentioned using SEM based on a client’s “learning style,” and yet another suggested using SEM in order to “teach

them things that would be hard to cover in session with clothes on coaching.” Other therapists mentioned using SEM to provide additional information or ideas. For example, “give them ideas about how to be sexual in their own life,” “learn new things,” and “helps to demonstrate procedures they probably have never been exposed to” were all noted as theoretical rationales for using SEM in sex therapy.

Desensitization

Desensitization was acknowledged as a theoretical rationale by ten of the therapists. Most commonly, it was stated simply as “desensitization.” Other answers that were coded in this category were “increasing comfort,” “make them more comfortable,” and “reducing anxiety.” Desensitization was also associated with education, as six of the ten therapists mentioned both education and desensitization in their responses, for instance, “Education and Desensitization” and “Psycho-Educational, Behavioral Desensitization.”

Stimulation

Arousal and/or stimulation was suggested as a theoretical rationale for using SEM by six sex therapists. Some therapists simply stated “arousal” or “sexual stimulation.” Others put their response in context of a specific client population and type of SEM: “to help women especially get in touch with their sexual desire” or “Erotica and Pornography: Increased stimuli to create effective sexual arousal.” One sex therapist highlighted arousal in the use of SEM within the framework of relationships, “Healthy sexual response/arousal is achieved when the climate and the transference is eroticized. Additionally, patients can understand theirs and their partner’s erotic selves in the context of SEM.”

Theory

The final theme identified was *Theory*. In asking this question, it was expected that therapists would associate their use of SEM with a specific theory. However, if psychoeducation is excluded from this discussion, only eight therapists mentioned a specific theory. The majority of those who mentioned a specific theory identified either cognitive, behavioral, or both. For example one therapist stated “I am a largely a behavioral therapist so this material...fits right into my theoretical framework.” A couple therapists also stated “CBT” and others reported “cognitive perspective,” or “Cognitive/behavioral.” Some therapists provided specific techniques or reasons, within their theoretical framework: “increase of acceptance and challenging negative sexual messages regarding sex and intimacy,” “cognitive restructuring,” and “used as homework.” Other theories referenced in therapists’ responses included “Social learning theory” or “vicarious learning,” “systemic,” “didactic therapy,” and “Bowen’s Family Systems.”

There were a few responses which did not adequately fit into education, desensitization, stimulation, or theory. These responses also appeared not to provide any theoretical rationale for the use of SEM in sex therapy. Some referred to SEM as a “tool.” For example, one therapist stated: “to me it is a tool and I use every tool possible to work with couples.” Others were more general in their responses: “Powerful treatment modality for some,” “It is an effective part in sex therapy,” and “It is helpful in some situations.” Another therapist simply stated, “I’m not sure how to answer this question.”

Instances in which SEM would not be recommended.

Finally, sex therapists were asked if there were any instances in which they would not recommend using SEM. Of the 73 participants who answered this question, six indicated that there were no instances in which they would not recommend using SEM. Qualitative responses were collected from 62 of the therapists who indicated that there were instances in which they

would not recommend using SEM in sex therapy. Responses were categorized into three themes: Client Opposition or Discomfort, Sexual Compulsivity, and Trauma History.

Client opposition or discomfort.

Nearly two-thirds (40) of the participants stated they would not recommend using SEM in therapy with client's who expressed opposition or discomfort. Twenty-three of these therapists indicated they would not recommend SEM in therapy when a client's opposition was due to religious and/or cultural beliefs. This subgroup will be described in the following paragraph. Other therapists highlighted a client's opposition without specifying religious or cultural reasons. Some examples included "If the couple is uncomfortable with the idea of using SEM," "When the client(s) are very opposed to it," "If the patient is uncomfortable with it," "Client has strong feelings about not using the materials," and "When a client or couple has indicated no interest, negative attitudes toward videos or porn, or react negatively when I make a suggestion to try watching SEM."

Religious and/or cultural beliefs.

Indicative of this category is the response from one therapist, "If the client refuses due to religious or cultural grounds." Also, several therapists attached the adjective strong or rigid to the client's religious/cultural beliefs. For example, "Those people...whose cultural or religious beliefs are rigidly opposed," "Rigid fundamental Christians," "individuals who profess a strong religious or cultural aversion to SEM," and "If there are strong religious values." Some sex therapists qualified their responses in this category with potential justifications for using SEM even if clients presented with religious or cultural prohibitions. One therapist suggested "strong religious or cultural prohibitions" but added the following, "but I explore if this is really the case or just the individual using a 'road block'." Other qualifying statements which followed religious

and cultural reasons include: “strong religious persons *without proper education* first” and “rigidly religious couples who *are not ready for such exercise.*” (emphasis added)

Trauma history.

Several therapists indicated that they would not recommend using SEM with a client with a traumatic history. Most therapists who indicated they would not recommend SEM under these circumstances specifically identified the trauma as “sexual abuse” or “sexual trauma.” Other therapists simply mentioned they would not recommend using SEM with clients who had “PTSD.”

Sexual compulsivity.

The term “sexual compulsivity” was used to capture the idea of “sexual addiction” or “compulsive sexual behavior.” A total of 13 therapists indicated that they would not recommend using SEM with a client with compulsive sexual behaviors, while an additional therapist would not recommend SEM “to individuals with a risk for addiction.” Some therapists specifically mentioned the relationship between compulsive or addictive behaviors and pornography, reporting phrases such as “compulsive porn use,” “problems with pornography,” and “porn addicts.”

There were also a small number of responses that did not fit with the aforementioned themes. Two respondents referred to aspects of the couple relationship which may prevent them from using SEM: “When a client uses it to manipulate partners” and “where there are uneven power dynamics that have not been addressed in a person’s [family of origin] or in the couple relationship.” One therapist answered that there were instances in which they would not recommend using SEM but suggested “I would tailor it to the individual’s identity, problems,

and character.” Lastly, one therapist selected “Yes”, suggesting there were instances when he or she would not recommend using SEM, but instead of indicating a specific instance offered the following insight:

“These questions are very general, and the diversity of SEM material available is vast. I find that by carefully matching the particular material with the client, its use is dramatically helpful at best, and at the least either provocative... with reactions leading to further insight...or merely neutral. I don't think I've ever used it in a case where the material was harmful or problematic in and of itself.”

Chapter 5 - Discussion

This exploratory study found that prevalence rates for the use of sexually explicit educational material and erotica in sex therapy were very high, 92.6% and 81.1% respectively; while the use of pornography was much lower (29.5%). In general, younger therapists and therapists with less experience, were more likely than older therapists and therapists with more experience to use SEM in sex therapy. Sex therapists were generally comfortable with sexually explicit educational material and erotica but less comfortable with pornography. Although the majority of therapists were not comfortable with the use of pornography, those who were comfortable were more likely to be younger therapists and/or female therapists. Also, although each person included in the survey was a member of AASECT and practiced sex therapy, only 30% identified their primary professional identity as a sex therapist. Professional identity was not related to use or feelings towards SEM.

One surprising finding was the lack of theory guiding the use of SEM, although these findings may have been impacted by participants interpreting “theoretical rationale” differently than predicted. The primary “theoretical rationale” reported by sex therapists for using SEM was education, while only eight therapists highlighted an actual theoretical framework (e.g., cognitive-behavioral therapy). Not surprising was that several therapists indicated that they would not recommend the use of SEM in sex therapy with clients who expressed opposition or discomfort, clients who exhibit sexually compulsive behaviors, and with clients who have a history of sexual trauma.

As stated in the introduction, sexually explicit material has been cited as an intervention in sex therapy (Woody, 1992), yet there are disagreements concerning the use of SEM in sex therapy (Jankovich & Miller, 1978; Maltz, 2009; Striar & Bartlik, 1999). With the increased

access to sexually explicit material in our society (Cooper, 1998), the media exposure of the sex therapy profession (Kleinplatz, 2009), and thus a likely increase in persons seeking help from sex therapists, the implications of these arguments become magnified. Whether or not the uses of some types of SEM are a help or hindrance to sex therapy clients has yet to be examined adequately. Unfortunately, it was beyond the scope of this study to examine the efficacy of SEM in sex therapy. However, answers to questions such as “How prevalent is the use of SEM in sex therapy?” and “Why do sex therapists use SEM?” do provide empirical grounding for future studies.

Prevalence of SEM Use

As mentioned previously, the use of SEM is noted as a sex therapy intervention and 74% of US and Czech/Slovak mental health and health professionals reported “ever” using SEM (type not specified) in their work (Robinson, 1999). However, no previous research has presented how common the use of each type of SEM is among sex therapists, as well as how often they use each type of SEM. In examining this research question, it seems that the prevalence of professional SEM use among sex therapists is substantially higher than what was reported among mental health and health professionals generally. Prevalence rates in the current study also seem to be predicated upon type of SEM, with exceptionally high rates of use with educational material (92.6%) and erotica (81.1%) and a much lower prevalence rate with pornography (29.5%). This result seemed to highlight a theme in this study in that participant’s had similar rates of use and feelings regarding the helpfulness of sexually explicit educational material and erotica, and much lower rates of use and greater concerns about the helpfulness of pornography. This theme was interesting considering the literature offers a clearer distinction between educational material and erotica/pornography than between erotica and pornography (Robinson et al., 1996).

The large difference between responses regarding the use of sexually explicit educational material/erotica and pornography in the current study could be influenced by a couple factors. First, over the years pornography has developed a negative connotation in our society, often being associated with addiction and violence. On the other hand, erotica and educational material simply sound more benign. Secondly, pornography was defined in this study as content containing “dehumanizing” and/or violent content, whereas educational material and erotica were defined as material with the “sole purpose to educate” or “arouse” without sexist, dehumanizing content. When presented these options, it is likely that fewer professionals are going to use, or report using, “dehumanizing violent content.” Notwithstanding the negative description associated with pornography, as well as the accompanied derogatory connotations, still, nearly one-third indicated using pornography professionally.

The results of this study can be interpreted in different ways, depending on the position taken regarding the use of SEM in sex therapy. For example, the proponents of using SEM in sex therapy may see that most sex therapists use each type of SEM with less than 25% of their clients and suggest that those rates are expected and justified. Those opposed to the use of SEM in sex therapy may notice that nearly 1 out of 5 sex therapists use erotica with the majority of their clients and feel that too many therapists are using too much erotica. Proponents of SEM may look at the roughly 4% of therapists who use pornography with the majority of their clients and see nothing wrong with it. Those opposed may suggest that given the fact that much of what we know regarding pornography use is negative (Manning, 2006) it is shocking that any therapist reported using pornography with the majority of their clientele. Regardless of the position taken, with the negative connotation of pornography, it is understandable that sex therapists use educational material and erotica more frequently than pornography.

Several demographic variables were included in the study to determine if different types of individuals used SEM more or less often. Most notably, religiosity was found to have no significant relationship with the use of SEM in sex therapy. Although no prior studies have examined the relationship between religiosity and the use of SEM in sex therapy, studies have purported religiosity to be related to less favorable views towards SEM (Robinson, 1996; Lottes et al., 1993). The inability to replicate previous findings could be due to the low number of participants who identified as being anything more than “somewhat religious.”

Age, however, was significantly related to the use of erotica and pornography. The fact that younger therapists were more likely to report using SEM could simply be a generational effect with younger persons having more favorable views toward sexually explicit material and thus more inclined to use it professionally. Another factor that should be considered is the amount of clinical experience younger therapists have. Typically younger therapists have less clinical experience than older therapists, and in this study, therapists with more sex therapy experience were less inclined to use pornography in sex therapy. In a recent publication, one sex therapist reported that over the years her views towards pornography have changed as she worked with survivors of sexual abuse and considered further the negative content of pornography (Maltz, 2009). Obviously this experience cannot be projected upon all who choose not to use pornography in sex therapy; however this therapist’s decision did not appear to result from a generational effect. Additional research should be conducted to replicate these findings and to determine whether the results related to years of experience are important, above and beyond an age or generational cohort effect.

Feelings towards the Use of SEM in Sex Therapy

Results in the current study were similar to those presented by Robinson et al. (1996) regarding professionals' feelings towards sexually explicit materials. Although Robinson and colleagues distinguished the types of SEM differently than in the current study, in both studies, professionals held the most favorable views towards sexually explicit educational materials, followed by erotica (soft-core and hard-core material in Robinson's study), with the least favorable attitudes towards pornography (violent material and bizarre material in Robinson's study). Also, in both studies there were limited gender differences in most types of SEM. In Robinson's study there were no significant gender differences after controlling for religiosity. The current study found no significant gender differences in feelings toward educational material and erotica. There was, however, a significant gender difference in feelings towards pornography. In fact, the findings of the current study, that significantly more female therapists than male therapists expressed comfortable views towards pornography, were contrary to several studies which have examined gender differences and found males to have more favorable views toward SEM (Carroll et al., 2008; Cowan & Dunn, 1994; Leiblum et al., 1993). With a population of sex therapists and a relatively small sample size ($n = 99$), these findings cannot be generalized to the general public. However, these findings do suggest that perhaps there are additional variables which influence female sex therapists that do not impact women who are not sex therapists. Future research is needed to replicate these findings.

Least Helpful Components of SEM

In the debate regarding the use of SEM in sex therapy, little is known about what aspects of SEM are viewed as unhelpful. Sex therapists in the current study identified several aspects of SEM that they viewed as unhelpful, despite their widespread use and comfort with sexually

explicit educational material and erotica. Exacerbating body image concerns, facilitating unrealistic expectations, and being culturally distasteful were marked as the least helpful components of sexually explicit educational material and erotica. Two of these components, exacerbating body image concerns and facilitating unrealistic expectations, have also been expressed as negative effects on persons who view SEM or who have a partner who views SEM (Bergner & Bridges, 2002; Russell, 1980; Zillmann & Bryant, 1982). With the majority of sex therapists acknowledging potential negative effects of educational material and erotica, and yet reporting using this material with clients, future research should examine how the decision is made to use educational material and erotica with clients as well as how sex therapists account or assess for these potential negative effects.

Amidst the increase in clients' presenting to therapy with "sexual addiction" (Bird, 2006) it is interesting that the fewest number of participants noted "potential for addiction" as a "least helpful component of using SEM." It is also interesting that the number of sex therapists who indicated "potential for addiction" as a least helpful component of pornography (47.5%) nearly tripled the amount of sex therapists who indicated "potential for addiction" for educational material (16.3%) and erotica (17.5%). What is it about pornography that distinguishes it as something more addictive than erotica? Is there something in the actual content that is more addictive? Or is it simply a matter of frequently hearing the phrases "addicted to porn" and "porn addiction" rather than "addicted to erotica" and "erotica addiction" that this association is made with pornography and not erotica? Whatever the answers to these questions are, it is apparent that sex therapists view erotica to be much more similar to educational material than pornography. One concern this finding presents is that perhaps sex therapists utilize material under the pretense of "erotica," perceived as less capable of contributing to addiction [i.e., few

therapists associate erotica with addiction compared to pornography, over double the amount of therapists who reported using pornography (29.5%) reported using erotica (81.1%)], when in fact the “addictive” content in erotica and pornography may actually be quite similar. For instance, the initial pull to erotica and pornography is likely their ability to arouse sexually, which is often the intent of both pornography and erotica (Russell, 1980).

Instances in Which Sex Therapists Do Not Recommend Using SEM

Robinson and colleagues (1999) called for future research from both a professional and clients’ perspective to test their best practice recommendations on the therapeutic use of SEM. Although the current study did not examine the attitudes and feelings of clients, several sex therapists in this study did agree with their findings that suggested professionals use some degree of caution in using SEM with clients who have been sexually abused or with clients with strong religious convictions. In fact, many therapists in the current study simply recommended not using SEM with clients with a history of sexual trauma or strong cultural/religious beliefs in opposition of SEM.

The findings of the present study suggest an additional recommendation could be made to the list of best practices presented by Robinson and colleagues: to exercise caution in using SEM with clients who may be more susceptible to sexually compulsive behaviors. A number of therapists in this study indicated they would not recommend using SEM with clients who are addicted to pornography or exhibited compulsive sexual behavior. Additional research is needed to understand how sex therapists assess for these behaviors or conditions (i.e., sexual compulsivity, history of sexual abuse, and strong opposition to SEM) as well as how and why therapists decide to use or not use SEM in such cases.

Theoretical Rationales for Using SEM in Sex Therapy

Previously little research had been done to examine *why* SEM was used in sex therapy. One article, published over 20 years ago, suggested several educational theories and desensitization as the primary rationales used to justify the employment of SEM in sex therapy, none of which have enough empirical evidence to suggest clinical efficacy (Neidigh & Kinder, 1987). Results of the current study found similar theoretical rationales as those presented in Neidigh and Kinder's study. With education noted most frequently as the primary theoretical rationale for the use of SEM, it begs the question: What educational value does erotica and pornography possess that is not available in sexually explicit educational material? The negative implications of using educational material seem to pale in comparison with the potential negative implications of erotica or pornography, so why use them? A handful of therapists specified additional theoretical rationales, such as stimulation and arousal. While stimulation and arousal should not be considered a "theoretical rationale," it does offer a reason to use erotica or pornography over educational material. In fact, some believe that clients learn best when aroused (Striar & Bartlik, 1999). However, whether or not that reason is legitimate is unknown because it has yet to be tested empirically.

There were also a few therapists who did not report having a guiding theoretical rationale. Bearing in mind the potential negative effects of SEM, it is troubling that some sex therapists were unable to provide a framework for using SEM. With little empirical basis for the use of SEM in sex therapy, the theory or lack of theory ought to be examined further in order to determine if the use of SEM should be justified by these guiding theories.

Limitations and Future Directions

There were several limitations to the current study. First, the results of this study should be interpreted with a certain amount of caution because only 21% of those contacted chose to participate in the study. In addition, only 77% of those who did choose to participate ($n = 99$), completed the entire survey. Another limitation was that because sex therapists were invited to complete the survey via email, only those sex therapists that had an email address posted on AASECT's website were invited to participate. Therefore, these findings may not be generalized to all sex therapists, or even to all members of AASECT. Also, the categories of sexually explicit material, although defined in the study, were also subject to interpretation by each participant. Because of the difficulty in defining SEM, participants may have interpreted each definition of SEM according to their own preference and understanding, which was not likely to be a universal interpretation. In order to address the definitional difficulties of SEM, future researchers and practitioners should work together to establish standard, explicit definitions of each type of sexually explicit material. Lastly, some questions (e.g., "What is your primary theoretical rationale for the use of SEM?") were vague and could have been interpreted in different ways by the participants.

This was an exploratory study and therefore was limited in scope regarding the use of SEM in sex therapy. Although there is limited research about the impact of SEM in sex therapy, there is evidence which suggests that SEM may have a negative influence on some individuals, couples, and families (Bergner & Bridges, 2002; Manning, 2006; Oddone-Paolucci et al., 2000). Therefore, sex therapists should be judicious in utilizing this method with clients. With the potential downside of SEM (Court, 1984; Maltz, 2009; Neidigh & Kinder, 1987), future research must carefully examine the efficacy of SEM in sex therapy. This examination should be

administered from both the perspective of therapist and client and look at short and long term effects. In doing so, therapists may have confidence that the methods involving SEM are empirically sound and clinically helpful. Also, with education reported as the most prominent rationale guiding the use of SEM, the educational value of erotica and pornography needs to be evaluated further in order to determine their place in sex therapy.

Conclusion

Notwithstanding the limitations of this study, several important discoveries were made. Prior to this study, little was known about how often SEM was used in sex therapy. We now know that the use of sexually explicit educational material and erotica are methods the vast majority of sex therapists in this sample use and that younger therapists and therapists with less clinical experience are more likely to use them. We also learned that sex therapists in this sample viewed erotica much differently than they did pornography, although some previous research assessing the negative effects of SEM have not adequately distinguished between pornography and erotica. These findings increase the urgency of future research to determine whether or not all types of SEM are actually helpful or if in some instances, like suggested by the findings of this study, SEM is less helpful or should not be recommended. The findings of the current study are an initial step in understanding the use of SEM among therapists and the results of this study call for additional research to examine the efficacious use of SEM in sex therapy.

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Appendix A - Tables

Table 1.

Demographic Information for the Sample (n=99)

	<i>n</i>	<i>%</i>
Gender		
Male	32	32.3
Female	67	67.7
Age		
40's and younger	15	15.2
50's	33	33.3
60's and older	51	51.5
Marital Status		
Married/Remarried	73	73.7
Not Married	26	26.3
Religious Affiliation		
Catholic	12	12.1
Christian	29	29.3
Jewish	18	18.2
None	25	25.3
Other	15	15.2
Professional Identity		
Marriage and Family Therapist	20	20.2
Psychologist	30	30.3
Sex Therapist	29	29.3
Other	20	20.2
Geographical Location		
Northeast	26	26.3
Southeast	20	20.2
Mideast	14	14.1
Midwest	12	12.1
Intermountain West	11	11.1
Pacific Coast	16	16.2
Years Practiced Sex Therapy		
10 years or less	24	24.2
11-20 years	17	17.2
21-30 years	27	27.3
More than 30 years	28	28.3
Client Population		
Mostly Individuals	12	15.6
Individuals and Couples equally	48	62.3
Mostly Couples	17	22.1
Exposure of SEM in graduate training		
None	53	55.2
Discussion only	10	10.4
Viewing and discussing SEM	29	30.2
Did therapy with SEM in grad program	4	4.2

Table 2.

Percentage of Feelings towards the Use of Sexually Explicit Material in Sex Therapy

SEM	<i>n</i>	<u>Percentage of Feelings towards SEM in Sex Therapy</u>		
		Uncomfortable	Neutral	Comfortable
SEM in General	95	4.2	8.4	87.4
Educational	95	4.2	12.6	83.2
Erotica	95	15.8	10.5	73.7
Pornography	95	50.5	23.2	26.3

Table 3.

Variables Associated with the Feelings towards the Use of Pornography in Sex Therapy

Variable and Level	n	Percentage of Feelings towards Pornography in Sex Therapy		
		Uncomfortable	Neutral	Comfortable
Gender				
Male	31	67.7	9.7	22.6
Female	64	42.2	29.7	28.1
			$\chi^2 (2) = 6.55, p < .05$	
Age				
40's and younger	13	23.1	23.1	53.8
50's	33	39.4	27.3	33.3
60's and older	49	65.3	20.4	14.3
			$\chi^2 (4) = 12.32, p < .05^*$	
Marital Status				
Married	71	52.1	26.8	21.1
Not Married	24	45.8	12.5	41.7
Professional Identity				
MFT	19	63.2	15.8	21.1
Psychologist	29	48.3	27.6	24.1
Sex Therapist	28	46.4	21.4	32.1
Other	19	47.4	26.3	26.3
Years Practiced Sex Therapy				
10 Years or less	23	47.8	26.1	26.1
11-20 Years	17	41.2	29.4	29.4
21-30 Years	27	55.6	14.8	29.6
More than 30 Years	28	53.6	25.0	21.4

* Cells with expected count less than 5 exceed Chi Square assumption criteria.

Table 4.

Variables Associated with Use of Sexually Explicit Material in Sex Therapy

Variable and Level	<i>n</i>	Percentage Use SEM or Do Not Use SEM					
		Use Educ	Not Use	Use Erotica	Not Use	Use Porn	Not Use Porn
Overall	95	92.6	7.4	81.1	18.9	29.5	70.5
Gender							
Male	31	90.3	9.7	71.0	29.0	22.6	77.4
Female	64	93.8	6.3	85.9	14.1	32.8	67.2
$\chi^2 (1) = 3.05, p < .1$							
Age							
40's and younger	13	100.0	0.0	92.3	7.7	76.9	23.1
50's	33	93.9	6.1	90.9	9.1	36.4	63.6
60's and older	49	89.8	10.2	71.4	28.6	12.2	87.8
$\chi^2 (2) = 6.12, p < .05$ $\chi^2 (4) = 21.83, p < .001$							
Marital Status							
Married	71	93.0	7.0	81.7	18.3	26.8	73.2
Not Married	24	91.7	8.3	79.2	20.8	37.5	62.5
Professional Identity							
MFT	19	84.2	15.8	78.9	21.1	21.1	78.9
Psychologist	29	89.7	10.3	79.3	20.7	31.0	69.0
Sex Therapist	28	96.4	3.6	82.1	17.9	28.6	71.4
Other	19	100.0	0.0	84.2	15.8	36.8	63.2
Years Practiced Sex Therapy							
10 Years or less	23	95.7	4.3	87.0	13.0	52.2	47.8
11-20 Years	17	100.0	0.0	76.5	23.5	29.4	70.6
21-30 Years	27	88.9	11.1	85.2	14.8	22.2	77.8
More than 30 Years	28	89.3	10.7	75.0	25.0	17.9	82.1
$\chi^2 (4) = 8.20, p < .05$							

Table 5.

Frequency Report for What Sex Therapists Believe is Most Helpful in Using SEM (N =80)

Variables	Educational (%)	Erotica (%)	Pornography (%)
Efficiency of communication of sexual material	71 (88.8)	42 (52.5)	10 (12.5)
Power of visual stimuli	56 (70.0)	56 (70.0)	35 (43.8)
Facilitating a sense of ease with his/her own sexuality	65 (81.3)	57 (71.3)	10 (12.5)
Desensitize against sexual anxiety	59 (73.8)	45 (56.3)	10 (12.5)
Erotic arousal	49 (61.3)	62 (77.5)	36 (45.0)
Novelty	20 (25.0)	29 (36.3)	26 (32.5)
No components of SEM are helpful	1 (1.3)	8 (10.0)	28 (35.0)

Table 6.

Frequency Report for What Sex Therapists Believe is Least Helpful in Using SEM (N =80)

Variables	Educational (%)	Erotica (%)	Pornography (%)
Culturally distasteful	46 (57.5)	46 (57.5)	56 (70.0)
Potential for addiction	13 (16.3)	14 (17.5)	38 (47.5)
Dehumanizing own sexuality	20 (25.0)	22 (27.5)	60 (75.0)
Exacerbating body image concerns	48 (60.0)	51 (63.8)	59 (73.8)
Facilitate unrealistic expectations	46 (57.5)	54 (67.5)	66 (82.5)
Detaching spiritual and physical dimensions of sexuality	16 (20.0)	22 (27.5)	51 (63.8)
All components of SEM are helpful	10 (12.5)	8 (10.0)	3 (3.8)

Appendix B - Survey Questions

1. What is your age?
 - a. 20's
 - b. 30's
 - c. 40's
 - d. 50's
 - e. 60's
 - f. 70's and above
2. What is your gender?
 - a. Male
 - b. Female
 - c. Transgendered
3. What is your marital status?
 - a. Single
 - b. Single, but in relationship
 - c. Married
 - d. Divorced and Single
 - e. Remarried
 - f. Widowed
4. What is your religious affiliation?
 - a. Catholic
 - b. Mainline Protestant Christian
 - c. LDS (Latter-day Saint)
 - d. Other Christian
 - e. Jewish
 - f. Muslim
 - g. Buddhist
 - h. Hindu
 - i. None
 - j. Other
5. What is your level of religiosity? (How religious are you by your religion's standards?)
 - a. Not at all religious
 - b. Not very religious
 - c. Somewhat religious
 - d. Very religious
 - e. Extremely religious
6. In what geographical region do you do most of your work?
 - a. Northeast (MD, DC, PA, NY, DE, NJ, CT, MA, RI, NH, VT, ME)
 - b. Southeast (VA, WV, NC, SC, KY, TN, GA, FL, AL, AR, LA, MS, PR)

- c. Mideast (OH, IN, MI, IL, WI,)
 - d. Midwest (MN, ND, SD, IA, NE, KS, MO)
 - e. Southwest (OK, TX, AZ, NM)
 - f. Mountain States (CO, UT, NV, WY, MT, ID)
 - g. Pacific Coast (CA, OR, WA, AK, HI)
7. Which of the following best describe your professional identity?
- a. Counselor
 - b. MFT
 - c. Psychologist
 - d. Psychiatrist
 - e. Sex Therapist
 - f. Social Worker
 - g. Other
8. Did your training to become a sex therapist include implicit SEM, explicit SEM, both implicit and explicit SEM, or no SEM?
- a. Implicit SEM
 - b. Explicit SEM
 - c. Both implicit and explicit SEM
 - d. No SEM
9. Was the core of your training in_____
- a. Counseling
 - b. Marriage and Family Therapy
 - c. Psychology
 - d. Psychiatry
 - e. Sex Therapy
 - f. Social Work
 - g. Other (please specify)
10. In your graduate training, what was the exposure you had to SEM?
- a. None
 - b. Discussion only
 - c. Viewing and Discussing SEM
 - d. Did therapy using SEM in graduate program
11. How pervasive was the use of SEM in your core program?
- a. Never
 - b. 1 or 2 classes
 - c. 4 or 5 classes
 - d. Majority of classes
12. How long have you practiced sex therapy?
- a. 5 years or less
 - b. 5-10 years

- c. 11-20 years
 - d. 21-30 years
 - e. More than 30 years
13. How would you best describe your feelings towards sexually explicit material in general?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
14. How would you describe your feelings towards the use of sexually explicit educational material in sex therapy?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
15. How would you describe your feelings towards the use of erotica in sex therapy?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
16. How would you describe your feelings towards the use of pornography in sex therapy?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
17. At what point in the process of therapy do you decide to use sexually explicit educational material in sex therapy?
- a. Assessment
 - b. Diagnosis
 - c. Education
 - d. Early therapeutic intervention
 - e. Later therapeutic intervention
18. At what point in the process of therapy do you decide to use erotica in sex therapy?
- a. Assessment
 - b. Diagnosis
 - c. Education
 - d. Early therapeutic intervention

- e. Later therapeutic intervention
19. At what point in the process of therapy do you decide to use pornography in sex therapy?
- a. Assessment
 - b. Diagnosis
 - c. Education
 - d. Early therapeutic intervention
 - e. Later therapeutic intervention
20. In general, what is your client's initial reaction to sexually explicit educational material?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
21. In general, what is your client's initial reaction to erotica?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
22. In general, what is your client's initial reaction to pornography?
- a. Very uncomfortable
 - b. Uncomfortable
 - c. Neutral
 - d. Comfortable
 - e. Very comfortable
23. Identify which type of sexually explicit material you would consider using with the following client concerns:
- a. Hyposexual disorder
 - i. None
 - ii. Sexually explicit educational material
 - iii. Erotica
 - iv. Pornography
 - b. Arousal concerns
 - i. None
 - ii. Sexually explicit educational material
 - iii. Erotica
 - iv. Pornography
 - c. Erectile Dysfunction
 - i. None
 - ii. Sexually explicit educational material

- iii. Erotica
 - iv. Pornography
 - d. Primary orgasmic disorder
 - i. None
 - ii. Sexually explicit educational material
 - iii. Erotica
 - iv. Pornography
 - e. Sexual Anxiety
 - i. None
 - ii. Sexually explicit educational material
 - iii. Erotica
 - iv. Pornography
24. Overall, how effective do you feel sexually explicit educational material is in treating the following problems:
- a. Hyposexual disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - b. Arousal concerns
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - c. Erectile Dysfunction
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - d. Primary orgasmic disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - e. Sexual Anxiety
 - i. Very ineffective

- ii. Ineffective
- iii. Sometimes effective
- iv. Effective
- v. Very effective

25. Overall, how effective do you feel erotica is in treating the following problems:

- a. Hyposexual disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
- b. Arousal concerns
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
- c. Erectile Dysfunction
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
- d. Primary orgasmic disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
- e. Sexual Anxiety
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective

26. Overall, how effective do you feel pornography is in treating the following problems:

- a. Hyposexual disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective

- iv. Effective
 - v. Very effective
 - b. Arousal concerns
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - c. Erectile Dysfunction
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - d. Primary orgasmic disorder
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
 - e. Sexual Anxiety
 - i. Very ineffective
 - ii. Ineffective
 - iii. Sometimes effective
 - iv. Effective
 - v. Very effective
- 27. With what percentage of clients do you use sexually explicit educational material?
 - a. Never
 - b. Below 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% and above
- 28. With what percentage of clients do you use erotica?
 - a. Never
 - b. Below 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% and above
- 29. With what percentage of clients do you use pornography?
 - a. Never

- b. Below 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% and above
30. What components of sexually explicit educational material are most helpful? (check all that apply)
- a. Efficiency of the transfer of sexual material
 - b. Power of visual stimuli
 - c. Facilitate a sense of ease with his/her own sexuality
 - d. Desensitize against sexual anxiety
 - e. Erotic arousal
 - f. Novelty
 - g. Other (please specify)
31. What components of sexually explicit educational material are least helpful? (check all that apply)
- a. Culturally distasteful
 - b. Potential for addiction
 - c. Dehumanizing own sexuality
 - d. Exacerbating body image concerns
 - e. Facilitate unrealistic expectations
 - f. Detaching spiritual and physical dimensions of sexuality
 - g. Other (please specify)
32. What components of erotica are most helpful?
- a. Efficiency of the transfer of sexual material
 - b. Power of visual stimuli
 - c. Facilitate a sense of ease with his/her own sexuality
 - d. Desensitize against sexual anxiety
 - e. Erotic arousal
 - f. Novelty
 - g. Other (please specify)
33. What components of erotica are least helpful?
- a. Culturally distasteful
 - b. Potential for addiction
 - c. Dehumanizing own sexuality
 - d. Exacerbating body image concerns
 - e. Facilitate unrealistic expectations
 - f. Detaching spiritual and physical dimensions of sexuality
 - g. Other (please specify)
34. What components of pornography are most helpful?
- a. Efficiency of the transfer of sexual material

- b. Power of visual stimuli
 - c. Facilitate a sense of ease with his/her own sexuality
 - d. Desensitize against sexual anxiety
 - e. Erotic arousal
 - f. Novelty
 - g. Other (please specify)
35. What components of pornography are least helpful?
- a. Culturally distasteful
 - b. Potential for addiction
 - c. Dehumanizing own sexuality
 - d. Exacerbating body image concerns
 - e. Facilitate unrealistic expectations
 - f. Detaching spiritual and physical dimensions of sexuality
 - g. Other (please specify)
36. How much do your clients use SEM at home in conjunction with therapy?
- a. Never
 - b. Seldom
 - c. Occasionally
 - d. Frequently
 - e. Very frequently
37. How percentage of your clients use SEM in their sex life at home unrelated to therapy?
- a. Never
 - b. Under 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% or more
38. What percentage of your clients use SEM, as a couple in their sex life at home, unrelated to therapy?
- a. Never
 - b. Under 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% or more
39. When you introduce SEM to clients, what percentage of clients have been exposed to SEM or have utilized SEM previously?
- a. Never
 - b. Under 25%
 - c. 26-50%
 - d. 51-75%
 - e. 76% or more

40. How would you describe your client population?
 - a. Individuals only
 - b. Mostly individuals
 - c. Individuals and couples evenly
 - d. Mostly couples
 - e. Couples only
41. When you see people in sex therapy, do you tend to see individuals, couples, or both individuals and couples?
 - a. Individuals
 - b. Couples
 - c. Both individuals and couples
42. Typically when you administer SEM, which type of client population do you tend to use it with most?
 - a. Individuals
 - b. Couples
 - c. Either individuals and couples
 - d. Don't use SEM with any clients
43. How do you introduce SEM to clients?
44. If clients are uncomfortable with SEM, how do you handle the situation?
45. If you push past client discomfort, how do you do it?
46. What is your primary theoretical rationale for using SEM?
47. Are there any instances in which you would not recommend using SEM?
 - a. Yes (what are they?)
 - b. No
48. Anything else you would like to share?